# AMMIS SUR User Manual

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# 1 Document control

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## 1.1 Document Information Page

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|---|---|
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| Author: | SUR Team |
| Approved by: | |
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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 |
|---|---|---|---|---|
| 01/28/2008 | 1.0 | | Initial Version | |
| 10/08/2013 | 2.0 | | Application of ICD-10 project change orders and bring up-to-date all reports affected by ICD-10 | CO 10209<br>Update section 2.4.2 Random Sample 2 – Request Filters Tab – Add ICD Version Code list<br>Update the following sections to reflect the change from ICD-9 to ICD per COs 10227, 10228 and bring up-to-date per CO 10039: 3.2.1, 3.5.4, 3.5.5, 3.5.8, 3.5.9, 3.5.22, 3.5.23, 3.5.34, 3.5.35, 3.5.60, 3.5.61, 3.5.74, 3.5.75, 3.5.84, 3.5.85, 3.5.93, 3.5.97, 3.5.100, 3.5.108, 3.5.112 |


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| Date | Document Version | Author | Reason for the Change | Changes (Section, Page(s) and Text Revised |
|---|---|---|---|---|
| | | | | **CO 10210**<br>Update section 2.4.5 Random Sample – 5 – Claim Detail window layout |
| 03/26/2014 | 2.1 | | Update report captures to reflect latest version of ETG (8.0) | **CO 11772**<br>Sections 3.5.93 thru 3.5.102 |
| 05/14/2014 | 2.2 | | Add missing ETG Description report and correct the verbiage for ETG Number and Description fields. | **CO 10039**<br>New section 3.5.93 and previous sections 3.5.93 thru 3.5.102 incremented by one and ETG Number/Description verbiage corrected in these sections |
| 04/27/2016 | 3.0 | | General Update to change HPES to HPE- updated cover page and footers | |
| 09/27/2016 | 4.0 | | Application of RCO project change orders. | **CO 13223**<br>Sections 3.5.8, 3.5.9, 3.5.10, 3.5.11, 3.5.24, 3.5.25, 3.5.26, 3.5.27, 3.5.38, 3.5.39, 3.5.40, 3.5.41, 3.5.66, 3.5.67, 3.5.68, 3.5.69, 3.5.82, 3.5.83, 3.5.84, 3.5.85, 3.5.94, 3.5.95, 3.5.96, 3.5.97, 3.5.136-3.5.143, 3.5.145<br>**CO 13228**<br>Sections 2.4.2, 2.4.3, 2.4.5<br>**CO 13234**<br>Sections 3.2.2, 3.5.106-3.5.135<br>Also updated screenshots of initial screens and directions for initial navigation. |
| 01/25/2017 | 5.0 | | Application of RCO FQHC project change orders. | **CO 13693**<br>Updated report images and field descriptions in |


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| Date | Document Version | Author | Reason for the Change | Changes (Section, Page(s) and Text Revised |
|---|---|---|---|---|
| | | | Note: Changes were put into production and are available in SUR, but will not be applicable until the RCO Go Live Date of 10/01/2017 | Sections 3.5.66, 3.5.67, 3.5.82, 3.5.83<br>Updated report search criteria in Sections 3.5.136, 3.5.137, 3.5.139, 3.5.140, 3.5.142<br>Updated report image and field description in Sections 3.5.141<br>**CO 13694**<br>Updated report images and field descriptions in Sections 3.5.106, 3.5.118, 3.5.127<br>**CO 13696**<br>Update panel images for Random Sample in sections 2.4.2 and 2.4.3 |
| 04/18/2017 | 6.0 | | Application of CO 13788 | **CO 13788**<br>3.5.143 TG- Inpatient – Related Readmissions- updated report layout and field descriptions. |
| 12/19/2017 | | | Application of CO 14455 | **CO 14455**<br>Update SUR UM by removing all 'RCO' related reports and updating screenshots for any panel that was modified to remove the RCO label. |
| 4/6/2018 | 7.0 | | Updated document to remove images with PHI. | **CO 14849**<br>Review the Alabama Medicaid Surveillance and Utilization Review (SUR) Case Tracking Manual and Alabama Medicaid Surveillance and Utilization Review (SUR) User Manual documents for PHI and PII information. Redact any PHI/ PII information found these documents and then upload them back into iTrace |


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## 1.3 Related documentation

| Document | Description | url |
|---|---|---|
| | | |
| | | |
| | | |


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# 1. Introduction to SUR

The Surveillance and Utilization Review (SUR) subsystem provides the capability to identify potential fraud and/or abuse candidates. The modular design of the solution enables detection components to accept data directly from the interChange DSS. The SUR Components are:

- Episode Treatment Grouper (ETG);
- Random Sample Generator; and
- DSSProfiler.

These components are accessed through the DSSNavigator. The Data Warehouse is populated with data from interChange, which allows the Data Warehouse to source data to the Random Sample application, Targeted Queries and the DSSProfiler process. Having everything contained within the Data Warehouse helps to ensure that all of the data used to identify a suspect list comes from the same source and speeds verification.

## 1.1 Episode Treatment Grouper (ETG)

The Episode Treatment Grouper (ETG) integrated in the SUR subsystem allows for measuring the effect of health care services on cost and quality. The ETG solution does this by identifying episodes of care, which encompass all health care services provided to an individual patient during a single illness. An episode of care is defined as all clinically related services for a single illness and a discrete diagnostic condition from the onset of symptoms until treatment is complete. Episodes of care provide a clinically meaningful unit of measuring both the cost and quality of patient care.

## 1.2 Random Sample Generator

The Data Warehouse also provides the ability to generate summary reports from a statistically valid random sampling process. The random sample process is initiated and accessed through browser-based windows from the Data Warehouse web site.

Through this web site, users can specify if they want to sample claims for providers or recipients, and they can specify the date ranges and other filter conditions such as specific claim types or code values. The results from the sample are stored in the Data Warehouse where the results can be reported on summary web screens or from reports generated through the Data Warehouse.


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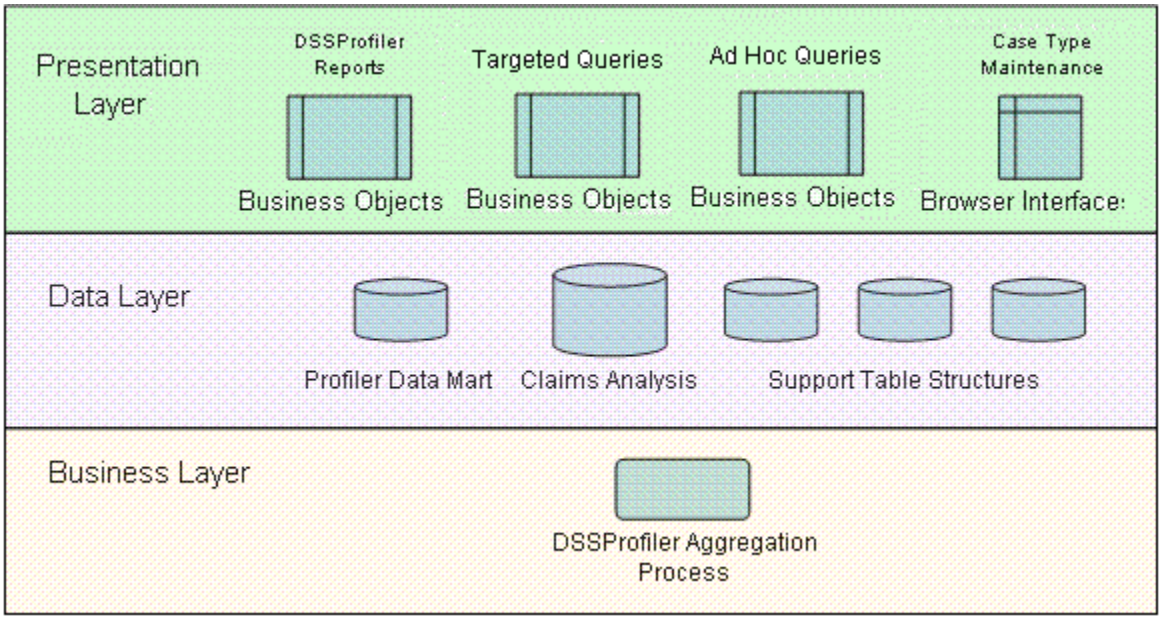
## 1.3 DSSProfiler

The DSSProfiler is made up of three layers: presentation, data and business. These layers interface with each other to provide the tools and data necessary for fraud and abuse monitoring.




### 1.3.1 Presentation Layer

The presentation layer is comprised of Business Objects and a Browser Interface.

Business Objects is the main tool used to run and review DSSProfiler reports. This tool allows the user to define many of the parameters used to create a report with the requested data. The data presented is based on the aggregation totals run during the previous quarterly process.

The Business Objects tool is also used to run targeted and ad hoc queries. Targeted queries are established reports where the user may re-fresh data when needed. Ad hoc queries allows the user to develop a query as needed.

The Browser Interface allows the user access to the Case Type Maintenance windows. Case Types can be added, deleted and updated through the Case Type Maintenance windows.

### 1.3.2 Data Layer

The data layer is comprised of the DSSProfiler Data Mart, Claims Analysis, and Support Table Structures.

The DSSProfiler Data Mart contains all the aggregations produced by the quarterly run of the DSSProfiler. Summaries of each Case Type within each Peer Group, Report Category (Claim Types) and Aggregation Type (Type of claim – Fee for Service (FFS), Encounter or both) are included within the tables of the data mart. By storing the aggregates at these levels, the user can run many reports looking at data in many different ways.

The Claims Analysis Data Mart is utilized to gather the claims information for the DSSProfiler to aggregate in the quarterly process.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The Support Table Structures provide extra data for reports and queries. This data includes provider and recipient demographic data, descriptions and other data not normally found on specific claims tables.

### 1.3.3 Business Layer

The Business Layer is comprised of the DSSProfiler Aggregation Process.

The DSSProfiler aggregation process runs once a quarter. This process summarizes data based on claims from the previous 12 months. The aggregations are created by processing each claim against the user defined Case Types and accumulating data as necessary. The aggregations are then saved in the DSSProfiler Data Mart.


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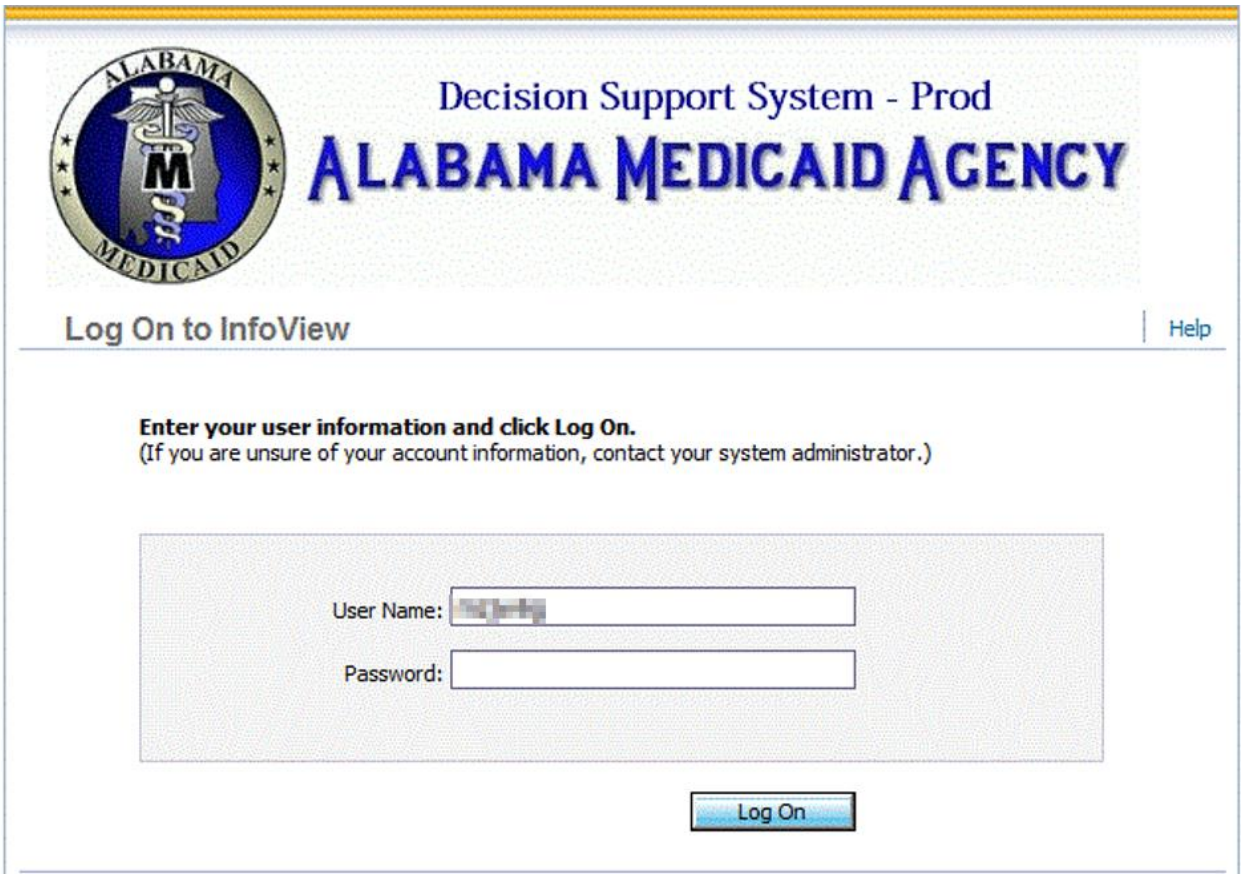
# 2. Internal Web Pages

## 2.1 Accessing the SUR DSSProfiler Application

Log on to the InfoView DSSNavigator.




A Welcome window is displayed.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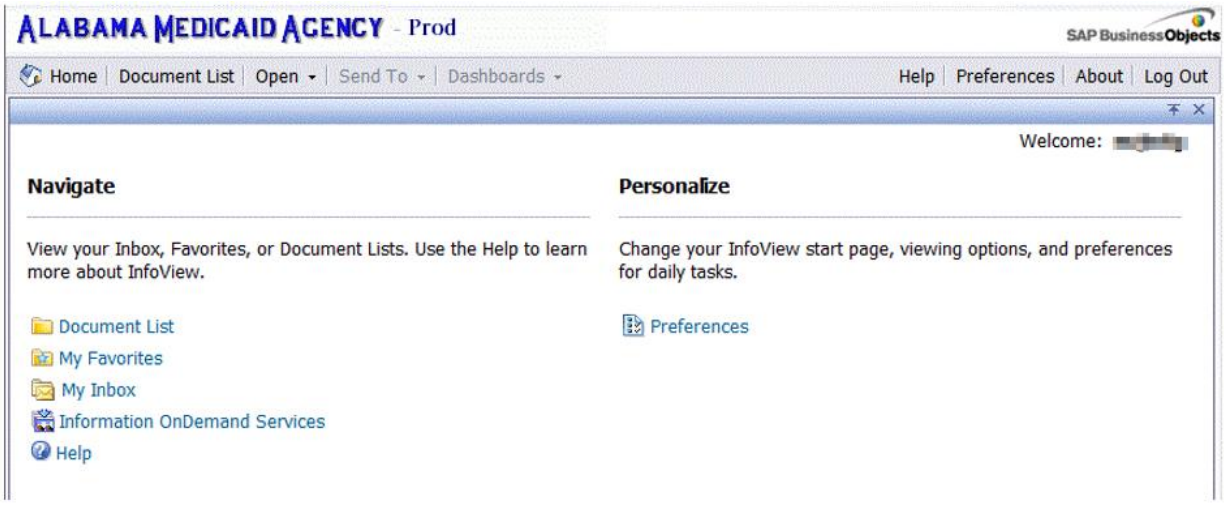
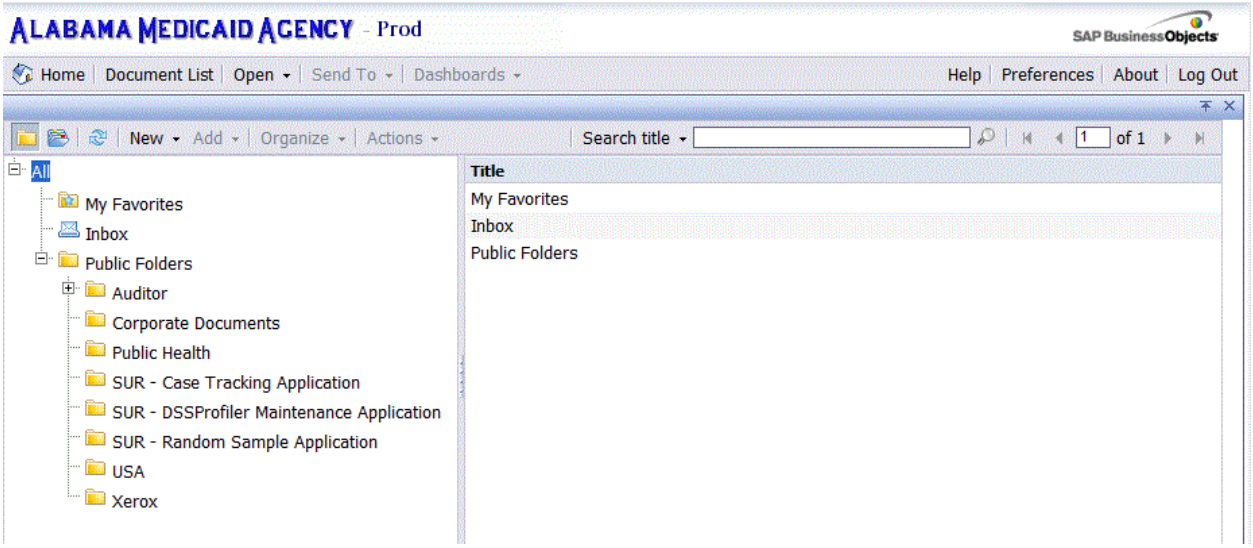



Click on “Document List” and then expand “Public Folders” and a list of applications is displayed as unopened folders.




Click on one of the folders to start an application, in this case the “SUR – DSSProfiler Maintenance Application”.

### 2.1.1 Case Category Maintenance

From the Document List window select the hyperlink for “Case Type Maintenance”; then select the Case Category Maintenance tab at the top. A case category is used to group or create subsets for case types and case groups within a report category. Use the Case Category Maintenance window to view, add or delete Case Categories.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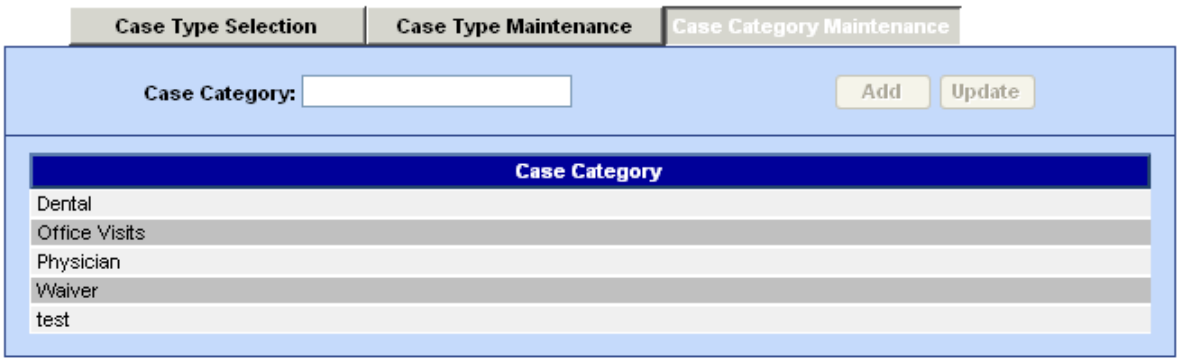
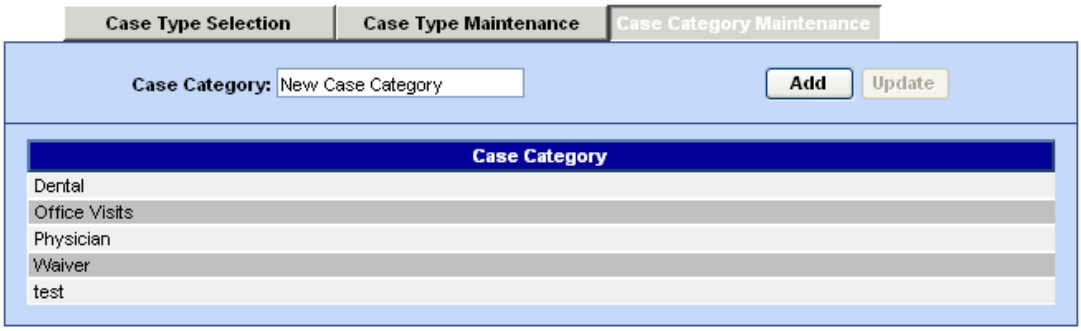


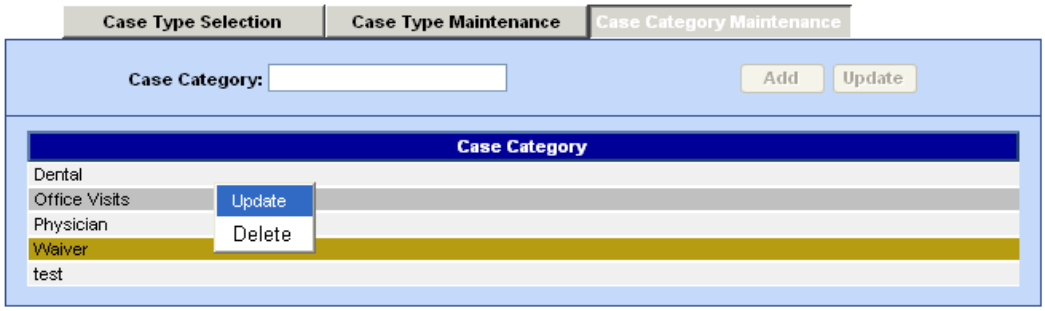

### 2.1.1.1 To Add a New Case Category

Place the cursor in the Case Category field and enter the name. After the first position of the name is entered, the Add button is activated. Select the **Add** button to create a new Case Category. A window displays stating the Case Category was added successfully, select **OK**. The new Case Category is added to the list.




### 2.1.1.2 To Update a Case Category

To make an update to an existing Case Category, highlight the Case Category and right click the mouse; then select **Update**.




The Case Category Maintenance window is re-displayed with the Update button available. The user may update the Case Category name and select **Update**. A window displays stating the Case Category was updated successfully, select **OK**.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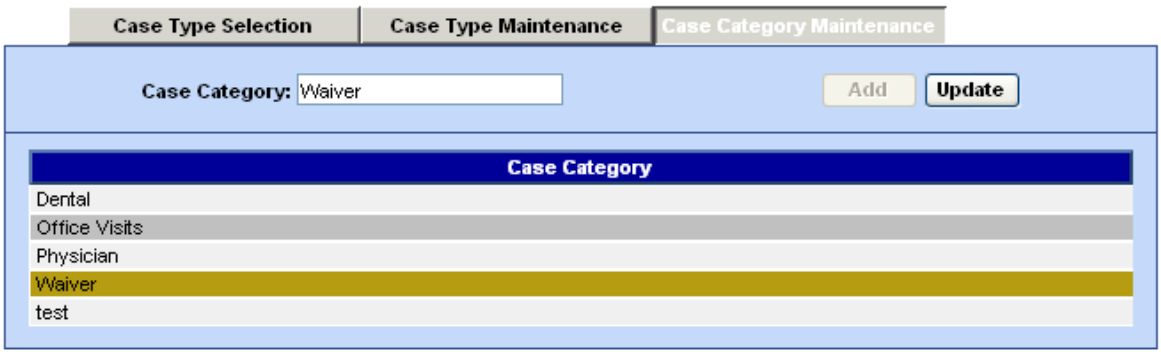
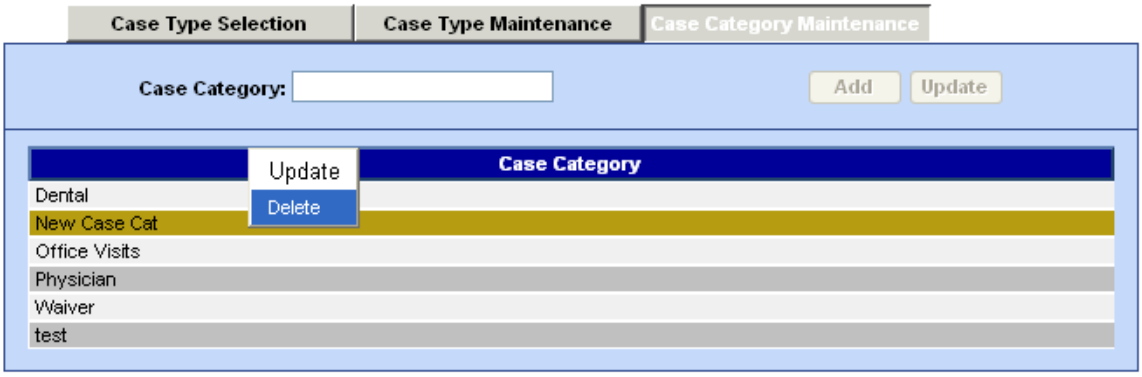



### 2.1.1.3 To Delete a Case Category

To delete an existing Case Category, highlight the Case Category and right click the mouse; then select **Delete**. A window displays to ensure you wish to delete the Case Category, select **OK**. The Case Category is deleted and removed from the list.





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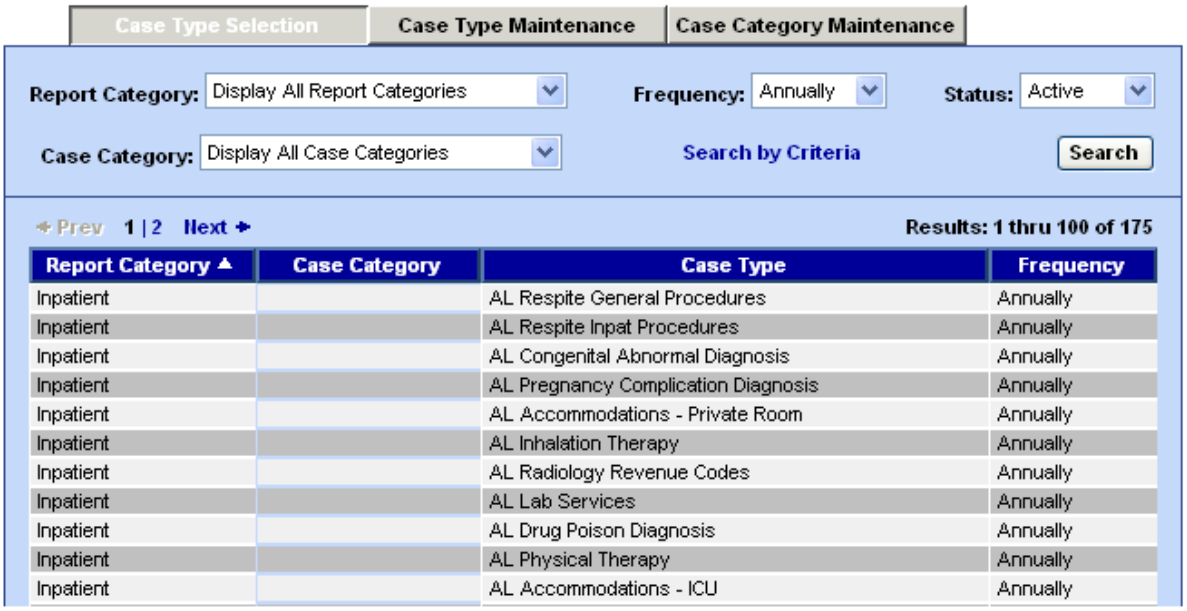
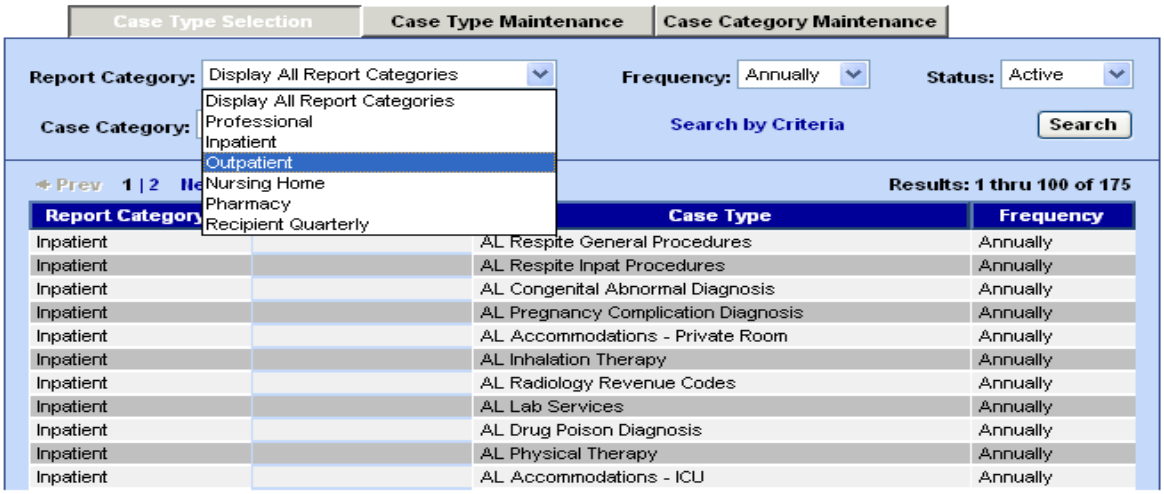
### 2.1.2 Case Type Maintenance

From the Document List window select the hyperlink for “Case Type Maintenance”. A case type is defined as data criteria used to group claims into different buckets that is used in evaluating peer groups and by the case group logic. Use the Case Type Selection window to view all Case Types or selected Case Types displayed as the result of a search. The Case Type Maintenance window allows the user to enter criteria for new Case Types or update existing ones.




#### 2.1.2.1 To Search for an Existing Case Type

Use the drop down boxes for Report Category, Frequency, Status and Case Category to narrow the search criteria. Click the Search button. The Case Types meeting the search criteria are displayed. To change the sort order, click on the column for the desired sort. The triangle pointed down represents descending order and the triangle pointed up means ascending order.





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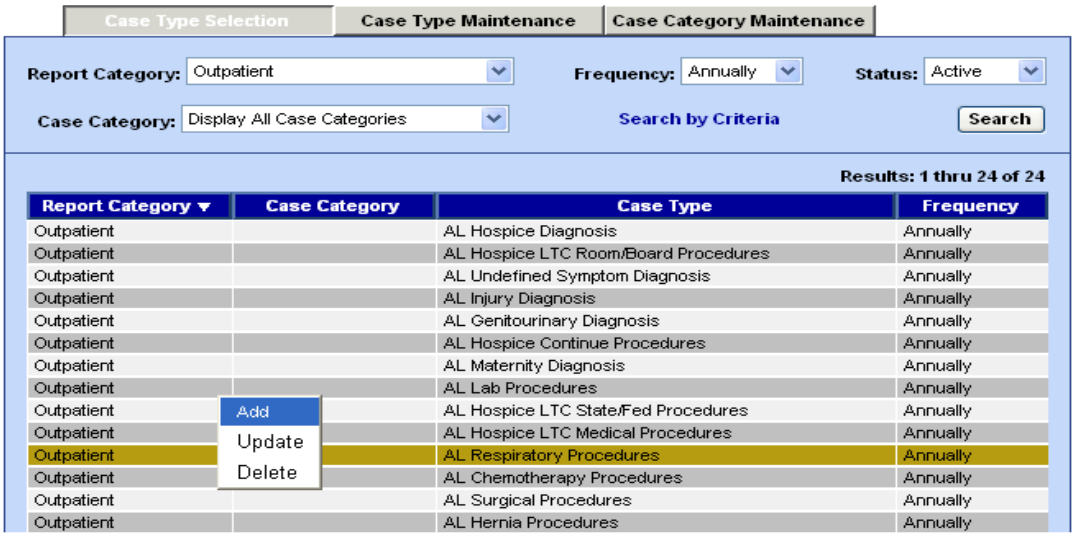
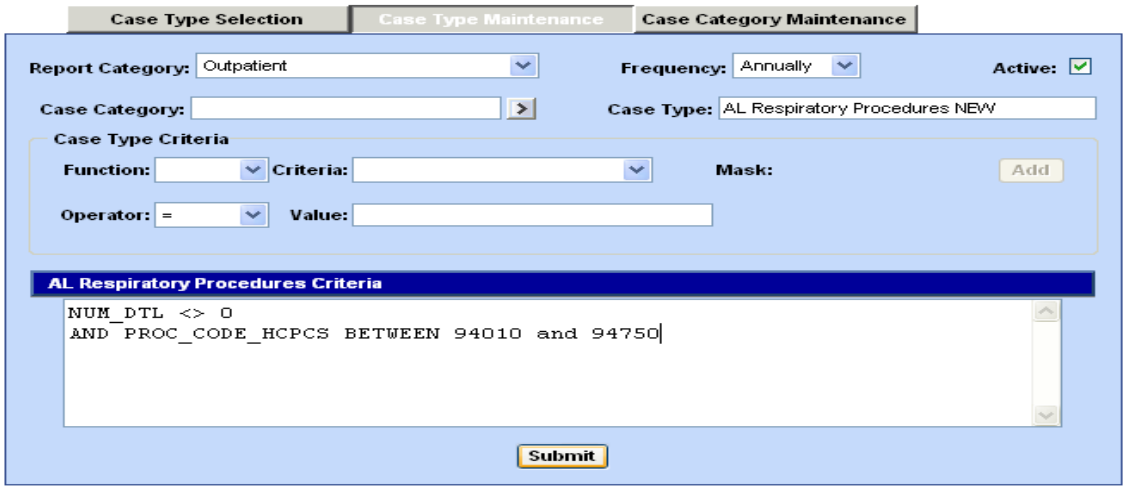
### 2.1.2.2 To Add a New Case Type

Highlight any Case Type, right click the mouse and select **Add**. To copy an existing Case Type in order to create a new one, locate and highlight the Case type. The Case Type Maintenance window is displayed.




The original Case Type selected on the Selection window is displayed, use the drop down boxes for Report Category, Frequency and Case Category to establish the correct criteria for the new Case Type. Change the Case Type name to represent the new one. The user must enter a new name and it must contain the prefix “AL – “. Use the Case Type Criteria items in the middle of the window to identify the criteria for the new Case Type. After the Case Type Criteria selections are made, select the Add button. The criteria will now be added to the white criteria box at the bottom.

Another way to make an update is to place the cursor in the white criteria box at the bottom and type the correct conditions. NOTE: Specific field names must be used as these are database names. Select the Submit button to create the new Case Type. A message window displays to let the user know the Case Type was added.





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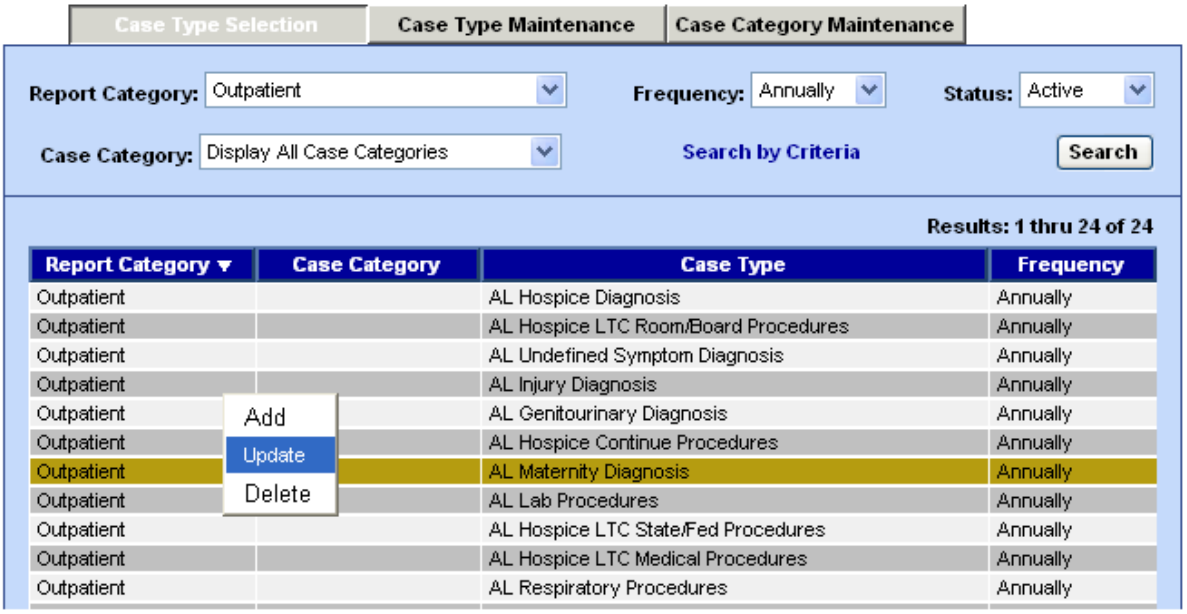
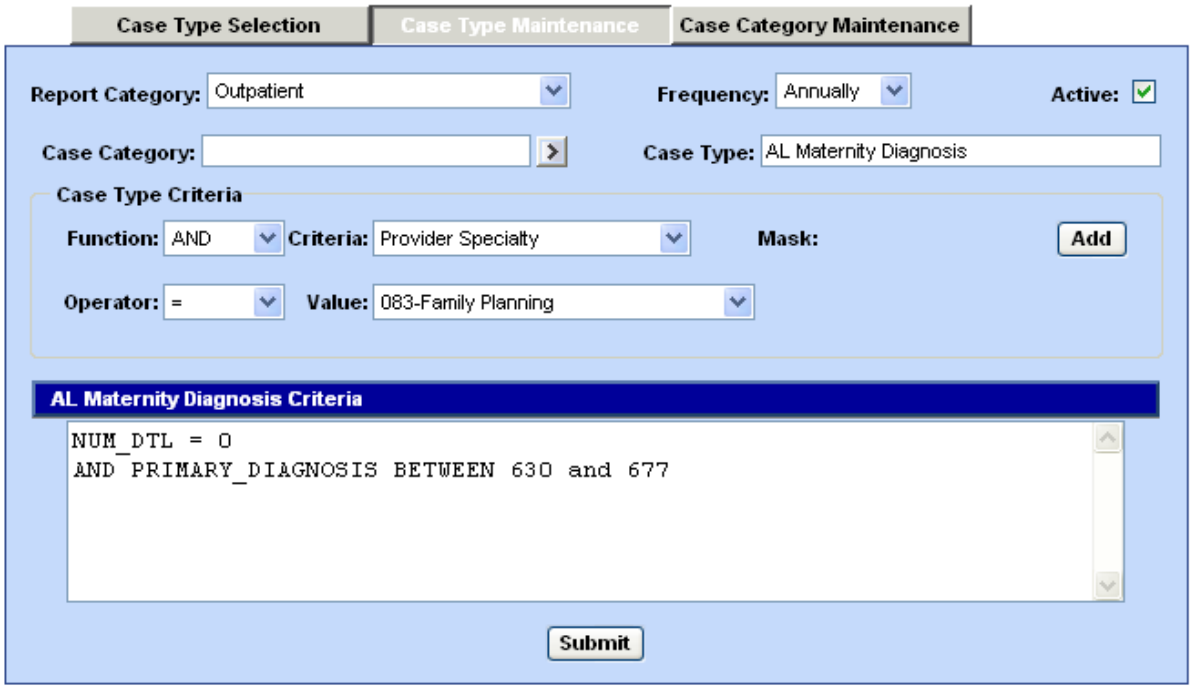
### 2.1.2.3 To Update a Case Type

Highlight the Case Type shown on the Case Type Selection tab, right click the mouse and select Update. Another way to select a Case Type for Update is double click on the Case Type. The criteria for the Case Type is displayed on the Case Type Maintenance window.




Use the drop down boxes for Report Category, Frequency and Case Category to update criteria for the Case Type.





