AMMIS Claims User Manual

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1. Document Control

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1.1 Document Information Page

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1.2 Amendment History

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

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
20110810	1.1		EIP CO8123	Added the following reports: CLM-4710-Q, CLM-4720-Q, CLM-4760-Q, CLM-4770-Q, CLM-4810-Q, CLM-4820-Q, CLM-4830-Q, CLM-4860-Q, CLM-4870-Q
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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				6.19 UB04 Navigation Panel Added the following new Panel: 6.46 NCCI Related History Panel
20110928	2.0		Agency approved	
20111107	2.1		Application of HIPAA EIP 5010 changes	CO 9018 – Added new fields:Medicare Copay Amount and Medicaid Late Filing Amount Medicare Information- Physician Panel (6.43.2, 6.43.3 and 6.43.4) Medicare Information – UB-04 Panel (6.44.2, 6.44.3, 6.44.4) CO 8788 – expand prescription number field from 7 to 12 characters. Pharmacy Data Correction Panel (6.69.1, 6.69.2, 6.69.3) CO 9027 - Increased Medical Record # from 30 to 50 characters. Physician Data Correction Panel (6.70.3) Physician Claim Panel (6.12.3) UB-04 Claim Panel (6.16.3) UB-04 Claim Correction Panel (6.71.3) **CO 9264 -** added “Other Payer Pat Resp Amt field. Pharmacy Claim Panel (6.8.3) - Pharmacy Data Correction Panel (6.69.2, 6.69.3) **CO 8634 –** expanded HIPAA value field from 30 to 50 characters. Claim Reference Detail Panel (6.22.2, 6.22.3) **CO 8675 –** Diagnosis Ind field – changed value from 1-8 to 1 to 12 for electronic claims. **Note:** Field displays the Maximum four Diagnosis Ind.) Physician Claim Detail Panel (6. 13.3) Physician Data Correction Panel (6.70.2, 6.70.3, 6.70.4) **CO 8687 –** changed last name length and size from 35 to 60 characters. Additional Claim Information Panel (6.29.2, 6.29.3)

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

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

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

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

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

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

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

1.3 Related documentation

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

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2. Claims Introduction

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

This manual covers the following:

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

2.1 Claims User Manual Objective

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

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

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3. Claims Overview

3.1 Introduction to Claims

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

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

The AMMIS Claims Processing function includes:

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

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4. Claims Review System Navigation

4.1 Overview

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

4.2 System Security

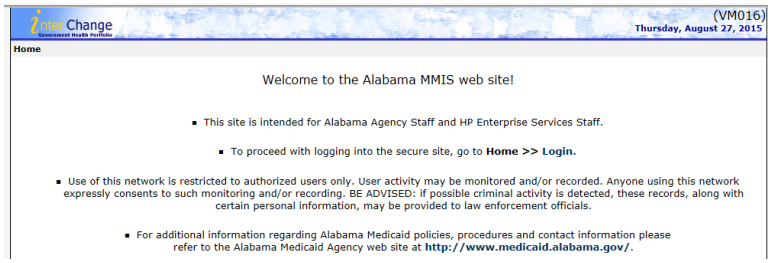
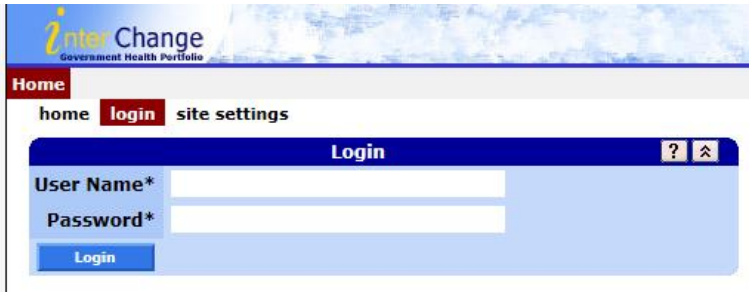
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

4.3 Logging In/Logging Out

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

4.3.1 Logging into the AMMIS

Follow the steps below to log in to the website:

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

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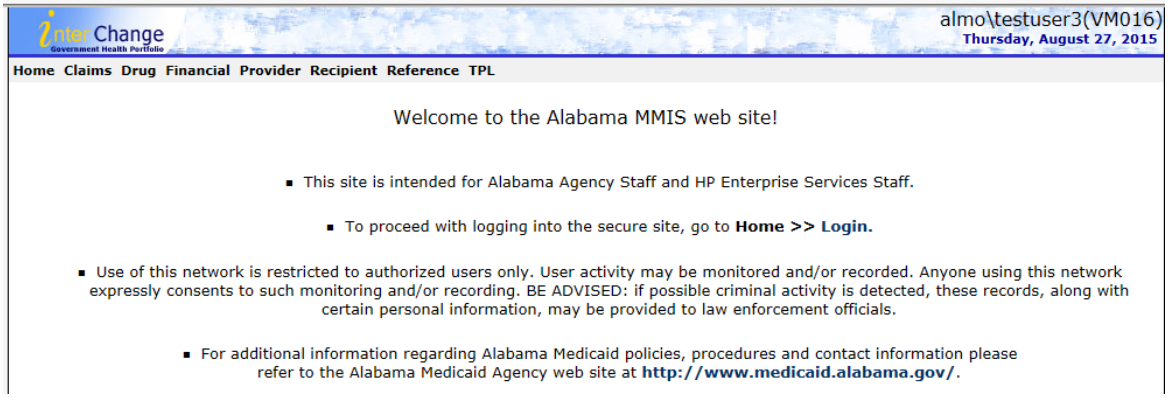
Step	Action	Response
		

4.3.2 Logging off the AMMIS

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

4.4 Changing Passwords

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

Navigation Path: [Home] – [Change Password]

NOTE:

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

Follow the steps below to change your password:

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

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

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The following message displays if an invalid password is entered:

EDS Domain Password Manager

Error: Invalid username or password

Back

The following message displays upon successful password change:

iTRACE Password Manager

Password successfully changed.

" Back to "

4.5 Screen Display Features

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

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

4.5.1 To Set System Text Size

To set system text size, perform the following steps:

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

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5. System Wide Common Terminology and Layouts

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

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

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

Page

Page Header

Page Footer

Sub Menu

Shortcut Keys (ctrl + alt + letter)

Main Menu bar

Panel

Advanced Search

Mini Search panel

Hot Link

Information panel

Navigation panel

Task List panel

Title Bar Icons

Help Functionality

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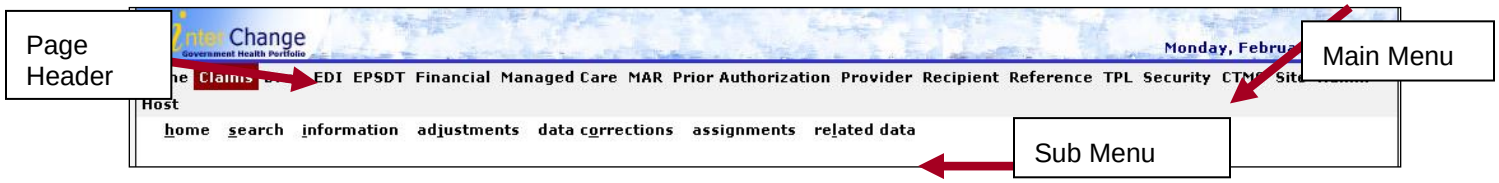
5.1 Page Layout

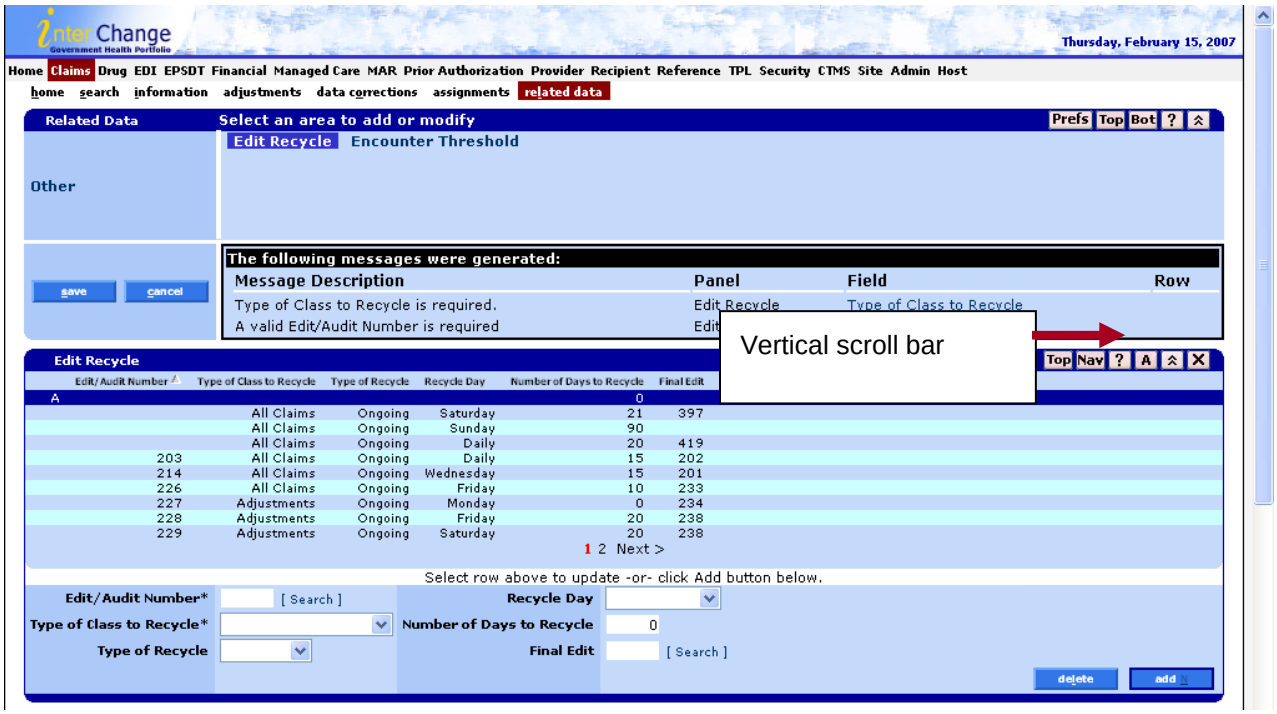
A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed, a Main Menu bar, a Sub Menu, and any associated panels. The bottom of the page contains the Page Footer with the HPE copyright text displayed.

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

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



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



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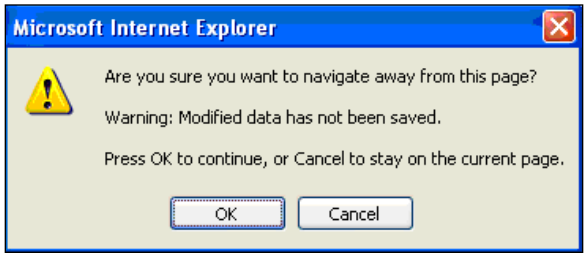
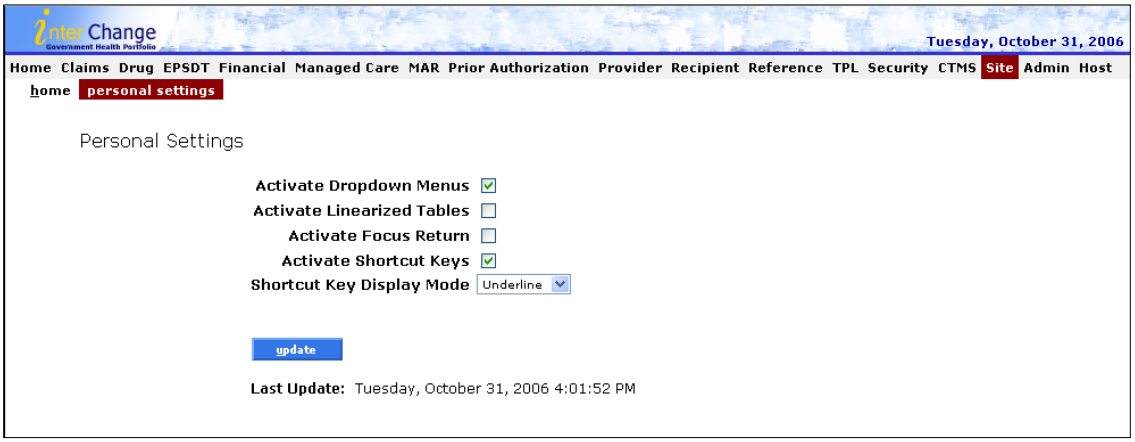
If a user attempts to add, update, or delete information within the page, then tries to navigate away from the page without saving or canceling the changes, the system prompts the user with a pop-up window message. When the system generates the message, the detail panels are locked open, and navigation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



5.2 Shortcut Keys

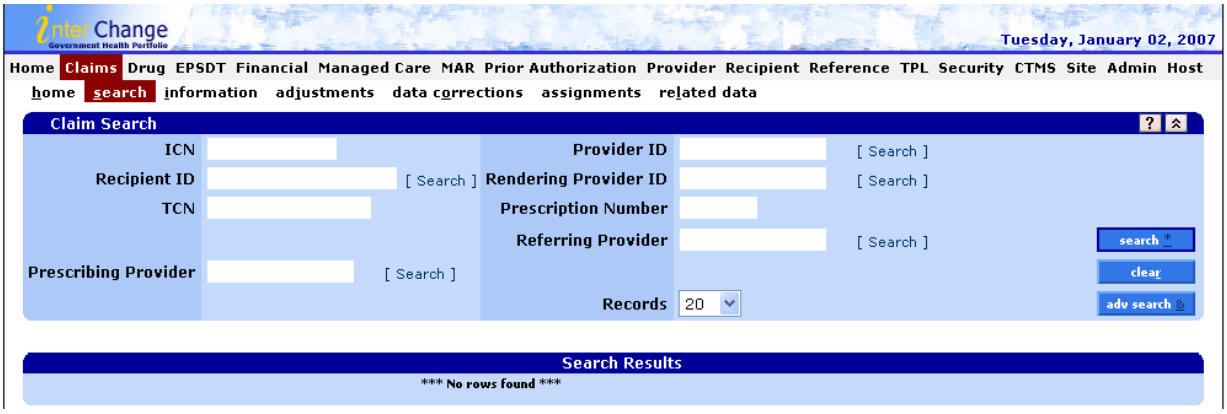
If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + letter) to quickly open the associated page.

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



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

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



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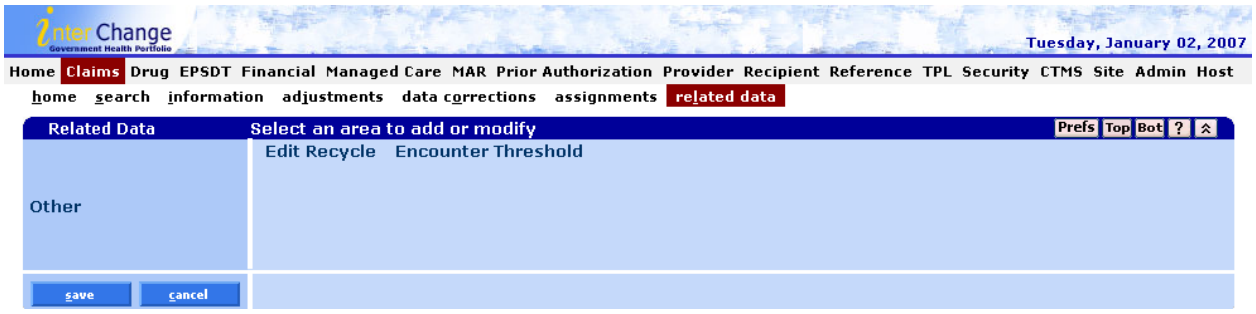


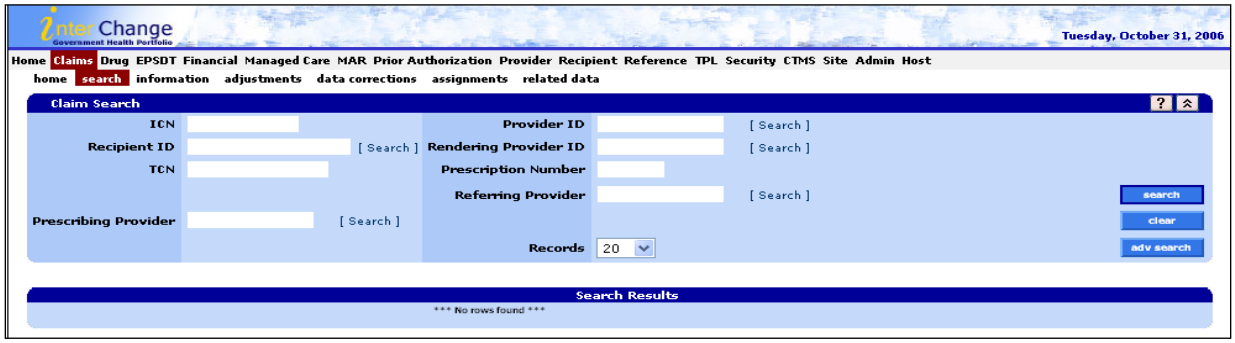
5.3 Search Options

There are several search options available within theAMMIS.

5.3.1 Search Panels

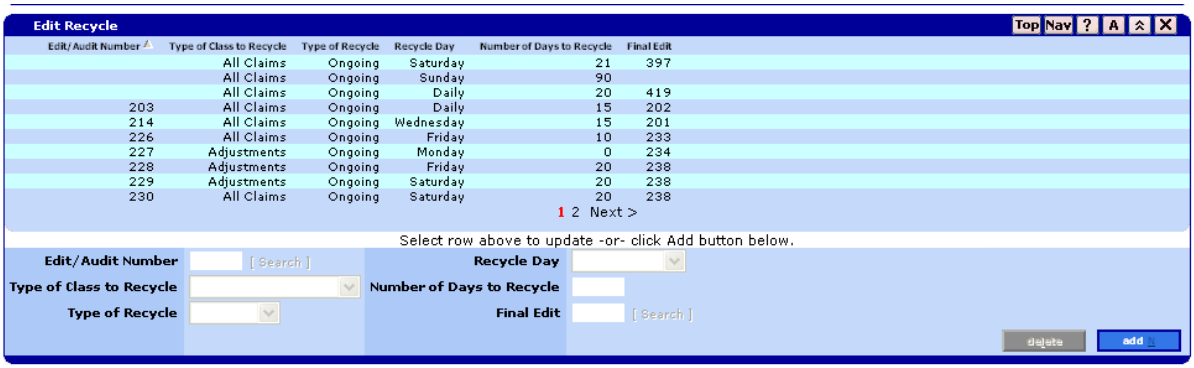
The AMMIS contains more than one type of search panel: Search and Advanced Search. Some subsystems such as the Claims subsystem contain a search panel without an advanced search button included on the panel, such as the image below.

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



5.3.2 Search Results

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



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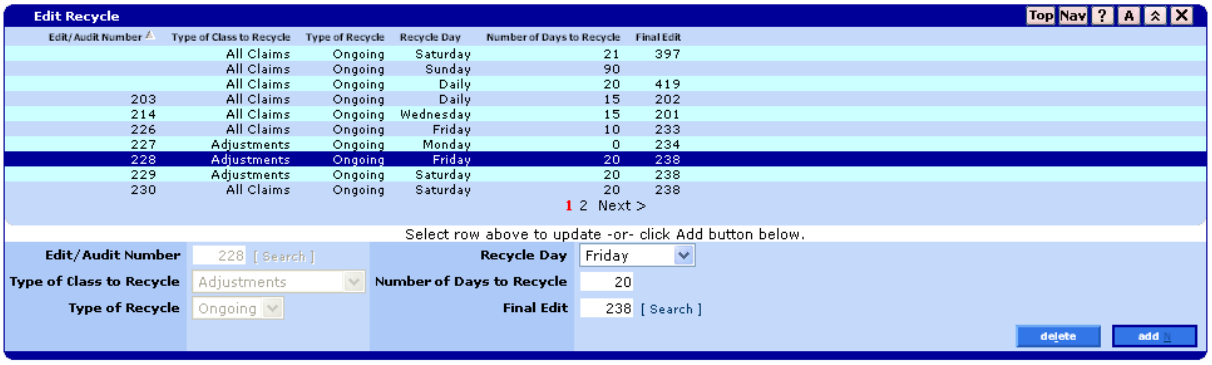
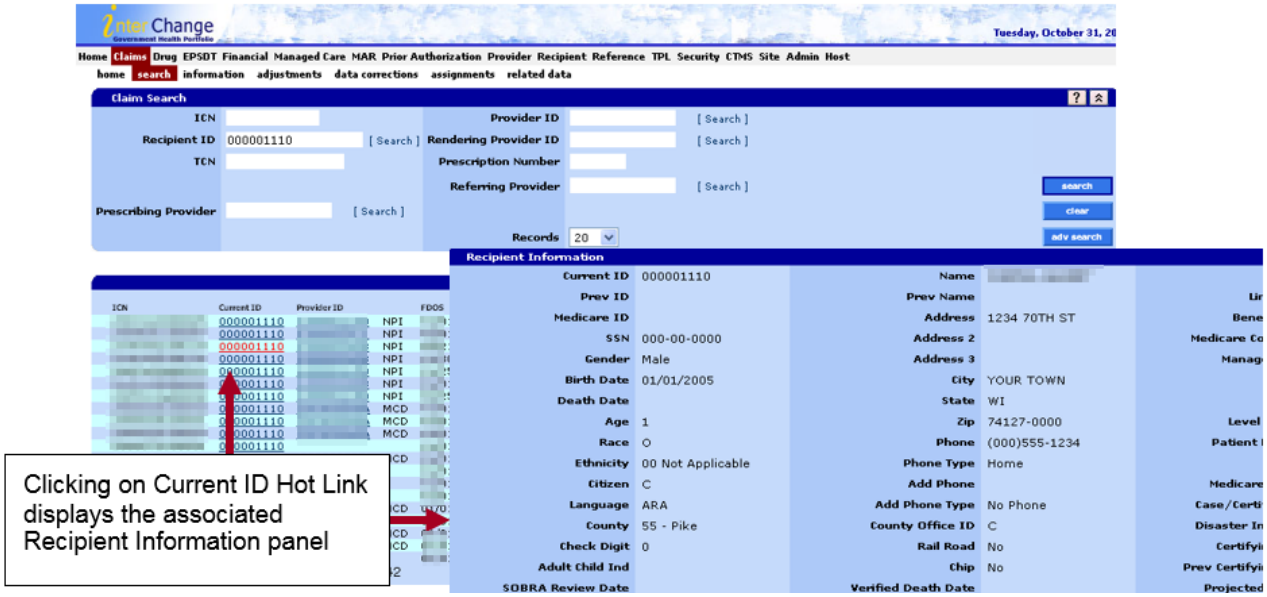
If the user clicks once on a search result row, the associated information panel opens. In the following figure, the user clicks the eighth row of the Edit Recycle and detailed information is displayed at the bottom of the panel.



5.3.3 Hot Links

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



5.3.4 Mini Search

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

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

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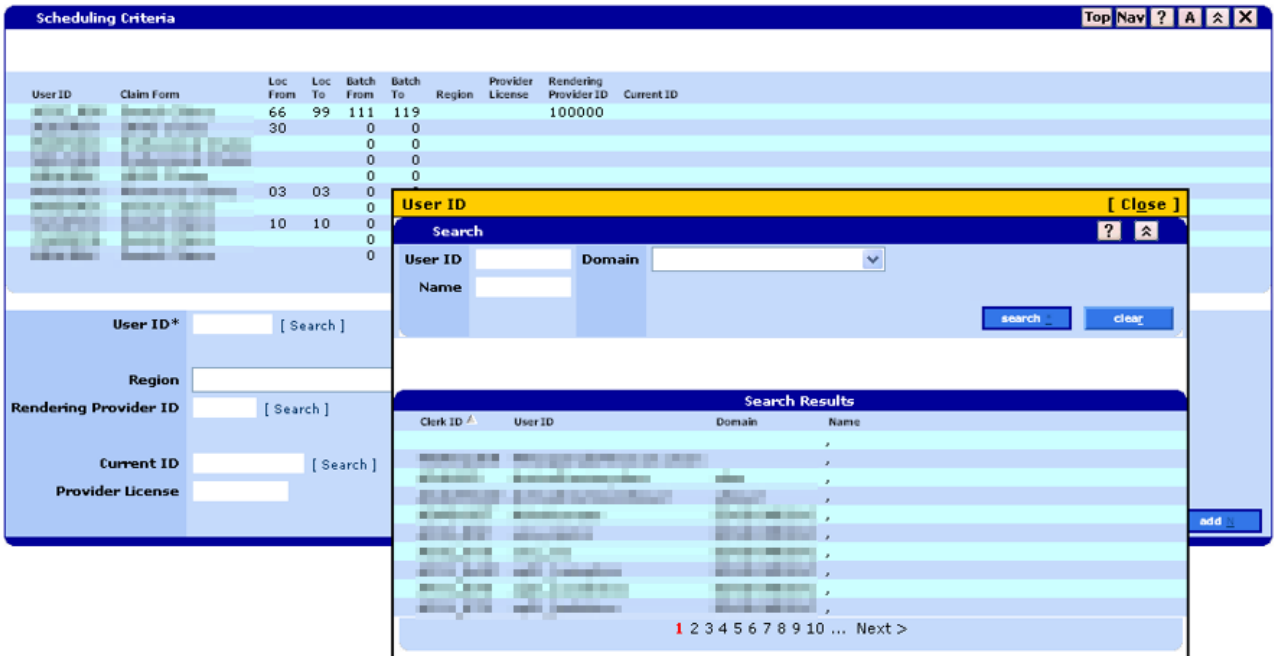
5.3.5 Pop-Up Search

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



5.4 Panel Layout

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

5.4.1 Panel Type and Functions

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

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

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

Among the panel types are the following:

Maintenance Panel

Task List Panel

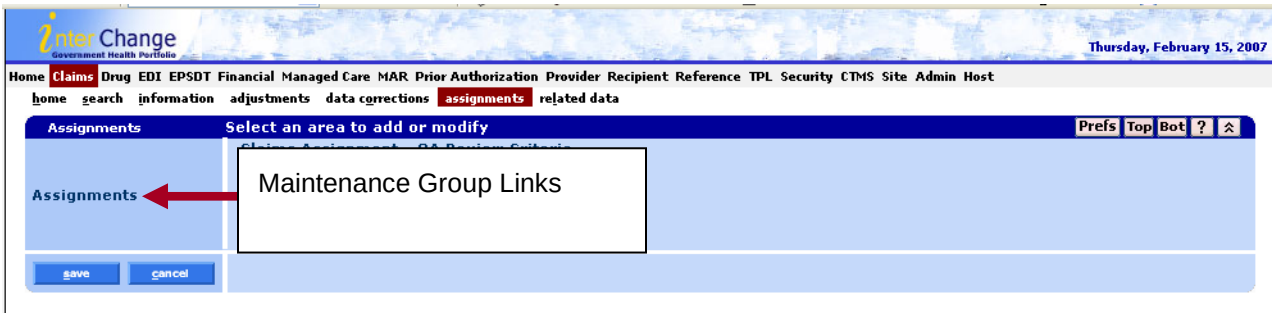
Maintenance Item Panel

Audit Panel

5.4.2 Maintenance Panel

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

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



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

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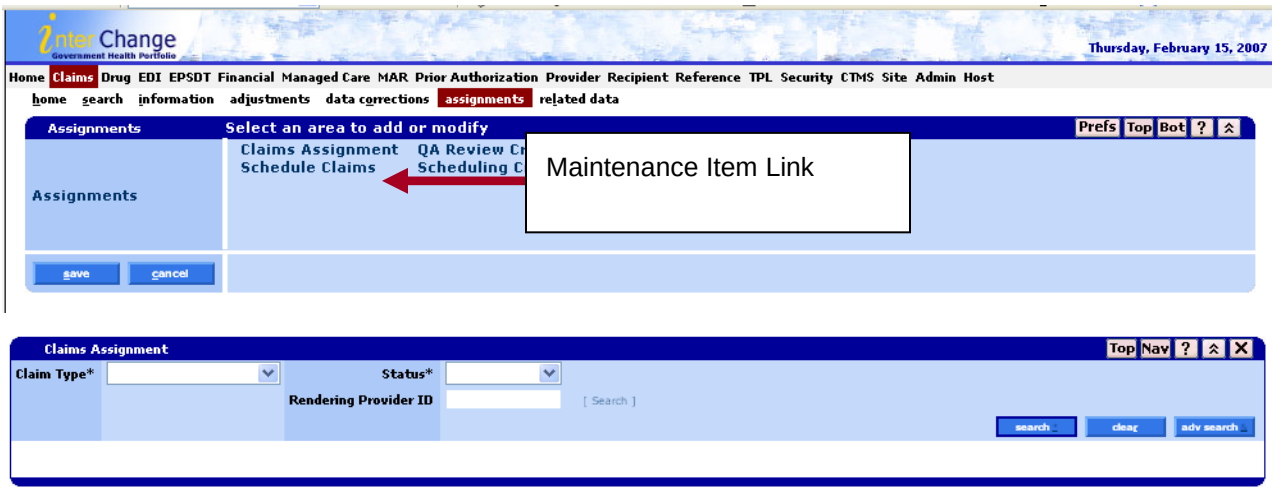
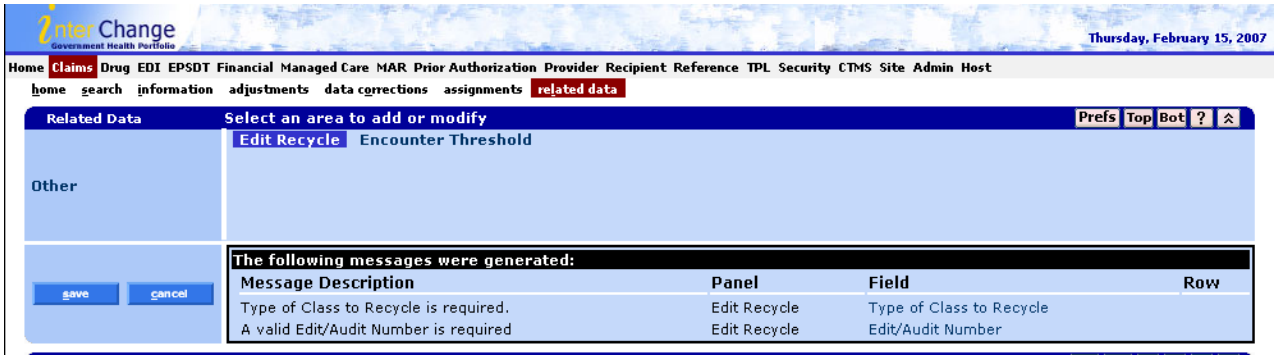


5.4.3 Task List Panel

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



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

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

5.4.4 Maintenance Item Panel

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

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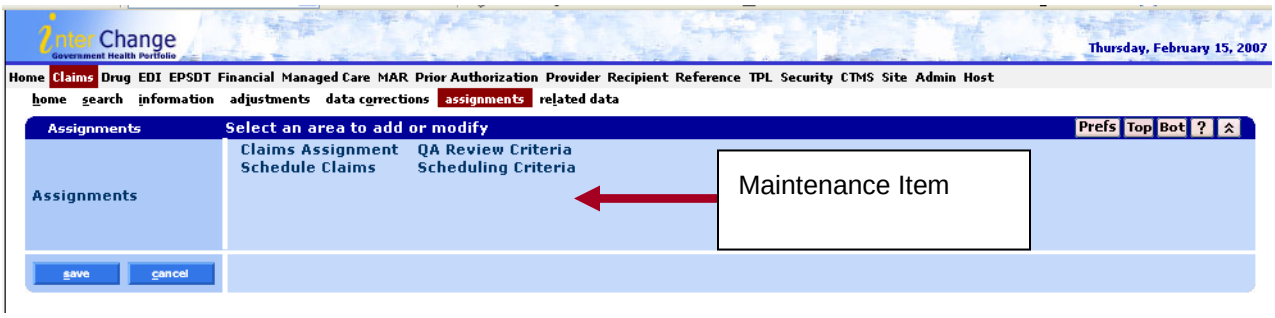
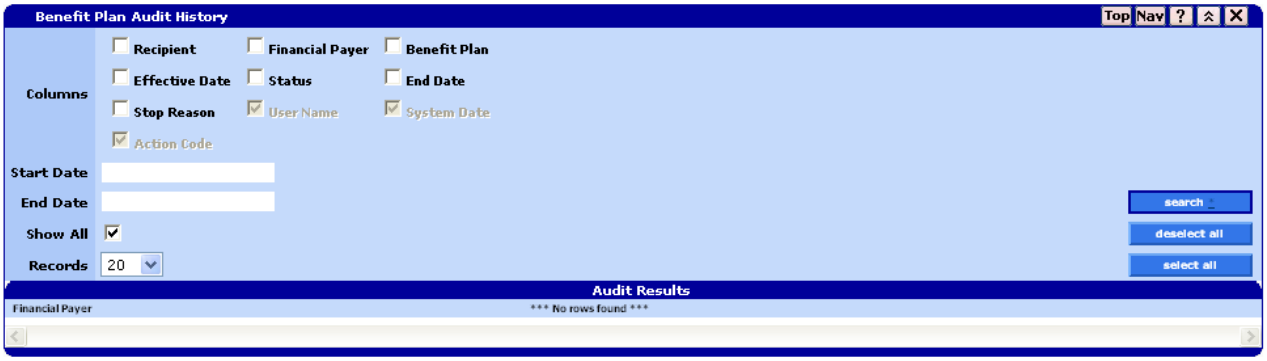


5.4.5 Audit Panel

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

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



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5.5 Help Functionality

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

5.5.1 Question Mark Icon ?

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

5.5.1.1 Panel Help Feature - Question Mark Function Description

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

Edit Recycle

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

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

Table: t_edit_recycle

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

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

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

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

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

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

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

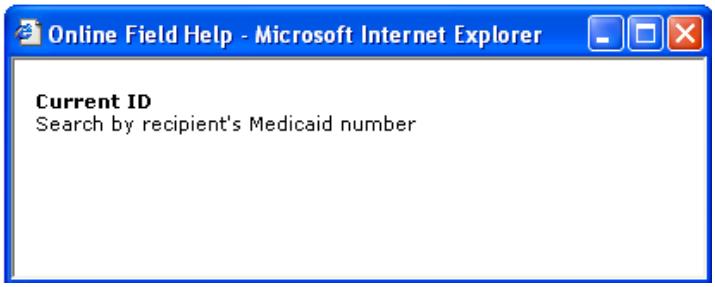
5.5.2 Field Level Help

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

5.5.2.1 Field Level Help Description

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

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



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

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6. Claim Pages/Panels

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

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

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

Each panel covers the following:

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

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6.1 Claim Search Panel

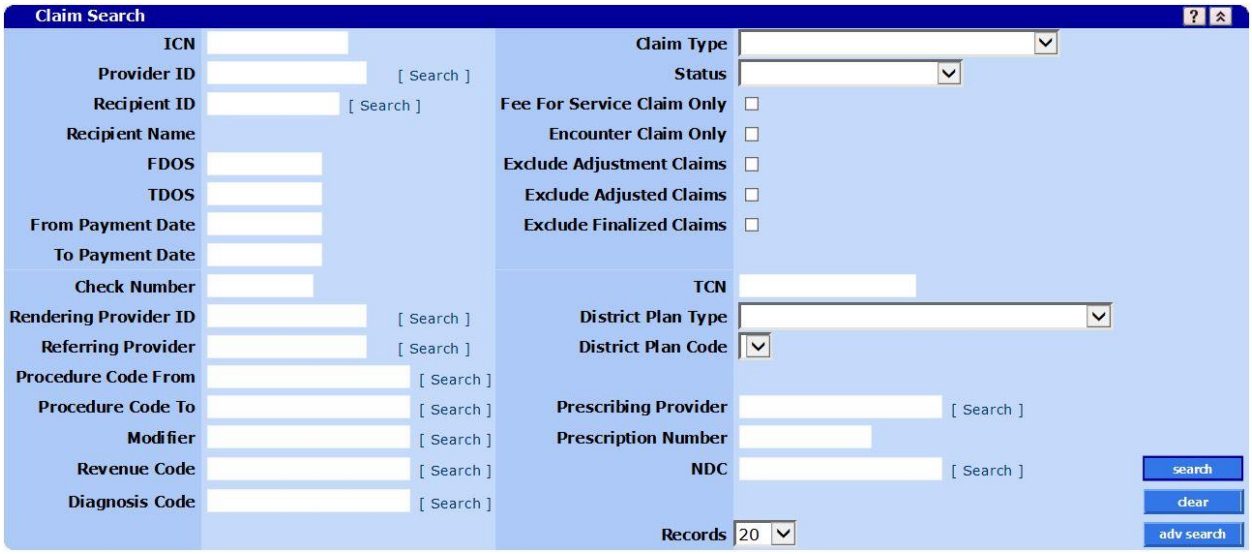
6.1.1 Claim Search Panel Narrative

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

This panel is inquiry only.

Navigation Path: [Claims] – [Search]

6.1.2 Claim Search Panel Layout



6.1.3 Claim Search Panel Field Descriptions

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

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

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

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

6.1.4 Claim Search Panel Field Edit Error Codes

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

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

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

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

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6.1.5 Claim Search Panel Extra Features

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

6.1.6 Claim Search Panel Accessibility

6.1.6.1 To Access the Claim Search Panel

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

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6.2 Claim Search Results Panel

6.2.1 Claim Search Results Panel Narrative

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

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

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

6.2.2 Claim Search Results Panel Layout

Search Results

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

Claim Count: 160

1 2 3 4 5 6 7 8 Next >

Pharmacy Claim Search Results Panel Layout

Pharmacy Claim Search Results

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

Claim Count: 7

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6.2.3 Claim Search Results Panel Field Descriptions

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

6.2.4 Claim Search Results Panel Field Edit Error Codes

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

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6.2.5 Claim Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.2.6 Claim Search Results Panel Accessibility

6.2.6.1 To Access the Claim Search Results Panel

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

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6.3 Claim Mini-Search Panel

6.3.1 Claim Mini-Search Panel Narrative

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

This panel is inquiry only.

Navigation Path: [Claims] – [Information]

6.3.2 Claim Mini-Search Panel Layout

6.3.3 Claim Mini-Search Panel Field Descriptions

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

6.3.4 Claim Mini-Search Panel Field Edit Error Codes

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

6.3.5 Claim Mini-Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.3.6 Claim Mini-Search Panel Accessibility

6.3.6.1 To Access the Claim Mini-Search Panel

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

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6.4 Dental Claim Panel

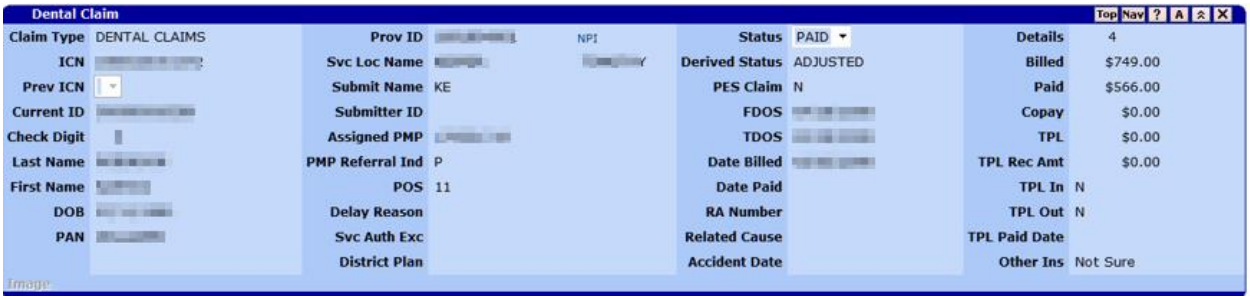
6.4.1 Dental Claim Panel Narrative

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

This panel is display only.

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

6.4.2 Dental Claim Panel Layout



6.4.3 Dental Claim Panel Field Descriptions

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

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

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

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

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

6.4.4 Dental Claim Panel Field Edit Error Codes

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

6.4.5 Dental Claim Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.4.6 Dental Claim Panel Accessibility

6.4.6.1 To Access the Dental Claim Panel

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

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6.5 Dental Claim Detail Panel

6.5.1 Dental Claim Detail Panel Narrative

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

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

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

6.5.2 Dental Claim Detail Panel Layout

6.5.3 Dental Claim Detail Panel Field Descriptions

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

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

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

6.5.4 Dental Claim Detail Panel Field Edit Error Codes

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

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

6.5.5 Dental Claim Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.5.6 Dental Claim Detail Panel Accessibility

6.5.6.1 To Access the Dental Claim Detail Panel

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

6.5.6.2 To Add on the Dental Claim Detail Panel

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

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6.5.6.3 To Delete on the Dental Claim Detail Panel

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

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6.6 Dental Claim Detail Navigation Panel

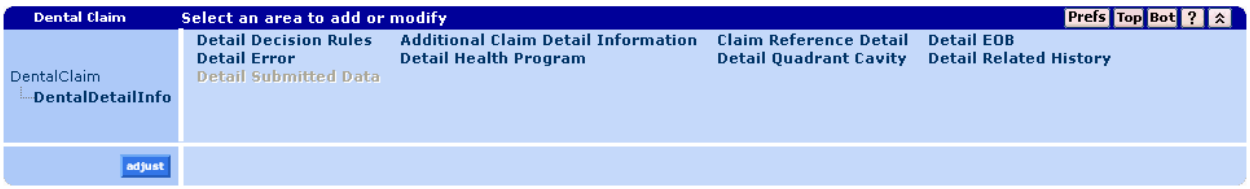
6.6.1 Dental Claim Detail Panel Narrative

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

This panel is inquiry only.

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

6.6.2 Dental Claim Detail Panel Layout



6.6.3 Dental Claim Detail Panel Field Descriptions

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

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6.6.3.1 Dental Claim Detail Field Edit Error Codes

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

6.6.4 Dental Claim Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.6.5 Dental Claim Detail Panel Accessibility

6.6.5.1 To Access the Dental Claim Detail Panel

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

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6.7 Dental Claim Navigation Panel

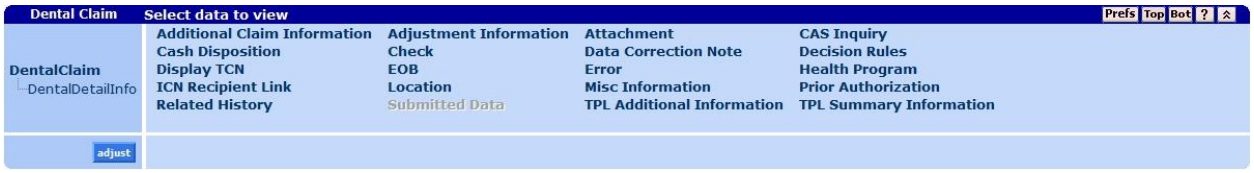
6.7.1 Dental Claim Navigation Panel Narrative

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

This panel is inquiry only.

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

6.7.2 Dental Claim Navigation Panel Layout



6.7.3 Dental Claim Navigation Panel Field Descriptions

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

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

6.7.4 Dental Claim Navigation Field Edit Error Codes

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

6.7.5 Dental Claim Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.7.6 Dental Claim Navigation Panel Accessibility

6.7.6.1 To Access the Dental Claim Navigation Panel

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

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

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6.8 Pharmacy Claim Panel

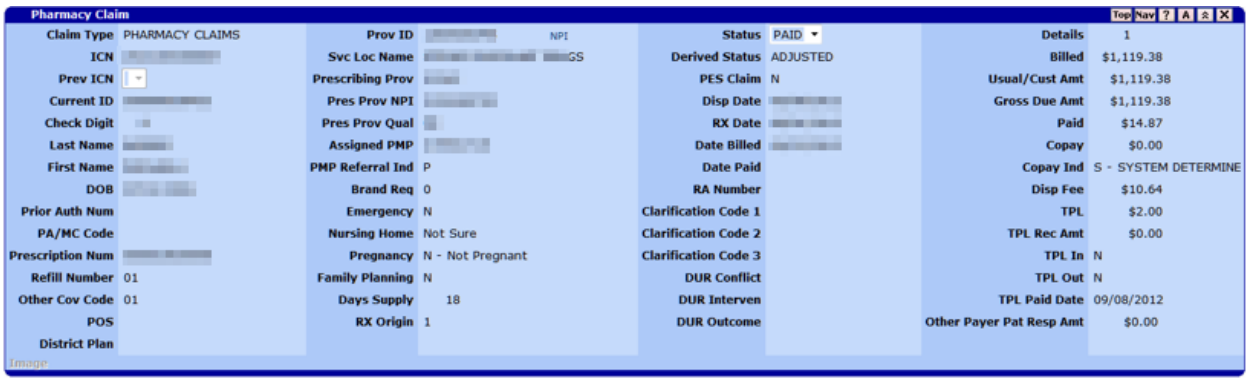
6.8.1 Pharmacy Claim Panel Narrative

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

This panel is display only.

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

6.8.2 Pharmacy Claim Panel Layout



6.8.3 Pharmacy Claim Panel Field Descriptions

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

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

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

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

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

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

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

6.8.4 Pharmacy Claim Panel Field Edit Error Codes

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

6.8.5 Pharmacy Claim Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.8.6 Pharmacy Claim Panel Accessibility

6.8.6.1 To Access the Pharmacy Claim Panel

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

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6.9 Pharmacy Claim Detail Navigation Panel

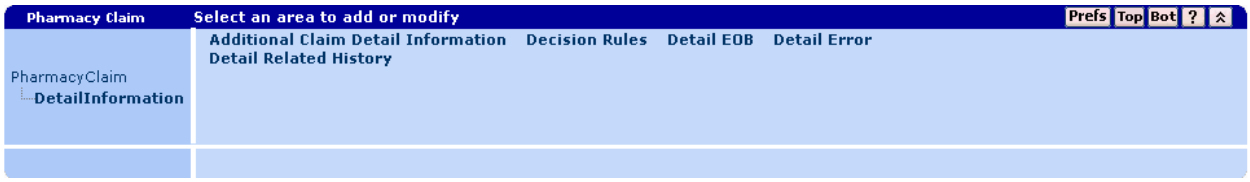
6.9.1 Pharmacy Claim Detail Navigation Panel Narrative

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

This panel is display only.

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

6.9.2 Pharmacy Claim Detail Navigation Panel Layout



6.9.3 Pharmacy Claim Detail Navigation Panel Field Descriptions

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

6.9.4 Pharmacy Claim Detail Navigation Panel Field Edit Error Codes

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

6.9.5 Pharmacy Claim Detail Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.9.6 Pharmacy Claim Detail Navigation Panel Accessibility

6.9.6.1 To Access the Pharmacy Claim Detail Navigation Panel

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

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

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6.10 Pharmacy Claim Navigation Panel

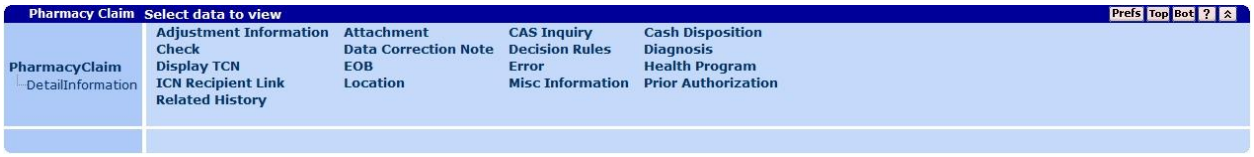
6.10.1 Pharmacy Claim Navigation Panel Narrative

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

This panel is inquiry only.

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

6.10.2 Pharmacy Claim Navigation Panel Layout



6.10.3 Pharmacy Claim Navigation Panel Field Descriptions

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

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

6.10.4 Pharmacy Claim Navigation Panel Field Edit Error Codes

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

6.10.5 Pharmacy Claim Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.10.6 Pharmacy Claim Navigation Panel Accessibility

6.10.6.1 To Access the Pharmacy Claim Navigation Panel

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

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6.11 Pharmacy Claim Detail Panel

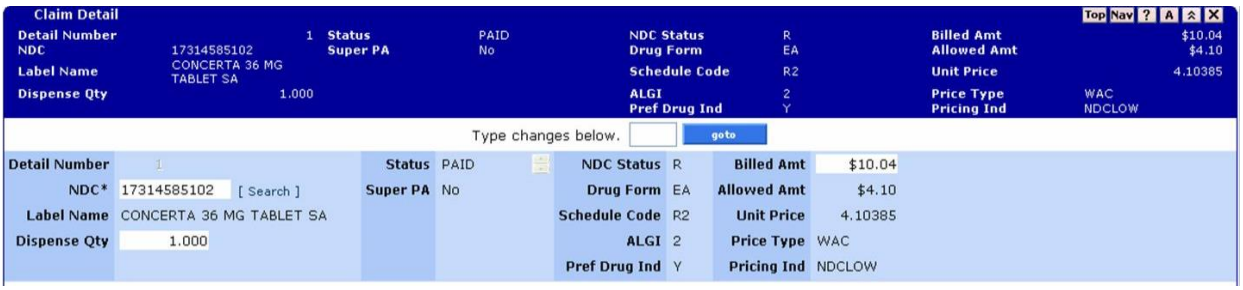
6.11.1 Pharmacy Claim Detail Panel Narrative

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

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

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

6.11.2 Pharmacy Claim Detail Panel Layout



6.11.3 Pharmacy Claim Detail Panel Field Descriptions

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

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

6.11.4 Pharmacy Claim Detail Panel Field Edit Error Codes

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

6.11.5 Pharmacy Claim Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.11.6 Pharmacy Claim Detail Panel Accessibility

6.11.6.1 To Access the Pharmacy Claim Detail Panel

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

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

6.11.6.2 To Update the Pharmacy Claim Detail Panel

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

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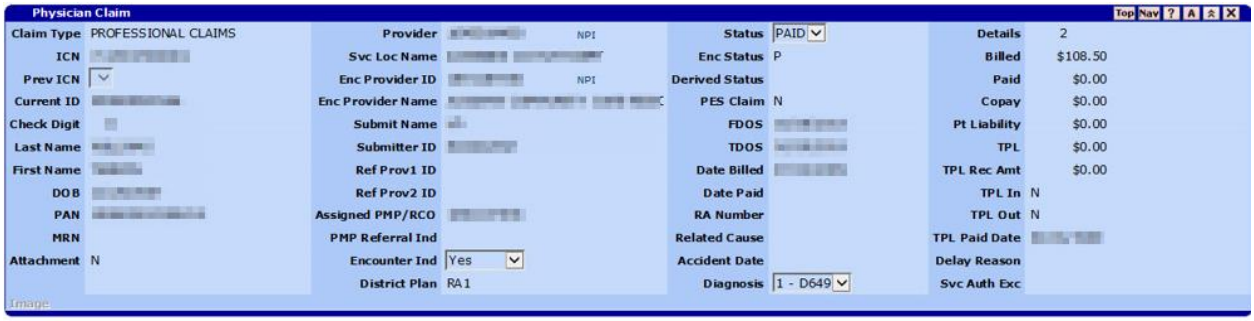
6.12 Physician Claim Panel

6.12.1 Physician Claim Panel Narrative

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

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

6.12.2 Physician Claim Panel Layout



6.12.3 Physician Claim Panel Field Descriptions

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

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

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

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

6.12.4 Physician Claim Panel Field Edit Error Codes

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

6.12.5 Physician Claim Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.12.6 Physician Claim Panel Accessibility

6.12.6.1 To Access the Physician Claim Panel

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

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6.13 Physician Claim Detail Panel

6.13.1 Physician Claim Detail Panel Narrative

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

This panel is display only.

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

6.13.2 Physician Claim Detail Panel Layout

6.13.3 Physician Claim Detail Panel Field Descriptions

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

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

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

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6.13.4 Physician Claim Detail Panel Field Edit Error Codes

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

6.13.5 Physician Claim Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.13.6 Physician Claim Detail Panel Accessibility

6.13.6.1 To Access the Physician Claim Detail Panel

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

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6.14 Physician Claim Detail Navigation Panel

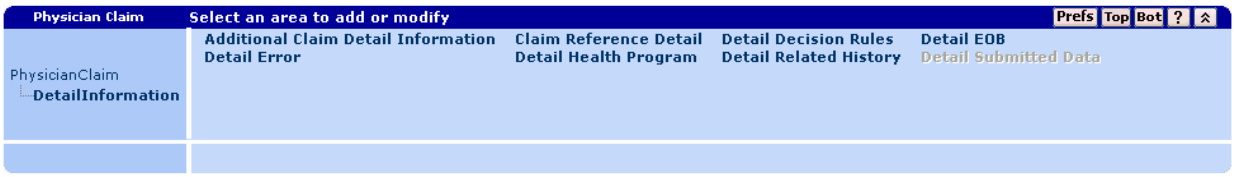
6.14.1 Physician Claim Detail Navigation Panel Narrative

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

This panel is inquiry only.

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

6.14.2 Physician Claim Detail Navigation Panel Layout



6.14.3 Physician Claim Detail Navigation Panel Field Descriptions

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

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6.14.4 Physician Claim Detail Navigation Panel Field Edit Error Codes

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

6.14.5 Physician Claim Detail Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.14.6 Physician Claim Detail Navigation Panel Accessibility

6.14.6.1 To Access the Physician Claim Detail Navigation Panel

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

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6.15 Physician Claim Navigation Panel

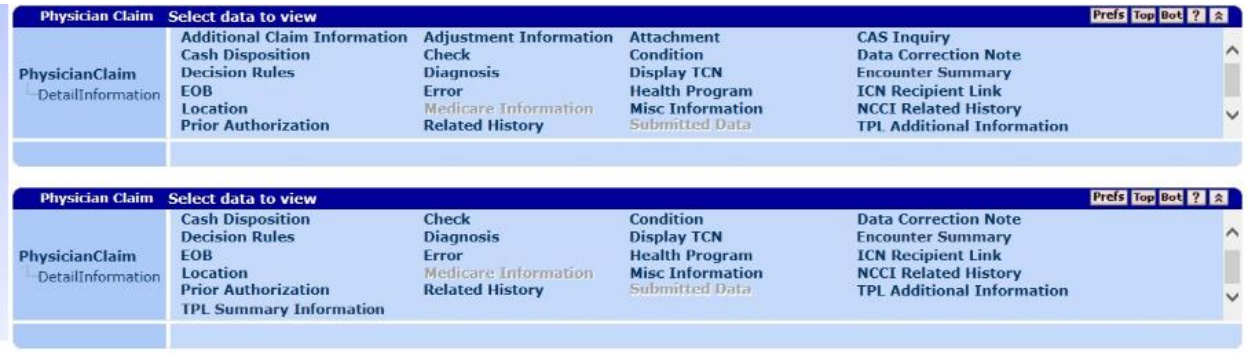
6.15.1 Physician Claim Navigation Panel Narrative

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

This panel is inquiry only.

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

6.15.2 Physician Claim Navigation Panel Layout



6.15.3 Physician Claim Navigation Panel Field Descriptions

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

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

6.15.4 Physician Claim Navigation Panel Field Edit Error Codes

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

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6.15.5 Physician Claim Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.15.6 Physician Claim Navigation Panel Accessibility

6.15.6.1 To Access the Physician Claim Navigation Panel

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

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6.16 UB04 Claim Panel

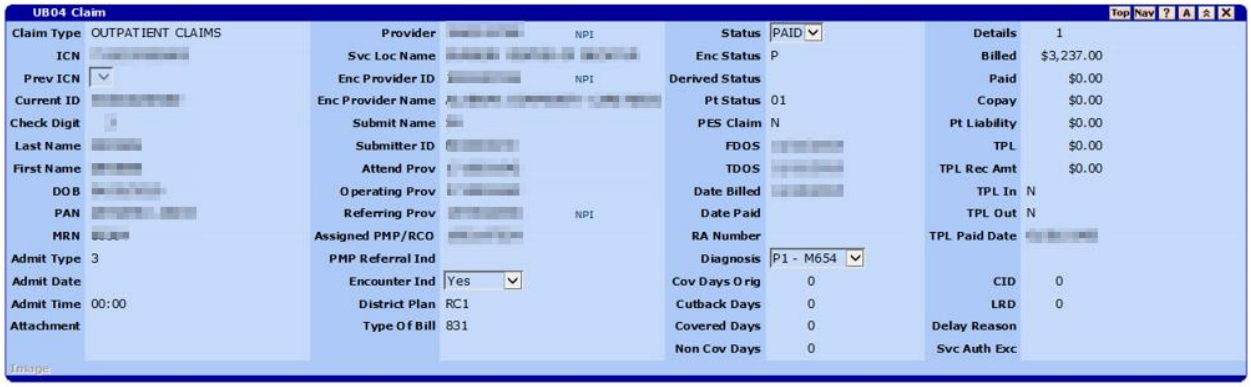
6.16.1 UB04 Claim Panel Narrative

The UB04 Claim panel displays UB04 claim header data.

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

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

6.16.2 UB04 Claim Panel Layout



6.16.3 UB04 Claim Panel Field Descriptions

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

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

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

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

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

6.16.4 UB04 Claim Panel Field Edit Error Codes

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

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6.16.5 UB04 Claim Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.16.6 UB04 Claim Panel Accessibility

6.16.6.1 To Access the UB04 Claim Panel

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

6.16.6.2 To Update the UB04 Claim Panel

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

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6.17 UB04 Claim Detail Panel

6.17.1 UB04 Claim Detail Panel Narrative

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

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

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

6.17.2 UB04 Claim Detail Panel Layout

6.17.3 UB04 Claim Detail Panel Field Descriptions

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

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

6.17.4 UB04 Claim Detail Panel Field Edit Error Codes

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

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6.17.5 UB04 Claim Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.17.6 UB04 Claim Detail Panel Accessibility

6.17.6.1 To Access the UB04 Claim Detail Panel

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

6.17.6.2 To Update the UB04 Claim Detail Panel

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

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6.18 UB04 Claim Detail Navigation Panel

6.18.1 UB04 Claim Detail Navigation Panel Narrative

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

This panel is inquiry only.

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

6.18.2 UB04 Claim Detail Navigation Panel Layout

6.18.3 UB04 Claim Detail Navigation Panel Field Descriptions

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

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6.18.4 UB04 Claim Detail Navigation Panel Field Edit Error Codes

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

6.18.5 UB04 Claim Detail Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.18.6 UB04 Claim Detail Navigation Panel Accessibility

6.18.6.1 To Access the UB04 Claim Detail Navigation Panel

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

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6.19 UB04 Claim Navigation Panel

6.19.1 UB04 Claim Navigation Panel Narrative

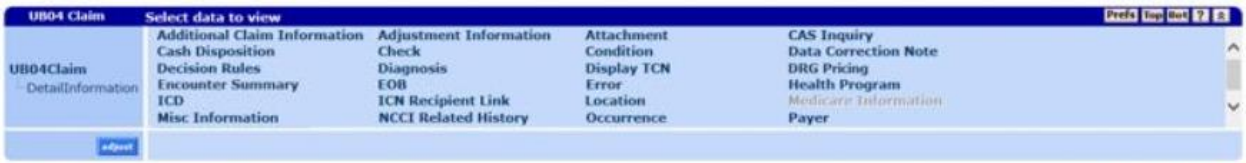
The UB04 Claim Navigation panel provides access to the various panels through which UB04 Claims data can be viewed and/or corrected.

This panel is inquiry only.