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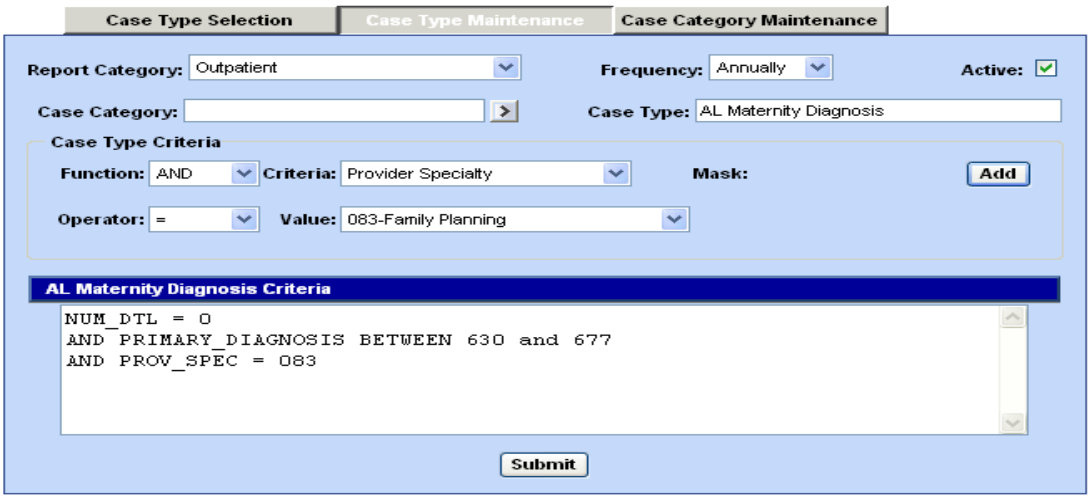
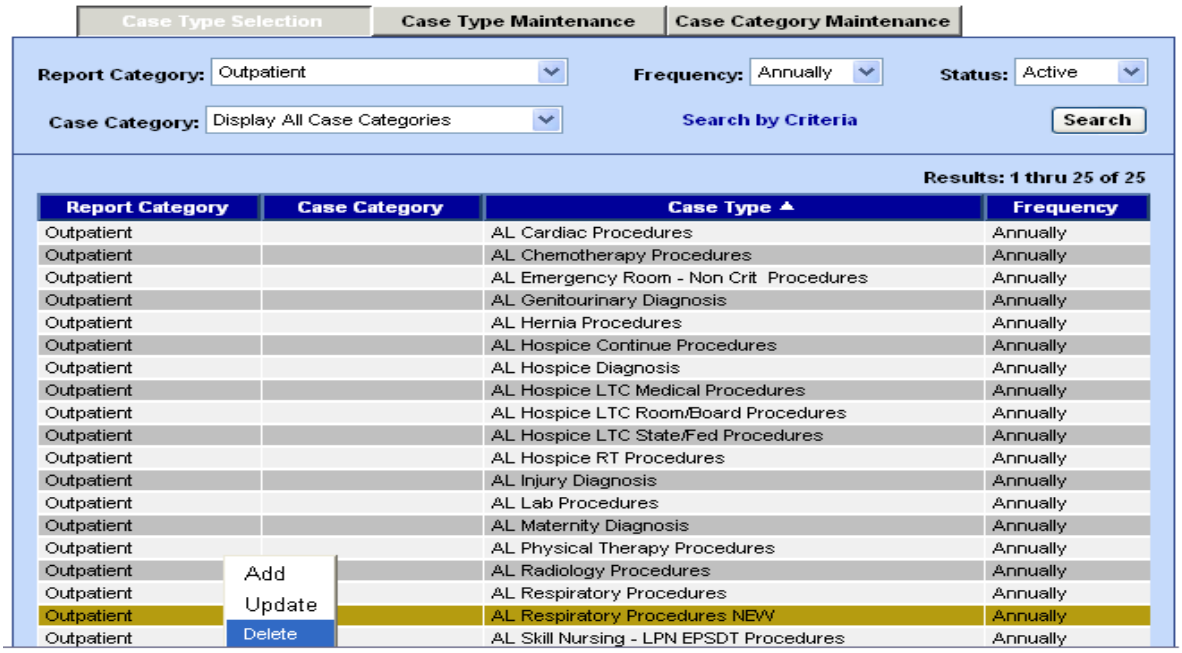
Use the Case Type Criteria items in the middle of the window to identify additional criteria. After the Case Type Criteria selections are made, select the Add button. The criteria will now be added to the white criteria box at the bottom. Another way to make an update is to place the cursor in the white criteria box at the bottom and type the correct conditions. NOTE: Specific field names must be used as these are database names. To remove existing conditions, highlight the condition and select the keyboard delete button. When all changes have been made select the Submit button. A message window displays to let the user know the Case Type was updated.




### 2.1.2.4 To Delete a Case Type

Highlight the Case Type shown on the Case Type Selection tab, right click the mouse and select **Delete**. A message window displays to ensure the Case Type selected is to be deleted, select **OK**. Another message window displays to let the user know the Case Type was deleted.





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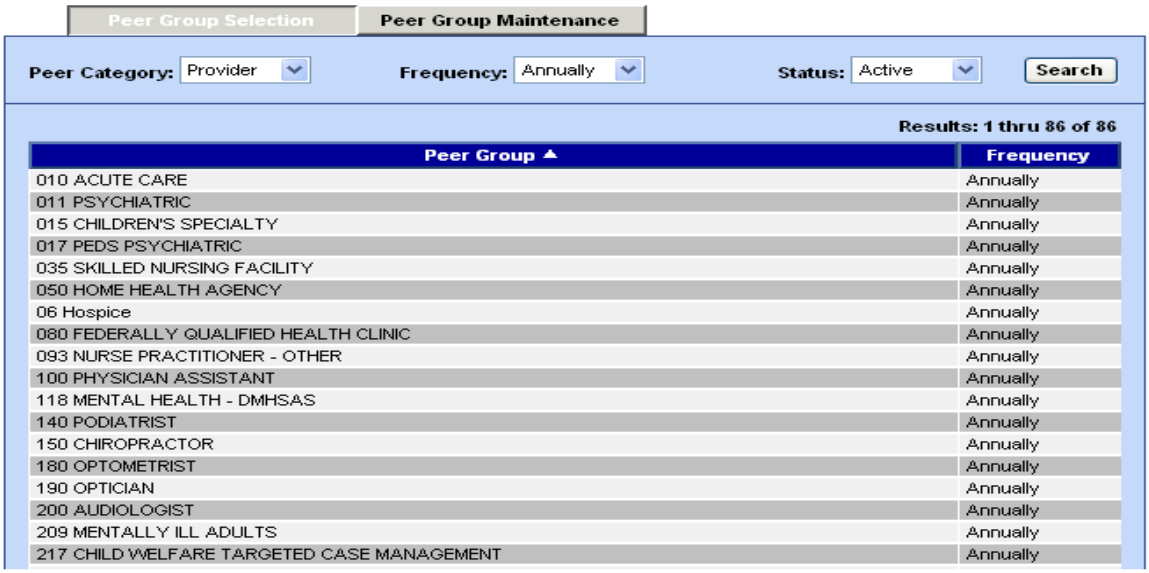
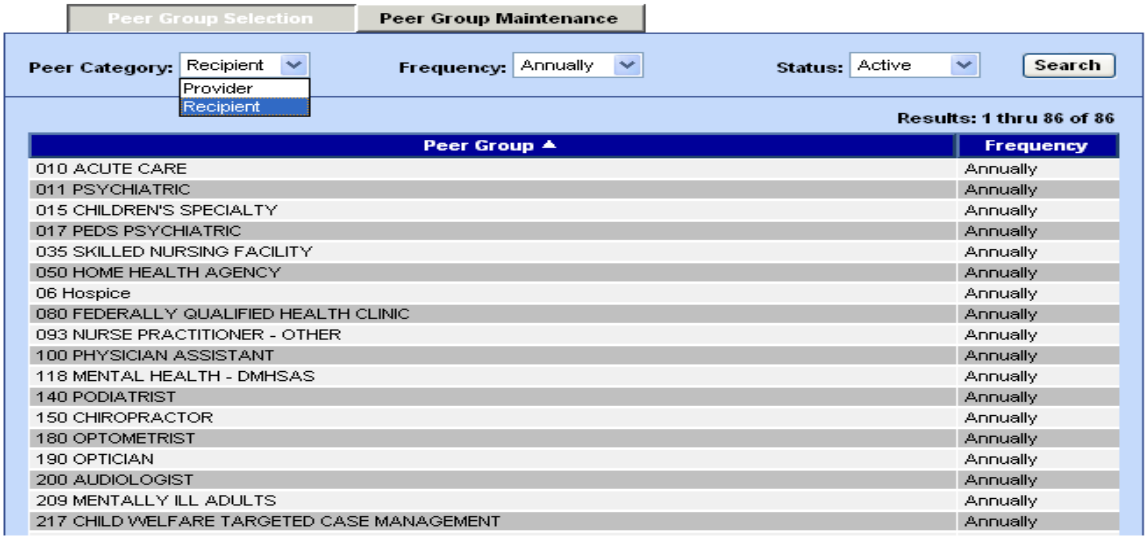
### 2.1.3 Peer Group Maintenance

From the Document List window select the hyperlink for “Peer Group Maintenance”. Peer group is defined as a grouping of providers or recipients that have similar characteristics, ( i.e. provider type or county code). Use the Peer Group Selection window to view all Peer Groups or selected Peer Groups displayed as the result of a search. The Peer Group Maintenance window allows the user to enter criteria for new Peer Groups or make updates to existing ones.




#### 2.1.3.1 To Search for an Existing Peer Group

Use the drop down boxes for Peer Category, Frequency and Status to narrow the search criteria. Click the Search button. The Peer Groups meeting the search criteria are displayed. To change the sort order, click on the column for the desired sort. The triangle pointed down represents descending order and the triangle pointed up represents ascending order.





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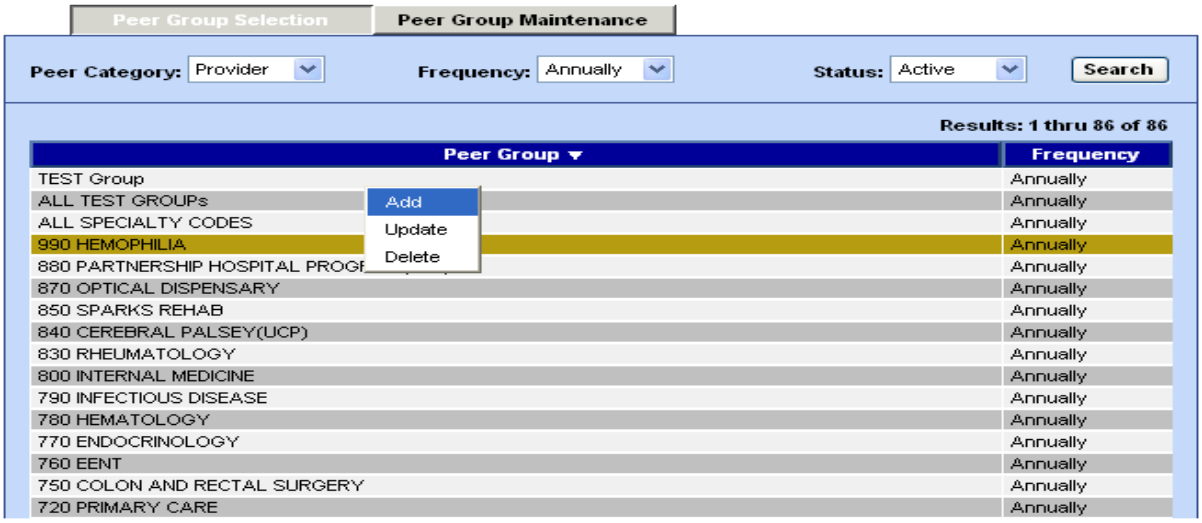
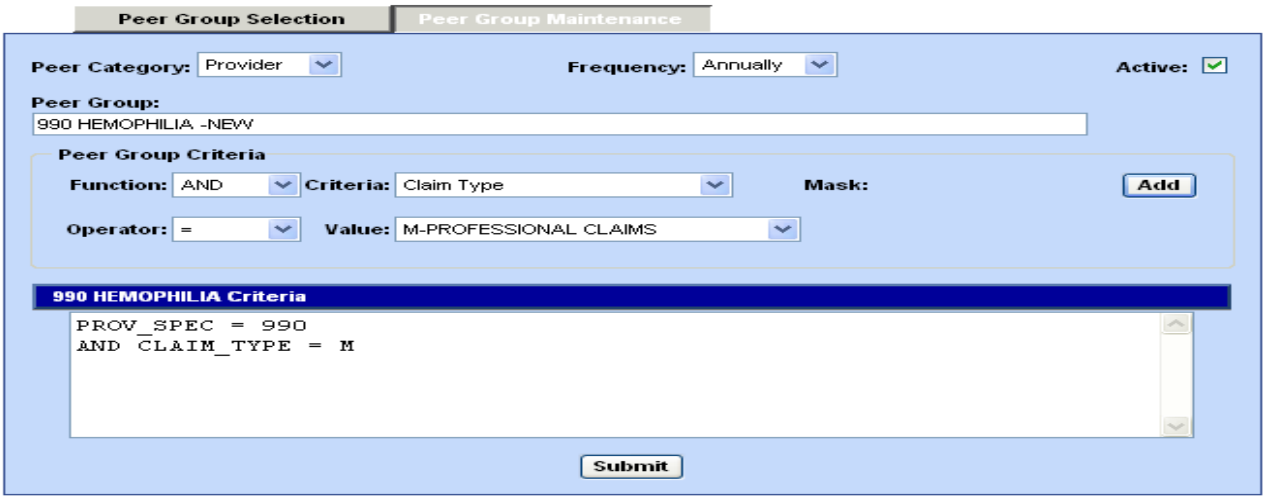
### 2.1.3.2 To Add a new Peer Group

Highlight any Peer Group, right click the mouse and select Add. To copy an existing Peer Group in order to create a new one, locate and highlight the Peer Group. The Peer Group Maintenance window is displayed.




The original Peer Group selected on the Selection window is displayed, use the drop down boxes for Peer Category, Frequency and Status to establish the correct criteria for the new Peer Group. Change the Peer Group name to represent the new one. You must change the name in order for a new Peer Group to be created. Use the Peer Group Criteria items in the middle of the window to identify the criteria for the new Peer Group. After the Peer Group Criteria selections are made, select the Add button. The criteria will now be added to the white criteria box at the bottom. Another way to make an update is to place the cursor in the white criteria box at the bottom and type the correct conditions. NOTE: Specific field names must be used as these are database names. Select the Submit button to create the new Peer Group. A message window displays to let the user know the Peer Group was added.





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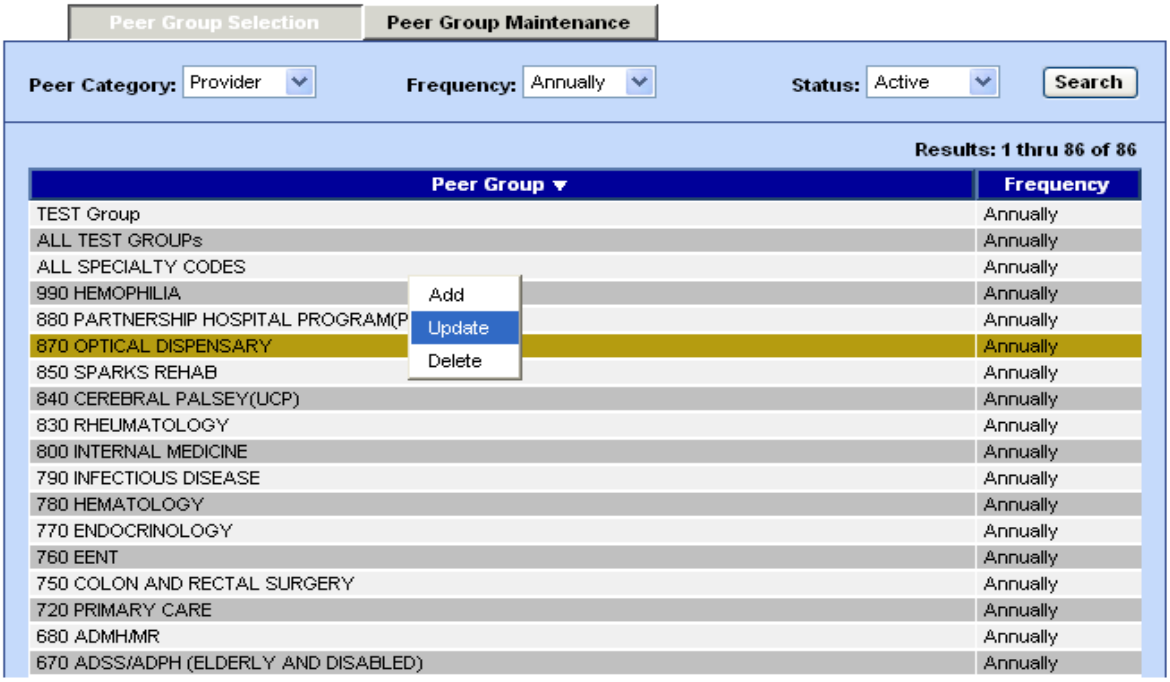
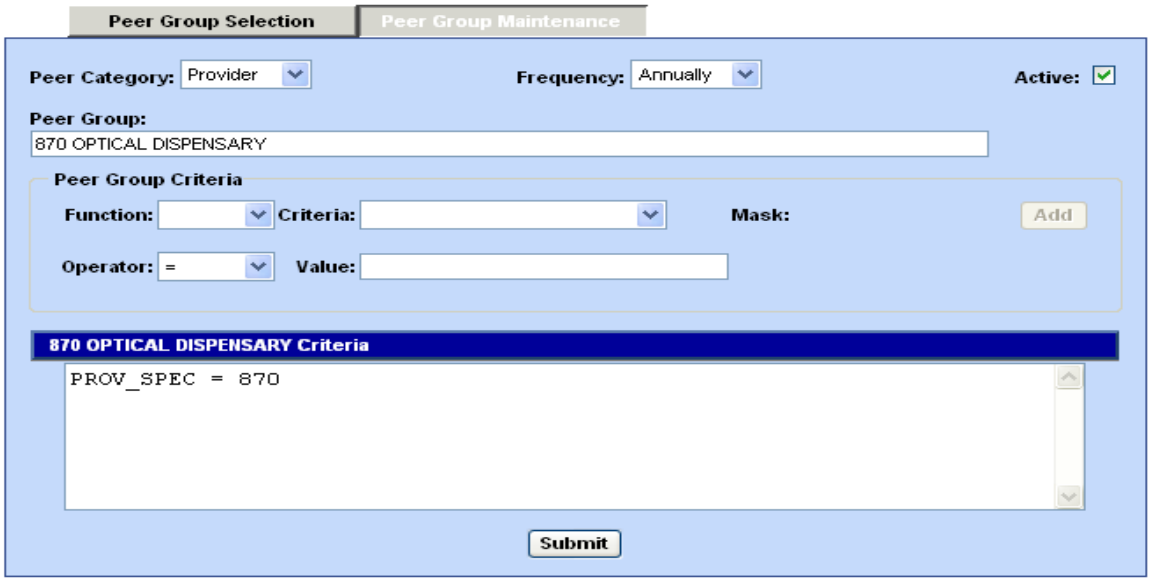
### 2.1.3.3 To Update a Peer Group

Highlight the Peer Group shown on the Peer Group Selection tab, right click the mouse and select Update. Another way to select a Peer Group for Update is double click on the Peer Group. The criteria for the Peer Group is displayed on the Peer Group Maintenance window.




Use the drop down boxes for Peer Category and Frequency to update criteria for the Peer Group.





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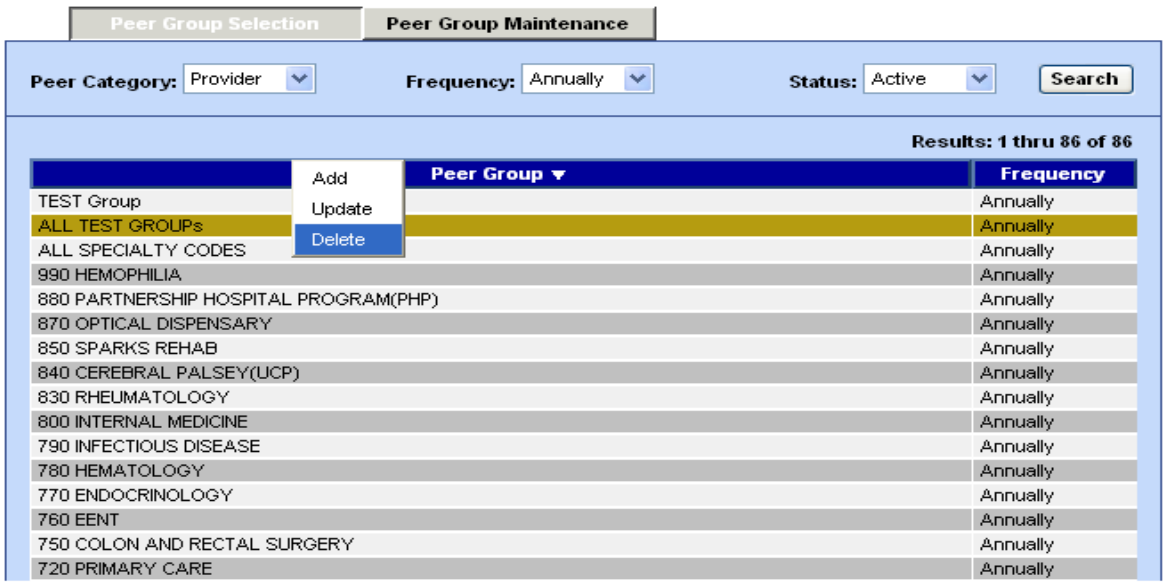
Use the Peer Group Criteria items in the middle of the window to identify additional criteria. After the Peer Group Criteria selections are made, select the Add button. The criteria will now be added to the white criteria box at the bottom. Another way to make an update is to place the cursor in the white criteria box at the bottom and type the correct conditions. NOTE: Specific field names must be used as these are database names. To remove existing conditions, highlight the condition and select the keyboard delete button. When all changes have been made select the Submit button. A message window displays to let the user know the Peer Group was updated.

### 2.1.3.4 To Delete a Peer Group

Highlight the Peer Group shown on the Peer Group Selection tab, right click the mouse and select Delete. A message window displays to ensure the Peer Group selected is to be deleted, select OK. Another message window displays to let the user know the Peer Group was deleted.





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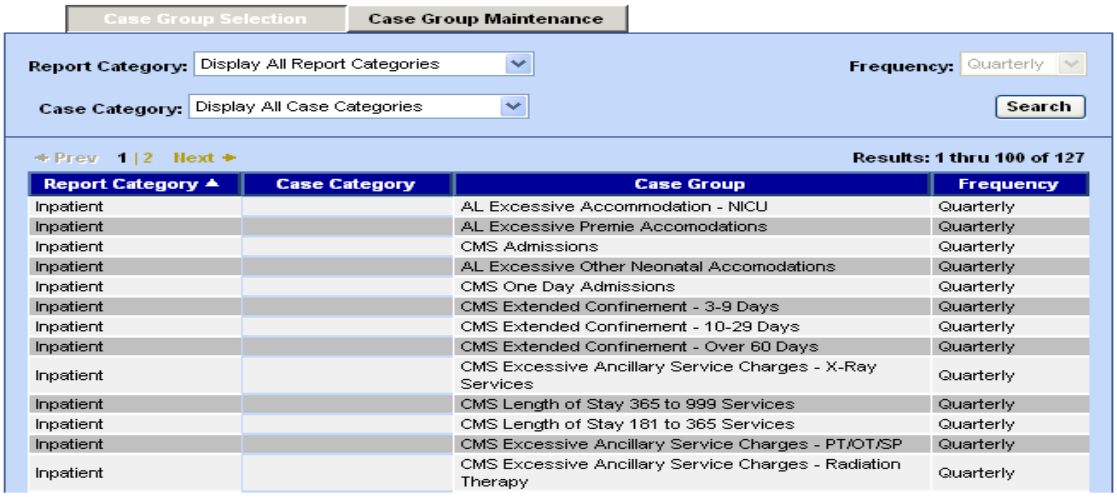
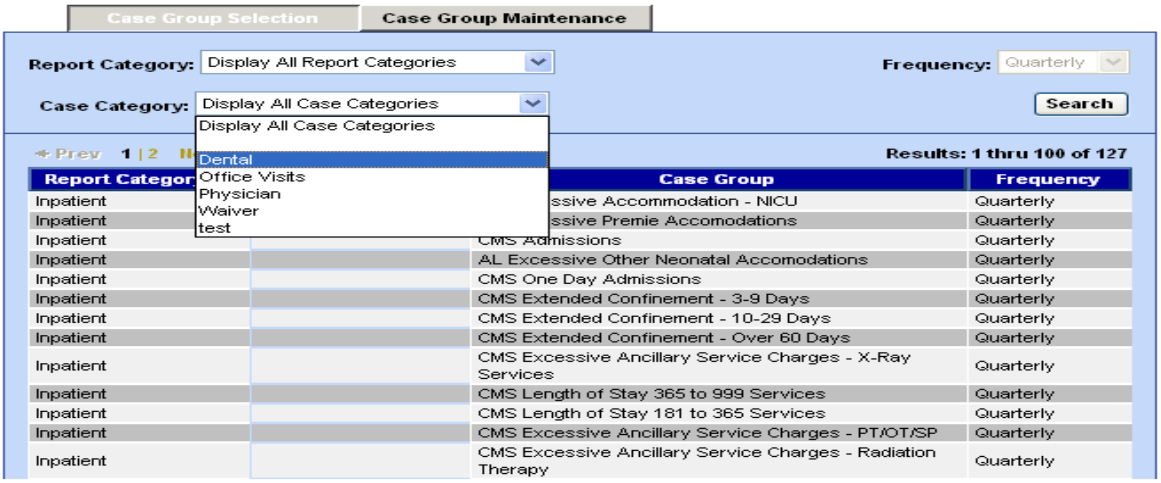
### 2.1.4 Case Group Maintenance

From the Document List window select the hyperlink for “Case Group Maintenance”. Case group is defined as a collection of case types used to define exception criteria for DSSProfiler reporting. Use the Case Group Selection window to view all Case Groups or selected Case Groups displayed as the result of a search. The Case Group Maintenance window allows the user to enter criteria for new Case Groups or make updates to existing ones. All Case Groups are associated with the quarterly Frequency so the Frequency selection is not available with Case Group Maintenance windows.




#### 2.1.4.1 To Search for an Existing Case Group

Use the drop down boxes for Report Category, and Case Category to narrow the search criteria. Click the **Search** button. The Case Groups meeting the search criteria are displayed. To change the sort order, click on the column for the desired sort. The triangle pointed down represents descending order and the triangle pointed up represents ascending order.




#### 2.1.4.2 To Add a New Case Group

Highlight any Case Group, right click the mouse and select **Add**. The Case Group Maintenance window is displayed.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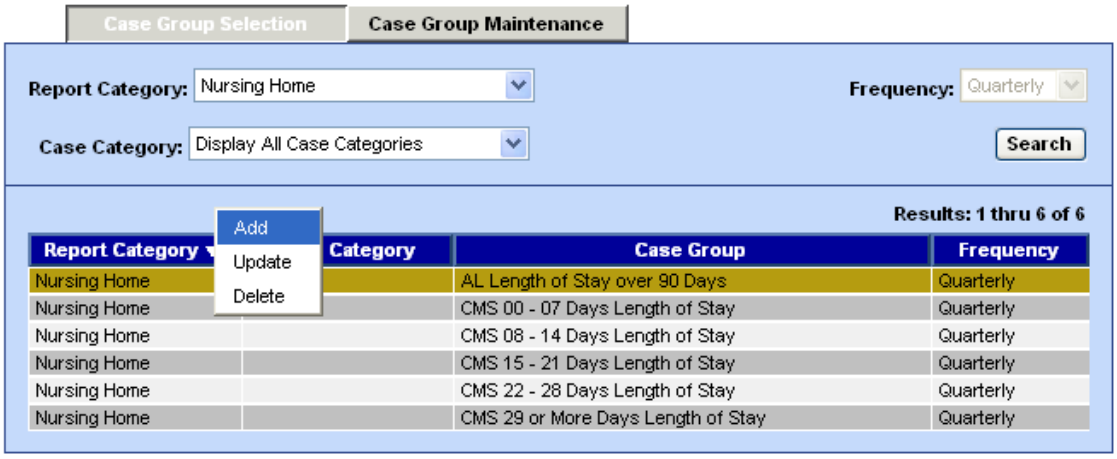
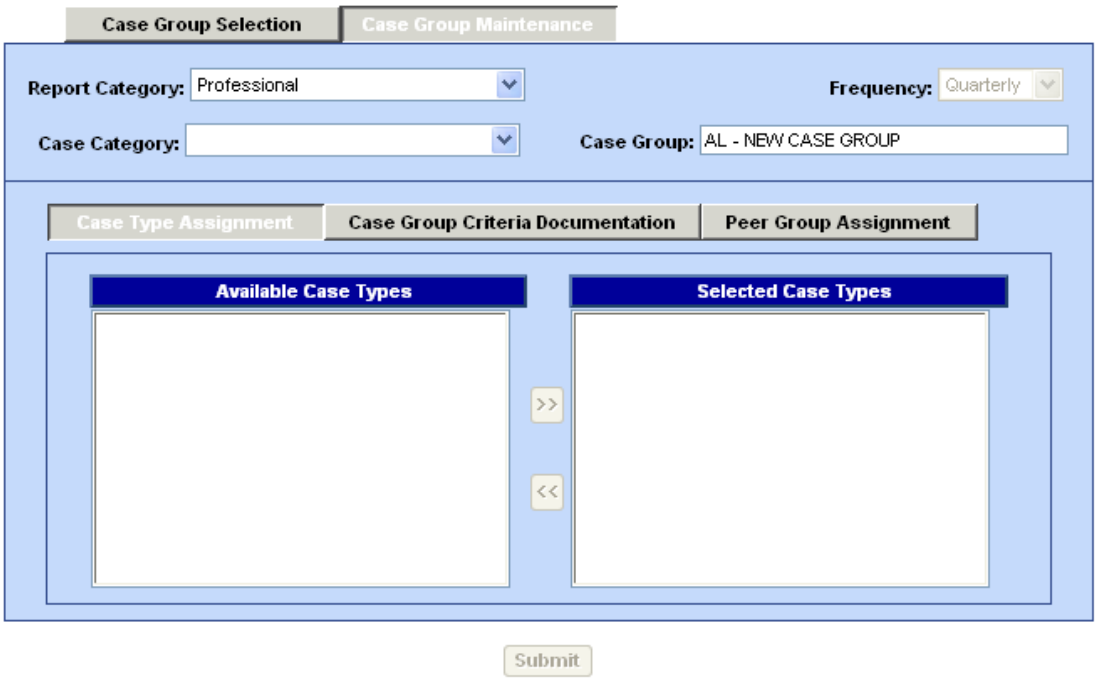



Use the drop down boxes for Report Category and Case Category to establish the correct criteria for the new Case Group. The user must enter a name and it must contain the prefix “AL – “. If the Case Types to be used in the new Case Group are associated with a specific Case Category, then select the same Case Category for the new Case Group; otherwise the list of available Case Types will not be displayed.




The user must assign Case Types to the Case Group and create the criteria before a Case Group can be saved. Click the mouse in the Available Case Types box for a list of Case Types. Use the >> and << buttons to select the correct Case Types to be used in the Case Group.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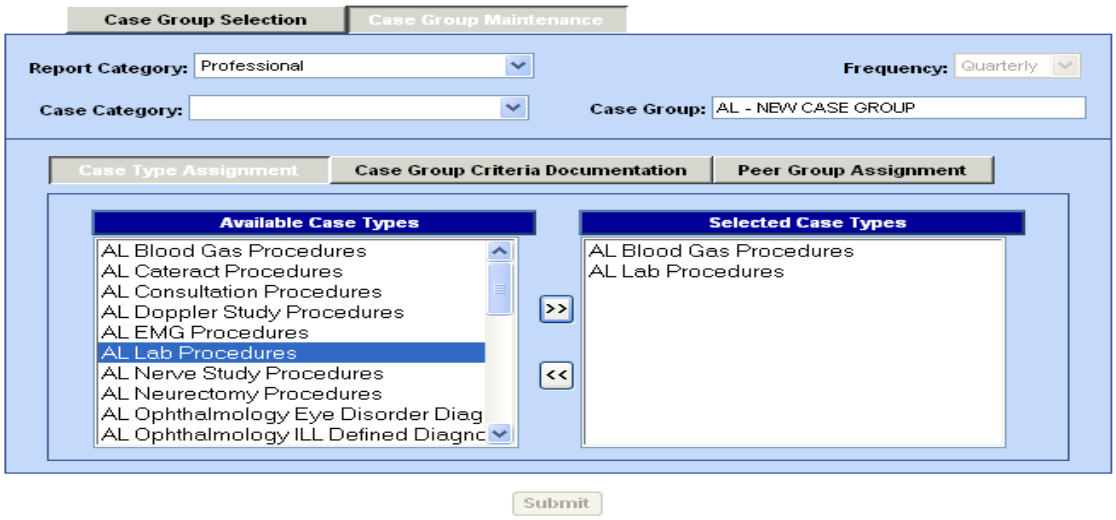
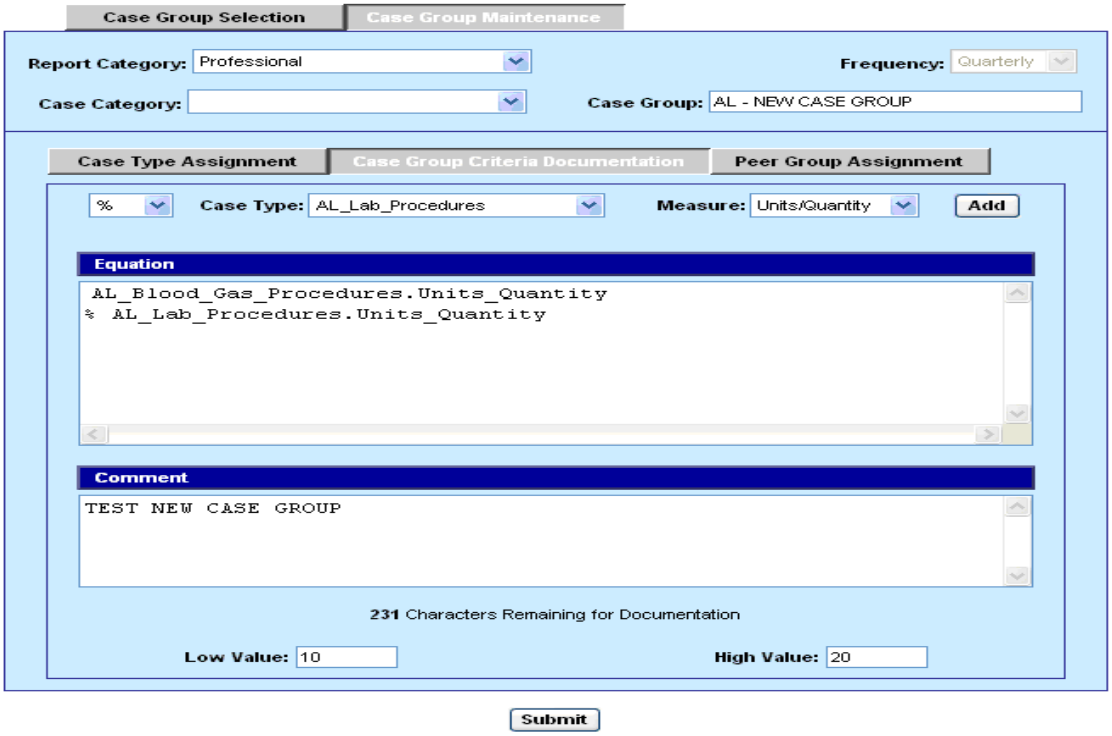



Select the Case Group Criteria Documentation tab in order to set up the equation to be used for the Case Group. Use the drop down boxes in the middle of the window to create the desired measure or equation. Select the Add button for the data to be added to the Equation box. Enter text in the Comments field and select the Low and High values to be used as default values. If the user does not need to specify a Low/High for a specific peer group, then select the Submit button to save the Case Group. A message window will display to let the user know the Case Group was added. Otherwise select the Peer Group Assignment tab.




If special limits are needed for certain peer groups, the Peer Group Assignment tab can be used to establish the limits. This tab is not required. The default limits at the bottom of the Case Group Criteria Documentation tab will be used as a default for all peer groups, unless different limits are established on this tab.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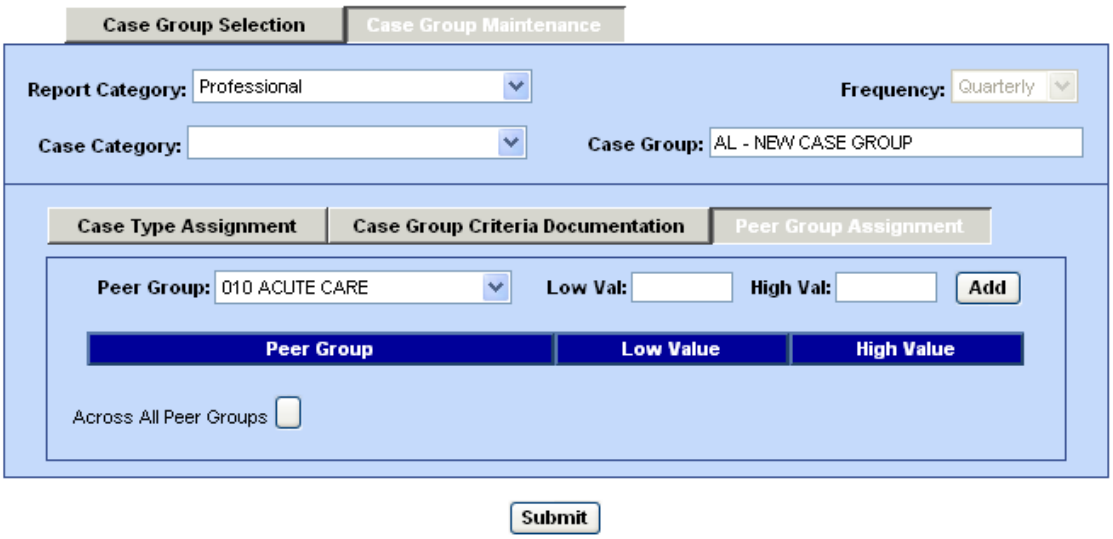
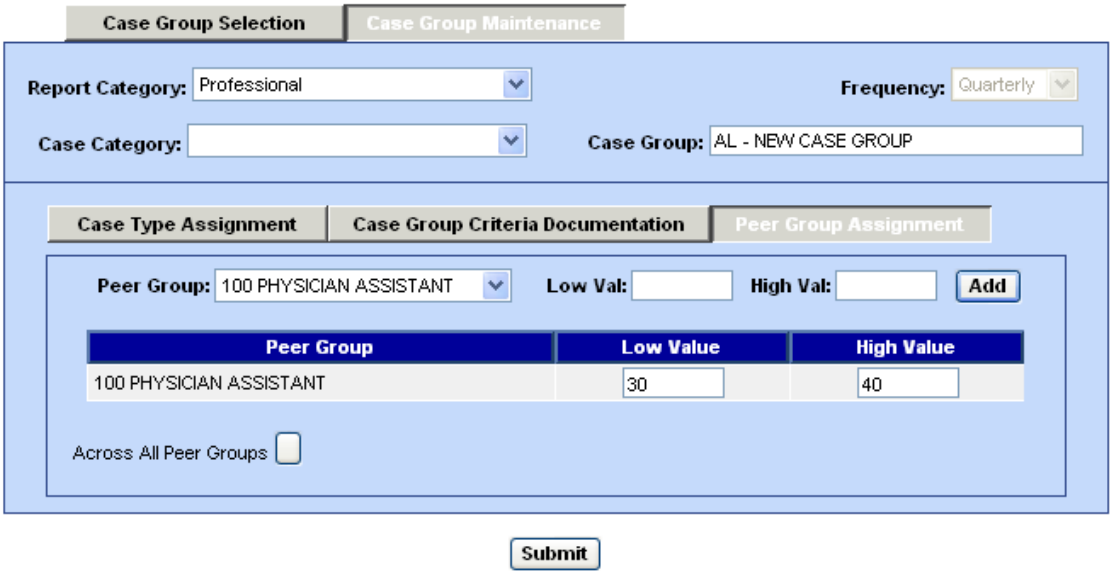



Use the drop down box to select the Peer Group. Enter the Low and High values that should apply to the selected Peer Group. Select the Add button and the limits will be added to the list at the bottom. Select the Submit button. A message window displays to let the user know the Case Group was added.