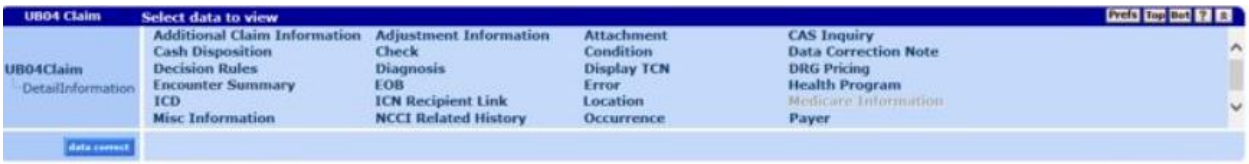
Navigation Path: [Claims] – [Information] – [Enter an ICN for a UB04 claim] – OR – [Claims -Search] – [Enter Criteria] – [Select a UB04 claim]

6.19.2 UB04 Claim Navigation Panel Layout

Adjust



Data Correct



6.19.3 UB04 Claim Navigation Panel Field Descriptions

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

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

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

6.19.4 UB04 Claim Navigation Panel Field Edit Error Codes

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

6.19.5 UB04 Claim Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.19.6 UB04 Claim Navigation Panel Accessibility

6.19.6.1 To Access the UB04 Claim Navigation Panel

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

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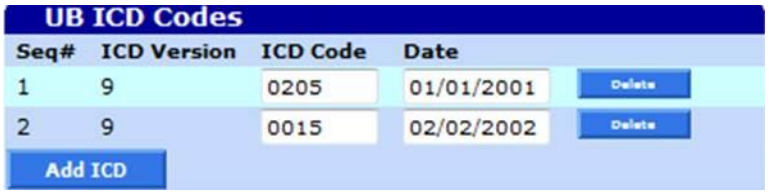
6.20 UB ICD Codes Panel – Data Correction

6.20.1 UB ICD Codes Panel Narrative

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

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

6.20.2 UB ICD Codes Panel Layout



6.20.3 UB ICD Codes Panel Field Descriptions

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

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6.20.4 UB ICD Codes Panel Field Edit Error Codes

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

6.20.5 UB ICD Codes Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.20.6 UB ICD Codes Panel Accessibility

6.20.6.1 To Access the UB ICD Codes Panel

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

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6.21 NDC Details Panel

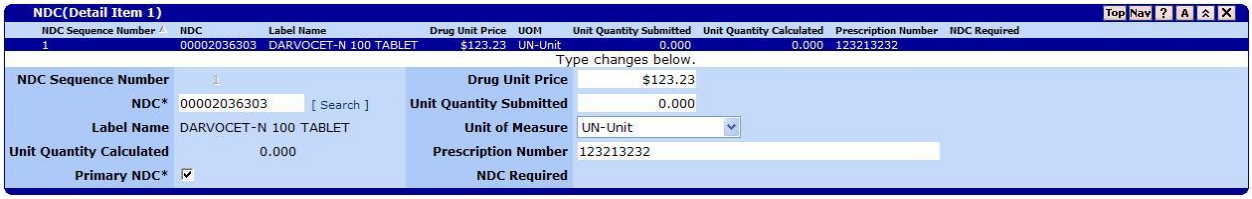
6.21.1 NDC Details Panel Narrative

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

This panel is display only.

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

6.21.2 NDC Details Panel Layout



6.21.3 NDC Details Panel Field Descriptions

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

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

6.21.4 NDC Details Panel Field Edit Error Codes

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

6.21.5 NDC Details Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.21.6 NDC Details Panel Accessibility

6.21.6.1 To Access the NDC Details Panel

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

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6.22 NDC Details – Data Correction Panel

6.22.1 NDC Details – Data Correction Panel

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

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

Only authorized users are allowed to perform maintenance tasks.

6.22.2 NDC Details – Data Correction Panel

6.22.3 NDC Details – Data Correction Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add NDC Detail	Add button to add a new NDC record.	Button	N/A	0
Delete	Delete button to remove any existing NDC record.	Button	N/A	0
Dtl#	Detail number of claim detail.	Combo Box	Number (Integer)	2
Primary NDC	Primary NDC Indicator.	Combo Box	Character	1
Unit of Measure	Code specifying the units in which a value is being expressed.	Combo Box	Character	2
Drug Unit Qty	This is the unit count that the provider submitted. The Drug – not HCPCS – units. May be zero for a single NDC but must be filled in for every NDC if more than one NDC is billed for this detail.	Field	Number (Integer)	15
NDC Code	The National Drug Code	Field	Character	16
Prescip. Num	The prescription number.	Field	Character	50
Seq. Num	Read only field Sequence number for the NDC record.	Field	Number (Integer)	2
Unit Price	Price per unit of product.	Field	Number (Decimal)	17
Unit of Measure (Raw DB Value)	Code specifying the units in which a value is being expressed.	Field	Character	2

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6.22.4 NDC Details – Data Correction Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
NDC Code	Field	1	INFO : NDC ##### is not on file.	Informational message, saves data with incorrect NDC value.
	Field	2	Only 25 NDC segments per claim detail are allowed.	Enter NDC less than 25.

6.22.5 NDC Details – Data Correction Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.22.6 NDC Details – Data Correction Panel Accessibility

6.22.7 To Access the NDC Details – Data Correction Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to Claims and click Data Corrections.	Claims Suspense List panel displays.
3	Enter a **Clerk ID** and click **Search**.	
4	Select a row of data.	

6.22.8 To Add on the NDC Details – Data Correction Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update the appropriate information.	
3	Click on **Save**.	Data Correction Note information is saved.

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6.23 Claim Reference Detail Panel

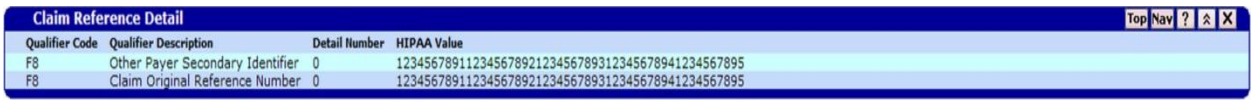
6.23.1 Claim Reference Detail Panel Narrative

Claim Reference Detail Panel. Displays all the claims (both header and detail) data received and stored in the T_CLM_REF table.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [DetailInfo] – [Claim Reference Detail] – OR – [Claims] – [Search] – [Enter search criteria] – (Select claim) – [DetailInfo] – [Claim Reference Detail] - OR - [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [DetailInfo] – [Claim Reference Detail]

6.23.2 Claim Reference Detail Panel Layout



6.23.3 Claim Reference Detail Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Detail Number	Applicable detail number. Header - 0.	Listview	Number (Integer)	4
HIPAA Value	HIPAA Value that was submitted.	Listview	Alphanumeric	50
Qualifier Code	Qualifier Code.	Listview	Character	3
Qualifier Description	Description of the Qualifier Code.	Listview	Alphanumeric	80

6.23.4 Claim Reference Detail Panel Field Edit Error Codes

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

6.23.5 Claim Reference Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.23.6 Claim Reference Detail Panel Accessibility

6.23.6.1 To Access the Claim Reference Detail Panel

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

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6.24 Detail Decision Rules Panel

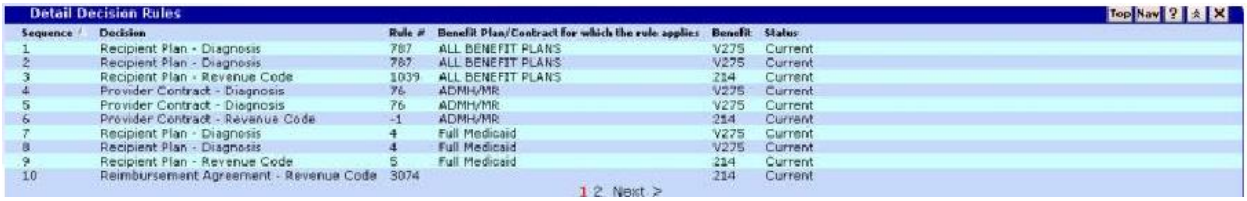
6.24.1 Detail Decision Rules Panel Narrative

The Detail Decision Rules panel displays Detail Decision Rules (Benefit Plan Rules, Assignment Plan Rules, Provider Contract Rules) used to process a claim.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [DetailInfo] – [Claim Reference Detail] – OR – [Claims] – [Search] – [Enter search criteria] – (Select claim) – [DetailInfo] – [Detail Decision Rules] - OR - [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [DetailInfo] – [Detail Decision Rules]

6.24.2 Detail Decision Rules Panel Layout



Detail Decision Rules

Sequence	Decision	Rule #	Benefit Plan/Contract for which the rule applies	Benefit	Status
1	Recipient Plan - Diagnosis	787	ALL BENEFIT PLANS	V275	Current
2	Recipient Plan - Diagnosis	787	ALL BENEFIT PLANS	V275	Current
3	Recipient Plan - Revenue Code	1039	ALL BENEFIT PLANS	214	Current
4	Provider Contract - Diagnosis	76	ADMH/MR	V275	Current
5	Provider Contract - Diagnosis	76	ADMH/MR	V275	Current
6	Provider Contract - Revenue Code	-1	ADMH/MR	214	Current
7	Recipient Plan - Diagnosis	4	Full Medicaid	V275	Current
8	Recipient Plan - Diagnosis	4	Full Medicaid	V275	Current
9	Recipient Plan - Revenue Code	5	Full Medicaid	214	Current
10	Reimbursement Agreement - Revenue Code	3074		214	Current

1 2 Next >

6.24.3 Detail Decision Rules Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit	Code used to uniquely identify a benefit. The benefit code may be a Procedure, Diagnosis, National Drug Code (NDC), Diagnosis Related Group (DRG), International Classification of Diseases, or Revenue code depending on the Decision.	Listview	Alphanumeric	11
Benefit Plan/Contract for which the rule applies	Code used to uniquely identify a Benefit Plan or Contract. This represents the Benefit Plan or Contract applicable to the Rule. This field may not always be present depending on the Decision (example Reimbursement Rules or Copay Rules).	Listview	Alphanumeric	50
Decision	Decision for which the rule applies. Examples are Recipient Benefit Plan - Procedure, Recipient Assignment Plan - Diagnosis, Provider Contract – Revenue.	Listview	Alphanumeric	80
Rule #	System assigned key used to uniquely identify a rule within a decision.	Listview	Number (Integer)	9
Sequence	The order in which the rule was applied to the claim.	Listview	Number (Integer)	4
Status	Code used to indicate if a rule on the claim is a current rule ('C') - a rule that was used in the most recent processing	Listview	Character	7

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Field	Description	Field Type	Data Type	Length
	of the claim, or an historical rule ('H') - a rule that was previously used when the claim previously processed.			

6.24.4 Detail Decision Rules Panel Field Edit Error Codes

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

6.24.5 Detail Decision Rules Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.24.6 Detail Decision Rules Panel Accessibility

6.24.6.1 To Access the Detail Decision Rules Panel

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

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6.25 Detail EOB Panel

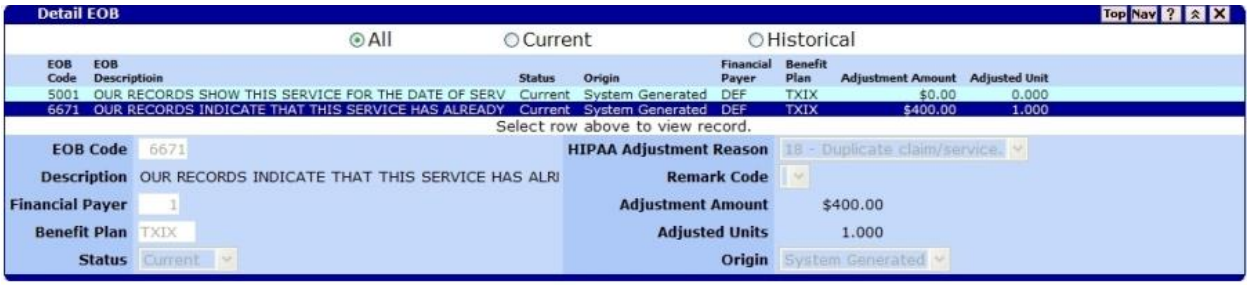
6.25.1 Detail EOB Panel Narrative

The Detail EOB panel is in view-only mode when accessed through Claims Inquiry. The panel is editable when accessed through Data Corrections. This panel displays the EOB codes and messages applicable to the claim that is in suspense. These codes and messages are generated to explain to the provider the reason that the claim is in suspense. In most cases, the same codes are generated to explain the denial of a claim.

This panel is display only.

Navigation Path:[Claims] – [Information] – [Enter an ICN] – [DentalDetailInfo or DetailInformation] – [Detail EOB] OR [Claims] – [Search] – [Enter search criteria] – (Select a claim) – [DentalDetailInfo or DetailInformation] – [Detail EOB]

6.25.2 Detail EOB Panel Layout



6.25.3 Detail EOB Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjusted Units	The quantity adjusted on the detail.	Field	Number (Decimal)	10
Adjustment Amount	The dollar amount adjusted on the detail.	Field	Number (Decimal)	9
All	Selected to display all current and historical EOB detail information.	Combo Boxc	Radio Button	0
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Character	5
Current	Selected to display all current EOB detail information.	Combo Box	Radio Button	0
Description	First line of text description for explanation of benefit code.	Field	Character	79
EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it.	Field	Number (Integer)	4
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	4

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Field	Description	Field Type	Data Type	Length
HIPAA Adjustment Reason	The Health Insurance Portability and Accountability Act (HIPAA) code explaining why the service or claim paid differently from the billed amount.	Combo Box	Drop Down List Box	0
Historical	Selected to display all historical EOB detail information.	Combo Box	Radio Button	0
Origin	Indicates how the EOB Code and message were generated: Valid values are 'S - System Generated' or 'U - User Assigned'.	Combo Box	Drop Down List Box	0
Remark Code	HIPAA Remarks code.	Combo Box	Drop Down List Box	0
Status	Code used to indicate whether the explanation of benefit code on the claim is a current EOB ('C'), one that failed in the current cycle, or a historical EOB ('H'), one that previously failed.	Combo Box	Drop Down List Box	0

6.25.4 Detail EOB Panel Field Edit Error Codes

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

6.25.5 Detail EOB Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.25.6 Detail EOB Panel Accessibility

6.25.6.1 To Access the Detail EOB Panel

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

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6.26 Detail Error Panel

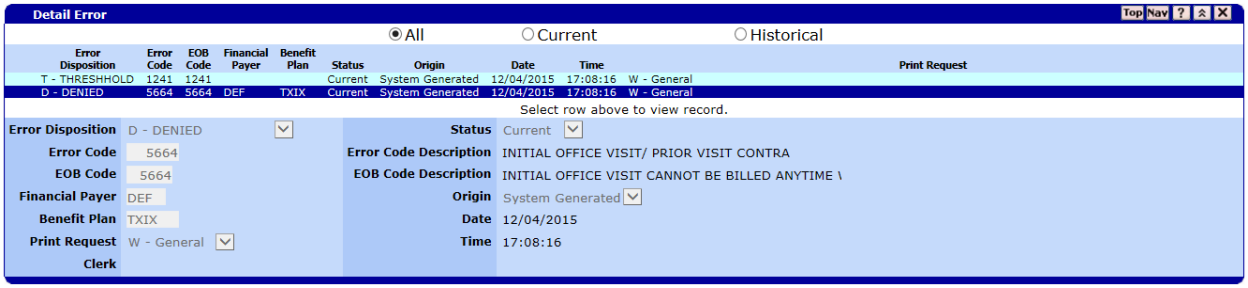
6.26.1 Detail Error Panel Narrative

The Detail Error panel is accessed from the paid, denied, or suspended claim panels. This panel displays the header and/or detail errors applicable to the claim being viewed.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Dental Claim] – [DentalDetailInfo or DetailInformation] – [Detail Error] – OR – [Claims] – [Search] – [Enter search criteria] – (Select a claim) – [Dental Claim] – [DentalDetailInfo or DetailInformation] – [Detail Error]

6.26.2 Detail Error Panel Layout



6.26.3 Detail Error Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
All	Selected to display all current and historical EOB detail information.	Combo Box	Radio Button	0
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Character	5
Clerk	Number used to identify the user who last updated the error record.	Field	Character	8
Current	Selected to display all current EOB detail information.	Combo Box	Radio Button	0
Date	Date of the error code.	Field	Date (MM/DD/CCYY)	8
EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it.	Field	Number (Integer)	4
EOB Code Description	Text description for the explanation of benefit code.	Field	Character	79
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit.	Field	Character	4
Error Code Description	Description of the error.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Error Disposition	Disposition of the error.	Combo Box	Drop Down List Box	0
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	4
Historical	Selected to display all historical EOB detail information.	Combo Box	Radio Button	0
Origin	Indicates how the EOB Code and message were generated: Valid values are 'S - System Generated' or 'U - User Assigned'.	Combo Box	Drop Down List Box	0
Print Request	The valid values for this indicator are Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report.	Combo Box	Drop Down List Box	0
Status	Code used to indicate whether the explanation of benefit code on the claim is a current EOB ('C'), one that failed in the current cycle, or a historical EOB ('H'), one that previously failed.	Combo Box	Drop Down List Box	0
Time	Time of the error code.	Field	Number (Integer)	8

6.26.4 Detail Error Panel Field Edit Error Codes

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

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6.26.5 Detail Error Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.26.6 Detail Error Panel Accessibility

6.26.6.1 To Access the Detail Error Panel

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

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6.27 Detail Health Program Panel

6.27.1 Detail Health Program Panel Narrative

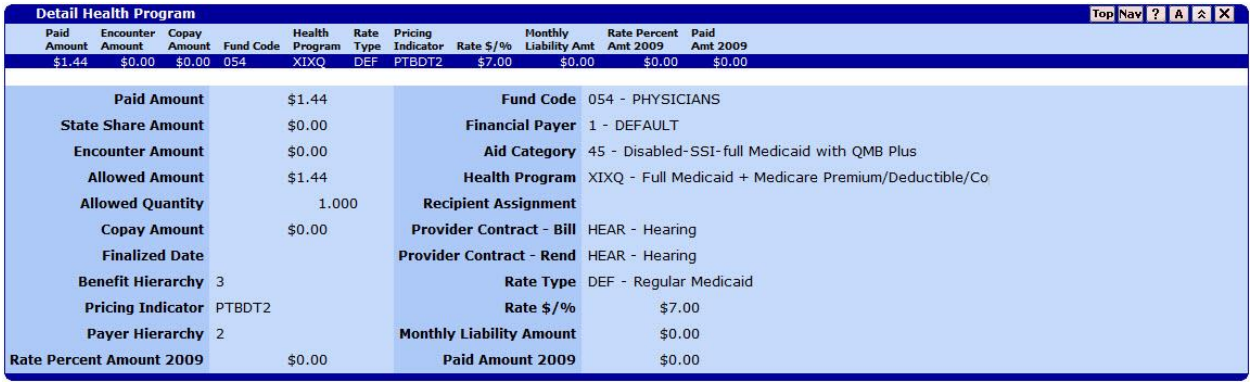
The Detail Health Program panel is applicable for all claim types and can be accessed from the paid, denied, or suspended claim panels. This panel displays the health program applicable to the claim detail being viewed.

This panel is display only.

To access Detail Health Program panel for Dental claims, select the DentalDetailInfo hyperlink from the maintenance window. For all other claim types, select the DetailInformation hyperlink.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [DentalDetailInfo or DetailInformation] – [Detail Health Program] – OR – [Claims] – [Search] – [Enter search criteria] – (Select a claim) – [DentalDetailInfo or DetailInformation] – [Detail Health Program]

6.27.2 Detail Health Program Panel Layout



6.27.3 Detail Health Program Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Aid Category for Medicaid coverage.	Field	Character	2
Allowed Amount	Amount allowed for payment on the claim.	Field	Number (Decimal)	9
Allowed Quantity	Number of units allowed under a financial payer/benefit plan.	Field	Number (Integer)	6
Benefit Hierarchy	This is the hierarchical order with which multiple, concurrent benefits assigned to a recipient are processed.	Field	Number (Integer)	9
Copay Amount	Amount paid by recipient for services rendered. This is the amount the Recipient is responsible for.	Field	Number (Decimal)	7

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Field	Description	Field Type	Data Type	Length
Encounter Amount	Contains the amount for encounter services on the claim detail indicated by the detail number on table.	Field	Number (Decimal)	10
Finalized Date	Date that financial finalizes the claim for this payer.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Number (Integer)	9
Fund Code	Indicates the budget category that the funds used to pay this claim/detail came from.	Listview	Number (Integer)	9
Funding Source	Indicates the budget category that the funds used to pay this claim/detail came from.	Field	Number (Integer)	9
Health Program	Identifies the medical assistance program that is supported in the system.	Field	Character	5
Monthly Liability Amount	The patient financial liability amount that must be paid by the recipient before Medicaid will make payment on the claim.	Field	Number (Decimal)	10
Paid Amount	The total amount paid on the claim.	Field	Number (Decimal)	10
Paid Amount 2009	This field indicates the 2009 paid amount for claims paid using the Primary Care Provider rate. Claims not paid the PCP rate will have zero in this field.	Field	Number (Decimal)	10
Payable Benefit	Unique system assigned key that identifies each row on this table.	Field	Number (Integer)	9
Payer Hierarchy	Payer Hierarchy is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment plans for recipient's who are enrolled in multiple entities of any of these types.	Field	Number (Integer)	9
Pricing Indicator	Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
Provider Contract - Bill	Provider contract, under which the service was deemed covered, for the Billing Provider.	Field	Character	20
Provider Contract - Rend	Provider contract, under which the service was deemed covered, for the Rendering Provider.	Field	Character	20
Rate	A daily per diem rate or percentage of charge value depending on the pricing indicator.	Field	Number (Decimal)	9
Rate Percent Amount 2009	This field indicates the rate used to calculate the 2009 paid amount for claims paid using the Primary Care Provider rate. Claims not paid the PCP rate will have zero in this field.	Field	Number (Decimal)	7
Rate Type	Code used to identify the rate type to use in determining provider reimbursement.	Field	Character	3
Recipient Assignment	This describes the relationships between the Recipient and Provider for purposes of care. This information encompasses the Recipient level of care nursing home information, Provider lock-in information, hospice information, some Provider specific waiver information, and other benefit information that relates a Recipient to a Provider.	Field	Character	5
State Share Amount	This is the amount of state share for this payment. The state share amount plus the amount Paid = Reimbursement amount. N/A for Alabama Medicaid.	Field	Number (Decimal)	10

6.27.4 Detail Health Program Panel Field Edit Error Codes

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

6.27.5 Detail Health Program Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.27.6 Detail Health Program Panel Accessibility

6.27.6.1 To Access the Detail Health Program Panel

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

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6.28 Detail Quadrant Cavity Panel

6.28.1 Detail Quadrant Cavity Panel Narrative

The Detail Quadrant Cavity panel displays the oral cavity codes for a claim.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Dental Claim] – [DentalDetailInfo] – [Detail Quadrant Cavity] – OR – [Claims] – [Search] – [Enter search criteria] – (Select a claim) – [Dental Claim] – [DentalDetailInfo] – [Detail Quadrant Cavity]

6.28.2 Detail Quadrant Cavity Panel Layout

6.28.3 Detail Quadrant Cavity Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Quadrant Code Cavity	First code identifying the area of the Oral Cavity in which service was rendered.	Combo Box	Drop Down List Box	0

6.28.4 Detail Quadrant Cavity Panel Field Edit Error Codes

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

6.28.5 Detail Quadrant Cavity Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.28.6 Detail Quadrant Cavity Panel Accessibility

6.28.6.1 To Access the Detail Quadrant Cavity Panel

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

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Step	Action	Response
6	Select the **Detail Quadrant Cavity** hyperlink from the Dental Claim Detail Navigation panel.	Detail Quadrant Cavity panel displays below the Claim Detail panel.

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6.29 Detail Related History Panel

6.29.1 Detail Related History Panel Narrative

The Detail Related History panel is accessed from the paid, denied, or suspended claim panels. The panel displays the related history applicable to the claim detail being viewed.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [DentalDetailInfo or DetailInformation] – [Detail Related History] – OR – [Claims - Search] – [Enter search criteria] – (Select a claim) – [DentalDetailInfo or DetailInformation] – [Detail Related History]

6.29.2 Detail Related History Panel Layout

6.29.3 Detail Related History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Character	5
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system.	Listview	Number (Integer)	4
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	30
Related Detail	Related detail information to the history claim displayed.	Field	Number (Integer)	4
Related ICN	Internal Control Number of the related claim.	Field	Character	13

6.29.4 Detail Related History Panel Field Edit Error Codes

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

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6.29.5 Detail Related History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.29.6 Detail Related History Panel Accessibility

6.29.6.1 To Access the Detail Related History Panel

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

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6.30 Additional Claim Information

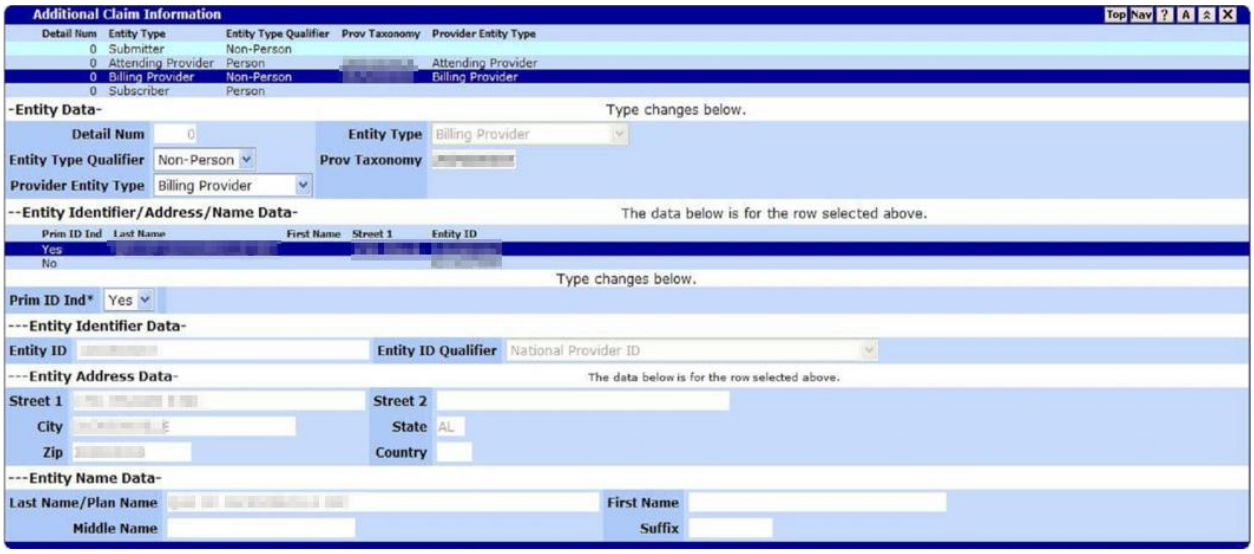
6.30.1 Additional Claim Information Panel Narrative

The Additional Claim Information panel allows the user to examine additional information submitted on the claim including information used to determine the correct service location assigned to a claim.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Additional Claim Information link] OR [Claims - Search] – [Enter Criteria] – [Select a Claim] – [Select Additional Claim Information link]

6.30.2 Additional Claim Information Panel Layout



6.30.3 Additional Claim Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
City	The city associated with the address for the Recipient/Provider.	Field	Alphanumeric	30
Country	The country associated with the address for the Recipient/Provider.	Listview	Character	3
Detail Num	Detail Number on the claim record (0 indicates Header).	Field	Number (Integer)	4
Entity ID	Entity's primary or secondary ID as specified by the ID qualifier.	Field	Alphanumeric	40
Entity ID Qualifier	The type of Entity ID Qualifier.	Combo Box	Character	2
Entity Type Qualifier	Indicates whether the entity is a person or a non-person.	Combo Box	Alphanumeric	2
First Name	First name of the recipient/provider.	Field	Alphanumeric	35

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Field	Description	Field Type	Data Type	Length
Last Name/Plan Name	Last name of the recipient/provider or the name of the organization.	Field	Alphanumeric	60
Middle Name	Middle name of the recipient/provider.	Field	Alphanumeric	25
Prim ID Ind	Indicates whether the ID is a primary (Y) or secondary (N) ID for the entity.	Combo Box	Character	1
Entity Type	Code that indicates if the information is for Recipient or Provider.	Listview	Character	3
Prov Taxonomy	The unique identifier for the entity type specified by the qualifier.	Field	Alphanumeric	30
Provider Entity Type	The type of practice for a provider.	Combo Box	Alphanumeric	3
State	The state associated with the address for the Recipient/Provider.	Field	Character	2
Street 1	The first address line of the recipient/provider.	Field	Alphanumeric	55
Street 2	The second address line of the recipient/provider.	Field	Alphanumeric	55
Suffix	Name suffix of the recipient/provider.	Field	Alphanumeric	10
Zip	The zip code associated with the address for the recipient/provider.	Field	Number (Integer)	15

6.30.4 Additional Claim Information Panel Field Edit Error Codes

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

6.30.5 Additional Claim Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.30.6 Additional Claim Information Panel Accessibility

6.30.6.1 To Access the Additional Claim Information Panel

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

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

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6.31 Attachment Panel

6.31.1 Attachment Panel Narrative

The Attachment panel displays the Attachment Control Numbers (ACN) that are applicable to the claim.

This panel is display only.

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

6.31.2 Attachment Panel Layout

6.31.3 Attachment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ACN	The attachment control number associated with an attachment that is being sent by the provider for an electronically submitted claim.	Listview	Character	80
Attachment Indicator	Indicates if the attachment has been received.	Listview	Character	3
Detail Number	The detail number of a claim record.	Listview	Number (Integer)	4

6.31.4 Attachment Panel Field Edit Error Codes

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

6.31.5 Attachment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.31.6 Attachment Panel Accessibility

6.31.6.1 To Access the Attachment Panel

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

6.31.6.2 To Update the Attachment Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Attachment** from the Claim Information navigation panel.	Attachment panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click on **Save**.	Attachment data is saved.

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6.32 CAS Inquiry Panel

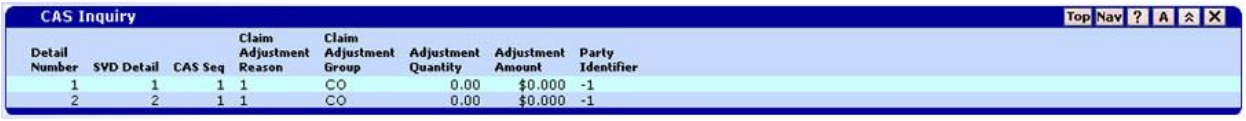
6.32.1 CAS Inquiry Panel Narrative

The CAS Inquiry Panel is used to view the Claim Level Adjustment Segments returned to the provider on the 835 transaction. The codes and amounts come directly from the 835 (RA) to report prior payers claim level adjustments which cause the paid amount to differ from the original paid amount.

This panel is display only.

Navigation Path: [Claims] - [Information] - (Enter ICN and click Search button) - [Physician/Dental/UB04 Claim] - [CAS Inquiry]

6.32.2 CAS Inquiry Panel Layout



CAS Inquiry

Detail Number	SVD Detail	CAS Seq	Claim Adjustment Reason	Claim Adjustment Group	Adjustment Quantity	Adjustment Amount	Party Identifier
1	1	1	1	CO	0.00	$0.000	-1
2	2	1	1	CO	0.00	$0.000	-1

6.32.3 CAS Inquiry Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Amount	Monetary amount of the adjustment. Format 9999999.99.	Field	Number (Decimal)	9
Adjustment Quantity	Number of units of service being adjusted. Format 999999.99.	Field	Number (Decimal)	8
CAS Seq	Identifies the iteration number for the Claim Level Adjustment Segments. A maximum of 99 Claim Level Adjustment Segments are allowed for a claim detail and 5 for the claim header.	Field	Number (Integer)	4
Claim Adjustment Group	Code identifying the general category of a payment adjustment.	Field	Character	2
Claim Adjustment Reason	Code identifying the detailed reason the adjustment was made.	Field	Character	2
Detail Number	Detail number on the claim record.	Field	Number (Integer)	4
Party Identifier	Unique identifier to identify a unique payer related to a claim.	Field	Character	80
SVD Detail	The SVD Detail (Service Line Adjudication) is the name of a segment sent in on a 837 claim file. It is returned on the CAS segment on the 835. The SVD on a claim will contain detail level adjustments.	Field	Number (Integer)	4

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6.32.4 CAS Inquiry Panel Field Edit Error Codes

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

6.32.5 CAS Inquiry Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.32.6 CAS Inquiry Panel Accessibility

6.32.6.1 To Access the Attachment Panel

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

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6.33 Cash Disposition Panel

6.33.1 Cash Disposition Panel Narrative

The Cash Disposition Panel is used to access cash-related information related to a particular adjustment. It displays the Cash Control Number (CCN), sequence number, and the refund (disposition) amount of the adjustment claim. This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Cash Disposition link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Cash Disposition link from the displayed panel]

6.33.2 Cash Disposition Panel Layout

6.33.3 Cash Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CCN	The Cash Control Number (CCN) associated with the adjustment transaction.	Listview	Character	11
Disposition Amount	The refund (disposition) amount for that line.	Listview	Number (Decimal)	10
Sequence	The disposition sequence number associated with the line. Each individual disposition to a check is given its own sequence number.	Listview	Number (Integer)	4

6.33.4 Cash Disposition Panel Field Edit Error Codes

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

6.33.5 Cash Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.33.6 Cash Disposition Panel Accessibility

6.33.6.1 To Access the Cash Disposition Panel

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

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Step	Action	Response
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **Cash Disposition** link from the maintenance item panel.	Cash Disposition panel displays below the Claim Detail panel.

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6.34 Check Panel

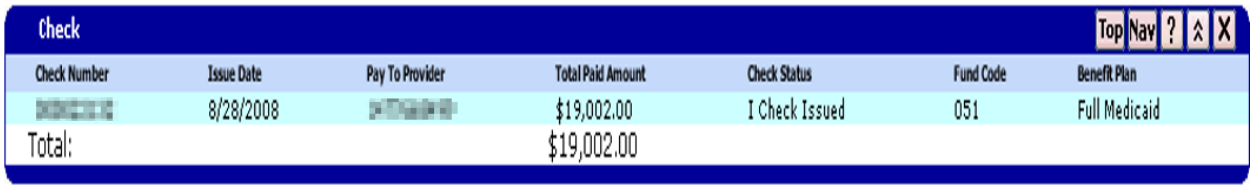
6.34.1 Check Panel Narrative

The Check panel allows the user to view the total amount paid from the current Remittance Advice (RA) for a specific claim.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Check link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Check link from the displayed panel]

6.34.2 Check Panel Layout



6.34.3 Check Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan	The medical assistance program associated with the related ICN.	Listview	Character	30
Check Status	The status of the check.	Listview	Character	30
Fund Code	Indicates the budget category that the funds used to pay this claim/detail came from.	Listview	Number (Integer)	9
Issue Date	The date when the check was issued or the electronic funds transfer was sent.	Listview	Date (MM/DD/CCYY)	8
Pay To Provider	The Provider who received the check or electronic funds transfer.	Listview	Character	10
Total Paid Amount	The total amount that was issued/paid to the provider.	Listview	Number (Decimal)	11
Check Number	This field displays the number of the check the provider received, or the number of the Electronic Funds Transfer.	Listview	Number (Integer)	9

6.34.4 Check Panel Field Edit Error Codes

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

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6.34.5 Check Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.34.6 Check Panel Accessibility

6.34.6.1 To Access the Check Panel

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

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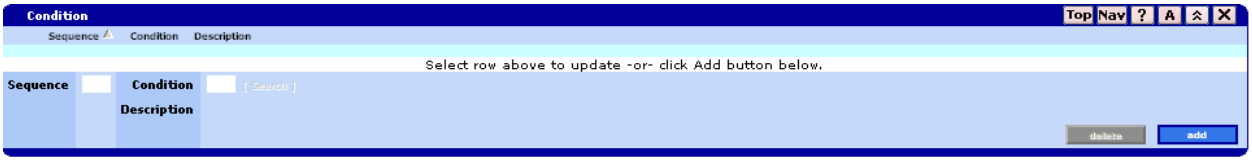
6.35 Condition Panel

6.35.1 Condition Panel Narrative

The Condition panel displays the Condition Codes applicable to the claim. These codes are generated to identify conditions relating to the claim that may affect payer processing. Only users with update authority are allowed to perform maintenance tasks.

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

6.35.2 Condition Panel Layout



6.35.3 Condition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new Condition Code.	Button	N/A	0
Condition	A code used to identify conditions relating to the claim that may affect payer processing.	Field	Number (Integer)	2
Delete	Allows a user to delete a Condition Code.	Button	N/A	0
Description	Description of the condition.	Field	Character	50
Sequence	Sequence numbers as they appeared on the claim.	Field	Number (Integer)	2

6.35.4 Condition Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Condition	Field	1	A valid Condition Code is required.	Enter a valid Condition Code or select a valid value from the [Search] panel.
	Field	107	Exceed maximum number of condition codes.	The maximum number of condition codes is 24.
Sequence	Field	1	Sequence contains duplicates.	Please select a sequence number that has not already been used.

6.35.5 Condition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.35.6 Condition Panel Accessibility

6.35.6.1 To Access the Condition Panel

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

6.35.6.2 To Add on the Condition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update the appropriate data.	
3	Click on **Save**.	Condition information saved.

6.35.6.3 To Delete on the Condition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.35.6.4 To Update the Condition Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Condition** from the Claim Information navigation panel.	Condition panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Condition data is saved.

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6.36 Data Correction Note Panel

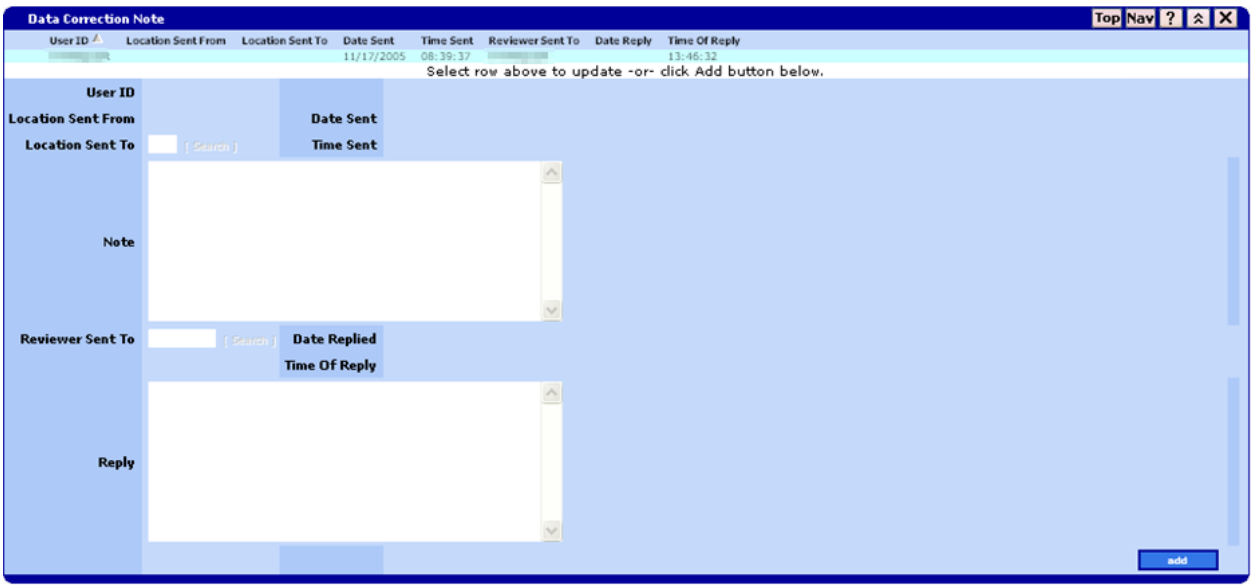
6.36.1 Data Correction Note Panel Narrative

The Data Correction Note panel is used by resolutions staff to forward questions to other people. Once the answer is received, the appropriate action can be taken by the note originator. When a note is sent, the claim is assigned to the location indicated on the note and reassigned to the new location the next time the claims scheduler is run to assign claims.

Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [Select Data Correction Note link from the displayed panel]

6.36.2 Data Correction Note Panel Layout



6.36.3 Data Correction Note Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new location note.	Button	N/A	0
Date Replied	The date the reply is sent.	Field	Date (MM/DD/CCYY)	8
Date Sent	The date the note is sent.	Field	Date (MM/DD/CCYY)	8
Location Sent From	The location that the note originates from. The user is required to use the [Search] to select a value.	Field	N/A	0
Location Sent To	The location that the note is being sent to. The user is required to use the [Search] to select a value.	Field	N/A	0
Note	The note that is sent.	Field	Character	256

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Field	Description	Field Type	Data Type	Length
Reply	The note containing the reply.	Field	Character	256
Reviewer Sent To	The identification of the person who reviews the note. The user is required to use the [Search] to select a value.	Field	N/A	0
Time Of Reply	The time that the reply is sent.	Field	Character	6
Time Sent	The time that the note is sent.	Field	Character	6
User ID	The identification of the User (clerk) who originates the note.	Field	Character	8

6.36.4 Data Correction Note Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Location Sent To	Field	1	A valid Location Sent To is required	Select a value for the Location from the [Search] panel.
Note	Field	1	Note is required.	Enter text for the note description.
Reviewer Sent To	Field	1	A valid Reviewer Sent To is required.	Select a User ID from the [Search] panel.

6.36.5 Data Correction Note Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.36.6 Data Correction Note Panel Accessibility

6.36.6.1 To Access the Data Correction Note Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to Claims and click Data Corrections.	Claims Suspense List panel displays.
3	Enter a **Clerk ID** and click **Search**.	
4	Select a row of data.	

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Step	Action	Response
5	Select **Data Correction Note** from the Physician Claim maintenance panel.	Data Correction Note panel displays.

6.36.6.2 To Add on the Data Correction Note Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update the appropriate information.	
3	Click on **Save**.	Data Correction Note information is saved.

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6.37 Decision Rules Panel

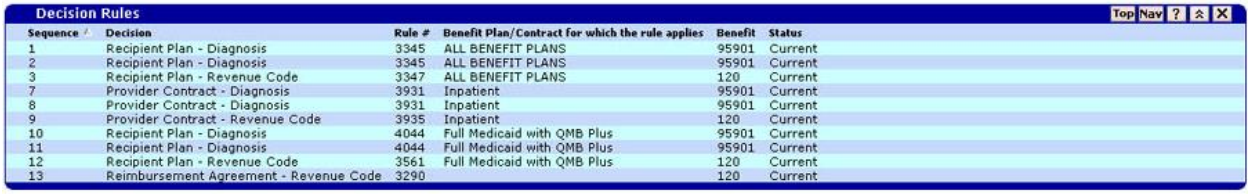
6.37.1 Decision Rules Panel Narrative

The Decision Rules panel displays Decision Rules (Benefit Plan Rules, Assignment Plan Rules, Provider Contract Rules) used to process a claim. *This panel is a new functionality and did not exist in the legacy system.*

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter ICN and click search button] – [Claim] – Decision Rules]

6.37.2 Decision Rules Panel Layout



Decision Rules

Sequence	Decision	Rule #	Benefit Plan/Contract for which the rule applies	Benefit	Status
1	Recipient Plan - Diagnosis	3345	ALL BENEFIT PLANS	95901	Current
2	Recipient Plan - Diagnosis	3345	ALL BENEFIT PLANS	95901	Current
3	Recipient Plan - Revenue Code	3347	ALL BENEFIT PLANS	120	Current
7	Provider Contract - Diagnosis	3931	Inpatient	95901	Current
8	Provider Contract - Diagnosis	3931	Inpatient	95901	Current
9	Provider Contract - Revenue Code	3935	Inpatient	120	Current
10	Recipient Plan - Diagnosis	4044	Full Medicaid with QMB Plus	95901	Current
11	Recipient Plan - Diagnosis	4044	Full Medicaid with QMB Plus	95901	Current
12	Recipient Plan - Revenue Code	3561	Full Medicaid with QMB Plus	120	Current
13	Reimbursement Agreement - Revenue Code	3290		120	Current

6.37.3 Decision Rules Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit	Code used to uniquely identify a benefit. The benefit code may be a Procedure, Diagnosis, National Drug Code (NDC), Diagnosis Related Group (DRG), International Classification of Diseases, or Revenue code depending on the Decision.	Listview	Alphanumeric	11
Benefit Plan/Contract for which the rule applies	Code used to uniquely identify a Benefit Plan or Contract. This represents the Benefit Plan or Contract applicable to the Rule. This field may not always be present depending on the Decision (example Reimbursement Rules or Copay Rules).	Listview	Alphanumeric	50
Decision	Decision for which the rule applies. Examples are Recipient Benefit Plan – Procedure, Recipient Assignment Plan – Diagnosis, Provider Contract – Revenue.	Listview	Alphanumeric	80
Rule #	System assigned key used to uniquely identify a rule within a decision.	Listview	Number (Integer)	9
Sequence	The order in which the rule was applied to the claim.	Listview	Number (Integer)	4
Status	Code used to indicate if a rule on the claim is a current rule ('C') – a rule that was used in the most recent processing	Listview	Character	7

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Field	Description	Field Type	Data Type	Length
	of the claim, or an historical rule ('H') – a rule that was previously used when the claim previously processed.			

6.37.4 Decision Rules Panel Field Edit Error Codes

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

6.37.5 Decision Rules Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.37.6 Decision Rules Panel Accessibility

6.37.6.1 To Access the Decision Rules Panel

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

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6.38 Diagnosis Panel

6.38.1 Diagnosis Panel Narrative

The Diagnosis panel displays the diagnosis codes applicable to the claim. Only users with update authority are allowed to perform maintenance tasks.

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

6.38.2 Diagnosis Panel Layout for Non-UB Claims

Diagnosis

Sequence	ICD Version	Diagnosis	Description
5	9	1234	DIPHYLLOBOTHRIASIS, INTESTINAL
3	9	2899	UNSPECIFIED DISEASES OF BLOOD AND BLOOD-
1	9	34540	PARTIAL EPILEPSY,W IMPAIRMENT OF CONSCIO
A	9	34540	PARTIAL EPILEPSY,W IMPAIRMENT OF CONSCIO
4	9	4011	BENIGN ESSENTIAL HYPERTENSION
2	9	9661	POISONING BY HYDANTOIN DERIVATIVES

6.38.2.1 Diagnosis Panel Layout for UB Claims

Diagnosis

Sequence	ICD Version	Diagnosis	Description	POA Indicator	POA Indicator Description
4	9	V270	MOTHER WITH SINGLE LIVEBORN	Y	DIAGNOSIS WAS PRESENT AT TIME OF INPATIENT ADMISSION
3	9	05410	GENITAL HERPES, UNSPECIFIED	N	DIAGNOSIS WAS NOT PRESENT AT TIME OF INPATIENT ADMISSION
2	9	64761	OTHER VIRAL DISEASES OF MOTHER, WITH DEL	1	EXEMPT FROM POA REPORTING.
1	9	64511	POST TERM PREGNANCY, OVER 40 WEEKS TO 42	U	DOCUMENTATION INSUFFICIENT TO DETERMINE IF CONDITION WAS PRESENT AT TIME OF INPATIENT ADMISSION
A	9	64511	POST TERM PREGNANCY, OVER 40 WEEKS TO 42	W	CLINICALLY UNDETERMINED IF THE CONDITION WAS PRESENT AT THE TIME OF INPATIENT ADMISSION

6.38.3 Diagnosis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Description of the Diagnosis Code, a short nomenclature for a medical condition.	Field	Character	50
Diagnosis	A code for the condition requiring medical attention. The medical classification of a disease or condition according to ICD.	Field	Character	7
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are '9' for ICD-9 and '0' for ICD-10.	Field	Character	1
POA Indicator	The Present On Admission (POA) field indicates if a recipient's condition existed at the time of admission. It applies only to Inpatient hospital claims and is required for a specific set of diagnosis codes in order to be paid. Valid values are: Y - Diagnosis was present at time of inpatient admission. W - Clinically undetermined if the condition was present at the time of inpatient admission. N - Diagnosis was not present at time of inpatient admission. U - Documentation insufficient to determine if condition was present at time of inpatient admission. 1 - Exempt from POA reporting.	Field	Alphanumeric	1

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Field	Description	Field Type	Data Type	Length
	Blank - Exempt from POA reporting.			
POA Indicator Description	Describes the corresponding POA Indicator code.	Field	Character	100
Sequence	Sequential order of the Diagnosis Codes submitted on the claim.	Field	Number (Integer)	2

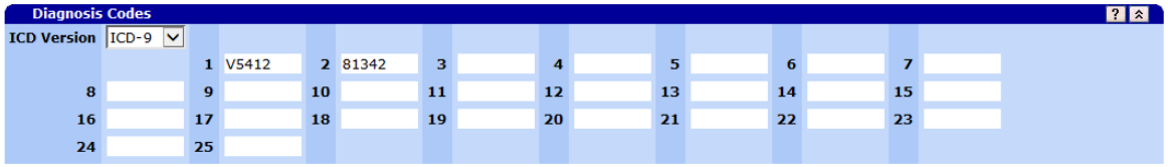
6.38.4 Diagnosis Codes – Data Correction Panel

The Diagnosis Codes panel displays the diagnosis codes applicable to the claim. Edits to diagnosis codes can be made via Data Correction.

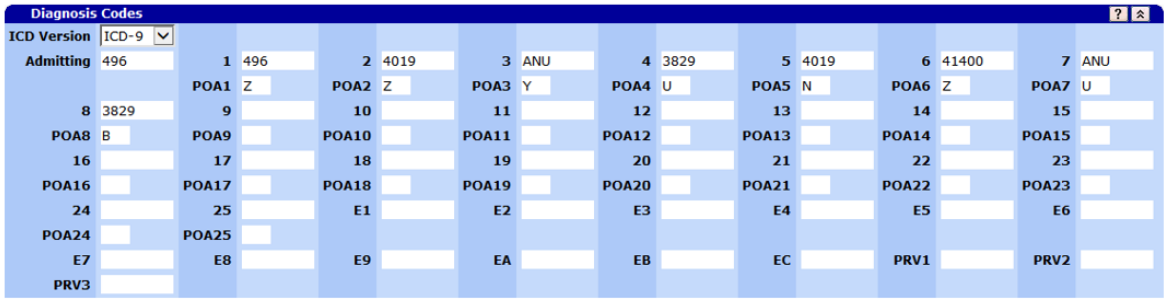
Navigation Path**:** [Claims**] –** [Data Correction] – [Enter Clerk ID**,** search then select a claim from the list] – [scroll down to Diagnosis panel] --OR-- [Claims] – [Information] – [Enter ICN, Click on Search] – [Click the "Data Correct" button]

6.38.5 Diagnosis Codes Panel Layout – Data Correction Panel

DC Panel for Non-UB Claim



DC Panel for UB Claim



6.38.6 Diagnosis Codes Panel Field Descriptions – Data Correction Panel

Field	Description	Field Type	Data Type	Length
Admitting	The admitting diagnosis code field.	Field	Character	7
Diagnosis 1, 2, 3, etc.	Sequence numbers for the related diagnosis code fields.	Field	Character	7
Emergency E1, E2, E3, etc.	The emergency diagnosis code field.	Field	Character	7

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Field	Description	Field Type	Data Type	Length
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are ICD-9 and ICD-10.	Combo Box	Drop Down List Box	1
POA 1,2,3, etc	POA1-POA25: Present On Admission (POA) indicator field displays the POA value for the related diagnosis code. Each diagnosis code has one present on admission indicator.	Field	Alphanumeric	1
PRV 1, 2 and 3.	PRV 1, 2, 3 codes for Patient Reason Visit fields.	Field	Character	7

6.38.7 Diagnosis Panel Field Edit Error Codes - Data Correction Panel

Field	Field Type	Error Code	Error Message	To Correct
Diagnosis	Field	1	A valid Diagnosis is required.	Enter a valid Diagnosis Code.
	Field	2	Diagnosis must be less than or equal to 7.	Enter a valid Diagnosis Code.
POA 1,2,3, etc	Field	1	POA Indicator not on file.	Enter correct POA indicator or even can be left null.

6.38.8 Diagnosis Panel Extra Features - Data Correction Panel

Field	Field Type
No extra features found for this panel.	

6.38.9 Diagnosis Panel Accessibility- Data Correction Panel

Field	Field Type
No extra features found for this panel.	

6.38.10 To Access the Diagnosis Panel - Data Correction Panel

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

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Step	Action	Response
5	Select the **Diagnosis** hyperlink from the Claim Detail Navigation panel.	Diagnosis panel displays below the Claim Detail panel.

6.38.11 To Update the Diagnosis Panel - Data Correction Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Diagnosis** from the Claim Information navigation panel.	Diagnosis panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Diagnosis data is saved.

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6.39 Display TCN Panel

6.39.1 Display TCN Panel Narrative

The Display TCN panel shows the transaction control number (TCN) number associated with the claim.

This panel is display only.

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

6.39.2 Display TCN Panel Layout

6.39.3 Display TCN Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
TCN	The transaction control number (TCN) used to uniquely identify claims on the previous MMIS.	Field	Character	17

6.39.4 Display TCN Panel Field Edit Error Codes

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

6.39.5 Display TCN Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.39.6 Display TCN Panel Accessibility

6.39.6.1 To Access the TCN Panel

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

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6.39.6.2 To Update the TCN Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **TCN** from the Claim Information navigation panel.	TCN panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	TCN data is saved.

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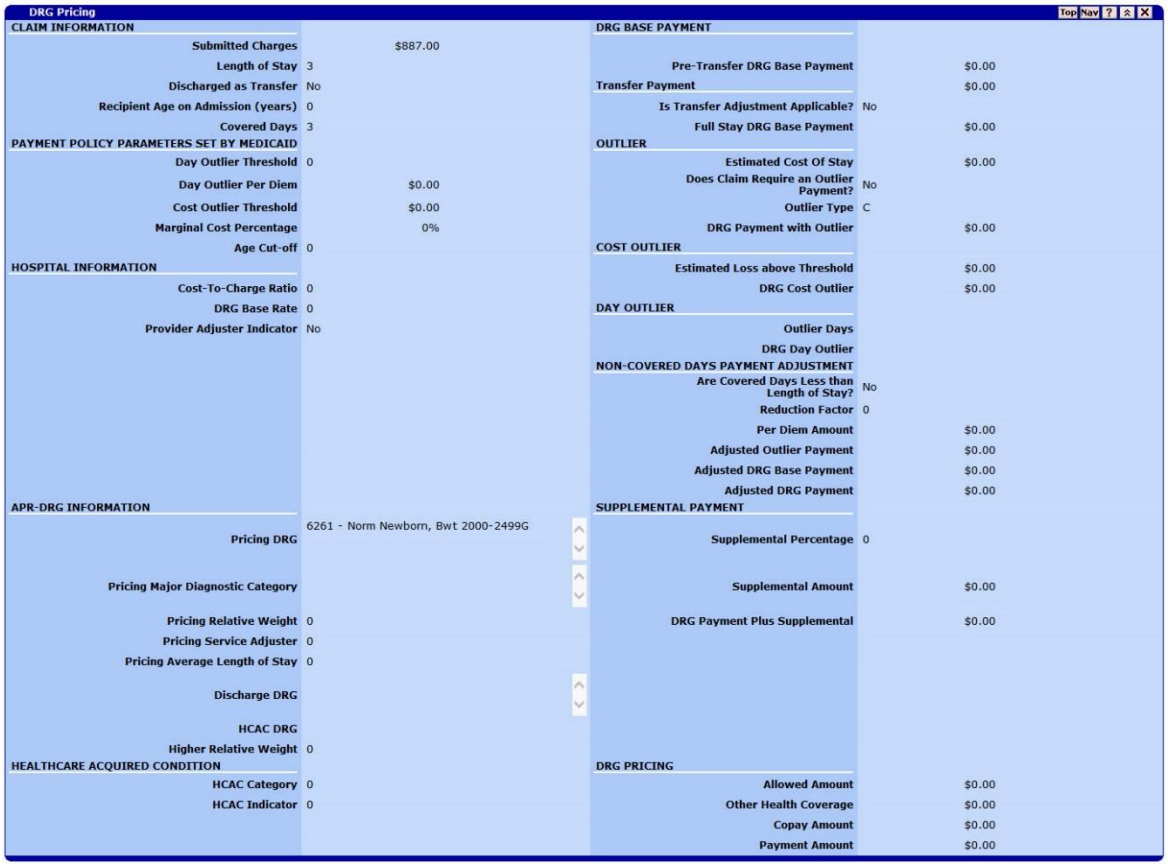
6.40 DRG Pricing Panel

6.40.1 DRG Pricing Panel Narrative

The Diagnosis Related Group (DRG) Assignment and Pricing panel displays DRG related data for an inpatient claim.

Navigation Path: [Claims] – [Search] – [Enter an ICN for a UB04 claim] – [Select DRG Pricing link from the UB04 Claim Navigation panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select DRG Pricing link from the UB04 Claim Navigation panel].

6.40.2 DRG Pricing Panel Layout



6.40.3 DRG Pricing Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjusted DRG Base Payment	DRG base payment adjusted by the non-covered days. Excludes outlier.	Field	Number (Decimal)	9
Adjusted DRG Payment	DRG payment adjusted by the non-covered days. Includes outlier.	Field	Number (Decimal)	9
Adjusted Outlier Payment	Outlier payment adjusted by the non-covered days.	Field	Number (Decimal)	9

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Field	Description	Field Type	Data Type	Length
Age Cut-off	The age cutoff used in applying the adult or pediatric DRG service adjuster. If the recipient is less than the cutoff, the pediatric service adjuster will be applied; otherwise, the adult service adjuster will be applied.	Field	Number	3
Allowed Amount	Claim allowed amount.	Field	Number (Decimal)	9
Are Covered Days Less than Length of Stay?	Yes or No. Compare length of inpatient stay to the covered days.	Field	Character	3
Copay Amount	Claim copayment amount.	Field	Number (Decimal)	9
Cost Outlier Threshold	Dollar amount set by Medicaid as the threshold for a cost outlier payment.	Field	Number (Decimal)	9
Cost-To-Charge Ratio	Hospital cost to charge ratio used in calculating a cost outlier.	Field	Number (Decimal)	6
Covered Days	Number of covered days on the claim after non-covered days adjustment.	Field	Number (Integer)	4
Day Outlier Per Diem	This is the day outlier per diem amount.	Field	Number (Decimal)	9
Day Outlier Threshold	This is the day outlier threshold.	Field	Number (Integer)	4
Discharge DRG	DRG code assigned to the claim for non-HCAC diagnoses and procedures.	Field	Character	60
Discharged as Transfer	Is the patient status a transfer status? Yes or No.	Field	Character	3
Does Claim Require an Outlier Payment?	Length of inpatient stay in days.	Field	Number (Decimal)	4
DRG Base Rate	Hospital base rate amount.	Field	Number (Decimal)	9
DRG Cost Outlier	This is the outlier amount if the outlier type is ‘C’ for Cost.	Field	Number (Decimal)	4
DRG Day Outlier	This is the outlier amount if the outlier type is ‘D’ for Day. It is calculated as Outlier Days x Day Outlier Per Diem.	Field	Number (Decimal)	9
DRG Payment Plus Supplemental	Final DRG payment amount plus the supplemental amount.	Field	Number (Decimal)	9
DRG Payment with Outlier	DRG full stay payment plus the outlier amount.	Field	Number (Decimal)	4

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Field	Description	Field Type	Data Type	Length
Estimated Cost Of Stay	The estimated cost of stay for provider for the claim.	Field	Number (Decimal)	4
Estimated Loss above Threshold	Provider estimated cost – DRG full stay – outlier threshold.	Field	Number (Decimal)	4
Full Stay DRG Base Payment	DRG base payment after the transfer adjustment is applied.	Field	Number (Decimal)	4
HCAC Category	HCAC diagnosis category returned by the grouper.	Field	Character	2
HCAC DRG	DRG code assigned to the claim for HCAC diagnoses and procedures. HCAC = Health Care Acquired Condition.	Field	Character	60
HCAC Indicator	HCAC DRG code involvement to the claim. Values spaces = No HCAC found, 1 = HCAC found but DRG did not change, 2 = HCAC found and affected DRG assignment.	Field	Character	1
Higher Relative Weight	Relative weight assigned to the DRG with the highest relative weight if there are two DRGs.	Field	Number (Decimal)	7
Is Transfer Adjustment Applicable?	Yes if the claim is a transfer. No if the claim is not a transfer.	Field	Number (Decimal)	4
Length of Stay	Length of inpatient stay in days.	Field	Number	4
Marginal Cost Percentage	Percentage amount set by Medicaid to calculate the cost outlier.	Field	Number (Decimal)	9
Other Health Coverage	Claim TPL amount.	Field	Number (Decimal)	9
Outlier days	This contains the number of days used for the day outlier calculation. It is calculated as Length Of Stay – Day Outlier Threshold. Negative result will show as zero.	Field	Number (Integer)	9
Outlier Type	This is the outlier type. C = Cost, D = Day. C (cost) will be the default and will be set even if the claim has no outlier amount.	Field	Character	1
Payment Amount	Claim paid amount.	Field	Number (Decimal)	9

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Field	Description	Field Type	Data Type	Length
Per Diem Amount	The per deim amount of the DRG payment. This will be zero if there are no non-covered days.	Field	Number (Decimal)	9
Pre-Transfer DRG Base Payment	DRG base payment prior to any transfer adjustment.	Field	Number (Decimal)	4
Pricing Average Length of Stay	Average length of inpatient stay for the pricing DRG.	Field	Number (Decimal)	5
Pricing DRG	DRG code used to price the claim. If there are two DRG codes on the claim, this will be the lower weight DRG.	Field	Character	60
Pricing Major Diagnostic Category	Major Diagnostic Category of the pricing DRG.	Field	Character	42
Pricing Relative Weight	Relative weight associated to the pricing DRG.	Field	Number (Decimal)	7
Pricing Service Adjuster	Service adjuster associated to the pricing DRG and the age of the recipient on the admit date.	Field	Number (Decimal)	6
Provider Adjuster Indicator	The Provider Adjuster Indicator.	Field	Character	3
Recipient Age on Admission (years)	Recipient age in years as of the admission date of the claim.	Field	Number	3
Reduction Factor	The non-covered days reduction factor.	Field	Number (Decimal)	6
Submitted Charges	Claim total billed amount.	Field	Number (Decimal)	9
Supplemental Amount	Supplemental amount.	Field	Number (Decimal)	9
Supplemental Percentage	Supplemental percentage to be applied to the claim from the DRG payment.	Field	Number (Decimal)	7
Transfer Payment	Payment calculated for a transfer status claim. This will be zero if the claim is not a transfer.	Field	Number (Decimal)	4

6.40.4 DRG Pricing Panel Field Edit Error Codes

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

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60.40.5 DRG Pricing Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.40.6 DRG Pricing Panel Accessibility

6.40.6.1 To Access the DRG Pricing Panel

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

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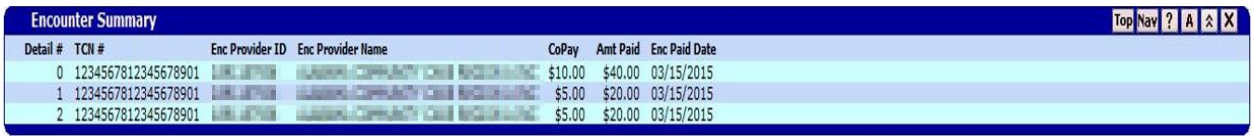
6.41 Encounter Summary Panel

6.41.1 Encounter Summary Panel Narrative

The Encounter Summary panel displays the Encounter information submitted on an encounter claim. This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN for an Encounter claim] – [Select Encounter Summary link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select an Encounter claim] – [Select Encounter Summary link from the displayed panel]

6.41.2 Encounter Summary Panel Layout



6.41.3 Encounter Summary Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amt Paid	This field displays the payment amount submitted by the Enc Provider Id.	Field	Number (Decimal)	9
CoPay	This field displays the amount of copay submitted by the Enc Provider Id.	Field	Number (Decimal)	9
Detail #	This field displays the claim detail number to which the data applies. A detail number of 0 (zero) indicates header data.	Field	Number (Integer)	4
Enc Paid Date	This field displays the date of payment submitted by the Enc Provider Id.	Field	Date (MM/DD/CCYY)	8
Enc Provider Id	This field displays the submitted Provider Identification Number.	Field	Character	60
Enc Provider Name	This field displays the name submitted by the Enc Provider Id.	Field	Character	60
TCN #	This field displays the transaction control number submitted by the Enc Provider Id.	Field	Character	15

6.41.4 Encounter Summary Information Panel Field Edit Error Codes

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

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6.41.5 Encounter Summary Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.41.6 Encounter Summary Panel Accessibility

6.41.6.1 To Access the Encounter Summary Panel

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

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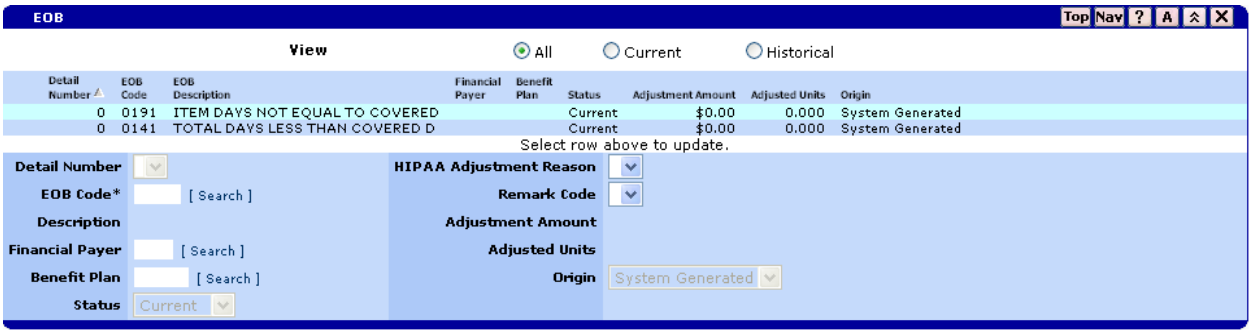
6.42 EOB Panel

6.42.1 EOB Panel Narrative

The EOB (Explanation of Benefit) panel is in view-only mode when accessed through Claims Inquiry. The panel is editable when accessed through Data Corrections. The Claim EOB Codes panel displays the EOB codes and messages applicable to the claim that is in suspense. These codes and messages are generated to explain to the provider the reason that the claim is in suspense. In most cases, the same codes are generated to explain the denial of a claim. Records may be added or deleted from this panel. The EOB Code and Detail number can be changed. Due to the data-relationship between EOB code and the HIPAA Adjustment Reason and Remarks Code fields, the latter 2 fields cannot be changed. Instead, when the EOB Code is changed, those other 2 fields are updated (they derive their value from the EOB Code and its Effective Date). If there are no corresponding HIPAA Adjustment Reasons or Remarks Codes for a given EOB Code, the panel displays those fields blank. The Adjustment Amt and Adjustment Units fields are updated in batch and are non-editable in the panel. Only users with update authority are allowed to perform maintenance tasks.

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

6.42.2 EOB Panel Layout



6.42.3 EOB Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
All	Selected to display all current and historical EOB detail information.	Combo Box	Radio Button	0
Adjusted Units	The quantity adjusted on the detail.	Field	Number (Decimal)	10
Adjustment Amount	The dollar amount adjusted on the detail.	Field	Number (Decimal)	9
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Character	5
Current	Selected to display all current EOB detail information.	Combo Box	Radio Button	0

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Field	Description	Field Type	Data Type	Length
Detail Number	The detail number to which the Explanation of Benefit message is attached.	Field	Number (Integer)	4
EOB Code	Code number attached to an Explanation of Benefit message.	Field	Character	4
(EOB) Description	First line of text description for Explanation of Benefit code.	Field	Character	79
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	4
HIPAA Adjustment Reason	The Health Insurance Portability and Accountability Act (HIPAA) code explaining why the service or claim paid differently from the billed amount.	Combo Box	Drop Down List Box	0
Historical	Selected to display all historical EOB detail information.	Combo Box	Radio Button	0
Origin	Indicates how the EOB Code and message were generated: Valid values are 'S - System Generated' or 'U - User Assigned'.	Combo Box	Drop Down List Box	0
Remark Code	The code for the remarks.	Combo Box	Drop Down List Box	0
Status	Indicates whether the Explanation of Benefit is current or history.	Combo Box	Drop Down List Box	0

6.42.4 EOB Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Benefit Plan	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select one from the [Search] panel.
EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
	Field	2	A valid EOB Code is required.	Enter a valid EOB Code or select a valid code from the [Search] panel.

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6.42.5 EOB Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.42.6 EOB Panel Accessibility

6.42.6.1 To Access the EOB Panel

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

6.42.6.2 To Update the EOB Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **EOB** from the Claim Information navigation panel.	EOB panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	EOB data is saved.

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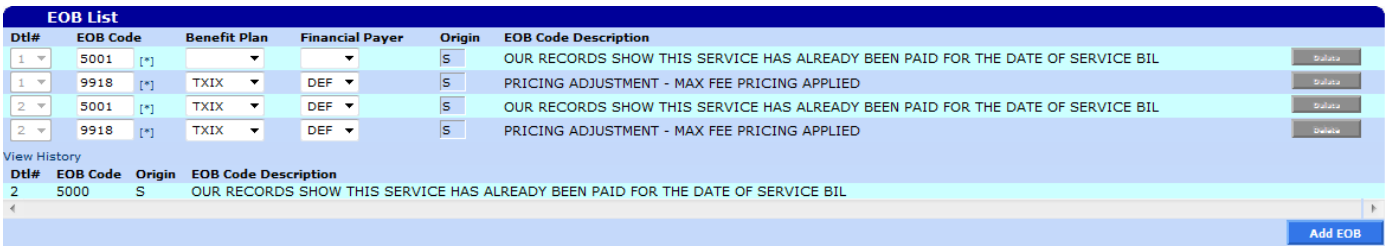
6.43 EOB List Panel

6.43.1 EOB List Panel Narrative

The EOB List panel for Data Correction is accessed for suspended claims. This panel displays the header and/or detail EOBs applicable to the claim being viewed.

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

6.43.2 EOB List Panel Layout



6.43.3 EOB List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add EOB	Adds a new EOB record.	Button	N/A	0
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Drop Down List Box	0
Delete	Deletes an EOB record.	Button	N/A	0
Dtl #	The number of the header or detail that contains an edit or an audit failure.	Field	Drop Down List Box	0
EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it.	Field	Number (Integer)	4
EOB Code Description	Description of the explanation of benefit code.	Field	Character	79
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Drop Down List Box	0
Origin	Indicates how the EOB Code and message were generated: Valid values are 'S - System Generated' or 'U - User Assigned.	Field	Character	1
View History	Displays all history records.	Hyperlink	N/A	0

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6.43.4 Error List Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
EOB Code	Field	1	Invalid EOB code (####) for detail #.	Enter a valid EOB Code or select a valid code from the search link [*].

6.43.5 EOB List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.43.6 EOB List Panel Accessibility

6.43.6.1 To Access the EOB List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Search**.	Claims Search panel displays.
3	Enter appropriate search criteria for suspended claim and click **Search.**	Claim Search Results Panel displays.
4	Click required record in search result	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Click **data correct** button.	Claim Header, Maintenance, Claim detail list, Error list, EOB List, Data Correction Note, Manual Pricing, Diagnosis Codes, NDC Details, Related History, Payer Code, ICD9 Codes, Occurrence codes, value codes, condition codes and Medicare data panels are displayed for data correction.

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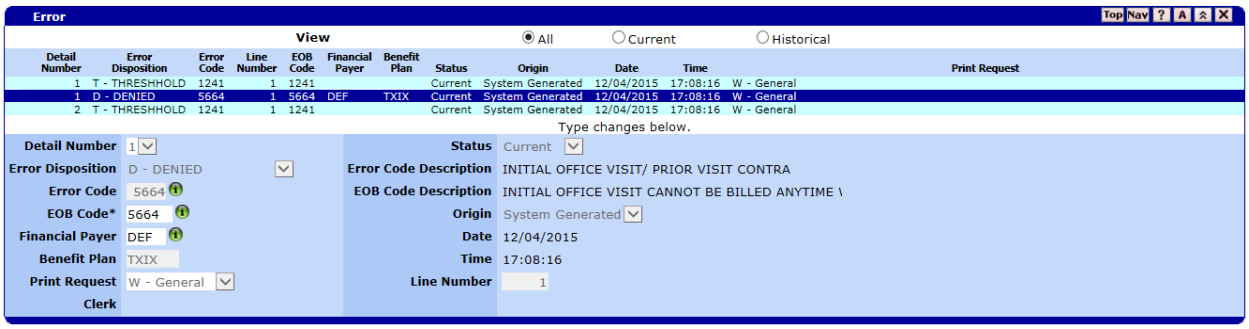
6.44 Error Panel

6.44.1 Error Panel Narrative

The Claim Error panel is accessed from the paid, denied, or suspended claim panels. This panel displays the header and/or detail errors applicable to the claim being viewed. Field edits and the Add/Delete buttons are for Data Correction only. Only users with update authority are allowed to perform maintenance tasks.

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

6.44.2 Error Panel Layout



6.44.3 Error Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record.	Button	N/A	0
All	Selected to display all current and historical Error information.	Combo Boxc	Radio Button	0
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Character	5
Clerk	Number used to identify the user who last updated the error record.	Field	Character	8
Current	Selected to display all current Error information.	Combo Box	Radio Button	0
Date	Date of the error code.	Field	Date (MM/DD/CCYY)	8
Delete	Allows a user to delete a record.	Button	N/A	0
Detail Number	The number of the header or detail that contains an edit or an audit failure.	Combo Box	Drop Down List Box	0
EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it.	Field	Number (Integer)	4

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Field	Description	Field Type	Data Type	Length
EOB Code Description	Description of the explanation of benefit code.	Field	Character	79
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit.	Field	Number (Integer)	4
Error Code Description	Description of the error.	Field	Character	50
Error Disposition	Code that represents the action that is taken on a claim at disposition time: pay (P), deny (D), suspend (S), force override (F), reject (J), or batch suspend (B).	Combo Box	Drop Down List Box	0
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	4
Historical	Selected to display all historical Error detail information.	Combo Box	Radio Button	0
Line Number	Represents the Error Disposition Key.	Field	Number (Integer)	4
Origin	Indicates how the EOB Code and message were generated: Valid values are 'S - System Generated' or 'U - User Assigned'.	Combo Box	Drop Down List Box	0
Print Request	The valid values are: Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report.	Combo Box	Drop Down List Box	0
Save	This allows the user to save a record on the Error panel.	Button	N/A	0
Status	Indicates whether the Error is current or history.	Combo Box	Drop Down List Box	
Time	Time of the error code. Format HH:MM:SS.	Field	Number (Integer)	6

6.44.4 Error Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Benefit Plan	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select a valid Benefit Plan from the [Search] panel.

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Field	Field Type	Error Code	Error Message	To Correct
EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
Error Code	Field	1	Invalid Error Code.	Enter a valid Error Code or select a valid code from the [Search] panel.
	Field	2	Error Code XXXX cannot be overridden.	Enter a valid Error Code or select a valid code from the [Search] panel.
	Field	3	Error Code XXXX cannot have the Error Disposition set to 'Deny'.	Enter a valid Error Code or select a valid code from the [Search] panel.
	Field	4	Invalid Error Code.	Invalid Error Code.
Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer or select one from the [Search] panel.

6.44.5 Error Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.44.6 Error Panel Accessibility

6.44.6.1 To Access the Error Panel

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

6.44.6.2 To Update the Error Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim Information panel displays.
3	Select **Error** from the Claim Information navigation panel.	Error panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Error data is saved.

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6.45 Health Program Panel

6.45.1 Health Program Panel Narrative

The Health Program panel is used to display the program information for a claim. Only users with update authority are allowed to perform maintenance tasks.

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

6.45.2 Health Program Panel Layout

6.45.3 Health Program Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Aid Category for Medicaid coverage.	Field	Number (Integer)	9
Allowed Amount	Amount allowed for payment on the claim.	Field	Number (Decimal)	9
Allowed Quantity	Number of units allowed under a financial payer/benefit plan.	Field	Number (Integer)	6
Benefit Hierarchy	This is the hierarchical order with which multiple, concurrent benefits assigned to a recipient are processed.	Field	Number (Integer)	9
Copay Amount	This is the amount of copay that is subtracted from the allowed amount. This is the amount the Recipient is responsible for.	Field	Number (Decimal)	7
Detail Number	Number that indicates the claim detail line.	Combo Box	Drop Down List Box	0
Encounter Amount	This contains the amount for encounter services on the claim	Field	Number (Decimal)	10

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Field	Description	Field Type	Data Type	Length
	detail indicated by the detail number on the table.			
Finalized Date	Date that Financial finalizes the claim for this payer. This is when the claims are processed in Financial cycle and paid or denied, and RAs are produced.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	9
Fund Code	Indicates the budget category that the funds used to pay this claim/detail came from.	Field	Number (Integer)	9
Header/Detail Number	Number that indicates the header claim line. Number is 0 (zero) to indicate header level.	Field	Number (Integer)	3
Health Program	Name of program the header/detail was processed and/or paid under.	Field	Character	50
Paid Amount	The total amount paid on the claim.	Field	Number (Decimal)	10
Paid Amount 2009	This field indicates the 2009 paid amount for claims paid using the Primary Care Provider rate. Claims not paid the PCP rate will have zero in this field.	Field	Number (Decimal)	10
Payer Hierarchy	Payer Hierarchy is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment plans for recipient's who are enrolled in multiple entities of any of these types.	Field	Character	9
Pricing Indicator	Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced.	Field	Character	6
Primary Plan Indicator	Indicator identifies this entry as having the most payable plan for a given claim. If a claim has paid under this plan, it will be primary regardless of what type of eligibility. If a claim does not pay at all, first covered plans get priority, then non-covered plans. Within those	Field	Character	1

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Field	Description	Field Type	Data Type	Length
	categories, non-verified eligibility will get priority over verified eligibility. Values ('Y' – plan is marked primary, 'N' – plan is not marked primary)			
Provider Contract - Bill	Provider contract, under which the service was deemed covered, for the Billing Provider.	Field	Character	20
Provider Contract - Rend	Provider contract, under which the service was deemed covered, for the Rendering Provider.	Field	Character	20
Rate Percent Amount 2009	This field indicates the rate used to calculate the 2009 paid amount for claims paid using the Primary Care Provider rate. Claims not paid the PCP rate will have zero in this field.	Field	Number (Decimal)	7
Rate Type	Code used to identify the rate type to use in determining provider reimbursement.	Field	Character	3
Recipient Assignment	This describes the relationships between the Recipient and Provider for purposes of care. This information encompasses the Recipient level of care nursing home information, Provider lock-in information, hospice information, some Provider specific waiver information, and other benefit information that relates a Recipient to a Provider.	Field	Character	9
State Share Amount	This is the amount of state share for this payment. The state share amount plus the amount Paid = Reimbursement amount. N/A for Alabama Medicaid.	Field	Number (Decimal)	10

6.45.4 Health Program Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Allowed Amount	Field	1	Enter a valid Value.	Verify allowed amount entered is less than billed amount on the detail for detail paid claims and less than the billed amount on the header for header paid claims.

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6.45.5 Health Program Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.45.6 Health Program Panel Accessibility

6.45.6.1 To Access the Health Program Panel

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

6.45.6.2 To Update the Health Program Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Health Program** from the Claim Information navigation panel.	Health Program panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Health Program data is saved.

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6.46 ICN Recipient Link Panel

6.46.1 ICN Recipient Link Panel Narrative

The ICN Recipient Link panel displays the rekey history added to table t_clm_recip_hist by the new rekey process.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter ICN and click search button] – [Select Decision Rules link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select "ICN Recipient Link" from the displayed panel]

6.46.2 ICN Recipient Link Panel Layout

6.46.3 ICN Recipient Link Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date	Date the claim recipient was changed.	Field	Date (MM/DD/CCYY)	8
ICN	Number assigned to a claim processed in the system.	Field	Character	13
New RID	Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_NEW.	Field	Character	12
New Recipient DOB	Date of birth of the new recipient assigned to the claim.	Field	Number (Integer)	8
New Recipient Name	Name of the new recipient assigned to the claim.	Field	Character	36
Old RID	Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_OLD.	Field	Character	12
Old Recipient DOB	Date of birth of the recipient formerly assigned to the claim.	Field	Number (Integer)	8
Old Recipient Name	Name of the recipient formerly assigned to the claim.	Field	Character	36
Time	Time the claim recipient was changed.	Field	Number (HH:MM:SS)	8

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6.46.4 ICN Recipient Link Panel Field Edit Error Codes

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

6.46.5 ICN Recipient Link Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.46.6 ICN Recipient Link Panel Accessibility

6.46.6.1 To Access the ICN Recipient Link Panel

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

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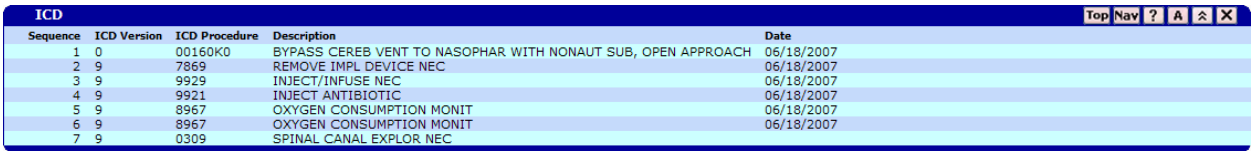
6.47 ICD Panel

6.47.1 ICD Panel Narrative

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

Navigation Path: [Claims] – [Information] – [Enter an ICN for a UB04 claim] – [Select ICD link from the displayed panel] – OR – [Claims] - Search] – [Enter Criteria] – [Select a UB04 claim] – [Select ICD link from the displayed panel]

6.47.2 ICD Panel Layout



ICD

Sequence	ICD Version	ICD Procedure	Description	Date
1	0	00160K0	BYPASS CEREB VENT TO NASOPHAR WITH NONAUT SUB, OPEN APPROACH	06/18/2007
2	9	7869	REMOVE IMPL DEVICE NEC	06/18/2007
3	9	9929	INJECT/INFUSE NEC	06/18/2007
4	9	9921	INJECT ANTIBIOTIC	06/18/2007
5	9	8967	OXYGEN CONSUMPTION MONIT	06/18/2007
6	9	8967	OXYGEN CONSUMPTION MONIT	06/18/2007
7	9	0309	SPINAL CANAL EXPLOR NEC	

6.47.3 ICD Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date	Date the ICD procedure was performed.	Field	Date (MM/DD/CCYY)	8
Description	Description of the surgical procedure code.	Field	Character	60
ICD Procedure	Code used to identify the surgical procedure code, principal or other.	Field	Alphanumeric	7
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are '9' for ICD-9 and '0' for ICD-10.	Field	Character	1
Sequence	This column contains the sequence number of the surgical procedure code. The principal procedure will always be sequence 1.	Field	Number (Integer)	4

6.47.4 ICD Panel Field Edit Error Codes

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

6.47.5 ICD Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.47.6 ICD Panel Accessibility

6.47.6.1 To Access the ICD Panel

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

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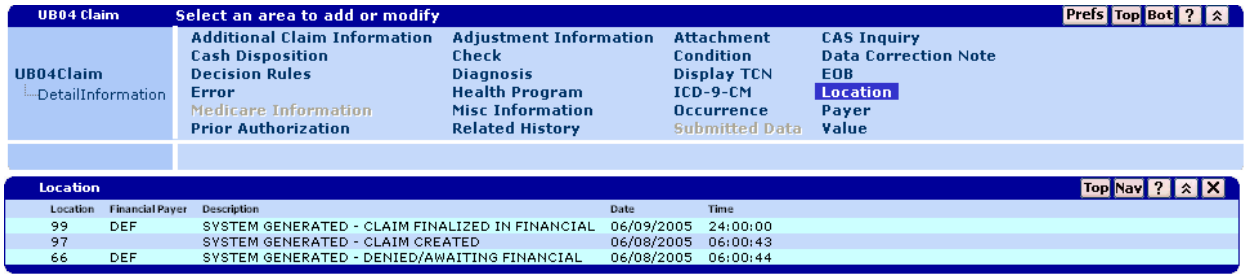
6.48 Location Panel

6.48.1 Location Panel Narrative

The Location panel displays claim location information. When opened from an inquiry panel, the Claim Location panel is not updateable. However, when opened from a Data Correction panel, the Add button is displayed allowing the user to add a location. This gives the user the ability to route the claim to another department for correction. This panel is shared by all claim types. This panel is display only.

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

6.48.2 Location Panel Layout



6.48.3 Location Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date	The date the claim went to this location.	Field	Date (MM/DD/CCYY)	8
Description	Description of the claim location within the claims processing system.	Field	Character	50
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	10
Location	Indicates claim location within the claims processing system.	Field	Character	2
Time	The time the claim went to this location.	Field	Number (Integer)	8

6.48.4 Location Field Panel Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Location	Field	1	Invalid Location Code.	Enter a valid Location Code or select a code from the [Search] panel.
	Field	2	A valid Claim Location is required.	Enter a valid Location Code before clicking the Save button.

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6.48.5 Location Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.48.6 Location Panel Accessibility

6.48.6.1 To Access the Location Panel

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

6.48.6.2 To Update the Location Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk id** and select a claim.	Claim information panel displays.
3	Select **Location** from the Claim Information navigation panel.	Location panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Location data is saved.

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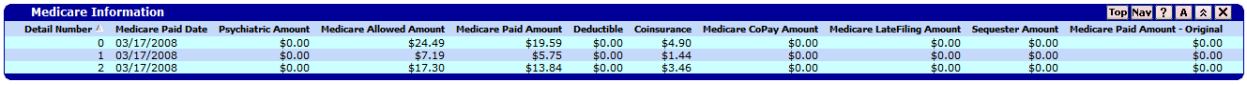
6.49 Medicare Information-Physician Panel

6.49.1 Medicare Information-Physician Panel Narrative

The Medicare Information panel displays the Medicare information applicable to the claim. This panel is display only.

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

6.49.2 Medicare Information-Physician Panel Layout



Medicare Information

Detail Number	Medicare Paid Date	Psychiatric Amount	Medicare Allowed Amount	Medicare Paid Amount	Deductible	Coinsurance	Medicare CoPay Amount	Medicare LateFiling Amount	Sequester Amount	Medicare Paid Amount - Original
0	03/17/2008	$0.00	$24.49	$19.59	$0.00	$4.90	$0.00	$0.00	$0.00	$0.00
1	03/17/2008	$0.00	$7.19	$5.75	$0.00	$1.44	$0.00	$0.00	$0.00	$0.00
2	03/17/2008	$0.00	$17.30	$13.84	$0.00	$3.46	$0.00	$0.00	$0.00	$0.00

6.49.3 Medicare Information-Physician Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Coinsurance	Amount which represents the recipient's coinsurance payment.	Field	Number (Decimal)	8
Deductible	The amount the recipient must pay before Medicare.	Field	Number (Decimal)	8
Detail Number	Indicates if the row pertains to the claim header or a claim detail line. The claim header is denoted by a zero.	Field	Number (Integer)	4
Medicare Allowed Amount	The dollar amount allowed by Medicare for the services.	Field	Number (Decimal)	8
Medicare Copay Amount	Dollar amount which represents the recipient copayment.	Field	Number (Decimal)	8
Medicare Late Filing Amount	The amount Medicare has determined that a recipient must pay for late filing.	Field	Number (Decimal)	8
Medicare Paid Date	The date Medicare paid for the services.	Field	Date (MM/DD/CCYY)	8
Medicare Paid Amount	The dollar amount paid by Medicare for the services.	Field	Number (Decimal)	8
Medicare Paid Amount - Original	The dollar amount paid by Medicare for the services provided. This amount reflects the subtraction of the 2% sequestration amount.	Field	Number (Decimal)	10

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Field	Description	Field Type	Data Type	Length
Psychiatric Amount	The amount Medicare has determined that a recipient must pay for psychiatric services received. N/A for Alabama Medicaid.	Field	Number (Decimal)	8
Sequester Amount	The dollar amount of the 2% sequestration as required by the ACC.	Field	Number (Decimal)	8

6.49.4 Medicare Information-Physician Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Coinsurance	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Coinsurance Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.
Deductible	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Deductible Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.
Medicare Allowed Amount	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Medicare Allowed Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.
Medicare Copay Amount	Field	1	Medicare Copay Amount must be less than or equal to 99999999.99	Enter a numeric value less than or equal to 99999999.99
	Field	2	Medicare Copay Amount must be greater than or equal to 0.	Enter a numeric value less than or equal to 0
Medicare Late Filing Amount	Field	1	Medicare Late Filing Amount must be less than or equal to 99999999.99	Enter a numeric value less than or equal to 99999999.99
	Field	2	Medicare Late Filing Amount must be	Enter a numeric value less than or equal to 0

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Field	Field Type	Error Code	Error Message	To Correct
			greater than or equal to 0.	
Medicare Paid Amount	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Medicare Paid Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.
Medicare Paid Amount – Original	Field	1	Enter a valid value.	Enter a numeric value. Format 99999999.99.
	Field	2	Medicare Paid Amount – Original must be less than or equal to 99999999.99.	Enter a value less than or equal to 99999999.99.
Medicare Paid Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY Format.
Psychiatric Amount	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Psychiatric Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.
Sequester Amount	Field	1	Enter a valid value	Enter a numeric value. Format 999999.99.
	Field	2	Sequester Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.

6.49.5 Medicare Information-Physician Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.49.6 Medicare Information-Physician Panel Accessibility

6.49.6.1 To Access the Medicare Information-Physician Panel

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

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Step	Action	Response
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **Medicare Information** hyperlink from the Physician Claim Information Navigation panel.	Medicare Information for Physician panel displays below the Claim Detail panel.

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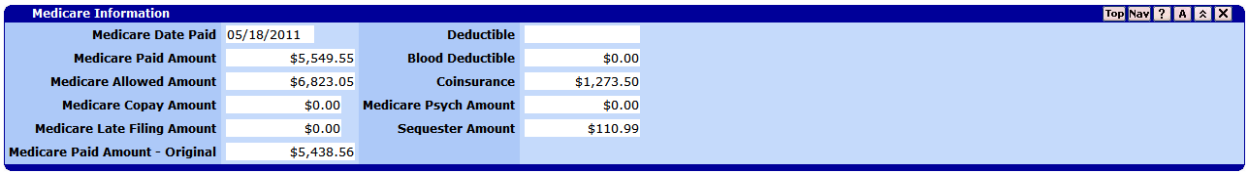
6.50 Medicare Information-UB04 Panel

6.50.1 Medicare Information-UB04 Panel Narrative

The Medicare Information panel displays the Medicare information applicable to the UB04 crossover claim. Field Edits are for Data correction only. This panel is display only.

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

6.50.2 Medicare Information-UB04 Panel Layout



6.50.3 Medicare Information-UB04 Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Blood Deductible	The amount Medicare has determined that a recipient must pay for blood procedures performed. N/A for Alabama Medicaid.	Field	Number (Decimal)	8
Coinsurance	Dollar amount which represents the recipient's coinsurance payment.	Field	Number (Decimal)	8
Deductible	The amount the recipient must pay before Medicare.	Field	Number (Decimal)	8
Medicare Allowed Amount	The dollar amount allowed by Medicare for the services.	Field	Number (Decimal)	8
Medicare Copay Amount	Dollar amount which represents the recipient copayment.	Field	Number (Decimal)	8
Medicare Date Paid	The date Medicare paid for the services.	Field	Date (MM/DD/CCYY)	8
Medicare Late Filing Amount	The amount Medicare has determined that a recipient must pay for late filing.	Field	Number (Decimal)	8
Medicare Paid Amount	The dollar amount paid by Medicare for the services. Format is 999999.99.	Field	Number (Decimal)	8

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Field	Description	Field Type	Data Type	Length
Medicare Paid Amount - Original	The dollar amount paid by Medicare for the services provided. This amount reflects the subtraction of the 2% sequestration amount.	Field	Number (Decimal)	10
Medicare Psych Amount	The amount Medicare has determined that a recipient must pay for psychiatric services received.	Field	Number (Decimal)	8
Sequester Amount	The dollar amount of the 2% sequestration as required by the ACC.	Field	Number (Decimal)	8

6.50.4 Medicare Information-UB04 Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Blood Deductible	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Blood Deductible Amount must be greater than or equal to 0.	Enter a numeric value greater than or equal to 0.
Coinsurance	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Coinsurance must be greater than or equal to 0.	Enter a numeric value greater than or equal to 0.
Deductible	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Deductible must be greater than or equal 0.	Enter a numeric value greater than or equal to 0.
Medicare Allowed Amount	Field	1	Medicare Allowed Amount must be less than or equal to 999999.99.	Enter a numeric value less than or equal to 999999.99.
	Field	2	Medicare Allowed Amount must be greater than or equal to 0.	Enter a numeric value greater than or equal to 0.
Medicare Copay Amount	Field	1	Medicare Copay Amount must be less than or equal to 99999999.99	Enter a numeric value less than or equal to 99999999.99

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Medicare Copay Amount must be greater than or equal to 0.	Enter a numeric value less than or equal to 0
Medicare Date Paid	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
Medicare Late Filing Amount	Field	1	Medicare Late Filing Amount must be less than or equal to 99999999.99	Enter a numeric value less than or equal to 99999999.99
	Field	2	Medicare Late Filing Amount must be greater than or equal to 0.	Enter a numeric value less than or equal to 0
Medicare Paid Amount	Field	1	Medicare Paid Amount must be less than or equal to 999999.99.	Enter a numeric value less than or equal to 999999.99.
	Field	2	Medicare Paid Amount must be greater than or equal to 0.	Enter a numeric value greater than or equal to 0.
Medicare Paid Amount – Original	Field	1	Enter a valid value.	Enter a numeric value. Format 99999999.99.
	Field	2	Medicare Paid Amount – Original must be less than or equal to 99999999.99.	Enter a value less than or equal to 99999999.99.
Medicare Psych Amount	Field	1	Medicare Psych Amount must be less than or equal to 99999999.99	Enter a numeric value less than or equal to 99999999.99
	Field	2	Medicare Psych Amount must be greater than or equal to 0.	Enter a numeric value less than or equal to 0
Sequester Amount	Field	1	Enter a valid value	Enter a numeric value. Format 999999.99.
	Field	2	Sequester Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.

6.50.5 Medicare Information-UB04 Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.50.6 Medicare Information-UB04 Panel Accessibility

6.50.6.1 To Access the Medicare Information-UB04 Panel

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

6.50.6.2 To Update the Medicare Information-UB04 Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Medicare Information** from the Claim Information navigation panel.	Medicare Information panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Medicare information data is saved.

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6.51 Miscellaneous Information

6.51.1 Miscellaneous Information Panel Narrative

The panel displays Miscellaneous Information for a UB04 or Physician claim detail.

Navigation: [Claims] – [Information] – [Enter an ICN and click on Search button] – [Select Misc Information link from the displayed panel] OR [Claims] – [Search] – [Enter Criteria] – [Select Misc Information link from the displayed panel]

6.51.2 Miscellaneous Information Panel Layout

6.51.3 Miscellaneous Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Adds a new record.	Button	N/A	0
Detail Number	The number of the detail on a claim record.	Field	Number (Integer)	4
Type Qualifier	This qualifier identifies the type of information under CDE_MISC.	Combo Box	Drop Down List Box	0
Value	A code used in claims processing.	Field	Character	11

6.51.4 Miscellaneous Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Detail Number	Field	0	Detail Number is required.	Select a Detail Number from the drop down box.
Type Qualifier	Field	0	Type Qualifier is a required field.	Select a Type Qualifier from the drop down box.
Value	Field	1	Value field is required.	Enter the Value.

6.51.5 Miscellaneous Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.51.6 Miscellaneous Information Panel Accessibility

6.51.6.1 To Access the Miscellaneous Information Panel

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

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6.52 NCCI Related History Panel

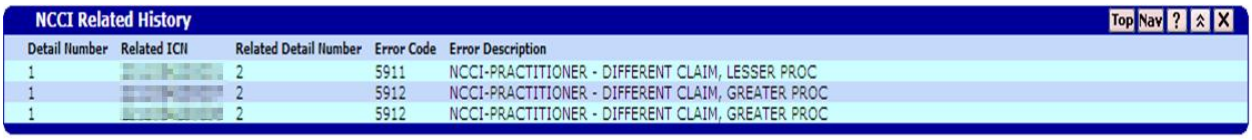
6.52.1 NCCI Related History Panel Narrative

The NCCI Related History panel displays the related claim detail and ESC description when an NCCI error is posted on a claim detail.

This panel is display only.

Navigation Path: [Claims] – [Search] – [Enter ICN and click search button] –[Select "NCCI Related History" from the listed links] – OR – [Claims] - [Information] - [Enter ICN and click search button] – [Select "NCCI Related History" from the listed links]

6.52.2 NCCI Related History Panel Layout



6.52.3 NCCI Related History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Detail Number	Displays the number of the detail on a claim record.	Field	Number	4
Error Code	Displays the code used to indicate an error was discovered on the claim during processing.	Field	Number	9
Error Description	Displays the description of the error which was discovered on the claim during processing.	Field	Character	50
Related Detail Number	Displays the detail number which relates to the detail of the history claim displayed.	Field	Number	4
Related ICN	Displays the Internal Control Number of the related claim.	Field	Number	13

6.52.4 NCCI Related History Panel Field Edit Error Codes

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

6.52.5 NCCI Related History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.52.6 NCCI Related History Panel Accessibility

6.52.6.1 To Access the NCCI Related History Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN**	
4	Click **Search**.	Claim Header, Navigation and Claim Detail panels are displayed.
5	Select NCCI Related History Link.	NCCI Related History panel displays below the Claim Detail panel.

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6.53 Occurrence Panel

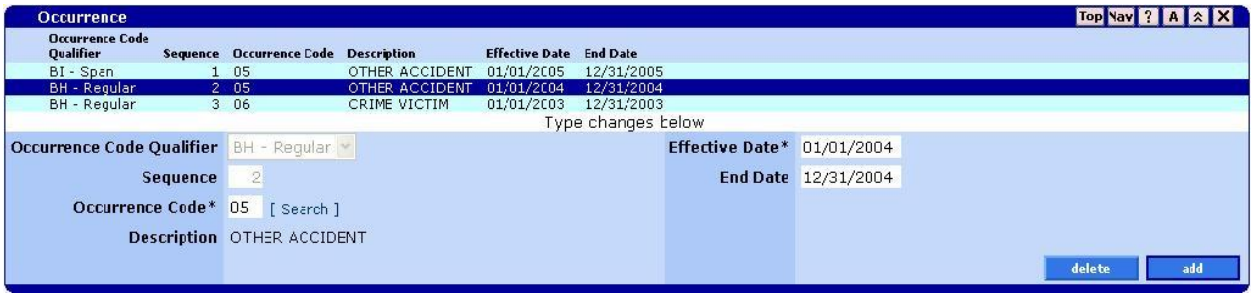
6.53.1 Occurrence Panel Narrative

The Occurrence panel displays the Occurrence Codes applicable to the claim. This panel includes the code and dates the event took place. Entries can be added and deleted from this panel. Field Edits are for Data Correction Only.

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

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

6.53.2 Occurrence Panel Layout



6.53.3 Occurrence Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record.	Button	N/A	0
Delete	Allows a user to delete a record.	Button	N/A	0
Description	Description of the Occurrence Code.	Field	Character	50
Effective Date	The date when the Occurrence Code began.	Field	Date (MM/DD/CCYY)	8
End Date	The date when the Occurrence Code ended.	Field	Date (MM/DD/CCYY)	8
Occurrence Code	The code identifying a significant event relating to this claim that may affect payer processing.	Field	Character	2
Sequence	The sequence number as it appeared on the claim.	Field	Number (Integer)	4

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6.53.4 Occurrence Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	2	Invalid Date.	Enter a valid Effective Date.
	Field	3	Effective Date must be less than or equal to End Date.	Verify dates. Effective Date must be less than or equal to End Date.
End Date	Field	1	Invalid Date.	Enter the date in MM/DD/CCYY format.
	Field	2	Effective Date must be less than or equal to End Date.	Verify dates. End Date must be greater than or equal to Effective Date.
Occurrence Code	Field	1	A valid Occurrence is required.	Enter a valid Occurrence Code.
	Field	107	Exceed maximum number of occurrence codes.	Verify there are no more than 24 occurrence codes.
Occurrence Code Qualifier	Field	1	Qualifier Code List is required.	Select an Occurrence Code Qualifier from the drop down box.

6.53.5 Occurrence Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.53.6 Occurrence Panel Accessibility

6.53.6.1 To Access the Occurrence Panel

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

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Step	Action	Response
5	Select the **Occurrence** hyperlink from the UB04 Claim Information Navigation panel.	Occurrence panel displays below the Claim Detail panel.

6.53.6.2 To Add on the Occurrence Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update appropriate information.	
3	Click **Save**.	Occurrence information is saved.

6.53.6.3 To Delete on the Occurrence Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.53.6.4 To Update the Occurrence Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Occurrence** from the Claim Information navigation panel.	Occurrence panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Occurrence data is saved.

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6.54 Payer Panel

6.54.1 Payer Panel Narrative

The Claims Payer Information panel displays the payer information applicable to the claim. This panel includes the payer's code, prior payment amount, and the estimated amount due. This panel is specific to UB04 claims and does not display for any other claim type.

The panel is in view-only mode when accessed through Claims Information for inquiry.

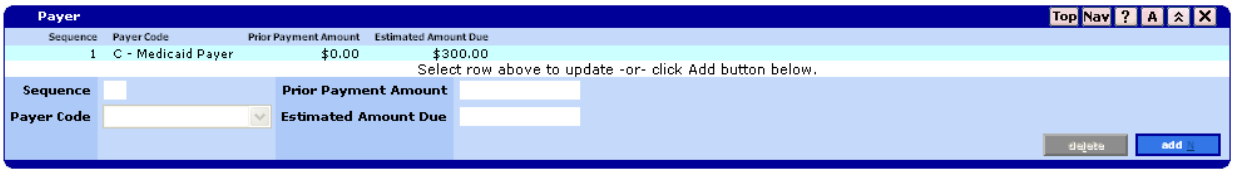
The panel is editable when accessed through Data Corrections.

Navigation Path:[Claims] – [Information] - [Enter a UB04 claim ICN] - [Select Payer link]

[Claims[- [Search] - [Enter criteria] - [Select a UB04 claim] - [Select Payer link]

[Claims]-[Data Correction] - [Enter clerk ID-search then select a UB04 claim from the list] - [Payer]

6.54.2 Payer Panel Layout



6.54.3 Payer Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Click on the add button on the panel to insert a new data record. A user must have proper permission to perform an add. The button is visible only when viewing the claim on the Claims Data Corrections page.	Button	N/A	0
Delete	Click the Delete button on the panel to delete the selected data record. A data record from the list must be selected before a user can perform a delete. A user must have the proper permissions to perform a delete. The button is visible only when viewing the claim on the Claims Data Corrections page.	Button	N/A	0
Estimated Amount Due	The amount estimated by the hospital that is due from the payer. Format 9999999.99.	Field	Number (Decimal)	9
Payer Code	The code that identifies each organization from which the provider might expect some payment for the bill.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Prior Payment Amount	The amount the hospital has received toward payment of this bill prior to the billing date by the payer. Format 9999999.99.	Field	Number (Decimal)	9
Sequence	The sequence of the payer information as they appeared on the claim.	Field	Number (Integer)	4

6.54.4 Payer Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Estimated Amount Due	Field	1	Enter a valid value.	Enter a numeric value.
Payer Code	Field	1	Payer Code is required.	Select a Payer Code from the drop down box.
	Field	108	Exceed maximum number of payer codes.	Select a Payer Code from the drop down box.
Prior Payment Amount	Field	1	Enter a Valid Value.	Enter a numeric value.

6.54.5 Payer Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.54.6 Payer Panel Accessibility

6.54.6.1 To Access the Payer Panel

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

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6.54.6.2 To Update the Payer Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Payer** from the Claim Information navigation panel.	Payer panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Payer data is saved.

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6.55 Prior Authorization Panel

6.55.1 Prior Authorization Panel Narrative

The Prior Authorization panel displays the prior authorization applicable to the claim. This panel includes the amount and units used in the claim. Only users with update authority are allowed to perform maintenance tasks.

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

6.55.2 Prior Authorization Panel Layout

Prior Authorization

Detail Number	PA Number	Line Item	Financial Payer	Units Used	Amount Used	Status
0	5002162000	A	DEF	0.000	$0	A
0			DEF	0.000	$0.00	A

6.55.3 Prior Authorization Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount Used	Prior Authorization amount applied to the claim.	Field	Number (Decimal)	9
Detail Number	Detail number which the Prior Authorization was applied.	Field	Number (Integer)	9
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	9
Line Item	Prior Authorization Line Item.	Field	Character	3
PA Number	Prior Authorization Number.	Field	Character	10
Status	Indicates the status of the claim within the system.	Field	Character	1
Units Used	Prior Authorization units applied to the claim.	Field	Number (Integer)	6

6.55.4 Prior Authorization Panel Field Edit Error Codes

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

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6.55.5 Prior Authorization Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.55.6 Prior Authorization Panel Accessibility

6.55.6.1 To Access the Prior Authorization Panel

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

6.55.6.2 To Update the Prior Authorization Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Prior Authorization** from the Claim Information navigation panel.	Prior Authorization panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Prior Authorization data is saved.

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6.56 Related History Panel

6.56.1 Related History Panel Narrative

The Related History panel lists other claims that are related to the current claim. The panel is non-updateable and is shared by all claim types. This panel is used to validate medical policy audits, duplicate payment audits, umbrella audits, limitation audits, bundling and unbundling audits.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Related History link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Related History link from the displayed panel]

6.56.2 Related History Panel Layout

6.56.3 Related History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Character	5
Error Code	Displays the Error Code.	Field	Number (Integer)	9
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	30
Related Detail	Related detail information to the history claim displayed.	Field	Number (Integer)	3
Related ICN	Internal control number related to the claim which caused the audit to post on this claim.	Field	Number (Integer)	13

6.56.4 Related History Panel Field Edit Error Codes

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

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6.56.5 Related History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.56.6 Related History Panel Accessibility

6.56.6.1 To Access the Related History Panel

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

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6.57 TPL Additional Information

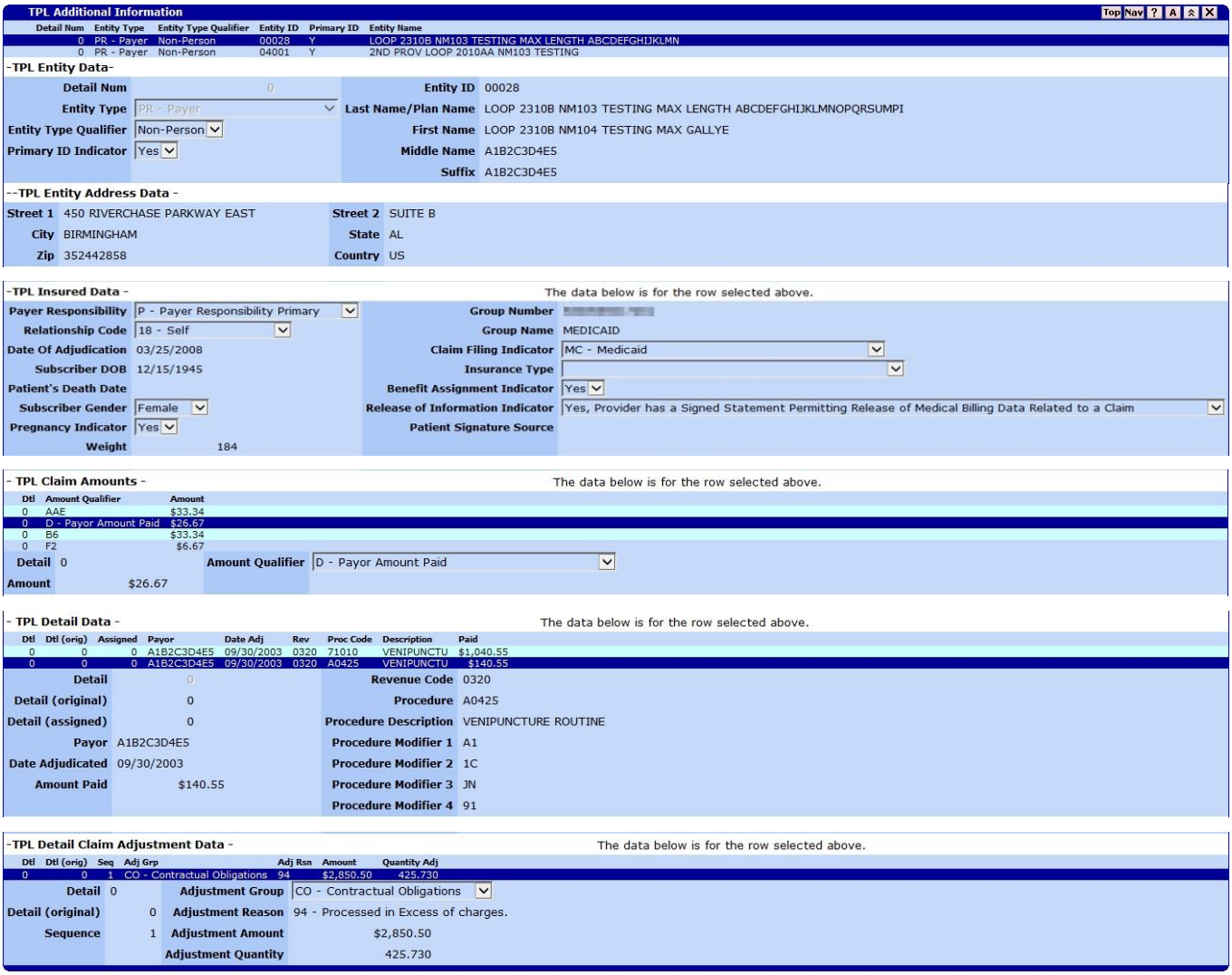
6.57.1 TPL Additional Information Panel Narrative

The TPL Additional Information panel allows the user to examine additional TPL information submitted on the claim including information about insurance, payments and additional TPL detail information.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select TPL Additional Information link] OR [Claims - Search] – [Enter Criteria] – [Select a Claim] – [Select TPL Additional Information link]

6.57.2 TPL Additional Information Panel Layout



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6.57.3 TPL Additional Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Amount	Monetary Amount of the Adjustment.	Field	Number (Decimal)	9
Adjustment Group	Claim Adjustment Group Code.	Field	Character	2
Adjustment Quantity	Number of units of service being adjusted.	Field	Number (Decimal)	15
Adjustment Reason	Claim Adjustment Reason Code.	Field	Character	5
Amount	Payer Estimated Amount Due.	Field	Number (Decimal)	9
Amount Paid	Service line paid amount.	Field	Number (Decimal)	10
Amount Qualifier	Qualifier for Payer Estimated Amount Due.	Field	Character	3
Benefit Assignment Indicator	Benefits Assignment Certification Indicator. Valid values: "Y" indicates insured or authorized person authorizes benefits to be assigned to the provider. "N" indicates benefits have not been assigned to the provider. "W" indicates not applicable.	Field	Character	1
City	The city associated with the address for the recipient/provider.	Field	Alphanumeric	30
Claim Filling Indicator	Claim Filing Indicator Code.	Field	Character	2
Country	The country associated with the address for the Recipient/Provider.	Field	Character	3
Date Adjudicated	Service Adjudication Date.	Field	Date (MM/DD/CCYY)	8
Date of Adjudication	Date when this Payer adjudicated the claim.	Field	Date (MM/DD/CCYY)	8
Detail Num	Detail Number on the claim record (0 indicates Header).	Field	Number (Integer)	4
Detail (assigned)	The service line into which this service line was bundled.	Field	Number (Integer)	6
Detail (original)	This is the number of the SVD segment within a claim detail.	Field	Number (Integer)	4
Entity ID	Entity's primary or secondary ID as specified by the ID qualifier.	Field	Alphanumeric	40

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Field	Description	Field Type	Data Type	Length
Entity Type	Indicates the type of entity.	Field	Character	3
Entity Type Qualifier	Indicates whether the entity is a person or a non-person.	Field	Alphanumeric	2
First Name	First name of the recipient/provider.	Field	Alphanumeric	35
Group Name	Insured Group Name. AKA Plan Name.	Field	Alphanumeric	60
Group Number	Reference Identification. Insured Group or Policy Number.	Field	Alphanumeric	50
Insurance Type	Code identifying the type of insurance policy within a specific insurance program.	Field	Character	3
Last Name/Plan Name	Last name of the recipient/provider or the name of the organization.	Field	Alphanumeric	60
Middle Name	Middle name of the recipient/provider.	Field	Alphanumeric	25
Patient Signature Source	Code identifying how the patient or subscriber authorization signatures were obtained and retained by the provider.	Field	Character	1
Patient’s Death Date	Patient's date of death.	Field	Date (MM/DD/CCYY)	8
Payer Responsibility	Code identifying the insurance carrier's level of responsibility for payment of a claim.	Field	Character	1
Payor	It captures the other payer party identifier which help to identify the provider associated with the Medicare paid amounts.	Field	Alphanumeric	80
Pregnancy Indicator	Indicates whether drug is related to the condition of being pregnant.	Field	Character	1
Primary ID indicator	Entity represented by this row.	Field	Character	1
Procedure	Procedure Code identifying the service provided.	Field	Alphanumeric	48
Procedure Description	A free-form description to clarify the related data elements and their content.	Field	Alphanumeric	80
Procedure Modifiers	Code used to further define a procedure provided.	Field	Character	2

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Field	Description	Field Type	Data Type	Length
Relationship Code	Code identifying the relationship between two individuals or entities.	Field	Character	2
Release of Information Indicator	Code identifying whether the provider has on file a signed statement by the patient authorizing release of medical data to other organizations.	Field	Character	1
Revenue Code	This identifies a specific accommodation or ancillary service.	Field	Alphanumeric	48
Sequence	This identifies the iteration number for the adjustment segment.	Field	Number (Integer)	4
State	The state associated with the address for the recipient/provider.	Field	Character	2
Street 1	The first address line of the recipient/provider.	Field	Alphanumeric	55
Street 2	The second address line of the recipient/provider.	Field	Alphanumeric	55
Subscriber DOB	Subscriber Date of Birth (DOB). AKA Other Insured Date of Birth (DOB).	Field	Date (MM/DD/CCYY)	8
Subscriber Gender	Other Insured Gender Code. Valid values are F –Female, M – Male.	Field	Character	1
Suffix	Name suffix of the recipient/provider.	Field	Alphanumeric	10
Weight	Patient's weight.	Field	Number (Integer)	10
Zip	The zip code associated with the address for the recipient/provider.	Field	Number (Integer)	15

6.57.4 TPL Additional Information Panel Field Edit Error Codes

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

6.57.5 TPL Additional Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.57.6 TPL Additional Information Panel Accessibility

6.57.6.1 To Access the TPL Additional Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claim Information Search panel displays.
3	Enter **ICN** or the sufficient search criteria.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select TPL **Additional Information** from the Claim Information Maintenance panel.	TPL Additional Information panel displays below the Claim Detail panel.

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6.58 TPL Summary Information Panel

6.58.1 TPL Summary Information Panel Narrative

The TPL Summary panel displays the information for each non-Medicare Third Party payer associated with a Claim or Claim detail.

This panel is applicable only to Dental, Professional, and Institutional Claims.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select TPL Summary Information link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select the "TPL Summary Information" link from the navigation panel].

6.58.2 TPL Summary Information Panel Layout

TPL Summary Information

Detail #	Sequence	Carrier Code	Payer Name	CoPay	CoInsurance	Deductible	TPL Paid	TPL Paid Date
0	1	9999888888	LOOP 2310B NM104 TESTING MAX GALLYE A1B2C3D4E5 LOOP 2310B NM103 TESTING MAX LENGTH ABCDEFGHIJKLMNOPQRSUMPI	$300.00	$200.00	$100.00	$500.00	08/17/2012
1	1	9999888888	LOOP 2310B NM104 TESTING MAX GALLYE A1B2C3D4E5 LOOP 2310B NM103 TESTING MAX LENGTH ABCDEFGHIJKLMNOPQRSUMPI	$800.00	$700.00	$600.00	$1,000.00	08/31/2012

6.58.3 TPL Summary Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Carrier Code	An unique identifier used to determine the type of carrier.	Field	Character	10
CoInsurance	Payer coinsurance amount.	Field	Number (Decimal)	9
CoPay	Payer copay amount.	Field	Number (Decimal)	9
Deductible	Payer deductible amount.	Field	Number (Decimal)	9
Detail #	Detail number on a claim record.	Field	Number (Integer)	4
Payer Name	Name of the Payer or the name of the Paying Organization.	Field	Character	60
Sequence	Payer hierarchy sequence.	Field	Number (Integer)	4
TPL Paid	Payer paid amount.	Field	Number (Decimal)	9
TPL Paid Date	Date adjudicated by the payer.	Field	Date (MM/DD/CCYY)	8

6.58.4 TPL Summary Information Panel Field Edit Error Codes

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

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6.58.5 TPL Summary Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.58.6 TPL Summary Information Panel Accessibility

6.58.6.1 To Access the Detail TPL Summary Information Panel

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

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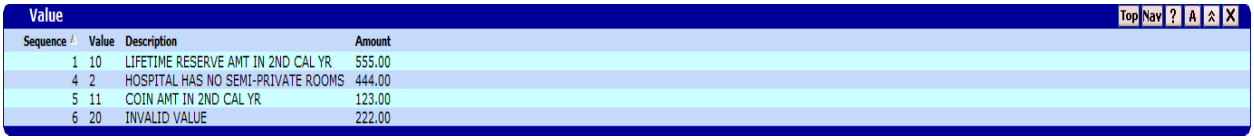
6.59 Value Panel

6.59.1 Value Panel Narrative

The Value panel displays the Value Codes applicable to the claim. This panel includes the value code and the amount of the value. Field Edits are for Data correction only. Only users with update authority are allowed to perform maintenance tasks.

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

6.59.2 Value Panel Layout



6.59.3 Value Panel Field Descriptions

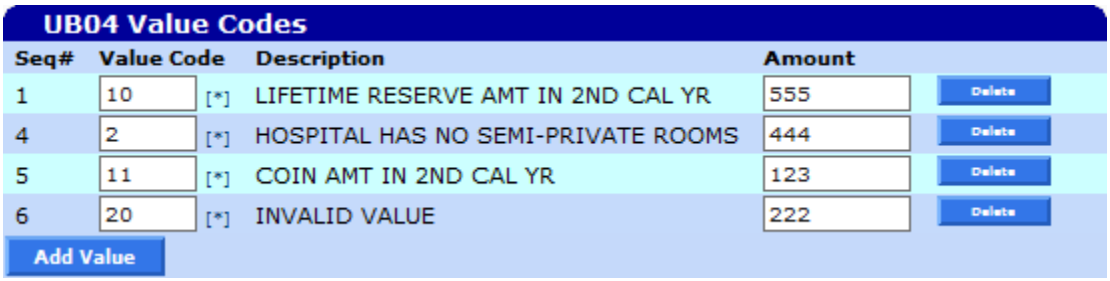
Field	Description	Field Type	Data Type	Length
Amount	The amount of the value code used to identify data elements that are necessary to process the claim.	Field	Number (Decimal)	9
Description	Description of the value.	Field	Character	50
Sequence	Sequence numbers as they appeared on the claim.	Field	Number (Integer)	4
Value	A code that relates to the value used to identify data elements that are necessary to process the claim.	Field	Character	2

6.59.4 UB04 Value Codes Panel – Data Correction Panel

The UB04 Value Codes panel displays the Value Codes applicable to the claim. This panel includes the value code and the amount of the value. Field Edits are for Data correction only.

Navigation Path: [Claim] – [Data Correction] – [Enter Clerk ID, search than select a clam from the list] – [scroll down to UB04 Value Codes Panel] --OR-- [Claims] – [Information] – [Enter ICN, Click on Search] – [Click the “Data Correct” button]

6.59.5 UB04 Value Codes Panel Layout – Data Correction Panel



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6.59.6 UB04 Value Codes Panel Field Description – Data Correction Panel

Field	Description	Field Type	Data Type	Length
Add Value	Add a new record.	Button	N/A	0
Amount	The amount of the value code used to identify data elements that are necessary to process the claim.	Field	Number (Decimal)	9
Delete	Allows a user to delete a record.	Button	N/A	0
Description	Description of the value.	Field	Character	50
Seq #	Sequence numbers as they appeared on the claim.	Field	Number (Integer)	4
Value Code	A code that relates to the value used to identify data elements that are necessary to process the claim.	Field	Character	2

6.59.5 UB-04 Value Codes Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Amount	Field	1	Enter a valid value.	Enter a numeric value in the Amount field.
	Field	2	Amount must be less than or equal to 9999999.99.	Enter an amount less than or equal to 9999999.99.
Sequence	Field	1	Sequence Contains Duplicates.	Please select a sequence number that has not already been used.
Value	Field	1	Enter Value Code.	Enter a Value Code or select a code from the [Search] panel.
	Field	2	A valid Value is required.	Enter a valid Value Code or select a code from the [Search] panel.
	Field	105	Exceeds maximum number of value codes.	Verify there are no more than 24 Value codes.
	Field	3	Value code ## not on file.	Enter a valid Value Code or select code from the [Search] panel.
	Field	4	Row with Seq # {0} cannot be saved without Value Code and Amount.	Enter a valid Value Code and Amount.

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6.59.6 Value Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.59.7 Value Panel Accessibility

6.59.7.1 To Access the Value Panel

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

6.59.7.1.1 To Update on the Value Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Value** from the Claim Information navigation panel.	Value panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Value data is saved.

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6.59.7.2 To Add on the Value Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Sequence.	
3	Enter **Value**.	
4	Enter Description.	
5	Click **Save**.	Value information is saved.