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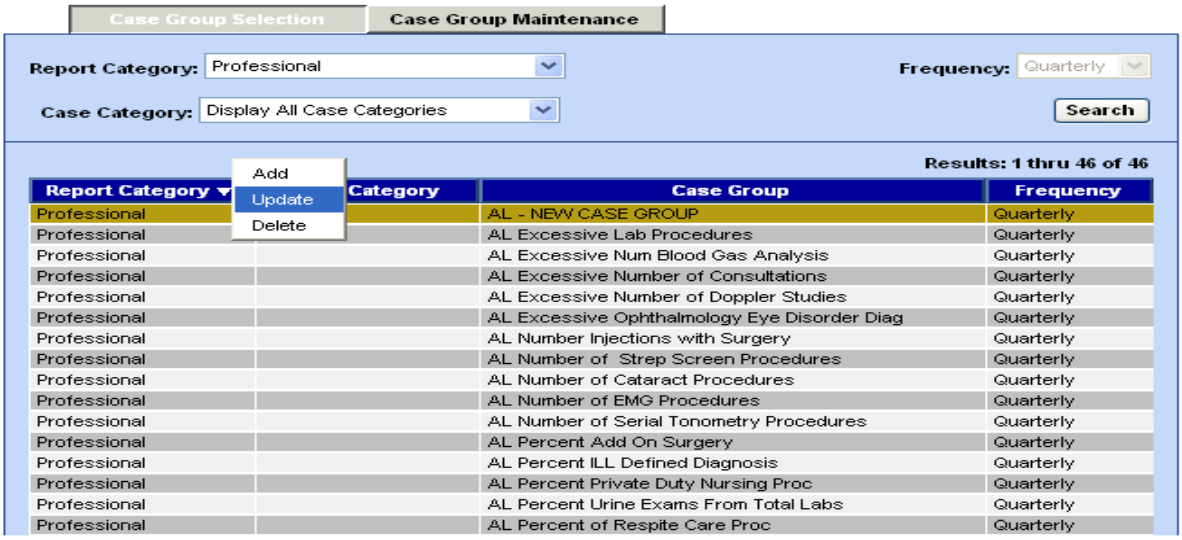
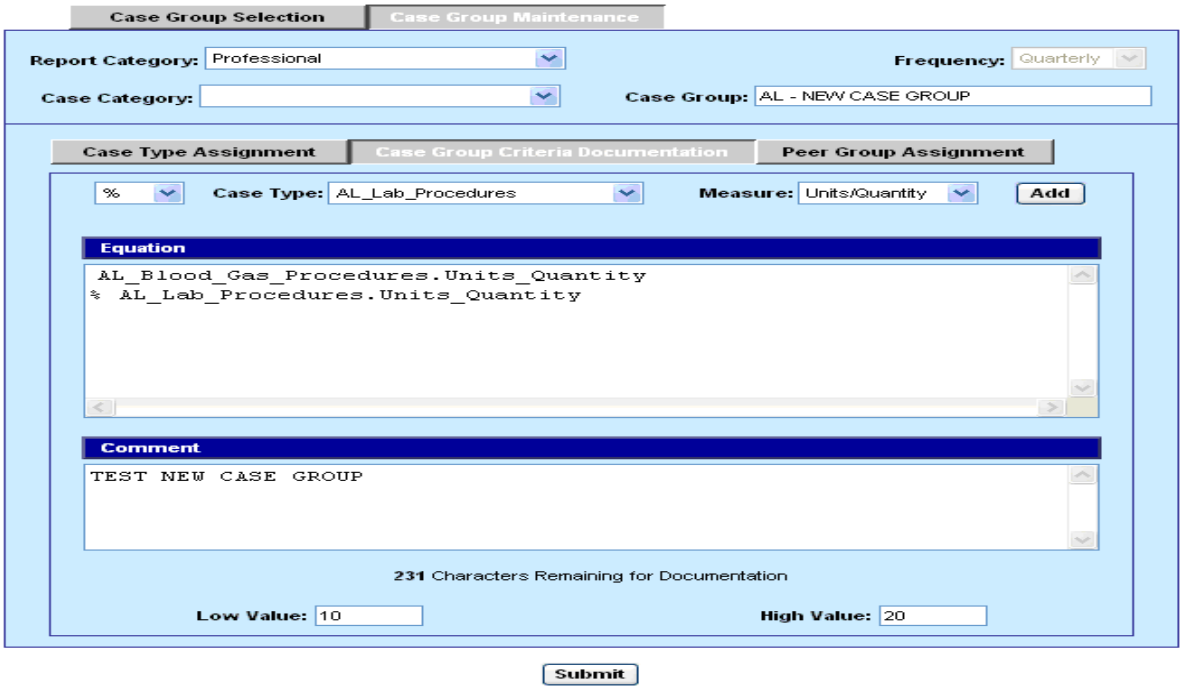
### 2.1.4.3 To Update a Case Group

Highlight a Case Group shown on the Case Group Selection window, right click the mouse and select Update. Another way to select a Case Group for Update is double click on the Case Group. The criteria for the Case Group is displayed on the Case Group Maintenance window.




Use the drop down boxes for Report Category and Case Category to update criteria for the Case Group. Select the Case Type Assignment tab to add or remove Case Types from the Case Group. Select the Case Group Criteria Documentation tab to update the measure or equation for the Case Group. Select the Peer Group Assignment tab to make updates to the peer group limits. Select the Submit button to save the updates. A message window displays to let the user know the Case Group was updated.





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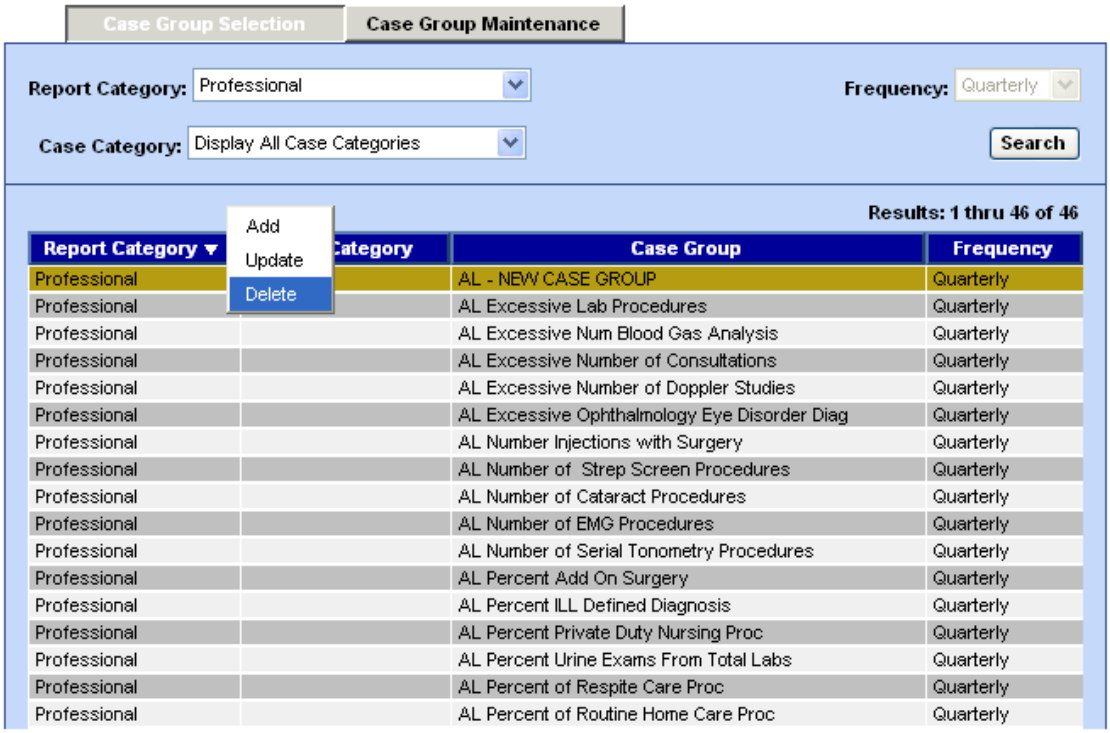
### 2.1.4.4 To Delete a Case Group

Highlight the Case Group shown on the Case Group Selection window, right click the mouse and select Delete. A message window displays to ensure the Case Group selected is to be deleted, select OK. Another message window displays to let the user know the Case Group was deleted.





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## 2.2 Case Tracking

The Alabama Surveillance and Utilization Review (SUR) Case Tracking function replaces many of the manual operations throughout the SUR case review process with systematic approaches. Browser-based windows replace many of the manual operations such as providing auto-assignment of case reviews and online updating of case documentation. In addition, the SUR Case Tracking function allows for the viewing of imaged incoming correspondence and photocopied medical records from on-site audits.

For further details related to the SUR Case Tracking function, refer to the SUR Case Tracking User Manual.

## 2.3 Random Sample Overview

The Random Sample Application provides the ability to generate summary reports from a statistically valid random sampling process. The random sample process is initiated and accessed through browser-based windows from the Data Warehouse web site. Through this web site, users can specify if they want to sample claims for providers or recipients, and they can specify the date ranges and other filter conditions such as specific claim types or code values. The results from the sample are stored in the Data Warehouse where the results can be reported on summary web screens or from reports generated through the Data Warehouse.

The Random Sample Application includes several windows to assist the user in either pulling a random sample of claims or 100% of the claims sorting and viewing the results. It also produces spreadsheets of the claims selected, as well as sends the results to the SUR universe in the DSS. The following pages include how to access the application, describe the windows and define the elements in the spreadsheets and SUR universe.

## 2.4 Accessing the Random Sample Application

Login to DSS InfoView. On the “Navigate” side of the panel, select the “Document List” folder hyperlink. Then expand the “Public Folders” folder, and select the folder entitled “SUR-Random Sample Application”. This takes you to the “Document List” window, with only the Random Sample application hyperlinks shown. Then double-click the hyperlink “Random Sample Request”.

After clicking the hyperlink, the user is taken to the Request Information window of the Random Sample application.

### 2.4.1 Random Sample - 1 -Request Information Tab

Use the Random Sample - 1 - Request Information Tab to generate a random claim sample for a provider or a recipient. Access this page by selecting the Random Sample link from the Navigator window. Use this first tab to set up the basic information on the request such as the provider/recipient, dates and the sample size. Other tabs described later in this document include information on filtering the request.

When the random sample request is entered, press Submit to generate the random sample request. The request is saved and a batch process runs the request. The Random Sample Log tab is available to check on the status of the request.


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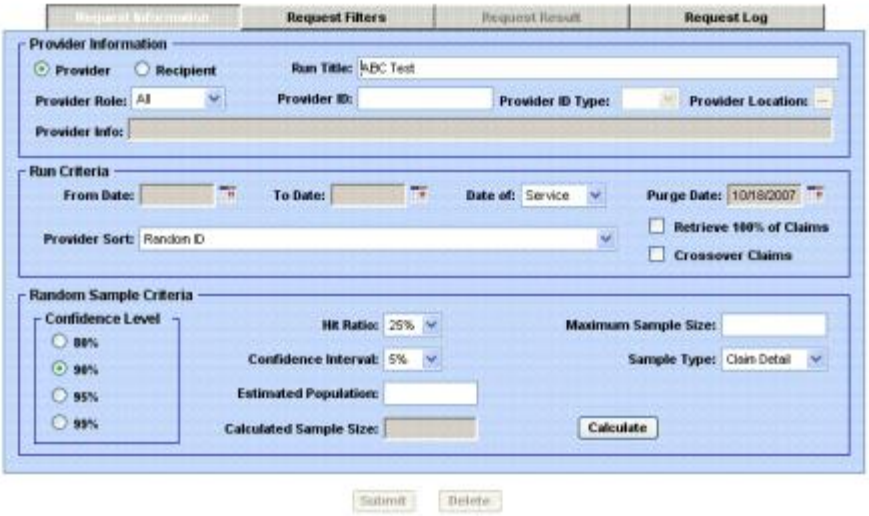
The page can be accessed in two different ways:

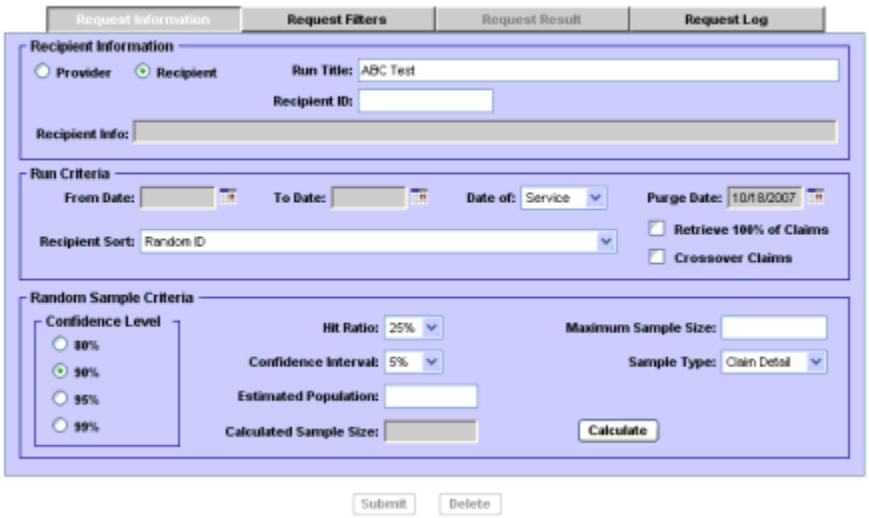
A. Open the Random Sample window and enter a provider ID and the claim criteria to restrict the results. The random sample is performed on the selected date range from at least three years plus the current year of claims data.

B. Open the Random Sample window and enter a recipient ID and the claim criteria to restrict the results. The random sample is performed on the selected date range from at least three years plus the current year of claims data.

**A**




**B**





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### 2.4.2 Random Sample - 2 - Request Filters Tab

Use the Random Sample - 2 - Request Filters Tab to enter specific criteria to limit the results of the Random Sample process.

Select from the following list for a Provider random sample:

- Billed Amount;
- Claim Type;
- Diagnosis Related Group (DRG) Code;
- Internal Control Number (ICN);
- Claim Indicator (‘F’ for Fee-for-Service and/or ‘E’ for Encounters; default is both);
- District Plan Code;
- National Drug Code (NDC);
- Paid Amount;
- Place of Service;
- Primary Diagnosis Code;
- ICD Version Code (9, 0, or # for "ICD-9", "ICD-10", and "undefined" respectively);
- Primary Procedure Code;
- Provider Type;
- Provider Specialty;
- Therapeutic Class;
- Prior Authorization Number;
- Lockin Indicator;
- Allowed Amount;
- Medicare Paid Amount;
- Other Insurance Amount;
- Wrap Payment Indicator

For a Recipient random sample, the following list is available:

- Billed Amount;
- Claim Type;
- DRG Code;
- ICN;
- Claim Indicator (‘F’ for Fee-for-Service and/or ‘E’ for Encounters; default is both);
- District Plan Code;
- NDC Code;
- Paid Amount;
- Place of Service;


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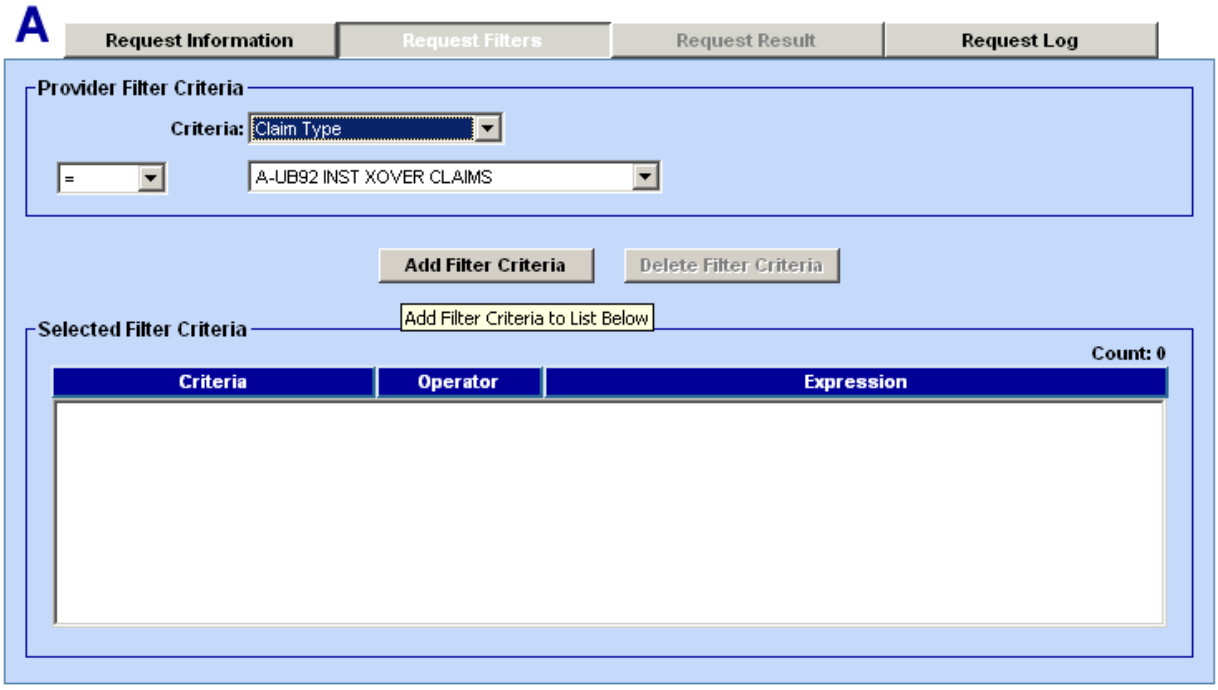
- Primary Diagnosis Code;
- ICD Version Code (9, 0, or # for "ICD-9", "ICD-10", and "undefined" respectively);
- Primary Procedure Code;
- Allowed Amount;
- Prior Authorization Number;
- Allowed Amount;
- Medicare Paid Amount;
- Other Insurance Amount;
- Referring Provider;
- Rendering Provider;
- Therapeutic Class;
- Wrap Payment Indicator

The user has the ability to add and delete from the list of filter condition codes.

There are two layouts for this window below. Layout A is the layout if a Random Sample of a Provider is selected. Layout B is for a Recipient Random Sample. The field names have a letter in front, designating the layout on which it can be found.

#### 2.4.2.1 Random Sample - 2 - Request Filters Tab Layout A





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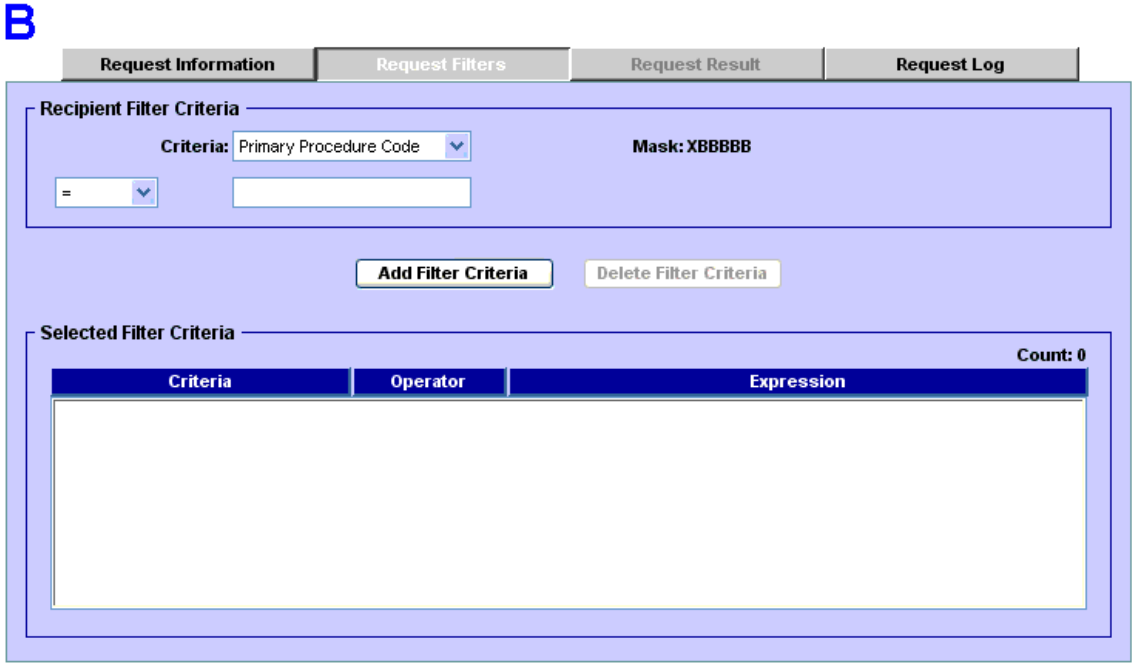
### 2.4.2.2 Layout B is for a Recipient Random Sample





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### 2.4.3 Random Sample - 3 - Request Result Tab

The Random Sample - 3 - Request Result Tab displays the Random Sample status and results. This tab displays the detail or header claim results of the Random Sample request. It displays the ICN, Detail Number (Dtl No), From Date of Service (DOS), To DOS, Amt Billed, Amt Paid, Amt MCO, Paid Date and Random ID. If the user requires more claim information, hyperlink to more claim information by clicking on the “Dtl No” associated with ICN they are interested in researching.

Two layouts for this Random Sample window are listed below. Layout A is for Provider Random Sample and layout B is for Recipient Random Sample. The field names have a letter in the front, designating the layout on which they can be found.

**A**

Request Information | Request Filters | Request Result | Request Log

Run Title: Prod test2
Request ID: 4096
Status: Completed
Provider Number: [redacted]
Date Type: Payment
Request User: [redacted]
Provider Info: SHERMAN, L ARMSTRONG JR. ; 1722 PINE ST STE 201 MONTGOMERY, AL 36106
All
From Date: 04/01/2017
Date/Time: 12/18/2017 09:46:54 AM
Sample Type: Details
To Date: 12/18/2017
Purge Date: 03/18/2018
Confidence Level:
Hit Ratio:
Population Size: 46
Confidence Interval:
Maximum Sample Size: 0
Sample Size: 46
Comment: Successfully completed!

Filter Criteria: Count: 0

| Criteria | Operator | Expression | | Expression |
|---|---|---|---|---|
| No Filter Criteria Found. | | | | |

Request Results: < Prev 1 Next > Results: 1 thru 46 of 46

| ICN | Dtl No | Recipient ID | From DOS | To DOS | Amt Billed | Amt Paid | Amt MCO | Payment Date | Random ID | Wrap Payment |
|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] | 000 | [redacted] | 06/16/2016 | 06/16/2016 | $398.40 | $280.31 | $0.00 | 04/21/2017 | 1 | N |
| [redacted] | 003 | [redacted] | 03/31/2017 | 03/31/2017 | $7,581.57 | $4,328.23 | $0.00 | 04/21/2017 | 2 | N |
| [redacted] | 002 | [redacted] | 05/03/2017 | 05/03/2017 | $47.00 | $13.31 | $0.00 | 05/19/2017 | 3 | N |


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B

Request Information | Request Filters | Request Result | Request Log

Run Title: Emile test
Recipient Number:
Recipient Info:
Sample Type: Details
Confidence Level:
Confidence Interval:
Comment: Successfully completed!

Request ID: 590
Date Type: Payment
From Date: 10/01/2016
To Date: 11/06/2017
Hit Ratio:
Maximum Sample Size: 0

Status: Completed
Request User:
Date/Time: 11/06/2017 03:05:10 PM
Purge Date: 02/06/2018
Population Size: 5
Sample Size: 5

Filter Criteria: Count: 0

| Criteria | Operator | Expression | | Expression |
|---|---|---|---|---|
| No Filter Criteria Found. | | | | |

Request Results: < Prev 1 Next > Results: 1 thru 5 of 5

| ICN | Dtl No | Provider ID | From DOS | To DOS | Amt Billed | Amt Paid | Amt MCO | Payment Date | Random ID | Wrap Payment |
|---|---|---|---|---|---|---|---|---|---|---|
| | 004 | | 10/09/2016 | 10/09/2016 | $109.40 | $0.52 | $0.00 | 10/26/2016 | 1 | N |
| | 005 | | 10/09/2016 | 10/09/2016 | $27.35 | $2.11 | $0.00 | 10/26/2016 | 2 | N |

### 2.4.4 Random Sample - 4 - Request Log Tab

The Random Sample - 4 - Request Log tab lets users view the status of all random sample requests. A batch process runs the random sample requests and stores the results in a table for the user to view. This page is the main entry point to view all requests.

The user may also access this window directly from the Document List window by using the hyperlink ‘Random Sample Log’.

The user has the ability to click on a request to view the following:

A. Request Information: Click the request ID hyperlink to access the Request Information tab. All fields are viewed only with the exception of the Purge Date.

B. Request Result: Click the Sample Size hyperlink to access the Request Result tab, which displays the claims that meet the criteria.

Request Information | Request Filters | Request Result | Request Log

Filter By User: Display All Users
Filter By Status: Display All Statuses

| Request ID | User | ID | Request Date | Status | Run Title | Sample Size | Population | Purge Date | Delete |
|---|---|---|---|---|---|---|---|---|---|
| 114 | | | 07/01/2005 01:49:59 PM | Completed | Recipient Test Case 5 | 4 | 4 | 10/01/2005 | ☐ |
| 113 | | | 07/01/2005 01:42:54 PM | Completed | Recipient Test Case 7 | 4 | 4 | 10/01/2005 | ☐ |
| 112 | | | 07/01/2005 01:41:22 PM | Completed | Recipient Test Case 6 | 11 | 11 | 10/01/2005 | ☐ |
| 110 | | | 07/01/2005 01:22:32 PM | Completed | Recipient Test Case 3 | 11 | 11 | 10/01/2005 | ☐ |
| 109 | | | 07/01/2005 01:21:09 PM | Completed | Recipient Test Case 2 | 11 | 11 | 10/01/2005 | ☐ |


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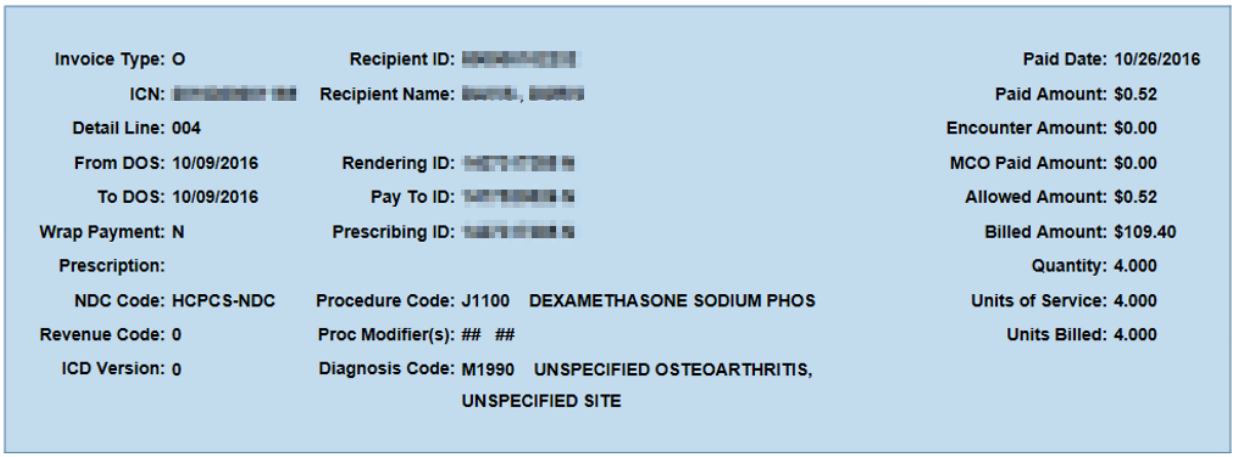
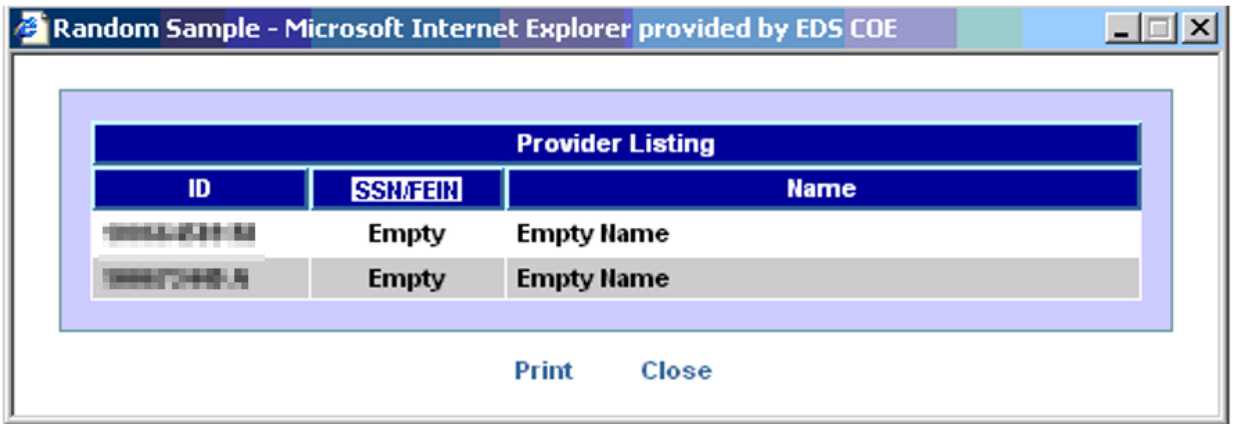
### 2.4.5 Random Sample - 5 - Claim Detail Window

By clicking the hyperlink ICN on the Random Sample 3 Request Results Tab the Random Sample - 5 - Claim Detail window is displayed to show the details of the selected ICN.




### 2.4.6 Random Sample - 6 - ID Listing Window

By clicking the hyperlink box next to the column heading for Recipient ID or Provider ID on the Random Sample 3 Request Results Tab the ID Listing window displays a listing of unique providers or recipients for a request. The list includes columns ID, Social Security Number/Federal Employer Identification Number (SSN/FEIN) and Name.





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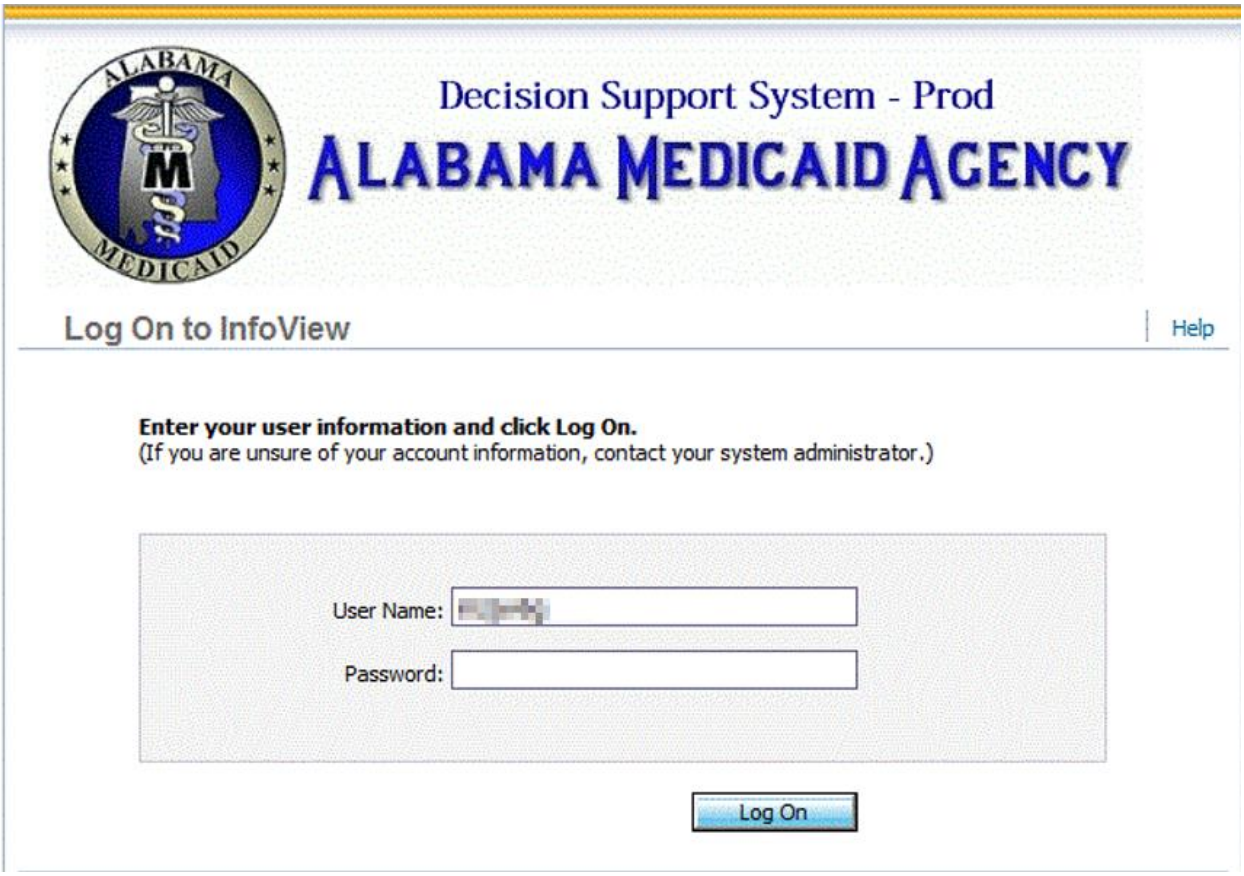
# 3. Reports

This manual contains a sample page for each report for this system with a short description.

## 3.1 Accessing the Reports from the InfoView DSSNavigator

Login to the InfoView DSSNavigator using your User Name and Password.




Results: The Welcome window displays.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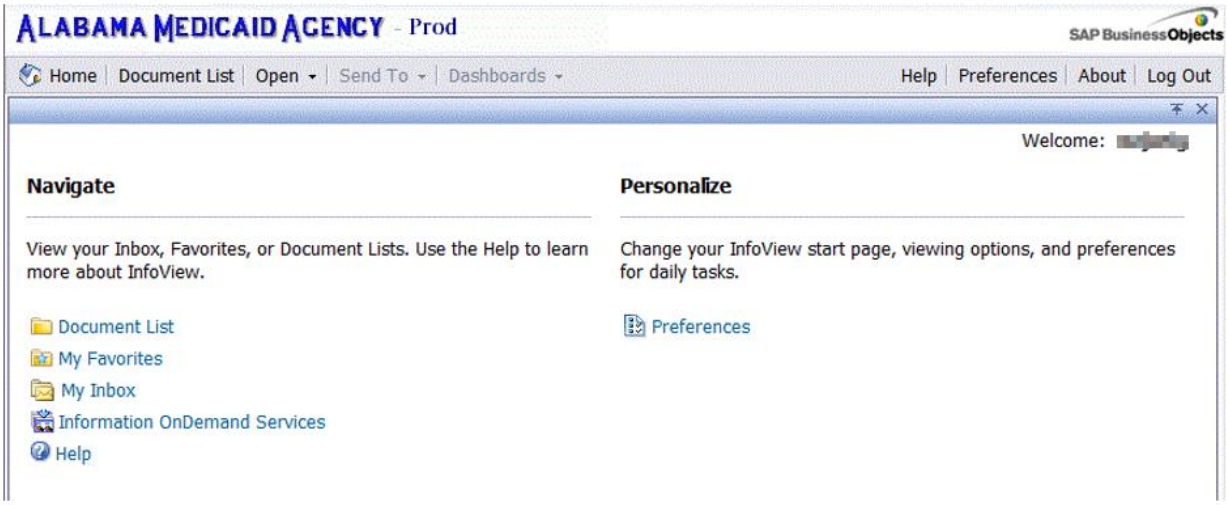


Click on “Document List”, then “Public Folders”, then double-click on “Corporate Documents”.


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## 3.2 List of Reports Available

### 3.2.1 DSSProfiler Reports

- Case Group Maintenance
- Case Type Maintenance
- Peer Group Maintenance
- Dental Claim Details by Provider
- Dental Claim Details by Provider Quarterly
- Inpatient Case Type Comparison by Peer Group
- Inpatient Case Type Comparison by Peer Group Quarterly
- Inpatient Claim Details by Provider - FFS
- Inpatient Claim Details by Provider Quarterly - FFS
- Inpatient Disease Global View
- Inpatient Disease Quick View
- Inpatient Distribution Analysis
- Inpatient Exception Quarterly
- Inpatient Frequency Distribution
- Inpatient Frequency Distribution Quarterly
- Inpatient Recipient Case Type Comparison by Peer Group
- Inpatient Recipient Case Type Comparison by Peer Group Quarterly
- Inpatient Provider Profile
- Inpatient Provider Profile Quarterly
- Nursing Facility Case Type Comparison by Peer Group
- Nursing Facility Case Type Comparison by Peer Group Quarterly
- Nursing Facility Claim Details by Provider - FFS
- Nursing Facility Claim Details by Provider Quarterly - FFS
- Nursing Facility Disease Quick View
- Nursing Facility Exception Quarterly
- Nursing Facility Frequency Distribution
- Nursing Facility Frequency Distribution Quarterly
- Nursing Facility Recipient Case Type Comparison by Peer Group
- Nursing Facility Recipient Case Type Comparison by Peer Group Quarterly
- Nursing Facility Provider Profile
- Nursing Facility Provider Profile Quarterly
- Outpatient Case Type Comparison by Peer Group


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


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- Professional Recipient Case Type Comparison by Peer Group
- Professional Recipient Case Type Comparison by Peer Group Quarterly
- Professional Provider Profile
- Professional Provider Profile Quarterly
- Professional Referrals Case Type Comparison by Peer Group
- Professional Referrals Case Type Comparison by Peer Group Quarterly
- Professional Referral Claim Details by Provider - FFS
- Professional Referral Claim Details by Provider Quarterly - FFS
- Professional Referral Distribution Analysis
- Professional Referral Exception Quarterly
- Professional Referral Frequency Distribution
- Professional Referral Frequency Distribution Quarterly
- Professional Referral Provider Profile
- Professional Referral Provider Profile Quarterly
- Provider Peer Group Comparison
- Provider Peer Group Comparison Quarterly
- Recipient Claim Details - FFS
- Recipient Claim Details Quarterly - FFS
- Recipient Exception Quarterly
- Recipient Frequency Distribution
- Recipient Frequency Distribution Quarterly
- Recipient Peer Group Comparison
- Recipient Peer Group Comparison Quarterly
- Recipient Profile
- Recipient Profile Quarterly


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### 3.2.2 ETG Reports

- ETG Details - FFS
- ETG Distribution Analysis - FFS
- ETG Episode Cross Reference - FFS
- ETG Recipient Comparison - FFS
- ETG Recipient Details - FFS
- ETG Recipient Summary - FFS
- ETG Provider Comparison - FFS
- ETG Provider Details - FFS
- ETG Provider Summary - FFS
- ETG Summary - FFS

### 3.2.3 Targeted Query Reports

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


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## 3.3 Report Layouts and Descriptions

Some information in this section is represented in table format. In order to fit information on the page, some data field information may wrap to the next line.

Within the DSSProfiler reports is a tab labeled as, Notes. This tab contains the report information which can also be found in the narrative for each report within this manual. Example A below shows the layout and narrative of DSSProfiler report, TQ – Antibiotics 12 Months or Longer. Example B below shows the Notes tab found on this report.

Example A:

TQ – Antibiotics 12 Months or Longer

This report is used to identify recipients who have continuously been on any combination of antibiotics for 12 months prior to the date of the end of From Date of Service or longer. The report looks for standard therapeutic class codes 21, 22, 24, 25, 26, and 27.

**Alabama Medicaid Agency**

Antibiotics 12 Months or Longer

From Date of Service: 03/31/2005

User ID:
Run Date: 09/20/2006
Run Time: 5:31:57 PM

| Recipient ID | Recipient Name | USER_ID | Recipient Age | Recipient Gender | ICN | Adjusted ICN | Previous ICN | Prescriber |
|---|---|---|---|---|---|---|---|---|

No Data This Report Run

Example B:

This report is to identify recipients who have continuously been on any combination of antibiotics for 12 months prior to the From Date of service entered.