6.59.7.3 To Update on the Value Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Value information is saved.

6.59.7.4 To Delete on the Value Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.60 Adjustment Search Panel

6.60.1 Adjustment Search Panel Narrative

The Adjustment Search panel is used to search for claim adjustments. This panel is inquiry only.

Navigation Path: [Claims] – [Adjustments]

6.60.2 Adjustment Search Panel Layout

6.60.3 Adjustment Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear data in the search fields.	Button	N/A	0
Date	The date of the adjustment request.	Field	Date (MM/DD/CCYY)	8
Entry Status	Indicates whether adjustment request is 'S' - submitted, 'I' - Claims Identified, 'P' - Processing, 'D' - Deleted, 'V' - Verified, or 'F' – Finalized.	Combo Box	Drop Down List Box	0
New Mass	Allows the user to create a new mass adjustment.	Button	N/A	0
New Single	Allows the user to create a new single adjustment.	Button	N/A	0
Records	Allows the user to select the number of records to display.	Combo Box	Drop Down List Box	0
Request Number	The request number to be associated with the adjustments for this batch. Format is RRYYDDDBBB; RR region, YYDDD Julian year and day, BBB batch number.	Field	Number (Integer)	10
Search	Returns the information for the entered search criteria.	Button	N/A	0
User ID	Identification number of the user who made the request.	Field	Character	8

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6.60.4 Adjustment Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.

6.60.5 Adjustment Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.60.6 Adjustment Search Panel Accessibility

6.60.6.1 To Access the Adjustment Search Panel

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

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6.61 Adjustment Search Results Panel

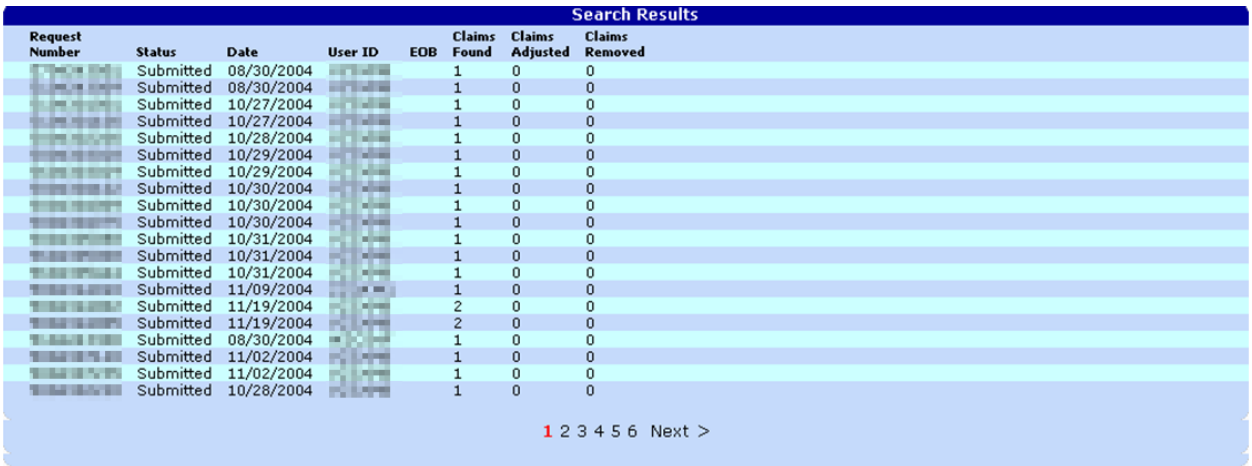
6.61.1 Adjustment Search Results Panel Narrative

The Adjustment Search Results panel displays the Claims Adjustment Search records returned by the search criteria.

This panel is inquiry only.

Navigation Path: [Claims] – [Adjustments] – [Click Search]

6.61.2 Adjustment Search Results Panel Layout



Search Results

Request Number	Status	Date	User ID	EOB	Claims Found	Claims Adjusted	Claims Removed
	Submitted	08/30/2004			1	0	0
	Submitted	08/30/2004			1	0	0
	Submitted	10/27/2004			1	0	0
	Submitted	10/27/2004			1	0	0
	Submitted	10/28/2004			1	0	0
	Submitted	10/29/2004			1	0	0
	Submitted	10/29/2004			1	0	0
	Submitted	10/30/2004			1	0	0
	Submitted	10/30/2004			1	0	0
	Submitted	10/30/2004			1	0	0
	Submitted	10/31/2004			1	0	0
	Submitted	10/31/2004			1	0	0
	Submitted	10/31/2004			1	0	0
	Submitted	11/09/2004			1	0	0
	Submitted	11/19/2004			2	0	0
	Submitted	11/19/2004			2	0	0
	Submitted	08/30/2004			1	0	0
	Submitted	11/02/2004			1	0	0
	Submitted	11/02/2004			1	0	0
	Submitted	10/28/2004			1	0	0

1 2 3 4 5 6 Next >

6.61.3 Adjustment Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claims Adjusted	Total number of claims adjusted in this adjustment request.	Field	Number (Integer)	9
Claims Found	Total number of claims retrieved in this adjustment request.	Field	Number (Integer)	9
Claims Removed	Total number of claims removed from this adjustment request.	Field	Number (Integer)	9
Date	Adjustment request entry date to search.	Field	Date (MM/DD/CCYY)	8
EOB	Explanation of Benefit code used for an item meeting the search criteria.	Field	Character	4
Request Number	A unique number that identifies the mass adjustment request. Format: RRYYJJJBBB (RR - Region, YYJJJ - Julian date, BBB - Batch number). It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.	Field	Number (Integer)	10
Status	Status of the adjustment request to search.	Field	Character	10

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Field	Description	Field Type	Data Type	Length
User ID	Clerk who entered the adjustment request.	Field	Character	8

6.61.4 Adjustment Search Results Panel Field Edit Error Codes

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

6.61.5 Adjustment Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.61.6 Adjustment Search Results Panel Accessibility

6.61.6.1 To Access the Adjustment Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustments**.	Adjustment Search panel displays.
3	Enter applicable search criteria and/or click **Search**.	Adjustment Search Results displays.

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6.62 Adjustment Mini-Search Panel

6.62.1 Adjustment Mini-Search Panel Narrative

The Adjustment Mini-Search panel permits new searches from both the Adjustment Information and the Mass Adjustment Information panels without having to return to the Adjustment Search panel.

This panel is inquiry only.

Navigation Path: [Claims] – [Adjustments] – [Click Search] – [select an adjustment request]

6.62.2 Adjustment Mini-Search Panel Layout

6.62.3 Adjustment Mini-Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Returns the full Adjustment Search panel.	Button	N/A	0
Clear	Clears the previous Adjustment Request Number from the search field.	Button	N/A	0
Request Number	A unique number that identifies the mass adjustment request. Format: RRYYJJJBBB (RR - Region, YYJJJ - Julian date, BBB - Batch number). It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.	Field	Number (Integer)	10
Search	Returns the information for the entered Request Number.	Button	N/A	0

6.62.4 Adjustment Mini-Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Request Number	Field	1	Enter a valid value.	Enter a numeric value in the Request Number field.
	Field	3	Record cannot be found for Request Number.	Enter a numeric value in the Request Number field.

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6.62.5 Adjustment Mini-Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.62.6 Adjustment Mini-Search Panel Accessibility

6.62.6.1 To Access the Adjustment Mini-Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustments**.	Adjustment Search panel displays.
3	Click **Search**.	
4	Select **Adjustment Request** from the results displayed.	Adjustment Information displays.

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6.63 Adjustment Information Panel

6.63.1 Adjustment Information Panel Narrative

The Adjustment Information panel displays information for a selected adjustment record. This panel is display only.

Navigation Path: [Claims] – [Adjustments] – [select an adjustment request for a single claim]

6.63.2 Adjustment Information Panel Layout

6.63.3 Adjustment Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Amount	The adjusted amount of the claim.	Field	Number (Decimal)	10
Claim Count	The number of claims found for the adjustment request.	Field	Number (Integer)	9
Entry Date	Adjustment request entry date.	Field	Date (MM/DD/CCYY)	8
Entry Status	Indicates whether adjustment request is 'S' - submitted, 'I' - Claims Identified, 'P' - Processing, 'D' - Deleted, 'V' - Verified, or 'F' - Finalized.	Field	Character	20
Net Amount	The amount by which the Original Amount was adjusted.	Field	Number (Decimal)	10
Original Amount	The original amount of the claim.	Field	Number (Decimal)	10
Request Number	A 10 byte unique number that identifies the mass adjustment request. Format: RRYYJJJBBB. It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.	Field	Number (Integer	10
User ID	Indicates a specific user of the system and can be used to identify who entered or last updated the Adjustment Request.	Field	Character	8

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6.63.4 Adjustment Information Panel Field Edit Error Codes

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

6.63.5 Adjustment Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.63.6 Adjustment Information Panel Accessibility

6.63.6.1 To Access the Adjustment Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustments**.	Adjustment Search panel displays.
3	Enter Request Number, Entry Status, Date or User ID.	
4	Click **Search**.	
5	Select a detail line from the results displayed.	Adjustment Information panel displays.

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6.64 Adjustment Information–Daughter or Mother Panel

6.64.1 Adjustment Information-Daughter or Mother Panel Narrative

The Adjustment Information panel displays information about adjustments to the current claim, including prior claims or adjustments and any subsequent adjustments. This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Adjustment Information link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Adjustment Information link from the displayed panel]

6.64.2 Adjustment Information-Daughter or Mother Panel Layout

6.64.3 Adjustment Information- Daughter or Mother Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Analyst Name	Name of the clerk that generated the adjustment request.	Field	Character	30
Adjustment Reason	Code identifying the detailed reason the adjustment was made.	Field	Character	4
Claim Status	The status of the claim, example ‘PAID‘.	Field	Character	10
Claims Status History Date	Date on which a claim was processed.	Field	Date (MM/DD/CCYY)	8
Date Adjusted	Date on which adjustment was made.	Field	Date (MM/DD/CCYY)	8
ICN	Internal control number which uniquely identifies a claim.	Field	Number (Integer)	13
Location	Location code of the claim.	Field	Character	2

6.64.4 Adjustment Information-Daughter or Mother Panel Field Edit Error Codes

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

6.64.5 Adjustment Information-Daughter or Mother Panel Field Extra Features

Field	Field Type
No extra features found for this panel.	

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6.64.6 Adjustment Information-Daughter or Mother Panel Accessibility

6.64.6.1 To Access the Adjustment Information-Daughter or Mother Panel

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

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6.65 Claim Adjustment Navigation Panel

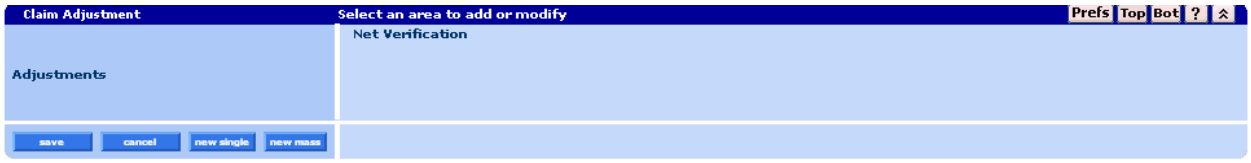
6.65.1 Claim Adjustment Navigation Panel Narrative

The Claim Adjustment Navigation panel allows the user to navigate to the Net Verification panel.

This panel is inquiry only.

Navigation Path: [Claims] – [Adjustments] – [Enter Criteria] – [Click Search] – [Select a request]

6.65.2 Claim Adjustment Navigation Panel Layout



6.65.3 Claim Adjustment Navigation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes made and close the panel.	Button	N/A	0
New Mass	Start a new mass adjustment.	Button	N/A	0
New Single	Start a new single adjustment.	Button	N/A	0
Save	Allows the user to save a record to the database.	Button	N/A	0
Net Verification	Activates the Net Verification display and update panel.	Hyperlink	N/A	0

6.65.4 Claim Adjustment Navigation Panel Field Edit Error Codes

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

6.65.5 Claim Adjustment Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.65.6 Claim Adjustment Navigation Panel Accessibility

6.65.6.1 To Access the Claim Adjustment Navigation Panel

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

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Step	Action	Response
3	Enter applicable search criteria and click **Search**.	Adjustment Search Results displays.

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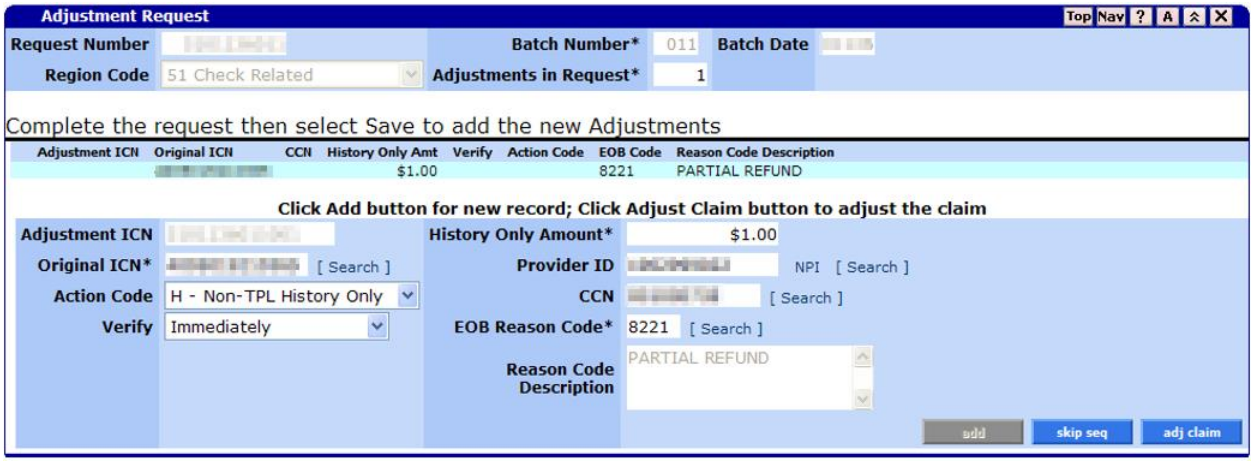
6.66 Adjustment Request Panel

6.66.1 Adjustment Request Panel Narrative

The Adjustment Request panel permits entry or update to single adjustment requests. Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Adjustments] – [select an adjustment request]

6.66.2 Adjustment Request Panel Layout



6.66.3 Adjustment Request Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new record.	Button	N/A	0
Action Code	Field to add or change action to be taken for selected adjustment claim.	Combo Box	Character	30
Adj claim	Starts the claim adjustment process	Button	N/A	0
Adjustment ICN	Field to add or change an adjustment internal control number.	Field	Character	13
Adjustments in Request	The number of adjustments contained in the Adjustment Request.	Field	Character	3
Batch Date	Julian date entered to generate the request number. This value is not stored in any table in the database. It is used only by the User Interface to generate the request number. It has to be entered in Julian date format and should be less than or equal to the Julian date on the day it is being entered. Format YYJJJ.	Field	Date (YYJJJ)	5
Batch Number	The batch number of the record that was subject to the Adjustment Request.	Field	Character	5

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Field	Description	Field Type	Data Type	Length
CCN	Field to add or change an adjusted cash control number.	Field	Character	13
EOB Reason Code	Field to add or change explanation of benefit reason codes for an adjusted claim.	Field	Number (Integer)	4
History Only Amount	Field to add or change Third Party Liability amount for an adjusted claim.	Field	Character	6
Original ICN	Field to add more linked internal control numbers.	Field	Character	13
Provider ID	The Provider Identification Number of the provider for the claim selected for adjusting.	Field	Character	15
Reason Code Description	Reason code description field.	Field	Alphanumeric	25
Region Code	The Adjustment Request category.	Combo Box	Character	25
Request Number	The Adjustment Request number for which a search is being conducted.	Field	Character	15
skip seq	Advances Adjustment ICN, to the next available sequence within a batch. Note: skipped sequence cannot be recovered	Button	N/A	0
Verify	Field to add or change an adjustment Verify code.	Combo Box	Character	20

6.66.4 Adjustment Request Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Action Code	Field	1	Action code is required.	For single adjustments, Action Code is required.
adj claim	Button	1	Invalid request. PHP claim cannot be adjusted.	N/A
	Button	2	Invalid request. Service past the filing limit.	N/A
	Button	3	Original claim paid date is more than three years ago. Continue processing?	Click Ok if you want to continue with an adjustment, otherwise

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Field	Field Type	Error Code	Error Message	To Correct
				click cancel button.
	Button	4	Claim is in a NCCI non-adjustable status and permission from the Agency must be obtained in order to adjust the claim. If the user continues to want to adjust the claim, it should be allowed to adjust.	Check the ignore checkbox and click on continue.
Adjustment ICN	Field	1	Adjustment ICN is required	Enter a valid ICN.
	Field	2	Adjustment ICN cannot be found.	Enter a valid Adjustment ICN.
Adjustments in Request	Field	1	Adjustments in Request cannot be zero.	Enter a numeric value greater than 0.
	Field	91151	Adjustments in Request number cannot be less than the current number of adjustments."	Correct the number of Adjustments in Request
Batch Date	Field	1	Batch Date must be 5 character(s) in length.	Enter a 5 character valid Julian date
	Field	100	Invalid Julian date in columns 5-7.	Enter a valid Julian date
	Field	104	Not able to save a Mass Adjustment with this Mass Request Number.	Enter a valid Julian date - it forms part of the Request Number

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Field	Field Type	Error Code	Error Message	To Correct
	Field	105	Batch Date is required	Enter a Julian date less then or equal to current Julian date.
	Field	106	Enter Batch Date in YYJJJ	Enter a valid Julian date in YYJJJ format
	Field	107	Batch Date should be less than or equal to current Julian date.	Enter a Julian date less than or equal to current Julian date.
	Field	108	Enter only numeric values in Batch Date.	Enter only numeric values in the Batch Date field.
Batch Number	Field	104	Not able to save a Mass Adjustment with this Mass Request Number.	Enter a valid batch number - it forms part of the Request Number.
CCN	Field	1	CCN Provider Service location does not match claim Provider service location	Check the provider ID on the cash receipt to ensure it matches the claim's provider ID and service location.
	Field	6740	CCN balance is not greater than zero	Verify CCN. CCN must have a balance remaining for an adjustment to be applied
	Field	6741	CCN is not allowed on non-	CCN only allowed for region 51

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Field	Field Type	Error Code	Error Message	To Correct
			check related adjustment.	check-related adjustment. Correct region or clear CCN
	Field	91037	CCN is required.	Enter a valid CCN number.
EOB Reason Code	Field	1	A valid EOB Reason Code is required.	Enter an EOB Reason Code between 8200-8299. Must have a valid value for EOB Reason Code.
	Field	2	EOB Reason codes 8220 and 8221 are exclusive for Refunds (Region Code 51).	Please enter another EOB Reason code.
	Field	3	Check Related Adjustments have to use EOB Reason codes 8220 and 8221 exclusively.	Please enter another EOB Reason code.
	Field	4	EOB Reason Code number not found.	Please enter a valid EOB Reason Code.
	Field	401	EOB is required.	Enter an EOB Reason Code.
History Only Amount	Field	1	History only TPL amount is required.	Enter a numeric value in the History Only TPL Amt field.
	Field	6709	Full Refund amount must match the Claim's Paid Amount.	Enter the exact Paid Amount for the Mother Claim.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	6710	Partial Refund amount must be less than the Claim's Paid Amount.	Enter an amount less than the Paid Amount of the Mmother Claim, but greater than zero.
Original ICN	Field	1	Cannot adjust a non-paid claim.	Only paid claims can be adjusted.
		2	Online adjustments to encounter claims are not allowed	Enter an ICN number that do not start with 7 because 7 refers to encounter region.
Provider ID	Field	1	Action code is required. Provider ID does not match.	Select an Action Code. Enter the Provider ID for this claim.
	Field	2	A valid Provider is required.	Enter a valid Provider ID.
Region Code	Field	1	Original claim paid date more than three years ago. Do you have Agency authorization to adjust this claim?	If Agency authorization is there, then click on ignore and continue to save the request. Else, click on cancel on the information page to cancel the entries
Request Number	Field	1	Request Number is a duplicate.	This Request Number already exists. Try changing the Batch Number to generate a

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Field	Field Type	Error Code	Error Message	To Correct
				new Request Number.
	Field	2	The request number must be in the format of RRYYJJJBBB.	Enter information for the request before clicking the Save button.

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6.66.5 Adjustment Request Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.66.6 Adjustment Request Panel Accessibility

6.66.6.1 To Access the Adjustment Request Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustments**.	Adjustment Search panel displays.
3	Click **Search**.	
4	Select **Adjustment Request** from the results displayed.	Adjustment Information displays.

6.66.6.2 To Add on the Adjustment Request Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update appropriate data.	
3	Click **Save**.	Adjustment Request information saved.

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6.67 Mass Adjustment Criteria Panel

6.67.1 Mass Adjustment Criteria Panel Narrative

The Mass Adjustment Criteria panel is a combined panel for adding and deleting Mass Adjustment criteria on new and existing mass adjustment request. Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Adjustments] – [select a mass adjustment request] – [Mass Adjustment Criteria]

6.67.2 Mass Adjustment Criteria Panel Layout

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6.67.3 Mass Adjustment Criteria Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a segment.	Button	N/A	0
Age Max	The high age of the recipient age range.	Field	Number (Integer)	3
Age Min	The low age of the recipient age range.	Field	Number (Integer)	3
Aid Category	Displays the aid category entered as search criteria.	Field	Character	2
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient. Displays Current ID(s) entered as search criteria.	Field	Character	12
Delete	Allows the user remove a segment.	Button	N/A	0
Diagnosis	Displays diagnosis code(s) as search criteria.	Field	Character	7
ESC	Code to indicate an error was discovered on a claim during processing. This can be either an edit or an audit code, which is used as search criteria.	Field	Number (Integer)	4
Gender	The sex of the recipient.	Combo Box	Drop Down List Box	0
Health Program Selection	Medical Assistance Programs chosen from the list at the bottom of the panel.	Combo Box	Drop Down List Box	0
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.	Combo Box	Character	1
Location	Provider service location(s) chosen as search criteria.	Field	Character	1
Modifier 1	First modifier to be used as search criteria.	Field	Alphanumeric	2
Modifier 2	Second modifier criteria.	Field	Alphanumeric	2
Modifier 3	Third modifier criteria.	Field	Alphanumeric	2

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Field	Description	Field Type	Data Type	Length
Modifier 4	Fourth modifier criteria.	Field	Alphanumeric	2
NDC	Displays NDC(s) found from the search criteria.	Field	Number (Integer)	11
Pgm	Medical Assistance Programs chosen from the list at the bottom of the panel.	Combo Box	Drop Down List Box	0
Procedure Code	Field used to enter procedure code as search criteria.	Field	Character	6
Provider ID	Provider number(s) chosen as search criteria.	Field	Character	15
Provider Spec	Code used to identify the specialty of the provider.	Field	Number (Integer)	3
Provider Type	Code used to identify the type of the provider.	Field	Number (Integer)	2
Region	Region codes chosen from the list at the bottom of the panel.	Field	Number (Integer)	2
Revenue	Displays revenue code(s) as search criteria.	Field	Number (Integer)	3
Type (Claim Type)	Claim type chosen from the list at the bottom of the panel.	Combo Box	Drop Down List Box	0
Type (ESC)	Value that indicates if the edit or audit fails at detail, header or both.	Combo Box	Radio Button	0

6.67.4 Mass Adjustment Criteria Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Age Max	Field	1	Max is required.	Enter a max age.
Age Min	Field	2	Min is required.	Enter a min age.
Aid Category	Field	1	A valid Aid Category is required.	Enter a valid Aid Category or click on search and select one from the search results.
	Field	2	Invalid Aid Category Code.	Enter a valid Aid Category or click on search and select one from the search results.

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Field	Field Type	Error Code	Error Message	To Correct
Current ID	Field	1	Invalid Current ID.	Enter in a valid Current ID or click on search and select one from the search results.
Diagnosis	Field	1	A valid Diagnosis is required.	Enter in a valid Diagnosis or click on search and select one from the search results.
	Field	2	Invalid Diagnosis Code.	Enter in a valid Diagnosis or click on search and select one from the search results.
ESC	Field	2	Invalid ESC Code.	Enter a valid ESC Code or click on search and select one from the search results.
	Field	3	A valid Claim Error is required.	Enter a valid ESC Code or click on search and select one from the search results.
Gender	Field	3	Gender is required.	Select a gender from the drop down box.
Health Program Selection	Field	1	Health Program Code is required.	Select a Health Program from the list.
Modifier 1	Field	1	Modifiers MUST BE entered in order, starting with 1.	Verify entry and correct values in Modifiers.
	Field	2	Invalid modifier 1 code.	Enter a valid Modifier 1 Code or click on search and select one from the search results.
Modifier 2	Field	1	Invalid modifier 2 code.	Enter a valid Modifier 2 Code or click on search and select one from the search results.
Modifier 3	Field	1	Invalid modifier 3 code.	Enter a valid Modifier 3 Code or click on search and select one from the search results.
Modifier 4	Field	1	Invalid modifier 4 code.	Enter a valid Modifier 4 code or click on search

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Field	Field Type	Error Code	Error Message	To Correct
				and select one from the search results.
NDC	Field	1	Invalid NDC Code.	Enter a valid NDC Code or click on search and select one from the search results.
Procedure Code	Field	1	Procedure Code is required.	Enter a valid Procedure Code or click on search and select one from the search results.
Provider ID	Field	1	A valid Provider is required.	Enter a valid Provider ID or click on search and select one from the search results.
	Field	2	Both a Provider ID is needed.	Verify entries in Provider ID field correct or click on search and select one from the search results.
Provider Specialty	Field	1	A valid Provider Specialty is required.	Select a Provider Specialty from the list.
Region	Field	1	A valid Region is required.	Select a Region from the list.
Revenue	Field	1	A valid Revenue is required.	Enter in a valid Revenue Code or click on search and select one from the search results.
	Field	2	Invalid Revenue Code.	Enter in a valid Revenue Code or click on search and select one from the search results.
Type	Field	1	A valid Type is required.	Select a value from the drop down list box.

6.67.5 Mass Adjustment Criteria Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.67.6 Mass Adjustment Criteria Panel Accessibility

6.67.6.1 To Access the Mass Adjustment Criteria Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustment**.	Adjustment Search panel displays.
3	Enter an Adjustment Request.	Adjustment panel displays.
4	Select **Mass Adjustment Criteria** hyperlink from the Adjustments Navigation panel.	Mass Adjustment Criteria panel displays.

6.67.6.2 To Add on the Mass Adjustment Criteria Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter appropriate data changes.	
3	Click **Save**.	Mass adjustment information is saved.

6.67.6.3 To Delete on the Mass Adjustment Criteria Panel

Step	Action	Response
1	Click **Delete** on the data fields that need to be removed.	
2	Click **Save**.	Mass Adjustment information is saved.

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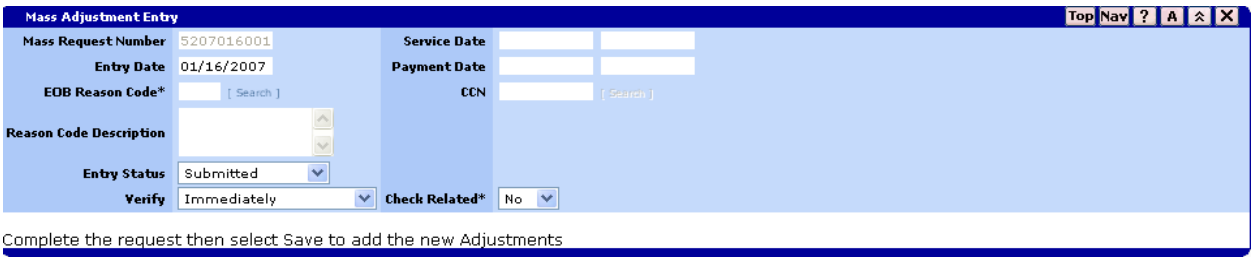
6.68 Mass Adjustment Entry Panel

6.68.1 Mass Adjustment Entry Panel Narrative

The Mass Adjustment Entry panel allows the adjustment analyst to enter a new mass adjustment request. Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Adjustment - Search - {select one from list}] – [Click on New Mass Button] – OR – [Claims] – [Adjustment - New Single] – [Click on New Mass Button] – OR – [Claims] – [Adjustment - Click on New Mass Button]

6.68.2 Mass Adjustment Entry Panel Layout



6.68.3 Mass Adjustment Entry Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CCN	Cash Control Number that refers to the cash receipt that is dispositioned against the adjustment.	Field	Character	11
Check Related	Indicates if the adjustment is related to a cash receipt.	Combo Box	Drop Down List Box	0
EOB Reason Code	The Explanation of Benefits (EOB) Reason identifies the reason for the request. The type of EOB also controls the processing action for editing and auditing purposes. Valid values: 8232 thru 8238, inclusive.	Field	Character	4
Entry Date	Indicates the date the request was entered, system assigned.	Field	Date (MM/DD/CCYY)	8
Entry Status	Indicates the current status of the request.	Combo Box	Drop Down List Box	0
Mass Request Number	The system assigned number for a Mass Adjustment Request.	Field	Number (Integer)	14
Payment Date (From)	Indicates the from payment date of the claims.	Field	Date (MM/DD/CCYY)	8
Payment Date (To)	Indicates the to payment date of the claims.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Reason Code Description	Explanation of the Explanation of Benefit Reason Code.	Field	Character	50
Service Date (From)	Indicates the beginning date of service.	Field	Date (MM/DD/CCYY)	8
Service Date (To)	Indicates the ending date of service.	Field	Date (MM/DD/CCYY)	8
Verify	Indicates the mass adjustment should suspend for review, the adjustment will process through the Claims Engine and will suspend for review at the end of processing. A – Suspend after running through the claims engine. B – Suspend before running through the claims engine. Immediately – Reprocess immediately, without a user's review and release.	Combo Box	Drop Down List Box	0

6.68.4 Mass Adjustment Entry Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
CCN	Field	1	CCN number not found.	Enter a valid CCN number or select a valid number from the [Search] panel.
EOB Reason Code	Field	1	EOB Reason Code not found.	Enter an existing EOB reason or select a code from the [Search] panel.
	Field	2	Adjustment Reason Code must be 8232 - 8238.	Enter an existing EOB reason or select a code from the [Search] panel.
	Field	3	Adjustment Reason Code is required.	Enter an existing EOB reason or select a code from the [Search] panel.
Mass Request Number	Field	2	The request must have one of the following: 1) List of recipients; 2) List of provider ID's and service locations; 3) List of Error Codes; 4) List of Procedure Code and Modifiers; 5) List of NDC Codes; 6) Revenue Codes (UB04 Only).	Enter data into the panel before clicking the Save button.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	The mass adjustment request must have either one or both of the Service Date and Payment Date.	Enter a Service Date and/or Payment Date.
Payment Date (From)	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
	Field	2	The payment date cannot be greater than Today's date.	Enter a valid date in MM/DD/CCYY format.
	Field	3	First Payment Date is required for an entered Last Payment Date.	Enter a valid date in MM/DD/CCYY format.
Payment Date (To)	Field	1	Invalid Date.	Enter an ending Payment Date in MM/DD/CCYY format.
	Field	2	Payment From Date must be less than or equal to Payment To Date.	Enter an ending Payment Date in MM/DD/CCYY format.
Service Date (From)	Field	1	Invalid Date.	Enter a date in MM/DD/CCYY format.
	Field	2	First Service Date is required for an entered Last Service Date.	Enter a valid date in MM/DD/CCYY format.
	Field	3	Last Service Date is required for an entered First Service Date.	Enter a valid date in MM/DD/CCYY format.
Service Date (To)	Field	1	Invalid Date.	Enter an ending Service Date in the format: MM/DD/CCYY.
	Field	2	Service Date must be less than or equal to Service To Date.	Enter an ending Service Date in the format: MM/DD/CCYY.
	Field	3	The service date cannot be greater than Today's date.	Enter an ending Service Date in the format: MM/DD/CCYY.

6.68.5 Mass Adjustment Entry Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.68.6 Mass Adjustment Entry Panel Accessibility

6.68.6.1 To Access the Mass Adjustment Entry Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustment**.	Adjustment Search panel displays.
3	Enter an Adjustment Request.	Adjustment panel displays.
4	Select the **New Mass** button.	Mass Adjustment Entry panel displays.

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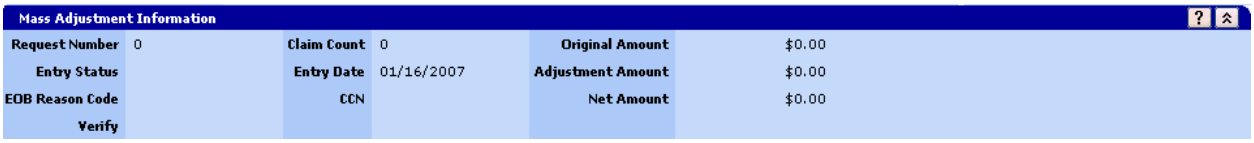
6.69 Mass Adjustment Information Panel

6.69.1 Mass Adjustment Information Panel Narrative

The Mass Adjustment Information panel displays information from a selected mass adjustment record. This panel is display only.

Navigation Path: [Claims] – [Adjustments] – [select a mass adjustment request]

6.69.2 Mass Adjustment Information Panel Layout



6.69.3 Mass Adjustment Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Amount	The adjusted amount of the claim.	Field	Number (Decimal)	10
CCN	Cash or check receipt control number used in dispositioning the adjustment with the cash received.	Field	Number (Integer)	11
Claim Count	The sequence number of the selected claim in the search list.	Field	Number (Integer)	6
EOB Reason Code	Explanation of Benefit reason for the adjustment.	Field	Number (Integer)	4
Entry Date	The date the adjustment request was entered into the system.	Field	Date (MM/DD/CCYY)	8
Entry Status	Status of the adjustment request to search.	Field	Character	10
Net Amount	The amount by which the Original Amount was adjusted.	Field	Number (Decimal)	10
Original Amount	The original amount of the claim.	Field	Number (Decimal)	10
Request Number	A number that uniquely identifies the adjustment request. Format RRYYJJJBBB (RR – Region, YY – Year, JJJ – Julian date, BBB – Batch number).	Field	Number (Integer)	10
Verify	Indicates the mass adjustment should suspend for review, the adjustment will process through the Claims Engine and will suspend for review at the end of processing.	Field	Character	20

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Field	Description	Field Type	Data Type	Length
	A – Suspend after running through the claims engine. B – Suspend before running through the claims engine. Immediately – Reprocess immediately, without a user's review and release.			

6.69.4 Mass Adjustment Information Panel Field Edit Error Codes

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

6.69.5 Mass Adjustment Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.69.6 Mass Adjustment Information Panel Accessibility

6.69.6.1 To Access the Mass Adjustment Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustment.**	Adjustment Search panel displays.
3	Enter an Adjustment Request.	Mass Adjustment Information panel displays.

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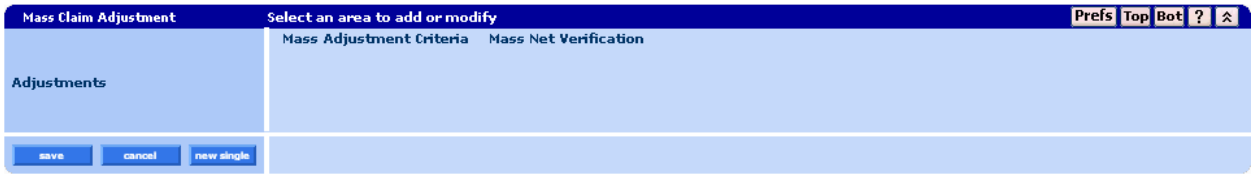
6.70 Mass Claim Adjustment Navigation Panel

6.70.1 Mass Claim Adjustment Navigation Panel Narrative

The Mass Claim Adjustment Navigation panel displays links to the Mass Net Verification panel and the Mass Adjustment Criteria panel. This panel is inquiry only.

Navigation Path: [Claims] – [Adjustments] – [Perform a search and select a mass adjustment request]

6.70.2 Mass Claim Adjustment Navigation Panel Layout



6.70.3 Mass Claim Adjustment Navigation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Cancels any unsaved changes on the page.	Button	N/A	0
Mass Adjustment Criteria	Activates the Mass Adjustment Criteria search, display, and update panels.	Hyperlink	N/A	0
Mass Net Verification	Activates the Net Verification display and update panels.	Hyperlink	N/A	0
New Single	Starts a new single adjustment.	Button	N/A	0
Save	Causes the record to be saved to the database.	Button	N/A	0

6.70.4 Mass Claim Adjustment Navigation Panel Field Edit Error Codes

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

6.70.5 Mass Claim Adjustment Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.70.6 Mass Claim Adjustment Navigation Panel Accessibility

6.70.6.1 To Access the Mass Claim Adjustment Navigation

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

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Step	Action	Response
3	Enter an **Adjustment Request** or perform a **Search** and select from the list.	Mass Claim Adjustment Navigation panel displays.

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6.71 Mass Net Verification Panel

6.71.1 Mass Net Verification Panel Narrative

The Mass Net Verification panel permits the user to verify and update the financial changes made to mass adjustment claims. Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Adjustments] – [select a mass adjustment request] – [Mass Net Verification]

6.71.2 Mass Net Verification Panel Layout

6.71.3 Mass Net Verification Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Action Code	The action code determining how the adjustment is processed in batch.	Field	Character	5
Adjusted Amount	Adjusted amount for the displayed claim.	Field	Number (Decimal)	9
Adjusted Status	Indicates the status of the claim which is being adjusted.	Field	Character	10
Adjustment ICN	Field to add a new Internal Control Number for an adjusted claim. User changes the view to a different ICN, but not actually changing the ICN.	Field	Character	13
Adjustment Status	Field to add or update the status of a claim being adjusted.	Field	Character	10
CCN	Cash or check receipt control number used in dispositioning the adjustment with the cash received.	Field	Character	11
Data Correct	Opens up the Corrections panel for the selected claim.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Delete All	Sets the Adjustment Status field to 'D' for all records. Clicking a 2nd time blanks out the adjustment status field.	Button	N/A	0
Delete Selected	The user may select the checkboxes to the left of the claims and click this button to delete the selected claims.	Button	N/A	0
EOB	Indicates the Explanation of Benefits code entered for the claim.	Field	Number (Integer)	4
Net Amount	Net amount for the displayed claim.	Field	Number (Decimal)	9
New Claim Status	The status of the adjusted claim.	Field	Character	10
Original Amount	Original amount for the displayed claim.	Field	Number (Decimal)	9
Original ICN	Field to add or change original Internal Control Number of an adjusted claim.	Field	Character	13
Resubmit All	Sets the Adjustment Status field to 'R' for all records. Clicking a 2nd time blanks out the adjustment status field.	Button	N/A	0
Resubmit Selected	The user may select the checkboxes to the left of the claims and click this button to set the Adjustment Status field to 'R' for the selected claims.	Button	N/A	0

6.71.4 Mass Net Verification Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Adjusted Status	Field	1	Cannot change Status.	The status cannot be changed based on the value of the current status.
First Service Date	Field	1	First Service Date is required.	Enter First Service Date.
Original ICN	Field	1	Adjustment ICN is required.	Must enter an Adjustment ICN.
Set Status	Field	1	Set Status is required.	Select Status from Set Status dropdown.
Super Suspend	Field	1	Super Suspend Status is required.	Select Status from Super Suspend dropdown.

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Field	Field Type	Error Code	Error Message	To Correct
Update	Combo Box	1	At least one row must be selected in the checkbox to update claim.	Select one row in the checkbox.

6.71.5 Mass Net Verification Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.71.6 Mass Net Verification Panel Accessibility

6.71.6.1 To Access the Mass Net Verification Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustment**.	Adjustment Search panel displays.
3	Enter an **Adjustment Request** or perform a **Search** and select from the list.	Mass Adjustment Navigation panel displays.
4	Select **Mass Net Verification** link from the Mass Adjustment Navigation panel.	Mass Net Verification panel displays.

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6.72 Net Verification Panel

6.72.1 Net Verification Panel Narrative

The Net Verification panel permits the user to verify and update the financial changes made to adjusted claims.

Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Adjustments] – [Enter Criteria] – [Click Search] – [Select a request] – [Net Verification]

6.72.2 Net Verification Panel Layout

6.72.3 Net Verification Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Action Code	The action code determining how the adjustment is processed in batch. Values: 'A' - reprocess entire claim, 'P' - only reprocess claim details, 'H' - history only, do not edit, audit, or re-price.	Field	Character	5
Adjusted Amount	Adjusted amount for the displayed claim.	Field	Number (Decimal)	9
Adjustment ICN	Field to add or change new Internal Control Number of an adjusted claim.	Field	Character	13
Adjusted Status	Indicates the status of the claim being adjusted.	Field	Character	10
Adjustment Status	Field to add or update the status of a claim being adjusted.	Combo Box	Drop Down List Box	0
CCN	Cash or check receipt control number used in dispositioning the adjustment with the cash received.	Field	Character	11
Data Correct	Opens up the Corrections panel for the selected claim.	Button	N/A	0
Delete All	Sets the Adjustment Status field to ‘D’ for all records. Clicking a 2nd time blanks out the adjustment status field.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
EOB	Explanation of Benefits Code, reason for the adjustment.	Field	Number (Integer)	4
Net Amount	Header total for net amount.	Field	Number (Decimal)	9
New Claim Status	The status of the adjusted claim.	Field	Character	10
Original Amount	Original amount for the displayed claim.	Field	Number (Decimal)	9
Original ICN	Field to add or change original Internal Control Number of an adjusted claim.	Field	Character	13
Resubmit All	Sets the Adjustment Status field to 'R' for all records. Clicking a 2nd time blanks out the adjustment status field.	Button	N/A	0

6.72.4 Net Verification Panel Field Edit Error Codes

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

6.72.5 Net Verification Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.72.6 Net Verification Panel Accessibility

6.72.6.1 To Access the Net Verification Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustment**.	Adjustment Search panel displays.
3	Enter an **Adjustment Request** or perform a **Search** and select from the list.	Adjustment Navigation panel displays.
4	Select **Net Verification** link from the Mass Adjustment Navigation panel.	Net Verification panel displays.

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6.72.6.2 To Delete on the Net Verification Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.72.6.3 To Update on the Net Verification Panel

Step	Action	Response
1	Click line item to be updated.	
2	Click **Resubmit All** or **Data Correct** and select Save.	Data is updated.

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6.73 Claims Suspense List Panel

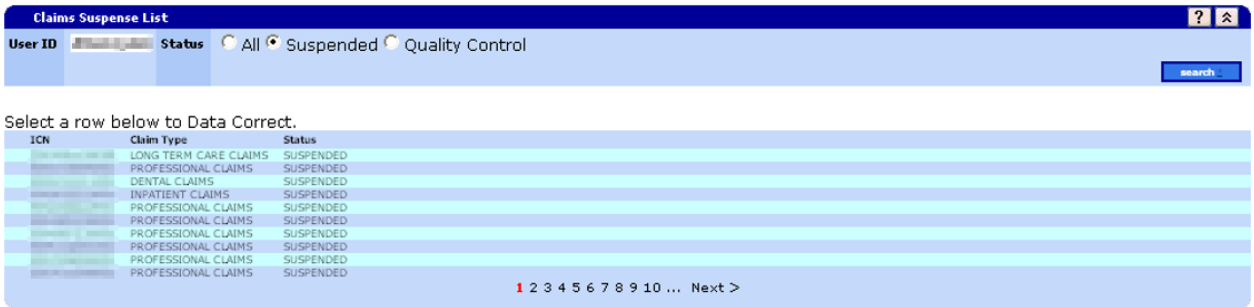
6.73.1 Claims Suspense List Panel Narrative

The Claims Suspense panel is used to list all claims that are in a suspended, or resubmit status. It only lists suspended claims for a given clerk, the clerk being the user who is currently logged onto the application. A user can make data corrections to a claim by selecting it from this listing.

This panel is inquiry only.

Navigation Path: [Claims] – [Data Corrections]

6.73.2 Claims Suspense List Panel Layout



6.73.3 Claims Suspense List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Type	Displays the type of claim in suspense.	Field	Alphanumeric	30
ICN	Internal control number (ICN) which uniquely identifies a claim.	Field	Number (Integer)	13
Search	Allows a user to search by User ID and Status.	Button	N/A	0
Status (List)	The status of the claim within the system.	Field	Character	9
Status (Search)	The claims selected by the user depending on the status selected from ALL/Suspended /Quality Control.	Combo Box	Radio Button	0
User ID	The identification number of the user to whom the claims have been assigned.	Field	Character	8

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6.73.4 Claims Suspense List Panel Field Edit Error Codes

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

6.73.5 Claims Suspense List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.73.6 Claims Suspense List Panel Accessibility

6.73.6.1 To Access the Claims Suspense List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to Claims and click Data Corrections.	Claims Suspense List panel displays.

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6.75 Dental Claim Correction Panel

6.75.1 Dental Claim Correction Panel Narrative

The Dental Data Correction panel is accessed by selecting suspended dental claims from the Claims Suspense List panel.

Only authorized users are allowed to perform maintenance tasks

Dental Claim Corrections are accomplished by changing the data in any of the following fields:

Accident Date

Billed

Current ID

Date Billed

FDOS

First Name

Other Ins

POS

Provider ID

TDOS

TPL

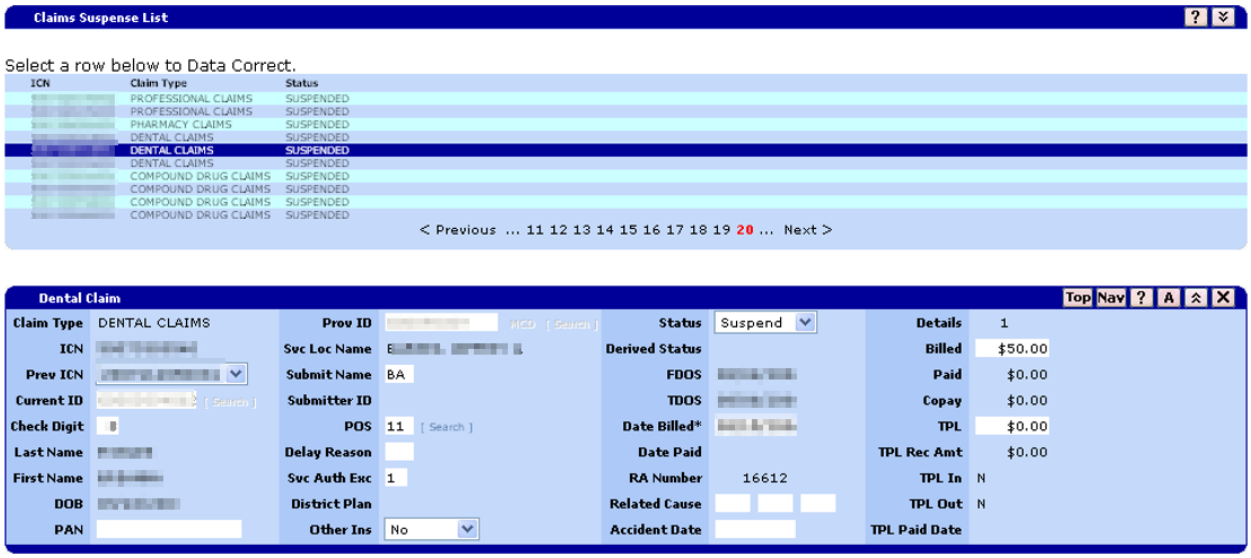
Status (Resubmit)

After data correction is complete, the examiner can resubmit the claim. Claim resubmission allows the claim to go through the claims processing cycle, subjecting it again to the edits and audits. The claim enters the processing cycle as soon as it is resubmitted. *This information is currently housed on the WC screen to view and update suspended dental claims in the legacy system.*

Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a Dental claim from the list]

6.75.2 Dental Claim Correction Panel Layout



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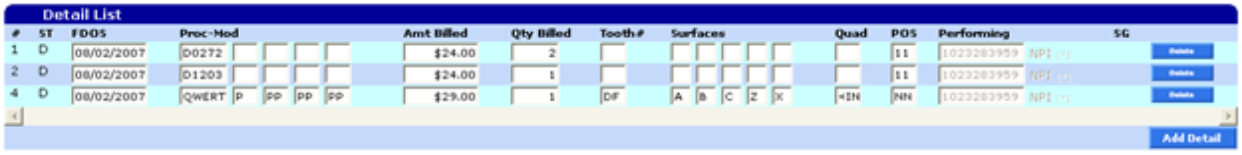

6.75.3 Dental Claim Correction Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident Date	Date of accident.	Field	Date (MM/DD/CCYY)	8
Add Detail	Adds a detail record.	Button	N/A	0
Amt Billed	Amount of money requested for payment by a provider for services rendered.	Field	Number (Decimal)	9
Billed	Amount of money requested for payment by a provider for services rendered.	Field	Number (Decimal)	8
Check Digit	The 13th digit of an assigned number which uniquely identifies a recipient.	Field	Number	1
Claim Type	Indicates the type of claim.	Field	Character	50
Copay	Amount paid by recipient for services rendered. This is the amount the Recipient is responsible for.	Field	Number (Decimal)	7
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
Date Billed	Date on which claim was submitted for processing.	Field	Date (MM/DD/CCYY)	8
Date Paid	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	8
Delay Reason	Code for delay.	Field	Number (Integer)	1
Delete	Deletes a detail record.	Button	N/A	0
Details	Indicates the number of detail service lines on the claim.	Field	Number (Integer)	9
Derived Status	The displayed status resulting from specific criteria.	Field	Character	20
District Plan	Partnership Hospital Program (PHP) code begins with 'H' and Maternity Waiver Program code begins with 'P'. The 2-digit number identifies the	Field	Character	3

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Field	Description	Field Type	Data Type	Length
	district within each program that controls payment for the claim.			
DOB	Recipient date of birth.	Field	Date (MM/DD/CCYY)	8
Dtl # (#)	The number of the detail on the claim record.	Field	Number(Integer)	4
FDOS	Date of first service on the claim.	Field	Date (MM/DD/CCYY)	8
First Name	The first name of the recipient associated with the Current ID. If the first name and the Current ID don't match the first character of the first name that was keyed is displayed.	Field	Character	15
ICN	Internal control number which uniquely identifies the claim being corrected.	Field	Number (Integer)	13
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three characters of the last that was keyed is displayed.	Field	Character	15
Other Ins	Indicates if another form of insurance was used.	Combo Box	Drop Down List Box	0
Paid	Amount paid on claim.	Field	Number (Decimal)	9
PAN	Identification for a recipient assigned by a provider. (Patient Account Number)	Field	Character	38
Performing	The identifier for the performing provider. User can enter the provider number or click on the search link [*].	Field	Character	15
POS	Place of Service. Place where services were rendered.	Field	Character	2
Prev ICN	This field allows the user to select any of the other Previous internal control numbers for the claim and view that information.	Combo Box	Drop Down List Box	0
Proc-Mod	Code used to identify a procedure and any corresponding modifiers to be billed (up to two); three separate fields.	Field	Character	6
Prov ID	The provider identification number and location that uniquely identifies the provider of services.	Field	Character	15
Quad	Displays the corresponding tooth quadrant code.	Field	Alphanumeric	3

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Field	Description	Field Type	Data Type	Length
Qty Billed	The number of units billed by the provider.	Field	Number (Integer)	6
RA Number	The unique identification number that identifies a Remittance Advice.	Field	Number	9
Related Cause	Related causes for accident.	Field	Character	3
SG	Indicates whether detail was added by system during claim's processing.	Field	Drop Down List Box	0
ST	Detail adjudication status.	Field	Character	10
Status	This field displays the status of the claim.	Combo Box	Drop Down List Box	0
Submitter ID	Submitter of Electronically submitted claims at the header level.	Field	Character	9
Submit Name	First two characters of the last name of provider or business.	Field	Alphanumeric	2
Surfaces	Code which indicates the Tooth Surface of a particular tooth (up to five).	Field	Character	4
Svc Auth Exc	Service Authorization Exception Code. Valid values include: 1 - Immediate/Urgent Care 2 – Services Rendered in a Retroactive Period 3 – Emergency Care 4 – Client as Temporary Medicaid 5 – Bypass Provider Contract Check 6 – Claim exempt from program edits 7 – Force into MAT Care Program	Field	Number (Integer)	1
Svc Loc Name	Service Location name of the provider.	Field	Character	30
TDOS	Date of last service on the claim.	Field	Date (MM/DD/CCYY)	8
Tooth #	The Tooth Number that identifies the tooth the provider rendered services on. An alpha indicates temporary teeth and numeric indicate permanent teeth.	Field	Character	2
TPL	Amount paid by third party for services, at the claim header level.	Field	Number (Decimal)	8

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Field	Description	Field Type	Data Type	Length
TPL In	The code reflects the input of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Out	The code reflects the output of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Paid Date	Displays the TPL paid date.	Field	Date (MM/DD/CCYY)	8
TPL Rec Amt	The casualty case recovery amount populated from the Settlement panel.	Field	Number (Decimal)	9

6.75.4 Dental Claim Correction Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Billed	Field	1	Enter a Valid Value.	Billed Amount must be numeric.
Date Billed	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
FDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
	Field	2	FDOS must be less than or equal to the TDOS.	Enter a valid date in MM/DD/CCYY format.
TDOS	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
TPL	Field	1	Enter a valid Value.	TPL Amount must be numeric.

6.75.5 Dental Claim Correction Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.75.6 Dental Claim Correction Panel Accessibility

6.75.6.1 To Access the Dental Claim Correction Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Data Correction**.	Claims Suspense List panel displays.
3	Enter **Clerk ID** and click **Search**.	
4	Select a Dental Claim.	Dental Claim Correction panel displays.

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6.75.6.2 To Update the Dental Claim Correction Panel

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

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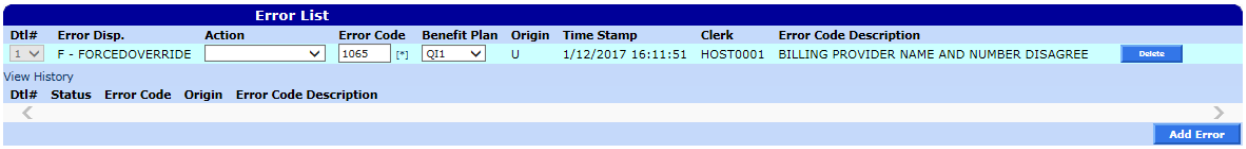
6.76 Error List Panel

6.76.1 Error List Panel Narrative

The Error List panel for Data Correction is accessed for suspended claims. This panel displays the header and/or detail errors applicable to the claim being viewed.

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

6.76.2 Error List Panel Layout



6.76.3 Error List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Action	Action the user takes - either to 'Force Override' or 'Force Deny' the error code.	Field	Drop Down List Box	0
Add Error	Adds a new error record.	Button	N/A	0
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Drop Down List Box	0
Clerk	Number used to identify the user who last updated the error record.	Field	Character	8
Delete	Deletes an error record.	Button	N/A	0
Dtll #	The number of the header or detail that contains an edit or an audit failure.	Field	Drop Down List Box	0
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit.	Field	Number (Integer)	4
Error Code Description	Description of the error.	Field	Character	30
Error Disp.	Code and its description that represents the action that is taken on a claim at disposition time: pay (P), deny (D), suspend (S), force override (F), reject (J), or batch suspend (B).	Field	Drop Down List Box	0
Origin	Indicates how the EOB Code and message were generated: Valid values	Field	Character	1

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Field	Description	Field Type	Data Type	Length
	are 'S - System Generated' or 'U - User Assigned.			
Status	Indicates whether the Error is current or history.	Field	Drop Down List Box	0
Time Stamp	Date and Time of the error code.	Field	Number (Integer)	8
View History	Displays all history records.	Hyperlink	N/A	0

6.76.4 Error List Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Action	Field	1	Action must be selected on Error List panel for detail number.	Select valid action from action dropdown.
Error Code	Field	1	A valid Error Code is required.	Enter a valid Error Code or select a valid code from the search link [*].
	Field	2	Error Code XXXX cannot be overridden.	Enter a valid Error Code or select a valid code from the search link [*].

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6.76.5 Error List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.76.6 Error List Panel Accessibility

6.76.6.1 To Access the Error List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Search**.	Claims Search panel displays.
3	Enter appropriate search criteria for suspended claim and click **Search.**	Claim Search Results Panel displays.
4	Click required record in search result	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Click **data correct** button.	Claim Header, Maintenance, Claim detail list, Error list, Data Correction Note, Manual Pricing, Diagnosis Codes, NDC Details, Related History, Payer Code, ICD9 Codes, Occurrence codes, value codes, condition codes and Medicare data panels are displayed for data correction.

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6.77 Pharmacy Data Correction Panel

6.77.1 Pharmacy Data Correction Panel Narrative

The Pharmacy Data Correction panel is accessed by selecting suspended pharmacy claims from the Claims Suspense List panel. Claim corrections are accomplished by changing the data in any of the following fields:

RX Date
Prescrib Prov
Days Supply
Refill Number
Date Billed
TPL
Prescription Number
Emergency
NursingHome
Clarification Code 1
Clarification Code 2
Clarification Code 3
Copay Exemption
RX Origin
Other Cov Code
Brand Req
Disp Date
Billed
Usual/Cust Amt
Gross Due Amt
Pregnancy
Other Payer Pat Resp Amt

After data correction is complete, the examiner can resubmit the claim. Claim resubmission allows the claim to go through the claims processing cycle, subjecting it again to the edits and audits. The claim enters the processing cycle as soon as it is resubmitted.

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a Pharmacy claim from the list]

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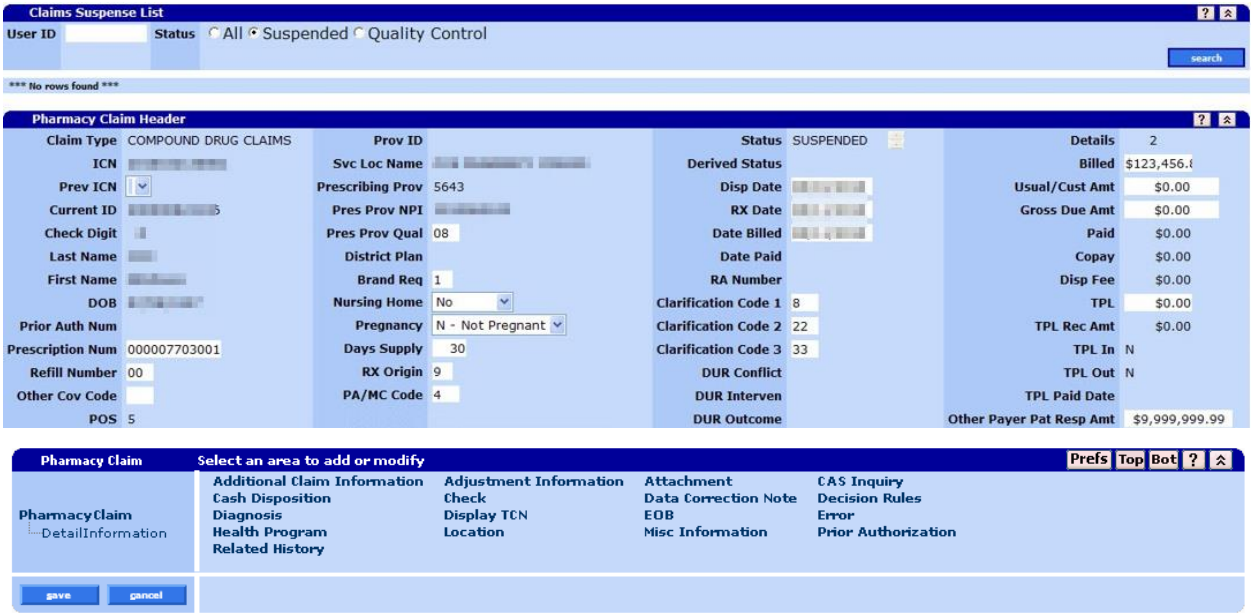
6.77.2 Pharmacy Data Correction Panel Layout



6.77.3 Pharmacy Data Correction Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Billed	Amount of money requested for payment by a provider for services rendered.	Field	Number (Decimal)	8
Brand Req	Indicates the reason, if any, that a brand name drug was dispensed as written.	Field	Character	1
Check Digit	Check Digit for Medicaid ID.	Field	Character	1
Claim Type	Indicates the type of claim.	Combo Box	Drop Down List Box	0
Clarification Code 1	The "Submission Clarification Code" is used on compound pharmacy claims. Providers use it to indicate if they want payment for only the ingredients that are approved (payable) , this would be a value of "8" (process compound for approved ingredients.) If they give us any other value, then we reject the claim if one of more ingredients is not payable or sets some sort of edit. Valid Values include: 0=Not Specified 1=No Override 2=Other Override 3=Vacation Supply	Field	Character	2

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

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Field	Description	Field Type	Data Type	Length
	4=Lost Prescription 5=Therapy Change 6=Starter Dose 7=Medically Necessary 8=Process Compound For Approved - this allows a compound claim to pay when one or more line items are not payable. 9=Encounters 99=Other			
Copay	Amount paid by recipient for services rendered. This is the amount the Recipient is responsible for.	Field	Number (Decimal)	7
Copay Exemption	Used to indicate if the claim is not subject to copayment. Valid values include: Y or blank.	Field	Character	2
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
Date Paid	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	8
District Plan	Partnership Hospital Program (PHP) code begins with 'H' and Maternity Waiver Program code begins with 'P'. The 2-digit number identifies the district within each program that controls payment for the claim.	Field	Character	3
DOB	Recipient's date of birth.	Field	Date (MM/DD/CCYY)	8
DUR Conflict	Reason for Service/Conflict Code used to override a Drug Utilization Review alert.	Field	Character	2
DUR Interven	The intervention response of the pharmacist to the Drug Utilization Review message.	Field	Character	2
DUR Outcome	The outcome response of the pharmacist to the Drug Utilization Review message.	Field	Character	2

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Field	Description	Field Type	Data Type	Length
Date Billed	The date on which a claim was submitted for processing.	Field	Date (MM/DD/CCYY)	8
Days Supply	Number of days a prescribed drug should last a recipient.	Field	Number (Integer)	9
Details	The number of detail service lines on the claim.	Field	Number (Integer)	9
Disp Date	Date pharmacy dispensed the drug to the recipient.	Field	Date (MM/DD/CCYY)	8
Disp Fee	Amount of dispensing fee, if paid.	Field	Number (Decimal)	7
First Name	The first name of the recipient associated with the Current ID. If the first name and the Current ID don't match the first character of the first name that was keyed is displayed.	Field	Character	15
Gross Due Amt	The value submitted by the provider in the gross amount due field (NCPDP field 430 –DU).	Field	Character	9
ICN	Internal control number which uniquely identifies a claim.	Field	Character	13
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three characters of the last that was keyed is displayed.	Field	Character	15
Nursing Home	Indicates whether the recipient is in a nursing home.	Combo Box	Drop Down List Box	0
Other Cov Code	This field holds the value submitted from the NCPDP request located in NCPDP field 308-C8.	Field	Character	2
Other Payer Pat Resp Amt	The patient's cost share from a previous payer.	Field	Number(Decimal)	10
Paid	Amount paid on claim.	Field	Number (Decimal)	8
Pregnancy	Indicates the claim is pregnancy related.	Combo Box	Drop Down List Box	0
POS	Place Of Service.	Field	Character	2

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Field	Description	Field Type	Data Type	Length
Prescribing Prov	Provider License Number that uniquely identifies the Prescribing Provider.	Field	Character	15
Prescription Num	Number assigned by a pharmacy to identify the drug dispensed to a recipient.	Field	Character	12
Pres Prov NPI	National Provider Identifier for the prescribing provider.	Field	Number (Integer)	10
Pres Prov Qual	The prescribing provider qualifier tells whether the provider's state license or NPI is used.	Field	Character	2
Prev ICN	This field allows the user to select any of the other Previous internal control numbers for the claim and view that information.	Combo Box	Dropdown Box	0
Prior Auth Num	Display the prior authorization number submitted by the provider on the pharmacy request.	Field	Character	10
Prov ID	The provider identification number that uniquely identifies the provider of services.	Field	Character	15
RA Number	The unique identification number that identifies a Remittance Advice.	Field	Number (Integer)	9
RX Date	The Date the drug prescription (Rx) was either filled or written.	Field	Date (MM/DD/CCYY)	8
RX Origin	Indicates the method used to submit a prescription to a pharmacy. Valid values include: 0 – Not specified 1 – Written 2 – Telephone 3 – Electronic 4 – Fax	Field	Character	1
Refill Number	Number of refills on the prescription.	Field	Character	2
Status	Identifies the status of the claim in the system.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Svc Loc Name	Service Location name of the provider.	Field	Character	30
TPL	Amount paid by third party for services, at the claim header level.	Field	Number (Decimal)	8
TPL In	The code reflects the input of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Out	The code reflects the output of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Paid Date	Displays the TPL paid date.	Field	Date (MM/DD/CCYY)	8
TPL Rec Amt	The casualty case recovery amount populated from the Settlement panel.	Field	Number (Decimal)	9
Usual/Cust Amt	The value submitted by the provider in the usual and customary field (NCPDP field 426-DQ).	Field	Character	9

6.77.4 Pharmacy Data Correction Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Date Billed	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
Disp Date	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
	Field	103	Dispense date must be prior to or equal to date billed.	Enter a valid date in MM/DD/CCYY format.
Gross Due Amt	Field	1	Gross Due Amt field must be equal to or greater than the Usual/Cust Amt field.	Verify the entry for fields Gross Due Amt and Usual/Cust Amt and correct it.
RX Date	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
	Field	2	Rx Date is required.	Enter a valid date in MM/DD/CCYY format.
TPL	Field	1	Enter a valid value.	Enter a valid numeric value.

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6.77.5 Pharmacy Data Correction Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.77.6 Pharmacy Data Correction Panel Accessibility

6.77.6.1 To Access the Pharmacy Data Correction Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Data Correction**.	Claims Suspense List panel displays.
3	Enter **Clerk ID** and click **Search**.	
4	Select a Pharmacy claim.	Pharmacy Claim panel displays.

6.77.6.2 To Update the Pharmacy Data Correction Panel

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

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6.78 Physician Data Correction Panel

6.78.1 Physician Data Correction Panel Narrative

The Physician Data Correction panel is opened by the system automatically from the first claim listed in the Claims Suspense List panel.

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

Claim corrections can be accomplished by changing the data in any of the following fields:

Status

Current ID

Last Name

First Name

FDOS

TDOS

Refer Prov 1

Refer Prov 2

Attachment

Patient Acct Number

Date Billed

TPL Amount

Accident Date

After data correction is done, the user can resubmit the claim. Claim resubmission allows the claim to go through the claims processing cycle, subjecting it again to the edits and audits. The claim enters the processing cycle as soon as it is resubmitted.

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a physician claim from the list]

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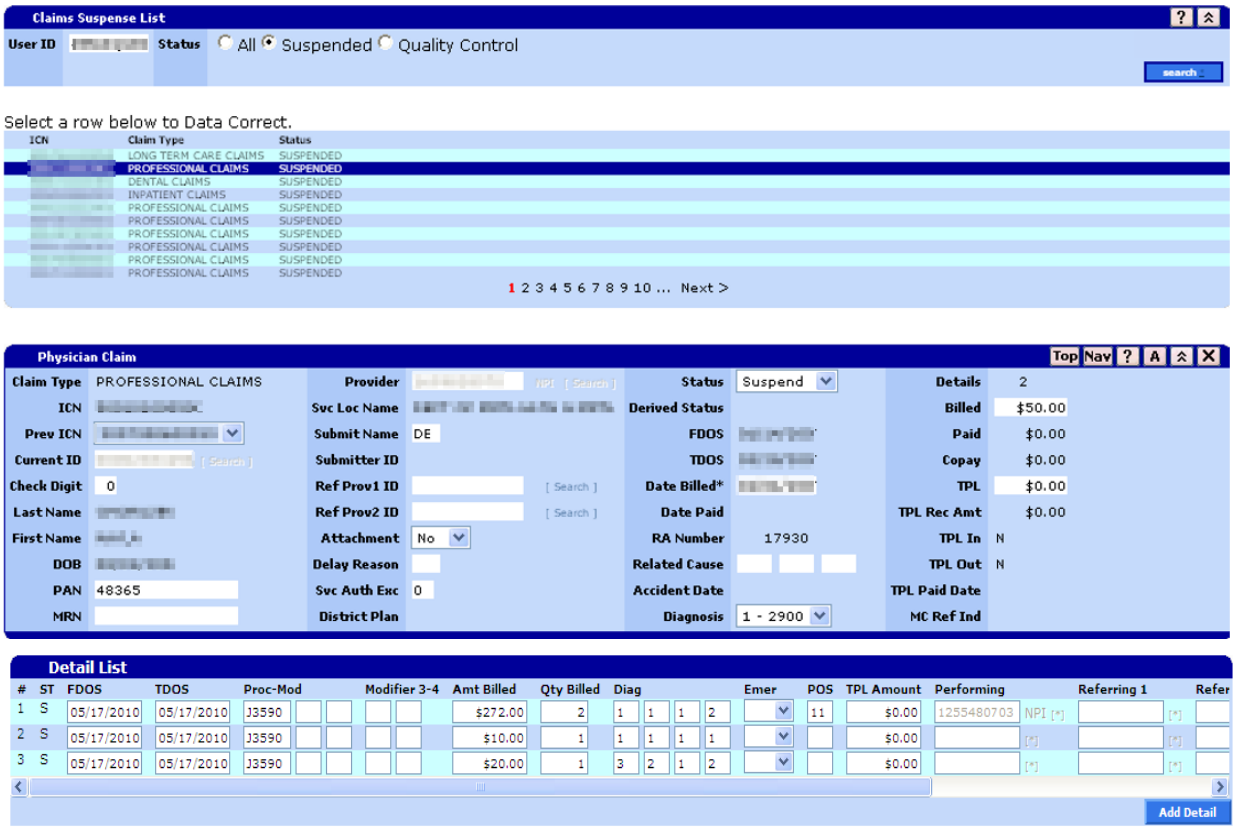
6.78.2 Physician Data Correction Panel Layout



6.78.3 Physician Data Correction Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident Date	Date of accident.	Field	Date (MM/DD/CCYY)	8
Add Detail	Adds a detail record.	Button	N/A	0
Amt Billed	Amount of money requested for payment by a provider for services rendered.	Field	Number (Decimal)	9
Attachment	Indicates whether an attachment is present.	Combo Box	Drop Down List Box	0
Billed	Amount requested by the provider for services rendered.	Field	Number (Decimal)	8
Check Digit	Check Digit for Medicaid ID.	Field	Character	1
Claim Type	Indicates the type of claim.	Field	Character	50
Copay	The sum of all the detail co-pay amounts applicable to the claim. This	Field	Number (Decimal)	7

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Field	Description	Field Type	Data Type	Length
	is the amount the Recipient is responsible for.			
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
DOB	Recipient date of birth.	Field	Date (MM/DD/CCYY)	8
Date Billed	Date on which claim was submitted for processing.	Field	Date (MM/DD/CCYY)	8
Date Paid		Field	Date (MM/DD/CCYY)	8
Delay Reason	Code for delay.	Field	Number (Integer)	1
Delete	Deletes a detail record.	Button	N/A	0
Details	The number of detail service lines on the claim.	Field	Number (Integer)	4
Diag 1	Indicates which diagnosis or diagnoses applies to the service billed on a particular detail line. Valid values are 1 to 4 for paper claims and 1 to 12 for electronic claims.	Field	Number (Integer)	2
Diag 2	Indicates which diagnosis or diagnoses applies to the service billed on a particular detail line. Valid values are 1 to 4 for paper claims and 1 to 12 for electronic claims.	Field	Number (Integer)	2
Diag 3	Indicates which diagnosis or diagnoses applies to the service billed on a particular detail line. Valid values are 1 to 4 for paper claims and 1 to 12 for electronic claims.	Field	Number (Integer)	2
Diag 4	Indicates which diagnosis or diagnoses applies to the service billed on a particular detail line. Valid values are 1 to 4 for paper claims and 1 to 12 for electronic claims.	Field	Number (Integer)	2
Diagnosis	Code used to identify the primary or other diagnoses.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
District Plan	Partnership Hospital Program (PHP) code begins with 'H' and Maternity Waiver Program code begins with 'P'. The 2-digit number identifies the district within each program that controls payment for the claim.	Field	Character	3
DOB	Recipient date of birth.	Field	Date (MM/DD/CCYY)	8
Dtl # (#)	The number of the detail on the claim record.	Field	Number(Integer)	4
Emer	Indicates whether the service was provided as result of emergency situation.	Field	Drop Down List Box	0
EPSDT FP	Code from the CMS 1500 claim form, block 24 H, indicating EPSDT or Family Planning.	Field	Character	1
EPSDT Ref	EPSDT referral/treatment information.	Field	Drop Down List Box	0
FDOS	Beginning date of service on the claim.	Field	Date (MM/DD/CCYY)	8
First Name	The first name of the recipient associated with the Current ID. If the first name and the Current ID don't match the first character of the first name that was keyed is displayed.	Field	Character	15
ICN	Internal control number which uniquely identifies a claim.	Field	Character	13
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three characters of the last that was keyed is displayed.	Field	Character	15
MC Ref Ind	Managed Care Referral Indicator.	Field	N/A	0
Modifier 3-4	Third and Fourth modifier to the procedure code; two separate fields.	Field	Character	2
MRN	Code representing the Medical Record Number.	Field	Character	50
PAN	Patient’s unique identification number assigned by the provider to track the patient’s financial records.	Field	Character	38

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Field	Description	Field Type	Data Type	Length
Paid	Amount paid on claim.	Field	Number (Decimal)	8
Performing	The rendering provider identification number and location that uniquely identifies the provider of services.	Field	Number (Integer)	10
POS	Place of Service where services were rendered.	Field	Character	2
Prev ICN	This field allows the user to select any of the claim's prior Internal Control Number and obtain information on them.	Combo Box	Drop Down List Box	0
Proc-Mod	Code used to identify a procedure and any corresponding modifiers to be billed (up to two); three separate fields.	Field	Character	6
Provider	The pay to provider identification number that uniquely identifies the provider of services.	Field	Character	15
Qty Billed	The number of units billed by the provider.	Field	Number (Integer)	6
RA Number	The unique identification number that identifies a Remittance Advice.	Field	Number (Integer)	9
Ref Prov1 ID	The license number of the referring physician other than the attending physician.	Field	Character	9
Ref Prov2 ID	Provider Identification Number that uniquely identifies the referring provider. N/A for Alabama Medicaid.	Field	Character	15
Referring Prov 1	Provider Identification Number that uniquely identifies the referring provider.	Field	Number (Integer)	10
Referring Prov 2	Provider Identification Number that uniquely identifies the referring provider. N/A for Alabama Medicaid.	Field	Number (Integer)	10
Related Cause	Related causes for accident.	Field	Character	3
SG	Indicates whether detail was added by system during claim's processing.	Field	Drop Down List Box	0
ST	Detail adjudication status.	Field	Character	10

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Field	Description	Field Type	Data Type	Length
Status	This field displays the status of the claim.	Combo Box	Drop Down List Box	0
Submitter ID	Submitter of Electronically submitted claims at the header level.	Field	Character	9
Submit Name	First two characters of the last name of provider or business.	Field	Alphanumeric	2
Svc Auth Exc	Service Authorization Exception Code. Valid values include: 1 - Immediate/Urgent Care 2 – Services Rendered in a Retroactive Period 3 – Emergency Care 4 – Client as Temporary Medicaid 5 – Bypass Provider Contract Check 6 – Claim exempt from program edits 7 – Force into MAT Care Program	Field	Number (Integer)	1
Svc Loc Name	Service Location name of the provider.	Field	Character	30
TDOS	Ending date of service on the claim.	Field	Date (MM/DD/CCYY)	8
TPL	Amount paid by third party for services, at the claim header level.	Field	Number (Decimal)	8
TPL Amount	Amount paid by third party for services (Not displayed in panel).	Field	Number (Decimal)	9
TPL In	The code reflects the input of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Out	The code reflects the output of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Paid Date	Displays the TPL paid date.	Field	Date (MM/DD/CCYY)	8
TPL Rec Amt	The casualty case recovery amount populated from the Settlement panel.	Field	Number (Decimal)	9

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6.78.4 Physician Data Correction Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Billed	Field	1	Enter a valid value.	Enter a numeric value.
Date Billed	Field	1	Invalid Date.	Verify format and re-enter.
	Field	2	TDOS must be less than or equal to Billed Date.	Verify format and re-enter.
Diag2	Field	1	[Informational Message] INFO : Diagnosis indicator must be less than or equal to number of header diagnoses on the claim.Boxes must be completed left to right and cannot be skipped.At least one diagnosis indicator is required on each detail.	Verify the value and re-enter a value to reference the header diagnosis code codes to which the procedure is related.
	Field	2	[Informational Message] INFO :Diagnosis Code Pointer cannot contain duplicate values.	Verify the value and re-enter a value to reference the header diagnosis code codes to which the procedure is related.
FDOS	Field	1	Invalid Date.	Verify date and format and re-enter.
	Field	2	FDOS can not be greater than today's date.	Verify date and format and re-enter.
	Field	3	First Service Date is required.	Verify date and format and re-enter.
	Field	4	FDOS must be less than or equal to TDOS.	Verify date and format and re-enter.
TDOS	Field	1	Invalid Date.	Enter a valid date.
	Field	2	TDOS cannot be greater than today's date.	Enter a valid date.
TPL	Field	1	Enter a valid value.	Enter a numeric value.

6.78.5 Physician Data Correction Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.78.6 Physician Data Correction Panel Accessibility

6.78.6.1 To Access the Physician Claim Correction Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Data Correction**.	Claims Suspense List panel displays.
3	Enter **Clerk ID** and click **Search**.	
4	Select a Physician claim.	Physician Claim panel displays.

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6.78.6.2 To Update the Physician Claim Correction Panel

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

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6.79 UB04 Claim Correction Panel

6.79.1 UB04 Claim Correction Panel Narrative

The UB04 Claims Correction UB04 Data Correction panel is accessed by selecting suspended Inpatient claims from the Claim Suspense Listing panel.

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

UB04 Claim corrections are accomplished by changing the data in any of the following fields.

Type of Bill

Claim Status

Current ID

Last Name

First Name

Provider ID

FDOS

TDOS

Attend Prov

Cvd Days

Ncvd Days

Admit Date

Other Prov 1

Other Prov 2

Date Billed

Admit Source

Admit Time

Admit Type

Patient Status

MRN

PAN

After data correction is complete, the examiner can resubmit the claim. Claim resubmission allows the claim to go through the claims processing cycle, subjecting it again to the edits and audits. The claim enters the processing cycle as soon as it is resubmitted.

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a UB04 claim from the list]

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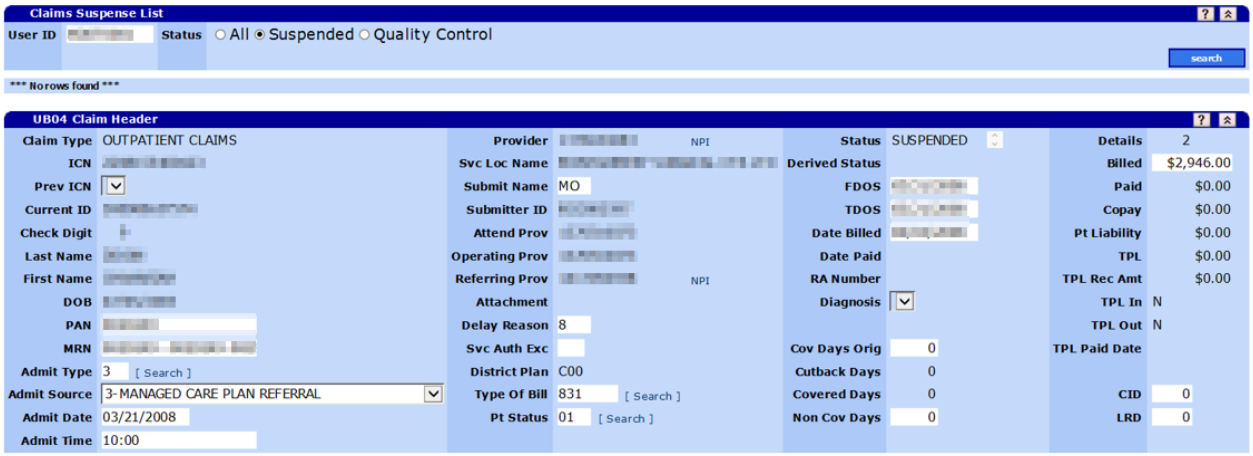
6.79.2 UB04 Claim Correction Panel Layout



6.79.3 UB04 Claim Correction Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Admit Date	The date the patient was admitted to the facility for care.	Field	Date (MM/DD/CCYY)	8
Admit Source	Displays the admit source for institutional claims.	Combo box	Drop Down List Box	0
Admit Time	The time that the recipient was admitted to the facility for care	Field	Number (HH:MM)	4
Admit Type	Code indicating the type of admission.	Field	Character	1
Attachment	Indicates whether an attachment is present.	Combo Box	Drop Down List Box	0
Attend Prov	Attending physician's NPI number.	Field	Character	10
Billed	Amount requested by the provider for services rendered.	Field	Number (Decimal)	8
CID	Co-insurance days.	Field	Number (Integer)	6
Check Digit	Check Digit for Medicaid ID.	Field	Character	1
Claim Type	Indicates the type of claim.	Field	Character	1
Copay	The sum of all the detail co-pay amounts applicable to the claim. This is the amount the Recipient is responsible for.	Field	Number (Decimal)	7
Cov Days Orig	Original number of covered days.	Field	Number (Integer)	3

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Field	Description	Field Type	Data Type	Length
Cutback Days	Days displayed will be the difference between total days and covered days.	Field	Number (Integer)	3
Current ID	The assigned number which uniquely identifies a recipient.	Field	Character	12
Covered Days	Number of days covered by the primary payer.	Field	Number (Integer)	4
District Plan	Partnership Hospital Program (PHP) code begins with 'H' and Maternity Waiver Program code begins with 'P'. The 2-digit number identifies the district within each program that controls payment for the claim.	Field	Character	3
DOB	Recipient date of birth.	Field	Date (MM/DD/CCYY)	8
Date Billed	Date on which claim was submitted for processing.	Field	Date (MM/DD/CCYY)	8
Date Paid	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	8
Delay Reason	A reason code for the delay in filing a claim.	Field	Alphanumeric	1
Details	The number of detail service lines on the claim.	Field	Number (Integer)	9
Diagnosis	Code used to identify the primary or other diagnoses.	Combo Box	Drop Down List Box	0
FDOS	Beginning date of service on the claim.	Field	Date (MM/DD/CCYY)	8
First Name	The first name of the recipient associated with the Current ID. If the first name and the Current ID don't match the first character of the first name that was keyed is displayed.	Field	Character	15
ICN	Internal control number which uniquely identifies a claim.	Field	Character	13
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three characters of the last that was keyed is displayed.	Field	Character	15
LRD	Lifetime Reserve Days.	Field	Number (Integer)	6
MRN	Code representing the Medical Record Number.	Field	Character	50
Non Cov Days	The number of days that were not covered.	Field	Number (Integer)	4

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Field	Description	Field Type	Data Type	Length
Operating Prov	The NPI number of the Operating physician.	Field	Character	10
PAN	Patient's unique identification number assigned by the provider to track the patient's financial records.	Field	Character	38
Paid	Amount paid on claim.	Field	Number (Decimal)	8
Pt Liability	The amount of patient liability that was used on the claim.	Field	Number (Decimal)	12
Pt Status	Codes indicating the patient's status as of the ending service date of the period covered on the claim.	Field	Character	2
Prev ICN	This field allows the user to select any of the claim's prior internal control numbers and obtain information on them.	Combo Box	Drop Down List Box	0
Provider	The provider identification number that uniquely identifies the provider of services.	Field	Character	15
RA Number	The unique identification number that identifies a Remittance Advice.	Field	Number (Integer)	9
Referring Prov	Provider Identification Number that uniquely identifies the Referring Provider.	Field	Character	15
Status	Identifies the status of the claim within the system.	Combo Box	Drop Down List Box	0
Submit Name	First two characters of the last name of provider or business.	Field	Alphanumeric	2
Submitter ID	Submitter of Electronically submitted claims at the header level.	Field	Character	9
Svc Auth Exc	Service Authorization Exception Code. Valid values include: 1 - Immediate/Urgent Care 2 – Services Rendered in a Retroactive Period 3 – Emergency Care 4 – Client as Temporary Medicaid 5 – Bypass Provider Contract Check 6 – Claim exempt from program edits 7 – Force into MAT Care Program	Field	Number (Integer)	1

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Field	Description	Field Type	Data Type	Length
Svc Loc Name	Service Location name of the provider.	Field	Character	30
TDOS	Ending date of service on the claim.	Field	Date (MM/DD/CCYY)	8
TPL	Amount paid by third party for services, at the claim header level.	Field	Number (Decimal)	8
TPL In	The code reflects the input of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Out	The code reflects the output of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Paid Date	Date TPL paid the claim.	Field	Date (MM/DD/CCYY)	8
TPL Rec Amt	The casualty case recovery amount populated from the Settlement panel.	Field	Number (Decimal)	9
Type of Bill	A code indicating the specific type of bill.	Field	Character	3
User ID	Indicates the identification number of the user assigned to the claims.	Field	Character	8

6.79.4 UB04 Claim Correction Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Admit Date	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
	Field	2	Admit Date must be greater than or equal to 01/01/1990.	Enter an Admit Date greater than or equal to 01/01/1990.
Admit Time	Field	2	Admit Time contains an invalid value.	Admit time must be between 0000 and 2359.
Billed	Field	1	Enter a valid value.	Billed amount must be numeric.
Date Billed	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
	Field	2	Date Billed must be greater than or equal to 01/01/1990.	Enter a Date Billed greater than or equal to 01/01/1990.
FDOS	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
	Field	2	FDOS must be greater than or equal to 01/01/1990.	Enter a FDOS date greater than or equal to 01/01/1990.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	102	First date of service must be prior to or equal to the last date of service.	Enter a valid date in MM/DD/CCYY format.
Pt Status	Field	1	A valid Patient Status is required.	Enter a valid Patient Status or select a value from the [Search] panel.
TDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
	Field	2	TDOS must be greater than or equal to 01/01/1990.	Enter a TDOS that is greater than or equal to 01/01/1990.

6.79.5 UB04 Claim Correction Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.79.6 UB04 Claim Correction Panel Accessibility

6.79.6.1 To Access the UB04 Claim Correction Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to Claims and click Data Corrections.	
3	Enter a **Clerk ID** and select a UB04 claim.	UB04 Claim panel displays.

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6.79.6.2 To Update the UB04 Claim Correction Panel

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

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6.80 Assignments Navigation Panel

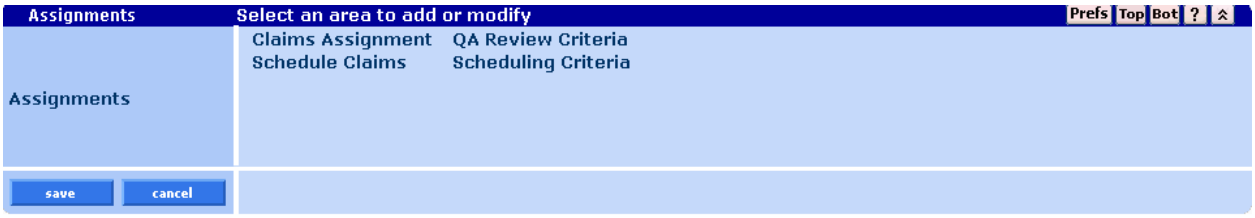
6.80.1 Assignments Navigation Panel Narrative

The Assignments Navigation panel contains links to the panels for Claims Assignment area.

This panel is inquiry only.

Navigation Path: [Claims] – [Assignments]

6.80.2 Assignments Navigation Panel Layout



6.80.3 Assignments Navigation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	This allows the user to cancel any changes on the Assignments panel.	Button	N/A	0
Claims Assignment	A link to the Claims Assignment panel.	Hyperlink	N/A	0
QA Review Criteria	A link to the QA Review Criteria panel.	Hyperlink	N/A	0
Save	This allows the user to save a record for Assignments.	Button	N/A	0
Schedule Claims	A link to the Schedule Claims panel.	Hyperlink	N/A	0
Scheduling Criteria	A link to the Scheduling Criteria panel.	Hyperlink	N/A	0

6.80.4 Assignments Navigation Panel Field Edit Error Codes

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

6.80.5 Assignments Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.80.6 Assignments Navigation Panel Accessibility

6.80.6.1 To Access the Assignments Navigation Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Assignments**.	Assignement Navigation panel displays.

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6.81 Claims Assignment Panel

6.81.1 Claims Assignment Panel Narrative

The Claims Assignment panel allows the manager, or lead, to reassign claims to the user by changing the User ID associated with a claim. These claims can be assigned by claim type or claim status.

Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Assignments] – [Claims Assignment]

6.81.2 Claims Assignment Panel Layout

6.81.3 Claims Assignment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Advanced Search Button, opens a panel with additional search criteria fields.	Button	N/A	0
Batch Range From	Batch Range From value that allows the manager to limit the selection of claims to a specific batch range.	Field	Character	3
Batch Range To	Batch Range To value that allows the manager to limit the selection of claims to a specific batch range.	Field	Character	3
Claim Type	Indicates the claim type assigned to the user.	Combo Box	Drop Down List Box	0
Clear	Clears the previous search criteria from the search fields.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Current ID	Allows the manager to limit the selection to a specific Recipient identification number.	Field	Character	12
Cycle Date	Allows the manager to limit the selection to a specific cycle date.	Field	Date (MM/DD/CCYY)	8
ICN	Allows the manager to limit the selection to a specific ICN (Internal Control Number) that uniquely identifies a claim.	Field	Number (Integer)	13
Location	Allows the manager to limit the selection of claims to a specific location.	Combo Box	Drop Down List Box	0
Region	Allows the manager to limit the selection of claims to a specific region.	Combo Box	Drop Down List Box	0
Rendering Provider ID	Allows the manager to limit the selection of claims to the individual provider number from the claims and provider.	Field	Character	15
Search	Performs a query on the database and returns the data for the entered search criteria.	Button	N/A	0
Status	Displays the claims selected by the user depending on the status selected.	Combo Box	Drop Down List Box	0
Update	Updates the claim assignment information.	Button	N/A	0
User ID	Indicates the identification number of the user assigned to the claims.	Field	Character	8

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6.81.4 Claims Assignment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Batch Range From	Field	1	Batch Entry must be numeric.	Enter a numeric value.
	Field	2	Batch To must be less than or Equal to Batch From.	Enter a numeric value.
Batch Range To	Field	1	Batch Entry must be numeric.	Enter a numeric value.
	Field	2	Batch To must be less than or equal to Batch From.	Enter a numeric value.
Claim Type	Field	1	Must select a Claim Type and Status.	Select a value for claim type.
Current ID	Field	1	Current ID must be numeric.	Enter a numeric value.
	Field	2	Current ID must be numeric.	Enter a numeric value.
Cycle Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify format and re-enter.
ICN	Field	1	ICN must be numeric.	Enter a numeric value.
Status	Field	1	Must select a Claim Type and Status.	Select a valid Status from the drop down box.
Update	Button	1000	User ID is required.	Enter a valid User ID in the User ID data entry box.
	Button	1001	No Claim Assignments selected.	Select at least one claim assignment from the data list.

6.81.5 Claims Assignment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.81.6 Claims Assignment Panel Accessibility

6.81.6.1 To Access the Claims Assignment Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Assignments**.	Assignments Maintenance panel displays.
3	Click Claims Assignment.	Claims Assignment panel displays.

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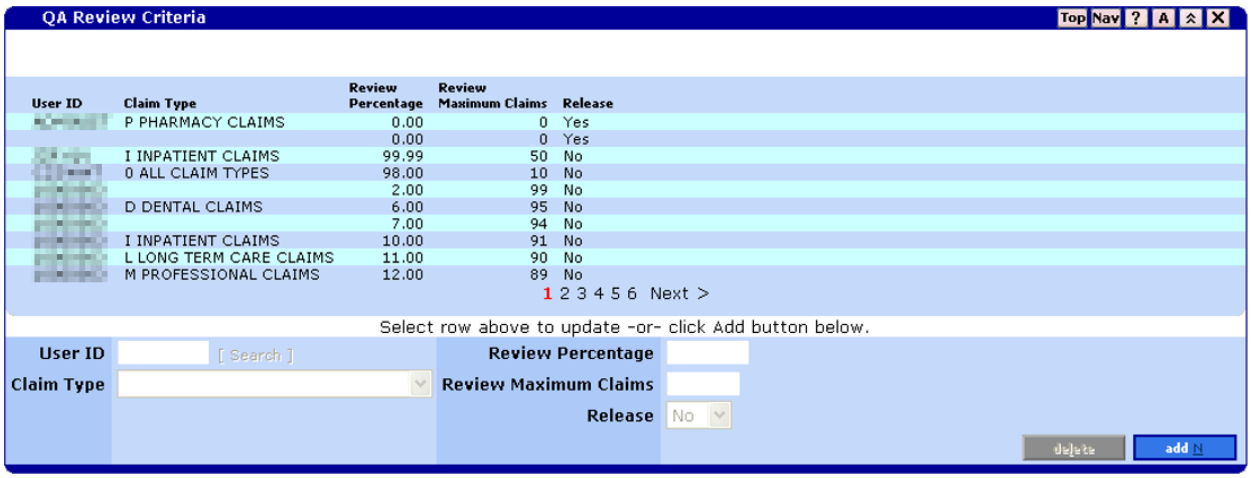
6.82 QA Review Criteria Panel

6.82.1 QA Review Criteria Panel Narrative

The QA Review Criteria panel allows the manager or lead, to set the number of claims for each user for quality review. These claims can be set by claim type. The percent and maximum number of claims needed for review can also be set. Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Assignments] – [QA Review Criteria]

6.82.2 QA Review Criteria Panel Layout



6.82.3 QA Review Criteria Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record.	Button	N/A	0
Claim Type	Indicates the type of claim assigned to the user for review.	Combo Box	Drop Down List Box	0
Delete	Allows a user to delete a record.	Button	N/A	0
Release	Indicates if the claims assigned to the user are to be released at the end of the day or held until reviewed by the manager or lead.	Combo Box	Drop Down List Box	0
Review Maximum Claims	Maximum number of claims needed from the percentage to be checked for quality.	Field	Number (Integer)	5
Review Percentage	The percent of the user's claims per day to be quality checked.	Field	Numeric (Decimal)	4
User ID	Indicates the user the claims are assigned.	Field	Character	8

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6.82.4 QA Review Criteria Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Claim Type	Field	1	A valid Claim Type is required.	Select a Claim Type from the list.
Release	Field	1	Release Indicator is required.	Select a Release Indicator from the list.
Review Maximum Claims	Field	1	Enter a valid value.	Verify value entered is numeric and greater than or equal to 0.
	Field	2	Review Maximum Claims is required.	Enter a valid value.
	Field	3	Review Maximum Claims must be less than or equal to 99999.	Enter a value less than or equal to 99999.
Review Percentage	Field	1	Percentage must be greater than or equal to 0.	Enter a Percentage greater than or equal to 0.
	Field	2	Enter a valid value.	Verify Percentage entered is numeric.
	Field	3	Percentage is required.	Enter a Review Percentage.
	Field	4	Percentage must be less than or equal to 99.99.	Enter a Review Percentage less than or equal to 99.99.
User ID	Field	1	A valid User ID is required.	Enter a User ID or click on search and select one from the list.

6.82.5 QA Review Criteria Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.82.6 QA Review Criteria Panel Accessibility

6.82.6.1 To Access the QA Review Criteria Panel

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

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Step	Action	Response
3	Select QA Review Criteria.	QA Review Criteria panel displays.

6.82.6.2 To Add on the QA Review Criteria Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update appropriate data.	
3	Select **Save**.	QA Review information data saved.

6.82.6.3 To Delete on the QA Review Criteria Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.83 Schedule Claims Panel

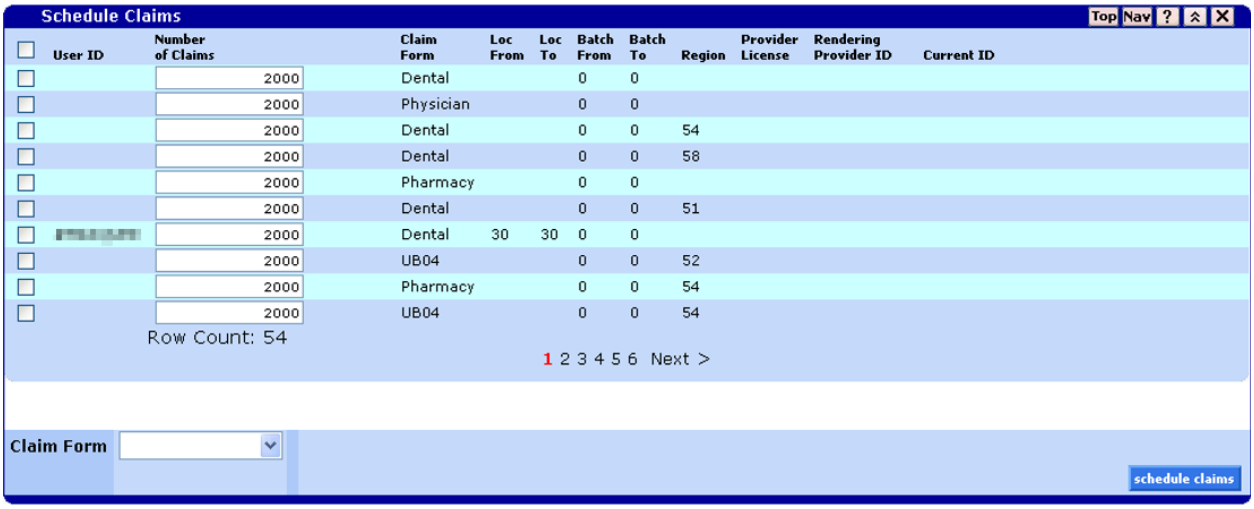
6.83.1 Schedule Claims Panel Narrative

The Schedule Claims panel allows the manager or lead, to distribute claims for the users on a daily basis. Claims can be assigned by claim type, or all claim types can be assigned at once.

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

Navigation Path: [Claims] – [Assignments] – [Schedule Claims]

6.83.2 Schedule Claims Panel Layout



6.83.3 Schedule Claims Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Batch From	The beginning batch number used to identify the grouping of the claims.	Field	Number (Integer)	3
Batch To	The ending batch number used to identify the grouping of the claims.	Field	Number (Integer)	3
Claim Form	Indicates the type of claim assigned to the user for review.	Combo Box	Drop Down List Box	0
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Number (Integer)	12
Loc From	The beginning location of the claims assigned to the user.	Field	Character	2
Loc To	The ending location of the claims assigned to the user.	Field	Character	2
Number of Claims	Number of claims found for the User.	Field	Number (Integer)	5
Provider License	License number of the provider of services.	Field	Character	9

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Field	Description	Field Type	Data Type	Length
Region	The beginning region code of the claims assigned to the user.	Field	Character	2
Rendering Provider ID	The provider identification number that uniquely identifies the provider.	Field	Character	15
Schedule Claims	Runs the process to schedule suspended claims to Users based on the Claim Type [form] and rows checked.	Button	N/A	0
User ID	Indicates the user the claims are assigned.	Field	Character	8

6.83.4 Schedule Claims Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Claim Form	Field	1	Claim Form was not specified.	Please choose a claim form.
User ID	Field	1	Select at least one user to schedule the claim.	Please choose a user ID.

6.83.5 Schedule Claims Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.83.6 Schedule Claims Panel Accessibility

6.83.6.1 To Access the Schedule Claims Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Assignments**.	Assignments Navigation panel displays.
3	Select **Schedule Claims** link from the Assignments navigation panel.	Schedule Claims panel displays.

6.83.6.2 To Update the Schedule Claims Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Schedule Claims information is saved.

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6.84 Scheduling Criteria Panel

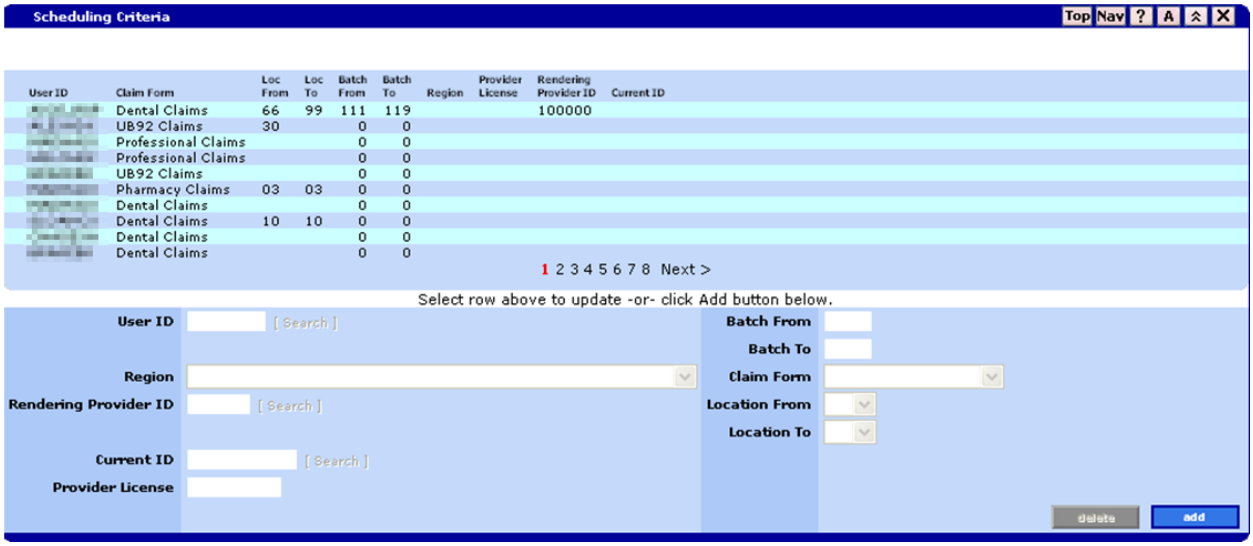
6.84.1 Scheduling Criteria Panel Narrative

The Scheduling Criteria Panel will allow assigning the user ID to a claim form, delete the already assigned user IDs and also change the criteria information for a user ID. Some of the fields on the Criteria Panel are optional. The Scheduling Criteria panel also allows the manager or lead to distribute claims for the users on a daily basis. Required criteria fields are User and Claim Type. Optional fields are Location Range, Batch Range, Region, Rendering Provider, and Current ID. Claims can be assigned by claim type, or all claim types can be assigned at once.

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

Navigation Path: [Claims] – [Assignments] – [Scheduling Criteria]

6.84.2 Scheduling Criteria Panel Layout



6.84.3 Scheduling Criteria Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record.	Button	N/A	0
Batch From	The beginning batch number used to identify the grouping of the claims.	Field	Number (Integer)	3
Batch To	The ending batch number used to identify the grouping of the claims.	Field	Number (Integer)	3
Claim Form	Indicates the claim form to assign.	Combo Box	Drop Down List Box	0
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Number (Integer)	12

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Field	Description	Field Type	Data Type	Length
Delete	Allows the user to delete a record.	Button	N/A	0
Location From	The beginning location of the claims assigned to the user.	Combo Box	Drop Down List Box	0
Location To	The ending location of the claims assigned to the user.	Combo Box	Drop Down List Box	0
Provider License	License number of the provider of services.	Field	Character	9
Region	The beginning region code of the claims assigned to the user.	Combo Box	Drop Down List Box	0
Rendering Provider ID [Search]	The provider identification number that uniquely identifies the provider and provider's service location. Select a valid Provider identification number from the [Search] panel.	Hyperlink	N/A	0
User ID [Search]	Indicates the user the claims are assigned to. Select a valid User identification number from the [Search] panel.	Hyperlink	N/A	0

6.84.4 Scheduling Criteria Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Batch From	Field	102	Must enter valid Batch From and To numbers.	Only numeric values are accepted in this field.
	Field	103	Batch From number must be less than or equal Batch To number.	Only numeric values are accepted in this field.
Batch To	Field	102	Must enter valid Batch From and To numbers.	Only numeric values are accepted in this field.
Claim Form	Field	1	Claim Type is required.	Select a valid Claim Form Type.
Location From	Field	1	A valid Location From is required.	Select a valid Location From value.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	101	Must enter valid from and to claim locations.	If a From location is entered, a To location must also be entered.
	Field	104	From claim location must be less than or equal to claim location.	If a From location is entered, a To location must also be entered.
Location To	Field	1	A valid Location To is required.	Select a valid Location To value.
	Field	101	Must enter valid from and to claim locations.	If a To value is entered, a valid From value must also be entered.
	Field	104	From claim location must be less than or equal to claim location.	If a To value is entered, a valid From value must also be entered.
Provider License	Field	106	Only Pharmacy claims are allowed to have provider license numbers. All other claims require NPIs.	If the claim is not a Pharmacy, then a License number cannot be entered.
Rendering Provider ID [Search]	Hyperlink	105	Only CMS and Dental Claims are allowed to have rendering providers.	Enter provider criteria for all claims except pharmacy claims. Pharmacy claims do not have rendering providers.
User ID [Search]	Hyperlink	1	A valid User ID is required.	Enter a valid User ID.

6.84.5 Scheduling Criteria Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.84.6 Scheduling Criteria Panel Accessibility

6.84.6.1 To Access the Scheduling Criteria Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Assignments**.	Assignments Navigation panel displays.
3	Select **Scheduling Criteria** link from the Assignments navigation panel.	Scheduling Criteria panel displays.

6.84.6.2 To Add on the Scheduling Criteria Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update the appropriate data.	
3	Click **Save**.	Scheduling Criteria information saved.

6.84.6.3 To Delete on the Scheduling Criteria Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.85 Related Data-Other Panel

6.85.1 Related Data-Other Panel Narrative

The Claims Related Data Panel contains a link to the Edit Recycle and Encounter Threshold panels.

This panel is inquiry only.

Navigation Path: [Claims] – [Related Data]

6.85.2 Related Data-Other Panel Layout

6.85.3 Related Data-Other Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Cancel Button.	Button	N/A	0
Edit Recycle	A link to Edit Recycle panel.	Hyperlink	N/A	0
Encounter Threshold	A link to Encounter Threshold panel.	Hyperlink	N/A	0
Save	Saves a record.	Button	N/A	0

6.85.4 Related Data-Other Panel Field Edit Error Codes

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

6.85.5 Related Data-Other Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.85.6 Related Data-Other Panel Accessibility

6.85.6.1 To Access the Related Data-Other Panel

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

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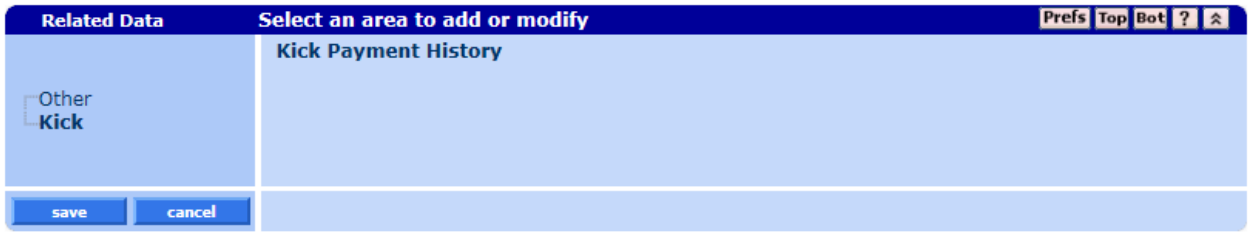
6.86 Related Data-Kick Panel

6.86.1 Related Data-Kick Panel Narrative

The Claims Related Data Panel – Kick contains a link to the Recoup KICK Payment Request panel.

Navigation Path: [Claims] – [Related Data] – [Kick].

6.86.2 Related Data-Kick Panel Layout



6.86.3 Related Data-Kick Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Cancel Button.	Button	N/A	0
Kick Payment History	A link to Kick Payment History panel.	Hyperlink	N/A	0
Save	Saves a record.	Button	N/A	0

6.86.4 Related Data-Kick Panel Field Edit Error Codes

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

6.86.5 Related Data-Kick Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.86.6 Related Data-Kick Panel Accessibility

6.86.1.1 To Access the Related Data-Kick Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Related Data**.	Related Data panel displays.
3	Click the **Kick** hyperlink located on the Related Data panel.	Related Data-Kick page displays.

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6.87 Kick Payment History Panel

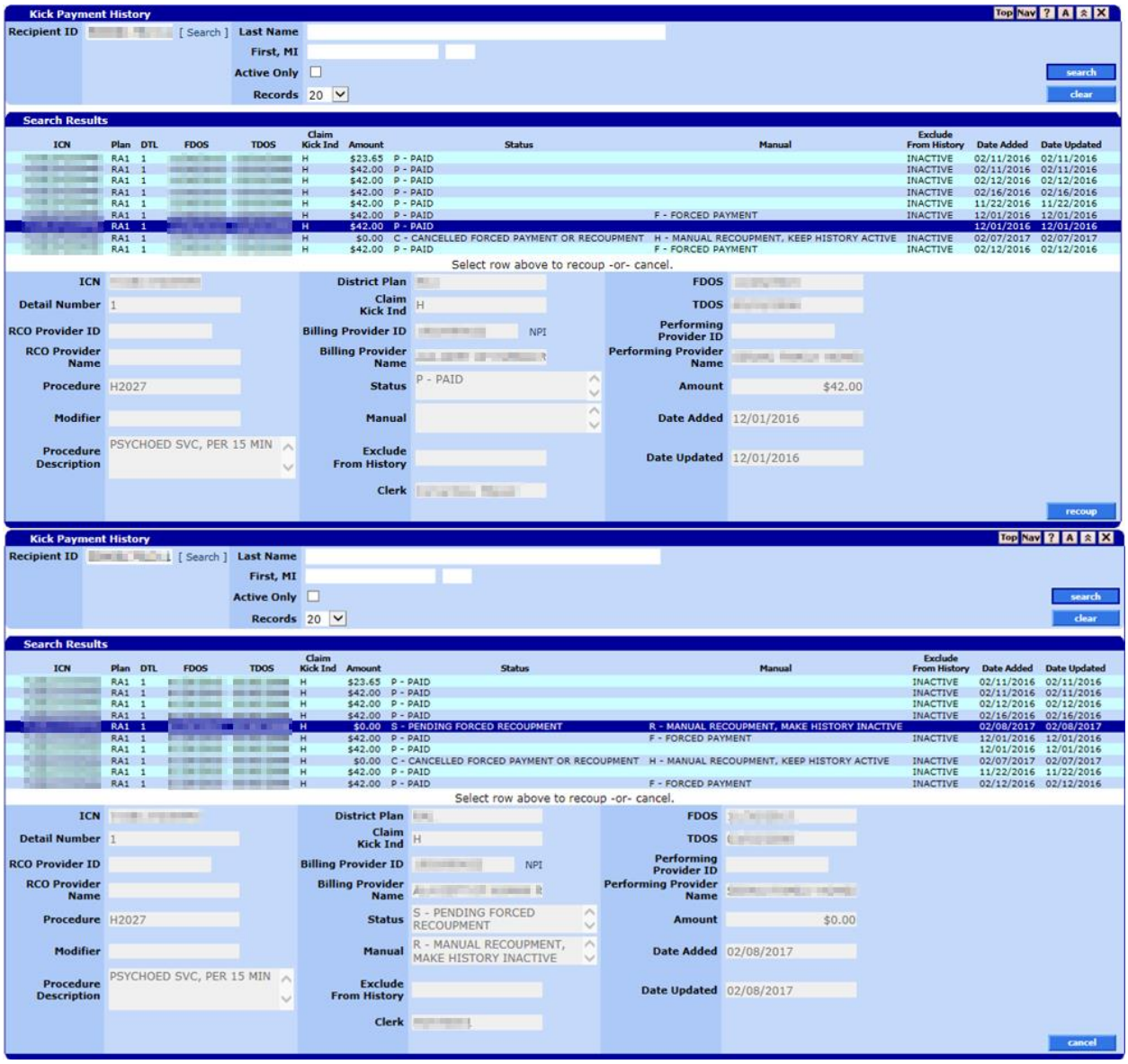
6.87.1 Kick Payment History Panel Narrative

The Kick Payment History panel allows the user to search for finalized Kick payments and FORCE a recoupment of the payment.

The panel allows the user to view prior Kick payments by Recipient ID. The user can then choose a Kick payment and select the RECOUP button to create a Kick payment recoupment request. The user will be prompted to indicate whether the record of the original payment should remain active in history for purpose of determining whether another Kick payment could be made for the recipient. The panel also allows users to view PENDING user-generated Kick payment requests or pending user-requested RECOUP request and CANCEL those requests.

Navigation Path: [Claims] – [Related Data] – [Kick] – [Kick Payment History].

6.87.2 Kick Payment History Layout



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6.87.3 Kick Payment History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Active Only	Allows the user to determine whether to select all records or only active records.	Check Box	Check Box	0
Amount	Amount of payment. Format 9999999.99	Field	Number (Decimal)	10
Billing Provider ID	Provider identification number that uniquely identifies the pay to provider.	Field	Character	15
Billing Provider Name	Name of the Billing Provider.	Field	Character	30
Claim Kick Ind	Indicates the system determined the claim met the criteria for a KICK payment at the time the claim adjudicated. An L indicates the claim met the LOW risk criteria, an H indicates the claim met the HIGH risk criteria.	Field	Character	1
cancel	Button displays for pending generate payment or recoupment requests. When selected, panel cancels the selected request.	Button	N/A	0
clear	Clears the fields in the search criteria panel.	Button	N/A	0
Clerk	Identifies the user who updated record.	Field	Character	8
Date Added	Date the transaction was added.	Field	Date (MM/DD/CCYY)	8
Date Updated	Date the transaction was last updated.	Field	Date (MM/DD/CCYY)	8
Detail Number	The number of the detail on a claim record.	Field	Number (Integer)	4
District Plan	RCO plan codes begins with ‘R’.	Field	Character	3
FDOS	From Date of Service for the claim.	Field	Date (MM/DD/CCYY)	8
First, MI	The first name and middle initial of the recipient associated with the Current ID. If the first name and the Current ID don't match the first	Field	Character	15

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Field	Description	Field Type	Data Type	Length
	character of the first name that was keyed is displayed.			
Exclude From History	Indicates if the record is active or historical. Valid values include: A = Historied. Spaces = Active	Field	Character	1
ICN	Internal Control Number that uniquely identifies a claim.	Field	Character	13
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three characters of the last that was keyed is displayed.	Field	Character	15
Manual	Indicates if the payment or recoupment was the result of a manual request. Valid values include: R= Manual recoup. H =Manual recoup – keep history.	Field	Character	1
Modifier	Code used to identify a procedure modifier.	Field	Character	2
Performing Provider ID	Provider identification number that uniquely identifies the performing provider.	Field	Character	15
Performing Provider Name	Name of the Performing Provider.	Field	Character	30
Procedure	Code used to identify a Medical procedure.	Field	Character	6
Procedure Description	A short medical description of a specific, singular medical or dental service which is performed for the express purpose of identification or treatment of the patient's condition.	Field	Character	40
recoup	Button displays for an active Kick payment that can be recouped. When selected, panel creates a recoupment request.	Button	N/A	0
RCO Provider ID	Provider identification number that uniquely identifies the RCO Plan.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
RCO Provider Name	Name of the RCO Provider.	Field	Character	30
Recipient ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
Records	Allows user to select the number or records in the datalist.	Combo Box	Drop Down List Box	0
search	Initiates the Search by entered Recipient ID.	Button	N/A	0
Status	Kick Capitation Status. Valid values include: P= Paid R= Recoup F= Pending force payment S= Pending force recoupment C= Cancelled force payment or recoupment E= Forced payment or recoupment that encountered an error in batch processing	Field	Character	1
TDOS	To Date of Service for the claim.	Field	Date (MM/DD/CCYY)	8

6.87.4 Kick Payment History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Recipient ID	Field	1	Recipient not found	Correct Recipient ID keyed or key a valid Recipient ID
		2	Recipient ID must be numeric.	Enter a numeric ID.
Search	Button	1	Recipient ID should be entered for search criteria.	An entry is required to search for a recipient. Type in the Recipient ID.

6.87.5 Kick Payment History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.87.6 Kick Payment History Panel Accessibility

6.87.6.1 To Access the Kick Payment History Panel

Step	Action	Response
1	Enter **Recipient ID** or an error message is displayed.	
2	Click **Search**.	All Kick payment transactions for the recipient are displayed.
3	Select a detail from the list.	Detail information populates to detail panel. If detail selected is an active Kick payment, RECOUP button displays. If detail selected is a pending recoupment or generated payment, CANCEL button is displayed.
4	Select CANCEL button -OR- Select RECOUP button	Cancel – panels cancels a pending request. Recoup – panel create a recoupment request.

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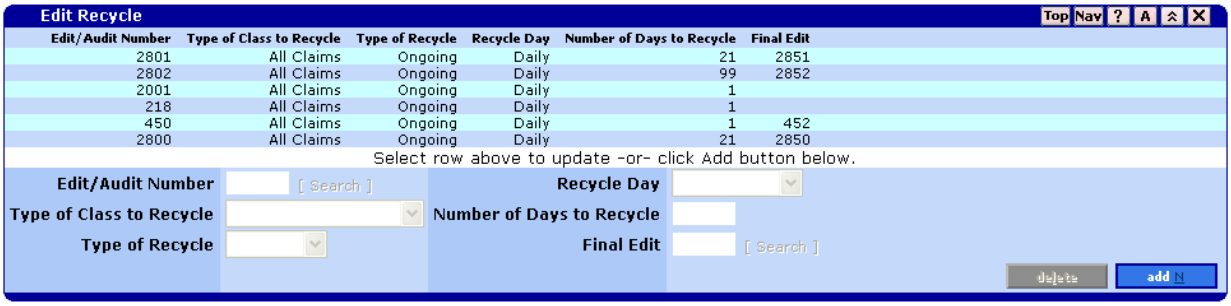
6.88 Edit Recycle Panel

6.88.1 Edit Recycle Panel Narrative

The Claims Edit Recycle panel allows select users to add and remove edits from the daily recycle parameter file. Only users with update authority are allowed to perform maintenance tasks.

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

6.88.2 Edit Recycle Panel Layout



6.88.3 Edit Recycle Panel Field Descriptions

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

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6.88.4 Edit Panel Recycle Field Edit Error Codes

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

6.88.5 Edit Recycle Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.88.6 Edit Recycle Panel Accessibility

6.88.6.1 To Access the Edit Recycle Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Related Data**.	Related Data panel displays.
3	Select the **Edit Recycle** hyperlink from the Other Navigation panel.	Edit Recycle panel displays.

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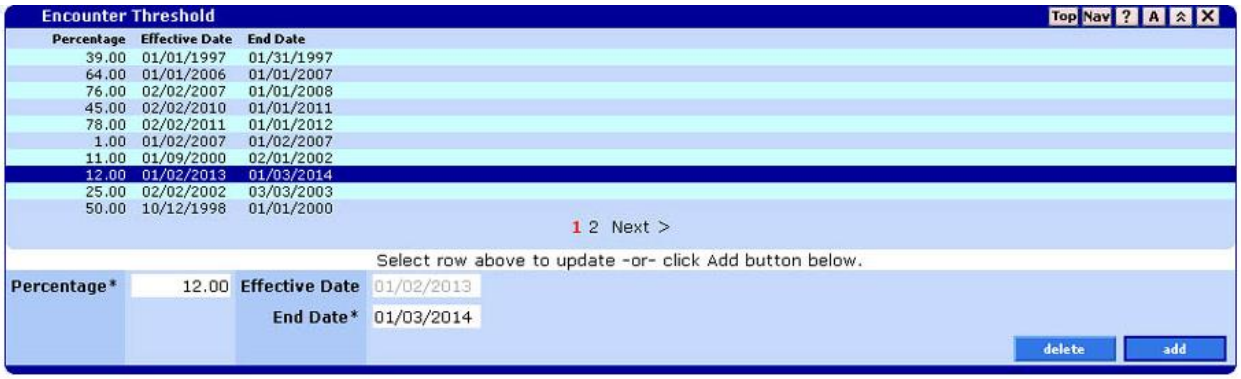
6.89 Encounter Threshold

The Claims Encounter Threshold Panel's information is used during encounter processing to determine if the batch is rejected or accepted. Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Claims] – [Related Data] – [Encounter Threshold]

6.89.1 Encounter Threshold Panel Layout



6.89.2 Encounter Threshold Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record.	Button	N/A	0
Delete	Allows a user to delete an existing record.	Button	N/A	0
End Date	End date for the associated Percentage.	Field	Date (MM/DD/CCYY)	8
Percentage	Percentage factor used during the encounter processing. The min. value is 0.00, Max is 100.00.	Field	Number (Decimal)	5
Start Date	Start date for the associated Percentage.	Field	Date (MM/DD/CCYY)	8

6.89.3 Encounter Threshold Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	Correction
Effective Date (Panel)	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	9057	Effective date must be less than or equal to End date.	Verify entry and re-enter a correct Date.
	Field	9060	Effective date and End date range overlap an existing entry.	Verify entry and re-enter a correct Date.
	Field	91001	Invalid date. Format is MM/DD/CCYY.	Verify entry and re-enter a correct Date.
End Date (Panel)	Field	1	End Date is required.	Enter a valid End Date.