Report criteria:
Claim Type = P or Q and
Claim Status = P or V and
Latest Claims Only and
All Prescribing Provider Types and
User specified From Day of Service range and
Standard Therapeutic Class Code = 21, 22, 24, 25, 26, 27 and
Fee for Service Claim only


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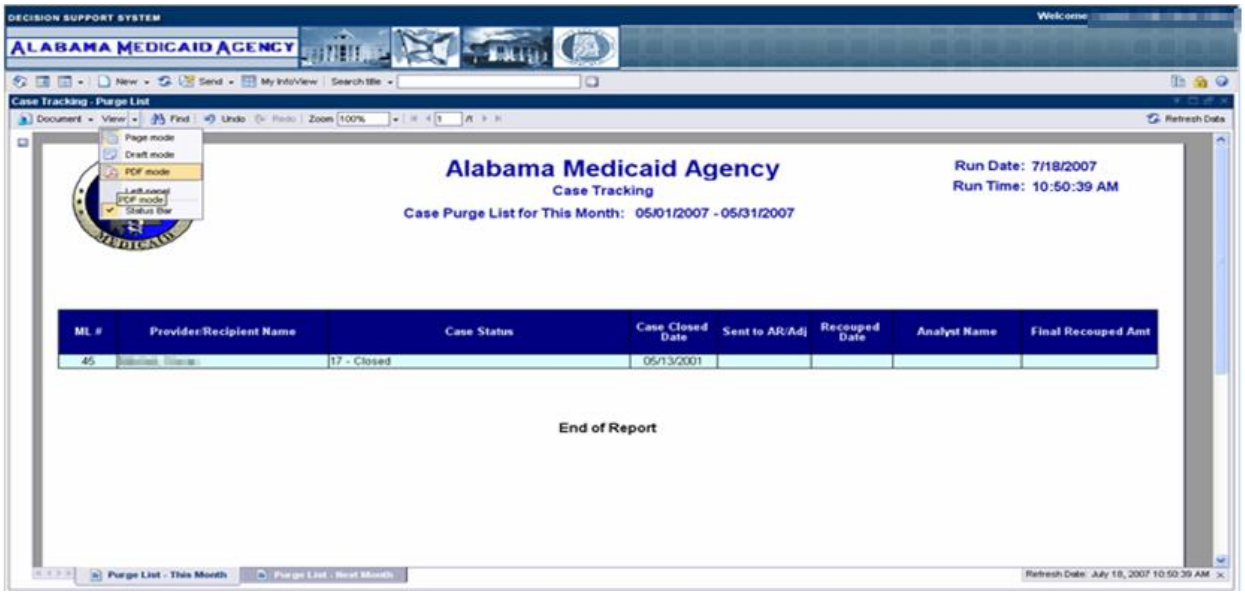
## 3.4 Printing Reports

All reports may be printed from InfoViewDSSNavigator window by using PDF function. The report will print to the local printer.

Step 1: Select **View** from the drop down menu bar.

Step 2: Select **PDF mode**.




Step 3: Click the printer icon on the PDF menu bar. Results: Report is displayed in PDF format.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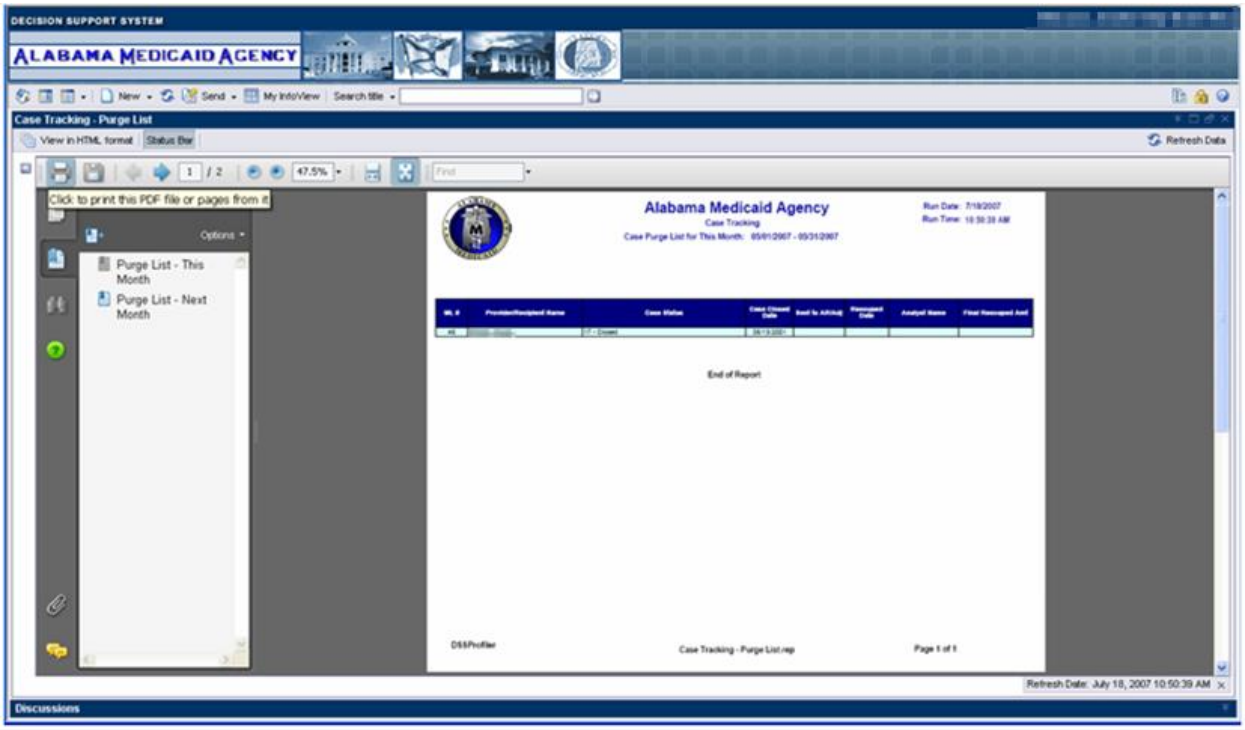



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## 3.5 Case Group Maintenance

This report lists all case groups that are used to run the profiler quarterly cycle. Information related to exception values, equations and measures for each case group is displayed.

```
REPORT:   SUR-8012-Q                                  Alabama Medicaid Agency                                  RUN DATE: 06/05/2006
PROCESS:  SURJQ801                                                                                             RUN TIME: 13:45:15
LOCATION: profilecg                                  CASE GROUP MAINTENANCE REPORT                                   PAGE:     4


REPORT CATEGORY:  Professional                  ***********************************************      FREQUENCY:  Quarterly

  *****CASE CATEGORY:  Not Assigned
          CASE GROUP:   Mark Test Group
       EXCEPTION VALUES:  Default                                          LOW VAL:          1    HIGH VAL:          5
                          328 OBSTETRICIAN/GYNECOLOGIST                    LOW VAL:          1    HIGH VAL:          4
      CRITERIA EQUATION:

                            Cholecystectomies.Paid Amount
                          +  Coronary Artery Bypasses.Paid Amount

REPORT CATEGORY:  Professional                  ***********************************************      FREQUENCY:  Quarterly

  *****CASE CATEGORY:  Not Assigned
          CASE GROUP:  Excessive Physician Office Initial Visits High Complexity
       EXCEPTION VALUES:  Default                                          LOW VAL:          5    HIGH VAL:          0
      CRITERIA EQUATION:

                            Evaluation and Management Office Visits Initial High Complexity.Units/Quantity
                          /  Evaluation and Management Office Visits Initial High Complexity.Units/Quantity
                          +  Evaluation and Management Office Visits Initial Low Complexity.Units/Quantity

REPORT CATEGORY:  Professional                  ***********************************************      FREQUENCY:  Quarterly

  *****CASE CATEGORY:  Not Assigned
          CASE GROUP:  Excessively High Average Days of Preoperative Stay per Incident of Surgery
       EXCEPTION VALUES:  Default                                          LOW VAL:          5    HIGH VAL:          0
      CRITERIA EQUATION:

                            Evaluation and Management Hospital Visits Initial.Units/Quantity
                          +  Evaluation and Management Hospital Visits Subsequent.Units/Quantity
                          /  Evaluation and Management Hospital Visits Initial.Recipient Count
```

### 3.5.1 Case Group Maintenance Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Case Category | The category that the Case Group is assigned to. | 50 | Character |
| Case Group | Name of the Case Group. | 75 | Character |
| Criteria Equation | The equation used to determine exceptions. | 1000 | Character |
| Frequency | Frequency of the report category - annually or quarterly. | 10 | Character |
| High Val | Highest allowed value for exception. | 10 | Number (Integer) |
| Low Val | Lowest allowed value for exception. | 10 | Number (Integer) |
| Peer Group Text | Name of Peer Group with established exception limits. | 20 | Character |
| Report Category | Report Category Description. Valid values are: Professional, Inpatient, Outpatient, Nursing Home, and Pharmacy. | 30 | Character |
| Exception Values | Documents the high and low values for specific groups. The default applies to all peer groups who do not have a specific limit identified. | 50 | Character |


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### 3.5.2 Case Type Maintenance

This report lists all case types, along with the case criteria, that are used to run the profiler quarterly cycle.

```
^LREPORT:   SUR-8010-Q                                  Alabama Medicaid Agency                          RUN DATE: 08/13/2007
PROCESS:  SURJQ801                                                                                     RUN TIME: 16:23:18
LOCATION: profilect                                  CASE TYPE CRITERIA REPORT                            PAGE:    46


REPORT CATEGORY:  Inpatient                                     FREQUENCY:  Annually              STATUS:  Active
  CASE CATEGORY:  Not Assigned

      CASE TYPE:  Physical Therapy Procedures
       CRITERIA:
           Detail Number = 0
           AND ( Procedure Code - ICD9  4 bytes BETWEEN 9311 AND 9319
           OR Procedure Code - ICD9  4 bytes BETWEEN 9331 AND 9339 )

                                     ********** E N D   O F   C A S E   T Y P E **********

REPORT CATEGORY:  Inpatient                                     FREQUENCY:  Annually              STATUS:  Inactive
  CASE CATEGORY:  Not Assigned
            *********   INACTIVE   *****   INCACTIVE   *****   INACTIVE   *****   INACTIVE   *****   INACTIVE   *****   INACTIVE  ****
      CASE TYPE:  ACS-Angina
       CRITERIA:
           Detail Number = 0
           ( ( NOT Procedure Code - ICD9  4 bytes BETWEEN 3601 AND 3602
           NOT Procedure Code - ICD9  4 bytes = 3605
           NOT Procedure Code - ICD9  4 bytes BETWEEN 3610 AND 3619
           NOT Procedure Code - ICD9  4 bytes BETWEEN 3750 AND 3759
           NOT Procedure Code - ICD9  4 bytes BETWEEN 3770 AND 3779 )
           AND ( Primary Diagnosis BETWEEN 4111 AND 41119
           OR Primary Diagnosis BETWEEN 4118 AND 41189
           OR Primary Diagnosis BETWEEN 413 AND 41399 ) )
```

#### 3.5.2.1 Case Type Maintenance Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Case Category | Case Category Description. | 50 | Character |
| Case Type | Case Type Description. | 100 | Character |
| Criteria | Criteria used to build the Case Type. | 4000 | Character |
| Frequency | Describes if the case type belongs to annual or quarterly reports. | 10 | Character |
| Report Category | Report Category Description. | 30 | Character |
| Status | This field shows whether the case type is active or inactive. | 10 | Character |


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### 3.5.3 Peer Group Maintenance

This report lists all provider and recipient peer groups, along with the criteria, that are used to run the profiler quarterly cycle.

```
REPORT:   SUR-8010-Q                                  Alabama Medicaid Agency                          RUN DATE: 06/05/2006
PROCESS:  SURJQ801                                                                                     RUN TIME: 13:44:44
LOCATION: profilepg                              PEER GROUP MAINTENANCE REPORT                            PAGE:     1

***PEER CATEGORY:  Provider                                                   FREQUENCY:  Annually       STATUS:  Active
      ****PEER GROUP:  010 ACUTE CARE
            CRITERIA:
                       Provider Specialty = 010
                       AND Provider Specialty = 016
                       AND Emergency Code = 0

                                   ********** E N D   O F   P E E R   G R O U P **********
***PEER CATEGORY:  Provider                                                   FREQUENCY:  Annually       STATUS:  Active
      ****PEER GROUP:  011 PSYCHIATRIC
            CRITERIA:
                       Provider Specialty = 011
                       AND Provider Specialty = 011
                       AND Provider Specialty = 015

                                   ********** E N D   O F   P E E R   G R O U P **********
***PEER CATEGORY:  Provider                                                   FREQUENCY:  Annually       STATUS:  Active
      ****PEER GROUP:  012 REHABILITATION
            CRITERIA:
                       Provider Specialty = 012
                       AND Provider Specialty = 040
                       AND Provider Specialty = 110

                                   ********** E N D   O F   P E E R   G R O U P **********
***PEER CATEGORY:  Provider                                                   FREQUENCY:  Annually       STATUS:  Active
      ****PEER GROUP:  013 RESIDENTIAL TREATMENT CENTER
            CRITERIA:
                       Provider Specialty = 013
                       AND Provider Specialty = 011
                       AND Provider Specialty = 016
```

#### 3.5.3.1 Peer Group Maintenance Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Criteria | Items that define the peer group criteria. | 1000 | Character |
| Frequency | Frequency of the peer group. | 10 | Character |
| Peer Category | Peer group - Provider or Recipient. | 10 | Character |
| Peer Group | Name of Peer Group. | 40 | Character |
| Status | Shows status of peer group - active or inactive. | 10 | Character |


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### 3.5.4 DSSProfiler - Dental Claim Details by Provider

Based on the user-entered date range of one year, this report lets the user drill down to the detail level for all inpatient annual case types for a given provider and service location. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

The four tabs in this report are:

A. Inpatient Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

**Alabama Medicaid Agency**

**Dental Claim Details By Provider**

**Dental Claim Details**

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

FAMILY ORIENTED PRIMARY HLTH

For Claim Types: D

User ID: [redacted]
Run Date: 11/1/2013
Run Time: 12:53:39 PM

| ICN | CT | POS | Dtl # | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | Proc | Proc Desc | Tooth # | SF 1 | SF 2 | SF 3 | SF 4 | SF 5 | Billed Qty | Billed Amt | Alwd Amt | Paid Amt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] | D | 11 | 1 | [redacted] | [redacted] | 11/12/2000 | 11 | 10/04/2012 | 10/04/2012 | # | ####### | | D2393 | Post 3 Srfc Resinbased Cmpst | 30 | M | O | B | # | # | 1 | $198.00 | $88.00 | $0.00 |
| [redacted] | D | 11 | 2 | [redacted] | [redacted] | 11/12/2000 | 11 | 10/04/2012 | 10/04/2012 | # | ####### | | D9430 | Office Visit During Hours | 30 | # | # | # | # | # | 1 | $0.00 | $140.78 | $65.78 |

End of Report

PHI has been covered


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B

**Alabama Medicaid Agency**

**Dental Claim Details By Provider**

**Recipient Listing**

**For Dates of Service: 10/01/2012 - 09/30/2013**

**Provider Base, Medicaid or NPI ID:** [redacted]

**FAMILY ORIENTED PRIMARY HLTH**

**For Claim Types: D**

**User ID:** [redacted]
**Run Date:** 11/1/2013
**Run Time:** 12:53:39 PM

| Recipient ID | Recipient Full Name |
|---|---|
| 5 | M |

C

**Alabama Medicaid Agency**

**Dental Claim Details By Provider**

**Diagnosis Listing**

**For Dates of Service: 10/01/2012 - 09/30/2013**

**Provider Base, Medicaid or NPI ID:** [redacted]

**FAMILY ORIENTED PRIMARY HLTH**

**For Claim Types: D**

**User ID:** [redacted]
**Run Date:** 11/1/2013
**Run Time:** 12:53:39 PM

| ICD | Diagnosis 1 - Code & Desc | ICD | Diagnosis 2 - Code & Desc | ICD | Diagnosis 3 - Code & Desc | ICN Count | Recipient Count |
|---|---|---|---|---|---|---|---|
| # | ####### - | # | ####### - | # | ####### - | 1 | 1 |

D

**Alabama Medicaid Agency**

**Dental Claim Details By Provider**

**Procedure Listing**

**For Dates of Service: 10/01/2012 - 09/30/2013**

**Provider Base, Medicaid or NPI ID:** [redacted]

**FAMILY ORIENTED PRIMARY HLTH**

**For Claim Types: D**

**User ID:** [redacted]
**Run Date:** 11/1/2013
**Run Time:** 12:53:39 PM

| Procedure Code & Description | ICN Count | Recipient Count |
|---|---|---|
| D2393 - Post 3 Srfc Resinbased Cmpst | 1 | 1 |
| D9430 - Office Visit During Hours | 1 | 1 |

### 3.5.4.1 DSSProfiler - Dental Claim Details by Provider Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age | The age of the recipient on the From Date of Service rounded down to a full year. | 4 | Number (Integer) |
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | particular grouping of claims for this specific recipient. | | |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Bill Qty | Quantity billed for the service rendered. | 2 | Number (Decimal) |
| (A) Claim Type (CT) | Shows what type of claim was submitted. | 1 | Character |
| (A) DOB | Recipient's Date of Birth | 10 | Date (MM/DD/CCYY) |
| (A) Detail Number (Dtl#) | Claim line number. | 4 | Number (Integer) |
| (A) Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag Desc | The primary ICD-CM diagnosis code description. | 60 | Character |
| (A) From Date of Service (FDOS) | Claim's first date of service. | 10 | Date (MM/DD/CCYY) |
| (A) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A)Place of Service (POS) | Place of Service code for where services were rendered. | 2 | Number (Decimal) |
| (A) Proc | Procedure Code for the detail. | 6 | Character |
| (A) Proc Desc | Procedure Code description for the detail. | 40 | Character |
| (A) SF 1 | A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service. | 1 | Character |
| (A) SF 2 | A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service. | 1 | Character |
| (A) SF 3 | A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service. | 1 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) SF 4 | A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service. | 1 | Character |
| (A) SF 5 | A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service. | 1 | Character |
| (A) SF 6 | A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service. | 1 | Character |
| (A) To Date of Service (TDOS) | Claim's last date of service. | 10 | Date (MM/DD/CCYY) |
| (A) Tooth # | A code to indicate the tooth on which the service was performed. | 2 | Character |
| (A,B) Recipient Full Name (Recip Name) | The recipient last name and first name. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID (Recip ID) | Recipient Medicaid Number. | 12 | Character |
| (A,C) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A-D) Claim Types (prompt) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |
| (A-D) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-D) Run Time | The time that the report was executed. | 11 | Character |
| (A-D) User ID | The user that created the report. | 50 | Character |
| (A-D) Provider Base, Medicaid or NPI ID (prompt) | Lists the NPI, Medicaid, and Base ID for the attending Provider. | 63 | Character |
| (C) Diagnosis 1 - Code & Desc | The primary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) ICD Version for Diagnosis 2 | The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (C) Diagnosis 2 - Code & Desc | The secondary ICD-CM diagnosis code and its description. | 70 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (C) ICD Version for Diagnosis 3 | The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (C) Diagnosis 3 - Code & Desc | The third ICD-CM diagnosis code and its description. | 70 | Character |
| (C) ICN Count | Unduplicated count of claims for Diagnosis codes. | 8 | Number (Integer) |
| (C,D) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (D) ICN Count | Unduplicated count of claims for procedure code. | 8 | Number (Integer) |
| (D) Procedure Code & Description | Concatenate procedure code and description into one object. | 47 | Character |


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### 3.5.5 DSSProfiler - Dental Claim Details by Provider Quarterly

Based on the user-entered date range of one quarter, this report lets the user drill down to the detail level for all inpatient quarterly case types for a given provider and service location. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

The four tabs in this report are:

A. Inpatient Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

**Alabama Medicaid Agency**

Dental Claim Details By Provider Qtrly
Dental Claim Details
For Dates of Service: 10/01/2012 - 09/30/2013
Provider Base, Medicaid or NPI ID: 20124
FAMILY ORIENTED PRIMARY HLTH
For Claim Types: D
Quarter: 20124

User ID:
Run Date: 11/1/2013
Run Time: 1:58:36 PM

| ICN | CT | POS | DH # | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | Proc | Proc Desc | Tooth # | SF 1 | SF 2 | SF 3 | SF 4 | SF 5 | Billed Qty | Billed Amt | Alwd Amt | Paid Amt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | D | 11 | 1 | | | 11/12/2000 | 11 | 10/04/2012 | 10/04/2012 | # | ####### | | D2393 | Post 3 Srfc Resinhased Cmpst | 30 | M | O | B | # | # | 1 | $198.00 | $88.00 | $0.00 |
| | D | 11 | 2 | | | 11/12/2000 | 11 | 10/04/2012 | 10/04/2012 | # | ####### | | D9430 | Office Visit During Hours | 30 | # | # | # | # | # | 1 | $0.00 | $140.78 | $65.78 |

End of Report

PHI has been covered

B

**Alabama Medicaid Agency**

Dental Claim Details By Provider Qtrly
Recipient Listing
For Dates of Service: 10/01/2012 - 09/30/2013
Provider Base, Medicaid or NPI ID: 20124
FAMILY ORIENTED PRIMARY HLTH
For Claim Types: D
Quarter: 20124

User ID:
Run Date: 11/1/2013
Run Time: 1:58:36 PM

| Recipient ID | Recipient Full Name |
|---|---|
| | |

End of Report

PHI has been covered


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C

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 11/1/2013
Run Time: 1:58:36 PM

**Dental Claim Details By Provider Qtrly**

Diagnosis Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: 20124

FAMILY ORIENTED PRIMARY HLTH

For Claim Types: D

Quarter: 20124

| ICD | Diagnosis 1 - Code & Desc | ICD | Diagnosis 2 - Code & Desc | ICD | Diagnosis 3 - Code & Desc | ICN Count | Recipient Count |
|---|---|---|---|---|---|---|---|
| # | ####### - | # | ####### - | # | ####### - | 1 | 1 |

D

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 11/1/2013
Run Time: 1:58:36 PM

**Dental Claim Details By Provider Qtrly**

Procedure Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: 20124

FAMILY ORIENTED PRIMARY HLTH

For Claim Types: D

Quarter: 20124

| Procedure Code & Description | ICN Count | Recipient Count |
|---|---|---|
| D2393 - Post 3 Srfc Resinbased Cmpst | 1 | 1 |
| D9430 - Office Visit During Hours | 1 | 1 |

End of Report

### 3.5.5.1 DSSProfiler – Dental Claim Details by Provider Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age | The age of the recipient on the From Date of Service rounded down to a full year. | 4 | Number (Integer) |
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Bill Qty | Quantity billed for the service rendered. | 2 | Number (Decimal) |
| (A) Claim Type (CT) | Shows what type of claim was submitted. | 1 | Character |
| (A) DOB | Recipient's Date of Birth | 10 | Date (MM/DD/CCYY) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Detail Number (Dtl#) | Claim line number. | 4 | Number (Integer) |
| (A) Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag Desc | The primary ICD-CM diagnosis code description. | 60 | Character |
| (A) From Date of Service (FDOS) | Claim's first date of service. | 10 | Date (MM/DD/CCYY) |
| (A) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A)Place of Service (POS) | Place of Service code for where services were rendered. | 2 | Number (Decimal) |
| (A) Proc | Procedure Code for the detail. | 6 | Character |
| (A) Proc Desc | Procedure Code description for the detail. | 40 | Character |
| (A) SF 1 | A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service. | 1 | Character |
| (A) SF 2 | A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service. | 1 | Character |
| (A) SF 3 | A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service. | 1 | Character |
| (A) SF 4 | A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service. | 1 | Character |
| (A) SF 5 | A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service. | 1 | Character |
| (A) SF 6 | A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service. | 1 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) To Date of Service (TDOS) | Claim's last date of service. | 10 | Date (MM/DD/CCYY) |
| (A) Tooth # | A code to indicate the tooth on which the service was performed. | 2 | Character |
| (A,B) Recipient Full Name (Recip Name) | The recipient last name and first name. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID (Recip ID) | Recipient Medicaid Number. | 12 | Character |
| (A,C) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A-D) Claim Types (prompt) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |
| (A-D) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-D) Run Time | The time that the report was executed. | 11 | Character |
| (A-D) User ID | The user that created the report. | 50 | Character |
| (A-D) Provider Base, Medicaid or NPI ID (prompt) | Lists the NPI, Medicaid, and Base ID for the attending Provider. | 63 | Character |
| (A-D) Quarter (prompt) | The quarter for the claims that are displayed on the report. | 4 | Number (Integer) |
| (C) Diagnosis 1 - Code & Desc | The primary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) ICD Version for Diagnosis 2 | The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (C) Diagnosis 2 - Code & Desc | The secondary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) ICD Version for Diagnosis 3 | The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (C) Diagnosis 3 - Code & Desc | The third ICD-CM diagnosis code and its description. | 70 | Character |
| (C) ICN Count | Unduplicated count of claims for Diagnosis codes. | 8 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (C,D) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (D) ICN Count | Unduplicated count of claims for procedure code. | 8 | Number (Integer) |
| (D) Procedure Code & Description | Concatenate procedure code and description into one object. | 47 | Character |


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### 3.5.6 DSSProfiler - Inpatient Case Type Comparison by Peer Group

The Inpatient Case Type Comparison by Peer Group report is created in DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar 'norms' on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Providers who have two standard deviations above or below the 'norm' for the peer group are highlighted.

This report provides a rapid method to find which providers need to be analyzed more closely at a case type level, utilizing other reports within the DSSProfiler. This report makes it easy to see, for example, which are the providers of asthma services who fall outside of the accepted 'norm' within the peer group.

The three tabs in this report are:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender.

A

**Alabama Medicaid Agency**

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:31:55 PM

Inpatient Case Type Comparison by Peer Group
Provider Comparison
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| Rank | Raw Rank | Expected Rank | Provider ID | Provider Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 1 | | NW GENERAL | $467,755.00 | $234,006.54 | $220,740.55 | $150,904.40 | $69,836.15 | * |
| 2 | 5 | 6 | | NW GENERAL | $3,459.38 | $11,172.43 | $11,172.43 | $6,073.53 | $5,098.90 | |
| 3 | 6 | 8 | | SEAMORE X-RAY CLINIC | $584.69 | $2,436.84 | $2,436.84 | $2,436.84 | $0.00 | |
| 4 | 9 | 9 | | NEW HORIZON REHAB CLINIC | $4,000.00 | $300.00 | $300.00 | $1,245.37 | $(945.37) | |
| 5 | 8 | 7 | | SEAMORE X-RAY CLINIC | $26,745.00 | $739.00 | $490.00 | $4,323.34 | $(3,833.34) | |
| 6 | 7 | 5 | | WATTSSS RE-TE ENROLL PROVIDER WITH-OUT LETTER | $6,225.00 | $1,400.00 | $1,400.00 | $20,607.23 | $(19,207.23) | |
| 7 | 2 | 4 | | SEAMORE X-RAY CLINIC | $101,700.00 | $72,153.69 | $15,473.43 | $35,718.49 | $(20,245.06) | |
| 8 | 3 | 3 | | MEMORIAL VALLEY MEDICAL | $12,235.00 | $15,957.00 | $13,271.50 | $37,902.60 | $(24,631.10) | |
| 9 | 4 | 2 | | BAILY MEDICAL SUPPLIES | $32,285.00 | $14,886.56 | $12,086.56 | $43,090.20 | $(31,003.64) | |
| | | | | | | | | 2 STD DEV | $56,554.05 | |

End of Report


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B

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:31:55 PM

Inpatient Case Type Comparison by Peer Group
Average Amount per Recipient by Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

[redacted] - SEAMORE X-RAY CLINIC

| Age Group | Gender | Recipient Count | Paid Amount Per Recipient |
|---|---|---|---|
| Age 06 - 17 | M | 1 | $418.00 |
| Age 65+ | M | 1 | $72.00 |
| | | AVG: | $245.00 |

[redacted] - NW GENERAL

| Age Group | Gender | Recipient Count | Paid Amount Per Recipient |
|---|---|---|---|
| Age 00 - 05 | F | 3 | $3,750.75 |
| Age 06 - 17 | F | 6 | $2,289.80 |
| Age 06 - 17 | M | 3 | $2,796.17 |
| Age 18 - 20 | F | 2 | $12,953.16 |
| Age 21 - 34 | F | 3 | $33,647.12 |
| Age 21 - 34 | M | 1 | $2,207.55 |
| Age 35 - 64 | M | 2 | $23,243.70 |
| Age 65+ | F | 3 | $1,657.23 |
| Age 65+ | M | 3 | $2,282.22 |

C

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:31:55 PM

Inpatient Case Type Comparison by Peer Group
Average Amount per Recipient All Providers by Selected Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Age 00 - 05

Gender: F

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| [redacted] | NW GENERAL | $3,750.75 |
| [redacted] | SEAMORE X-RAY CLINIC | $4,052.57 |
| | AVG: | $3,871.48 |

Gender: M

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| [redacted] | SEAMORE X-RAY CLINIC | $2,436.84 |
| | AVG: | $2,436.84 |


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### 3.5.6.1 DSSProfiler - Inpatient Case Type Comparison by Peer Group Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group. | 3 | Number (Integer) |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Rank | Provider's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A) Raw Rank | Provider's rank based on the amount provider was paid. | 3 | Number (Integer) |
| (A,B,C) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A,B,C) Case Type | A user defined group based on the case type created in Case Maintenance. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B,C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B,C) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B,C) Provider Name | Provider's full name. | 50 | Character |
| (A,B,C) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (B) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (B,C) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (B,C) Gender | Recipient's gender. | 1 | Character |
| (B,C) Paid Amount Per Recipient | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |
| (A,B,C) Provider ID | Provider identification number. | 15 | Character |


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### 3.5.7 DSSProfiler - Inpatient Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all providers within a quarterly inpatient peer group to determine which providers fall outside of service dollar 'norms' for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the 'norm' for the peer group are highlighted.

The three tabs in this report are:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender.

A

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 8/29/2007
Run Time: 3:19:29 PM

Inpatient Case Type Comparison by Peer Group Qtrly
Provider Comparison
For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 127 - CMS Sunday - Thursday Admissions
Provider Peer Group: 115 - 035 SKILLED NURSING FACILITY
Aggregation Code: 2 - Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

| Rank | Raw Rank | Expected Rank | Provider ID | Provider Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 1 | [redacted] | RIDGEVIEW HEALTH CARE C | $5,154.00 | $2,619.24 | $2,619.24 | $2,619.24 | $0.00 | |
| | | | | | | | | 2 STD DEV | | |

End of Report

B

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 8/29/2007
Run Time: 3:19:29 PM

Inpatient Case Type Comparison by Peer Group Qtrly
Average Amount per Recipient by Age/Gender
For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 127 - CMS Sunday - Thursday Admissions
Provider Peer Group: 115 - 035 SKILLED NURSING FACILITY
Aggregation Code: 2 - Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

[redacted] - RIDGEVIEW HEALTH CARE C

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 00 - 05 | F | 1 | $2,619.24 |
| | | Avg: | $2,619.24 |

End of Report


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C

**Alabama Medicaid Agency**

Inpatient Case Type Comparison by Peer Group Qtrly
Average Amount per Recipient All Providers
by Selected Age/Gender

User ID: [redacted]
Run Date: 8/29/2007
Run Time: 3:19:29 PM

For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 127 - CMS Sunday - Thursday Admissions
Provider Peer Group: 115 - 035 SKILLED NURSING FACILITY
Aggregation Code: 2 - Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

Age 00 - 05

Gender: F

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| [redacted] | RIDGEVIEW HEALTH CARE C | $2,619.24 |
| | Avg: | $2,619.24 |

End of Report

### 3.5.7.1 DSSProfiler - Inpatient Case Type Comparison by Peer Group Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group. | 3 | Number (Decimal) |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Rank | Provider's rank based on the actual money paid by the program. | 3 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Raw Rank | Provider's rank based on the amount provider was paid. | 3 | Number (Decimal) |
| (A,B,C) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A,B,C) Case Type | A user defined group based on the case type created in Case Maintenance. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B,C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B,C) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A,B,C) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A,B,C) Quarter | The quarter for which the report is being run. | 5 | Date(CCYYQ) |
| (A,B,C) Provider ID | Provider identification number. | 15 | Character |
| (A,B,C) Provider Name | Provider's full name. | 50 | Character |
| (B,C) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (B) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (B,C) Gender | Recipient's gender. | 1 | Character |
| (B,C) Paid Amount Per Recipient | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |


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### 3.5.8 DSSProfiler - Inpatient Claim Details by Provider - FFS

Based on the user-entered date range of one year, this report lets the user drill down to the detail level for all inpatient annual case types for a given provider and service location. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The four tabs in this report are:

A. Inpatient Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

**Alabama Medicaid Agency**

**Inpatient Claim Details By Provider - FFS**

**Inpatient Claim Details**

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: I

User ID: [redacted]
Run Date: 7/8/16
Run Time: 8:23:42 AM

| ICN | CT | PO S | Dtl # | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | ICD | Diag 2 | Diag 2 Desc | Proc | Proc Desc | MD1 | MD1 Desc | MD2 | MD2 Desc | MD3 | MD3 Desc | Bill Qty | Billed Amt | Alwd Amt | Paid Amt | DRG Code & Desc | DRG Relative Weight | DRG Service Adjuster |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] | | 21 | 1 | [redacted] | XXXXXXXXX XXXXXXXXX XX, XXXXXXXXX XXXXXX, X | MM/DD/YYY | 0 | 4/1/2016 | 4/3/2016 | 0 | E0811 | DIABETES DUE TO UNDERLYING CONDITION W HYPERGLOSSIS W CDIVA | 0 | E0811 | DIABETES DUE TO UNDERLYING CONDITION W HYPERGLOSSIS W CDIVA | ###### | Unknown or Not Applicable | # # | Unknown or Not Applicable | # # | Unknown or Not Applicable | # # | Unknown or Not Applicable | 2 | $2,000.00 | $32,481.49 | $32,481.49 | 4202 - DIABETES | 2.6 | 1 |
| [redacted] | | 21 | 1 | [redacted] | XXXXXXXXX XXXXXXXXX XX, XXXXXXXXX XXXXXX, X | MM/DD/YYY | 46 | 4/1/2016 | 4/1/2016 | 0 | Z3490 | ENDVTR FOR SURVISN OF NORMAL PREGNANCY, UNSP, UNSP TRIMESTER | 0 | Z3490 | ENDVTR FOR SURVISN OF NORMAL PREGNANCY, UNSP, UNSP TRIMESTER | ###### | Unknown or Not Applicable | # # | Unknown or Not Applicable | # # | Unknown or Not Applicable | # # | Unknown or Not Applicable | 1 | $532.00 | $27,734.20 | $27,734.20 | 3611 - SIGNS, SYMPTOMS AND OTH FACTORS | 2.22 | 1 |
| [redacted] | | 21 | 2 | [redacted] | XXXXXXXXX XXXXXXXXX XX, XXXXXXXXX XXXXXX, X | MM/DD/YYY | 0 | 4/1/2016 | 4/3/2016 | 0 | E0811 | DIABETES DUE TO UNDERLYING CONDITION W HYPERGLOSSIS W CDIVA | 0 | E0811 | DIABETES DUE TO UNDERLYING CONDITION W HYPERGLOSSIS W CDIVA | ###### | Unknown or Not Applicable | # # | Unknown or Not Applicable | # # | Unknown or Not Applicable | # # | Unknown or Not Applicable | 9 | $999.00 | $0.00 | $32,481.49 | 4202 - DIABETES | 2.6 | 1 |

End of Report

PHI has been removed


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B

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/8/16
Run Time: 8:23:42 AM

## Inpatient Claim Details By Provider - FFS

### Recipient Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: I

| Recipient ID | Recipient Full Name | ICN Count |
|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X | 576 |

End of Report

PHI has been removed

C

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/8/16
Run Time: 8:23:42 AM

## Inpatient Claim Details By Provider - FFS

### Diagnosis Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: I

| ICD | Diagnosis 1 - Code & Desc | ICD | Diagnosis 2 - Code & Desc | ICD | Diagnosis 3 - Code & Desc | ICN Count | Recipient Count |
|---|---|---|---|---|---|---|---|
| 0 | A419 - SEPSIS, UNSPECIFIED ORGANISM | 0 | L89153 - PRESSURE ULCER OF SACRAL REGION, STAGE 3 | 0 | L89154 - PRESSURE ULCER OF SACRAL REGION, STAGE 4 | 1 | 1 |
| 0 | E0811 - DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA | 0 | E0811 - DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA | 0 | A259 - RAT-BITE FEVER, UNSPECIFIED | 3 | 1 |
| 0 | E0811 - DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA | 0 | E0811 - DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA | 0 | J708 - RESPIRATORY CONDITIONS DUE TO OTH EXTERNAL AGENTS | 5 | 2 |
| 0 | E1142 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY | 0 | E1142 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY | 0 | J708 - RESPIRATORY CONDITIONS DUE TO OTH EXTERNAL AGENTS | 2 | 1 |

End of Report


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D

**Alabama Medicaid Agency**

**Inpatient Claim Details By Provider - FFS**
**Procedure Listing**
**For Dates of Service: 07/01/2015 - 06/30/2016**
**Provider Base, Medicaid or NPI ID:** [redacted]
**Billing Provider Name: UNIVERSITY OF ALABAMA**
**For Claim Types: I**

**User ID:** [redacted]
**Run Date:** 7/8/16
**Run Time:** 8:23:42 AM

| Procedure Code & Description | ICN Count | Recipient Count |
|---|---|---|
| ###### - Unknown or Not Applicable | 576 | 526 |

**End of Report**

### 3.5.8.1 DSSProfiler - Inpatient Claim Details by Provider - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age | The age of the recipient on the From Date of Service rounded down to a full year. | 4 | Number (Integer) |
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Bill Qty | Quantity billed for the service rendered. | 2 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Claim Type (CT) | Shows what type of claim was submitted. | 1 | Character |
| (A) DOB | Recipient's Date of Birth | 10 | Date (MM/DD/CCYY) |
| (A) Detail Number (Dtl#) | Claim line number. | 4 | Number (Integer) |
| (A) Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag Desc | The primary ICD-CM diagnosis code description. | 60 | Character |
| (A) Diag 2 | The secondary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag 2 Desc | The secondary ICD-CM diagnosis code description. | 60 | Character |
| (A) DRG Code and Description | Diagnosis Related Group Number assigned to the claim, and its description. | 60 | Character |
| (A) DRG Relative Weight | Relative weight for pricing DRG | 5 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) DRG Service Adjuster | This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor | 3 | Number (Decimal) |
| (A) From Date of Service (FDOS) | Claim's first date of service. | 10 | Date (MM/DD/CCYY) |
| (A) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A) MD1 | First Modifier code for the procedure code billed. | 2 | Character |
| (A) MD1 Desc | Description for the First Modifier code of the procedure code billed. | 40 | Character |
| (A) MD2 | Second Modifier code for the procedure code billed. | 2 | Character |
| (A) MD2 Desc | Description for the Second Modifier code of the procedure code billed. | 40 | Character |
| (A) MD3 | Third Modifier code for the procedure code billed. | 2 | Character |
| (A) MD3 Desc | Description for the Third Modifier code of the procedure code billed. | 40 | Character |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A)Place of Service (POS) | Place of Service code for where services were rendered. | 2 | Number (Decimal) |
| (A) Proc | Procedure Code for the detail. | 6 | Character |
| (A) Proc Desc | Procedure Code description for the detail. | 40 | Character |
| (A) To Date of Service (TDOS) | Claim's last date of service. | 10 | Date (MM/DD/CCYY) |
| (A,B)Recipient Full Name (Recip Name) | The recipient last name and first name. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B)Recipient ID (Recip ID) | Recipient Medicaid Number. | 12 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,C) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A,C) ICD Version for Diagnosis 2 | The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A-D) Claim Types (prompt) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |
| (A-D) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-D) Run Time | The time that the report was executed. | 11 | Character |
| (A-D) User ID | The user that created the report. | 50 | Character |
| (A-D) Provider Base, Medicaid or NPI ID (prompt) | Lists the NPI, Medicaid, and Base ID for the attending Provider. | 63 | Character |
| (B) ICN Count | Unduplicated count of claims for the recipient within that provider. | 8 | Number (Integer) |
| (C) Diagnosis 1 - Code & Desc | The primary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 2 - Code & Desc | The secondary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 3 - Code & Desc | The third ICD-CM diagnosis code and its description. | 70 | Character |
| (C) ICD Version for Diagnosis 3 | The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (C) ICN Count | Unduplicated count of claims for Diagnosis codes. | 8 | Number (Integer) |
| (C,D) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (D) ICN Count | Unduplicated count of claims for procedure code. | 8 | Number (Integer) |
| (D) Procedure Code & Description | Concatenate procedure code and description into one object. | 47 | Character |


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### 3.5.9 DSSProfiler - Inpatient Claim Details by Provider Quarterly - FFS

Based on the user-entered date range of one quarter, this report lets the user drill down to the detail level for all inpatient quarterly case types for a given provider and service location. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The four tabs in this report are:

A. Inpatient Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

**Alabama Medicaid Agency**

**Inpatient Claim Details By Provider Qtrly - FFS**

**Inpatient Claim Details**

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: I

Quarter: 20162

User ID: [redacted]
Run Date: 7/8/16
Run Time: 9:32:28 AM

| ICN | CT | POS | DB # | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | ICD | Diag 2 | Diag 2 Desc | Proc | Proc Desc | MD1 | MD1 Desc | MD2 | MD2 Desc | MD3 | MD3 Desc | Bill Qty | Billed Amt | Alwd Amt | Paid Amt | DRG Code & Desc | DRG Relative Weight | DRG Service Adjuster |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] | | 21 | 1 | 123456789012 | XXXXXXXX, XXXXXXXX, XXXX, XXXXXXXX, XXXXXXX, X | MM/DD/YYYY | 0 | 4/1/2016 | 4/3/2016 | 0 | E0811 | DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA | 0 | E0811 | DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA | ###### | Unknown or Not Applicable | ## | Unknown or Not Applicable | ## | Unknown or Not Applicable | ## | Unknown or Not Applicable | 2 | $2,000.00 | $32,481.49 | $32,481.49 | 202 - DIABETES | 2.6 | 1 |
| [redacted] | | 21 | 1 | 123456789012 | XXXXXXXX, XXXXXXXX, XXXX, XXXXXXXX, XXXXXXX, X | MM/DD/YYYY | 46 | 4/1/2016 | 4/1/2016 | 0 | Z3490 | ENDVTR FOR SUPRVSN OF NORMAL PREGNANCY, UNSP, UNSP TRIMESTER | 0 | Z3490 | ENDVTR FOR SUPRVSN OF NORMAL PREGNANCY, UNSP, UNSP TRIMESTER | ###### | Unknown or Not Applicable | ## | Unknown or Not Applicable | ## | Unknown or Not Applicable | ## | Unknown or Not Applicable | 1 | $532.00 | $27,734.20 | $27,734.20 | 611 - SIGNS, SYMPTOMS AND OTH FACTORS | 2.22 | 1 |
| [redacted] | | 21 | 2 | 123456789012 | XXXXXXXX, XXXXXXXX, XXXX, XXXXXXXX, XXXXXXX, X | MM/DD/YYYY | 0 | 4/1/2016 | 4/3/2016 | 0 | E0811 | DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA | 0 | E0811 | DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA | ###### | Unknown or Not Applicable | ## | Unknown or Not Applicable | ## | Unknown or Not Applicable | ## | Unknown or Not Applicable | 9 | $999.00 | $0.00 | $32,481.49 | 202 - DIABETES | 2.6 | 1 |

End of Report

PHI has been removed


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B

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/8/16
Run Time: 9:32:28 AM

## Inpatient Claim Details By Provider Qtrly - FFS

Recipient Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA
For Claim Types: I
Quarter: 20162

| Recipient ID | Recipient Full Name | ICN Count |
|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X | 9 |

End of Report

PHI has been removed

C

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/8/16
Run Time: 9:32:28 AM

## Inpatient Claim Details By Provider Qtrly - FFS

Diagnosis Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA
For Claim Types: I
Quarter: 20162

| ICD | Diagnosis 1 - Code & Desc | ICD | Diagnosis 2 - Code & Desc | ICD | Diagnosis 3 - Code & Desc | ICN Count | Recipient Count |
|---|---|---|---|---|---|---|---|
| 0 | E0811 - DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA | 0 | E0811 - DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA | 0 | J708 - RESPIRATORY CONDITIONS DUE TO OTH EXTERNAL AGENTS | 4 | 2 |
| 0 | E1142 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY | 0 | E1142 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY | 0 | J708 - RESPIRATORY CONDITIONS DUE TO OTH EXTERNAL AGENTS | 2 | 1 |
| 0 | O4702 - FALSE LABOR BEFORE 37 COMPLETED WEEKS OF GEST, SECOND TRI | 0 | O4702 - FALSE LABOR BEFORE 37 COMPLETED WEEKS OF GEST, SECOND TRI | 0 | O4702 - FALSE LABOR BEFORE 37 COMPLETED WEEKS OF GEST, SECOND TRI | 1 | 1 |
| 0 | Z3490 - ENCNTR FOR SUPRVSN OF NORMAL PREGNANCY, UNSP, UNSP TRIMESTER | 0 | Z3490 - ENCNTR FOR SUPRVSN OF NORMAL PREGNANCY, UNSP, UNSP TRIMESTER | 0 | O368130 - DECREASED FETAL MOVEMENTS, THIRD TRIMESTER, UNSP | 2 | 1 |

End of Report


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D

**Alabama Medicaid Agency**

**Inpatient Claim Details By Provider Qtrly - FFS**

**Procedure Listing**

**For Dates of Service: 07/01/2015 - 06/30/2016**

**Provider Base, Medicaid or NPI ID:** [redacted]

**Billing Provider Name: UNIVERSITY OF ALABAMA**

**For Claim Types: I**

**Quarter: 20162**

**User ID:** [redacted]
**Run Date: 7/8/16**
**Run Time: 9:32:28 AM**

| Procedure Code & Description | ICN Count | Recipient Count |
|---|---|---|
| ###### - Unknown or Not Applicable | 9 | 5 |

**End of Report**

### 3.5.9.1 DSSProfiler - Inpatient Claim Details by Provider Quarterly - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age | The age of the recipient on the From Date of Service rounded down to a full year. | 4 | Number (Integer) |
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Bill Qty | Quantity billed for the service rendered. | 2 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Claim Type (CT) | Shows what type of claim was submitted. | 1 | Character |
| (A) DOB | Recipient's Date of Birth | 10 | Date (MM/DD/CCYY) |
| (A) Detail Number (Dtl#) | Claim line number. | 4 | Number (Integer) |
| (A) Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag Desc | The primary ICD-CM diagnosis code description. | 60 | Character |
| (A) Diag 2 | The secondary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag 2 Desc | The secondary ICD-CM diagnosis code description. | 60 | Character |
| (A) DRG Code and Description | Diagnosis Related Group Number assigned to the claim, and its description. | 60 | Character |
| (A) DRG Relative Weight | Relative weight for pricing DRG | 5 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) DRG Service Adjuster | This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor | 3 | Number (Decimal) |
| (A) From Date of Service (FDOS) | Claim's first date of service. | 10 | Date (MM/DD/CCYY) |
| (A) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A) MD1 | First Modifier code for the procedure code billed. | 2 | Character |
| (A) MD1 Desc | Description for the First Modifier code of the procedure code billed. | 40 | Character |
| (A) MD2 | Second Modifier code for the procedure code billed. | 2 | Character |
| (A) MD2 Desc | Description for the Second Modifier code of the procedure code billed. | 40 | Character |
| (A) MD3 | Third Modifier code for the procedure code billed. | 2 | Character |
| (A) MD3 Desc | Description for the Third Modifier code of the procedure code billed. | 40 | Character |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A)Place of Service (POS) | Place of Service code for where services were rendered. | 2 | Number (Decimal) |
| (A) Proc | Procedure Code for the detail. | 6 | Character |
| (A) Proc Desc | Procedure Code description for the detail. | 40 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) To Date of Service (TDOS) | Claim's last date of service. | 10 | Date (MM/DD/CCYY) |
| (A,B)Recipient Full Name (Recip Name) | The recipient last name and first name. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B)Recipient ID (Recip ID) | Recipient Medicaid Number. | 12 | Character |
| (A,C) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A,C) ICD Version for Diagnosis 2 | The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A-D) Claim Types (prompt) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |
| (A-D) Quarter (prompt) | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A-D) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-D) Run Time | The time that the report was executed. | 11 | Character |
| (A-D) User ID | The user that created the report. | 50 | Character |
| (A-D) Provider Base, Medicaid or NPI ID (prompt) | Lists the NPI, Medicaid, and Base ID for the attending Provider. | 63 | Character |
| (B) ICN Count | Unduplicated count of claims for the recipient within that provider. | 8 | Number (Integer) |
| (C) Diagnosis 1 - Code & Desc | The primary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 2 - Code & Desc | The secondary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 3 - Code & Desc | The third ICD-CM diagnosis code and its description. | 70 | Character |
| (C) ICD Version for Diagnosis 3 | The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (C) ICN Count | Unduplicated count of claims for Diagnosis codes. | 8 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (C,D) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (D) ICN Count | Unduplicated count of claims for procedure code. | 8 | Number (Integer) |
| (D) Procedure Code & Description | Concatenate procedure code and description into one object. | 47 | Character |


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### 3.5.10 DSSProfiler - Inpatient Disease Global View

This report is created in DSSProfiler.

The Inpatient Case Type Global View report allows you to see all other services that recipients received from a selected inpatient case type. For example, you can look at all hypertension recipients who were in an inpatient facility and view all other associated services that they had.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-G in the layout below. The field names have the corresponding letter in front, identifying the tab it can be found on. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

The seven tabs in this report are:

A. General Health Demographics;

B. Other Professional Services;

C. Other Inpatient Services;

D. Other Outpatient Services;

E. Other Pharmacy Services;

F. Other Nursing Facility Services; and

G. Recipients.

A

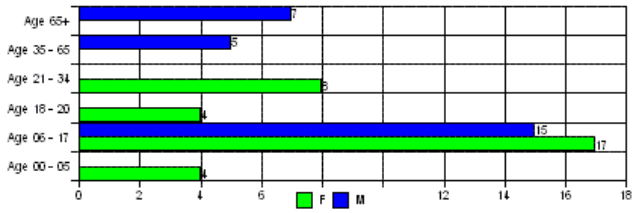
**Alabama Medicaid Agency**

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Inpatient Disease Global View
General Health Demographics

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Age/Gender Mix




| Case Type Description | Billed Amount | Allowed Amount | Paid Amount | Recipient Count | Percent of Recipients |
|---|---|---|---|---|---|
| 1 - All Claim Groupings | $555,409.69 | $307,440.20 | $237,093.95 | 30 | 100.00 % |

End of Report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B

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Inpatient Disease Global View
Other Professional Services
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

| Case Type Description | Billed Amount | Allowed Amount | Paid Amount | Recipient Count | Percent of Recipients |
|---|---|---|---|---|---|
| 1 - All Claim Groupings | $15,882.69 | $6,437.99 | $6,021.85 | 10 | 33.33 % |
| 300 - FQHC Encounter Procedures | $4,724.00 | $1,235.96 | $1,347.71 | 8 | 26.67 % |
| 381 - Evaluation & Management All Procedures | $2,815.00 | $275.98 | $346.23 | 7 | 23.33 % |
| 245 - Injury/Poisoning Diagnosis | $1,121.00 | $174.33 | $150.44 | 5 | 16.67 % |
| 237 - Infectious/Parasitic Diagnosis | $540.00 | $178.16 | $161.66 | 3 | 10.00 % |
| 243 - STD, Sexual Transmitted Disease Diagnosis | $540.00 | $178.16 | $161.66 | 3 | 10.00 % |
| 210 - Cholelithiasis Diagnosis | $1,420.00 | $747.04 | $747.04 | 2 | 6.67 % |
| 223 - Endocrine Disease Diagnosis | $1,030.00 | $161.10 | $151.10 | 2 | 6.67 % |
| 278 - Respiratory System Diagnosis | $1,420.00 | $747.04 | $747.04 | 2 | 6.67 % |
| 298 - Drugs Excluding Pharmacy Procedures | $140.00 | $140.00 | $49.00 | 2 | 6.67 % |
| 352 - Pathology All Procedures | $98.00 | $10.00 | $0.00 | 2 | 6.67 % |

C

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Inpatient Disease Global View
Other Inpatient Services
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

| Case Type Description | Billed Amount | Allowed Amount | Paid Amount | Recipient Count | Percent of Recipients |
|---|---|---|---|---|---|
| 1 - All Claim Groupings | $555,409.69 | $307,440.20 | $237,093.95 | 30 | 100.00 % |
| 454 - Admissions Excluding MH/SA/OB | $534,209.69 | $294,036.25 | $223,690.00 | 28 | 93.33 % |
| 626 - Discharged Home codes(01 - 01) | $248,709.69 | $89,223.18 | $77,708.19 | 24 | 80.00 % |
| 631 - Readmissions codes(01 - 04) | $248,709.69 | $89,223.18 | $77,708.19 | 24 | 80.00 % |
| 510 - Injury/Poisoning Diagnosis | $398,290.00 | $252,454.35 | $182,383.10 | 20 | 66.67 % |
| 489 - Endocrine Disease Diagnosis | $83,600.00 | $17,092.15 | $16,817.15 | 4 | 13.33 % |
| 491 - Diabetes Mellitus Diagnosis | $83,600.00 | $17,092.15 | $16,817.15 | 4 | 13.33 % |
| 502 - Infectious/Parasitic Diagnosis | $27,490.00 | $11,819.40 | $11,819.40 | 4 | 13.33 % |
| 419 - ACS-All Ambulatory Care Sensor Conditions | $5,645.00 | $3,133.00 | $3,133.00 | 3 | 10.00 % |
| 437 - ACS-Chronic | $5,645.00 | $3,133.00 | $3,133.00 | 3 | 10.00 % |
| 456 - V Codes Diagnosis | $43,445.00 | $16,378.80 | $16,378.80 | 3 | 10.00 % |
| 447 - ACS-Diabetes without Complication | $4,400.00 | $2,407.50 | $2,407.50 | 2 | 6.67 % |
| 536 - Obstetric Diagnosis | $21,200.00 | $13,403.95 | $13,403.95 | 2 | 6.67 % |
| 440 - ACS-Other Tuberculosis | $1,245.00 | $725.50 | $725.50 | 1 | 3.33 % |
| 509 - Tuberculosis Diagnosis | $1,245.00 | $725.50 | $725.50 | 1 | 3.33 % |
| 522 - Neoplasm Diagnosis | $584.69 | $2,436.84 | $2,436.84 | 1 | 3.33 % |
| 537 - Perinatal Diagnosis | $3,000.00 | $3,863.76 | $3,863.76 | 1 | 3.33 % |
| 572 - Musculoskeletal Procedures | $27,000.00 | $20,275.42 | $20,275.42 | 1 | 3.33 % |

End of Report


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D

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Inpatient Disease Global View
Other Outpatient Services
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

| Case Type Description | Billed Amount | Allowed Amount | Paid Amount | Recipient Count | Percent of Recipients |
|---|---|---|---|---|---|
| 1 - All Claim Groupings | $21,345.60 | $2,376.87 | $1,655.69 | 8 | 26.67 % |
| 687 - Endocrine Disease Diagnosis | $4,200.60 | $1,336.57 | $762.47 | 5 | 16.67 % |
| 689 - Diabetes Mellitus Diagnosis | $4,200.60 | $1,336.57 | $762.47 | 5 | 16.67 % |
| 656 - Circulatory System Disease Diagnosis | $10,600.00 | $927.19 | $780.11 | 4 | 13.33 % |
| 661 - Heart Disease Diagnosis | $9,600.00 | $827.19 | $680.11 | 3 | 10.00 % |
| 848 - Provider Type - Home Health Agency | $3,400.00 | $1,225.00 | $651.40 | 3 | 10.00 % |
| 701 - Infectious/Parasitic Diagnosis | $8,000.00 | $50.00 | $50.00 | 1 | 3.33 % |
| 709 - Injury/Poisoning Diagnosis | $45.00 | $13.11 | $13.11 | 1 | 3.33 % |
| 736 - Obstetric Diagnosis | $500.00 | $50.00 | $50.00 | 1 | 3.33 % |

End of Report

E

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Inpatient Disease Global View
Other Pharmacy Services
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

| Case Type Description | Billed Amount | Allowed Amount | Paid Amount | Recipient Count | Percent of Recipients |
|---|---|---|---|---|---|
| 1 - All Claim Groupings | $0.00 | $0.00 | $0.00 | 5 | 16.67 % |

End of Report

F

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Inpatient Disease Global View
Other Nursing Facility Services
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

| Case Type Description | Billed Amount | Allowed Amount | Paid Amount | Recipient Count | Percent of Recipients |
|---|---|---|---|---|---|
| 1 - All Claim Groupings | $22,609.40 | $15,747.08 | $15,622.08 | 4 | 13.33 % |

End of Report


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G

**Alabama Medicaid Agency**

Inpatient Disease Global View
Recipients

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Age 00 - 05

| Recipient Id | Recipient Full Name |
|---|---|
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |

Age 06 - 17

| Recipient Id | Recipient Full Name |
|---|---|
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |

### 3.5.10.1 DSSProfiler - Inpatient Disease Global View Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age/Gender Mix | Bar graph that shows the actual number of recipients in each morbidity group. | 0 | Character |
| (A,G) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64 and 65+. | 24 | Character |
| (A-F) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Character |
| (A-F) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-F) Case Type Description | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |
| (A-F) Paid Amount | This is the total amount paid by the program for the specific claim grouping. | 13 | Number (Decimal) |
| (A-F) Percent of Recipients | Percentage of recipients in the pre-defined diagnosis group that also fall under these specific claim groupings. | 8 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-F) Recipient Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (A-G) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-G) Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A-G) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (G) Recipient Full Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (G) Recipient ID | Recipient Medicaid Number. | 12 | Character |


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### 3.5.11 DSSProfiler - Inpatient Disease Quick View

This report is created in the DSSProfiler and displays recipient utilization services for selected case types with totals broken out by the number of services received. The last row gives the totals for each column.

The two tabs in this report are:

A. Inpatient Disease; and

B. Inpatient Disease By Peer Group.

A

**Alabama Medicaid Agency**

**Inpatient Disease Quick View**

**Inpatient Disease**

**For Dates of Service: 07/01/2004 - 06/30/2005**
**Case Type: 1 - All Claim Groupings**
**Aggregation Code: 7 - Fee for Service Claims by Recipient**

**User ID: Administrator**
**Run Date: 5/12/2006**
**Run Time: 1:35:13 PM**

| Each Recipient Had XX Claims | Unduplicated Recipients | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Total Paid Amount |
|---|---|---|---|---|---|---|
| 1 | 19 | 19 | 19 | $119,664.69 | $59,060.04 | $50,954.91 |
| 2 | 6 | 12 | 12 | $90,645.00 | $55,441.36 | $44,100.37 |
| 4 | 2 | 8 | 8 | $58,980.00 | $37,955.65 | $35,804.65 |
| 6 | 1 | 6 | 6 | $88,000.00 | $11,082.75 | $11,082.75 |
| 8 | 1 | 8 | 8 | $88,200.00 | $94,280.58 | $89,122.77 |
| 20 | 1 | 20 | 20 | $109,920.00 | $49,619.82 | $6,028.50 |
| Totals: | | | 73 | $555,409.69 | $307,440.20 | $237,093.95 |

**End of Report**


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B

**Alabama Medicaid Agency**

Inpatient Disease Quick View

Inpatient Disease By Peer Group

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:13 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Peer Group: 516 - Public Assistance, Blind

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 1 | 6 | 6 | 6 | $88,000.00 | $11,082.75 | $11,082.75 |
| Totals: | | | 6 | $88,000.00 | $11,082.75 | $11,082.75 |

Peer Group: 519 - Public Assistance, Disabled

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 1 | 1 | 1 | 1 | $1,245.00 | $725.50 | $725.50 |
| 1 | 2 | 2 | 2 | $2,200.00 | $10,009.05 | $10,009.05 |
| 1 | 4 | 4 | 4 | $54,000.00 | $37,555.65 | $35,404.65 |
| Totals: | | | 7 | $57,445.00 | $48,290.20 | $46,139.20 |

### 3.5.11.1 DSSProfiler - Inpatient Disease Quick View Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Total Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-B) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-B) Case Type | A user defined group based on the case type created in Case Maintenance. The claim grouping should be specific to the area of service. | 100 | Character |
| (A-B) Each Recipient Had XX Claims | This field shows how many claims each of the recipients had. | 4 | Character |
| (A-B) For Dates of Service | The dates for which the report is being run. | 20 | Date (MM/DD/CCYY) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Total Claims | This is the total number of claims billed based on the number of recipients and the number of claims each recipient had. | 9 | Character |
| (A-B) Total Quantity Billed | This is the total units billed for this particular claim category. | 9 | Character |
| (A-B) Unduplicated Recipients | This is a count of all recipients that have had a service within this claim grouping. The count is unduplicated, meaning each recipient is only counted once. | 9 | Character |
| (B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (B) Peer Group | Peer Group Code and Description. | 107 | Character |


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### 3.5.12 DSSProfiler - Inpatient Distribution Analysis

This report shows totals for all inpatient case types within the selected peer group. The totals include amount paid, number of unduplicated recipients, claim counts, units and exceptions. The report also provides a rapid method to identify which case types or service categories need to be looked at more closely with other reports within the DSSProfiler. The exception count is the count of distinct providers who have more than two standard deviations from the norms compared to their peers.

The five tabs of this report are:

A. Inpatient Distribution Summary;

B. TOP 20;

C. By Age;

D. By Gender; and

E. By Age/Gender.


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A

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:49:13 PM

## Inpatient Distribution Analysis
### Inpatient Distribution Summary

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| Case Type Description | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amount per Recip | Paid Amount per Recip | Claims per Recip | Exception Count |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 - All Claim Groupings | 59 | 59 | 30 | $585,169.07 | $303,592.86 | $231,285.11 | $19,505.64 | $7,709.50 | 1.97 | 2 |
| 419 - ACS-All Ambulatory Care Sensor Conditions | 4 | 4 | 3 | $5,500.00 | $3,208.00 | $3,208.00 | $1,833.33 | $1,069.33 | 1.33 | 3 |
| 437 - ACS-Chronic | 4 | 4 | 3 | $5,500.00 | $3,208.00 | $3,208.00 | $1,833.33 | $1,069.33 | 1.33 | 3 |
| 447 - ACS-Diabetes without Complication | 4 | 4 | 3 | $5,500.00 | $3,208.00 | $3,208.00 | $1,833.33 | $1,069.33 | 1.33 | 3 |
| 454 - Admissions Excluding MH/SA/OB | 58 | 58 | 29 | $566,169.07 | $300,197.96 | $227,890.21 | $19,523.07 | $7,858.28 | 2.00 | 2 |
| 456 - V Codes Diagnosis | 3 | 3 | 2 | $41,245.00 | $6,369.75 | $6,369.75 | $20,622.50 | $3,184.88 | 1.50 | 6 |
| 489 - Endocrine Disease Diagnosis | 9 | 9 | 5 | $64,900.00 | $12,268.15 | $9,857.65 | $12,980.00 | $1,971.53 | 1.80 | 3 |
| 491 - Diabetes Mellitus Diagnosis | 9 | 9 | 5 | $64,900.00 | $12,268.15 | $9,857.65 | $12,980.00 | $1,971.53 | 1.80 | 3 |
| 502 - Infectious/Parasitic Diagnosis | 6 | 6 | 5 | $75,000.00 | $28,815.15 | $28,815.15 | $15,000.00 | $5,763.03 | 1.20 | 6 |
| 510 - Injury/Poisoning Diagnosis | 38 | 38 | 18 | $381,439.38 | $246,444.31 | $176,547.06 | $21,191.08 | $9,808.17 | 2.11 | 0 |

B

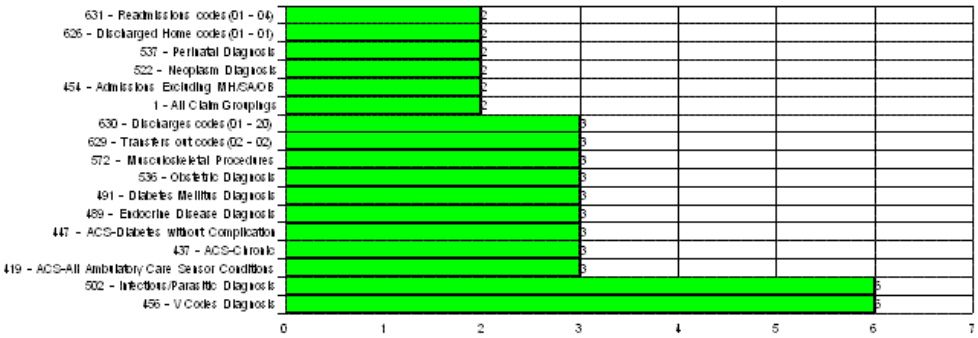
# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:49:13 PM

## Inpatient Distribution Analysis
### Top 20

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

### Top 20 Exceptions





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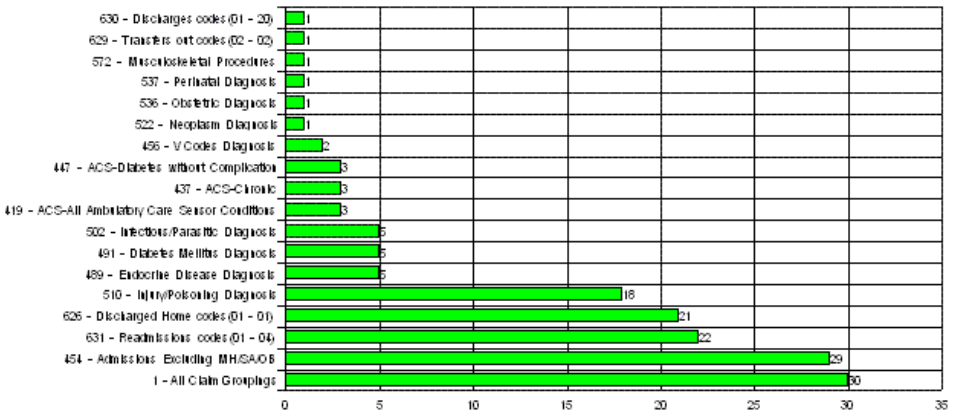
# Alabama Medicaid Agency

**Inpatient Distribution Analysis**
**Top 20**

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:49:13 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

**Top 20 By Number of Recipients**



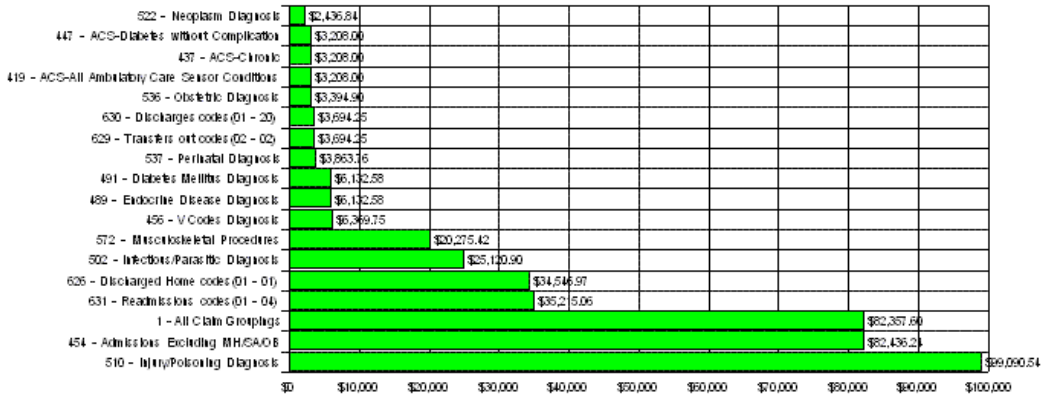

# Alabama Medicaid Agency

**Inpatient Distribution Analysis**
**Top 20**

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:49:13 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

**Top 20 By Paid Amount per Recipient**





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C

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:49:13 PM

## Inpatient Distribution Analysis
## By Age

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

### Case Type: 1 - All Claim Groupings

| Age Description | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| Age 00 - 05 | 6 | 6 | 6 | $42,984.69 | $29,899.36 | $21,794.23 | $7,164.12 | $4,983.23 | $3,632.37 | 1.00 |
| Age 06 - 17 | 18 | 18 | 9 | $179,825.00 | $81,687.12 | $27,203.81 | $19,980.56 | $9,076.35 | $3,022.65 | 2.00 |
| Age 18 - 20 | 5 | 5 | 3 | $69,300.00 | $33,274.62 | $33,274.62 | $23,100.00 | $11,091.54 | $11,091.54 | 1.67 |
| Age 21 - 34 | 10 | 10 | 3 | $107,200.00 | $97,971.83 | $92,814.02 | $35,733.33 | $32,657.28 | $30,938.01 | 3.33 |
| Age 35 - 64 | 12 | 12 | 4 | $144,500.00 | $51,849.40 | $47,287.90 | $36,125.00 | $12,962.35 | $11,821.98 | 3.00 |
| Age 65+ | 8 | 8 | 5 | $41,359.38 | $8,910.53 | $8,910.53 | $8,271.88 | $1,782.11 | $1,782.11 | 1.60 |
| Sum: | 59 | 59 | 30 | $585,169.07 | $303,592.86 | $231,285.11 | $19,505.64 | $10,119.76 | $7,709.50 | 1.97 |

### Case Type: 419 - ACS-All Ambulatory Care Sensor Conditions

| Age Description | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| Age 06 - 17 | 2 | 2 | 1 | $3,300.00 | $1,607.00 | $1,607.00 | $3,300.00 | $1,607.00 | $1,607.00 | 2.00 |
| Age 35 - 64 | 1 | 1 | 1 | $1,100.00 | $800.50 | $800.50 | $1,100.00 | $800.50 | $800.50 | 1.00 |
| Age 65+ | 1 | 1 | 1 | $1,100.00 | $800.50 | $800.50 | $1,100.00 | $800.50 | $800.50 | 1.00 |
| Sum: | 4 | 4 | 3 | $5,500.00 | $3,208.00 | $3,208.00 | $1,833.33 | $1,069.33 | $1,069.33 | 1.33 |

D

# Alabama Medicaid Agency

User ID: [redacted]
RunDate: 5/12/2006
Run Time: 12:49:13 PM

## Inpatient Distribution Analysis
## By Gender

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

### Case Type: 1 - All Claim Groupings

| Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| F | 29 | 29 | 18 | $291,245.00 | $184,464.82 | $157,725.39 | $16,180.28 | $10,248.05 | $8,762.52 | 1.61 |
| M | 30 | 30 | 12 | $293,924.07 | $119,128.04 | $73,559.72 | $24,493.67 | $9,927.34 | $6,129.98 | 2.50 |
| Sum: | 59 | 59 | 30 | $585,169.07 | $303,592.86 | $231,285.11 | $19,505.64 | $10,119.76 | $7,709.50 | 4.11 |

### Case Type: 419 - ACS-All Ambulatory Care Sensor Conditions

| Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| F | 1 | 1 | 1 | $1,100.00 | $800.50 | $800.50 | $1,100.00 | $800.50 | $800.50 | 1.00 |
| M | 3 | 3 | 2 | $4,400.00 | $2,407.50 | $2,407.50 | $2,200.00 | $1,203.75 | $1,203.75 | 1.50 |
| Sum: | 4 | 4 | 3 | $5,500.00 | $3,208.00 | $3,208.00 | $1,833.33 | $1,069.33 | $1,069.33 | 2.50 |


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E

**Alabama Medicaid Agency**

Inpatient Distribution Analysis
By Age/Gender

User ID: [redacted]
Run Date: 5/12/2006
Run Time: 12:49:13 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type: 1 - All Claim Groupings

| Age Description | Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Age 00 - 05 | F | 5 | 5 | 5 | $42,400.00 | $27,462.52 | $19,357.39 | $8,480.00 | $5,492.50 | $3,871.48 | 1.00 |
| Age 00 - 05 | M | 1 | 1 | 1 | $584.69 | $2,436.84 | $2,436.84 | $584.69 | $2,436.84 | $2,436.84 | 1.00 |
| Age 06 - 17 | F | 6 | 6 | 5 | $68,145.00 | $29,613.15 | $18,547.16 | $13,629.00 | $5,922.63 | $3,709.43 | 1.20 |
| Age 06 - 17 | M | 12 | 12 | 4 | $111,680.00 | $52,073.97 | $8,656.65 | $27,920.00 | $13,018.49 | $2,164.16 | 3.00 |
| Age 18 - 20 | F | 4 | 4 | 2 | $67,000.00 | $25,906.32 | $25,906.32 | $33,500.00 | $12,953.16 | $12,953.16 | 2.00 |
| Age 18 - 20 | M | 1 | 1 | 1 | $2,300.00 | $7,368.30 | $7,368.30 | $2,300.00 | $7,368.30 | $7,368.30 | 1.00 |
| Age 21 - 34 | F | 10 | 10 | 3 | $107,200.00 | $97,971.83 | $92,814.02 | $35,733.33 | $32,657.28 | $30,938.01 | 3.33 |
| Age 35 - 64 | F | 1 | 1 | 1 | $1,400.00 | $2,410.50 | $0.00 | $1,400.00 | $2,410.50 | $0.00 | 1.00 |
| Age 35 - 64 | M | 11 | 11 | 3 | $143,100.00 | $49,438.90 | $47,287.90 | $47,700.00 | $16,479.63 | $15,762.63 | 3.67 |
| Age 65+ | F | 3 | 3 | 2 | $5,100.00 | $1,100.50 | $1,100.50 | $2,550.00 | $550.25 | $550.25 | 1.50 |
| Age 65+ | M | 5 | 5 | 3 | $36,259.38 | $7,810.03 | $7,810.03 | $12,086.46 | $2,603.34 | $2,603.34 | 1.67 |
| | Sum: | 59 | 59 | 30 | $585,169.07 | $303,592.86 | $231,285.11 | $19,505.64 | $10,119.76 | $7,709.50 | 20.37 |

### 3.5.12.1 DSSProfiler - Inpatient Distribution Analysis Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Exception Count | Number of exceptions identified. An exception is defined as two standard deviations from the norm. | 8 | Number (Integer) |
| (A, C-E) Case Type Description | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |
| (A,C,D,E) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A,C,D,E) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A,C,D,E) Billed Amount per Recip | Total billed amount divided by the number of recipients. | 12 | Number (Decimal) |
| (A,C,D,E) Billed Quantity | Quantity billed. | 14 | Number (Integer) |
| (A,C,D,E) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (A,C,D,E) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient ( | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,C,D,E) Paid Amount per Recip | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |
| (A,C,D,E) Recip Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (A,D,E) Claims per Recip | Total claim count divided by the recipient count. | 4 | Number (Integer) |
| (A-E) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-E) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-E) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-E) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| B) Top 20 By Number of Recipients | Graph shows Top 20 exceptions by number of recipients. | 1 | Character |
| (B) Top 20 By Paid Amound per Recipients | Graph shows Top 20 exceptions by paid amount per recipient. | 1 | Character |
| (B) Top 20 Exceptions | Graph shows Top 20 exceptions. | 1 | Character |
| (C) Average Claims per Recip | Total claim count divided by the recipient count. | 4 | Number (Integer) |
| (C,D,E) Allowed Amt Per Recip | Total allowed amount divided by the number of recipients. | 13 | Number (Decimal) |
| (C,E) Age Description | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (D,E) Gender | Recipient's gender. | 1 | Character |


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### 3.5.13 DSSProfiler - Inpatient Exception Quarterly

The Inpatient Quarterly Exception report is produced for a selected provider, provider peer group and aggregation code. This report displays the number of high exceptions for case groups that occur during each reporting period. The case groups whose calculations are above the exception high value are marked as exceptions.

**Alabama Medicaid Agency**

Inpatient Exception Quarterly
For Dates of Service: 07/01/2004 - 06/30/2005

User ID: [redacted]
Run Date: 5/18/2006
Run Time: 12:39:55 PM

Provider Service Location Information:
NPI ID: [redacted]
Mcaid ID: [redacted]
Base ID: [redacted]
Name: TRINA O ROBERTS - ALL BSE
Type: 31 - Physician
Specialty: 316 - Family Practitioner
Address: PO BOX 3710

PORTLAND, OR 97501

Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

| | 20043 | | 20044 | | 20051 | |
|---|---|---|---|---|---|---|
| 100 - Extended Confinement - 3-9 Days; H: 002 L: 000 | | | 2.00 | | 7.00 | * |
| 130 - Extended Confinement - Over 60 Days; H: 002 L: 000 | 2.00 | | 2.00 | | | |
| 240 - Length of Stay 181 to 365 Services; H: 002 L: 000 | 2.00 | | 2.00 | | | |
| 260 - Average Stays per Recipient; H: 001 L: 000 | 1.00 | | 1.00 | | 1.67 | * |
| 270 - Discharges; H: 002 L: 000 | 2.00 | | 4.00 | * | 10.00 | * |

#### 3.5.13.1 DSSProfiler - Inpatient Exception Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| Case Type Group | Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item. | 4 | Number (Integer) |
| Exception | This column is marked with a '*' when the case group is above the exception high value. | 1 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Location Base ID | Lists the NPI, Medicaid, and Base ID for the provider. | 63 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| Provider Address | The address for the provider ID. | 200 | Character |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| Provider Name | The name of the provider. | 63 | Character |
| Provider NPI ID | Lists the NPI, Medicaid, and Base ID for the provider. | 63 | Character |
| Provider Specialty | The provider specialty for the provider identification number. | 15 | Character |
| Provider Type | The provider type for the provider identification number. | 15 | Character |
| Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| Service Mcaid ID | Lists the NPI, Medicaid, and Base ID for the provider. | 63 | Character |


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### 3.5.14 DSSProfiler - Inpatient Frequency Distribution

The Inpatient Frequency Distribution report is created in DSSProfiler. Based on the user-entered date range of one year, this report shows each inpatient case type, peer grouping, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 6/22/2006
Run Time: 6:51:06 PM

Inpatient Frequency Distribution

For Dates of Service: 07/01/04 - 06/30/05

Provider Peer Group Code: 1 - Inpatient Hospital By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type : 419 - ACS-All Ambulatory Care Sensor Conditions

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 12 | 12 | 12 | 12 | 12 | 12 |

Case Type : 437 - ACS-Chronic

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 4 | 4 | 4 | 4 | 4 | 4 |

Case Type : 447 - ACS-Diabetes without Complication

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 4 | 4 | 4 | 4 | 4 | 4 |

#### 3.5.14.1 DSSProfiler - Inpatient Frequency Distribution Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |
| 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |
| Case Type | Case type description. | 100 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Provider Aggregation Code | Aggregation Code and Description. | 100 | Character |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 8 | Character |
| Provider Peer Group Code | Peer Group Type Code and Description. | 54 | Character |


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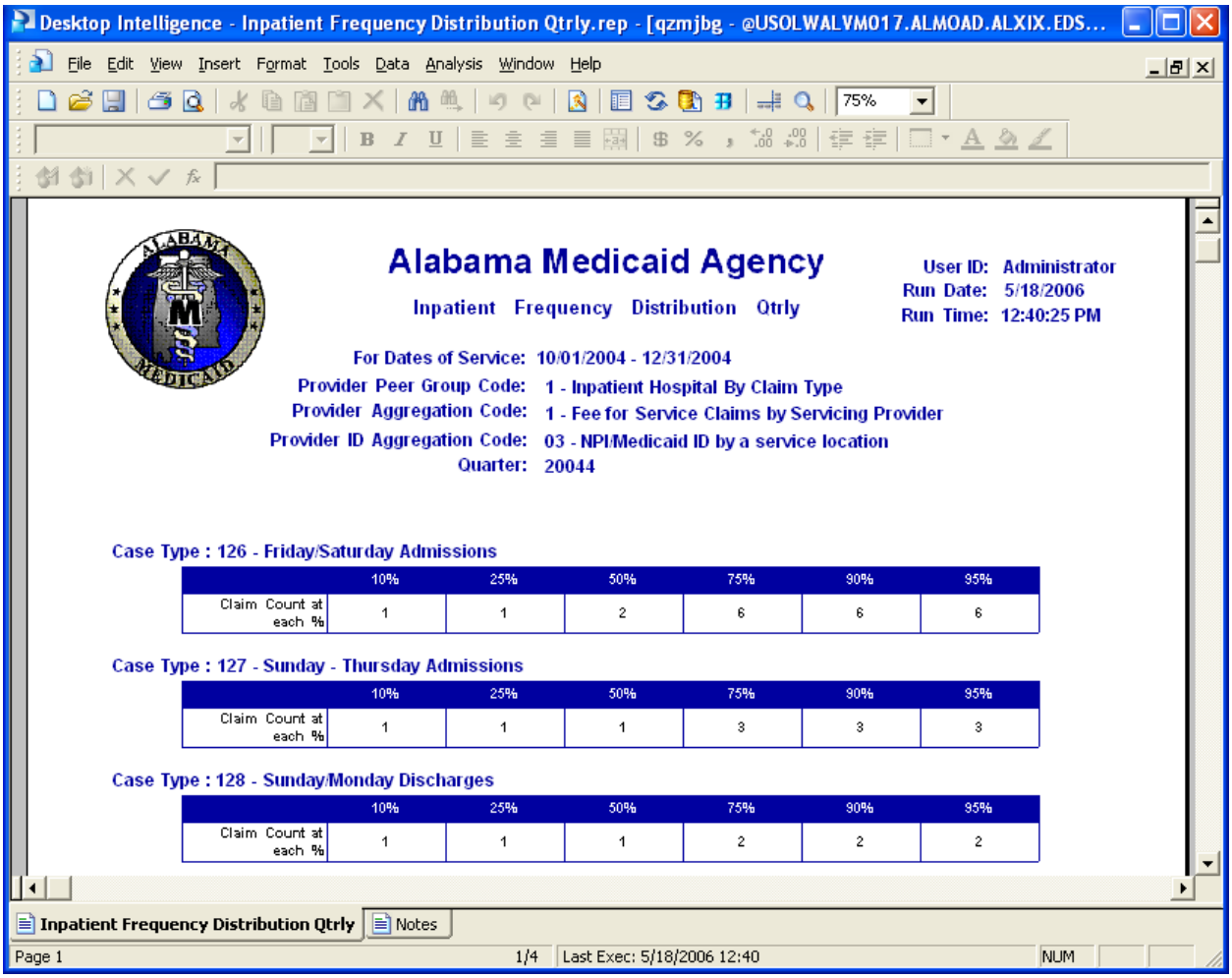
### 3.5.15 DSSProfiler - Inpatient Frequency Distribution Quarterly

The Inpatient Frequency Distribution Quarterly report is created in DSSProfiler. Based on the user-entered date range of one quarter, this report shows each inpatient case type, peer grouping, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.




#### 3.5.15.1 DSSProfiler - Inpatient Frequency Distribution Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |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| Field | Description | Length | Data Type |
|---|---|---|---|
| 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |
| Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Provider Aggregation Code | Aggregation Code and Description. | 100 | Character |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| Provider Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |


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### 3.5.16 DSSProfiler - Inpatient Recipient Case Type Comparison by Peer Group

The Inpatient Recipient Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all recipients within a peer group to determine which recipients fall outside of service dollar norms on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

This report provides a rapid method to find which recipients need to be analyzed more closely at a case type level, utilizing other reports within the DSSProfiler. This report makes it easy to see, for example, which recipients are the recipients of asthma services who fall outside of the accepted norm within the peer group.

The two tabs in the report are:

A. Recipient Comparison; and

B. Recipients Grouped by Age/Gender.

A

**Alabama Medicaid Agency**

Inpatient Recipient Case Type Comparison by Peer Group
Recipient Comparison
For Dates of Service: 07/01/2004 - 06/30/2005

User ID: Administrator
Run Date: 5/22/2006
Run Time: 11:38:37 AM

Case Type: 1 - All Claim Groupings
Recipient Peer Group: 526 - Medical Assistance, Categorically Needy, TANF
Recipient Aggregation: 7 - Fee for Service Claims by Recipient

| Rank | Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference From Expected | Exception |
|---|---|---|---|---|---|---|---|---|
| 1 | [redacted] | [redacted] | $15,000.00 | $8,127.35 | $8,127.35 | $3,178.22 | $4,949.13 | * |
| 4 | [redacted] | [redacted] | $17,000.00 | $6,286.06 | $6,286.06 | $3,178.22 | $3,107.84 | |
| 3 | [redacted] | [redacted] | $12,000.00 | $6,649.65 | $6,649.65 | $6,339.08 | $310.57 | |
| 6 | [redacted] | [redacted] | $3,000.00 | $3,863.76 | $3,863.76 | $3,779.01 | $84.75 | |
| 2 | [redacted] | [redacted] | $2,300.00 | $7,368.30 | $7,368.30 | $7,368.30 | $0.00 | |
| 10 | [redacted] | [redacted] | $10,000.00 | $735.85 | $735.85 | $735.85 | $0.00 | |
| 11 | [redacted] | [redacted] | $1,245.00 | $700.00 | $700.00 | $700.00 | $0.00 | |
| 7 | [redacted] | [redacted] | $13,000.00 | $3,694.25 | $3,694.25 | $3,779.01 | $(84.76) | |
| 5 | [redacted] | [redacted] | $109,920.00 | $49,619.82 | $6,028.50 | $6,339.08 | $(310.58) | |
| 8 | [redacted] | [redacted] | $1,200.00 | $738.85 | $738.85 | $3,178.22 | $(2,439.37) | |
| 8 | [redacted] | [redacted] | $1,245.00 | $738.85 | $738.85 | $3,178.22 | $(2,439.37) | |
| 12 | [redacted] | [redacted] | $15,900.00 | $11,065.99 | $0.00 | $3,178.22 | $(3,178.22) | |
| | | | | | | 2 STD DEV | $4,334.43 | |

End of Report


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B

**Alabama Medicaid Agency**

User ID: Administrator
Run Date: 5/22/2006
Run Time: 11:38:37 AM

Inpatient Recipient Case Type Comparison by Peer Group
Recipients Grouped by Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005

Case Type: 1 - All Claim Groupings
Recipient Peer Group: 526 - Medical Assistance, Categorically Needy, TANF
Recipient Aggregation: 7 - Fee for Service Claims by Recipient

Age 00 - 05

Gender: F

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| [illegible] | [illegible] | $3,000.00 | $3,863.76 | $3,863.76 |
| [illegible] | [illegible] | $13,000.00 | $3,694.25 | $3,694.25 |
| | | | Sum: | $7,558.01 |

Age 06 - 17

Gender: F

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| [illegible] | [illegible] | $1,200.00 | $738.85 | $738.85 |
| [illegible] | [illegible] | $15,900.00 | $11,065.99 | $0.00 |
| [illegible] | [illegible] | $1,245.00 | $738.85 | $738.85 |
| [illegible] | [illegible] | $15,000.00 | $8,127.35 | $8,127.35 |
| [illegible] | [illegible] | $17,000.00 | $6,286.06 | $6,286.06 |

### 3.5.16.1 DSSProfiler - Inpatient Recipient Case Type Comparison by Peer Group Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Dollar Difference from Expected | Difference in the actual amount the provider was paid and the amount the provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates recipients who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Number (Integer) |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Rank | Recipient's rank based on the actual money paid by the program. | 3 | Number (Decimal) |
| (A,B) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A,B) Billed Amount | Amount the provider billed for the service. | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A,B) Recipient Aggregation | Classification of the provider rendering health and medical services as approved under the state plan. | 2 | Character |
| (A,B) Recipient Full Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID | Recipient Medicaid Number. | 12 | Character |
| (A,B) Recipient Peer Group | Recipient Peer Group Code and Description. | 40 | Character |
| (B) Age | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Number (Integer) |
| (B) Gender | Recipient's gender. | 1 | Character |


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### 3.5.17 DSSProfiler - Inpatient Recipient Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all recipients within a peer group to determine which providers fall outside of service dollar norms on a user specified case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

The two tabs in this report are:

A. Recipient Comparison; and

B. Recipients Grouped by Age/Gender.

**A**

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 10/9/2007
Run Time: 2:34:30 PM

**Inpatient Recipient Case Type Comparison**
**By Peer Group Qtrly**

**Recipient Comparison**
**For Dates of Service: 01/01/2006 - 03/31/2006**
**Case Type: 5 - Morbidity 3**
**Peer Group Code: 846 - 41 Disabled-SSI- full Mcaid**
**Aggregation Code: 7 - Fee For Service Claims by Recipient**
**Quarter: 20061**

| Rank | Expected Rank | Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | [redacted] | [redacted] | $42,147.00 | $21,073.50 | $42,147.00 | $24,628.54 | $17,518.46 | |
| 2 | 4 | [redacted] | [redacted] | $33,118.96 | $5,306.98 | $31,841.88 | $17,111.34 | $14,730.54 | |
| 4 | 7 | [redacted] | [redacted] | $58,219.30 | $952.00 | $19,844.00 | $11,350.00 | $8,494.00 | |
| 5 | 6 | [redacted] | [redacted] | $33,888.00 | $952.00 | $15,232.00 | $15,232.00 | $0.00 | |
| 3 | 3 | [redacted] | [redacted] | $61,244.64 | $952.00 | $22,550.00 | $22,550.00 | $0.00 | |
| 7 | 7 | [redacted] | [redacted] | $12,589.50 | $952.00 | $2,856.00 | $11,350.00 | $(8,494.00) | |
| 8 | 4 | [redacted] | [redacted] | $28,021.24 | $5,538.54 | $2,380.80 | $17,111.34 | $(14,730.54) | |
| 6 | 1 | [redacted] | [redacted] | $7,110.08 | $3,555.04 | $7,110.08 | $24,628.54 | $(17,518.46) | |
| | | | | | | | 2 STD DEV | $24,413.79 | |

**End of Report**


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**B**

# Alabama Medicaid Agency

**Inpatient Recipient Case Type Comparison**
**By Peer Group Qtrly**

**Recipients Grouped by Age/Gender**

**For Dates of Service: 01/01/2006 - 03/31/2006**
**Case Type: 5 - Morbidity 3**
**Peer Group Code: 846 - 41 Disabled-SSI- full Mcaid**
**Aggregation Code: 7 - Fee For Service Claims by Recipient**
**Quarter: 20061**

**User ID:** [redacted]
**Run Date: 10/9/2007**
**Run Time: 2:34:30 PM**

**Age 06 - 17**

**Gender: F**

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| [redacted] | [redacted] | $28,021.24 | $5,538.54 | $2,380.80 |
| [redacted] | [redacted] | $33,118.96 | $5,306.98 | $31,841.88 |
| | | | **Sum:** | **$34,222.68** |

**Gender: M**

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| [redacted] | [redacted] | $42,147.00 | $21,073.50 | $42,147.00 |
| [redacted] | [redacted] | $7,110.08 | $3,555.04 | $7,110.08 |
| | | | **Sum:** | **$49,257.08** |

### 3.5.17.1 DSSProfiler - Inpatient Recipient Case Type Comparison by Peer Group Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Recipient's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group. | 3 | Number (Decimal) |
| (A) Rank | Recipient's rank based on the actual money paid by the program. | 3 | Number (Decimal) |
| (A,B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A,B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A,B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A,B) Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A,B) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A,B) Recipient Full Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID | Recipient Medicaid Number. | 12 | Character |
| (B) Age | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Number (Integer) |
| (B) Gender | Recipient's gender. | 1 | Character |


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### 3.5.18 DSSProfiler - Inpatient Provider Profile

The Inpatient Provider Profile report is created in the DSSProfiler. Based on the user-entered date range of one year, this report flags any category or case type that exceeds the accepted norm within the inpatient provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Inpatient Services -Tab B has two sections. The first section of this report contains a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

**Report Prompts (Search Criteria):**

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group- The peer group to which the profiled provider is being compared; and
- Aggregation Code - The code to which the profiled provider is being compared.


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A

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 5/30/2006
Run Time: 1:29:53 PM

**Inpatient Provider Profile**
**Provider Summary**

For Dates of Service: 07/01/2004 - 06/30/2005
Provider ID: [redacted]
Peer Group Code: 479 - 337 PLASTIC SURGEON
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

## Provider Information

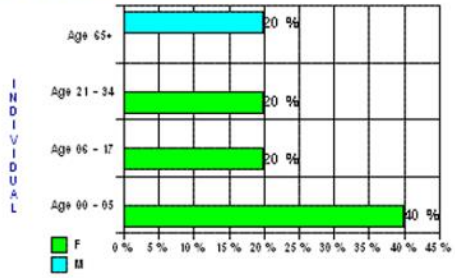
NPI ID: [redacted]
Mcaid ID: [redacted]
Base ID: [redacted]
Name: COUNTRY MEDICAL CLINIC
Type: 31 - Physician
Specialty: 345 - General Pediatrician
Address: 5888 PARK AVE

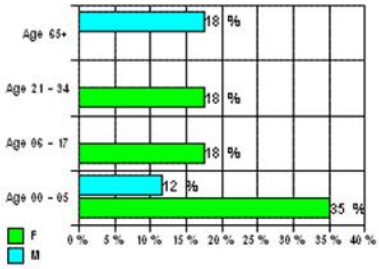
SALEM, OR 97501

## Ranks

| | |
|---|---|
| $ Paid Amount Actual | 1 |
| $ Paid Amount Expected | 1 |
| $ Billed Amount Actual | 1 |
| Recipient Rank | 1 |
| # Units Rank | 1 |
| # Claims Rank | 1 |
| Peer Group Size | 1 |

## Patient Age/Gender Breakdown




# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/1/2007
Run Time: 7:30:11 AM

**Inpatient Provider Profile**
**Provider Summary**

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 450 - 316 FAMILY PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

## Provider's General Service Profile

| Service Type | Recip Count | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|
| 3 - Inpatient Services | 5 | $3,808.00 | $102,383.32 | $3,708.00 | $4,657.77 | $(949.77) | (20.39) % |

End of Report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B

**Alabama Medicaid Agency**

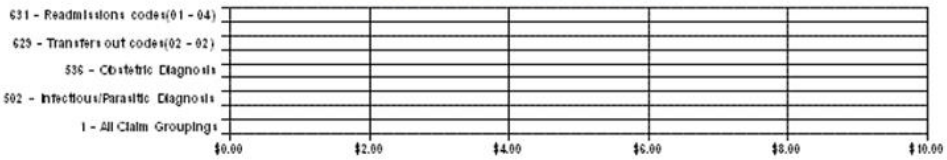
Inpatient Provider Profile

Inpatient Services

User ID: [redacted]
Run Date: 5/30/2006
Run Time: 1:29:53 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider ID: [redacted]
Peer Group Code: 479 - 337 PLASTIC SURGEON
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 10 Case Types: Dollar Difference




**Alabama Medicaid Agency**

Inpatient Provider Profile

Inpatient Services

User ID: [redacted]
Run Date: 11/1/2007
Run Time: 7:30:11 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 450 - 316 FAMILY PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| Case Type | Recip Count | Claim Count | Quantity | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|---|
| 3 - Morbidity 1 | 3 | 3 | 3 | $2,856.00 | $37,924.62 | $2,756.00 | $2,744.99 | $11.01 | 0.40 % |
| 5 - Morbidity 3 | 1 | 1 | 1 | $952.00 | $26,392.60 | $952.00 | $963.59 | $(11.59) | (1.20) % |
| 6 - Morbidity 4 | 1 | 1 | 1 | $0.00 | $38,066.10 | $0.00 | $949.20 | $(949.20) | (100.00) % |

End of Report

### 3.5.18.1 DSSProfiler - Inpatient Provider Profile Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) # Claims Rank | Rank is based on the number of paid claims. | 5 | Number (Decimal) |
| (A) # Units Rank | Rank based on the quantity billed. | 5 | Number (Decimal) |
| (A) $ Billed Amount Actual | Rank based on the actual money billed by the provider. | 5 | Number (Decimal) |
| (A) $ Paid Amount Actual | Rank based on the actual money paid by the program in the specific time period. | 5 | Number (Decimal) |
| (A) $ Paid Amount Expected | Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and | 5 | Number (Decimal) |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| Field | Description | Length | Data Type |
|---|---|---|---|
| | comparison of the provider's specialty peer group. | | |
| (A) Patient Age/Gender Breakdown | It compares the providers to their specialty peer group based on the recipients they serve. | 10 | Character |
| (A) Peer Group Size | Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings. | 5 | Number (Integer) |
| (A) Provider Information | Provider's demographic information. This includes the provider type, specialty, name, street address, city, state, zip code, and telephone number. | 200 | Character |
| (A) Provider Rank | Rank based on the number of eligible recipients the provider served in a specific time period. | 5 | Number (Integer) |
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. Claims can be further aggregated by billing or servicing provider where the servicing provider is the performing, referring, attending or prescribing provider, depending on claim type, or claims can be further aggregated by recipient. | 50 | Number (Decimal) |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-B) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (A-B) Dollar Difference | Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest). | 13 | Number (Decimal) |
| (A-B) Expected Amount | Amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment method for the particular claim group that is based on peer group norms. | 13 | Number (Decimal) |
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-B) Percent Difference | Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the | 8 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | variance of dollars from the expected value to the actual value in a percentage. | | |
| (A-B) Provider | Provider identification number entered at the prompt. | 13 | Character |
| (A-B) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A-B) Quantity Billed. | The quantity of billed units. | 8 | Number (Integer) |
| (A-B) Recipient Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (B) Top 10 Claim Groupings: Dollar Difference | Difference in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. | 60 | Character |


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### 3.5.19 DSSProfiler - Inpatient Provider Profile Quarterly

The Inpatient Provider Profile Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report flags any category or case type that exceeds the accepted norm within the inpatient provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Inpatient Services -Tab B has two sections. The first section of this report contains a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

**Report Prompts (Search Criteria):**

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - The peer group to which the profiled provider is being compared;
- Aggregation Code - The code to which the profiled provider is being compared; and
- Quarter - Quarter of the provider being profiled in the report.


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A

# Alabama Medicaid Agency

User ID:
Run Date: 9/27/2007
Run Time: 2:06:54 PM

**Inpatient Provider Profile Qtrly**
**Provider Summary**
**For Dates: 01/01/2006 - 12/31/2006**
**Provider ID:**
**Provider Peer Group: 102 - 010 ACUTE CARE**
**Aggregation Code: 1 - Fee for Service Claims by Servicing Provider**
**Provider ID Aggregation Code: 01 - Base ID all locations**
**Quarter: 20061**

## Provider Information

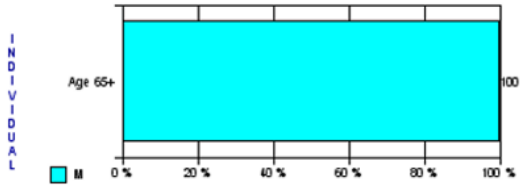
NPI ID:
Mcaid ID:
Base ID:
Name: ST JAMES HEALTHCARE - ALL BSE
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 400 SOUTH CLARK STREET

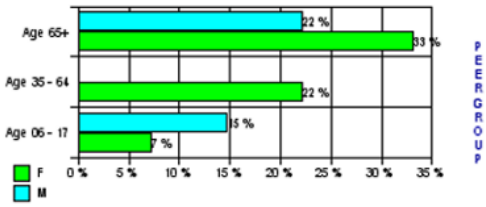
BUTTE, MT 59701

## Rank

| | |
|---|---|
| $ Paid Amount Actual | 66 |
| $ Paid Amount Expected | 79 |
| $ Billed Amount Actual | 43 |
| Recipient Rank | 114 |
| # Units Rank | 161 |
| # Claims Rank | 152 |
| Peer Group Size | 184 |

## Patient Age/Gender Breakdown




# Alabama Medicaid Agency

User ID:
Run Date: 11/1/2007
Run Time: 3:37:34 PM

**Inpatient Provider Profile Qtrly**
**Provider Summary**
**For Dates: 01/01/2006 - 12/31/2006**
**Provider ID:**
**Provider Peer Group: 102 - 010 ACUTE CARE**
**Aggregation Code: 1 - Fee for Service Claims by Servicing Provider**
**Provider ID Aggregation Code: 01 - Base ID all locations**
**Quarter: 20061**

## Provider's General Service Profile

| Report Category | Recipient Count | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|
| 3 - Inpatient Services | 1 | $6,664.00 | $12,730.00 | $952.00 | $935.33 | $16.67 | 1.78 % |

**End of Report**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B

**Alabama Medicaid Agency**

Inpatient Provider Profile Qtrly

Inpatient Services

For Dates: 01/01/2006 - 12/31/2006

Provider ID:

Provider Peer Group: 102 - 010 ACUTE CARE

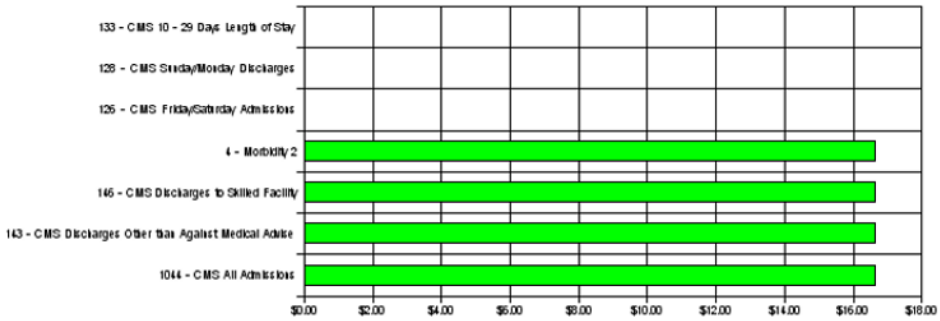
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider

Provider ID Aggregation Code: 01 - Base ID all locations

Quarter: 20061

User ID:
Run Date: 9/27/2007
Run Time: 2:06:54 PM

Top 10 Case Types: Dollar Difference




**Alabama Medicaid Agency**

Inpatient Provider Profile Qtrly

Inpatient Services

For Dates: 01/01/2006 - 12/31/2006

Provider ID:

Provider Peer Group: 102 - 010 ACUTE CARE

Aggregation Code: 1 - Fee for Service Claims by Servicing Provider

Provider ID Aggregation Code: 01 - Base ID all locations

Quarter: 20061

User ID:
Run Date: 9/27/2007
Run Time: 2:06:54 PM

| Case Type | Recip Count | Claim Count | Billed Quantity | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|---|
| 1044 - CMS All Admissions | 1 | 1 | 1 | $952.00 | $12,730.00 | $952.00 | $935.33 | $16.67 | 1.78 % |
| 143 - CMS Discharges Other than Against Medical Advise | 1 | 1 | 1 | $952.00 | $12,730.00 | $952.00 | $935.33 | $16.67 | 1.78 % |
| 146 - CMS Discharges to Skilled Facility | 1 | 1 | 1 | $952.00 | $12,730.00 | $952.00 | $935.33 | $16.67 | 1.78 % |
| 4 - Morbidity 2 | 1 | 1 | 1 | $952.00 | $12,730.00 | $952.00 | $935.33 | $16.67 | 1.78 % |
| 126 - CMS Friday/Saturday Admissions | 1 | 1 | 1 | $952.00 | $12,730.00 | $952.00 | $952.00 | $0.00 | 0.00 % |
| 128 - CMS Sunday/Monday Discharges | 1 | 1 | 1 | $952.00 | $12,730.00 | $952.00 | $952.00 | $0.00 | 0.00 % |
| 133 - CMS 10 - 29 Days Length of Stay | 1 | 1 | 1 | $952.00 | $12,730.00 | $952.00 | $952.00 | $0.00 | 0.00 % |

End of Report

### 3.5.19.1 DSSProfiler - Inpatient Provider Profile Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) # Claims Rank | Rank is based on the number of paid claims. | 5 | Number (Decimal) |
| (A) # Units Rank | Rank based on the quantity billed. | 5 | Number (Decimal) |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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) $ Billed Amount Actual | Rank based on the actual money billed by the provider. | 5 | Number (Decimal) |
| (A) $ Paid Amount Actual | Rank based on the actual money paid by the program in the specific time period. | 5 | Number (Decimal) |
| (A) $ Paid Amount Expected | Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group. | 5 | Number (Decimal) |
| (A) Patient Age/Gender Breakdown | Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve. | 10 | Character |
| (A) Peer Group Size | Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings. | 5 | Number (Integer) |
| (A) Provider Information | Provider's demographic information. This includes the provider type, specialty, name, street address, city, state, zip code, and telephone number. | 200 | Character |
| (A) Recipient Rank | Rank based on the number of eligible recipients the provider served in a specific time period. | 5 | Number (Decimal) |
| (A) Report Category | User-defined variables used to categorize case types into service groups. | 21 | Character |
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-B) Allowed Amount | The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-B) Dollar Difference | Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest). | 13 | Number (Decimal) |
| (A-B) Expected Amount | Amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment method for the particular claim group that is based on peer group norms. | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-B) Percent Difference | Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage. | 8 | Number (Decimal) |
| (A-B) Provider ID | Provider ID entered at the prompt. | 13 | Character |
| (A-B) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-B) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A-B) Recipient Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (A-B) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (B) Billed Quantity | Quantity billed. | 14 | Number (Decimal) |
| (B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (B) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (B) Top 10 Case Types: Dollar Difference | Difference in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference. | 60 | Character |


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### 3.5.20 DSSProfiler - Nursing Facility Case Type Comparison by Peer Group

Based on the user-entered date range of one year, this report displays and compares all providers within a nursing facility peer group to determine which providers fall outside of service dollar norms for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

The tabs on this report include:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender.

A

**Alabama Medicaid Agency**

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:31:18 PM

Nursing Facility Case Type Comparison by Peer Group
Provider Comparison
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

| Rank | Raw Rank | Expected Rank | Provider ID | Provider Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 1 | [redacted] | JOHN D SMITH - ALL NPI | $36,680.00 | $32,697.27 | $30,074.27 | $18,497.66 | $11,576.61 | |
| 2 | 4 | 4 | [redacted] | GRACE COMMUNITY PHYSICAL THERAPY - ALL NPI | $1,004.90 | $1,004.90 | $574.90 | $574.90 | $0.00 | |
| 3 | 2 | 2 | [redacted] | DAVISON NW MEDICAL - ALL NPI | $2,000.00 | $3,975.60 | $3,975.60 | $8,705.47 | $(4,729.87) | |
| 4 | 3 | 2 | [redacted] | WEST HILLS MEMORIAL - ALL NPI | $3,167.15 | $3,167.15 | $1,858.72 | $8,705.47 | $(6,846.75) | |
| | | | | | | | | 2 STD DEV | $14,257.19 | |

End of Report


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B

## Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:31:18 PM

Nursing Facility Case Type Comparison by Peer Group
Average Amount per Recipient by Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

WEST HILLS MEMORIAL - ALL NPI

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 35 - 64 | M | 1 | $1,858.72 |
| | | SUM: | $1,858.72 |

GRACE COMMUNITY PHYSICAL THERAPY - ALL NPI

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 65+ | F | 1 | $574.90 |
| | | SUM: | $574.90 |

C

## Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:31:18 PM

Nursing Facility Case Type Comparison by Peer Group
Average Amount per Recipient All Providers by Selected Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Age 00 - 05

Gender: F

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| | JOHN D SMITH - ALL NPI | $5,570.02 |
| | SUM: | $5,570.02 |

Age 06 - 17

Gender: M

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| | JOHN D SMITH - ALL NPI | $392.76 |
| | SUM: | $392.76 |


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#### 3.5.20.1 DSSProfiler - Nursing Facility Case Type Comparison by Peer Group Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Allowed Amount | The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group. | 3 | Number (Integer) |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Rank | Provider's rank based on the actual money paid by the program. | 3 | Number (Decimal) |
| (A) Raw Rank | Provider's rank based on the amount provider was paid. | 3 | Number (Decimal) |
| (A,B,C) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A,B,C) Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B,C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B,C) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A,B,C) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping | 20 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | | |
| (A,C) Provider ID | Provider identification number. | 15 | Character |
| (A,C) Provider Name | Provider's full name. | 50 | Character |
| (B,C) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (B) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (B,C) Gender | Recipient's gender. | 1 | Character |
| (B,C) Paid Amount per Recipient | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |


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### 3.5.21 DSSProfiler - Nursing Facility Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all providers within a quarterly nursing facility peer group to determine which providers fall outside of service dollar norms for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

The tabs on this report include:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender.

**Alabama Medicaid Agency**

User ID:
Run Date: 10/2/2006
Run Time: 9:22:07 PM

Nursing Facility Case Type Comparison by Peer Group Qtrly

Provider Comparison

For Dates of Service: 07/01/2004 - 09/30/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20043

| Rank | Raw Rank | Expected Rank | Provider ID | Provider Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 1 | | JOHN D SMITH - ALL NPI | $17,500.00 | $19,932.57 | $18,641.57 | $9,973.64 | $8,667.93 | |
| 2 | 4 | 4 | | GRACE COMMUNITY PHYSICAL THERAPY - ALL NPI | $1,004.90 | $1,004.90 | $574.90 | $574.90 | $0.00 | |
| 3 | 2 | 2 | | DAVISON NW MEDICAL - ALL NPI | $2,000.00 | $3,975.60 | $3,975.60 | $7,251.13 | $(3,275.53) | |
| 4 | 3 | 2 | | WEST HILLS MEMORIAL - ALL NPI | $3,167.15 | $3,167.15 | $1,858.72 | $7,251.13 | $(5,392.41) | |
| | | | | | | | | 2 STD DEV | 12,379.56 | |

End of Report


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# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/2/2006
Run Time: 9:22:07 PM

Nursing Facility Case Type Comparison by Peer Group Qtrly

Average Amount per Recipient by Age/Gender

For Dates of Service: 07/01/2004 - 09/30/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20043

[redacted] - WEST HILLS MEMORIAL - ALL NPI

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 35 - 64 | M | 1 | $1,858.72 |
| | | AVG: | $1,858.72 |

[redacted] - GRACE COMMUNITY PHYSICAL THERAPY - ALL NPI

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 65+ | F | 1 | $574.90 |
| | | AVG: | $574.90 |

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/2/2006
Run Time: 9:22:07 PM

Nursing Facility Case Type Comparison by Peer Group Qtrly

Average Amount per Recipient All Providers by Selected Age/Gender

For Dates of Service: 07/01/2004 - 09/30/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20043

Age 00 - 05

Gender: F

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| [redacted] | JOHN D SMITH - ALL NPI | $2,722.51 |
| | AVG: | $2,722.51 |

Age 35 - 64

Gender: M

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| [redacted] | WEST HILLS MEMORIAL - ALL NPI | $1,858.72 |
| [redacted] | DAVISON NW MEDICAL - ALL NPI | $3,975.60 |


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#### 3.5.21.1 DSSProfiler - Nursing Facility Case Type Comparison by Peer Group Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient | 13 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group. | 3 | Number (Decimal) |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Rank | Provider's rank based on the actual money paid by the program. | 3 | Number (Decimal) |
| (A) Raw Rank | Provider's rank based on the amount provider was paid. | 3 | Number (Decimal) |
| (A,B,C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B,C) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A,B,C) Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B,C) Provider ID | Provider identification number. | 15 | Character |
| (A,B,C) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B,C) Provider Name | Provider's full name. | 50 | Character |
| (A,B,C) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A,B,C) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (B,C) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (B,C) Gender | Recipient's gender. | 1 | Character |
| (B,C) Paid Amount per Recipient | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |


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### 3.5.22 DSSProfiler - Nursing Facility Claim Details by Provider - FFS

Based on the user-entered date range of one year, this report lets the user drill down to the detail level for all nursing facility case types for a given provider and service location. This report displays all detailed claims information categorized by the individual case types, additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The tabs on this report include:

A. Nursing Facility Claim Details - Shows all the claims the provider submitted.

B. Inpatient/Outpatient Claim Details - Shows the details for the claims.

C. Recipient Listing - Lists the individual recipient ID and names.

D. Diagnosis Listing - Lists the primary, secondary, and tertiary diagnosis codes.

E. Procedure Code Listing - Lists the procedure codes and counts.

A

**Alabama Medicaid Agency**

**Nursing Facility Claim Details By Provider - FFS**

**Nursing Facility Claim Details**

**For Dates of Service: 07/01/2015 - 06/30/2016**

**Provider Base, Medicaid or NPI ID:** [redacted]

**Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION**

**For Claim Types: I**

**User ID:** [redacted]
**Run Date: 7/12/16**
**Run Time: 5:12:06 PM**

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| ICN | CT | POS | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | ICD | Diag 2 | Diag 2 Desc | Cov Days | Billed Amt | Alwd Amt | Paid Amt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX, X | 2/23/1957 | 58 | 8/1/2015 | 8/31/2015 | 9 | 319 | UNSPECIFIED MENTAL RETARDATION | 9 | 2449 | UNSPECIFIED ACQUIRED HYPOTHYROIDISM | 31 | $6,239.68 | $6,239.68 | $5,266.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX, X | 7/26/1946 | 69 | 8/1/2015 | 8/31/2015 | 9 | 25000 | DIABETES UNCOMPL ADULT-TYPE II | 9 | 4439 | PERIPHERAL VASCULAR DISEASE, UNSPECIFIED | 31 | $6,239.68 | $6,239.68 | $5,539.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX, X | 9/10/1941 | 73 | 8/1/2015 | 8/31/2015 | 9 | 25000 | DIABETES UNCOMPL ADULT-TYPE II | 9 | 78039 | OTHER CONVULSIONS | 31 | $6,239.68 | $6,239.68 | $6,239.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX, X | 1/7/1936 | 79 | 8/1/2015 | 8/31/2015 | 9 | 40310 | HYPERTENSIVE RENAL DISEASE BENIGN | 9 | 5853 | CHRONIC KIDNEY DISEASE, STAGE III | 31 | $6,239.68 | $6,239.68 | $6,239.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX, X | 9/28/1955 | 59 | 8/1/2015 | 8/31/2015 | 9 | 3349 | SPINOCEREBELLAR DISEASE, UNSPECIFIED | 9 | 5851 | CHRONIC KIDNEY DISEASE, STAGE I | 31 | $6,239.68 | $6,239.68 | $5,322.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX, X | 12/18/1939 | 75 | 8/1/2015 | 8/31/2015 | 9 | 25000 | DIABETES UNCOMPL ADULT-TYPE II | 9 | V5867 | LONG-TERM (CURRENT) USE OF INSULIN | 31 | $6,239.68 | $6,239.68 | $5,509.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX, X | 9/20/1969 | 45 | 8/1/2015 | 8/31/2015 | 9 | 25000 | DIABETES UNCOMPL ADULT-TYPE II | 9 | V5867 | LONG-TERM (CURRENT) USE OF INSULIN | 31 | $6,239.68 | $6,239.68 | $6,239.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX, X | 11/30/1939 | 75 | 8/1/2015 | 8/26/2015 | 9 | 25000 | DIABETES UNCOMPL ADULT-TYPE II | 9 | V5867 | LONG-TERM (CURRENT) USE OF INSULIN | 26 | $5,233.28 | $5,233.28 | $5,233.28 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX, X | 9/26/1919 | 95 | 8/1/2015 | 8/31/2015 | 9 | 4439 | PERIPHERAL VASCULAR DISEASE, UNSPECIFIED | 9 | 44023 | ATHEROSCL-EXTREM W ULCERATION | 31 | $6,239.68 | $6,239.68 | $5,231.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX, X | 9/28/1964 | 50 | 8/1/2015 | 8/31/2015 | 9 | 25062 | DIAB NEURO MANIF ADULT-UNCONTRLLD | 9 | 3572 | POLYNEUROPATHY IN DIABETES | 31 | $6,239.68 | $6,239.68 | $6,055.64 |

B

**Alabama Medicaid Agency**

**Nursing Facility Claim Details By Provider - FFS**

**Inpatient/Outpatient Claim Details**

**For Dates of Service: 07/01/2015 - 06/30/2016**

**Provider Base, Medicaid or NPI ID:** [redacted]

**Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION**

**For Claim Types: I;A;C;O**

**User ID:** [redacted]
**Run Date: 7/12/16**
**Run Time: 5:12:06 PM**

| ICN | CT | POS | Dtl # | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | ICD | Diag 2 | Diag 2 Desc | Proc | Proc Desc | MD 1 | MD1 Desc | MD 2 | MD2 Desc | MD 3 | MD3 Desc | Bill Qty/ Cov Days | Billed Amt | Alwd Amt | Paid Amt | DRG Code & Desc | DRG Relative Weight | DRG Service Adjuster |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1234567890123 | I | 21 | 0 | 123456789012 | XXXXXXXXX XXXXXXXXX XX, XXXXXXXXX XXXXXX, X | 11/30/1939 | 75 | 7/2/2015 | 7/7/2015 | 9 | 41071 | OF OTHER ANTERIOR WALL | 9 | 5188 1 | RESPIRATO RY FAILURE | ###### | Unknown or Not Applicable | # # | Unknown or Not Applicable | # # | Unknown or Not Applicabl e | # # | Unknown or Not Applicable | 5 | $23,286.50 | $4,787.30 | $4,787.30 | #### - | 0 | 0 |

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**End of Report**


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C

# Alabama Medicaid Agency

## Nursing Facility Claim Details By Provider - FFS

### Recipient Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION

For Claim Types: L

| Recipient ID | Recipient Full Name | ICN Count |
|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X | 74 |

End of Report

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D

# Alabama Medicaid Agency

## Nursing Facility Claim Details By Provider - FFS

### Diagnosis Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION

For Claim Types: L

| ICD | Diagnosis 1 - Code & Desc | ICD | Diagnosis 2 - Code & Desc | ICD | Diagnosis 3 - Code & Desc | ICN Count | Recipient Count |
|---|---|---|---|---|---|---|---|
| 9 | 042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS | 9 | 40310 - HYPERTENSIVE RENAL DISEASE BENIGN | 9 | 5852 - CHRONIC KIDNEY DISEASE, STAGE II (MILD) | 1 | 1 |
| 9 | 042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS | 9 | 40310 - HYPERTENSIVE RENAL DISEASE BENIGN | 9 | 5853 - CHRONIC KIDNEY DISEASE, STAGE III | 1 | 1 |
| 9 | 1509 - MALIGNANT NEOPLASM OF ESOPHAGUS, UNSPECI | 9 | 78720 - DYSPHAGIA, UNSPECIFIED | 9 | 1977 - MALIGNANT NEOPLASM OF LIVER, SPECIFIED A | 1 | 1 |
| 9 | 185 - MALIGNANT NEOPLASM OF PROSTATE | 9 | 1539 - MALIGNANT NEOPLASM OF COLON, UNSPECIFIED | 9 | 40310 - HYPERTENSIVE RENAL DISEASE BENIGN | 1 | 1 |
| 9 | 185 - MALIGNANT NEOPLASM OF PROSTATE | 9 | 40310 - HYPERTENSIVE RENAL DISEASE BENIGN | 9 | 5853 - CHRONIC KIDNEY DISEASE, STAGE III | 1 | 1 |
| 9 | 25000 - DIABETES UNCOMPL ADULT-TYPE II | 9 | 40310 - HYPERTENSIVE RENAL DISEASE BENIGN | 9 | 5852 - CHRONIC KIDNEY DISEASE, STAGE II (MILD) | 1 | 1 |
| 9 | 25000 - DIABETES UNCOMPL ADULT-TYPE II | 9 | 40310 - HYPERTENSIVE RENAL DISEASE BENIGN | 9 | 5853 - CHRONIC KIDNEY DISEASE, STAGE III | 3 | 3 |


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E

**Alabama Medicaid Agency**

**Nursing Facility Claim Details By Provider - FFS**

**Procedure Listing**

**For Dates of Service: 07/01/2015 - 06/30/2016**

**Provider Base, Medicaid or NPI ID:**

**Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION**

**For Claim Types: L**

**User ID:**
**Run Date: 7/12/16**
**Run Time: 5:12:06 PM**

| Procedure Code & Description | ICN Count | Recipient Count |
|---|---|---|
| | 0 | 0 |

**End of Report**

### 3.5.22.1 DSSProfiler - Nursing Facility Claim Details by Provider - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Bill Quantity | The units of service billed for payment. | 15 | Number (Decimal) |
| (A,B) Claim Type (CT) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |
| (A,B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 10 | Number (Decimal) |
| (A,B) Place of Service (POS) | A code to indicate where the service was provided. | 2 | Character |
| (B) MD1 Desc | The description associated with the first modifier. | 40 | Character |
| (B) MD3 Desc | The description associated with the third modifier. | 40 | Character |
| (B,E) Procedure Description (Proc Desc) | The description associated with the primary procedure code. | 40 | Character |
| (A,B) Age | The age of the recipient based on the FDOS of the claim and the current eligibility date of birth rounded down to a full year. | 4 | Number |
| (A,B) Allowed Amount | Amount allowed by the specific program (Medicaid, 590, and so on.) for the procedure. | 9 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Billed Amount | Amount of money requested for payment by a provider for services rendered to a recipient. | 13 | Character |
| (A,B) Covered Days | The number of days covered for the statement period of the claim. | 9 | Number (Decimal) |
| (A,B) DOB | Recipient's date of birth. | 10 | Date (MM/DD/YY) |
| (A,B) Diag 2 | The secondary ICD-CM diagnosis code. | 7 | Character |
| (A,B) Diag 2 Desc | The secondary ICD-CM diagnosis code description. | 70 | Character |
| (A,B) From Date of Service (FDOS) | The date the service was incurred. | 10 | Date (MM/DD/CCYY) |
| (A,B) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A,B) To Date of Service | Date on which the statement period on the claim ended. | 10 | Date (MM/DD/CCYY) |
| (A,B,C) Recipient Full Name | Concatenates the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 39 | Character |
| (A,B,C) Recipient ID (Recip ID) | Recipient Medicaid Number | 12 | Character |
| (A,B,D) Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A,B,D) Diag Desc | The primary ICD-CM diagnosis code description. | 60 | Character |
| (A,B,D) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. | 1 | Character |
| (A,B,D) ICD Version for Diagnosis 2 | The ICD Version code for the secondary ICD-CM payment level diagnosis code. | 1 | Character |
| (A-E) Claim Type(s) (prompt) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |
| (A-E) Provider, Base, Medicaid or NPI ID (prompt) | Provider’s ID. | 15 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-E) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-E) Run Time | The time that the report was executed. | 11 | Character |
| (A-E) User ID | The id of the user that created the report. | 50 | Character |
| (B) Detail Number | Claim line number. | 4 | Number (Integer) |
| (B) MD1 | The first of four possible codes that may be used to supplement the procedure code. | 2 | Character |
| (B) MD2 | The second of four possible codes that may be used to supplement the procedure code. | 2 | Character |
| (B) MD2 Desc | The description associated with the second modifier. | 40 | Character |
| (B) MD3 | The third of four possible codes that may be used to supplement the procedure code. | 2 | Character |
| (B, E) Procedure code (Proc) | A code from the fee schedule to indicate the service performed. | 6 | Character |
| (C,D,E) ICN Count | Unduplicated count of claims for the recipient (C), Diagnosis code (D) or Procedure code (E). | 8 | Number (Integer) |
| (D) Diagnosis 2 - Code & Desc | The secondary ICD-CM diagnosis code and its description. | 70 | Character |
| (D) Diagnosis 3 - Code & Desc | The third ICD-CM diagnosis code and its description. | 70 | Character |
| (D) ICD Version for Diagnosis 3 | The ICD Version code for the third ICD-CM payment level diagnosis code. | 1 | Character |
| (D,E) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |


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### 3.5.23 DSSProfiler - Nursing Facility Claim Details by Provider Quarterly - FFS

Based on the user-entered date range of one quarter, this report lets the user drill down to the detail level for all nursing facility case types for a given provider ID and service location. This report displays all detailed claims information categorized by the individual case types additionally the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The tabs on this report include:

A. Nursing Facility Claim Details - Shows all the claims the provider submitted.

B. Inpatient/Outpatient Claim Details - Shows the details for the claims.

C. Recipient Listing - Lists the individual recipient ID and names.

D. Diagnosis Listing - Lists the primary, secondary, and tertiary diagnosis codes.

E. Procedure Code Listing - Lists the procedure codes and counts.

A

**Alabama Medicaid Agency**

**Nursing Facility Claim Details By Provider Qtrly - FFS**

**Nursing Facility Claim Details**

**For Dates of Service: 07/01/2015 - 06/30/2016**

**Provider Base, Medicaid or NPI ID:**

**Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION**

**For Claim Types: L**

**Calendar Year Quarter: 20153**

**User ID:**
**Run Date: 7/12/16**
**Run Time: 5:12:06 PM**

| ICN | CT | POS | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | ICD | Diag 2 | Diag 2 Desc | Cov Days | Billed Amt | Alwd Amt | Paid Amt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 2/23/1957 | 58 | 8/1/2015 | 8/31/2015 | 9 | 319 | UNSPECIFIED MENTAL RETARDATION | 9 | 2449 | UNSPECIFIED ACQUIRED HYPOTHYROIDISM | 31 | $6,239.68 | $6,239.68 | $5,266.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 7/26/1946 | 69 | 8/1/2015 | 8/31/2015 | 9 | 25000 | DIABETES UNCOMPL ADULT-TYPE II | 9 | 4439 | PERIPHERAL VASCULAR DISEASE, UNSPECIFIED | 31 | $6,239.68 | $6,239.68 | $5,539.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 9/10/1941 | 73 | 8/1/2015 | 8/31/2015 | 9 | 25000 | DIABETES UNCOMPL ADULT-TYPE II | 9 | 78039 | OTHER CONVULSIONS | 31 | $6,239.68 | $6,239.68 | $6,239.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 1/7/1936 | 79 | 8/1/2015 | 8/31/2015 | 9 | 40310 | HYPERTENSIVE RENAL DISEASE BENIGN | 9 | 5853 | CHRONIC KIDNEY DISEASE, STAGE III | 31 | $6,239.68 | $6,239.68 | $6,239.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 9/28/1955 | 59 | 8/1/2015 | 8/31/2015 | 9 | 3349 | SPINOCEREBELLAR DISEASE, UNSPECIFIED | 9 | 5851 | CHRONIC KIDNEY DISEASE, STAGE I | 31 | $6,239.68 | $6,239.68 | $5,322.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 12/18/1939 | 75 | 8/1/2015 | 8/31/2015 | 9 | 25000 | DIABETES UNCOMPL ADULT-TYPE II | 9 | V5867 | LONG-TERM (CURRENT) USE OF INSULIN | 31 | $6,239.68 | $6,239.68 | $5,509.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 9/26/1969 | 45 | 8/1/2015 | 8/31/2015 | 9 | 25000 | DIABETES UNCOMPL ADULT-TYPE II | 9 | V5867 | LONG-TERM (CURRENT) USE OF INSULIN | 31 | $6,239.68 | $6,239.68 | $6,239.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 11/30/1939 | 75 | 8/1/2015 | 8/26/2015 | 9 | 25000 | DIABETES UNCOMPL ADULT-TYPE II | 9 | V5867 | LONG-TERM (CURRENT) USE OF INSULIN | 26 | $5,233.28 | $5,233.28 | $5,233.28 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 9/26/1919 | 95 | 8/1/2015 | 8/31/2015 | 9 | 4439 | PERIPHERAL VASCULAR DISEASE, UNSPECIFIED | 9 | 44023 | ATHEROSCL-EXTREM W ULCERATION | 31 | $6,239.68 | $6,239.68 | $5,231.68 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 9/28/1964 | 50 | 8/1/2015 | 8/31/2015 | 9 | 25062 | DIAB NEURO MANIF ADULT-UNCONTRLLD | 9 | 3572 | POLYNEUROPATHY IN DIABETES | 31 | $6,239.68 | $6,239.68 | $6,055.64 |
| 1234567890123 | L | 31 | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 7/20/1952 | 63 | 8/1/2015 | 8/31/2015 | 9 | 4280 | CONGESTIVE HEART FAILURE | 9 | 40310 | HYPERTENSIVE RENAL DISEASE BENIGN | 31 | $6,239.68 | $6,239.68 | $5,824.68 |

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B

**Alabama Medicaid Agency**

**Nursing Facility Claim Details By Provider Qtrly- FFS**

**Inpatient/Outpatient Claim Details**

**For Dates of Service: 07/01/2015 - 06/30/2016**

**Provider Base, Medicaid or NPI ID:** [redacted]

**Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION**

**For Claim Types: I;A;C;O**

**Calendar Year Quarter: 20153**

**User ID:** [redacted]
**Run Date: 7/12/16**
**Run Time: 5:12:06 PM**

| ICN | CT | POS | DII # | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | ICD | Diag 2 | Diag 2 Desc | Proc | Proc Desc | MD1 | MD1 Desc | MD2 | MD2 Desc | MD3 | MD3 Desc | Bill Qty/ Cov Days | Billed Amt | Alwd Amt | Paid Amt | DRG Code & Desc | DRG Relative Weight | DRG Service Adjuster |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 123456789023 | I | 21 | 0 | 123456789012 | XXXXXXXXXX XXXXXXXXXX XX, XXXXXXXXXX XXXXXX, X | 11/30/1939 | 75 | 7/2/2015 | 7/7/2015 | 9 | 41071 | OF OTHER INTERIOR WALL | 9 | 5188 1 | RESPIRATO RY FAILURE | ###### | UNKNOWN or Not Applicable | # # | UNKNOWN or Not Applicable | # # | UNKNOWN or Not Applicable | # # | UNKNOWN or Not Applicable | 5 | $23,286.50 | $4,787.30 | $4,787.30 | ##### - | 0 | 0 |

**End of Report**

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C

# Alabama Medicaid Agency

## Nursing Facility Claim Details By Provider Qtrly - FFS

## Recipient Listing

**For Dates of Service: 07/01/2015 - 06/30/2016**

**Provider Base, Medicaid or NPI ID:** [redacted]

**Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION**

**For Claim Types: L**

**Calendar Year Quarter: 20153**

| Recipient ID | Recipient Full Name | ICN Count |
|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X | 74 |

**End of Report**

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D

# Alabama Medicaid Agency

**Nursing Facility Claim Details By Provider Qtrly - FFS**
**Diagnosis Listing**

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION

For Claim Types: L

Calendar Year Quarter: 20153

| ICD | Diagnosis 1 - Code & Desc | ICD | Diagnosis 2 - Code & Desc | ICD | Diagnosis 3 - Code & Desc | ICN Count | Recipient Count |
|---|---|---|---|---|---|---|---|
| 9 | 042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS | 9 | 40310 - HYPERTENSIVE RENAL DISEASE BENIGN | 9 | 5852 - CHRONIC KIDNEY DISEASE, STAGE II (MILD) | 1 | 1 |
| 9 | 042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS | 9 | 40310 - HYPERTENSIVE RENAL DISEASE BENIGN | 9 | 5853 - CHRONIC KIDNEY DISEASE, STAGE III | 1 | 1 |
| 9 | 1509 - MALIGNANT NEOPLASM OF ESOPHAGUS, UNSPECI | 9 | 78720 - DYSPHAGIA, UNSPECIFIED | 9 | 1977 - MALIGNANT NEOPLASM OF LIVER, SPECIFIED A | 1 | 1 |
| 9 | 185 - MALIGNANT NEOPLASM OF PROSTATE | 9 | 1539 - MALIGNANT NEOPLASM OF COLON, UNSPECIFIED | 9 | 40310 - HYPERTENSIVE RENAL DISEASE BENIGN | 1 | 1 |
| 9 | 185 - MALIGNANT NEOPLASM OF PROSTATE | 9 | 40310 - HYPERTENSIVE RENAL DISEASE BENIGN | 9 | 5853 - CHRONIC KIDNEY DISEASE, STAGE III | 1 | 1 |
| 9 | 25000 - DIABETES UNCOMPL ADULT-TYPE II | 9 | 40310 - HYPERTENSIVE RENAL DISEASE BENIGN | 9 | 5852 - CHRONIC KIDNEY DISEASE, STAGE II (MILD) | 1 | 1 |
| 9 | 25000 - DIABETES UNCOMPL ADULT-TYPE II | 9 | 40310 - HYPERTENSIVE RENAL DISEASE BENIGN | 9 | 5853 - CHRONIC KIDNEY DISEASE, STAGE III | 3 | 3 |

E

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/12/16
Run Time: 5:12:06 PM

**Nursing Facility Claim Details By Provider Qtrly - FFS**
**Procedure Listing**

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION

For Claim Types: L

Calendar Year Quarter: 20153

| Procedure Code & Description | ICN Count | Recipient Count |
|---|---|---|
| | 0 | 0 |

End of Report

### 3.5.23.1 DSSProfiler - Nursing Facility Claim Details by Provider Quarterly - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Bill Quantity | The units of service billed for payment. | 15 | Number |
| (A,B) DOB | Recipient's date of birth. | 10 | Date (MM/DD/YY) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Age | The age of the recipient based on the FDOS of the claim and the current eligibility date of birth rounded down to a full year. | 4 | Number |
| (A,B) Allowed Amount | Amount allowed by the specific program (Medicaid, 590, and so on.) for the procedure. | 9 | Number (Decimal) |
| (A,B) Billed Amount | Amount of money requested for payment by a provider for services rendered to a recipient. | 13 | Character |
| (A,B) Claim Type (CT) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |
| (A,B) Covered Days | The number of days covered for the statement period of the claim. | 9 | Number (Decimal) |
| (A,B) Diag 2 | The secondary ICD-CM diagnosis code. | 7 | Character |
| (A,B) Diag 2 Desc | The secondary ICD-CM diagnosis code description. | 60 | Character |
| (A,B) From Date of Service (FDOS) | The date the service was incurred. | 10 | Date (MM/DD/CCYY) |
| (A,B) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A,B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 10 | Number (Decimal) |
| (A,B) Place of Service (POS) | A code to indicate where the service was provided. | 2 | Character |
| (A,B) To Date of Service | Date on which the statement period on the claim ended. | 10 | Date (MM/DD/CCYY) |
| (A,B,C) Recipient Full Name | Concatenates the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 39 | Character |
| (A,B,C) Recipient ID (Recip ID) | Recipient Medicaid Number | 12 | Character |
| (A,B,D) Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A,B,D) Diag Desc | The primary ICD-CM diagnosis code description. | 60 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B,D) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. | 1 | Character |
| (A,B,D) ICD Version for Diagnosis 2 | The ICD Version code for the secondary ICD-CM payment level diagnosis code. | 1 | Character |
| (A-E) Claim Type(s) (prompt) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |
| (A-E) Provider, Base, Medicaid or NPI ID (prompt) | Provider's ID. | 15 | Character |
| (A-E) Quarter (prompt) | The quarter for which the report is being run. | 5 | Number (Integer) |
| (A-E) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-E) Run Time | The time that the report was executed. | 11 | Character |
| (A-E) User ID | The id of the user that created the report. | 50 | Character |
| (B) Detail Number | Claim line number. | 4 | Number (Integer) |
| (B) MD1 | The first of four possible codes that may be used to supplement the procedure code. | 2 | Character |
| (B) MD1 Desc | The description associated with the first modifier. | 40 | Character |
| (B) MD2 | The second of four possible codes that may be used to supplement the procedure code. | 2 | Character |
| (B) MD2 Desc | The description associated with the second modifier. | 40 | Character |
| (B) MD3 | The third of four possible codes that may be used to supplement the procedure code. | 2 | Character |
| (B) MD3 Desc | The description associated with the third modifier. | 40 | Character |
| (B,E) Procedure Description (Proc Desc) | The description associated with the primary procedure code. | 40 | Character |
| (B, E) Procedure code (Proc) | A code from the fee schedule to indicate the service performed. | 6 | Character |
| (C,D,E) ICN Count | Unduplicated count of claims for the recipient (C), Diagnosis code (D) or Procedure code (E). | 8 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (D) Diagnosis 2 - Code & Desc | The secondary ICD-CM diagnosis code and its description. | 70 | Character |
| (D) Diagnosis 3 - Code & Desc | The third ICD-CM diagnosis code and its description. | 70 | Character |
| (D) ICD Version for Diagnosis 3 | The ICD Version code for the third ICD-CM payment level diagnosis code. | 1 | Character |
| (D,E) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |

### 3.5.24 DSSProfiler - Nursing Facility Disease Quick View

This report is created in the DSSProfiler. This report displays recipient utilization services for selected case types with totals broken out by the number of services received. This report can also be used for disease management for nursing facility residents. The first row gives the totals for each column.

The tabs on this report include:

A. Nursing Facility Disease; and

B. Nursing Facility Disease by Peer Group.

A

**Alabama Medicaid Agency**

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:01 PM

Nursing Facility Disease Quick View
Nursing Facility Disease
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 1 | 2 | 1 | 2 | $2,000.00 | $3,975.60 | $3,975.60 |
| 2 | 4 | 4 | 8 | $8,000.00 | $6,087.78 | $5,962.78 |
| 1 | 6 | 3 | 6 | $5,929.40 | $5,829.89 | $5,829.89 |
| 2 | 10 | 10 | 20 | $11,847.15 | $6,996.56 | $5,688.13 |
| 1 | 16 | 8 | 16 | $20,000.00 | $22,780.08 | $20,282.08 |
| Totals: | | | 52 | $47,776.55 | $45,669.91 | $41,738.48 |

End of Report


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B

**Alabama Medicaid Agency**

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:01 PM

Nursing Facility Disease Quick View
Nursing Facility Disease By Peer Group
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Peer Group: 521 - Institutionalized with income < 300%, Disabled

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 1 | 2 | 1 | 2 | $2,000.00 | $3,975.60 | $3,975.60 |
| 1 | 6 | 3 | 6 | $5,929.40 | $5,829.89 | $5,829.89 |
| 1 | 16 | 8 | 16 | $20,000.00 | $22,780.08 | $20,282.08 |
| Totals: | | | 24 | $27,929.40 | $32,585.57 | $30,087.57 |

Peer Group: 525 - Public Assistance, TANF

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 2 | 10 | 10 | 20 | $11,847.15 | $6,996.56 | $5,688.13 |
| Totals: | | | 20 | $11,847.15 | $6,996.56 | $5,688.13 |

Peer Group: 526 - Medical Assistance, Categorically Needy, TANF

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|

### 3.5.24.1 DSSProfiler - Nursing Facility Disease Quick View Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-B) Allowed Amount | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A-B) Each Recipient Had XX Claims | This field shows us how many claims each of the recipients had. | 4 | Character |
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Paid Amount | This is the total amount paid by the program for the specific claim grouping. | 13 | Number (Decimal) |
| (A-B) Total Claims | This is the total number of claims billed based on the number of recipients and the number of claims for each recipient. | 9 | Character |
| (A-B) Total Quantity Billed | This is the total units billed for this particular claim category. | 9 | Character |
| (A-B) Unduplicated Recipients | This is a count of all recipients that had a service within this claim grouping. The count is unduplicated, meaning each recipient is only counted once. | 9 | Character |
| (B) Peer Group | Peer Group Code and Description. | 7 | Character |


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### 3.5.25 DSSProfiler - Nursing Facility Exception Quarterly

The Nursing Facility Quarterly Exception report is produced for a selected provider, provider peer group and aggregation code. The report displays the number of high exceptions for case groups that occur during each reporting period. The case groups whose calculations are above the exception high value are marked as exceptions.

**Alabama Medicaid Agency**

Nursing Facility Quarterly Exception

For Dates of Service: 07/01/2004 - 06/30/2005

User ID:
Run Date: 5/18/2006
Run Time: 12:46:14 PM

Provider Service Location Information:
NPI ID:
Mcaid ID:
Base ID:
Name: JOHN D SMITH
Type: 03 - Extended Care Facility
Specialty: 034 - ICF/MR < 6 Beds
Address: 5975 NE 1ST ST
DROP CODE 10404
SALEM, OR 97501

Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Peer Group Code: 3 - Nursing Home By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider

| | 20043 | | 20044 | | 20051 | |
|---|---|---|---|---|---|---|
| 600 - 00 - 07 Days Length of Stay; H: 002 L: 000 | | | | | 6.00 | * |
| 630 - 22 - 28 Days Length of Stay; H: 002 L: 000 | 7.00 | * | 4.00 | * | | |

End of Report

#### 3.5.25.1 DSSProfiler - Nursing Facility Exception Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| Case Type Group Display | Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item. | 4 | Number (Integer) |
| Exception | This column is marked with a '*' when the case group is above the exception high value. | 1 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |


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### 3.5.26 DSSProfiler - Nursing Facility Frequency Distribution

The Nursing Home Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one year, this report shows for each nursing facility case type, peer grouping, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type and peer grouping.

**Alabama Medicaid Agency**

**Nursing Facility Frequency Distribution**

For Dates of Service: 07/01/04 - 06/30/05
Provider Peer Group Code: 3
Provider Aggregation Code: 1
Provider ID Aggregation Code: 01

User ID:
Run Date: 5/22/2006
Run Time: 11:19:48 AM

Case Type :

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | | | | | | |

#### 3.5.26.1 DSSProfiler - Nursing Facility Frequency Distribution Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |
| 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |
| Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Provider Aggregation Code | Aggregation Code and Description. | 100 | Character |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| Provider Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer | 20 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | | |


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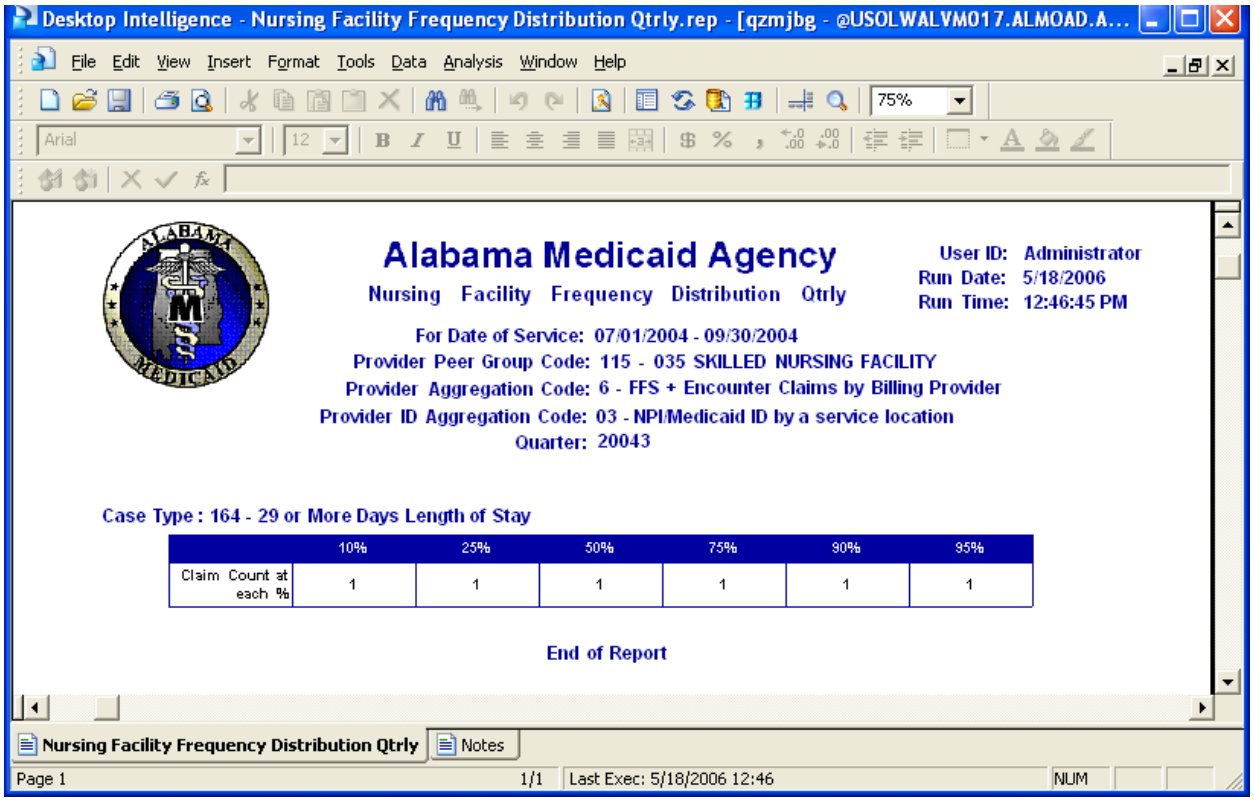
### 3.5.27 DSSProfiler - Nursing Facility Frequency Distribution Quarterly

Based on the user-entered date range of one quarter, this report displays provider claim counts by percentile for nursing facility services for the selected peer group and aggregation type. Each percentile represents a percentage of the number of providers with claims in the specific claim grouping. The percentile groups are determined by ordering providers by the number of paid claims each has for the case type and then grouping the providers into the percentiles starting with the provider with the least number of claims. The claim count displayed for each percentile represents the maximum number of claims for any provider falling in the percentile.




#### 3.5.27.1 DSSProfiler - Nursing Facility Frequency Distribution Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |
| 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |
| Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |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| Field | Description | Length | Data Type |
|---|---|---|---|
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Provider Aggregation Code | Aggregation Code and Description. | 100 | Character |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| Provider Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |


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### 3.5.28 DSSProfiler - Nursing Facility Recipient Case Type Comparison by Peer Group

The Nursing Facility Recipient Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all recipients within a peer group to determine which ones fall outside of service dollar norms for nursing home claims. All information is age and sex adjusted so that differences in patient mix do not affect the results. Individuals who have two standard deviations above the norm for the peer group are highlighted.

The tabs on this report include:

A. Recipient Comparison; and

B. Recipients Grouped by Age/Gender.

A

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 9/11/2007
Run Time: 2:50:37 PM

Nursing Facility Recipient Case Type Comparison by Peer Group

Recipient Comparison
For Dates of Service: 01/01/2006 - 12/31/2006

Case Type: 906 - AL MI and MR Diagnosis
Recipient Peer Group: 1026 - 95 D.O. QMB Only with no money QMB only
Aggregation Code: 7 - Fee For Service Claims by Recipient

| Rank | Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference From Expected | Exception |
|---|---|---|---|---|---|---|---|---|
| 1 | [redacted] | [redacted] | $3,689.00 | $3,689.00 | $3,689.00 | $1,785.00 | $1,904.00 | |
| 4 | [redacted] | [redacted] | $1,071.00 | $1,071.00 | $1,071.00 | $1,071.00 | $0.00 | |
| 2 | [redacted] | [redacted] | $5,291.93 | $2,737.00 | $2,737.00 | $2,737.00 | $0.00 | |
| 3 | [redacted] | [redacted] | $2,486.30 | $1,785.00 | $1,785.00 | $1,785.00 | $0.00 | |
| 5 | [redacted] | [redacted] | $5,609.13 | $357.00 | $357.00 | $1,785.00 | $(1,428.00) | |
| 6 | [redacted] | [redacted] | $238.00 | $238.00 | $238.00 | $1,785.00 | $(1,547.00) | |
| 7 | [redacted] | [redacted] | $119.00 | $119.00 | $119.00 | $1,785.00 | $(1,666.00) | |
| | | | | | | 2 STD DEV | $2,361.96 | |

End of Report


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B

**Alabama Medicaid Agency**

User ID:
Run Date: 9/11/2007
Run Time: 2:50:37 PM

Nursing Facility Recipient Case Type Comparison by Peer Group

Recipients Grouped by Age/Gender
For Dates of Service: 01/01/2006 - 12/31/2006

Case Type: 906 - AL MI and MR Diagnosis
Recipient Peer Group: 1026 - 95 D.O. QMB Only with no money QMB only
Aggregation Code: 7 - Fee For Service Claims by Recipient

Age 35 - 64
Gender: M

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| | | $2,486.30 | $1,785.00 | $1,785.00 |
| | | | Sum: | $1,785.00 |

### 3.5.28.1 DSSProfiler - Nursing Facility Recipient Case Type Comparison by Peer Group Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Dollar Difference from Expected | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates recipients who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Number (Decimal) |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Rank | Recipient's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-B) Allowed Amount | The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-B) Billed Amount | Amount the provider billed for the service. | 13 | Number (Decimal) |
| (A-B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-B) Recipient Full Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A-B) Recipient ID | Recipient Medicaid Number. | 12 | Character |
| (A-B) Recipient Peer Group | Recipient Peer Group Code and Description. | 40 | Character |
| (B) Age | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (B) Gender | Recipient's gender. | 1 | Character |


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### 3.5.29 DSSProfiler - Nursing Facility Recipient Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all recipients within a peer group to determine which recipients fall outside of service dollar norms on a user specified case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

The tabs on this report include:

A. Recipient Comparison; and

B. Recipients Grouped by Age/Gender.

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 5/22/2006
Run Time: 9:12:12 AM

Nursing Facility Recipient Case Type Comparison
By Peer Group Qtrly
Recipient Comparison
For Dates of Service: 07/01/2004 - 09/30/2004
Case Type: 1 - All Claim Groupings
Peer Group Code: 297 - Institutionalized with income < 300%, Disabled
Aggregation Code: 7 - Fee for Service Claims by Recipient
Quarter: 20043

| Rank | Expected Rank | Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | [redacted] | [redacted] | $15,000.00 | $17,085.06 | $15,919.06 | $9,947.33 | $5,971.73 | |
| 3 | 3 | [redacted] | [redacted] | $2,714.70 | $2,714.70 | $2,714.70 | $2,714.70 | $0.00 | |
| 2 | 1 | [redacted] | [redacted] | $2,000.00 | $3,975.60 | $3,975.60 | $9,947.33 | $(5,971.73) | |
| | | | | | | | 2 STD DEV | $9,751.79 | |

End of Report


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# Alabama Medicaid Agency

User ID:
Run Date: 5/22/2006
Run Time: 9:12:12 AM

Nursing Facility Recipient Case Type Comparison
By Peer Group Qtrly

Recipients Grouped by Age/Gender
For Dates of Service: 07/01/2004 - 09/30/2004
Case Type: 1 - All Claim Groupings
Peer Group Code: 297 - Institutionalized with income < 300%, Disabled
Aggregation Code: 7 - Fee for Service Claims by Recipient
Quarter: 20043

Age 35 - 64

Gender: M

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| | | $15,000.00 | $17,085.06 | $15,919.06 |
| | | $2,000.00 | $3,975.60 | $3,975.60 |
| | | | Sum: | $9,947.33 |

Age 65+

Gender: F

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| | | $2,714.70 | $2,714.70 | $2,714.70 |
| | | | Sum: | $2,714.70 |

### 3.5.29.1 DSSProfiler - Nursing Facility Recipient Case Type Comparison by Peer Group Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Recipient's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group. | 3 | Number (Integer) |
| (A) Rank | Recipient's rank based on the actual money paid by the program. | 3 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. . Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A,B) Allowed Amount | The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A,B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A,B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B) For Dates of Service | The dates for which the report is being run. | 20 | Date (MM/DD/CCYY) |
| (A,B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A,B) Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A,B) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A,B) Recipient Full Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID | Recipient Medicaid Number. | 12 | Character |
| (B) Age | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Number (Integer) |
| (B) Gender | Recipient's gender. | 1 | Character |


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### 3.5.30 DSSProfiler - Nursing Facility Provider Profile

The Nursing Facility Provider Profile report is created in the DSSProfiler. Based on the user-entered date range of one year, this report flags any category or case type for a nursing facility provider that exceeds the accepted norm within the provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient health status, recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Nursing Facility Services - The first section displays a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time.

The second section of the report lists all case types for which the provider was reimbursed over a particular time period. They include the following:

C. Professional Billing - This report lists all professional case types for which the profiled nursing facility was the billing provider;

D. Inpatient Billing - This report lists all inpatient case types for which the profiled nursing facility was the billing provider;

E. Outpatient Billing - This report lists all outpatient case types for which the profiled nursing facility was the billing provider; and

F. Pharmacy Billing - This report lists all pharmacy case types for which the profiled nursing facility was the billing provider.

**Report Prompts (Search Criteria):**

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - the peer group to which the profiled provider is being compared; and
- Aggregation Code - the aggregation code to which the profiled provider is being compared.


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A

# Alabama Medicaid Agency

User ID:
Run Date: 10/15/2007
Run Time: 8:31:22 AM

Nursing Facility Provider Profile
Provider Summary
For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

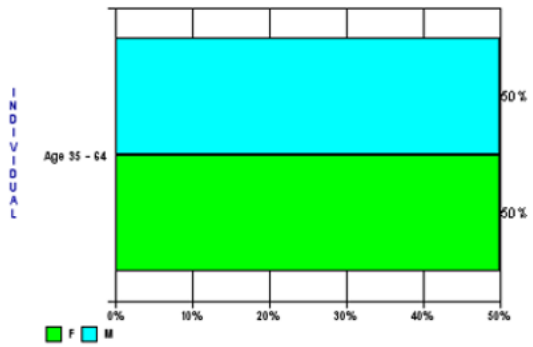
## Provider Information

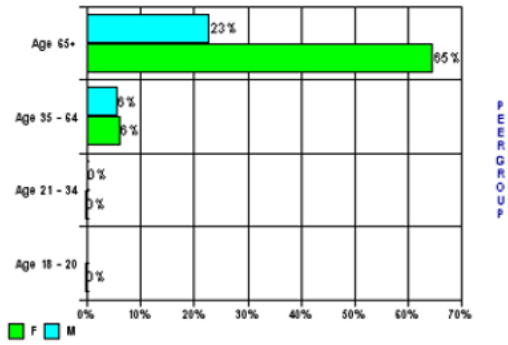
NPI ID:
Mcaid ID:
Base ID:
Name: JONES, SUSAN E
Type: 31 - Physician
Specialty: 800 - Internal Medicine
Address: 121 NORTH 20TH ST
SUITE 6
OPELIKA, AL 36801

## Ranks

| | |
|---|---|
| $ Paid Amount Actual | 68 |
| $ Paid Amount Expected | 124 |
| $ Billed Amount Actual | 124 |
| Recipient Rank | 195 |
| # Units Rank | 2 |
| # Claims Rank | 64 |
| Peer Group Size | 345 |

## Patient Age/Gender Breakdown




# Alabama Medicaid Agency

User ID:
Run Date: 10/15/2007
Run Time: 8:31:22 AM

Nursing Facility Provider Profile
Provider Summary
For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

## Provider's General Service Profile

| Report Category Code and Description | Recipient Count | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|
| 5 - Nursing Facility Services | 2 | $32,102.08 | $9,044.00 | $31,292.46 | $15,124.00 | $16,168.46 | 106.91 % |

End of Report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**B**

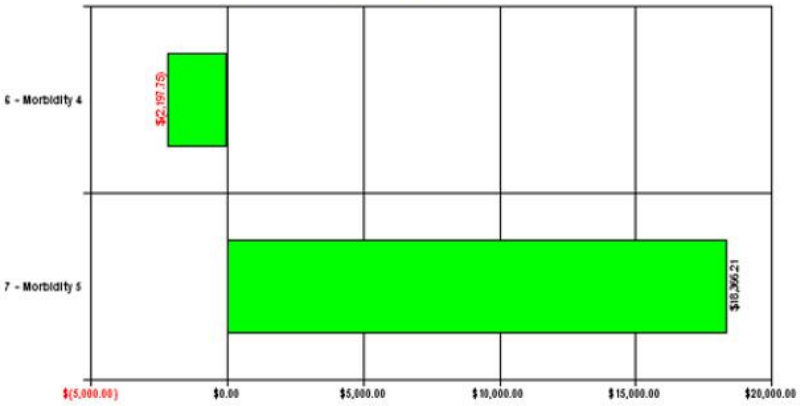
## Alabama Medicaid Agency

User ID:
Run Date: 10/10/2007
Run Time: 8:15:32 AM

Nursing Facility Provider Profile
Nursing Facility Services

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 10 Case Type Groupings: Dollar Difference




## Alabama Medicaid Agency

User ID:
Run Date: 10/15/2007
Run Time: 8:31:22 AM

Nursing Facility Provider Profile
Nursing Facility Services

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| Case Type Code and Description | Recipient Count | Claim Count | Billed Quantity | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|---|
| 7 - Morbidity 5 | 1 | 19 | 509 | $26,647.32 | $8,687.00 | $30,935.46 | $12,569.25 | $18,366.21 | 146.12 % |
| 6 - Morbidity 4 | 1 | 1 | 1 | $5,454.76 | $357.00 | $357.00 | $2,554.75 | $(2,197.75) | (86.03) % |

End of Report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C

## Alabama Medicaid Agency

User ID:
Run Date: 10/10/2007
Run Time: 8:45:27 AM

Nursing Facility Provider Profile
Professional Billing

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 339 - 035 SKILLED NURSING FACILITY
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| Case Type Code Description | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|
| 996 - AL Consultation Procedures | $98.00 | $60.00 | $60.00 |
| 1000 - AL Dormicilla Procedures | $970.00 | $0.00 | $4.48 |
| 1031 - AL Platelet - Cell Count Procedures | $246.42 | $40.00 | $1,131.73 |
| 1035 - AL Injectable Drug Procedures | $11,490.82 | $3,127.64 | $0.00 |
| 1066 - AL Eval and Mgmt Consultation Procedures | $98.00 | $60.00 | $60.00 |
| 1071 - AL Hypertension Diagnosis | $65.00 | $0.00 | $0.00 |
| 1072 - AL Decubitus Diagnosis | $42.40 | $0.00 | $0.00 |
| 1118 - AL Surgery Procedures | $256.00 | $66.72 | $0.00 |

End of Report

D

## Alabama Medicaid Agency

User ID:
Run Date: 10/24/2007
Run Time: 11:25:54 AM

Nursing Facility Provider Profile
Inpatient Billing

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 339 - 035 SKILLED NURSING FACILITY
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| Case Type Code Description | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|
| 6 - Morbidity 4 | $20,095.23 | $4,665.64 | $4,665.64 |

End of Report

E

## Alabama Medicaid Agency

User ID:
Run Date: 10/10/2007
Run Time: 8:45:27 AM

Nursing Facility Provider Profile
Outpatient Billing

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 339 - 035 SKILLED NURSING FACILITY
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| Case Type Code Description | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|
| 3 - Morbidity 1 | $700.00 | $220.50 | $0.00 |
| 4 - Morbidity 2 | $498.50 | $20.25 | $20.25 |
| 5 - Morbidity 3 | $585.97 | $307.00 | $0.00 |
| 787 - AL Emergency Room - Non Crit Procedures | $425.20 | $70.29 | $70.29 |
| 794 - AL Radiology Procedures | $498.50 | $20.25 | $20.25 |
| 1043 - AL Undefined Symptom Diagnosis | $903.39 | $329.10 | $0.00 |

End of Report


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F

**Alabama Medicaid Agency**

Nursing Facility Provider Profile
Pharmacy Billing

User ID:
Run Date: 10/24/2007
Run Time: 11:25:54 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 339 - 035 SKILLED NURSING FACILITY
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| Case Type Code Description | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|
| 4 - Morbidity 2 | $517.75 | $200.31 | $200.31 |
| 5 - Morbidity 3 | $4,681.45 | $3,018.33 | $3,018.33 |
| 6 - Morbidity 4 | $7,304.17 | $4,815.35 | $4,815.35 |

End of Report

### 3.5.30.1 DSSProfiler - Nursing Facility Provider Profile Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) # Claims Rank | Rank is based on the number of paid claims. | 5 | Number (Integer) |
| (A) # Units Rank | Rank based on the quantity billed. | 5 | Number (Integer) |
| (A) $ Billed Amount Actual | Rank based on the actual money billed by the provider. | 5 | Number (Decimal) |
| (A) $ Paid Amount Actual | Rank based on the actual money paid by the program in the specific time period. | 5 | Number (Decimal) |
| (A) $ Paid Amount Expected | Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group. | 5 | Number (Decimal) |
| (A) Patient Age/Gender Breakdown | Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve. | 10 | Character |
| (A) Peer Group Size | Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings. | 5 | Number (Integer) |
| (A) Provider Information | Provider's demographic information. This includes the provider type, specialty, name, street address, city, state, zip code, and telephone number. | 200 | Character |
| (A) Recipient Rank | Rank based on the number of eligible recipients the provider served in a specific time period. | 5 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-F) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-F) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-F) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-B) Dollar Difference | Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest). | 13 | Number (Decimal) |
| (A-B) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A-F) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-F) Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A-B) Percent Difference | Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage. | 8 | Number (Decimal) |
| (A-F) Provider ID | Provider's identification number. | 13 | Character |
| (A-F) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-B) Recipient Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Report Category Code and Description | User-defined variables used to categorize case types into service groups. | 21 | Character |
| (B-F) Case Type Code and Description | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (B) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (B) Billed Quantity | Quantity billed. | 8 | Number (Integer) |
| (B) Top 10 Case Type Groupings: Dollar Difference | Different in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference. | 60 | Character |
| (A-F) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |


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### 3.5.31 DSSProfiler - Nursing Facility Provider Profile Quarterly

Nursing Facility Provider Profile Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report flags any category or case type for a nursing facility provider that exceeds the accepted norm within the provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient health status, recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Nursing Facility Services - The first section displays a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time.

The second section of the report lists all case types for which the provider was reimbursed over a particular time period.

**Report Prompts (Search Criteria):**

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - the peer group to which the profiled provider is being compared; and
- Aggregation Code is the aggregation code to which the profiled provider is being compared.