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Field	Field Type	Error Code	Error Message	Correction
	Field	9060	Effective date and End date range overlap an existing record.	Verify entry and re-enter a correct Date span.
	Field	91001	Invalid date. Format is MM/DD/CCYY.	Verify entry and re-enter a correct Date.
Percentage (Panel)	Field	1	Threshold Percentage is Required.	Verify entry and re-enter a correct Percent.
	Field	2	Threshold Percentage must be greater than or equal to zero.	Verify entry and re-enter a correct Percent.
	Field	3	Threshold Percentage must be less than or equal to 100.00.	Verify entry and re-enter a correct Percent.

6.89.4 Encounter Threshold Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.89.5 Encounter Threshold Panel Accessibility

6.89.5.1 To Access the Encounter Threshold Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu panel displays.
2	Point to **Claims** and click **Related Data**.	Related Data panel displays.
3	Select Encounter Threshold.	Encounter Threshold panel displays.

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7. Reports

The Claims User Manual provides the following information for each report:

Narrative: Provides a brief description of the report functionality and usage

Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information

Field Descriptions: Lists the fields included on the report, with a definition of each field

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7.1 CLM-0010-D -- Online Adjustment Daily Report

7.1.1 CLM-0010-D -- Online Adjustment Daily Report Narrative

The Online Adjustment Daily report is used to support the on-line updates made to the credit/adjustment data entry. This report is produced daily.

7.1.2 CLM-0010-D -- Online Adjustment Daily Report Layout

```
Report  : CLM-0010-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : CLMJD10D                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLM0010D                         ON-LINE DAILY ADJUSTMENT REPORT                                Page:       9999
-------------------------------------------------------------------------------------------------------------------------------


ICN           ICN TO CREDIT    ADJUSTMENT      PROVIDER ID          RECIPIENT ID    BEGIN DATE   END DATE     REASON   CLERK ID
                               REQUEST NUMBER                                                                  CODE
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXX  XXXXXXXXXXXXX  XXXXXXXXXX       XXX XXXXXXXXXXXXXXX   XXXXXXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXX      XXXXXXXX


                                                          END OF REPORT
                                                         NO DATA THIS RUN
```

7.1.3 CLM-0010-D -- Online Adjustment Daily Report Field Descriptions

Field	Description	Length	Data Type
Adjustment Request Number	Identifies the mass adjustment request.	10	Number (Integer)
Begin Date	First date of service.	10	Date (MM/DD/CCYY)
Clerk ID	On-line clerk identification.	8	Character
End Date	Last date of service.	10	Date (MM/DD/CCYY)
ICN	Internal control number.	13	Character
ICN To Credit	Internal control number to credit/adjust.	13	Character
Provider ID	Provider number.	15	Character

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Field	Description	Length	Data Type
Reason Code	Primary reason the adjustment is needed.	4	Character
Recipient ID	Identification number assigned to recipient.	12	Character

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7.2 CLM-0011-D -- Clerk ID Recycle Claims Report

7.2.1 CLM-0011-D -- Clerk ID Recycle Claims Report Narrative

The Clerk ID Recycle Claims report is used to determine the number of edits each clerk ID has worked in the Suspense Table. This report is produced daily.

7.2.2 CLM-0011-D -- Clerk ID Recycle Claims Report Layout

```
Report  : CLM-0011-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : CLMJD011                             MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MI:SS
Location: CLM0011D                               CLERK ID RECYCLED CLAIMS REPORT                               Page:       9999


                CLERK ID         DENIED          FORCED                  MANUALLY PRICED    OTHER          CLAIMS
                XXXXXXXX         9999999         9999999                  9999999          9999999         9999999
                XXXXXXXX         9999999         9999999                  9999999          9999999         9999999
                XXXXXXXX         9999999         9999999                  9999999          9999999         9999999
                XXXXXXXX         9999999         9999999                  9999999          9999999         9999999

                TOTALS           9999999         9999999                  9999999          9999999         9999999

***   END OF REPORT   ***

***   NO DATA THIS RUN   ***
```


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7.2.3 CLM-0011-D -- Clerk ID Recycle Claims Report Field Descriptions

Field	Description	Length	Data Type
Claims	Total number of claim records processed for clerk.	7	Number (Integer)
Clerk ID	On-line clerk identification field.	8	Character
Denied	Total number of denied edits for clerk.	7	Number (Integer)
Forced	Total number of forced edits for clerk.	7	Number (Integer)
Manually Priced	Total number of manually priced edits for clerk.	7	Number (Integer)
Other	Total number of other records processed for clerk.	7	Number (Integer)
Totals	Total for each subheading.	7	Number (Integer)

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7.3 CLM-0012-D -- EOB Listing Report

7.3.1 CLM-0012-D -- EOB Listing Report Narrative

The EOB Listing report lists each Explanation of Benefit (EOB) code and its description. This report is produced daily.

7.3.2 CLM-0012-D -- EOB Listing Report Layout

```
Report  : CLM-0012-D                                    ALABAMA MEDICAID AGENCY                                     Run Date: MM/DD/CCYY
Process : CLMJD012                              MEDICAID MANAGEMENT INFORMATION SYSTEM                              Run Time:   HH:MM:SS
Location: CLM0012D                                            EOB LISTING                                               Page:        999
------------------------------------------------------------------------------------------------------------------------------------
        EXCEPTION
        CODE                    DESCRIPTION

-------------------------------------------------------------------------------------------
9999                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

9999                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

9999                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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9999                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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9999                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

9999                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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7.3.3 CLM-0012-D -- EOB Listing Report Field Descriptions

Field	Description	Length	Data Type
Description (Line 1)	EOB description (first line).	79	Character
Description (Line 2)	EOB description (second line).	79	Character
EOB Code	The Explanation of Benefit Code.	4	Character

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7.4 CLM-0015-D-- Bundling Potential History to Adjust Report

7.4.1 CLM-0015-D-- Bundling Potential History to Adjust Report Narrative

This report contains claim detail lines audited by bundling, which can require adjustment if from paid history.

The information on this report refreshes on a daily basis and, therefore, does not reflect an accumulation of unadjusted bundled claim details. In order to view a previous day's activity, simply refer to that day's report.

7.4.2 CLM-0015-D-- Bundling Potential History to Adjust Report Layout

```
REPORT:   CLM-0015-D                                  ALABAMA MEDICAID AGENCY                                RUN DATE: MM/DD/CCYY
PROCESS:  CLMJD015                                 REPORTING SYSTEM                                           RUN TIME: HH:MM:SS
LOCATION: CLM0015D                            BUNDLING POTENTIAL HISTORY TO ADJUST                                  PAGE: 99,999
                                             REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

HIST/CURR   ICN            PROVIDER         DATE        PROC     MODIFIERS     REPL                                      ALLOWED
                                            OF SVC      CODE     M1 M2 M3 M4   PROC    UNITS    BUNDLING AUDIT(S)          AMOUNT

ORIGINAL RECIPIENT ID:     999999999999                  BUNDLING CLAIM NUMBER:     9999999999999


HISTORY CLAIM LINES POTENTIALLY AFFECTED

  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX

OTHER CURRENT AND HISTORY CLAIM LINES

  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
```

7.4.3 CLM-0015-D-- Bundling Potential History to Adjust Report Field Descriptions

Field	Description	Data Type	Length
Allowed Amount	This is the amount allowed.	Character	10
Bundling Audit(s)	This is the bundling audit number(s).	Number	4

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Field	Description	Data Type	Length
Bundling Claim Number	This is the ICN of the current claim.	Character	13
Date Of Svc	This is the date of service.	Character	10
Hist/Curr	This is a code indicating if the detail comes from history or the current claim.	Character	1
ICN	This is the Internal Control Number.	Character	13
Modifiers M1	This is the first procedure code modifier.	Character	2
Modifiers M2	This is the second procedure code modifier.	Character	2
Modifiers M3	This is the third procedure code modifier.	Character	2
Modifiers M4	This is the fourth procedure code modifier.	Character	2
Original Recipient ID	This is the original recipient ID.	Character	12
Proc Code	This is the procedure code that was on the original claim.	Character	6
Provider	This is the Provider number on the detail line.	Character	15
Repl Proc	This is the procedure code that should be added or bundled on the claim. This field can be blank or the same as the original procedure code.	Character	6
Units	This is the number of units billed.	Number	3

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7.5 CLM-0016-D -- Claims Processing Daily Summary Report

7.5.1 CLM-0016-D -- Claims Processing Daily Summary Report Narrative

The purpose of the Claims Processing Daily Summary report is to list summary information by claim type for a claim adjudication cycle. For CMS-1500 an additional break out by provider type is listed. This report is produced daily.

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7.5.2 CLM-0016-D -- Claims Processing Daily Summary Report Layout

```
Report  : CLM-0016-D                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJD016                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLM0018D                                  CLAIMS PROCESSING DAILY SUMMARY                                    Page:       9999

-------------------------------------------------------------------------------------------------------------------------------------
CLAIM  *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *---------SUSPENDED---------*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %    TOTAL AMT  AVG CHG   NUMBER %      TOTAL CHG AVG CHG
-------------------------------------------------------------------------------------------------------------------------------------

MEDICAL
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

DENTAL
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

DRUG
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

COMPOUND
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

HOME HEALTH
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

LTC
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

XOVER A
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

XOVER B
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

XOVER C
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

INPATIENT
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

OUTPATIENT
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999



GRAND TOTAL FOR ALL CLAIM TYPES:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99




-------------------------------------------------------------------------------------------------------------------------------------
Report  : CLM-0016-D                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
```


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```
Process : CLMJD016                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                    Run Time:   HH:MM:SS
Location: CLM0016D                                 CLAIMS PROCESSING DAILY SUMMARY                                           Page:       9999

-------------------------------------------------------------------------------------------------------------------------------------------
PROV   *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *---------SUSPENDED---------*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %    TOTAL  AMT AVG CHG   NUMBER %      TOTAL CHG AVG CHG
-------------------------------------------------------------------------------------------------------------------------------------------
PROV TYPE:  XX
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

PROV TYPE:  XX
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

PROV TYPE:  XX
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

GRAND TOTAL FOR ALL PROVIDER TYPES PER 1500 CLAIM FORMS:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99

                                        * * * * * * *   End Of Report * * * * *
```

7.5.3 CLM-0016-D -- Claims Processing Daily Summary Report Field Descriptions

Field	Description	Length	Data Type
Approved For Denial-%	Percentage of claims for a specific claim type that have been denied.	4	Character
Approved For Denial-Avg Chg	Average charge of submitted claims for a specific claim type that have been denied.	10	Character
Approved For Denial-Number	Number of claims that have been denied for a specific claim type.	7	Character
Approved For Denial-Total Amt	Total charge of submitted claims for a specific claim type that have been denied.	11	Character
Approved For Payment-%	Percentage of claims approved for payment for a specific claim type.	4	Character
Approved For Payment-Avg Pmt	Average payment amount approved for a specific claim type.	10	Character
Approved For Payment-Number	Number of claims approved for payment for a specific claim type.	5	Character
Approved For Payment-Payment Amt	Total amount approved for payment for a specific claim type.	11	Character
Claim Type	'English' name for a specific claim type.	11	Character
Grand Total For All Claim Types	Grand total for all columns.	84	Character

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Field	Description	Length	Data Type
Grand Total For All Provider Types Per 1500 Claim Forms	Grand total for all columns.	84	Character
Prov Type	Code used to identify the type of the provider.	2	Character
Suspended Number	Total number of suspended claims for a specific claim type.	5	Character
Suspended-%	Percentage of claims suspended for a specific claim type.	4	Character
Suspended-Avg Chg	Average charge for suspended claims for a specific claim type.	7	Character
Suspended-Total Chg	Total charge for suspended claims for a specific claim type.	11	Character
Total Processed-Avg Chg	Average charge for processed claims for a specific claim type.	9	Character
Total Processed-Number	Total claims processed for a specified claim type.	6	Character
Total Processed-Total Chg	Total charge for processed claims for a specific claim type.	11	Character

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7.6 CLM-0017-D -- Original Claims Processing Daily Summary Report

7.6.1 CLM-0017-D -- Original Claims Processing Daily Summary Report Narrative

The purpose of the Original Claims Processing Daily Summary report is to list summary information by claim type for original claims for a claim adjudication cycle. For CMS 1500, an additional break out by provider type is listed. This report is produced daily.

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7.6.2 CLM-0017-D -- Original Claims Processing Daily Summary Report Layout

```
Report  : CLM-0017-D                                        ALABAMA MEDICAID AGENCY                                                  Run Date: MM/DD/CCYY
Process : CLMJD017                                   MEDICAID MANAGEMENT INFORMATION SYSTEM                                          Run Time:   HH:MM:SS
Location: CLM0018D                                  ORIGINAL CLAIMS PROCESSING DAILY SUMMARY                                             Page:       9999

-------------------------------------------------------------------------------------------------------------------------------------------
CLAIM  *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *---------SUSPENDED---------*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %   TOTAL CHG   AVG CHG   NUMBER %      TOTAL CHG AVG CHG
-------------------------------------------------------------------------------------------------------------------------------------------
MEDICAL
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

DENTAL
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

DRUG
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

COMPOUND
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

HOME HEALTH
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

LTC
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

XOVER A
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

XOVER B
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

XOVER C
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

INPATIENT
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

OUTPATIENT
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

GRAND TOTAL FOR ALL CLAIM TYPES:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99
```


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```
-----------------------------------------------------------------------------------------------------------------------------------------
Report  : CLM-0017-D                                        ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJD017                                   MEDICAID MANAGEMENT INFORMATION SYSTEM                                  Run Time:   HH:MM:SS
Location: CLM0017D                                  ORIGINAL CLAIMS PROCESSING DAILY SUMMARY                                     Page:       9999

-----------------------------------------------------------------------------------------------------------------------------------------
PROV   *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *---------SUSPENDED---------*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %   TOTAL CHG   AVG CHG   NUMBER %      TOTAL CHG AVG CHG
-----------------------------------------------------------------------------------------------------------------------------------------
PROV TYPE:  XX
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

PROV TYPE:  XX
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

PROV TYPE:  XX
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

GRAND TOTAL FOR ALL PROVIDER TYPES PER 1500 CLAIM FORMS:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99

                                                  * * * *   End Of Report * * *
```

7.6.3 CLM-0017-D -- Original Claims Processing Daily Summary Report Field Descriptions

Field	Description	Length	Data Type
Approved For Denial-%	Percentage of claims that have been denied for a specific claim type.	4	Character
Approved For Denial-Avg Chg	Average charge of submitted claims for a specific claim type that have been denied.	10	Character
Approved For Denial-Number	Number of claims that have been denied for a specific claim type.	5	Character
Approved For Denial-Tot Chg	Total charge of submitted claims for a specific claim type.	11	Character
Approved For Payment-%	Percentage of claims approved for payment for a specific claim type.	4	Character
Approved For Payment-Avg Pmt	Average payment amount approved for a specific claim type.	10	Character
Approved For Payment-Number	Number of claims approved for payment for a specific claim type.	5	Character
Approved For Payment-Payment Amt	Total amount approved for payment for a specific claim type.	11	Character
Claim Type	'English' name for a specific claim type.	11	Character

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Field	Description	Length	Data Type
Grand Total For All Claim Types	Grand total for all columns.	84	Character
Grand Total For All Provider Types Per 1500 Claim Forms	Grand total for all columns.	84	Character
Prov Type	Code used to identify the type of the provider.	2	Character
Suspended Number	Total number of suspended claims for a specific claim type.	5	Character
Suspended-%	Percentage of claims suspended for a specific claim type.	4	Character
Suspended-Avg Chg	Average charge for suspended claims for a specific claim type.	7	Character
Suspended-Total Chg	Total charge for suspended claims for a specific claim type.	11	Character
Total Processed-Avg Chg	Average charge for processed claims for a specific claim type.	9	Character
Total Processed-Number	Total claims processed for a specified claim type.	6	Character
Total Processed-Total Chg	Total charge for processed claims for a specific claim type.	11	Character

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7.7 CLM-0018-D -- Adjustment Credit Claims Processing Daily Summary Report (SAR - Part of M2500R02)

7.7.1 CLM-0018-D -- Adjustment Credit Claims Processing Daily Summary Report (SAR - Part of M2500R02) Narrative

The purpose of the Adjustment Credit Claims Processing Daily Summary report is to list summary information by claim type for adjustments and credits for a claim adjudication cycle. This report is produced daily.

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7.7.2 CLM-0018-D -- Adjustment Credit Claims Processing Daily Summary Report (SAR - Part of M2500R02) Layout

```
Report  : CLM-0018-D                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJD018                                 MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:   HH:MM:SS
Location: CLM0018D                              ADJUSTMENT/CREDIT CLAIMS PROCESSING DAILY SUMMARY                           Page:       9999

-------------------------------------------------------------------------------------------------------------------------------------------
CLAIM  *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *---------SUSPENDED---------*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %   PAYMENT AMT AVG PMT   NUMBER %      TOTAL CHG AVG CHG
-------------------------------------------------------------------------------------------------------------------------------------------

MEDICAL
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

DENTAL
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

DRUG
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

COMPOUND
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

HOME HEALTH
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

LTC
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

XOVER A
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

XOVER B
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

XOVER C
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

INPATIENT
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

OUTPATIENT
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

GRAND TOTAL FOR ALL CLAIM TYPES:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99
-------------------------------------------------------------------------------------------------------------------------------------------
```


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```
Report  : CLM-0018-D                                        ALABAMA MEDICAID AGENCY                                                  Run Date: MM/DD/CCYY
Process : CLMJD018                                  MEDICAID MANAGEMENT INFORMATION SYSTEM                                           Run Time:   HH:MM:SS
Location: CLM0018D                          ADJ/CREDIT CLAIM PROCESSING DAILY SUMMARY BY MEDICAL PROVIDER                                Page:       9999

-------------------------------------------------------------------------------------------------------------------------------------------
PROV   *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *---------SUSPENDED---------*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %   PAYMENT AMT AVG PMT   NUMBER %      TOTAL CHG AVG CHG
-------------------------------------------------------------------------------------------------------------------------------------------
PROV TYPE:  XX
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

PROV TYPE:  XX
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

PROV TYPE:  XX
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

GRAND TOTAL FOR ALL PROVIDER TYPES PER 1500 CLAIM FORMS:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99

                                                  * * * *   End Of Report * * *
```

7.7.3 CLM-0018-D -- Adjustment Credit Claims Processing Daily Summary (SAR - Part of M2500R02) Field Descriptions

Field	Description	Length	Data Type
Approved For Denial-%	Percentage of claims that have been denied for a specific claim type.	4	Number (Decimal)
Approved For Denial-Avg Pmt	Average charge of submitted claims for a specific claim type that have been denied.	10	Number (Decimal)
Approved For Denial-Number	Number of claims that have been denied for a specific claim type.	5	Number (Decimal)
Approved For Denial-Payment Amt	Total charge of submitted claims for a specific claim type that have been denied.	11	Number (Decimal)
Approved For Payment-%	Percentage of claims approved for payment for a specific claim type.	4	Number (Decimal)
Approved For Payment-Avg Pmt	Average payment amount approved for a specific claim type.	10	Number (Decimal)
Approved For Payment-Number	Number of claims approved for payment for a specific claim type.	5	Number (Decimal)
Approved For Payment-Payment Amt	Total amount approved for payment for a specific claim type.	11	Number (Decimal)

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Field	Description	Length	Data Type
Claim Type	'English' name for a specific claim type.	11	Character
Grand Total For All Claim Types	Grand total for all claim type columns.	84	Number (Decimal)
Grand Total For All Provider Types Per 1500 Claim Forms	Grand total for all columns.	84	Number (Decimal)
Prov Type	Code used to identify the type of the provider.	2	Character
Suspended Number	Total number of suspended claims for a specific claim type.	5	Number (Decimal)
Suspended-%	Percentage of claims suspended for a specific claim type.	4	Number (Decimal)
Suspended-Avg Chg	Average charge for suspended claims for a specific claim type.	7	Number (Decimal)
Suspended-Total Chg	Total charge for suspended claims for a specific claim type.	11	Number (Decimal)
Total Processed-Avg Chg	Average charge for processed claims for a specific claim type.	9	Number (Decimal)
Total Processed-Number	Total claims processed for a specific claim type.	6	Number (Decimal)
Total Processed-Total Chg	Total charge for processed claims for a specific claim type.	11	Number (Decimal)

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7.8 CLM-002-R Claim Status Change And Exception Report

7.8.1 CLM-002-R Claim Status Change And Exception Report Narrative

This report is results of processing update requests from the Agency SUR or unit other Agency-contracted company (such as HWT). Report will also be created for Ingenix.

7.8.2 CLM-002-R Claim Status Change And Exception Report Layout

```
Report  : CLM-002-R                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : CLMJO002                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLMPO002                    CLAIM STATUS CHANGE AND EXCEPTION REPORT                            Page:       9999


      ICN           RECIP        PROV     CONTROL    ORIG      STATUS               REQST  CHANGE
                     MID          NBR        NBR     STAT   DESCRIPTION             BY...  RESULT
 XXXXXXXXXXXXX   XXXXXXXXXXXX  XXXXXXXXXX XXXXXXXXX    X    XXXXXXXXXXXXXXXXXXXXX   XXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXXXXXXX   XXXXXXXXXXXX  XXXXXXXXXX XXXXXXXXX    X    XXXXXXXXXXXXXXXXXXXXX   XXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXXXXXXX   XXXXXXXXXXXX  XXXXXXXXXX XXXXXXXXX    X    XXXXXXXXXXXXXXXXXXXXX   XXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                   *** END OF REPORT ***
                                                          or
                                                  *** NO DATA THIS RUN ***
```

7.8.3 CLM-002-R Claim Status Change And Exception Report Field Descriptions

Field	Description	Length	Data Type
CHANGE RESULT	Resulting change description. Reports if the status was changed.	30	Character
CONTROL NBR	Control number from the sent request.	10	Character
ICN	Internal Control Number (ICN) associated with the claim.	13	Character
ORIG STAT	Original claim status. If there is an ‘A’ in this field, then the ICN has already been adjusted. If there is an ‘E’ in this field, then the claim is an Encounter.	1	Character
PROV NBR	Provider NPI.	9	Character
RECIP MID	Recipient Medicaid Identification number.	12	Character
REQST BY	Agency requesting the change.	3	Character

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Field	Description	Length	Data Type
STATUS DESCRIPTION	Description of the Status.	21	Character

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7.9 CLM-0020-D -- Aged Detail Suspense Report (HCA)

7.9.1 CLM-0020-D -- Aged Detail Suspense Report (HCA) Narrative

The Aged Detail Suspense report displays a detail listing by claim type of claims that have been in the suspense file longer than a certain number of days specified by parameter. This report is produced daily.

7.9.2 CLM-0020-D -- Aged Detail Suspense Report (HCA) Layout

```
Report  : CLM-0020-D                              ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJD020                        MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLM0020D                              AGED DETAIL SUSPENSE REPORT                                    Page:       9999

THE FOLLOWING CLAIMS IN THE SYSTEM AT LEAST 999 DAYS                                                 CLAIM TYPE: DENTAL CLAIMS

ICN                RECIPIENT        PROVIDER ID         LOCATION   EDITS                                                CLAIM-AGE
                                                                                                                         (DAYS)
XXXXXXXXXXXXX     XXXXXXXXXXXXX     XXXXXXXXXXXXXXX      99        XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX        999
XXXXXXXXXXXXX     XXXXXXXXXXXXX     XXXXXXXXXXXXXXX      99        XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX        999
XXXXXXXXXXXXX     XXXXXXXXXXXXX     XXXXXXXXXXXXXXX      99        XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX        999
XXXXXXXXXXXXX     XXXXXXXXXXXXX     XXXXXXXXXXXXXXX      99        XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX        999
XXXXXXXXXXXXX     XXXXXXXXXXXXX     XXXXXXXXXXXXXXX      99        XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX        999


*** END OF REPORT ***
```

7.9.3 CLM-0020-D -- Aged Detail Suspense Report (HCA) Field Descriptions

Field	Description	Length	Data Type
Claim Type	The claim type description.	60	Character
Claim-Age (Days)	Age of claim - number of days.	3	Number (Integer)
Edits	Edit codes - the claim failed. Note: There can be multiple occurrences of edits in this field.	4	Character
ICN	Internal control number of the claim.	13	Character
Location	Suspense location of the claim.	2	Number (Integer)
Provider ID	Provider Identification number.	15	Character
Recipient	Identification number of recipient.	13	Character

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7.10 CLM-0021-D -- Suspense Analysis by Exception Code Report

7.10.1 CLM-0021-D -- Suspense Analysis by Exception Code Report Narrative

The Suspense Analysis by Exception Code report is a list of the occurrences of each exception code in the suspense file. This report is produced daily.

7.10.2 CLM-0021-D -- Suspense Analysis by Exception Code Report Layout

```
Report  : CLM-0021-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJD021                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLM0021D                    SUSPENSE FILE ANALYSIS BY EXCEPTION CODE                             Page:       9999
                                   START DATE:  MM/DD/CCYY   END DATE:  MM/DD/CCYY

CLAIM TYPE                    EXC         EXC DESCRIPTION                                        CURRENT              TOTAL
                              CODE                                                             OCCURRENCES         OCCURRENCES
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXXXXXXXXXXXX     9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999999999            999999999
XXXXXXXXXXXXXXXXXXXXXXXXX     9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999999999            999999999
XXXXXXXXXXXXXXXXXXXXXXXXX     9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999999999            999999999
XXXXXXXXXXXXXXXXXXXXXXXXX     9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999999999            999999999
XXXXXXXXXXXXXXXXXXXXXXXXX     9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999999999            999999999

                                            ******   GRAND TOTAL BY EXC CODE   ******                 9999999999           9999999999
                                                        *** END OF REPORT ***
```

7.10.3 CLM-0021-D -- Suspense Analysis by Exception Code Report Field Descriptions

Field	Description	Length	Data Type
Claim Type	Type of claim.	25	Character
Current Occurrences	Number of current occurrences in suspense file.	9	Number (Integer)
Exc Code	The code for each claim type in suspense.	4	Number (Integer)
Exc Description	Description of each occurring exception.	50	Character
Grand Total By Exc Code	Grand total by exception code.	9	Number (Integer)
Total Occurrences	Total occurrences of each exception code.	9	Character

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7.11 CLM-0023-D -- Claim Exception Report

7.11.1 CLM-0023-D -- Claim Exception Report Narrative

The Claim Exception report is used by the Claims Resolution Unit as an inventory of claims to be resolved. Detailed Exception Reports by claim type are used by clerks to resolve claims. This report is produced daily.

7.11.2 CLM-0023-D -- Claim Exception Report Layout

```
Report  : CLM-0023-D                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJD023                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                   Run Time:   HH:MM:SS
Location: CLM0023D                                      CLAIMS EXCEPTION REPORT                                              Page:      99999


     ICN       RECIPIENT ID  LOC   PROVIDER+LOC        PROV  PROV     DATES OF SERVICE       NET CLAIM   PAYMENT     EXCEP   CLAIM DISP       EXCEPTION
                                      NUMBER            SPEC  TYPE     FIRST       LAST       CHARGE      AMOUNT      CODE    PD SUSP DENY      FORCED
9999999999999  999999999999  99    999999999999999      999   99      MM/DD/CCYY  MM/DD/CCYY  999999999   999999999   9999           X            X
9999999999999  999999999999  99    999999999999999      999   99      MM/DD/CCYY  MM/DD/CCYY  999999999   999999999   9999           X            X
9999999999999  999999999999  99    999999999999999      999   99      MM/DD/CCYY  MM/DD/CCYY  999999999   999999999   9999           X            X
9999999999999  999999999999  99    999999999999999      999   99      MM/DD/CCYY  MM/DD/CCYY  999999999   999999999   9999           X            X
9999999999999  999999999999  99    999999999999999      999   99      MM/DD/CCYY  MM/DD/CCYY  999999999   999999999   9999           X            X


                                                        *** END OF REPORT ***
```

7.11.3 CLM-0023-D -- Claim Exception Report Field Descriptions

Field	Description	Length	Data Type
Claim Disp-Pd Susp Deny	Status of claim.	1	Character
Dates Of Service First	First date of service on the claim	10	Date (MM/DD/CCYY)
Dates Of Service Last	Last date of service on the claim.	10	Date (MM/DD/CCYY)
Excep Code	Code to uniquely identify an exception condition.	4	Number (Integer)
Exception Forced	Indicator designating if error was forced through the system.	1	Character
ICN	Internal control number used to uniquely identify a claim.	13	Character

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Field	Description	Length	Data Type
Loc	Current location of the claim.	2	Character
Net Claim Charge	Net claim charge after spend down, third party liability payments applied, etc.	9	Character
Payment Amount	Amount reimbursed to provider.	9	Character
Prov Spec	Provider specialty.	3	Character
Prov Type	Code used to identify the type of the provider.	2	Character
Provider +LOC Number	Provider identification number.	15	Character
Recipient ID	Recipient identification number.	12	Character

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7.12 CLM-0024-D -- Daily Exception Summary By Claim Type Report

7.12.1 CLM-0024-D -- Daily Exception Summary By Claim Type Report Narrative

The Daily Exception Summary by Claim Type report shows how many times each exception occurred by claim type. In addition, disposition of the exception is reported (super-suspend, deny, suspend, pay/report, or pay).

7.12.2 CLM-0024-D -- Daily Exception Summary By Claim Type Report Layout

```
Report  : CLM-0024-D                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJDER2                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                   Run Time:   HH:MM:SS
Location: CLMPER01                                DAILY EXCEPTION SUMMARY BY CLAIM TYPE                                      Page:        999

Claim
Type: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


EXCP                                                      MM/DD/CCYY     MM/DD/CCYY      MM/DD/CCYY      MM/DD/CCYY      MM/DD/CCYY
CODE     EXCEPTION DESCRIPTION                            OCC.  CLAIMS   OCC.  CLAIMS    OCC.   CLAIMS   OCC.   CLAIMS   OCC.   CLAIMS

9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX

TOTALS BY CLAIM TYPE:
                                                         9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999

GRAND TOTAL:
                                                        99,999 99,999   99,999 99,999   99,999 99,999   99,999 99,999   99,999 99,999

                                                 **** END OF REPORT ****
```

7.12.3 CLM-0024-D -- Daily Exception Summary By Claim Type Report Field Descriptions

Field	Description	Length	Data Type
Claim Type	Type of claim.	50	Character
Claims	Number of records or exception codes for each cycle.	4	Characters
Cycle Dates (OCC. and Claims)	The billing cycle dates by number of occurrences (OCC) and claims.	10	Date (MM/DD/CCYY)
Exception Description	Exception code description on the claim.	50	Character
Excp Code	Exception code on the claim.	4	Number (Integer)

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Field	Description	Length	Data Type
Grand Total	Total number of exception codes.	6	Number (Decimal)
OCC	Number of occurrences (OCC) of exception codes.	4	Characters
Totals By Claim Type	Total number of exception codes for each claim type.	5	Number (Decimal)

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7.13 CLM-0025-D -- Services to be Clerically Denied Report

7.13.1 CLM-0025-D -- Services to be Clerically Denied Report Narrative

The Services to be Clerically Denied report lists the claims that had services denied by a clerk, thereby enabling supervisory personnel to identify those clerks who appear to resolve an inordinate number of suspended claims by denying exception codes. This report is produced daily.

7.13.2 CLM-0025-D -- Services to be Clerically Denied Report Layout

```
Report  : CLM-0025-D                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJD25D                                MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLM0025D                               SERVICES TO BE CLERICALLY DENIED REPORT                             Page:        999


ICN             DETAIL  RECIPIENT ID   PROVIDER          PROV   PROVIDER     DATES OF SERVICE        NET  BILLED     DENIED    CLERK ID
                NUMBER                 ID                TYPE   SPECIALTY    FIRST       LAST        AMT             ERRORS
XXXXXXXXXXXX    XXX     XXXXXXXXXXXX   XXXXXXXXXXXXXXX    XX    XXX          MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX     XXXX      XXXXXXX
XXXXXXXXXXXX    XXX     XXXXXXXXXXXX   XXXXXXXXXXXXXXX    XX    XXX          MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX     XXXX      XXXXXXX
XXXXXXXXXXXX    XXX     XXXXXXXXXXXX   XXXXXXXXXXXXXXX    XX    XXX          MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX     XXXX      XXXXXXX
XXXXXXXXXXXX    XXX     XXXXXXXXXXXX   XXXXXXXXXXXXXXX    XX    XXX          MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX     XXXX      XXXXXXX
XXXXXXXXXXXX    XXX     XXXXXXXXXXXX   XXXXXXXXXXXXXXX    XX    XXX          MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX     XXXX      XXXXXXX


*****CLERK ID RECAP*****
CLERK ID     CLAIM COUNT

XXXXXXXX       XXXXXXX

                                                 *** END OF REPORT ***
```

7.13.3 CLM-0025-D -- Services to be Clerically Denied Report Field Descriptions

Field	Description	Length	Data Type
Claim Count	Claim count per clerk.	7	Character
Clerk ID	On-line clerk identification number.	8	Character
Date Of Service-First	First date of service on the claim.	10	Date (MM/DD/CCYY)
Date Of Service-Last	Last date of service on the claim.	10	Date (MM/DD/CCYY)
Denied Errors	Denied errors on claim.	4	Character
Detail Number	Detail that was clerically denied.	3	Character
ICN	Internal control number.	13	Character

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Field	Description	Length	Data Type
Net Billed Amount	Net billed amount.	11	Character
Provider ID	Provider identification number.	15	Character
Provider Specialty	Specialty code for the provider.	3	Character
Prov Type	Code used to identify the type of the provider.	2	Character
Recipient ID	Recipient identification number on claim.	12	Character

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7.14 CLM-0026-D -- Claims Paid Due To Force Report

7.14.1 CLM-0026-D -- Claims Paid Due To Force Report Narrative

The Claims Paid Due to Force report lists those claims that have exceptions that were clerically forced or overridden, thereby enabling supervisory personnel to identify those clerks who appear to resolve an inordinate number of suspended claims by forcing exception codes. This report is produced daily.

7.14.2 CLM-0026-D -- Claims Paid Due To Force Report Layout

```
Report  : CLM-0026-D                                ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJD26D                            MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: CLM0026D                             CLAIMS TO BE PAID DUE TO FORCE REPORT                                     Page:       999


ICN            DETAIL RECIPIENT ID   PROVIDER          PROV    PROV    DATES OF SERVICE        NET BILLED          PAYMENT       FORCED      CLERK ID
               NUMBER                NUMBER            TYPE    SPEC    FIRST       LAST        AMT                 AMOUNT        ERRORS
XXXXXXXXXXXXX  XXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXX   XX      XXX     MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX         XXXXXXXXXXX    XXXX       XXXXXXXX
XXXXXXXXXXXXX  XXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXX   XX      XXX     MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX         XXXXXXXXXXX    XXXX       XXXXXXXX
XXXXXXXXXXXXX  XXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXX   XX      XXX     MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX         XXXXXXXXXXX    XXXX       XXXXXXXX
XXXXXXXXXXXXX  XXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXX   XX      XXX     MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX         XXXXXXXXXXX    XXXX       XXXXXXXX
XXXXXXXXXXXXX  XXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXX   XX      XXX     MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX         XXXXXXXXXXX    XXXX       XXXXXXXX


*****CLERK ID RECAP*****
CLERK ID     CLAIM COUNT

XXXXXXXX       XXXXXXX
                                                      *** END OF REPORT ****
```

7.14.3 CLM-0026-D -- Claims Paid Due To Force Report Field Descriptions

Field	Description	Length	Data Type
Claim Count	Claim count per clerk.	7	Character
Clerk ID	Clerk identification number.	8	Character
Date Of Service First	First date of service on the claim.	10	Date (MM/DD/CCYY)
Date Of Service Last	Last date of service on the claim.	10	Date (MM/DD/CCYY)
Detail Number	Detail that was clerically denied.	3	Character
Forced Errors	Total number of forced errors.	4	Character

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Field	Description	Length	Data Type
ICN	Internal control number.	13	Character
Net Billed Amt	Claim charge.	11	Character
Payment Amount	Amount due the provider.	11	Character
Provider Number	Provider identification number.	15	Character
Prov Spec	Specialty code for the provider.	3	Character
Prov Type	Code used to identify the type of the provider.	2	Character
Recipient ID	Recipient identification number.	12	Character

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7.15 CLM-0027-D -- Transaction Register Report

7.15.1 CLM-0027-D -- Transaction Register Report Narrative

The purpose of the Transaction Register report is to identify every claim processed in a daily claim adjudication cycle. Each claim is identified by ICN, Recipient ID Number, Provider Number, Transaction Code, Dates of Service, and Payment Amount. Additionally, this report displays any exception codes posted to the claim throughout the daily claim adjudication cycle. This report is produced daily.

7.15.2 CLM-0027-D -- Transaction Register Report Layout

```
Report  : CLM-0027-D                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJD027                                 MEDICAID MANAGEMENT INFORMATION SYSTEM                                          Run Time:   HH:MM:SS
Location: CLM0027D                                          TRANSACTION REGISTER                                                       Page:          1

ICN            RECIPIENT     PROVIDER ID       FROM             TO         REMIMBURSEMENT AMT  EXCEPTIONS
-------------------------------------------------------------------------------------------------------------------------------------------------------

XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXX       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX
XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXX       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX
XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXX       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX
XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXX       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX
XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXX       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX



                                                                  *** END OF REPORT ***
```

7.15.3 CLM-0027-D -- Transaction Register Report Field Descriptions

Field	Description	Length	Data Type
From	First date of service on the claim.	10	Date (MM/DD/CCYY)
TO	Last date of service on the claim.	10	Date (MM/DD/CCYY)
Exception	Exception code posted to claim.	4	Character
ICN	Internal control number.	13	Character
Provider ID	Identification number of provider.	15	Character
Recipient	Recipient identification number.	12	Character
Reimbursement Amt	Reimbursement amount.	11	Character

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7.16 CLM-0029-W -- Title XIX - Adjudicated Claims Report

7.16.1 CLM-0029-W -- Title XIX - Adjudicated Claims Report Narrative

The purpose of Title XIX-Adjudicated Claims report is to show Family Planning Services by clinic in each county. In order for a claim to be included on the report, it must meet the following criteria. The criteria includes claims submitted by a provider with 'HF' as the state share agency code. The claim must have at least one detail line with a procedure code in the 'FAMPLNDH' procedure group. This report is produced weekly.

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7.16.2 CLM-0029-W -- Title XIX - Adjudicated Claims Report Layout

```
Report  : CLM-0029-W                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJW029                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: CLMR029W                              FAMILY PLANNING SERVICES ADJUDICATED CLAIMS                                Page:        999

COUNTY XX  CLINIC TYPE XXX
  (XXXXXXXXXXXXX)

RECIPIENT NAME                  RECIP ID/       DATE OF  SRVC   *--- CHARGES ---*  ERROR CODES
                                PATIENT #       SERVICE  RECVD  SUBMITTED ALLOWED  1    2    3    4    5    6    7    8    9    10

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXX MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                XXXXXXXXXXXX
                                             MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                   9999 9999
                                             MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
WARRANT AMOUNT THIS CLAIM:  XXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXX MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                XXXXXXXXXXXX                                       9999 9999 9999 9999 9999
                                             MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                             MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
WARRANT AMOUNT THIS CLAIM:  XXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXX MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                XXXXXXXXXXXX
                                             MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                             MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
WARRANT AMOUNT THIS CLAIM:  XXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXX MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                XXXXXXXXXXXX
WARRANT AMOUNT THIS CLAIM:  XXXXXXXXXXXX


TOTAL CHARGES SUBMITTED/ALLOWED THIS CLINIC TYPE:    XXXXXXXXXXXXX  XXXXXXXXXXXXX
TOTAL WARRANT AMOUNT THIS CLINIC TYPE:   XXXXXXXXXXXXXX
TOTAL CLAIMS THIS CLINIC TYPE:   XXXXXXX


TOTAL CHARGES SUBMITTED/ALLOWED THIS COUNTY:        XXXXXXXXXXXXXX XXXXXXXXXXXXXX
TOTAL WARRANT AMOUNT THIS COUNTY:      XXXXXXXXXXXXXXXX
TOTAL CLAIMS THIS COUNTY:      XXXXXXXXX

                                                  *** END OF REPORT ****
```


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7.16.3 CLM-0029-W -- Title XIX - Adjudicated Claims Report Field Descriptions

Field	Description	Length	Data Type
Charges Allowed	Allowed charges for payment.	8	Character
Charges Submitted	Submitted charges for service.	8	Character
Clinic Type	Clinic indicator. This translates to the pay to provider's specialty code.	3	Character
County	Code assigned to the county.	2	Character
County Description	County name (below county code and clinic code).	13	Character
Date Of Service	Date service was performed.	10	Date (MM/DD/CCYY)
Error Codes - 1,11	Exception code(s) 1 and 11 (if appropriate).	4	Number (Integer)
Error Codes - 10,20	Exception code(s) 10 and 20 (if appropriate).	4	Number (Integer)
Error Codes - 2,12	Exception code(s) 2 and 12 (if appropriate).	4	Number (Integer)
Error Codes - 3, 13	Exception code(s) 3 and 13 (if appropriate).	4	Number (Integer)
Error Codes - 4,14	Exception code(s) 4 and 14 (if appropriate).	4	Number (Integer)
Error Codes - 5, 15	Exception code(s) 5 and 15 (if appropriate).	4	Number (Integer)
Error Codes - 6, 16	Exception code(s) 6 and 16 (if appropriate).	4	Number (Integer)
Error Codes - 7, 17	Exception code(s) 7 and 17 (if appropriate).	4	Number (Integer)
Error Codes - 8, 18	Exception code(s) 8 and 18 (if appropriate).	4	Number (Integer)
Error Codes - 9, 19	Exception code(s) 9 and 19 (if appropriate).	4	Number (Integer)
Recip ID	Recipient identification number.	12	Character

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Field	Description	Length	Data Type
Patient #	Number assigned to the recipient by the provider for identification purposes.	12	Character
Recipient Name	Name of recipient covered.	31	Character
SRVC RECVD	Procedure code.	6	Character
Total Charges Allowed This Clinic Type	Total charges allowed for this clinic.	13	Character
Total Charges Allowed This County	Total charges allowed for this county.	14	Character
Total Charges Submitted This Clinic	Total charges submitted for this clinic.	13	Character
Total Charges Submitted This County	Total charges submitted for this county.	14	Character
Total Claims This Clinic Type	Total number of claims for this clinic.	7	Character
Total Claims This County	Total number of claims for this county.	9	Character
Total Warrant Amount This Clinic Type	Total warrant amount for this clinic.	14	Character
Total Warrant Amount This County	Total warrant amount for this county.	16	Character
Warrant Amount This Claim	This is the am_paid at the header level (num_dtl = 0) on the t_clm_pgm_xref table. This amount may not be equal to the sum of the allowed amounts at the detail level since any state share (N/A for Alabama Medicaid) deducted from the reimbursed amount. That is, the 'Warrant Amount This Claim' total will likely be less than the sum of the 'allowed' charges for the claim detail lines. This amt_paid on t_clm_pgm_xref is at the claim level so the actual check amount would equal the sum of all of the claims for the recipient during the weekly financial cycle.	12	Character

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7.17 CLM-0030-M -- Pharmacy Report for Waiver Recipients Report

7.17.1 CLM-0030-M -- Pharmacy Report for Waiver Recipients Report Narrative

The Pharmacy Report for Waiver Recipients report displays all pharmacy claims filled over the Title 19 limit of 3 when the recipient is Waiver type W1 -- W9, C1 or C2. (Combination of OHCA reports: M2885R01, M2885R02, M2885R03.) This report is only for adults with over 3 claims and is produced monthly.

7.17.2 CLM-0030-M -- Pharmacy Report for Waiver Recipients Report Layout

```
Report  : CLM-0030-M                                        ALABAMA MEDICAID AGENCY                                                              Run Date: MM/DD/CCYY
Process : CLMJM031                                   MEDICAID MANAGEMENT INFORMATION SYSTEM                                                      Run Time:   HH:MM:SS
Location: CLMP0030                                    PHARMACY REPORT FOR WAIVER RECIPIENTS                                                          Page:        999
                                          WITH MORE THAN 3 CLAIMS FOR PERIOD: MM/DD/CCYY - MM/DD/CCYY

BENEFIT PLAN: XX-XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                    PRESCRIBING    DATE OF                                     REIMBURSE
RECIPIENT      PROVIDER NUMBER      PHYSICIAN      SERVICE      ICN              DRUG CODE     AMOUNT

XXXXXXXXXXXX   XXX XXXXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY   XXXXXXXXXXXXX    XXXXXXXXXXX   XXXXXXXXXXXX
XXXXXXXXXXXX   XXX XXXXXXXXXXXXXXX  XXXXXXXX       MM/DD/CCYY   XXXXXXXXXXXXX    XXXXXXXXXXX   XXXXXXXXXXXX
XXXXXXXXXXXX   XXX XXXXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY   XXXXXXXXXXXXX    XXXXXXXXXXX   XXXXXXXXXXXX
XXXXXXXXXXXX   XXX XXXXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY   XXXXXXXXXXXXX    XXXXXXXXXXX   XXXXXXXXXXXX
XXXXXXXXXXXX   XXX XXXXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY   XXXXXXXXXXXXX    XXXXXXXXXXX   XXXXXXXXXXXX
XXXXXXXXXXXX   XXX XXXXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY   XXXXXXXXXXXXX    XXXXXXXXXXX   XXXXXXXXXXXX
XXXXXXXXXXXX   XXX XXXXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY   XXXXXXXXXXXXX    XXXXXXXXXXX   XXXXXXXXXXXX

TOTAL PER RECIPIENT
                                                                                          XXXXXXXXXXXXX



                    REPORT TOTALS
                                 BY WAIVER TYPE:     XXXXXX CLAIMS     XXXXXXXXXXXX REIMBURSED

                                                                    **** END OF REPORT ****
```

7.17.3 CLM-0030-M -- Pharmacy Report for Waiver Recipients Report Field Descriptions

Field	Description	Length	Data Type
Benefit Plan	The medical assistance program associated with the related ICN. (Format is 2-digit abbreviation (hyphen) 50-character description.)	53	Character
Date Of Service	Service date of claim.	10	Date (MM/DD/CCYY)
Drug Code	National Drug Code (NDC) on the claim.	11	Character

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Field	Description	Length	Data Type
ICN	Internal control number.	13	Character
Prescribing Physician	Prescribing physician license number.	9	Character
Provider Number	Provider identification number.	15	Character
Recipient	Recipient identification number.	12	Character
Reimburse Amount	Amount given for reimbursement.	12	Character
Report Totals (Claims)	Total number of claims for the report.	6	Character
Report Totals (Reimbursed)	Total reimbursement amount for the report.	12	Character
Total Per Recipient	Total amount reimbursed per recipient.	13	Character

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7.18 CLM-0031-M -- Suspense File Analysis by Claim Type 2 v

7.18.1 CLM-0031-M -- Suspense File Analysis by Claim Type 2 Report Narrative

The Suspense File Analysis by Claim Type 2 report prints a suspense file analysis by claim type of current and last fiscal years. The second page of the report is a break out by Provider type with CMS 1500. This report is produced monthly.

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7.18.2 CLM-0031-M -- Suspense File Analysis by Claim Type 2 Report Layout

```
Report  : CLM-0031-M                                ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJM031                            MEDICAID MANAGEMENT INFORMATION SYSTEM                                           Run Time:   HH:MM:SS
Location: CLM0031M                             SUSPENSE FILE ANALYSIS BY CLAIM TYPE                                                Page:        999

                                                         ***   X I X   ***
-------------------------------------------------------------------------------------------------------------------------------------------
 CLAIM                        FY   CCYY                                  PREVIOUS FY   CCYY
 TYPE                 NUMBER      DOLLAR VALUE                        NUMBER      DOLLAR VALUE
-------------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

  TOTAL               XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX
```


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```
Report  : CLM-0031-M                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJM031                                 MEDICAID MANAGEMENT INFORMATION SYSTEM                               Run Time:   HH:MM:SS
Location: CLM0031M                                SUSPENSE FILE ANALYSIS BY MEDICAL PROVIDER                                 Page:        999
-------------------------------------------------------------------------------------------------------------------------------------------
 PROV                          FY   CCYY                                  PREVIOUS FY   CCYY
 TYPE                 NUMBER      DOLLAR VALUE                          NUMBER      DOLLAR VALUE
-------------------------------------------------------------------------------------------------------------------------------------------
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX

  TOTAL              XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX

                                                                 *** END OF REPORT ***
```

7.18.3 CLM-0031-M -- Suspense File Analysis by Claim Type 2 Report Field Descriptions

Field	Description	Length	Data Type
Claim Type	Type of claim code.	10	Character
FY CCYY Dollar Value	Fiscal year dollar value of reimbursement.	14	Character
FY CCYY Number	Fiscal year count of claims.	6	Character
Previous FY CCYY Dollar Value	Previous fiscal year reimbursement amount.	14	Character
Previous FY CCYY Number	Previous fiscal year count of claims.	6	Character
Prov Type	Identifies the type of provider (i.e. doctor, hospital, ACS, etc).	2	Character
Total Dollar Value	Total of each dollar value subheading.	14	Character
Total Number	Total of each number value subheading.	6	Character

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7.19 CLM-0035-M -- Advantage Waiver Recipient Report

7.19.1 CLM-0035-M -- Advantage Waiver Recipient Report Narrative

The Advantage Waiver Recipient report lists payments made to providers for Advantage Waiver recipient services. This report is produced monthly.

7.19.2 CLM-0035-M -- Advantage Waiver Recipient Layout

```
Report  : CLM-0035-M                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJM035                                MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLM0035M                                    ADVANTAGE WAIVER RECIPIENT                                      Page:        999

RECIPIENT NAME:  XXXXXXXXXXXXXXXXXXXX    RECIPIENT ID:  XXXXXXXXXXXX
                                                                                                   PROV
PROVIDER NAME           PROVIDER ID        SERV CODE      SERVICE DESCRIPTION         FDOS        LDOS     SPEC     DATE PAID   AMOUNT PAID

XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY  XXX     MM/DD/CCYY   99999999999
XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY  XXX     MM/DD/CCYY   99999999999
XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY  XXX     MM/DD/CCYY   99999999999
XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY  XXX     MM/DD/CCYY   99999999999
XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY  XXX     MM/DD/CCYY   99999999999


                                                                                 RECIP/PROVIDER TOTAL-  9999999999999
                                                                                 RECIPIENT TOTAL-       9999999999999
                                                   *** END OF REPORT ***
```

7.19.3 CLM-0035-M -- Advantage Waiver Recipient Report Field Descriptions

Field	Description	Length	Data Type
Amount Paid	Amount paid to claim.	11	Character
Date Paid	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	10	Date (MM/DD/CCYY)
FDOS	First date of service.	10	Date (MM/DD/CCYY)
LDOS	Last date of service.	10	Date (MM/DD/CCYY)
Provider ID	Provider identification number.	15	Character
Provider Name	Name of provider.	22	Character
Prov Spec	Provider specialty code.	3	Character

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Field	Description	Length	Data Type
Recip/Provider Total	Total amount paid to provider for the recipient.	13	Character
Recipient ID	Recipient identification number.	12	Character
Recipient Name	Name of recipient on claim.	31	Character
Recipient Total	Total amount paid for recipient.	13	Character
Serv Code	Procedure code.	14	Character
Service Description	Procedure name.	25	Character

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7.20 CLM-0036-M -- Claims With Excluded Provider Prescriber Numbers Report

7.20.1 CLM-0036-M -- Claims With Excluded Provider Prescriber Numbers Report Narrative

The Claims with Excluded Provider Prescriber Numbers report lists claims with selected excluded provider prescriber numbers. This report is produced monthly.

7.20.2 CLM-0036-M -- Claims With Excluded Provider Prescriber Numbers Report Layout

```
Report  : CLM-0036-M                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJM036                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                           Run Time:      HH:MI
Location: CLM0036M                            CLAIMS WITH EXCLUDED PROVIDER PRESCRIBER NUMBERS                                         Page:          1

     ICN       PROVIDER        PRESCRIBER  PRESCRIBER                 PROGRAM   PROGRAM      FILED         FIRST DATE    REIMB
                               NUMBER      NAME                       CODE      END DATE      RID            OF SVC      AMOUNT
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXX  XXXXXXXXXXXXXXX 9999999999  XXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY   XXXXXXXXXXXX  MM/DD/CCYY    99,999,999.99
XXXXXXXXXXXX  XXXXXXXXXXXXXXX 9999999999  XXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY   XXXXXXXXXXXX  MM/DD/CCYY    99,999,999.99
XXXXXXXXXXXX  XXXXXXXXXXXXXXX 9999999999  XXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY   XXXXXXXXXXXX  MM/DD/CCYY    99,999,999.99
XXXXXXXXXXXX  XXXXXXXXXXXXXXX 9999999999  XXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY   XXXXXXXXXXXX  MM/DD/CCYY    99,999,999.99
XXXXXXXXXXXX  XXXXXXXXXXXXXXX 9999999999  XXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY   XXXXXXXXXXXX  MM/DD/CCYY    99,999,999.99


                                                                  End Of Report
```

7.20.3 CLM-0036-M -- Claims With Excluded Provider Prescriber Numbers Report Field Descriptions

Field	Description	Length	Data Type
First Date of Service	First date of service.	10	Date (MM/DD/CCYY)
Filed RID	Filed recipient identification number.	12	Character
ICN	Internal control number.	13	Character
Prescriber Name	Name of the Prescriber.	25	Character
Prescriber Number	Prescriber license number.	10	Number (Integer)
Program Code	Program code that the provider was excluded from.	5	Character
Program End Date	The last day the provider was eligible for the program.	10	Date (MM/DD/CCYY)
Provider	Servicing provider identification number.	15	Character

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Field	Description	Length	Data Type
Reimb Amount	Reimbursement amount.	13	Number (Decimal)

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7.21 CLM-0046-M -- Potential Schedule 2 Narcotic Drug Abuse Report

7.21.1 CLM-0046-M -- Potential Schedule 2 Narcotic Drug Abuse Report Narrative

The purpose of the Potential Schedule 2 Narcotic Drug Abuse report is to summarize prescribing information relating to narcotic drugs. This report is produced monthly.

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7.21.2 CLM-0046-M -- Potential Schedule 2 Narcotic Drug Abuse Report Layout

```
Report  : CLM-0046-M                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJM046                               MEDICAID MANAGEMENT INFORMATION SYSTEM                                        Run Time:      HH:MM:SS
Location: CLMP046M                              POTENTIAL SCHEDULE 2 NARCOTIC DRUG ABUSE                                            Page:      99999
                                                         RECIPIENT NUMBER ORDER
                                                         MONTHNAME CCYY SERVICES

-------------------------------------------------------------------------------------------------------------------------------------------------------
RECIPIENT ID  RECIP NAME                                          PRESC
   PROVIDER NO PROVIDER NAME                                -     NUM-     ICN           DT SERV    DRUG CODE   DRUG NAME                    SUP  QTY
-------------------------------------------------------------------------------------------------------------------------------------------------------

XXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
99999.999
  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
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  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
99999.999

                                                  *** END OF REPORT ***
```

7.21.3 CLM-0046-M -- Potential Schedule 2 Narcotic Drug Abuse Report Field Descriptions

Field	Description	Length	Data Type
Drug Code	National Drug Code (NDC) on the claim.	11	Character
Drug Name	Name of drug prescribed as it appears on the package label provided by the manufacturer. Does not include strength.	30	Character
Dt Serv	First date of service.	10	Date (MM/DD/CCYY)
ICN	Internal control number.	13	Character
Presc Num	Prescription number assigned by a pharmacy to identify the drug dispensed to a recipient.	9	Number (Integer)
Provider Name	Provider name on file who wrote the prescription; usually 50 bytes but truncated due to space constraints on report.	48	Character
Provider No.	Provider identification number.	15	Character
Qty	The quantity dispensed.	9	Number (Decimal)
Recip Name	Name of recipient.	31	Character

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Field	Description	Length	Data Type
Recipient ID	Recipient identification number.	12	Character
Sup	Days supplied.	3	Character

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7.22 CLM-0048-W -- Weekly POS Activity Report

7.22.1 CLM-0048-W -- Weekly POS Activity Report Narrative

The Weekly POS Activity report provides a statistical summary of non-network originated transactions (Paper and EMC) and network originated transactions (POS) for the week.

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7.22.2 CLM-0048-W -- Weekly POS Activity Report Layout

```
Report  : CLM-0048-W                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJW048                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: CLM0048W                                              POINT OF SALE                                              Page:      99999
                                                          WEEKLY POINT OF SALE ACTIVITY

------------------- NON-NETWORK ORIGINATED TRANSACTIONS --------------

             CLAIMS      CLAIMS       CLAIMS       CLAIMS        CLAIMS  CLAIMS
TYPE         PROCESSED   SUSPENDED     PAID      PAID AMOUNT     DENIED  REJECTED

PAPER        999,999     999,999      999,999   99,999,999.99   999,999  999,999
EMC          999,999     999,999      999,999   99,999,999.99   999,999  999,999

-----------------------------------------------------NETWORK ORIGINATED TRANSACTIONS -------------------------------------------
                --------------- POINT OF SALE CLAIMS ----------------   ------------ OTHER TYPES OF POS TRANSACTIONS ------------

                CLAIMS    CLAIMS      CLAIMS        CLAIMS  AVG RESP   REVERSALS  REVERSALS RECIP.ELIG. POS COMM  PA      PA
HOURS RECEIVED  RECEIVED  PAID      PAID AMOUNT     DENIED    TIME     RECEIVED   REJECTED   INQUIRES   REJECTED  INQ     RQST

99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
                -------   -------   --------------  -------   ------   -------    -------   -------     -------   ------- -------
TOTAL           999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999

                                                          *** END OF REPORT ****
```


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7.22.3 CLM-0048-W -- Weekly POS Activity Report Field Descriptions

Field	Description	Length	Data Type
Avg Resp Time	Average response time of point of service claims for each hour of the day.	6	Number (Decimal)
Claims Denied	Total point of service claims denied for each hour of the day.	7	Number (Decimal)
Claims Denied (Paper/EMC)	Total paper/EMC claims denied for the week.	7	Number (Decimal)
Claims Paid	Total number of point of service claims paid for each hour of the day.	7	Number (Decimal)
Claims Paid (Paper/EMC)	Total paper/EMC claims paid for the week.	7	Number (Decimal)
Claims Paid Amount	Total dollar amount of point of service claims paid for each hour of the day.	14	Number (Decimal)
Claims Paid Amount (Paper/EMC)	Total dollar amount of paper/EMC claims paid for the week.	14	Number (Decimal)
Claims Processed (Paper/EMC)	Total paper/EMC claims processed for the week.	7	Number (Decimal)
Claims Received	Total point of service claims received for each hour of the day.	7	Number (Decimal)
Claims Rejected	Total paper/EMC claims rejected for the week.	7	Number (Decimal)
Claims Suspended (Paper/EMC)	Total paper/EMC claims suspended for the week	7	Number (Decimal)
Hours Received	Hour of the day the point of service claim was received by the minicomputer.	11	Time (HH:MM)
PA Inq	Total number of prior authorization inquiries for the hour of the day.	7	Number (Decimal)

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Field	Description	Length	Data Type
PA Rqst	Total number of prior authorization requests for the hour of the day.	7	Number (Decimal)
POS Comm Rejected	Total point of service communication records rejected for each hour of the day.	7	Number (Decimal)
Recip Elig Inquiries	Total recipient eligibility inquiries received for each hour of the day.	7	Number (Decimal)
Reversals Received	Total point of service reversals received for each hour of the day.	7	Number (Decimal)
Reversals Rejected	Total point of service reversals rejected for each hour of the day.	7	Number (Decimal)
Total	Total of each subheading.	14	Number (Decimal)

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7.23 CLM-0050-L -- Retro Adjustments due to Patient Liability Changes Report

7.23.1 CLM-0050-L -- Retro Active Rate Adjustment Report Narrative

The Retro Active Rate Adjustment report lists the retroactive patient liability adjustments by provider. This report is produced monthly.

7.23.2 CLM-0050-L -- Retro Active Rate Adjustment Report Layout

```
Report  : CLM-0050-L                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJ050L                                MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLM0050M                           Retro Adjustments due to Patient Liability Changes                      Page:      99999
                                                        MM/DD/CCYY - MM/DD/CCYY

CL                                                  ----------------ORIGINAL----------------  -------------------ADJUSTMENT------------------
TY PROV NPI   PROVR MCD RECIP NO     FROM DOS   TO DOS      ICN                PAID AMT   PATLIAB AMT  ICN                PAID AMT   PATLIAB AMT  STAT

X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X

                                                        *** END OF REPORT ***
```

7.23.3 CLM-0050-L -- Retro Active Rate Adjustment Report Field Descriptions

Field	Description	Length	Data Type
Adjustment CLM STAT	Claim status of the adjustment claim.	1	Character
Adjustment ICN	ICN of the adjustment claim created.	13	Number (Integer)
Adjustment PAID AMT	Paid amount of the adjustment claim.	12	Number (Decimal)
Adjustment PATLIAB AMT	Patient Liability amount for the recipient when the adjustment claim paid.	12	Number (Decimal)
CL TY	Claim type of the current claim example 'O' for outpatient, 'I' for inpatient, etc.	2	Character
FROM DOS	Claim From Date of Service	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
Original ICN	ICN of the claim that was adjusted.	13	Number (Integer)
Original PAID AMT	Paid amount of the claim that was adjusted.	12	Number (Decimal)
Original PATLIAB AMT	Patient Liability amount for the recipient when the original claim paid.	12	Number (Decimal)
PROV MCD	Provider Medicaid ID for provider on claim.	9	Character
PROV NPI	NPI Provider ID	10	Character
RECIP NO	Recipient ID	12	Character
TO DOS	Claim To Date of Service	10	Date (MM/DD/CCYY)

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7.24 CLM-0050-P -- Retro Adjustments due to Provider Rate Changes Report

7.24.1 CLM-0050-P -- Retro Adjustments due to Provider Rate Changes Report Narrative

The Retro Active Rate Adjustment report lists the retroactive provider rate adjustments by provider. This report is produced monthly.

7.24.2 CLM-0050-P -- Retro Adjustments due to Provider Rate Changes Report Layout

```
Report  : CLM-0050-P                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJ050P                                MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLM0050M                            Retro Adjustments due to Provider Rate Changes                         Page:      99999
                                                        MM/DD/CCYY - MM/DD/CCYY

CL                                                   ----------------ORIGINAL----------------  -------------------ADJUSTMENT------------------
TY PROV NPI   PROV MCD  RECIP NO     FROM DOS   TO DOS      ICN                PAID AMT     PROV RATE  ICN                PAID AMT     PROV RATE  STAT

X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X

                                                        *** END OF REPORT ***
```

7.24.3 CLM-0050-P -- Retro Adjustments due to Provider Rate Changes Report Field Descriptions

Field	Description	Length	Data Type
Adjustment ICN	ICN of the adjustment claim created.	13	Number (Integer)
Adjustment PAID AMT	Paid amount of the adjustment claim.	12	Number (Decimal)
Adjustment PROV RATE	Provider rate of the adjustment claim.	12	Number (Decimal)
Adjustment STAT	Claim status of the adjustment claim.	1	Character

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Field	Description	Length	Data Type
CL TY	Claim type of the current claim example 'O' for outpatient, 'I' for inpatient, etc.	2	Character
FROM DOS	Claim From Date of Service	10	Date (MM/DD/CCYY)
Original ICN	ICN of the claim that was adjusted.	13	Number (Integer)
Original PAID AMT	Paid amount of the claim that was adjusted.	12	Number (Decimal)
Original PROV RATE	Provider rate of the claim that was adjusted.	12	Number (Decimal)
PROV MCD	Provider Medicaid number for provider on claim.	9	Character
PROV NPI	NPI Provider id.	16	Character
RECIP NO	Recipient Id	12	Character
TO DOS	Claim To Date of Service	10	Date (MM/DD/CCYY)

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7.25 CLM-0051-D -- Aged Detail Adjustment Report

7.25.1 CLM-0051-D -- Aged Detail Adjustment Report Narrative

The Aged Detail Adjustment report displays adjustments that have aged. This report is produced daily.

7.25.2 CLM-0051-D -- Aged Detail Adjustment Report Layout

```
Report  : CLM-0051-D                                ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJD051                             MEDICAID MANAGEMENT INFORMATION SYSTEM                                          Run Time:   HH:MM:SS
Location: CLM0051D                                  AGED DETAIL ADJUSTMENT REPORT                                                  Page:       9999

THE FOLLOWING CLAIMS IN THE SYSTEM AT LEAST 999 DAYS                                                   CLAIM TYPE: DENTAL CLAIMS

ICN                RECIPIENT        PROVIDER ID         LOCATION     EDITS                                                   CLAIM-AGE
                                                                                                                               (DAYS)
XXXXXXXXXXXXX     XXXXXXXXXXXX      XXXXXXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX          999
XXXXXXXXXXXXX     XXXXXXXXXXXX      XXXXXXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX          999
XXXXXXXXXXXXX     XXXXXXXXXXXX      XXXXXXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX          999
XXXXXXXXXXXXX     XXXXXXXXXXXX      XXXXXXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX          999
XXXXXXXXXXXXX     XXXXXXXXXXXX      XXXXXXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX          999

                                                     *** END OF REPORT ****
```

7.25.3 CLM-0051-D -- Aged Detail Adjustment Report Field Descriptions

Field	Description	Length	Data Type
Claim Age (Days)	The number of days that an adjustment has been in process.	3	Number (Integer)
Claim Type	The claim type description.	60	Character
Edits	Code used to identify errors. Note: There can be multiple occurrences of edits in this field.	4	Character
ICN	Internal control number which uniquely identifies an adjustment.	13	Character
Location	Code which identifies the suspense location of the adjustment.	2	Number (Integer)
Provider ID	Provider identification number.	15	Character
Recipient	Recipient identification number which uniquely identifies the recipient.	12	Character

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7.26 CLM-0054-D -- Edit Recycle Maintenance Report

7.26.1 CLM-0054-D -- Edit Recycle Maintenance Report Narrative

The Edit Recycle Maintenance report lists each suspense transaction input to the system. It also prints appropriate error messages. This report is produced daily.

7.26.2 CLM-0054-D -- Edit Recycle Maintenance Report Layout

```
Report  : CLM-0054-D                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJD054                              MEDICAID MANAGEMENT INFORMATION SYSTEM                             Run Time:   HH:MM:SS
Location: CLM0054D                                      EDIT RECYCLE PARAMETERS                                        Page:        999


EDIT/AUDIT          TYPE OF CLAIMS          TYPE OF                RECYCLE            # OF DAYS              FINAL
  NUMBER              TO RECYCLE            RECYCLE                  DAY             TO RECYCLE             EDIT

   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX

**** END OF REPORT ****
```

7.26.3 CLM-0054-D -- Edit Recycle Maintenance Report Field Descriptions

Field	Description	Length	Data Type
# Of Days To Recycle	Number of days for the recycle process.	3	Number (Integer)
Edit/Audit Number	Code used to identify errors.	4	Character
Final Edit	Final error code.	4	Character
Recycle Day	Day the claim is recycled.	9	Character
Type Of Claims To Recycle	Claim type needed to resubmit.	10	Character
Type Of Recycle	Type of resubmission.	10	Character

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7.27 CLM-0055-D -- Daily Exception Summary By Claim Type Original Claims Report

7.27.1 CLM-0055-D -- Daily Exception Summary By Claim Type Original Claims Report Narrative

The Daily Exception Summary by Claim Type Original Claims report shows how many times each exception occurred by claim type for the last 5 cycles. This report is produced daily.

7.27.2 CLM-0055-D -- Daily Exception Summary By Claim Type Original Claims Report Layout

```
Report  : CLM-0055-D                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJDER2                               MEDICAID MANAGEMENT INFORMATION SYSTEM                                            Run Time:   HH:MM:SS
Location: CLMPER01                        DAILY EXCEPTION SUMMARY BY CLAIM TYPE ORIGINAL CLAIMS                                       Page:        999
Claim
Type: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

EXCP                                                        MM/DD/CCYY       MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY
CODE EXC DESCRIPTION                                       OCC.     RECS     OCC      RECS     OCC.     RECS     OCC.     RECS     OCC.     RECS

XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX

TOTAL BY CLAIM TYPE
                                                           XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX

GRAND TOTAL
                                                          XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX

                                                           *** END OF REPORT ***
```

7.27.3 CLM-0055-D -- Daily Exception Summary By Claim Type Original Claims Report Field Descriptions

Field	Description	Length	Data Type
Claim Type	Type of claim.	50	Character
RECS (Cycle 1)	Number of records recycled.	6	Character
RECS (Cycle 2)	Number of records recycled.	6	Character
RECS (Cycle 3)	Number of records recycled.	6	Character
RECS (Cycle 4)	Number of records recycled.	6	Character
RECS (Cycle 5)	Number of records recycled.	6	Character

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Field	Description	Length	Data Type
Cycle 1 Dates	Date that cycle 1 ran.	10	Date (MM/DD/CCYY)
Cycle 2 Dates	Date that cycle 2 ran.	10	Date (MM/DD/CCYY)
Cycle 3 Dates	Date that cycle 3 ran.	10	Date (MM/DD/CCYY)
Cycle 4 Dates	Date that cycle 4 ran.	10	Date (MM/DD/CCYY)
Cycle 5 Dates	Date that cycle 5 ran.	10	Date (MM/DD/CCYY)
Exc Description	Description of the exception code.	50	Character
Excp Code	Edit or audit number.	4	Character
Grand Total	Grand total of all occurrences.	6	Character
Occ (Cycle 1)	Edit Occurrences.	6	Character
Occ (Cycle 2)	Edit Occurrences.	6	Character
Occ (Cycle 3)	Edit Occurrences.	6	Character
Occ (Cycle 4)	Edit Occurrences.	6	Character
Occ (Cycle 5)	Edit Occurrences.	6	Character
Total By Claim Type	Total of occurrences per cycle by claim type.	5	Character

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7.28 CLM-0056-D -- Daily Exception Summary By Claim Type Adjustments Report

7.28.1 CLM-0056-D -- Daily Exception Summary By Claim Type Adjustments Report Narrative

The Daily Exception Summary by Claim Type Adjustments report shows how many times each exception occurred by claim type for the last 5 cycles. This report is produced daily.

7.28.2 CLM-0056-D -- Daily Exception Summary By Claim Type Adjustments Report Layout

```
Report  : CLM-0056-D                                ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJDER2                            MEDICAID MANAGEMENT INFORMATION SYSTEM                                           Run Time:   HH:MM:SS
Location: CLMPER01                        DAILY EXCEPTION SUMMARY BY CLAIM TYPE ADJUSTMENTS                                       Page:        999
Claim
Type: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


EXCP                                                        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY
CODE EXC DESCRIPTION                                       OCC.     RECS     OCC.     RECS     OCC.     RECS     OCC.     RECS     OCC.     RECS

XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX

TOTAL BY CLAIM TYPE
                                                          XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX

GRAND TOTAL
                                                         XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX

                                                         *** END OF REPORT ***
```

7.28.3 CLM-0056-D -- Daily Exception Summary By Claim Type Adjustments Report Field Descriptions

Field	Description	Length	Data Type
Claim Type	Type of claim.	50	Character
RECS (Cycle 1)	Number of records recycled.	6	Character
RECS (Cycle 2)	Number of records recycled.	6	Character
RECS (Cycle 3)	Number of records recycled.	6	Character
RECS (Cycle 4)	Number of records recycled.	6	Character

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Field	Description	Length	Data Type
RECS (Cycle 5)	Number of records recycled.	6	Character
Cycle 1 Dates	Date that cycle 1 ran.	10	Date (MM/DD/CCYY)
Cycle 2 Dates	Date that cycle 2 ran.	10	Date (MM/DD/CCYY)
Cycle 3 Dates	Date that cycle 3 ran.	10	Date (MM/DD/CCYY)
Cycle 4 Dates	Date that cycle 4 ran.	10	Date (MM/DD/CCYY)
Cycle 5 Dates	Date that cycle 5 ran.	10	Date (MM/DD/CCYY)
Exc Description	Description of the exception code.	50	Character
Excp Code	Edit or audit number.	4	Character
Grand Total	Grand total of all occurrences.	6	Character
Occ (Cycle 1)	Edit Occurrences.	6	Character
Occ (Cycle 2)	Edit Occurrences.	6	Character
Occ (Cycle 3)	Edit Occurrences.	6	Character
Occ (Cycle 4)	Edit Occurrences.	6	Character
Occ (Cycle 5)	Edit Occurrences.	6	Character
Total By Claim Type	Total of occurrences per cycle by claim type.	5	Character

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7.29 CLM-0057-D -- Daily Exception Summary By Claim Type Capitated Plus Report

7.29.1 CLM-0057-D -- Daily Exception Summary By Claim Type Capitated Plus Report Narrative

The Daily Exception Summary by Claim Type Capitated Plus report shows how many times each exception occurred by claim type. In addition, disposition of the exception is reported (super-suspend, deny, suspend, pay/report, or pay). This report is produced daily.

7.29.2 CLM-0057-D -- Daily Exception Summary By Claim Type Capitated Plus Report Layout

```
Report  : CLM-0057-D                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJDER2                               MEDICAID MANAGEMENT INFORMATION SYSTEM                                            Run Time:   HH:MM:SS
Location: CLM0057D                            DAILY EXCEPTION SUMMARY BY CLAIM TYPE CAPITATED                                          Page:        999
Claim
Type:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


EXCP                                                      MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY
CODE EXC DESCRIPTION                                     OCC.     RECS     OCC.     RECS     OCC.     RECS     OCC.     RECS     OCC.     RECS

XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX

TOTAL BY CLAIM TYPE
                                                         XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX

GRAND TOTAL
                                                       XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX

                                                                *** END OF REPORT ***
```

7.29.3 CLM-0057-D -- Daily Exception Summary By Claim Type Capitated Plus Report Field Descriptions

Field	Description	Length	Data Type
Claim Type	Type of claim.	50	Character
RECS (Cycle 1)	Number of records recycled.	6	Character
RECS (Cycle 2)	Number of records recycled.	6	Character
RECS (Cycle 3)	Number of records recycled.	6	Character
RECS (Cycle 4)	Number of records recycled.	6	Character
RECS (Cycle 5)	Number of records recycled.	6	Character

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Field	Description	Length	Data Type
Cycle 1 Dates	Date that cycle 1 ran.	10	Date (MM/DD/CCYY)
Cycle 2 Dates	Date that cycle 2 ran.	10	Date (MM/DD/CCYY)
Cycle 3 Dates	Date that cycle 3 ran.	10	Date (MM/DD/CCYY)
Cycle 4 Dates	Date that cycle 4 ran.	10	Date (MM/DD/CCYY)
Cycle 5 Dates	Date that cycle 5 ran.	10	Date (MM/DD/CCYY)
Exc Description	Description of the exception code.	50	Character
Excp Code	Edit or audit number.	4	Character
Grand Total	Grand total of all occurrences.	6	Character
Occ (Cycle 1)	Edit Occurrences.	6	Character
Occ (Cycle 2)	Edit Occurrences.	6	Character
Occ (Cycle 3)	Edit Occurrences.	6	Character
Occ (Cycle 4)	Edit Occurrences.	6	Character
Occ (Cycle 5)	Edit Occurrences.	6	Character
Total By Claim Type	Total of occurrences per cycle by claim type.	5	Character

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7.30 CLM-0059-D -- Alabama EOB Report

7.30.1 CLM-0059-D -- Alabama EOB Report Narrative

The Alabama EOB report lists EOB numbers, status and descriptions for Alabama. This report is produced daily.

7.30.2 CLM-0059-D -- Alabama EOB Report Layout

```
Report  : CLM-0059-D                                  ALABAMA MEDICAID AGENCY                                                 Run Date: MM/DD/CCYY
Process : CLMJD059                             MEDICAID MANAGEMENT INFORMATION SYSTEM                                         Run Time:   HH:MM:SS
Location: CLM0059D                                        ALABAMA EOB REPORT                                                  Page:          999
-----------------------------------------------------------------------------------------------------------------------------------
     EXCEPTION
     CODE            STATUS            DESCRIPTION
-----------------------------------------------------------------------------------------------------------------------------------

     9999              X               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

     9999              X               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

     9999              X               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

     9999              X               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

     9999              X               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

     9999              X               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                    *** END OF REPORT ***
```

7.30.3 CLM-0059-D -- Alabama EOB Report Field Descriptions

Field	Description	Length	Data Type
Description (Line 1)	EOB description (first line).	79	Character
Description2 (Line 2)	EOB description (second line).	79	Character
Exception Code	Code for the error.	4	Number (Integer)

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Field	Description	Length	Data Type
Status	Status code for the claim.	1	Character

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7.31 CLM-0060-D -- Suspense File Analysis By Claim Type 3 Report

7.31.1 CLM-0060-D -- Suspense File Analysis By Claim Type 3 Report Narrative

The Suspense File Analysis by Claim Type 3 report lists the number and dollar value totals of the various claim types that are currently in the suspense file. It also includes the same totals for claims that are 1 to 30 days old, 31 to 60 days old, 61 to 90 days old and over 90 days old, as well as totals for each of the above. This report is produced daily.

7.31.2 CLM-0060-D -- Suspense File Analysis By Claim Type 3 Report Layout

```
Report  : CLM-0060-D                                    ALABAMA MEDICAID AGENCY                                                  Run Date: MM/DD/CCYY
Process : CLMJD060                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                         Run Time:   HH:MM:SS
Location: CLM0060D                                 SUSPENSE FILE ANALYSIS BY CLAIM TYPE                                              Page:        999
-------------------------------------------------------------------------------------------------------------------------------------
CLAIM        *------CURRENT------*  *---01 TO 30 DAYS---*  *---31 TO 60 DAYS---*  *---61 TO 90 DAYS---*  *---OVER 90 DAYS---*    AVG
TYPE         NUMBER  DOLLAR VALUE   NUMBER  DOLLAR VALUE   NUMBER  DOLLAR VALUE   NUMBER  DOLLAR VALUE   NUMBER  DOLLAR VALUE    DAY
-------------------------------------------------------------------------------------------------------------------------------------

MEDICAL      XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

DENTAL       XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

DRUG         XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

COMPOUND     XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

HOME HEALTH  XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

LTC          XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

XOVER A      XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

XOVER B      XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

XOVER C      XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

INPATIENT    XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

OUTPATIENT   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

TOTAL        XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

                                                   *** END OF REPORT ***
```


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7.31.3 CLM-0060-D -- Suspense File Analysis By Claim Type 3 Report Field Descriptions

Field	Description	Length	Data Type
01 To 30 Days Dollar Value	Total value of claim type in past 1 to 30 days.	11	Character
01 To 30 Days Dollar Value Total	Total value of claims in past 1 to 30 days.	11	Character
01 To 30 Days Number	Number of claims in past 1 to 30 days.	7	Character
01 To 30 Days Number Total	Total number of claims in past 1 to 30 days.	7	Character
31 To 60 Days Dollar Value	Total value of claim type in past 31 to 60 days.	11	Character
31 To 60 Days Dollar Value Total	Total value of claims in past 31 to 60 days	11	Character
31 To 60 Days Number	Number of claims in past 31 to 60 days.	7	Character
31 To 60 Days Number Total	Total number of claims in past 31 to 60 days.	7	Character
61 To 90 Days Dollar Value	Total value of claim type in past 61 to 90 days	11	Character
61 To 90 Days Dollar Value Total	Total value of claims in past 61 to 90 days.	11	Character
61 To 90 Days Number	Number of claims in past 61 to 90 days.	7	Character
61 To 90 Days Number Total	Total number of claims in past 61 to 90 days.	7	Character
Avg Day	Average claims per day.	3	Character
Claim Type	Name of the claim type identified in report.	11	Character
Current Dollar Value	Total value of claim type in current day.	11	Character
Current Dollar Value Total	Total value of claims on current day.	11	Character
Current Number	Number of claim type in current day.	7	Character
Current Number Total	Total number of claims on current day.	7	Character

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Field	Description	Length	Data Type
Over 90 Days Dollar Value	Total value of claim type over 90 days.	11	Character
Over 90 Days Dollar Value Total	Total value of claims over 90 days.	11	Character
Over 90 Days Number	Number of claims over 90 days.	7	Character
Over 90 Days Number Total	Total number of claims over 90 days.	7	Character

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7.32 CLM-0064-W -- Suspended Claims by Claim Type – Region Report

7.32.1 CLM-0064-W -- Suspended Claims by Claim Type - Region Report Narrative

The Suspended Claims by Claim Type-Region report identifies the number of suspended claims by region and claim type. This report is produced weekly.

7.32.2 CLM-0064-W -- Suspended Claims by Claim Type - Region Report Layout

```
Report:   CLM-0064-W                                ALABAMA MEDICAID AGENCY                                                  Run Date: MM/DD/CCYY
Process:  CLMJW064                            MEDICAID MANAGEMENT INFORMATION SYSTEM                                      Run Time:   HH:MM:SS
Location: CLMPW064                             SUSPENDED CLAIMS BY CLAIM TYPE / REGION                                    Page    :        999


                            A-UB   B-1500  C-UB OP  D-DENTAL  H-HOME  I-INPAT  L-LTC  M-1500  O-OUTPAT  P-RX   Q-CMPND  TOTALS  %
                            XOVER  XOVER   XOVER                                                            POS      RX

99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%

TOTAL                      99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999 999,999
                            99.9%   99.9% 99.9%     99.9%    99.9%    99.9%   99.9%  99.9%   99.9%    99.9%   99.9%
** END OF REPORT **
```

7.32.3 CLM-0064-W -- Suspended Claims by Claim Type - Region Report Field Descriptions

Field	Description	Length	Data Type
A-UB XOVER	Number of UB crossover claims that have suspended.	5	Number (Integer)
B-1500 XOVER	Number of CMS crossover claims that have suspended.	5	Number (Integer)
C-UB OP XOVER	Number of UB Outpatient crossover claims that have suspended.	5	Number (Integer)

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Field	Description	Length	Data Type
D-DENTAL	Number of Dental claims that have suspended.	5	Number (Integer)
H-HOME	Number of Home health claims that have suspended. N/A for Alabama.	5	Number (Integer)
I-INPAT	Number of Inpatient claims that have suspended.	5	Number (Integer)
L-LTC	Number of Long Term Care claims that have suspended.	5	Number (Integer)
M-1500	Number of CMS claims that have suspended.	5	Number (Integer)
O-OUTPAT	Number of Outpatient claims that have suspended.	5	Number (Integer)
P-RX POS	Number of Pharmacy Point of Sale claims that have suspended.	5	Number (Integer)
Q-CMPND RX	Number of Compound Pharmacy claims that have suspended.	5	Number (Integer)
Region	The two byte code that represents the claim type and region.	2	Number (Integer)
Region Description	Classification of the media on which a claim is submitted into the MMIS system or the type of transaction performed on a claim that already exists in the MMIS system.	25	Character
TOTALS %	Total percent of suspended claims by region.	4	Number (Decimal)
TOTAL	Total number of claims suspended by claim type.	5	Number (Integer)
TOTAL (percent)	Total percent of claims suspended by claim type.	3	Number (Decimal)

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7.33 CLM-0065-D -- Aged Suspended Report

7.33.1 CLM-0065-D -- Aged Suspended Report Narrative

The Aged Suspended report shows the number of claims suspended by location code for a period of time ranging from current to over 99,999 days. This report is produced daily.

7.33.2 CLM-0065-D -- Aged Suspended Report Layout

```
Report  : CLM-0065-D                          ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJD065                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                            Run Time:   HH:MM:SS
Location: CLM0065D                    AGED SUSPENDED CLAIMS BY LOCATION REPORT                                               Page:          1
```

Location Code	Current to 30 days	Aged > 30 days	Aged > 60 days	Aged > 90 days	Total of all Aged
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999

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```
|        99        |          99,999        |         99,999        |          99,999        |          99,999        |            99,999      |
-------------------------------------------------------------------------------------------------------------------------------------------
|        99        |          99,999        |         99,999        |          99,999        |          99,999        |            99,999      |
-------------------------------------------------------------------------------------------------------------------------------------------
|        99        |          99,999        |         99,999        |          99,999        |          99,999        |            99,999      |
-------------------------------------------------------------------------------------------------------------------------------------------
|        99        |          99,999        |         99,999        |          99,999        |          99,999        |            99,999      |
-------------------------------------------------------------------------------------------------------------------------------------------
|        99        |          99,999        |         99,999        |          99,999        |          99,999        |            99,999      |
-------------------------------------------------------------------------------------------------------------------------------------------
|        99        |          99,999        |         99,999        |          99,999        |          99,999        |            99,999      |
-------------------------------------------------------------------------------------------------------------------------------------------
|      TOTAL       |         999,999        |        999,999        |         999,999        |         999,999        |           999,999      |
-------------------------------------------------------------------------------------------------------------------------------------------

                                                    END OF REPORT
```

7.33.3 CLM-0065-D -- Aged Suspended Report Field Descriptions

Field	Description	Length	Data Type
Aged > 30 Days	Total number of days claims have been suspended.	9	Number (Decimal)
Aged > 60 Days	Total number of days claims have been suspended.	9	Number (Decimal)
Aged > 90 days	Total number of days claims have been suspended.	9	Number (Decimal)
Current to 30 days	Total number of days claims have been suspended.	9	Number (Decimal)
Location Code	The location of the suspended claim.	2	Number (Integer)
Total	Total of each subheading.	9	Number (Decimal)
Total of all Aged	Total number of claims that are aged.	9	Number (Decimal)

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7.33 CLM-0610-W Kick Payment Processing Report

7.33.1 CLM-0610-W Kick Payment Processing Report Narrative

This report contains the processing kick payment data that is run after each financial. The Report is organized by RCOs in alphabetical order. For each RCO we will report the sum of all capitations and recoupments. At the end of the report, we will provide a capitations Grand total that is a sum of all capitations and recoupments for all RCOs.

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7.33.2 CLM-0610-W Kick Payment Processing Report Layout

```
Report  : CLM-0610-W                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJW610                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLMPW610                                         KICK PAYMENT PROCESSING                                 Page:            XXX
                                                  REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY


RCO RECIPIENT ID    RECIPIENT NAME    ORIG:  ICN     DTL  ST    DOS           AMOUNT        ACTION/MESSAGE
                                      NEW :

RA1 999999999999 ABCDEFGHIJKLMNOPQRST 7116240001001  999   P  MM/DD/YY  99,999,999.99   12345678901234567890123456789012345678901234567890
                                      7116259001001  999   P  MM/DD/YY  99,999,999.99   12345678901234567890123456789012345678901234567890

RA1 999999999999 LAST, FIRST          7116240001001  999   P  MM/DD/YY  99,999,999.99   CAPITATION GENERATED

RA1 999999999999 LAST, FIRST          7116240001002  999   P  MM/DD/YY  99,999,999.99   CAPITATION GENERATED - FORCED

RA1 - CAPITATIONS TOTAL:                                               99,999,999.99


RA2 999999999999 LAST, FIRST          7116240001003  999   P  MM/DD/YY           0.00   CAPITATION NOT GENERATED - ALREADY PAID

RA2 - CAPITATIONS TOTAL:                                               99,999,999.99


RB1 999999999999 LAST, FIRST          7116240001004  999   P  MM/DD/YY           0.00   CAPITATION NOT GENERATED - TOO SOON

RB1 - CAPITATIONS TOTAL:                                               99,999,999.99


RB2 999999999999 12345678901234567890 7116240001005  999   P  MM/DD/YY  99,999,999.99   TRACKING UPDATED - ICN REPLACED
                                      7716272001043  999   P  MM/DD/YY  99,999,999.99

RB2 999999999999 12345678901234567890 7116240001006  999   P  MM/DD/YY  99,999,999.99   CAPITATION RECOUPED - DENIED ADJUSTMENT
                                      7716275001016  999   D  MM/DD/YY           0.00

RB2 999999999999 LAST, FIRST          7116240001007  999   P  MM/DD/YY  99,999,999.99   CAPITATION PAID - FORCED

RB2 - CAPITATIONS TOTAL:                                               99,999,999.99


CAPITATIONS GRAND TOTAL:                                               99,999,999.99


                                                     *** END OF REPORT ***
                                                              or
                                                    *** NO DATA THIS RUN ***
```


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7.33.3 CLM-0610-W Kick Payment Processing Report Field Descriptions

Field	Description	Length	Data Type
Action/Message	Text indicating whether a capitation or recoupment was generated along with a message explaining the action.	50	Character
Amount	Amount the kick payment processed. If this field is negative, then the kick payment was recouped. If the field is positive, a capitation was paid.	12	Number (Decimal)
Capitations Grand Total	Sum of all capitations and recoupments for all RCOs.	12	Number (Decimal)
DOS	Date of service of the respective claim.	8	Date (MM/DD/YY)
DTL	Detail number with the Kick Payment Indicator.	3	Number (Integer)
ICN	Internal control number of the claim.	13	Number (Integer)
RCO	RCO of the recipient during the date of service.	3	Character
RCO-ID – Capitation Total	Total sum of the RCO-ID's capitation and recoupments.	12	Number (Decimal)
Recipient ID	Medicaid identification number of the recipient.	12	Character
Recipient Name	First and last name of the recipient. This field is truncated at 20 characters.	20	Character
ST	Status (paid or denied) of the respective claim.	1	Character

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7.34 CLM-0640-W Random Sample ICN Report

7.34.1 CLM-0640-W Random Sample ICN Balancing Report Narrative

The Random Sample ICN Report lists two ICNs per region per claim type. This report is produced every Friday for claims processed through the system Saturday through Friday.

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7.34.2 CLM-0640-W Random Sample ICN Balancing Report Layout

```
Report:   CLM-0640-W                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process:  CLMJW640                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time: HH:MM:SS
Location: CLMPW640                          RANDOM SAMPLE ICN REPORT                                       Page:     XXX

FOR: MM/DD/YYY    THRU   MM/DD/YYYY

RGN CT        ICN
10  IX            9999999999999             9999999999999
    OX            9999999999999             9999999999999
    MX            9999999999999             9999999999999
    IP            9999999999999             9999999999999
    OP            9999999999999             9999999999999
    LT            9999999999999             9999999999999
    HC            9999999999999             9999999999999
    DE            9999999999999             9999999999999
    PH            9999999999999             9999999999999
    PC            9999999999999             9999999999999

11  IX            9999999999999             9999999999999
    OX            9999999999999             9999999999999
    MX            9999999999999             9999999999999
    IP            9999999999999             9999999999999
    OP            9999999999999             9999999999999
    LT            9999999999999             9999999999999
    HC            9999999999999             9999999999999
    DE            9999999999999             9999999999999
    PH            9999999999999             9999999999999
    PC            9999999999999             9999999999999

90  IX            9999999999999             9999999999999
    OX            9999999999999             9999999999999
    MX            9999999999999             9999999999999
    IP            9999999999999             9999999999999
    OP            9999999999999             9999999999999
    LT            9999999999999             9999999999999
    HC            9999999999999             9999999999999
    DE            9999999999999             9999999999999
    PH            9999999999999             9999999999999
    PC            9999999999999             9999999999999

91  IX            9999999999999             9999999999999
    OX            9999999999999             9999999999999
    MX            9999999999999             9999999999999
    IP            9999999999999             9999999999999
    OP            9999999999999             9999999999999
    LT            9999999999999             9999999999999
    HC            9999999999999             9999999999999
    DE            9999999999999             9999999999999
    PH            9999999999999             9999999999999
    PC            9999999999999             9999999999999

                                                   ***END OF REPORT ***
```


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7.34.3 CLM-0640-W Random Sample ICN Report Field Descriptions

Field	Description	Length	Data Type
For MM/DD/YYYY	The beginning date range from which ICNs are being reported.	10	Character
Thru MM/DD/YYYY	The ending date range from which ICNs are being reported	10	Character
RGN	Region of the claim (excludes converted regions 40 – 48 and encounters 70)	2	Number (Integer)
CT	Claim types IX – Inpatient Crossover OX – Outpatient Crossover MX – Medical Crossover IP - Inpatient OP – Outpatient HC – Medical LT – Long Term Care DE – Dental PH - Pharmacy PC – Pharmacy Compound	2	Character
ICN	Random ICN for that claim type and region. 2 occurrences	13	Number (Integer)

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7.35 CLM-0670-D FEITH Images to Claims Balancing Report

7.35.1 CLM-0670-D FEITH Images to Claims Balancing Report Narrative

The FEITH Images to Claims Balancing Report lists the number the electronic and paper claims accepted into the MMIS and the number of electronic and paper claims images residing in FEITH. This report is produced daily.

7.35.2 CLM-0670-D FEITH Images to Claims Balancing Report Layout

```
                                CLAIMS ACCEPTED     PAPER PHARM DTLS*   CLAIM IMAGES        CLAIMS MISSING      IMAGES MISSING

     ELECTRONIC                    999999                                        9                                999999
999999                          999999

     PAPER                                999999                                999999                              999999
999999                          999999

     TOTAL                              9999999                                                                        9999999

     *  This number represents the number of additional claims created when there are multiple details on a paper pharmacy form.

                                                   *** END OF REPORT ***
```

7.35.3 CLM-0670-D FEITH Image to Claims Balancing Report Field Descriptions

Field	Description	Length	Data Type
For MM/DD/YYYY	The beginning date range being reported. Date determined by value in t_system_parms where nam_program=CLMPBAL	10	Character
Thru MM/DD/YYYY	The ending date range being reported. Date determined by value in t_system_parms where nam_program=CLMPBAL	10	Character
Electronic Claims Accepted	Total number of electronic claims accepted into the MMIS for the date given	4	Number (Integer)
Paper Claims Accepted	Total number of paper claims accepted into the MMIS for the date given	4	Number (Integer)
Total Claims Accepted	Total number of paper and electronic claims accepted into the MMIS for the date given	5	Number (Integer)

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Field	Description	Length	Data Type
Paper Pharm Details	A paper pharmacy form has up to three details which creates three claims in MMIS while FEITH only has one image. This number represents the additional claims created in MMIS that will not have an individual image in FEITH.	4	Number (Integer)
Electronic Claim Images	Total number of electronic claim facsimiles residing in FEITH for the date given	6	Number (Integer)
Paper Claim Images	Total number of paper claims images residing in FEITH for the date given	6	Number (Integer)
Total Claims Images	Total number of paper and electronic claims images residing in FEITH for the date given	7	Number (Integer)
Electronic Claims Missing	Number of electronic images that are missing claims	6	Number (Integer)
Paper Claims Missing	Number of paper images that are missing claims	6	Number (Integer)
Electronic Images Missing	Number of electronic claims that are missing facsimiles	6	Number (Integer)
Paper Images Missing	Number of paper claims that are missing images	6	Number (Integer)

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7.36 CLM-0671-D Images Missing Claims Report

7.36.1 CLM-0671-D Images Missing Claims Report Narrative

The Images Missing Claims Report is broken in two parts – the Summary Report which lists the number of electronic and paper images that do not have a corresponding claim in the MMIS. The Detail Report lists the specific ICNs that are missing a claim in the MMIS. An email is sent to the Claims team with the ICNs for them to research the ICN and take corrective action. This report is produced daily.

7.36.2 CLM-0671-D Images Missing Claims Report Layout

```
Report :  CLM-0671-D                                          ALABAMA MEDICAID
AGENCY                                                          Run Date: MM/DD/YYYY
Process : CLMJD670                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                    Run
Time:   HH:MM:SS
Location:  CLMPBALRPT                               IMAGES MISSING CLAIMS SUMMARY
REPORT                                             Page:          X

FOR: MM/DD/YYY   THRU   MM/DD/YYYY

                      NUMBER OF IMAGESS MISSING CLAIMS
   ELECTRONIC                        9999
   PAPER                             9999
   TOTAL                                99999

                                                                          *** END OF REPORT ***
Report  :  CLM-0671-D                                        ALABAMA MEDICAID
AGENCY                                                          Run Date: MM/DD/YYYY
Process : CLMJD671                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                    Run
Time:   HH:MM:SS
Location:  CLMPBALRPT                              IMAGES MISSING CLAIMS DETAIL
REPORT                                             Page:          X

                                   FOR: MM/DD/YYY THRU   MM/DD/YYYY

THE FOLLOWING IMAGES WILL BE RESEARCHED TO DETERMINE WHY CLAIMS ARE MISSING.

ICN                           DATE RECEIVED
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
                                                            *** END OF REPORT ***
```


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7.36.3 CLM-0671-D Images Missing Claims Report Field Descriptions

Field	Description	Length	Data Type
For MM/DD/YYYY	The beginning date range being reported. Date determined by value in t_system_parms where nam_program=CLMPBAL	10	Character
Thru MM/DD/YYYY	The ending date range being reported. Date determined by value in t_system_parms where nam_program=CLMPBAL	10	Character
Summary Report			
Electronic Number of images missing	Total number of electronic facsimiles missing claims for the date given	4	Number (Integer)
Paper Number of images missing	Total number of paper images missing claims for the date given	4	Number (Integer)
Total Number of imagesmissing	Total number of paper and electronic images missing claims for the date given	5	Number (Integer)
Detail Report			
ICN	Specific ICN of the image missing a claim	13	Number (Integer)
Date Received	Date image was received into the system	10	Character

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7.37 CLM-0672-D Claims Missing Images Report

7.37.1 CLM-0672-D Claims Missing Images Report Narrative

The Claims Missing Images Report is broken into two parts – the Summary Report which lists the number of electronic and paper claims that do not have a corresponding image in FEITH. The Detail Report lists the specific ICNs that are missing an image in FEITH. An email is sent to the Claims team with the ICNs for them to research the ICN and take corrective action. This report is produced daily.

7.37.2 CLM-0672-D Claims Missing Images Report Layout

```
Report  :  CLM-0672-D                                          ALABAMA MEDICAID
AGENCY                                                           Run Date: MM/DD/YYYY
Process : CLMJD670                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                        Run
Time:   HH:MM:SS
Location:  CLMPBALRPT                                 CLAIMS MISSING IMAGES SUMMARY
REPORT                                        Page:          X

                                                   FOR: MM/DD/YYY    THRU   MM/DD/YYYY

                      NUMBER OF CLAIMS MISSING IMAGES
   ELECTRONIC                         9999
   PAPER                              9999
   TOTAL                                 99999

                                                                                  *** END OF REPORT ***
Report  :  CLM-0672-D                                          ALABAMA MEDICAID
AGENCY                                                           Run Date: MM/DD/YYYY
Process : CLMJD670                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                        Run
Time:   HH:MM:SS
Location:  CLMPBALRPT                                 CLAIMS MISSING IMAGES DETAIL
REPORT                                           Page:          X

                                     FOR: MM/DD/YYY THRU   MM/DD/YYYY

IMAGES WILL BE SYSTEMATICALLY GENERATED FOR THE FOLLOWING CLAIMS:

ICN                           DATE RECEIVED
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY

                                                                 *** END OF REPORT ***
```


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7.37.3 CLM-0672-D Claims Missing Images Report Field Descriptions

Field	Description	Length	Data Type
For MM/DD/YYYY	The beginning date range being reported. Date determined by value in t_system_parms where nam_program=CLMPBAL	10	Character
Thru MM/DD/YYYY	The ending date range being reported. Date determined by value in t_system_parms where nam_program=CLMPBAL	10	Character
Summary Report			
Electronic Number of claims missing images	Total number of electronic claims missing facsimiles for the date given	4	Number (Integer)
Paper Number of claims missing images	Total number of paper claims missing images for the date given	4	Number (Integer)
Total Number of claims missing images	Total number of paper and electronic claims missing images for the date given	5	Number (Integer)
Detail Report			
ICN	Specific ICN of the claim missing an image	13	Number (Integer)
Date Received	Date claim was received into the system	10	Character

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7.38 CLM-0690-O Facsimiles Corrected Report

7.38.1 CLM-0690-O Facsimiles Corrected Report Narrative

The Facsimiles Corrected Report is broken in two parts – the Summary Report which lists the number of facsimiles that the action taken to ensure that every claim in the MMIS has a facsimile was verified. The Detail Report lists the specific ICNs that have been verified as having been corrected and the action taken for that ICN. This report is produced on request.

7.38.2 CLM-0690-O Claims Missing Facsimiles Report Layout

```
Report  :  CLM-0690-D                                        ALABAMA MEDICAID
AGENCY                                                         Run Date: MM/DD/YYYY
Process : CLMJD690                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                        Run
Time:   HH:MM:SS
Location:  CLMPBALVER                           FACSIMILES CORRECTED SUMMARY
REPORT                                                 Page:          X


                     NUMBER OF FACSIMILES CORRECTED

   DELETED                           9999

   ADDED                      9999

   TOTAL                         99999


                                                                        *** END OF REPORT ***
```


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```
Report  : CLM-0690-D                          ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/YYYY
Process : CLMJD690                     MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MM:SS
Location: CLMPBALVER                     FACSIMILES CORRECTED DETAIL REPORT                            Page:          X
THE FOLLOWING FACSIMILES HAVE BEEN CORRECTED AND VERIFIED:
        ICN                  DATE CORRECTED       DATE VERIFIED     ACTION
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
*** END OF REPORT ***
```

7.38.3 CLM-0690-O Facsimiles Corrected Report Field Descriptions

Field	Description	Length	Data Type
Summary Report			
Number of facsimiles corrected - deleted	Total number of facsimiles that were deleted from FEITH.	4	Number (Integer)
Number of facsimiles corrected - added	Total number of facsimile that were added to FEITH.	4	Number (Integer)
Total number of facsimiles that have been corrected.	Total number of facsimiles for which corrective action was taken.	5	Number (Integer)
Detail Report			

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Field	Description	Length	Data Type
ICN	Specific ICN of the facsimile corrected	13	Number (Integer)
Date Corrected	Date claim was corrected in FEITH.	10	Character
Date Verified	Date claim was confirmed as being corrected in FEITH.	10	Character
Action	The specific action taken and verified for this ICN. Added – indicates a facsimile was generated for the claim. Deleted means there was not a claim for the facsimile and therefore, the facsimile was deleted from FEITH.	9	Character

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7.39 CLM-0130-D -- CLM Claims Submission Statistics – Daily Report

7.39.1 CLM-0130-D -- CLM Claims Submission Statistics - Daily Report Narrative

The CLM Claims Submission Statistics Daily report provides summary of CLM claim counts sent to the claims engine by submission type (NCPDP, WEB DDE, ASC x12). It lists the information at the summary level, and at the submitter level. Does not report paper claims. This report is produced daily.

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7.39.2 CLM-0130-D -- CLM Claims Submission Statistics - Daily Report Layout

```
Report  : CLM-0130-D                  ALABAMA MCLMCAID AGENCY                  Run Date:  MM/DD/CCYY
Process : CLMJD130           MCLMCAID MANAGEMENT INFORMATION SYSTEM            Run Time:    HH:MM:SS
Location: CLM0130D          CLM CLAIMS SUBMISSION STATISTICS - DAILY           Page:            9999

Submission Type
Claim Type        Accepted Claims  Claims Suspended Claims Paid      Claims Denied

NCPDP             999,999,999      999,999,999      999,999,999      999,999,999
xxxxxxxx           999,999          999,999          999,999          999,999
xxxxxxxx          999,999           999,999          999,999          999,999
xxxxxxxx          999,999           999,999          999,999          999,999

WEB DDE           999,999,999      999,999,999      999,999,999      999,999,999
xxxxxxxx          999,999          999,999          999,999          999,999
xxxxxxxx          999,999          999,999          999,999          999,999
xxxxxxxx          999,999          999,999          999,999          999,999

ASC X12           999,999,999      999,999,999      999,999,999      999,999,999
Xxxxxxxx          999,999          999,999          999,999          999,999
xxxxxxxx          999,999          999,999          999,999          999,999
xxxxxxxx          999,999          999,999          999,999          999,999

System Totals     999,999,999      999,999,999      999,999,999      999,999,999



Summitter 1   Submission Type: NCPDP

Claim Type        Accepted Claims  Claims Suspended Claims Paid      Claims Denied
xxxxxxxx              999,999          999,999          999,999          999,999
xxxxxxxx              999,999          999,999          999,999          999,999
xxxxxxxx              999,999          999,999          999,999          999,999


Totals                999,999           999,999          999,999           999,999


Summitter 2   Submission Type: WEB DDE

Claim Type        Accepted Claims  Claims Suspended Claims Paid      Claims Denied
xxxxxxxx              999,999          999,999          999,999          999,999
xxxxxxxx              999,999          999,999          999,999          999,999
xxxxxxxx              999,999          999,999          999,999          999,999


Totals                999,999           999,999          999,999           999,999
```


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```
Summitter 3   Submission Type: ASC X12

Claim Type       Accepted Claims  Claims Suspended Claims Paid      Claims Denied
Xxxxxxxx         999,999          999,999          999,999          999,999
Xxxxxxxx         999,999          999,999          999,999          999,999
Xxxxxxxx         999,999          999,999          999,999          999,999

Totals           999,999          999,999          999,999          999,999

                                        *** END OF REPORT ***
```

7.39.3 CLM-0130-D -- CLM Claims Submission Statistics - Daily Report Field Descriptions

Field	Description	Length	Data Type
Accepted Claims	Total count of CLM claims submitted by indicated submission type and sent to the claims engine. This total should equal the count of suspended, paid, and denied claims in this report.	6	Number (Decimal)
Claim Type	MMIS Claim Type.	15	Character
Claims Denied	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and denied by the claims engine.	6	Number (Integer)
Claims Paid	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and paid by the claims engine.	6	Number (Integer)
Claims Suspended	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and suspended by the claims engine.	6	Number (Integer)
Submission Type	Origination of transmission (NCPDP, WEB DDE, ASC X12)	15	Character
Submitter	The submitter code for the claim.	50	Character
System Totals	The total number of accepted, denied, paid and suspended claims submitted for all claim types.	11	Number (Integer)
Totals	The total number of accepted, denied, paid, and suspended claims per claim type.	7	Number (Integer)

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7.40 CLM-0130-M -- CLM Claims Submission Statistics – Monthly Report

7.40.1 CLM-0130-M -- CLM Claims Submission Statistics - Monthly Report Narrative

The CLM (Electronic Data Interchange) Claims Submission Statistics report is a monthly summary of CLM claim counts sent to the claims engine by submission type (NCPDP, WEB DDE, ASC x12). It is reported at the summary level, and at the submitter level. Does not report paper claims. This report is produced monthly.

7.40.2 CLM-0130-M -- CLM Claims Submission Statistics - Monthly Layout Report

```
Report  : CLM-0130-M                  ALABAMA MEDICAID AGENCY                  Run Date:  MM/DD/CCYY
Process : CLMJM130           MCLMCAID MANAGEMENT INFORMATION SYSTEM           Run Time:    HH:MM:SS
Location: CLM0130M          CLM CLAIMS SUBMISSION STATISTICS - DAILY          Page:            9999

 Submission    Claim Type    Accepted Claims   Claims Suspended   Claims Paid      Claims
 Type                                                                            Denied
 NCPDP                       999,999,999       999,999,999        999,999,999      999,999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999

 WEB DDE                     999,999,999       999,999,999        999,999,999      999,999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999

 ASC X12                     999,999,999       999,999,999        999,999,999      999,999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999

 System                      999,999,999       999,999,999        999,999,999      999,999,999
 Totals
Summitter 1   Submission Type: NCPDP
 Claim Type       Accepted       Claims           Claims Paid      Claims Denied
                  Claims         Suspended
 xxxxxxxx         999,999        999,999          999,999          999,999
 xxxxxxxx         999,999        999,999          999,999          999,999
 xxxxxxxx         999,999        999,999          999,999          999,999

 Totals           999,999        999,999          999,999          999,999
 Summitter 2   Submission Type: WEB DDE
 Claim Type       Accepted       Claims           Claims Paid      Claims Denied
                  Claims         Suspended
 xxxxxxxx         999,999        999,999          999,999          999,999
 xxxxxxxx         999,999        999,999          999,999          999,999
 xxxxxxxx         999,999        999,999          999,999          999,999

 Totals           999,999        999,999          999,999          999,999
 Summitter 3   Submission Type: ASC X12
```


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```
Claim Type        Accepted       Claims          Claims Paid      Claims Denied
                  Claims         Suspended
Xxxxxxxx          999,999        999,999         999,999          999,999
Xxxxxxxx          999,999        999,999         999,999          999,999
Xxxxxxxx          999,999        999,999         999,999          999,999

Totals            999,999        999,999         999,999          999,999
                                          *** END OF REPORT ***
```

7.40.3 CLM-0130-M -- CLM Claims Submission Statistics - Monthly Report Field Descriptions

Field	Description	Length	Data Type
Accepted Claims	Total count of CLM claims submitted by indicated submission type and sent to the claims engine. This total should equal the count of suspended, paid, and denied claims in this report.	6	Number (Integer)
Claim Type	MMIS Claim Type.	15	Character
Claims Denied	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and denied by the claims engine.	6	Number (Integer)
Claims Paid	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and paid by the claims engine.	6	Number (Integer)
Claims Suspended	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and suspended by the claims engine.	6	Number (Integer)
Submission Type	Origination of transmission (NCPDP, WEB DDE, ASC X12).	15	Character
Submitter	The submitter code for the claim.	50	Character
System Totals	The total number of accepted, denied, paid and suspended claims submitted for all claim types.	11	Number (Integer)
Totals	The total number of accepted, denied, paid, and suspended claims per claim type.	7	Number (Integer)

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7.41 CLM-0130-W -- CLM Claims Submission Statistics – Weekly Report

7.41.1 CLM-0130-W -- CLM Claims Submission Statistics - Weekly Report Narrative

The CLM Claims Submission Statistics report is a weekly summary of CLM claim counts sent to the claims engine by submission type (NCPDP, WEB DDE, ASC x12). It provides information at the summary level, and at the submitter level. Does not report paper claims.

7.41.2 CLM-0130-W -- CLM Claims Submission Statistics - Weekly Report Layout

```
Report  : CLM-0130-W                ALABAMA MCLMCAID AGENCY                    Run Date:  MM/DD/CCYY
Process : CLMJW130           MCLMCAID MANAGEMENT INFORMATION SYSTEM           Run Time:    HH:MM:SS
Location: CLM0130W          CLM CLAIMS SUBMISSION STATISTICS - WEEKLY          Page:            9999
 Submission    Claim Type    Accepted Claims   Claims Suspended   Claims Paid      Claims Denied
 Type
 NCPDP                       999,999,999       999,999,999        999,999,999      999,999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999

 WEB DDE                     999,999,999       999,999,999        999,999,999      999,999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
 ASC X12                     999,999,999       999,999,999        999,999,999      999,999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999

 System                      999,999,999       999,999,999        999,999,999      999,999,999
 Totals
Summitter 1   Submission Type: NCPDP
 Claim Type       Accepted Claims    Claims            Claims Paid      Claims Denied
                                     Suspended
 xxxxxxxx         999,999            999,999           999,999          999,999
 xxxxxxxx         999,999            999,999           999,999          999,999
 xxxxxxxx         999,999            999,999           999,999          999,999

 Totals           999,999            999,999           999,999          999,999
```


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```
Summitter 2   Submission Type: WEB DDE


 Claim Type       Accepted       Claims          Claims Paid      Claims Denied
                  Claims         Suspended

 xxxxxxxx         999,999        999,999         999,999          999,999

 xxxxxxxx         999,999        999,999         999,999          999,999

 xxxxxxxx         999,999        999,999         999,999          999,999


 Totals           999,999        999,999         999,999          999,999

 Summitter 3   Submission Type: ASC X12


 Claim Type       Accepted       Claims          Claims Paid      Claims Denied
                  Claims         Suspended

 Xxxxxxxx         999,999        999,999         999,999          999,999

 Xxxxxxxx         999,999        999,999         999,999          999,999

 Xxxxxxxx         999,999        999,999         999,999          999,999


 Totals           999,999        999,999         999,999          999,999

                                  *** END OF REPORT ***
```

7.41.3 CLM-0130-W -- CLM Claims Submission Statistics - Weekly Report Field Descriptions

Field	Description	Length	Data Type
Accepted Claims	Total count of CLM claims submitted by indicated submission type and sent to the claims engine. This total should equal the count of suspended, paid, and denied claims in this report.	6	Number (Integer)
Claim Type	MMIS Claim Type.	15	Character
Claims Denied	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and denied by the claims engine.	6	Number (Integer)

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Field	Description	Length	Data Type
Claims Paid	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and paid by the claims engine.	6	Number (Integer)
Claims Suspended	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and suspended by the claims engine.	6	Number (Integer)
Submission Type	Origination of transmission (NCPDP, WEB DDE, ASC X12).	15	Character
Submitter	The submitter code for the claim.	50	Character
System Totals	The total number of accepted, denied, paid and suspended claims submitted for all claim types.	11	Number (Integer)
Totals	The total number of accepted, denied, paid, and suspended claims per claim type.	7	Number (Integer)

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7.42 CLM-0300-W -- CLM ICD Version Edit Failures by Provider – Weekly Report

7.42.1 CLM-0300-W -- CLM ICD Version Edit Failures by Provider - Weekly Report Narrative

The CLM ICD Version Edit Failures by Provider report is a weekly list of the claims failing edit 309 or 310 for incorrect version of ICD procedure (309) or diagnosis (310). This weekly report will be used to monitor ICD-10 compliance and to contact providers as needed. There are two sections to the report: 1) Detail section sorted by provider, ICN, and Edit number that lists the diagnosis codes and/or ICD procedure codes on the claim. 2) Summary section sorted by the total claims failing these edits in descending order and listing the Provider summary counts and contact information.

7.42.2 CLM-0300-W -- CLM ICD Version Edit Failures by Provider - Weekly Report Layout

```
REPORT  : CLM-0300-W                                ALABAMA MEDICAID AGENCY                                RUN DATE: MM/DD/CCYY
PROCESS : CLMJW300                            MEDICAID MANAGEMENT INFORMATION SYSTEM                     RUN TIME:   HH:MM:SS
LOCATION: CLMP0300                      ICD VERSION EDIT FAILURES REPORT BY PROVIDER - DETAIL                PAGE:    999,999
                                              REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

                         C                                 --------------- ICD PROCEDURE (309) OR DIAGNOSIS (310) ----------------
PROVIDER    ICN          T FDOS/DISCH  PAID DATE  ICD  EDT  QLF PROC/DX QLF PROC/DX QLF PROC/DX QLF PROC/DX QLF PROC/DX QLF PROC/DX
-------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXX  XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
            XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        310  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
            XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
XXXXXXXXXX  XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
XXXXXXXXXX  XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   310  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        310  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
XXXXXXXXXX  XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
XXXXXXXXXX  XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX

REPORT  : CLM-0300-W                                ALABAMA MEDICAID AGENCY                                RUN DATE: MM/DD/CCYY
```


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```
PROCESS : CLMJW300                          MEDICAID MANAGEMENT INFORMATION SYSTEM                        RUN TIME:   HH:MM:SS
LOCATION: CLMP0300                    ICD VERSION EDIT FAILURES REPORT BY PROVIDER - SUMMARY                  PAGE:    999,999
                                              REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

PROVIDER   CONTACT NAME                       CONTACT PHONE   EXT       TOT CLAIMS FAILING      COUNT EDIT 309       COUNT EDIT 310
-------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999) 999-9999  9999        999,999,999            999,999,999          999,999,999
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999) 999-9999  9999        999,999,999            999,999,999          999,999,999
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999) 999-9999  9999        999,999,999            999,999,999          999,999,999
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999) 999-9999  9999        999,999,999            999,999,999          999,999,999
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999) 999-9999  9999        999,999,999            999,999,999          999,999,999

GRAND TOTALS:                                                           999,999,999            999,999,999          999,999,999

                                                   ** END OF REPORT **
                                                 ** NO DATA THIS RUN **
```

7.42.3 CLM-0300-W -- CLM ICD Version Edit Failures by Provider - Weekly Report Field Descriptions

Field	Description	Length	Data Type
Contact Name	The name of the contact person on file for this provider.	35	Character
Contact Phone	The phone number of the contact person on file for this provider.	14	Character
Count Edit 309	Calculated count of the number of claims reported as failing edit 309.	9	Number (Integer)
Count Edit 310	Calculated count of the number of claims reported as failing edit 310.	9	Number (Integer)
CT	The claim type for the claim being reported.	1	Character
EDT	This is the edit associated with the report line. Value will be either 309 for ICD Procedure codes or 310 for Diagnosis codes.	3	Character
EXT	The phone extension of the contact person on file for this provider.	4	Character

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Field	Description	Length	Data Type
FDOS/DISCH	For inpatient claims this will be the Last Date of Service (discharge date). For all other claim types it will be the First Date of Service from the header. This is the date that the system uses to determine the correct ICD version that should be on the claim.	10	Date (MM/DD/CCYY)
Grand Totals	Calculated grand total count of the three numbers being reported on the summary section of the report.	9	Number (Integer)
ICD	The ICD version that should have been used for this claim. Calculated using the Claim Type and either the From Date of Service for non-Inpatient claims or the Through Date of Service (Discharge Date) for Inpatient claims. Values are: '9' = ICD-9, '0' = ICD-10.	1	Character
ICN	Claim internal control number	13	Character
Paid Date	The date on which the claim was denied	10	Date (MM/DD/CCYY)
PROC/DX	If EDT is 309, this will be the ICD procedure code. If EDT is 310, this will be the diagnosis code. T_CLM_DIAG_XREF or T_UB92_HDR_DIAG_X for diagnosis codes, or T_UB92_HDR_ICD9CM for procedure codes.	7	Character
Provider	The Billing Provider Location Medicaid Number: CDE_PROV_ID_TYPE = 'MCD'.	10	Character
QLF	The diagnosis or procedure qualifier associated with the code. T_CLM_DIAG_XREF or T_UB92_HDR_DIAG_X for diagnosis codes, or T_UB92_HDR_ICD9CM for procedure codes. ICD-10 qualifiers will be 3 characters and ICD qualifiers will be 2 bytes long.	3	Character
Report Period	This is a weekly report. The report period will be displayed in the headings.	10	Date (MM/DD/CCYY)
Tot Claims Failing	Calculated count of the number of claims reported as failing either edit 309 or 310.	9	Number (Integer)

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7.43 CLM-2011-P -- RECIPIENT DATA SHEET REQUEST PROCESS REPORT

7.43.1 CLM-2011-P – Recipient Data Sheet Request Process Report Narrative

Reports of Datasheet requests received and processed including any errors encountered.

7.43.2 CLM-2011-P – Recipient Data Sheet Request Process Report Layout

```
REPORT  : CLM-2011-P                          ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/CCYY
PROCESS : CLMJO201                       MEDICAID MANAGEMENT INFORMATION SYSTEM                RUN TIME:   HH:MM:SS
LOCATION: CLMPO201                    RECIPIENT DATA SHEET REQUEST PROCESS REPORT                  PAGE:    999,999


          REVIEW                                        CLAIMS       ERROR
REQUESTOR NUMBER SEQ  RECIPIENT       REQUEST DATES     REQUESTED    MESSAGES

   XXX    XXXXX  999 XXXXXXXXXXXXX  XXXXXXXX XXXXXXXX   XXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXX    XXXXX  999 XXXXXXXXXXXXX  XXXXXXXX XXXXXXXX   XXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXX    XXXXX  999 XXXXXXXXXXXXX  XXXXXXXX XXXXXXXX   XXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXX    XXXXX  999 XXXXXXXXXXXXX  XXXXXXXX XXXXXXXX   XXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXX    XXXXX  999 XXXXXXXXXXXXX  XXXXXXXX XXXXXXXX   XXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXX    XXXXX  999 XXXXXXXXXXXXX  XXXXXXXX XXXXXXXX   XXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                        .....  END OF REPORT  .....
```


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7.43.3 CLM-2011-P – Recipient Data Sheet Request Process Report Field Descriptions

Field	Description	Length	Data Type
Claims Requested	REQUESTOR indicates the claims to report in this field. The REQUESTOR may indicate ALL for all claim types, or ALLXzzzz to report all claims types "except" those indicated (the zzzz) values. The REQUESTOR may also indicate the specific claim types to include using the 1-character interchange claim type codes (REFERENCE > RELATED DATA > > Codes > Claim Type).	8	Character
Error Messages	Issues or errors encountered while processing the Recipient Data Sheet requests are reported in this field.	60	Character
Recipient	A 12-digit number that uniquely identifies an individual eligible for Medicaid benefits.	12	Character
Request Dates	Two ten character date fields (MM/DD/CCYY) indicating the from and through dates of service of claims for this request. These fields are optional. If not provided, the default is to report the past 37 months of data.	20	Character
Requestor	Identifier submitted on the request to identify the source of the request.	3	Character
Review Number	This field is submitted on the request to identify a specific review to the REQUESTOR. This field is optional.	5	Number (Integer)
SEQ	Displays the total number of providers that have invalid Account Routing Numbers.	3	Number (Integer)

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7.44 CLM-2011-R -- RECIPIENT DATA SHEET REPORT

7.44.1 CLM-2011-R – Recipient Data Sheet Report Narrative

Lists claims data for recipients and dates requested.

7.44.2 CLM-2011-R – Recipient Data Sheet Reports Layout

```
REPORT  : CLM-2011-R                                    ALABAMA MEDICAID AGENCY                        RUN DATE: MM/DD/CCYY
PROCESS : CLMJO201                                MEDICAID MANAGEMENT INFORMATION SYSTEM               RUN TIME:   HH:MM:SS
LOCATION: CLMPO201                                         RECIPIENT DATA SHEET                            PAGE:    999,999

                                                                                                 RECIPIENT PAGE NUM:    999,999

RECIPIENT: XXXXXXXXXXX  LASTXXXXXXXXXXXXXXXXX, FIRSTXXXXXXXXXX M  REQUESTOR:XXX REVIEW XXXXX SEQ:999 DATES:MM/DD/CCYY TO MM/DD/CCYY

CLAIM SECTION: DENTAL

    ICN       BILLING NPI SPC FROM DOS   THRU  DOS  PAID DATE  BILLED AMT   ALLOWED     TPL  AMT   PAID AMT    POS  T P  ESC1 F S
  ADJ ICN     CS DERIVED STAT                                                                                        I A  ESC2 F S
XXXXXXXXXXXXX XXXXXXXXXX  XXX MM/DD/CCYY MM/DD/CCYY MM/DD/CCYY 9999999.99  9999999.99  9999999.99  9999999.99  XX   X X  XXXX X X
XXXXXXXXXXXXX X  XXXXXXXXXXXX                                                                                          XXXX X X

     DT S SERVICE DT  PERF PROV   SPC  PROC  TN OC SFSFSFSF  UNITS BLLD    BILLED AMT  ALLOWD AMT  PAID AMT     ESC1 F S ESC2 F S
     99 X MM/DD/CCYY  XXXXXXXXXX  XXX  XXXXX XX X  X X X X   999999.999    9999999.99  9999999.99  9999999.99   XXXX X X XXXX X X
     99 X MM/DD/CCYY  XXXXXXXXXX  XXX  XXXXX XX X  X X X X   999999.999    9999999.99  9999999.99  9999999.99   XXXX X X XXXX X X
     99 X MM/DD/CCYY  XXXXXXXXXX  XXX  XXXXX XX X  X X X X   999999.999    9999999.99  9999999.99  9999999.99   XXXX X X XXXX X X
TOTAL PAID AMOUNT:999,999,999,999.99

P R O C E D U R E   C O D E   S U M M A R Y

CODE   DESCRIPTION
XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
P R O V I D E R   S U M M A R Y
NPI NUMBER  MEDICAID   NAME
XXXXXXXXXX  XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TYPE: XX-XXXXXXXXXX
SPECIALTIES: XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX

E S C   S U M M A R Y

CODE  DESCRIPTION
XXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  .....  END OF REPORT  .....
```


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```
REPORT  : CLM-2011-R                                    ALABAMA MEDICAID AGENCY                        RUN DATE: MM/DD/CCYY
PROCESS : CLMJO201                                 MEDICAID MANAGEMENT INFORMATION SYSTEM              RUN TIME:   HH:MM:SS
LOCATION: CLMPO201                                          RECIPIENT DATA SHEET                           PAGE:    999,999

                                                                                                 RECIPIENT PAGE NUM:    999,999

RECIPIENT: XXXXXXXXXXX  LASTXXXXXXXXXXXXXXXXX, FIRSTXXXXXXXXXX M  REQUESTOR:XXX REVIEW XXXXX SEQ:999 DATES:MM/DD/CCYY TO MM/DD/CCYY

CLAIM SECTION: INPATIENT AND INPATIENT CROSSOVERS

    ICN       CS DERIVED STAT FROM DOS    THRU  DOS  ADMIT  DT  PAID DATE   BILLED AMT  COPAY  AMT TOB  C F E T S E C M P Q ESC1 F S
  ADJ ICN     BILLING NPI SPC REFERRING   ATTENDING  DISCHARGE  PAID AMT    ALLOWED     TPL  AMT   CDYS T P P I V C P E A M ESC2 F S
XXXXXXXXXXXXX X  XXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY MM/DD/CCYY MM/DD/CCYY  9999999.99    99999.99 XXX  X X X X X X X X X X XXXX X X
XXXXXXXXXXXXX XXXXXXXXXX  XXX XXXXXXXXXX  XXXXXXXXXX MM/DD/CCYY 9999999.99  9999999.99  9999999.99 XXXX                    XXXX X X

DIAGNOSIS: XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX
           XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX

MEDICARE  ALLWD:9999999.99  COINS:9999999.99  DED:9999999.99  PAID:999999999.99  PD DT:MM/DD/CCYY   LTR:999   CID:999

SURG CODES:    X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX

             DTL S FROM DOS   THRU DOS    REV   UNITS BLLD  SUBM RATE  BILLED AMT  ALLOWD AMT                 ESC1 F S  ESC2 F S
             999 X MM/DD/CCYY MM/DD/CCYY  XXXX  999999.999  999999.99  9999999.99  9999999.99                 XXXX X X  XXXX X X
             999 X MM/DD/CCYY MM/DD/CCYY  XXXX  999999.999  999999.99  9999999.99  9999999.99                 XXXX X X  XXXX X X
TOTAL PAID AMOUNT:999,999,999,999.99

R E V E N U E   C O D E   S U M M A R Y
CODE   DESCRIPTION
XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

D I A G N O S I S   C O D E   S U M M A R Y
ICD CODE     DESCRIPTION
 X  XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

S U R G E R Y   C O D E   S U M M A R Y
ICD CODE     DESCRIPTION
 X  XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

P R O V I D E R   S U M M A R Y
NPI NUMBER  MEDICAID   NAME
XXXXXXXXXX  XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TYPE: XX-XXXXXXXXXX
SPECIALTIES: XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX

E S C   S U M M A R Y
CODE  DESCRIPTION
XXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  .....  END OF REPORT  .....
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```
REPORT  : CLM-2011-R                                    ALABAMA MEDICAID AGENCY                        RUN DATE: MM/DD/CCYY
PROCESS : CLMJO201                                 MEDICAID MANAGEMENT INFORMATION SYSTEM              RUN TIME:   HH:MM:SS
LOCATION: CLMPO201                                          RECIPIENT DATA SHEET                           PAGE:    999,999

                                                                                                 RECIPIENT PAGE NUM:    999,999

RECIPIENT: XXXXXXXXXXX  LASTXXXXXXXXXXXXXXXXX, FIRSTXXXXXXXXXX M  REQUESTOR:XXX REVIEW XXXXX SEQ:999 DATES:MM/DD/CCYY TO MM/DD/CCYY

CLAIM SECTION: OUTPATIENT AND OUTPATIENT CROSSOVERS

    ICN       CS DERIVED STAT FROM DOS    THRU  DOS             PAID DATE   BILLED AMT  COPAY  AMT  TOB  C F E T S E C M P ESC1 F S
  ADJ ICN     BILLING NPI SPC REFERRING                         PAID AMT    ALLOWED     TPL  AMT    PAT  T P P I V C P E A ESC2 F S
XXXXXXXXXXXXX X  XXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY            MM/DD/CCYY  9999999.99    99999.99  XXX  X X X X X X X X X XXXX X X
XXXXXXXXXXXXX XXXXXXXXXX  XXX XXXXXXXXXX                        9999999.99  9999999.99  9999999.99  XX                     XXXX X X

DIAGNOSIS: XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX
           XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX
           XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX

MEDICARE  ALLWD:9999999.99  COINS:9999999.99  DED:9999999.99  PAID:999999999.99  PD DT:MM/DD/CCYY

  DTL S FROM DOS   THRU DOS    REV  PROC  M1 M2 M3 M4 UNITS BLLD UNITS ALLW BILLED AMT  ALLOWD AMT  PAID  AMT  Q ESC1 F S  ESC2 F S
  999 X MM/DD/CCYY MM/DD/CCYY  XXXX XXXXX XX XX XX XX 999999.999 999999.999 9999999.99  9999999.99  9999999.99 X XXXX X X  XXXX X X
  999 X MM/DD/CCYY MM/DD/CCYY  XXXX XXXXX XX XX XX XX 999999.999 999999.999 9999999.99  9999999.99  9999999.99 X XXXX X X  XXXX X X
TOTAL PAID AMOUNT:999,999,999,999.99

R E V E N U E   C O D E   S U M M A R Y
CODE   DESCRIPTION
XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

P R O C E D U R E   C O D E   S U M M A R Y
CODE   DESCRIPTION
XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

D I A G N O S I S   C O D E   S U M M A R Y
ICD CODE     DESCRIPTION
 X  XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

P R O V I D E R   S U M M A R Y
NPI NUMBER  MEDICAID   NAME
XXXXXXXXXX  XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TYPE: XX-XXXXXXXXXX
SPECIALTIES: XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX

E S C   S U M M A R Y
CODE  DESCRIPTION
XXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  .....  END OF REPORT  .....
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```
REPORT  : CLM-2011-R                                    ALABAMA MEDICAID AGENCY                        RUN DATE: MM/DD/CCYY
PROCESS : CLMJO201                                 MEDICAID MANAGEMENT INFORMATION SYSTEM              RUN TIME:   HH:MM:SS
LOCATION: CLMPO201                                          RECIPIENT DATA SHEET                           PAGE:    999,999

                                                                                                 RECIPIENT PAGE NUM:    999,999

RECIPIENT: XXXXXXXXXXX  LASTXXXXXXXXXXXXXXXXX, FIRSTXXXXXXXXXX M  REQUESTOR:XXX REVIEW XXXXX SEQ:999 DATES:MM/DD/CCYY TO MM/DD/CCYY

CLAIM SECTION: PHARMACY AND COMPOUND PHARMACY

    ICN       BILLING NPI SPC PRESCRIBER DISPENSED  PAID DATE   BILLED AMT   DISP FEE     TPL  AMT    DAYS  C F P T C P E B
  ADJ ICN     CS DERIVED STAT PRSCRB NPI PRESCRIBED SCRIPNO RF  ALLOWED      COPAY        PAID AMT          T P G I P A M R
XXXXXXXXXXXXX XXXXXXXXXX  XXX XXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  9999999.99   99999.99    9999999.99   9999  X X X X X X X X
XXXXXXXXXXXXX X  XXXXXXXXXXXX XXXXXXXXXX MM/DD/CCYY XXXXXXX XX  9999999.99   99999.99    9999999.99

     DT S NDC          ALGI  PREF  SC    CLASS     PACKAGE  SIZE   QTY DISP       UNIT RATE    RATE  BILLED AMT  ESC1 F S
          DESCRIPTION                               STRENGTH                                        ALLOWD AMT  ESC2 F S
     99 X 99999999999   X     X    XX  XXXXXXXXX  99999999999.999  9999999.999  9999999.99999  XXXX  9999999.99  XXXX X X
          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      9999999.99  XXXX X X
     99 X 99999999999   X     X    XX  XXXXXXXXX  99999999999.999  9999999.999  9999999.99999  XXXX  9999999.99  XXXX X X
          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      9999999.99  XXXX X X
     99 X 99999999999   X     X    XX  XXXXXXXXX  99999999999.999  9999999.999  9999999.99999  XXXX  9999999.99  XXXX X X
          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      9999999.99  XXXX X X


TOTAL PAID AMOUNT:999,999,999,999.99


P R O V I D E R   S U M M A R Y

NPI NUMBER  MEDICAID   NAME
XXXXXXXXXX  XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TYPE: XX-XXXXXXXXXX
SPECIALTIES: XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX


E S C   S U M M A R Y

CODE  DESCRIPTION
XXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  .....  END OF REPORT  .....
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```
REPORT  : CLM-2011-R                                    ALABAMA MEDICAID AGENCY                        RUN DATE: MM/DD/CCYY
PROCESS : CLMJO201                                 MEDICAID MANAGEMENT INFORMATION SYSTEM              RUN TIME:   HH:MM:SS
LOCATION: CLMPO201                                          RECIPIENT DATA SHEET                           PAGE:    999,999

                                                                                                 RECIPIENT PAGE NUM:    999,999

RECIPIENT: XXXXXXXXXXX  LASTXXXXXXXXXXXXXXXXX, FIRSTXXXXXXXXXX M  REQUESTOR:XXX REVIEW XXXXX SEQ:999 DATES:MM/DD/CCYY TO MM/DD/CCYY

CLAIM SECTION: PROFESSIONAL AND PROFESSIONAL CROSSOVERS

    ICN       CS DERIVED STAT FROM DOS    THRU  DOS            PAID DATE   BILLED AMT  COPAY  AMT  TOB  C F E T S E C M P ESC1 F S
  ADJ ICN     BILLING NPI SPC REFERRING                        PAID AMT    ALLOWED     TPL  AMT    PAT  T P P I V C P E A ESC2 F S
XXXXXXXXXXXXX X  XXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY           MM/DD/CCYY  9999999.99    99999.99  XXX  X X X X X X X X X XXXX X X
XXXXXXXXXXXXX XXXXXXXXXX  XXX XXXXXXXXXX                       9999999.99  9999999.99  9999999.99  XX                    XXXX X X

DIAGNOSIS: XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX
           XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX

     DT S FROM DOS    PERF PROV  SPC PROC  M1    UNITS BD    UNTS ALW  BILLED AMT  ALLOWD AMT   PAID  AMT      ESC1 F S  ESC2 F S
        Q THRU DOS    REFERRING  POS M2 M3 M4  MC PAID DT    MC COINS  MC DEDUCT   MC ALLOWED   MC PD AMT
     99 X MM/DD/CCYY  XXXXXXXXXX XXX XXXXX XX    9999.999    9999.999  9999999.99  9999999.99  9999999.99      XXXX X X  XXXX X X
        X MM/DD/CCYY  XXXXXXXXXX XXX XX XX XX  MM/DD/CCYY  9999999.99  9999999.99  9999999.99  9999999.99
     99 X MM/DD/CCYY  XXXXXXXXXX XXX XXXXX XX    9999.999    9999.999  9999999.99  9999999.99  9999999.99      XXXX X X  XXXX X X
        X MM/DD/CCYY  XXXXXXXXXX XXX XX XX XX  MM/DD/CCYY  9999999.99  9999999.99  9999999.99  9999999.99
TOTAL PAID AMOUNT:999,999,999,999.99

P R O C E D U R E   C O D E   S U M M A R Y
CODE   DESCRIPTION
XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

D I A G N O S I S   C O D E   S U M M A R Y
ICD CODE     DESCRIPTION
 X  XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

P R O V I D E R   S U M M A R Y
NPI NUMBER  MEDICAID   NAME
XXXXXXXXXX  XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TYPE: XX-XXXXXXXXXX
SPECIALTIES: XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX

XXXXXXXXXX  XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TYPE: XX-XXXXXXXXXX
SPECIALTIES: XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX

E S C   S U M M A R Y
CODE  DESCRIPTION
XXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  .....  END OF REPORT  .....
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7.44.3 CLM-2011-R – Recipient Datasheets Report Field Descriptions

Field	Description	Length	Data Type
ADJ ICN	Adjusted Internal control number	13	Character
ADMIT DT	The admit date on the claim.	10	Date (MM/DD/CCYY)
ALGI	Alabama Generic Indicator – 1 is a generic or over the counter drug, 2 is a name brand drug and 0 is a bulk chemical	1	Number
ALLOWD AMT	The allowed amount on the claim	10	Number (Decimal)
ALLOWED	The allowed amount on the claim	10	Number (Decimal)
ATTENDING	The license number of the attending physician on the claim.	10	Character
BILLED AMT	Detail record amount submitted for services.	10	Number (Decimal)
BILLING NPI	The billing providers npi #.	10	Number
CID	Coinsurance Days	3	Number (Integer)
CLAIM SECTION	Name of claim section displayed on this page	50	
CLASS	The therapeutic class code.	10	Character
COINS	The Medicare coinsurance amount which is subject to payment by Medicaid.	10	Number (Decimal)
COPAY	The copay amount.	8	Number (Decimal)
COPAY AMT	The copay amount.	8	Number (Decimal)
CP	Copay indicator.	2	Character

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Field	Description	Length	Data Type
CS	Claim Status D=Denied, P=Paid, S=Suspended, V=Voided	1	Character
CT	Claim type indicator.	2	Character
DAY SUP	Number of days supply.	4	Number (Integer)
DAYS	Number of covered days on claim.	4	Character
DED	The header Medicare deductible amount.	10	Number (Decimal)
DERIVED STAT	Derived Status of the claim.	12	Character
DIAGNOSIS	The diagnosis will be displayed in the format ss-v-ddddddd where ss is the sequence, v is the icd version, and ddddddd is the diagnosis code.	12	Character
DIAGNOSIS DESCRIPTION	The description for all of the detail diagnosis codes on the claims.	60	Character
DISCHARGE DATE	The date of discharge on the claim.	10	Date (MM/DD/CCYY)
DISP FEE	The dispensed fee for the drug on the claim.	8	Number (Decimal)
DISPENSED Date	The date upon which the drug was dispensed to the recipient	10	Date (MM/DD/CCYY)
DT	The detail number on the claim.	2	Number (Integer)
DTL NUM	The detail number on the claim.	3	Number (Integer)
EC	Encounter claim indicator	2	Character
EI	Emergency indicator.	2	Character
EP	EPSDT Referral.	2	Character

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Field	Description	Length	Data Type
ESC 1	First error status code on the claim.	4	Number
ESC 2	Second error status code on the claim.	4	Number
FI	Forced code indicator.	2	Character
FP	Family Planning Indicator	2	Character
FROM DOS	From Date of service on claim	10	Date (MM/DD/CCYY)
First Date Requested	First Date of Service in range requested	10	Date (MM/DD/CCYY)
ICD	ICD Version of a Diagnosis code or a Surgical Procedure Code. Value is '9' for ICD-9 and '0' for ICD-10.	1	Character
ICN	Internal control number.	13	Number (Integer)
LTR	Lifetime Reserve Days	3	Character
Last Date Requested	Last Date of Service in range requested	10	Date (MM/DD/CCYY)
M1	Modifier 1 on the claim.	2	Character
M2	Modifier 2 on the claim.	2	Character
M3	Modifier 3 on the claim.	2	Character
M4	Modifier 4 on the claim.	2	Character
MC ALLOWED	Medicare allowed amount on claim.	10	Number (Decimal)
MC COINS	Medicare coinsurance amount on claim.	10	Number (Decimal)
MC DEDUCT	Medicare deductible amount on claim.	10	Number (Decimal)
MC PAID DT	Medicare paid date on claim.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
MC PD AMT	Medicare paid amount on claim.	10	Number (Decimal)
MEDICARE ALLWD	Medicare allowed amount on claim.	10	Number (Decimal)
NDC	The National Drug Code on the claim	11	Number (Integer)
NDC DESCRIPTION	The National Drug Code Description on the claim.	30	Character
OC	Tooth Quadrant on the claim.	2	Character
PA	Prior Authorization indicator.	2	Character
PACKAGE SIZE	Package Size - The metric quantity used to drive a unit price; the usual labeled quantify form which the pharmacist dispenses (for example, 100 tablets).	15	Number (Integer)
PAID AMOUNT	Provider reimbursement amount.	12	Number (Decimal)
PAID AMT	The header paid amount on the claim.	15	Number (Decimal)
PAID DATE	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	10	Date (MM/DD/CCYY)
PAT	Patient Status on the claim.	2	Character
PD DT	Date the claim paid.	10	Date (MM/DD/CCYY)
PERF PROV	Performing providers name on the claim	10	Character
PI	Pricing indicator.	2	Character
POS	The place of service code.	3	Character
PRESCRIBER	Prescribing providers name on the claim.	10	Character
PROC	The procedure code on the claim.	5	Character

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Field	Description	Length	Data Type
PROC CODE	The procedure code on the claim.	5	Character
PROCEDURE CODE DESCRIPTION	The description for all of the procedure codes profiled on the report.	60	Character
PRSB PHY	Prescribing physician's license number.	10	Character
PRSCRB NPI	Prescribing providers NPI number on the claim	10	Number (Integer)
Q	QMB (Qualified Medicare Beneficiary) indicator.	1	Character
QI	QMB (Qualified Medicare Beneficiary) indicator.	2	Character
QTY DISP	Quantity or units of drugs dispensed.	5	Number (Integer)
RATE	Code used to identify the rate type use to pay the claim. Allowable values are: AWP=Average Wholesale Price, SMAC=State MAC, WAC=Wholesale Acquisition Cost, FUL=Federal Upper Limit, DOJ=Department of Justice.	4	Character
RECIPIENT	A 12-digit number that uniquely identifies an individual eligible for Medicaid benefits. (Only one base number is issued per recipient and remains constant; Recipient Current ID can change frequently). Also, the recipient name is included in the format as LAST, FIRST M	54	Number (Integer)
RECIPIENT PAGE NUM	Recipient page number. This number is reset with each recipient printed. This is addition to the main page number printed at the top of each page of the report.	9	Number (Integer)
REF NO	Number of refills.	1	Number
REFERRING	The referring provider's name on the claim.	10	Character
REV	Revenue Code on the claim.	4	Number (Integer)

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Field	Description	Length	Data Type
RLCD	First Detail EOB code.	3	Character
S	The status for that detail. D=Denied, P=Paid, S=Suspended, V=Voided	1	Character
SC	The unique two character code for the description of the Alabama Schedule.	2	Character
SCRIPNO	Prescription number.	10	Character
SERVICE DATES FIRST	The first date of services on the claim.	10	Date (MM/DD/CCYY)
SERVICE DATES LAST	The last date of services on the claim.	10	Date (MM/DD/CCYY)
SERVICE FIRST	The First dates of services on the claim.	10	Date (MM/DD/CCYY)
SERVICE LAST	The last dates of services on the claim.	10	Date (MM/DD/CCYY)
SF	Tooth Surface on the claim.	1	Character
SPC	The billing provider specialty code.	3	Character
STRENGTH	Recommended dosage.	20	Character
SUBM RATE	Submitted Rate on the claim	10	Number (Decimal)
SURG CODES	Surgical Procedure Code	7	Character
SURG CODE DESCRIPTION	Surgical Procedure Code Description	60	Character
SVCD	The revenue code.	4	Number
Sum	Sum of Paid Amount column	5	Number (Decimal)
THRU DOS	Thru Date of service on claim	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
TI	Third party indicator.	2	Character
TN	Tooth Number on the claim.	2	Character
TOB	The type of bill.	3	Number (Integer)
TOT DAY	The number of Medicaid covered days.	3	Number (Integer)
TOTAL BILLED	The total billed by the provider.	12	Number (Decimal)
TOTAL PAID AMOUNT	Sum of the Paid Amount Column	18	Number (Decimal)
TPL AMT	Third party liability amount.	9	Number (Decimal)
UNIT RATE	The detailed billed amount divided by the quantity billed code	13	Number (Integer)
UNIT RATE	Rate amount used to price the claim.	13	Number (Decimal)
UNITS	The quantity billed count.	5	Number (Integer)
UNITS ALLW	Units Allowed on the claim.	10	Number (Integer)
UNITS BD	Units Billed on the claim.	10	Number (Integer)
UNITS BLLD	Units Billed on the claim.	10	Number (Integer)

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7.45 CLM-4301-W -- CLM NCCI Medically Unlikely Edit (MUE) Reporting

7.45.1 CLM-4301-W -- CLM NCCI Medically Unlikely Edit (MUE) Reporting - Report Narrative

The CLM NCCI Medically Unlikely Edit (MUE) report has three sections.

The first section is a single line displaying the total number of claims that received the MUE Error Status Code during the reporting period.

The second section is a list of procedure codes and a count of claim details for each procedure code. The list includes up to 50 procedure codes with the highest number of claim details that received the MUE Error Status Code during the reporting period. The list is in descending order by number of claim details.

The third section is a list of 10 to 20 claim details for each of the top 50 procedure codes listed in the second section of the report. The list includes up to 20 claim details if the count for the procedure code is greater than 100 and up to 10 claim details otherwise. The list is in the same order as the top 50 procedure codes and, within a particular procedure code, the claim details are in random order.

Each of the three sections is produced twice on this report, once for professional claims and once for outpatient claims. The order of the sections as listed on the report is: Totals by ESC for Professional, Procedures/Counts for Professional, Totals by ESC for Outpatient, Procedures/Counts for Outpatient, Claim Details for Professional, Claim Details for Outpatient.

This report is run bi-weekly toward the end of the Financial cycle.

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7.45.2 CLM-4301-W -- CLM NCCI Medically Unlikely Edit (MUE) Reporting - Report Layout

```
Report  : CLM-4301-W                          ALABAMA MEDICAID AGENCY                                    Run Date: 99/99/9999
Process : CLMJW430                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   99:99:99
Location: CLMPW430                    NCCI MEDICALLY UNLIKELY EDIT (MUE) REPORTING                           Page:          9
                                        REPORTING PERIOD: 99/99/9999 - 99/99/9999
  Total Claims for MUE ESC 5900 - Professional:  999,999,999

  Top 50 Procedures for Professional Claims

  Procedure            Procedure Description              Count
    XXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999
  ** End of Top 50 Procedures for Professional Claims **

Report  : CLM-4301-W                          ALABAMA MEDICAID AGENCY                                    Run Date: 99/99/9999
Process : CLMJW430                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   99:99:99
Location: CLMPW430                    NCCI MEDICALLY UNLIKELY EDIT (MUE) REPORTING                           Page:          9
                                        REPORTING PERIOD: 99/99/9999 - 99/99/9999
  Total Claims for MUE ESC 5900 - Outpatient:  999,999,999

  Top 50 Procedures for Outpatient Claims

  Procedure            Procedure Description              Count
    XXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999
  ** End of Top 50 Procedures for Outpatient Claims **

Report  : CLM-4301-W                          ALABAMA MEDICAID AGENCY                                    Run Date: 99/99/9999
Process : CLMJW430                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   99:99:99
Location: CLMPW430                    NCCI MEDICALLY UNLIKELY EDIT (MUE) REPORTING                           Page:          9
                                        REPORTING PERIOD: 99/99/9999 - 99/99/9999
  Claim Details - Professional

       ICN        DTL   PT   Procedure            Procedure Description             M1   M2   M3   M4     CLM QTY        MUE QTY
  9999999999999  9999   99     XXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XX   XX   XX   XX  999,999,999.99     99999
  ** End of Claim Details - Professional **

Report  : CLM-4301-W                          ALABAMA MEDICAID AGENCY                                    Run Date: 99/99/9999
Process : CLMJW430                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   99:99:99
Location: CLMPW430                    NCCI MEDICALLY UNLIKELY EDIT (MUE) REPORTING                           Page:          9
                                        REPORTING PERIOD: 99/99/9999 - 99/99/9999
  Claim Details - Outpatient

       ICN        DTL   PT   Procedure            Procedure Description             M1   M2   M3   M4     CLM QTY        MUE QTY
  9999999999999  9999   99     XXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XX   XX   XX   XX  999,999,999.99     99999
  ** End of Claim Details - Outpatient **
                                                 ** END OF REPORT **
```


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7.45.3 CLM-4301-W -- CLM NCCI Medically Unlikely Edit (MUE) Reporting - Report Field Descriptions

Field	Description	Length	Data Type
Reporting Period MM/DD/YYYY – MM/DD/YYYY	The date range being reported. Dates determined by the values in t_system_parms where nam_program is NCCIRPTW.	23	Character
Report Section 1			
Total Claims for MUE ESC 5900	Total count of claim details that received the MUE Error Status Code during the reporting period.	9	Number (Decimal)
Report Section 2			
Procedure	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	40	Character
Count	Total count of claim details for a Procedure Code that received the MUE Error Status Code during the reporting period.	5	Number (Decimal)
Report Section 3			
ICN	Claim Internal Control Number.	13	Number (Integer)
DTL	Claim detail number.	4	Number (Integer)
PT	Provider Type.	2	Character
Procedure	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	40	Character
M1	First procedure code modifier.	2	Character
M2	Second procedure code modifier.	2	Character

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Field	Description	Length	Data Type
M3	Third procedure code modifier.	2	Character
M4	Fourth procedure code modifier.	2	Character
CLM QTY	Quantity of units billed on a claim.	11	Number (Decimal)
MUE QTY	Maximum quantity of units for a procedure code on the CCI MUE table.	5	Number (Integer)

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7.46 CLM-4302-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner Claims

7.46.1 CLM-4302-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner Claims - Report Narrative

The CLM NCCI Procedure-To-Procedure (P2P) - Practitioner Claims report is an on-request report. The request to run this report must include 1 to 3 pairs of procedure codes and set of dates to be the reporting period. For each procedure pair, the report will display all claims that received any of the P2P Error Status Codes during the reporting period.

7.46.2 CLM-4302-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner Claims - Report Layout

```
Report  : CLM-4302-O                          ALABAMA MEDICAID AGENCY                                          Run Date: 99/99/9999
Process : CLMJO430                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                  Run Time:   99:99:99
Location: CLMPO430             NCCI PROCEDURE-TO-PROCEDURE (P2P) REPORTING - PRACTITIONER                          Page:          9
                                     REPORTING PERIOD: 99/99/9999 - 99/99/9999

  Procedure-To-Procedure Edit Occurrence - Claim Details

                                                                                                                          NCCI
                    Prov                                                                                                Modifier
      ICN       DTL Type Proc   Procedure Description  M1  M2  M3  M4  Proc   Procedure Description  M1  M2  M3  M4  Indicator

  9999999999999 9999  XX  XXXXX  XXXXXXXXXXXXXXXXXXXXX  XX  XX  XX  XX  XXXXX  XXXXXXXXXXXXXXXXXXXXX  XX  XX  XX  XX      X

  ** End of Procedure-To-Procedure Edit Occurrence - Claim Details **

                                                  ** END OF REPORT **
```

7.46.3 CLM-4302-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner Claims - Report Field Descriptions

Field	Description	Length	Data Type
ICN	Claim Internal Control Number.	13	Number (Integer)
DTL	Claim detail number.	4	Number (Integer)
Prov Type	Provider Type.	2	Character
Proc	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	21	Character
M1	First procedure code modifier.	2	Character
M2	Second procedure code modifier.	2	Character

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Field	Description	Length	Data Type
M3	Third procedure code modifier.	2	Character
M4	Fourth procedure code modifier.	2	Character
NCCI Modifier Indicator	The NCCI Modifier Indicator for the Procedure Code pair.	1	Character

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7.47 CLM-4302-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner

7.47.1 CLM-4302-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner - Report Narrative

The CLM NCCI Procedure-To-Procedure (P2P) - Practitioner report has three sections.

The first section is a list of the total number of Practitioner claims that received each of the P2P Error Status Codes.

The second section is a list of procedure code pairs and a count of claim details for each procedure code. The list includes up to 50 procedure code pairs with the highest number of claim details that received one of the P2P Error Status Codes during the reporting period. The list is in descending order by number of claim details.

The third section is a list of 10 to 20 claim details for each of the top 50 procedure code pairs listed in the second section of the report. The list includes up to 20 claim details if the count for the procedure code pair is greater than 100 and up to 10 claim details otherwise. The list is in the same order as the top 50 procedure code pairs and, within a particular procedure code pair, the claim details are in random order.

This report is run bi-weekly toward the end of the Financial cycle.

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7.47.2 CLM-4302-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner - Report Layout

```
Report  : CLM-4302-W                         ALABAMA MEDICAID AGENCY                                          Run Date: 99/99/9999
Process : CLMJW430                       MEDICAID MANAGEMENT INFORMATION SYSTEM                               Run Time:   99:99:99
Location: CLMPW430                  NCCI PROCEDURE-TO-PROCEDURE (P2P) REPORTING - PRACTITIONER                   Page:           9
                                             REPORTING PERIOD: 99/99/9999 - 99/99/9999

  Edit        Count        Edit Description

  5910     999,999,999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  5911     999,999,999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  5912     999,999,999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  Top 50 Procedure-To-Procedure Edit Count by Procedure Pair and Provider Type

                                                                                                      Modifier  Provider
  Procedure         Procedure Description          Procedure         Procedure Description           Indicator   Type     Count

    XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X        XX     999,999

  ** End of Top 50 Procedure Pairs **

Report  : CLM-4302-W                         ALABAMA MEDICAID AGENCY                                      Run Date: 99/99/9999
Process : CLMJW430                       MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   99:99:99
Location: CLMPW430                  NCCI PROCEDURE-TO-PROCEDURE (P2P) REPORTING - PRACTITIONER               Page:           9
                                             REPORTING PERIOD: 99/99/9999 - 99/99/9999


  Procedure-To-Procedure Edit Occurrence - Claim Details

                                                                                                                   NCCI
                  Prov                                                                                           Modifier
      ICN       DTL Type  Proc    Procedure Description  M1   M2   M3   M4   Proc    Procedure Description  M1   M2   M3   M4  Indicator

  9999999999999 9999  XX  XXXXX  XXXXXXXXXXXXXXXXXXXXX  XX   XX   XX   XX  XXXXX  XXXXXXXXXXXXXXXXXXXXX  XX   XX   XX   XX      X

  ** End of Procedure-To-Procedure Edit Occurrence - Claim Details **

                                                       ** END OF REPORT **
```

7.47.3 CLM-4302-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner - Report Field Descriptions

Field	Description	Length	Data Type
Reporting Period MM/DD/YYYY – MM/DD/YYYY	The date range being reported. Dates determined by the values in t_system_parms where nam_program is NCCIRPTW.	23	Character

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Field	Description	Length	Data Type
Report Section 1			
Edit	Procedure-To-Procedure (P2P) Error Status Code	4	Number (Integer)
Count	Total count of claim details that received the P2P Error Status Code during the reporting period.	9	Number (Decimal)
Edit Description	Description of the Procedure-To_Procedure (P2P) Error Status Code.	50	Character
Report Section 2			
Proc	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	40	Character
NCCI Modifier Indicator	The NCCI Modifier Indicator for the Procedure Code pair.	1	Character
Prov Type	Provider Type.	2	Character
Count	Total count of claim details for a Procedure Code pair that received a P2P Error Status Code during the reporting period.	5	Number (Decimal)
Report Section 3			
ICN	Claim Internal Control Number	13	Number (Integer)
DTL	Claim detail number	4	Number (Integer)
PT	Provider Type.	2	Character
Procedure	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	21	Character

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Field	Description	Length	Data Type
M1	First procedure code modifier.	2	Character
M2	Second procedure code modifier.	2	Character
M3	Third procedure code modifier.	2	Character
M4	Fourth procedure code modifier.	2	Character
NCCI Modifier Indicator	The NCCI Modifier Indicator for the Procedure Code pair.	1	Character

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7.48 CLM-4303-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient Claims

7.48.1 CLM-4303-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient Claims - Report Narrative

The CLM NCCI Procedure-To-Procedure (P2P) - Outpatient Claims report is an on-request report. The request to run this report must include 1 to 3 pairs of procedure codes and set of dates to be the reporting period. For each procedure pair, the report will display all claims that received any of the P2P Error Status Codes during the reporting period.

7.48.2 CLM-4303-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient Claims - Report Layout

```
Report  : CLM-4303-O                          ALABAMA MEDICAID AGENCY                                          Run Date: 99/99/9999
Process : CLMJO430                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                  Run Time:   99:99:99
Location: CLMPO430             NCCI PROCEDURE-TO-PROCEDURE (P2P) REPORTING - OUTPATIENT                              Page:          9
                                     REPORTING PERIOD: 99/99/9999 - 99/99/9999

  Procedure-To-Procedure Edit Occurrence - Claim Details

                                                                                                                          NCCI
                    Prov                                                                                                Modifier
      ICN       DTL Type Proc   Procedure Description  M1  M2  M3  M4  Proc   Procedure Description  M1  M2  M3  M4  Indicator

  9999999999999 9999  XX  XXXXX  XXXXXXXXXXXXXXXXXXXXX  XX  XX  XX  XX  XXXXX  XXXXXXXXXXXXXXXXXXXXX  XX  XX  XX  XX      X

  ** End of Procedure-To-Procedure Edit Occurrence - Claim Details **

                                                  ** END OF REPORT **
```

7.48.3 CLM-4303-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting – Outpatient Claims - Report Field Descriptions

Field	Description	Length	Data Type
ICN	Claim Internal Control Number.	13	Number (Integer)
DTL	Claim detail number.	4	Number (Integer)
Prov Type	Provider Type.	2	Character
Proc	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	21	Character
M1	First procedure code modifier.	2	Character
M2	Second procedure code modifier.	2	Character

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Field	Description	Length	Data Type
M3	Third procedure code modifier.	2	Character
M4	Fourth procedure code modifier.	2	Character
NCCI Modifier Indicator	The NCCI Modifier Indicator for the Procedure Code pair.	1	Character

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7.49 CLM-4303-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient

7.49.1 CLM-4303-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient - Report Narrative

The CLM NCCI Procedure-To-Procedure (P2P) - Outpatient report has three sections.

The first section is a list of the total number of Outpatient claims that received each of the P2P Error Status Codes.

The second section is a list of procedure code pairs and a count of claim details for each procedure code. The list includes up to 50 procedure code pairs with the highest number of claim details that received one of the P2P Error Status Codes during the reporting period. The list is in descending order by number of claim details.

The third section is a list of 10 to 20 claim details for each of the top 50 procedure code pairs listed in the second section of the report. The list includes up to 20 claim details if the count for the procedure code pair is greater than 100 and up to 10 claim details otherwise. The list is in the same order as the top 50 procedure code pairs and, within a particular procedure code pair, the claim details are in random order.

This report is run bi-weekly toward the end of the Financial cycle.

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7.49.2 CLM-4303-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient - Report Layout

```
Report  : CLM-4302-W                              ALABAMA MEDICAID AGENCY                                          Run Date: 99/99/9999
Process : CLMJW430                         MEDICAID MANAGEMENT INFORMATION SYSTEM                                  Run Time:   99:99:99
Location: CLMPW430              NCCI PROCEDURE-TO-PROCEDURE (P2P) REPORTING - OUTPATIENT                              Page:          9
                                         REPORTING PERIOD: 99/99/9999 - 99/99/9999

  Edit        Count        Edit Description

  5910     999,999,999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  5911     999,999,999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  5912     999,999,999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  Top 50 Procedure-To-Procedure Edit Count by Procedure Pair and Provider Type

                                                                                                  Modifier  Provider
  Procedure          Procedure Description           Procedure          Procedure Description           Indicator   Type    Count

    XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X        XX    999,999

  ** End of Top 50 Procedure Pairs **

Report  : CLM-4302-W                              ALABAMA MEDICAID AGENCY                                          Run Date: 99/99/9999
Process : CLMJW430                         MEDICAID MANAGEMENT INFORMATION SYSTEM                                  Run Time:   99:99:99
Location: CLMPW430              NCCI PROCEDURE-TO-PROCEDURE (P2P) REPORTING - OUTPATIENT                          Page:          9
                                         REPORTING PERIOD: 99/99/9999 - 99/99/9999

  Procedure-To-Procedure Edit Occurrence - Claim Details
                                                                                                                          NCCI
                     Prov                                                                                              Modifier
       ICN       DTL Type Proc   Procedure Description  M1  M2  M3  M4  Proc   Procedure Description  M1  M2  M3  M4  Indicator

  9999999999999 9999  XX  XXXXX  XXXXXXXXXXXXXXXXXXXXX  XX  XX  XX  XX  XXXXX  XXXXXXXXXXXXXXXXXXXXX  XX  XX  XX  XX      X

  ** End of Procedure-To-Procedure Edit Occurrence - Claim Details **

                                                    ** END OF REPORT **
```


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7.49.3 CLM-4303-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient - Report Field Descriptions

Field	Description	Length	Data Type
Reporting Period MM/DD/YYYY – MM/DD/YYYY	The date range being reported. Dates determined by the values in t_system_parms where nam_program is NCCIRPTW.	23	Character
Report Section 1			
Edit	Procedure-To-Procedure (P2P) Error Status Code.	4	Number (Integer)
Count	Total count of claim details that received the P2P Error Status Code during the reporting period.	9	Number (Decimal)
Edit Description	Description of the Procedure-To_Procedure (P2P) Error Status Code.	50	Character
Report Section 2			
Procedure	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	40	Character
Modifier Indicator	The NCCI Modifier Indicator for the Procedure Code pair.	1	Character
Provider Type	Provider Type.	2	Character
Count	Total count of claim details for a Procedure Code pair that received a P2P Error Status Code during the reporting period.	5	Number (Decimal)
Report Section 3			
ICN	Claim Internal Control Number.	13	Number (Integer)
DTL	Claim detail number.	4	Number (Integer)

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Field	Description	Length	Data Type
PT	Provider Type.	2	Character
Procedure	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	21	Character
M1	First procedure code modifier.	2	Character
M2	Second procedure code modifier.	2	Character
M3	Third procedure code modifier.	2	Character
M4	Fourth procedure code modifier.	2	Character
NCCI Modifier Indicator	The NCCI Modifier Indicator for the Procedure Code pair.	1	Character

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7.50 CLM-4710-Q - NCCI COST SAVINGS REPORTS - MUE - PROFESSIONAL

7.50.1 CLM-4710-Q - NCCI COST SAVINGS REPORTS - MUE - PROFESSIONAL Narrative

Summarizes cost savings attributable to NCCI MUE edits for professional claims.

7.50.2 CLM-4710-Q - NCCI COST SAVINGS REPORTS - MUE - PROFESSIONAL Layout

```
Report  : CLM-4710-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJQ471                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLMPQ471                         NCCI COST SAVINGS REPORT - MUE                                   Page:    999,999
                                    REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY


 Medically Unlikely Edits - Professional

 PROCEDURE             PROCEDURE DESCRIPTION                          COUNT          SAVINGS
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99

            TOTALS FOR MUE - Professional  =================>      9999999    9999999999.99

                                                  ** End of Report **

                                                ** No Data This Report **
```

7.50.3 CLM-4710-Q - NCCI COST SAVINGS REPORTS - MUE - PROFESSIONAL Descriptions

Field	Description	Data Type	Length
COUNT	Number of claims counted for a particular procedure.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
SAVINGS	Amount saved for a particular procedure.	Number (Decimal)	11
TOTALS FOR MUE – Professional (COUNT)	It represents the total claims counted during the report run period.	Number (Integer)	7

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Field	Description	Data Type	Length
TOTALS FOR MUE – Professional (SAVINGS)	It represents the total amount saved during the report run period.	Number (Integer)	13

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7.51 CLM-4720-Q - NCCI COST SAVINGS REPORTS - MUE - INSTITUTIONAL

7.51.1 CLM-4720-Q - NCCI COST SAVINGS REPORTS - MUE - INSTITUTIONAL Narrative

Summarizes cost savings attributable to NCCI MUE edits for institutional claims.

7.51.2 CLM-4720-Q - NCCI COST SAVINGS REPORTS - MUE - INSTITUTIONAL Layout

```
Report  : CLM-4720-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJQ472                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLMPQ472                         NCCI COST SAVINGS REPORT - MUE                                   Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY


 Medically Unlikely Edits - Outpatient

 PROCEDURE             PROCEDURE DESCRIPTION                          COUNT          SAVINGS
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99

            TOTALS FOR MUE - Outpatient    =================>      9999999    9999999999.99

                                                  ** End of Report **

                                                ** No Data This Report **
```

7.51.3 CLM-4720-Q - NCCI COST SAVINGS REPORTS - MUE - INSTITUTIONAL Descriptions

Field	Description	Data Type	Length
COUNT	Number of claims counted for a particular procedure.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
SAVINGS	Amount saved for a particular procedure.	Number (Decimal)	11
TOTALS FOR MUE – Outpatient (COUNT)	It represents the total claims counted during the report run period.	Number (Integer)	7
TOTALS FOR MUE – Outpatient (SAVINGS)	It represents the total amount saved during the report run period.	Number (Integer)	13

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7.52 CLM-4760-Q - NCCI COST SAVINGS REPORTS - P2P - PROFESSIONAL

7.52.1 CLM-4760-Q - NCCI COST SAVINGS REPORTS - P2P - PROFESSIONAL Narrative

Summarizes cost savings attributable to NCCI P2P (procedure-to-procedure) edits for professional claims.

7.52.2 CLM-4760-Q - NCCI COST SAVINGS REPORTS - P2P - PROFESSIONAL Layout

```
Report  : CLM-4760-Q                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : CLMJQ476                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLMPQ476                          NCCI COST SAVINGS REPORT - P2P                                  Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY

 Procedure-to-Procedure Edits - Professional

 PROCEDURE  PROCEDURE DESCRIPTION                     PROCEDURE  PROCEDURE DESCRIPTION                          COUNT         SAVINGS
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99

                                 TOTALS FOR PROCEDURE TO PROCEDURE - Professional  ================>       9999999   9999999999.99

                                                   ** End of Report **

                                                 ** No Data This Report **
```

7.52.3 CLM-4760-Q - Quarterly CCI Professional Cost Saving Report Field Descriptions

Field	Description	Data Type	Length
COUNT	Number of claims counted for a particular procedure.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
SAVINGS	Amount saved for a particular procedure.	Number (Decimal)	11
TOTALS FOR PROCEDURE TO PROCEDURE – Professional (COUNT)	It represents the total claims counted during the report run period.	Number (Integer)	7
TOTALS FOR PROCEDURE TO PROCEDURE – Professional (SAVINGS)	It represents the total amount saved during the report run period.	Number (Integer)	13

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7.53 CLM-4770-Q - NCCI COST SAVINGS REPORTS - P2P - INSTITUTIONAL

7.53.1 CLM-4770-Q - NCCI COST SAVINGS REPORTS - P2P - INSTITUTIONAL Narrative

Summarizes cost savings attributable to NCCI P2P (procedure-to-procedure) edits for institutional claims.

7.53.2 CLM-4770-Q - NCCI COST SAVINGS REPORTS - P2P - INSTITUTIONAL Layout

```
Report  : CLM-4760-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJQ476                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLMPQ476                           NCCI COST SAVINGS REPORT - P2P                                  Page:    999,999
                                      REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY


 Procedure-to-Procedure Edits - Outpatient

 PROCEDURE  PROCEDURE DESCRIPTION                      PROCEDURE PROCEDURE DESCRIPTION                          COUNT         SAVINGS
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99

                                 TOTALS FOR PROCEDURE TO PROCEDURE - Outpatient  ================>       9999999   9999999999.99

                                                   ** End of Report **

                                                 ** No Data This Report **
```

7.53.3 CLM-4770-Q - NCCI COST SAVINGS REPORTS - P2P - INSTITUTIONAL Descriptions

Field	Description	Data Type	Length
COUNT	Number of claims counted for a particular procedure.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
SAVINGS	Amount saved for a particular procedure.	Number (Decimal)	11
TOTALS FOR PROCEDURE TO PROCEDURE – Outpatient (COUNT)	It represents the total claims counted during the report run period.	Number (Integer)	7

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Field	Description	Data Type	Length
TOTALS FOR PROCEDURE TO PROCEDURE – Outpatient (SAVINGS)	It represents the total amount saved during the report run period.	Number (Integer)	13

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7.54 CLM-4810-Q – NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - PRACTITIONER

7.54.1 CLM-4810-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - PRACTITIONER Narrative

Summary of services paid due to NCCI MUE edit deactivation - professional practitioner claims.

7.54.2 CLM-4810-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - PRACTITIONER Layout

```
Report  : CLM-4810-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJQ481                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLMPQ481                       NCCI DEACTIVATED EDITS REPORT - MUE                               Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY

 Deactivated or Overridden - Practitioner - Professional

 PROCEDURE  PROCEDURE                                EFFECTIVE      END      MAX         CLEID        LAST         RECORD
            DESCRIPTION                              DATE           DATE     QUANTITY                 UPDATE       TYPE

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX

 Claims PAID as a result of deactivation or override - Practitioner - Professional

 PROCEDURE  PROCEDURE DESCRIPTION                      COUNTS          AMOUNT PAID

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99

       Totals for Practitioner Professional        :   9999999        9999999999.99
       Totals Providers                            :   9999999

                                                     ** End of Report **
                                                  ** No Data This Report **
```

7.54.3 CLM-4810-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - PRACTITIONER Descriptions

Field	Description	Data Type	Length
AMOUNT PAID	Total amount paid for a particular procedure due to deactivation.	Number (Decimal)	11
CLEID	Correspondence Language Example Identification Number.	Character	12

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Field	Description	Data Type	Length
COUNTS	Number of claims that were paid for a particular procedure due to deactivation.	Number (Integer)	5
EFFECTIVE DATE	Begin date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
END DATE	End date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
LAST UPDATE	The latest date for which the record is updated.	Date (MM/DD/CCYY)	10
MAX QUANTITY	Quantity of units allowed.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
RECORD TYPE	Identifies the record type. BASE – CMS record. OVERRIDE – Override record for the CMS record. AUDIT – The Override records that were deleted during the report period.	Character	8
Totals for Practitioner Professional (AMOUNT PAID)	It represents the whole total amount paid during the report run period due to deactivation.	Number (Decimal)	13
Totals for Practitioner Professional (COUNTS)	It represents the total claims counted during the report run period.	Number (Integer)	7
Totals Providers (COUNTS)	The total number of providers counted during the run period.	Number (Integer)	7

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7.55 CLM-4820-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - DME

7.55.1 CLM-4820-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - DME Narrative

Summarizes cost savings attributable to NCCI P2P (procedure-to-procedure) edits for institutional claims.

7.55.2 CLM-4820-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - DME Layout

```
Report  : CLM-4820-Q                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : CLMJQ482                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLMPQ482                        NCCI DEACTIVATED EDITS REPORT - MUE                              Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY


 Deactivated or Overridden - DME - Professional

 PROCEDURE  PROCEDURE                                EFFECTIVE      END      MAX         CLEID        LAST         RECORD
            DESCRIPTION                              DATE           DATE     QUANTITY                 UPDATE       TYPE
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX

 Claims PAID as a result of deactivation or override - DME - Professional

 PROCEDURE  PROCEDURE DESCRIPTION                      COUNTS          AMOUNT PAID

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99

       Totals for DME Professional                 :   9999999        9999999999.99
       Totals Providers                            :   9999999

                                                     ** End of Report **

                                                   ** No Data This Report **
```

7.55.3 CLM-4820-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - DME Descriptions

Field	Description	Data Type	Length
AMOUNT PAID	Total amount paid for a particular procedure due to deactivation.	Number (Decimal)	11
CLEID	Correspondence Language Example Identification Number.	Character	12

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Field	Description	Data Type	Length
COUNTS	Number of claims that were paid for a particular procedure due to deactivation.	Number (Integer)	5
EFFECTIVE DATE	Begin date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
END DATE	End date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
LAST UPDATE	The latest date for which the record is updated.	Date (MM/DD/CCYY)	10
MAX QUANTITY	Quantity of units allowed.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
RECORD TYPE	Identifies the record type. BASE – CMS record. OVERRIDE – Override record for the CMS record. AUDIT – The Override records that were deleted during the report period.	Character	8
Totals Providers (COUNTS)	The total number of providers counted during the run period.	Number (Integer)	7
Totals for DME Professional (AMOUNT PAID)	It represents the whole total amount paid during the report run period due to deactivation.	Number (Decimal)	13
Totals for DME Professional (COUNTS)	It represents the total claims that were paid for a particular procedure due to deactivation.	Number (Integer)	7

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7.56 CLM-4830-Q - NCCI EDIT DEACTIVATION REPORT - MUE - INSTITUTIONAL

7.56.1 CLM-4830-Q - NCCI EDIT DEACTIVATION REPORT - MUE - INSTITUTIONAL Narrative

Summarizes cost savings attributable to NCCI P2P (procedure-to-procedure) edits for institutional claims.

7.56.2 CLM-4830-Q - NCCI EDIT DEACTIVATION REPORT - MUE - INSTITUTIONAL Layout

```
Report  : CLM-4830-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJQ483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLMPQ483                        NCCI DEACTIVATED EDITS REPORT - MUE                                Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY


 Deactivated or Overridden - Medically Unlikely Edits - Outpatient

 PROCEDURE  PROCEDURE                                EFFECTIVE      END      MAX         CLEID        LAST         RECORD
            DESCRIPTION                              DATE           DATE     QUANTITY                 UPDATE       TYPE

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX

 Claims PAID as a result of deactivation or override - Medically Unlikely Edits - Outpatient

 PROCEDURE  PROCEDURE DESCRIPTION                      COUNTS          AMOUNT PAID

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99

       Totals for Outpatient MUE                  :   9999999        9999999999.99
       Totals Providers                           :   9999999

                                                    ** End of Report **

                                                  ** No Data This Report **
```


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7.56.3 CLM-4830-Q - NCCI EDIT DEACTIVATION REPORT - MUE - INSTITUTIONAL Descriptions

Field	Description	Data Type	Length
AMOUNT PAID	Total amount paid for a particular procedure due to deactivation.	Number (Decimal)	11
CLEID	Correspondence Language Example Identification Number	Character	12
COUNTS	Number of claims that were paid for a particular procedure due to deactivation.	Number (Integer)	5
EFFECTIVE DATE	Begin date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
END DATE	End date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
LAST UPDATE	The latest date for which the record is updated.	Date (MM/DD/CCYY)	10
MAX QUANTITY	Quantity of units allowed.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
RECORD TYPE	Identifies the record type. BASE – CMS record. OVERRIDE – Override record for the CMS record. AUDIT – The Override records that were deleted during the report period.	Character	8
Totals Providers (COUNTS)	The total number of providers counted during the run period.	Number (Integer)	7
Totals for Outpatient MUE (AMOUNT PAID)	It represents the whole total amount paid during the report run period due to deactivation.	Number (Decimal)	13
Totals for Outpatient MUE (COUNTS)	It represents the total claims that were paid for a particular procedure due to deactivation.	Number (Integer)	7

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7.57 CLM-4860-Q - NCCI EDIT DEACTIVATION REPORT - P2P - PROFESSIONAL

7.57.1 CLM-4860-Q - NCCI EDIT DEACTIVATION REPORT - P2P - PROFESSIONAL Narrative

Summarizes cost savings attributable to NCCI P2P (procedure-to-procedure) edits for institutional claims.

7.57.2 CLM-4860-Q - NCCI EDIT DEACTIVATION REPORT - P2P - PROFESSIONAL Layout

```
Report  : CLM-4860-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJQ486                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLMPQ486                        NCCI DEACTIVATED EDITS REPORT - P2P                                Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY

 Deactivated or Overridden - Procedure to Procedure Edits - Practitioner - Professional

 PROC_1 /   GREATER PROCEDURE DESCRIPTION /          EFFECTIVE      END       MOD      CLEID        DATE LAST    RECORD
 PROC_2     LESSER PROCEDURE DESCRIPTION             DATE           DATE      IND                   UPDATE       TYPE

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   X      XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   X      XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   X      XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

 Claims PAID as a result of deactivation or override - Procedure to Procedure Edits - Practitioner - Professional

 PROCEDURE PROCEDURE DESCRIPTION                     PROCEDURE  PROCEDURE DESCRIPTION                      COUNTS    AMOUNT PAID
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999    99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999    99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999    99999999.99

                                                          Totals for Proc to Proc Practitioner :      9999999  9999999999.99
                                                          Totals Providers                     :      9999999

                                                     ** End of Report **

                                                  ** No Data This Report **
```

7.57.3 CLM-4860-Q - NCCI EDIT DEACTIVATION REPORT - P2P - PROFESSIONAL Descriptions

Field	Description	Data Type	Length
AMOUNT PAID	Total amount paid for a particular procedure due to deactivation.	Number (Decimal)	11
CLEID	Correspondence Language Example Identification Number	Character	12

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Field	Description	Data Type	Length
COUNTS	Number of claims that were paid for a particular procedure due to deactivation.	Number (Integer)	5
EFFECTIVE DATE	Begin date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
END DATE	End date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
DATE LAST UPDATE	The latest date for which the record is updated.	Date (MM/DD/CCYY)	10
GREATER PROCEDURE DESCRIPTION	Brief description about the greater procedure code.	Character	40
LESSER PROCEDURE DESCRIPTION	Brief description about the lesser procedure code.	Character	40
MOD IND	Modifier indicator.	Character	1
PROC 1	Greater procedure code.	Character	6
PROC 2	Lesser procedure code.	Character	6
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
RECORD TYPE	Identifies the record type. BASE – CMS record. OVERRIDE – Override record for the CMS record. AUDIT – The Override records that were deleted during the report period.	Character	8
Totals Providers (COUNTS)	The total number of providers counted during the run period.	Number (Integer)	7
Totals for Proc to Proc Practitioner (AMOUNT PAID)	It represents the whole total amount paid during the report run period due to deactivation.	Number (Decimal)	13
Totals for Proc to Proc Practitioner (COUNTS)	It represents the total claims that were paid for a particular procedure due to deactivation.	Number (Integer)	7

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7.58 CLM-4870-Q - NCCI EDIT DEACTIVATION REPORT - P2P - INSTITUTIONAL

7.58.1 CLM-4870-Q - NCCI EDIT DEACTIVATION REPORT - P2P - INSTITUTIONAL Narrative

Summarizes cost savings attributable to NCCI P2P (procedure-to-procedure) edits for institutional claims.

7.58.2 CLM-4870-Q - NCCI EDIT DEACTIVATION REPORT - P2P - INSTITUTIONAL Layout

```
Report  : CLM-4870-Q                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : CLMJQ487                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLMPQ487                        NCCI DEACTIVATED EDITS REPORT - P2P                               Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY

Deactivated or Overridden - Procedure to Procedure Edits - Outpatient

 PROC_1 /   GREATER PROCEDURE DESCRIPTION /          EFFECTIVE      END       MOD      CLEID        DATE LAST    RECORD
 PROC_2     LESSER PROCEDURE DESCRIPTION             DATE           DATE      IND                   UPDATE       TYPE

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   X      XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   X      XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   X      XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

 Claims PAID as a result of deactivation or override - Procedure to Procedure Edits - Outpatient

 PROCEDURE PROCEDURE DESCRIPTION                     PROCEDURE  PROCEDURE DESCRIPTION                      COUNTS    AMOUNT PAID
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999    99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999    99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999    99999999.99

                                                           Totals for Proc to Proc Outpatient   :      9999999  9999999999.99
                                                           Totals Providers                     :      9999999

                                                     ** End of Report **

                                                  ** No Data This Report **
```

7.58.3 CLM-4870-Q – NCCI EDIT DEACTIVATION REPORT - P2P - INSTITUTIONAL Descriptions

Field	Description	Data Type	Length
AMOUNT PAID	Total amount paid for a particular procedure due to deactivation.	Number (Decimal)	11
CLEID	Correspondence Language Example Identification Number.	Character	12

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Field	Description	Data Type	Length
COUNTS	Number of claims that were paid for a particular procedure due to deactivation.	Number (Integer)	5
EFFECTIVE DATE	Begin date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
END DATE	End date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
DATE LAST UPDATE	The latest date for which the record is updated.	Date (MM/DD/CCYY)	10
GREATER PROCEDURE DESCRIPTION	Brief description about the greater procedure code.	Character	40
LESSER PROCEDURE DESCRIPTION	Brief description about the lesser procedure code.	Character	40
MOD IND	Modifier indicator.	Character	1
PROC 1	Greater procedure code.	Character	6
PROC 2	Lesser procedure code.	Character	6
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
RECORD TYPE	Identifies the record type. BASE – CMS record. OVERRIDE – Override record for the CMS record. AUDIT – The Override records that were deleted during the report period.	Character	8
Totals Providers (COUNTS)	The total number of providers counted during the run period.	Number (Integer)	7
Totals for Proc to Proc Outpatient (AMOUNT PAID)	It represents the whole total amount paid during the report run period due to deactivation.	Number (Decimal)	13
Totals for Proc to Proc Outpatient (COUNTS)	It represents the total claims that were paid for a particular procedure due to deactivation.	Number (Integer)	7

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