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A

# Alabama Medicaid Agency

Nursing Facility Provider Profile Qtrly
Provider Summary

User ID:
Run Date: 10/11/2007
Run Time: 8:08:50 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee For Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20063

## Provider Information

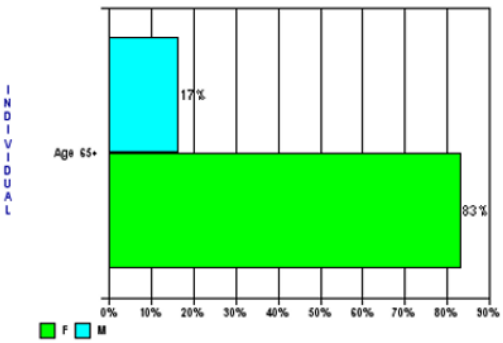
NPI ID:
Mcaid ID:
Base ID:
Name: CROWNE HLTH CARE OF GREENVIL
Type: 03 - Extended Care Facility
Specialty: 035 - Nursing Facility
Address: 408 COUNTRY CLUB DRIVE

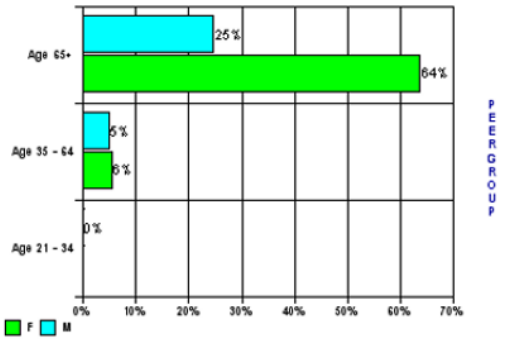
GREENVILLE, AL 36037

## Ranks

| | |
|---|---|
| $ Paid Amount Actual | 113 |
| $ Paid Amount Expected | 102 |
| $ Billed Amount Actual | 152 |
| Recipient Rank | 82 |
| # Units Rank | 111 |
| # Claims Rank | 106 |
| Peer Group Size | 190 |

## Patient Age/Gender Breakdown




# Alabama Medicaid Agency

Nursing Facility Provider Profile Qtrly
Provider Summary

User ID:
Run Date: 10/11/2007
Run Time: 8:08:50 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee For Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20063

## Provider's General Service Profile

| Service Type | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|
| 10 - Nursing Facility Services by Billing Provider | 6 | $9,834.07 | $10,115.00 | $9,218.40 | $13,033.04 | $(3,814.64) | (29.27) % |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**B**

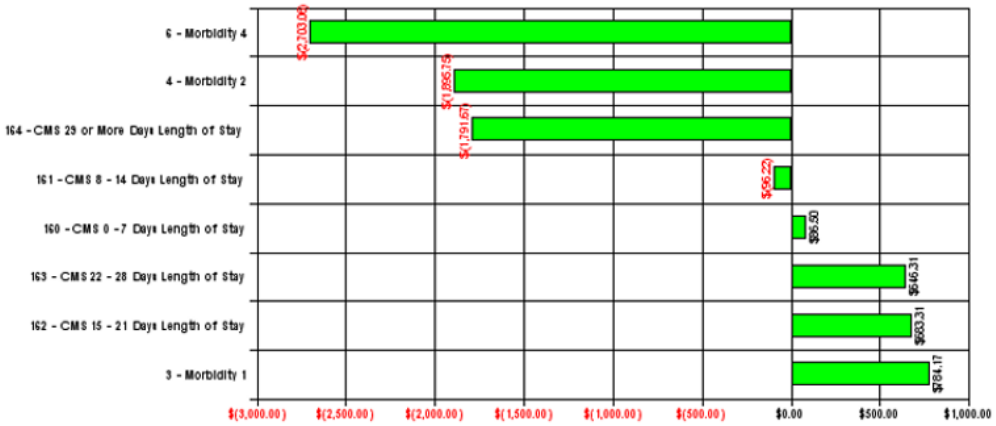
# Alabama Medicaid Agency

Nursing Facility Provider Profile Qtrly
Nursing Facility Services

User ID: [redacted]
Run Date: 10/11/2007
Run Time: 8:08:50 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee For Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20063

Top 10 Case Type Groupings: Dollar Difference




# Alabama Medicaid Agency

Nursing Facility Provider Profile Qtrly
Nursing Facility Services

User ID: [redacted]
Run Date: 10/11/2007
Run Time: 8:08:50 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee For Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20063

| Case Type Code and Description | Recipient Count | Claim Count | Billed Quantity | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|---|
| 3 - Morbidity 1 | 1 | 1 | 1 | $3,451.00 | $3,451.00 | $2,835.33 | $2,051.16 | $784.17 | 38.23 % |
| 162 - CMS 15 - 21 Days Length of Stay | 1 | 1 | 1 | $2,499.00 | $2,499.00 | $2,499.00 | $1,815.69 | $683.31 | 37.63 % |
| 163 - CMS 22 - 28 Days Length of Stay | 2 | 2 | 2 | $4,360.07 | $4,641.00 | $3,744.40 | $3,098.09 | $646.31 | 20.86 % |
| 160 - CMS 0 - 7 Days Length of Stay | 1 | 1 | 1 | $595.00 | $595.00 | $595.00 | $508.50 | $86.50 | 17.01 % |
| 161 - CMS 8 - 14 Days Length of Stay | 1 | 1 | 1 | $1,190.00 | $1,190.00 | $1,190.00 | $1,286.22 | $(96.22) | (7.48) % |
| 164 - CMS 29 or More Days Length of Stay | 1 | 1 | 1 | $1,190.00 | $1,190.00 | $1,190.00 | $2,981.67 | $(1,791.67) | (60.09) % |
| 4 - Morbidity 2 | 3 | 3 | 3 | $4,598.07 | $4,879.00 | $4,598.07 | $6,493.82 | $(1,895.75) | (29.19) % |
| 6 - Morbidity 4 | 2 | 2 | 2 | $1,785.00 | $1,785.00 | $1,785.00 | $4,488.06 | $(2,703.06) | (60.23) % |

End of Report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#### 3.5.31.1 DSSProfiler - Nursing Facility Provider Profile Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) # Claims Rank | Rank is based on the number of paid claims. | 5 | Number (Integer) |
| (A) # Units Rank | Rank based on the quantity billed. | 5 | Number (Integer) |
| (A) $ Billed Amount Actual | Rank based on the actual money billed by the provider. | 5 | Number (Decimal) |
| (A) $ Paid Amount Actual | Rank based on the actual money paid by the program in the specific time period. | 5 | Number (Decimal) |
| (A) $ Paid Amount Expected | Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group. | 5 | Number (Decimal) |
| (A) Patient Age/Gender Breakdown | Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve. | 10 | Character |
| (A) Peer Group Size | Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings. | 5 | Number (Integer) |
| (A) Provider Information | Provider's demographic information. This includes the provider type, specialty, name, street address, city, state, zip code, and telephone number. | 20 | Character |
| (A) Recipient Rank | Rank based on the number of eligible recipients the provider served in a specific time period. | 5 | Number (Integer) |
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-B) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (B) Billed Quantity | Quantity billed. | 14 | Number (Integer) |
| (A-B) Dollar Difference | Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest). | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-B) Percent Difference | Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage. | 8 | Number (Decimal) |
| (A-B) Provider ID | Provider identification number. | 15 | Character |
| (A-B) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-B) Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A-B) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A-B) Recip Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (B) Case Type Code and Description | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |
| (B) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (B) Top 10 Case Types: Dollar Difference | Different in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference. | 60 | Character |


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### 3.5.32 DSSProfiler - Outpatient Case Type Comparison by Peer Group

Based on the user-entered date range of one year, this report displays and compares all outpatient providers within a peer group to determine which providers fall outside of service dollar norms for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

The tabs on this report include:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All by Selected Age/Gender.

**Alabama Medicaid Agency**

User ID:
Run Date: 10/4/2006
Run Time: 2:42:40 PM

Outpatient Case Type Comparison by Peer Group
Provider Comparison

For Dates of Service: 10/01/2004 - 09/30/2005
Case Type: 709 - Injury/Poisoning Diagnosis
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| Rank | Raw Rank | Expected Rank | Provider ID | Provider Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 5 | 5 | | COUNTRY MEDICAL CLINIC | $2,100.00 | $(200.00) | $0.00 | $0.00 | $0.00 | * |
| 2 | 1 | 1 | | TIM J BEAL | $400.00 | $50.00 | $50.00 | $50.00 | $0.00 | * |
| 3 | 1 | 1 | | GEORGE F WILSON | $15,000.00 | $50.00 | $50.00 | $50.00 | $0.00 | * |
| 4 | 4 | 4 | | NEW HORIZON REHAB CLINIC | $45.00 | $13.11 | $13.11 | $13.11 | $0.00 | * |
| 5 | 3 | 3 | 2003052195 | JOHN D SMITH | $220.00 | $17.00 | $17.00 | $17.00 | $0.00 | * |
| | | | | | | | | 2 STD DEV | $0.00 | |

End of Report


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# Alabama Medicaid Agency

User ID:
Run Date: 10/4/2006
Run Time: 2:42:40 PM

Outpatient Case Type Comparison by Peer Group
Average Amount per Recipient by Age/Gender

For Dates of Service: 10/01/2004 - 09/30/2005
Case Type: 709 - Injury/Poisoning Diagnosis
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

- COUNTRY MEDICAL CLINIC

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 18 - 20 | F | 1 | $0.00 |
| | | AVG: | $0.00 |

- TIM J BEAL

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 35 - 64 | M | 1 | $50.00 |
| | | AVG: | $50.00 |

# Alabama Medicaid Agency

User ID:
Run Date: 10/4/2006
Run Time: 2:42:40 PM

Outpatient Case Type Comparison by Peer Group
Average Amount per Recipient All Providers by Selected Age/Gender

For Dates of Service: 10/01/2004 - 09/30/2005
Case Type: 709 - Injury/Poisoning Diagnosis
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Age 06 - 17

Gender: M

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| | NEW HORIZON REHAB CLINIC | $13.11 |
| | AVG: | $13.11 |

Age 18 - 20

Gender: F

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| | COUNTRY MEDICAL CLINIC | $0.00 |
| | AVG: | $0.00 |

### 3.5.32.1 DSSProfiler - Outpatient Case Type Comparison by Peer Group Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | particular grouping of claims for this specific recipient. | | |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group. | 3 | Number (Integer) |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Rank | Provider's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A) Raw Rank | Provider's rank based on the amount provider was paid. | 3 | Number (Integer) |
| (A,B,C) Aggregation Type | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 2 | Character |
| (A,B,C) Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B,C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B,C) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A,B,C) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical | 20 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | | |
| (A,C) Provider ID | Provider identification number. | 15 | Character |
| (A,C) Provider Name | Provider's full name. | 50 | Character |
| (B,C) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (B,C) Gender | Recipient's gender. | 1 | Character |
| (B,C) Paid Amount per Recipient | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |


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### 3.5.33 DSSProfiler - Outpatient Case Type Comparison by Peer Group Quarterly

The Outpatient Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar norms on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

This report provides a rapid method to find which providers need to be analyzed more closely at a case type level, utilizing other reports within the DSSProfiler. This report makes it easy to see, for example, which are the providers of asthma services who fall outside of the accepted 'norm' within the peer group.

There are tabs in this report:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All by Selected Age/Gender.

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 10/2/2006
Run Time: 9:24:20 PM

Outpatient Case Type Comparison by Peer Group Qtrly
Provider Comparison

For Dates of Service: 10/01/2004 - 12/31/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20044

| Rank | Raw Rank | Expected Rank | Provider ID | Provider Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 1 | [redacted] | TIM J BEAL - ALL NPI | $716.40 | $320.21 | $317.21 | $264.01 | $53.20 | |
| 2 | 3 | 6 | [redacted] | GEORGE F WILSON - ALL NPI | $15,000.00 | $50.00 | $50.00 | $50.00 | $0.00 | |
| 3 | 2 | 2 | [redacted] | COUNTRY MEDICAL CLINIC - ALL NPI | $18,000.00 | $150.00 | $150.00 | $150.00 | $0.00 | |
| 4 | 3 | 4 | [redacted] | NW GENERAL - ALL NPI | $525.60 | $50.00 | $50.00 | $71.37 | $(21.37) | |
| 5 | 6 | 4 | [redacted] | JILL E JANES - ALL NPI | $72.80 | $21.37 | $21.37 | $71.37 | $(50.00) | |
| 6 | 5 | 3 | [redacted] | DONALD B JONES - ALL NPI | $51.20 | $25.60 | $25.60 | $78.80 | $(53.20) | |
| | | | | | | | | 2 STD DEV | 78.83 | |

End of Report


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# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:34:17 PM

## Outpatient Case Type Comparison by Peer Group Qtrly

Average Amount per Recipient by Age/Gender
For Dates of Service: 10/01/2004 - 12/31/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20044

[redacted] - TIM J BEAL - ALL NPI

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 06 - 17 | M | 2 | $105.40 |
| Age 21 - 34 | F | 1 | $36.74 |
| Age 35 - 64 | F | 2 | $22.08 |
| | | Avg: | $58.34 |

[redacted] - JILL E JANES - ALL NPI

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 06 - 17 | F | 1 | $21.37 |
| | | Avg: | $21.37 |


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# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:34:17 PM

Outpatient Case Type Comparison by Peer Group Qtrly
Average Amount per Recipient All Providers by Selected Age/Gender

For Dates of Service: 10/01/2004 - 12/31/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20044

Age 00 - 05

Gender: F

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| [redacted] | COUNTRY MEDICAL CLINIC - ALL NPI | $50.00 |
| | Avg: | $50.00 |

Age 06 - 17

Gender: F

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| [redacted] | JILL E JANES - ALL NPI | $21.37 |
| [redacted] | NW GENERAL - ALL NPI | $50.00 |
| | Avg: | $35.69 |

### 3.5.33.1 DSSProfiler - Outpatient Case Type Comparison by Peer Group Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Expected Rank | Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group. | 3 | Number (Decimal) |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Provider ID | Provider identification number. | 15 | Character |
| (A) Rank | Provider's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A) Raw Rank | Provider's rank based on the amount provider was paid. | 3 | Number (Integer) |
| (A,B,C) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A,B,C) Case Type | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |
| (A,B,C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B,C) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A,,C) Provider Name | Provider's full name. | 50 | Character |
| (A,B,C) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A,B,C) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (B) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (B,C) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (B,C) Gender | Recipient's gender. | 1 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (B,C) Paid Amount per Recipient | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |


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### 3.5.34 DSSProfiler - Outpatient Claim Details by Provider - FFS

Based on the user-entered date range of one year, this report lets the user drill down to the detail level for all outpatient case types for a given provider and service location. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

There are tabs in this report:

A. Outpatient Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

**Alabama Medicaid Agency**

**Outpatient Claim Details By Provider - FFS**

**Outpatient Claim Details**

**For Dates of Service: 07/01/2015 - 06/30/2016**

**Provider Base, Medicaid or NPI ID:** [redacted]

**Billing Provider Name: UNIVERSITY OF ALABAMA**

**For Claim Types: O**

**User ID:** [redacted]
**Run Date:** 7/11/16
**Run Time:** 2:37:19 PM

| ICN | CT | POS | Dtl # | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | ICD | Diag 2 | Diag 2 Desc | Proc | Proc Desc | MD1 | MD1 Desc | MD2 | MD2 Desc | MD3 | MD3 Desc | Bill Qty | Billed Amt | Alwd Amt | Paid Amt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1234567890123 | O | 22 | 10 | 12345678901 2 | XXXXXXXX XXXX, XXXXXXXX XXXXXXX, | MM/DD/YYYY | 22 | 7/27/2015 | 7/27/2015 | 9 | V252 | STERILIZATIO N | 9 | 75982 | WARFAIN SYNDROME | 58670 | Laparoscopi Tubal Cauter | LT | LEFT SIDE | RT | RIGHT SIDE | # # | UNKNOWN or Not Applicable | 1 | ######## | $333.94 | $333.94 |
| 1234567890123 | O | 22 | 13 | 12345678901 2 | XXXXXXXX XXXX, XXXXXXXX XXXXXXX, | MM/DD/YYYY | 24 | 8/8/2015 | 8/8/2015 | 9 | 9170 | ABRASION OR FRICTION BURN OF FOOT AND TO | 9 | 9160 | ABRASION OR FRICTION BURN OF HIP, THIGH, | 73630 | X-Ray Exam Of Foot | LT | LEFT SIDE | RT | RIGHT SIDE | # # | UNKNOWN or Not Applicable | 1 | $706.00 | $15.16 | $15.16 |
| 1234567890123 | O | 22 | 14 | 12345678901 2 | XXXXXXXX XXXX, XXXXXXXX XXXXXXX, | MM/DD/YYYY | 24 | 8/8/2015 | 8/8/2015 | 9 | 9170 | ABRASION OR FRICTION BURN OF FOOT AND TO | 9 | 9160 | ABRASION OR FRICTION BURN OF HIP, THIGH, | 73610 | X-Ray Exam Of Ankle | LT | LEFT SIDE | RT | RIGHT SIDE | # # | UNKNOWN or Not Applicable | 1 | $704.00 | $15.16 | $15.16 |

**End of Report**

PHI has been removed


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B

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/11/16
Run Time: 2:37:19 PM

## Outpatient Claim Details By Provider - FFS

Recipient Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: O

| Recipient ID | Recipient Full Name | ICN Count |
|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X | 3210 |

End of Report

C

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/11/16
Run Time: 2:37:19 PM

## Outpatient Claim Details By Provider - FFS

Diagnosis Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

| ICD | Diagnosis 1 - Code & Desc | ICD | Diagnosis 2 - Code & Desc | ICD | Diagnosis 3 - Code & Desc | ICN Count | Recipient Count |
|---|---|---|---|---|---|---|---|
| 0 | B20 - HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE | 0 | B20 - HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE | # | ####### - Unknown or Not Appl. | 6 | 6 |
| 0 | B20 - HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE | 0 | K219 - GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS | 0 | B20 - HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE | 1 | 1 |
| 0 | B349 - VIRAL INFECTION, UNSPECIFIED | 0 | M791 - MYALGIA | 0 | R918 - OTHER NONSPECIFIC ABNORMAL FINDING OF LUNG FIELD | 1 | 1 |

End of Report


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D

**Alabama Medicaid Agency**

**Outpatient Claim Details By Provider - FFS**

**Procedure Listing**

**For Dates of Service: 07/01/2015 - 06/30/2016**

**Provider Base, Medicaid or NPI ID:** [redacted]

**Billing Provider Name: UNIVERSITY OF ALABAMA**

**For Claim Types: O**

**User ID:** [redacted]
**Run Date: 7/11/16**
**Run Time: 2:37:19 PM**

| Procedure Code & Description | ICN Count | Recipient Count |
|---|---|---|
| 11043 - Deb Musc/Fascia 20 Sq Cm/< | 1 | 1 |
| 11044 - Deb Bone 20 Sq Cm/< | 1 | 1 |
| 11100 - Biopsy Skin Lesion | 2 | 2 |
| 11424 - Exc H-F-Nk-Sp B9+Marg 3.1-4 | 1 | 1 |
| 13151 - Cmplx Rpr E/N/E/L 1.1-2.5 Cm | 1 | 1 |
| 14060 - Tis Trnfr E/N/E/L 10 Sq Cm/< | 1 | 1 |
| 17106 - Destruction Of Skin Lesions | 3 | 3 |

**End of Report**

### 3.5.34.1 DSSProfiler - Outpatient Claim Details by Provider - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age | The age of the recipient on the From Date of Service rounded down to a full year. | 4 | Number (Integer) |
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Bill Qty | Quantity billed for the service rendered. | 2 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Claim Type (CT) | Shows what type of claim was submitted. | 1 | Character |
| (A) DOB | Recipient's Date of Birth | 10 | Date (MM/DD/CCYY) |
| (A) Detail Number (Dtl#) | Claim line number. | 4 | Number (Integer) |
| (A) Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag Desc | The primary ICD-CM diagnosis code description. | 60 | Character |
| (A) Diag 2 | The secondary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag 2 Desc | The secondary ICD-CM diagnosis code description. | 60 | Character |
| (A) From Date of Service (FDOS) | Claim's first date of service. | 10 | Date (MM/DD/CCYY) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A) MD1 | First Modifier code for the procedure code billed. | 2 | Character |
| (A) MD1 Desc | Description for the First Modifier code of the procedure code billed. | 40 | Character |
| (A) MD2 | Second Modifier code for the procedure code billed. | 2 | Character |
| (A) MD2 Desc | Description for the Second Modifier code of the procedure code billed. | 40 | Character |
| (A) MD3 | Third Modifier code for the procedure code billed. | 2 | Character |
| (A) MD3 Desc | Description for the Third Modifier code of the procedure code billed. | 40 | Character |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Place of Service (POS) | Place of Service code for where services were rendered. | 2 | Number (Decimal) |
| (A) Proc | Procedure Code for the detail. | 6 | Character |
| (A) Proc Desc | Procedure Code description for the detail. | 40 | Character |
| (A) To Date of Service (TDOS) | Claim's last date of service. | 10 | Date (MM/DD/CCYY) |
| (A,B) Recipient Full Name (Recip Name) | The recipient last name and first name. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID (Recip ID) | Recipient Medicaid Number. | 12 | Character |
| (A,C) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A,C) ICD Version for Diagnosis 2 | The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-D) Claim Types (prompt) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |
| (A-D) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-D) Run Time | The time that the report was executed. | 11 | Character |
| (A-D) User ID | The user that created the report. | 50 | Character |
| (A-D) Provider Base, Medicaid or NPI ID (prompt) | Lists the NPI, Medicaid, and Base ID for the attending Provider. | 63 | Character |
| (B) ICN Count | Unduplicated count of claims for the recipient within that provider. | 8 | Number (Integer) |
| (C) Diagnosis 1 - Code & Desc | The primary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 2 - Code & Desc | The secondary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 3 - Code & Desc | The third ICD-CM diagnosis code and its description. | 70 | Character |
| (C) ICD Version for Diagnosis 3 | The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (C) ICN Count | Unduplicated count of claims for Diagnosis codes. | 8 | Number (Integer) |
| (C,D) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (D) ICN Count | Unduplicated count of claims for procedure code. | 8 | Number (Integer) |
| (D) Procedure Code & Description | Concatenate procedure code and description into one object. | 47 | Character |


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### 3.5.35 DSSProfiler - Outpatient Claim Details by Provider Quarterly - FFS

Based on the user-entered date range of one quarter, this report lets the user drill down to the detail level for all outpatient case types for a given provider and service location. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

There are tabs in this report:

A. Outpatient Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

**Alabama Medicaid Agency**

Outpatient Claim Details By Provider Qtrly - FFS

Outpatient Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: O

Quarter: 20153

User ID: [redacted]
Run Date: 7/11/16
Run Time: 5:44:16 PM

| ICN | CT | POS | Dtl # | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | ICD | Diag 2 | Diag 2 Desc | Proc | Proc Desc | MD1 | MD1 Desc | MD2 | MD2 Desc | MD3 | MD3 Desc | Bill Qty | Billed Amt | Alwd Amt | Paid Amt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 123456789012 3 | O | 22 | 4 | 123456789012 | XXXXXXXX XXXXXXXX XXXX, XXXXXXXX XXXXXX, X | MM/DD/YYYY | 64 | 8/14/2015 | 8/14/2015 | 9 | 7202 | SACROILITIS, NOT ELSEWHERE CLASSIFIED | 9 | 72252 | DEGENERATION OF LUMBAR OR LUMBOSACRAL IN | 27096 | INJ SACROILIAC JOINT | R T | RIGHT SIDE | L T | LEFT SIDE | # # | Unknown or not Applicable | 1 | ####### | $217.05 | $217.05 |

End of Report

PHI has been removed

B

**Alabama Medicaid Agency**

Outpatient Claim Details By Provider Qtrly - FFS

Recipient Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: O

Quarter: 20153

User ID: [redacted]
Run Date: 7/11/16
Run Time: 5:44:16 PM

| Recipient ID | Recipient Full Name | ICN Count |
|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX, X | 3032 |

End of Report


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C

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/11/16
Run Time: 5:44:16 PM

## Outpatient Claim Details By Provider Qtrly - FFS

### Diagnosis Listing

For Dates of Service: 07/01/2015 - 06/30/2016
Provider Base, Medicaid or NPI ID: [redacted]
Billing Provider Name: UNIVERSITY OF ALABAMA
For Claim Types: O
Quarter: 20153

| ICD | Diagnosis 1 - Code & Desc | ICD | Diagnosis 2 - Code & Desc | ICD | Diagnosis 3 - Code & Desc | ICN Count | Recipient Count |
|---|---|---|---|---|---|---|---|
| 9 | 042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS | 9 | 042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS | # | ####### - Unknown or Not Appl. | 50 | 49 |
| 9 | 042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS | 9 | 07070 - UNSPECIFIED VIRAL HEPATITIS C W/O HEPATI | 9 | 042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS | 1 | 1 |
| 9 | 042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS | 9 | 2724 - OTHER AND UNSPECIFIED HYPERLIPIDEMIA | 9 | 042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS | 1 | 1 |

End of Report

D

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/11/16
Run Time: 5:44:16 PI

## Outpatient Claim Details By Provider Qtrly - FFS

### Procedure Listing

For Dates of Service: 07/01/2015 - 06/30/2016
Provider Base, Medicaid or NPI ID: [redacted]
Billing Provider Name: UNIVERSITY OF ALABAMA
For Claim Types: O
Quarter: 20153

| Procedure Code & Description | ICN Count | Recipient Count |
|---|---|---|
| 11043 - Deb Musc/Fascia 20 Sq Cm/< | 1 | 1 |
| 11044 - Deb Bone 20 Sq Cm/< | 1 | 1 |
| 11100 - Biopsy Skin Lesion | 2 | 2 |
| 11424 - Exc H-F-Nk-Sp B9+Marg 3.1-4 | 1 | 1 |
| 13151 - Cmplx Rpr E/N/E/L 1.1-2.5 Cm | 1 | 1 |
| 14060 - Tis Trnfr E/N/E/L 10 Sq Cm/< | 1 | 1 |
| 17106 - Destruction Of Skin Lesions | 3 | 3 |

End of Report


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### 3.5.35.1 DSSProfiler - Outpatient Claim Details by Provider Quarterly - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age | The age of the recipient on the From Date of Service rounded down to a full year. | 4 | Number (Integer) |
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Bill Qty | Quantity billed for the service rendered. | 2 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Claim Type (CT) | Shows what type of claim was submitted. | 1 | Character |
| (A) DOB | Recipient's Date of Birth | 10 | Date (MM/DD/CCYY) |
| (A) Detail Number (Dtl#) | Claim line number. | 4 | Number (Integer) |
| (A) Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag Desc | The primary ICD-CM diagnosis code description. | 60 | Character |
| (A) Diag 2 | The secondary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag 2 Desc | The secondary ICD-CM diagnosis code description. | 60 | Character |
| (A) From Date of Service (FDOS) | Claim's first date of service. | 10 | Date (MM/DD/CCYY) |
| (A) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A) MD1 | First Modifier code for the procedure code billed. | 2 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) MD1 Desc | Description for the First Modifier code of the procedure code billed. | 40 | Character |
| (A) MD2 | Second Modifier code for the procedure code billed. | 2 | Character |
| (A) MD2 Desc | Description for the Second Modifier code of the procedure code billed. | 40 | Character |
| (A) MD3 | Third Modifier code for the procedure code billed. | 2 | Character |
| (A) MD3 Desc | Description for the Third Modifier code of the procedure code billed. | 40 | Character |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Place of Service (POS) | Place of Service code for where services were rendered. | 2 | Number (Decimal) |
| (A) Proc | Procedure Code for the detail. | 6 | Character |
| (A) Proc Desc | Procedure Code description for the detail. | 40 | Character |
| (A) To Date of Service (TDOS) | Claim's last date of service. | 10 | Date (MM/DD/CCYY) |
| (A,B) Recipient Full Name (Recip Name) | The recipient last name and first name. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID (Recip ID) | Recipient Medicaid Number. | 12 | Character |
| (A,C) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A,C) ICD Version for Diagnosis 2 | The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A-D) Claim Types (prompt) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |
| (A-D) Quarter (prompt) | The quarter for which the report is being run. | 5 | Number |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-D) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-D) Run Time | The time that the report was executed. | 11 | Character |
| (A-D) User ID | The user that created the report. | 50 | Character |
| (A-D) Provider Base, Medicaid or NPI ID (prompt) | Lists the NPI, Medicaid, and Base ID for the attending Provider. | 63 | Character |
| (B) ICN Count | Unduplicated count of claims for the recipient within that provider. | 8 | Number (Integer) |
| (C) Diagnosis 1 - Code & Desc | The primary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 2 - Code & Desc | The secondary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 3 - Code & Desc | The third ICD-CM diagnosis code and its description. | 70 | Character |
| (C) ICD Version for Diagnosis 3 | The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (C) ICN Count | Unduplicated count of claims for Diagnosis codes. | 8 | Number (Integer) |
| (C,D) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (D) ICN Count | Unduplicated count of claims for procedure code. | 8 | Number (Integer) |
| (D) Procedure Code & Description | Concatenate procedure code and description into one object. | 47 | Character |


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### 3.5.36 DSSProfiler - Outpatient Disease Quick View

This report is created in the DSSProfiler. The report displays recipient utilization services for selected case types with totals broken out by the number of services received. This report can also be used for disease management. The first row gives the totals for each column.

There are tabs in this report:

A. Outpatient Disease; and

B. Outpatient Disease By Peer Group.

**Alabama Medicaid Agency**

User ID:
Run Date: 8/6/2006
Run Time: 9:27:01 PM

Outpatient Disease Quick View
Outpatient Disease
For Dates of Service: 10/01/2004 - 09/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 12 | 1 | 12 | 12 | $2,683.20 | $711.45 | $711.45 |
| 2 | 2 | 4 | 4 | $156.80 | $35.50 | $35.50 |
| 5 | 3 | 15 | 15 | $18,721.60 | $453.74 | $453.74 |
| 4 | 4 | 16 | 16 | $5,811.20 | $(95.34) | $404.66 |
| 2 | 5 | 10 | 10 | $32,478.60 | $475.94 | $475.94 |
| 2 | 6 | 12 | 12 | $8,287.80 | $418.68 | $194.50 |
| 1 | 9 | 9 | 9 | $305.60 | $25.19 | $21.69 |
| 1 | 10 | 10 | 10 | $2,000.00 | $0.00 | $0.00 |
| 1 | 33 | 33 | 33 | $12,000.00 | $1,588.39 | $1,077.39 |
| 1 | 37 | 37 | 37 | $20,200.00 | $(1,600.00) | $0.00 |
| Totals: | | | 158 | $2,683.20 | $2,013.55 | $3,374.87 |

End of Report


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# Alabama Medicaid Agency

Outpatient Disease Quick View

Outpatient Disease By Peer Group

For Dates of Service: 10/01/2004 - 09/30/2005

Case Type: 1 - All Claim Groupings

Aggregation Code: 7 - Fee for Service Claims by Recipient

User ID: [redacted]
Run Date: 8/6/2006
Run Time: 9:27:01 PM

Peer Group: 504 - Blank Aid Category

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 5 | 1 | 5 | 5 | $1,757.80 | $147.46 | $147.46 |
| 6 | 2 | 12 | 12 | $12,771.20 | $175.19 | $275.19 |
| 2 | 3 | 6 | 6 | $3,735.00 | $50.00 | $38.00 |
| 1 | 4 | 4 | 4 | $4,800.00 | $(400.00) | $0.00 |
| 1 | 10 | 10 | 10 | $2,000.00 | $0.00 | $0.00 |
| Totals: | | | 37 | $25,064.00 | $(27.35) | $460.65 |

Peer Group: 508 - Presumptive Eligible

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 1 | 1 | 1 | 1 | $115.00 | $94.40 | $94.40 |
| Totals: | | | 1 | $115.00 | $94.40 | $94.40 |

### 3.5.36.1 DSSProfiler - Outpatient Disease Quick View Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Paid Amount | This is the total amount paid by the program for the specific claim grouping. | 13 | Number (Decimal) |
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-B) Allowed Amount | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Each Recipient Had XX Claims | This field shows us how many claims each of the recipients had. | 4 | Character |
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-B) Total Claims | This is the total number of claims billed based on the number of recipients and the number of claims each recipient had. | 9 | Number (Integer) |
| (A-B) Total Quantity Billed | This is the total units billed for this particular claim category. | 9 | Number (Integer) |
| (A-B) Unduplicated Recipients | This is a count of all recipients that have had a service within this claim grouping. The count is unduplicated, meaning each recipient is only counted once. | 9 | Number (Integer) |
| (B) Peer Group | Peer Group Code and Description. | 7 | Character |


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### 3.5.37 DSSProfiler - Outpatient Distribution Analysis

This report shows totals for all outpatient case types within the selected peer group. The totals include amount paid, number of unduplicated recipients, claim counts, units and exceptions. The report also provides a rapid method to identify which case types or service categories need to be looked at more closely with other reports within the DSSProfiler. The exception count is the count of distinct providers who have more than two standard deviations from the norms compared to their peers.

There are tabs in this report:

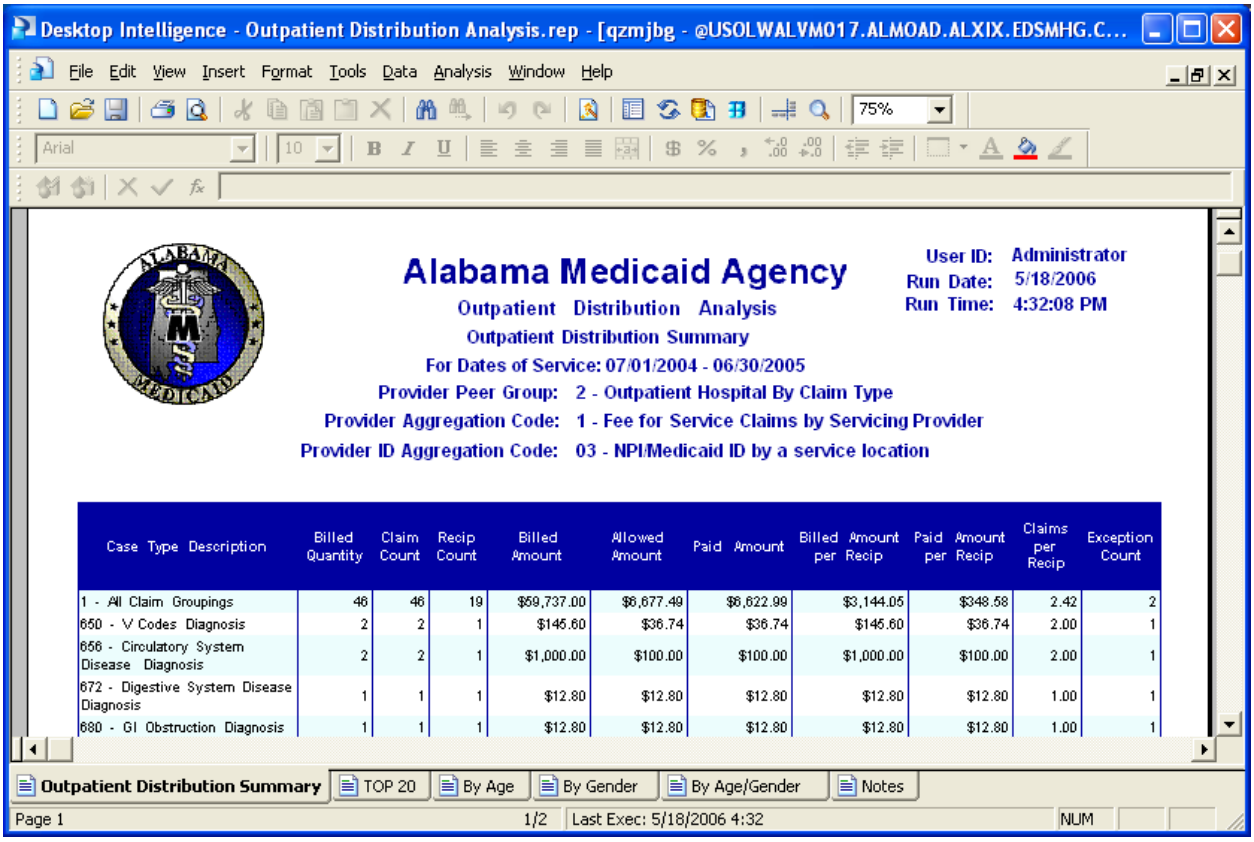
A. Outpatient Distribution Summary;

B. TOP 20;

C. By Age;

D. By Gender; and

E. By Age/Gender.




| Case Type Description | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amount per Recip | Paid Amount per Recip | Claims per Recip | Exception Count |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 - All Claim Groupings | 46 | 46 | 19 | $59,737.00 | $6,677.49 | $6,622.99 | $3,144.05 | $348.58 | 2.42 | 2 |
| 650 - V Codes Diagnosis | 2 | 2 | 1 | $145.60 | $36.74 | $36.74 | $145.60 | $36.74 | 2.00 | 1 |
| 656 - Circulatory System Disease Diagnosis | 2 | 2 | 1 | $1,000.00 | $100.00 | $100.00 | $1,000.00 | $100.00 | 2.00 | 1 |
| 672 - Digestive System Disease Diagnosis | 1 | 1 | 1 | $12.80 | $12.80 | $12.80 | $12.80 | $12.80 | 1.00 | 1 |
| 680 - GI Obstruction Diagnosis | 1 | 1 | 1 | $12.80 | $12.80 | $12.80 | $12.80 | $12.80 | 1.00 | 1 |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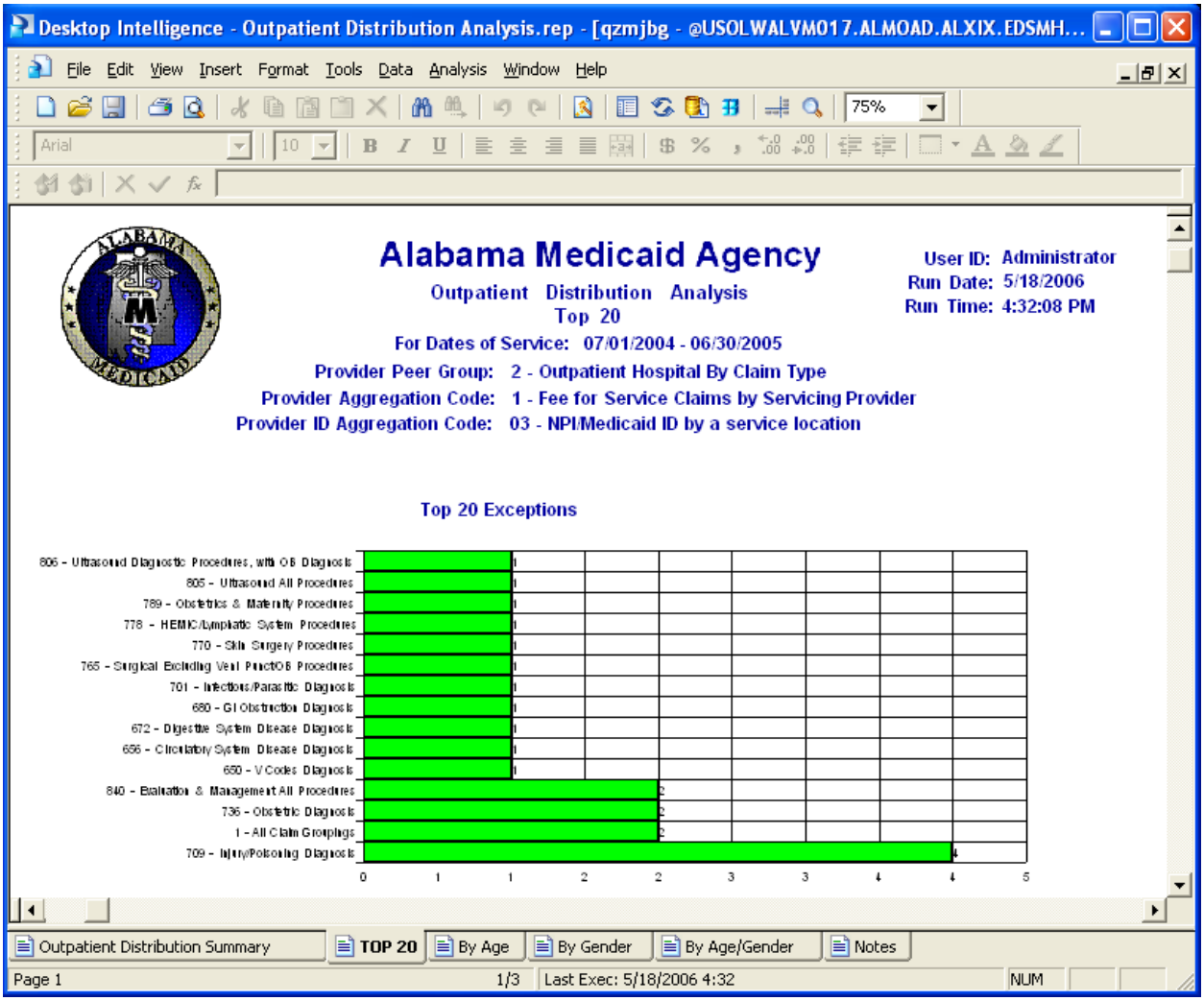



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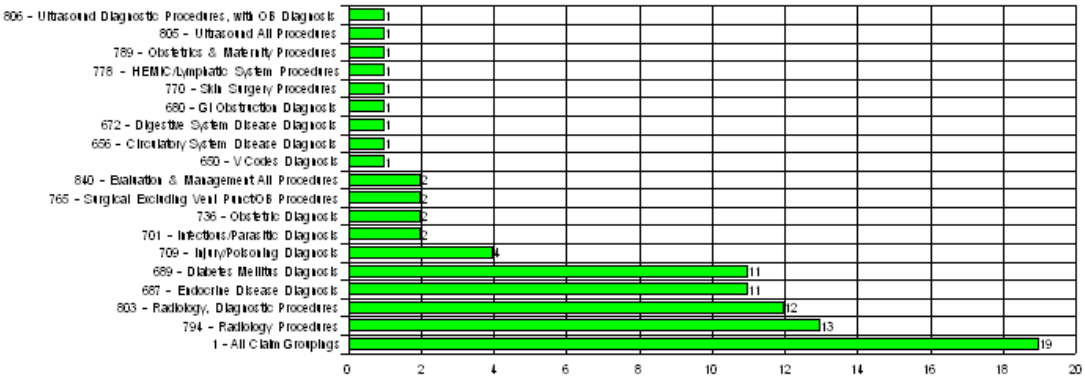
# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:32:08 PM

Outpatient Distribution Analysis
Top 20
For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 20 By Number of Recipients

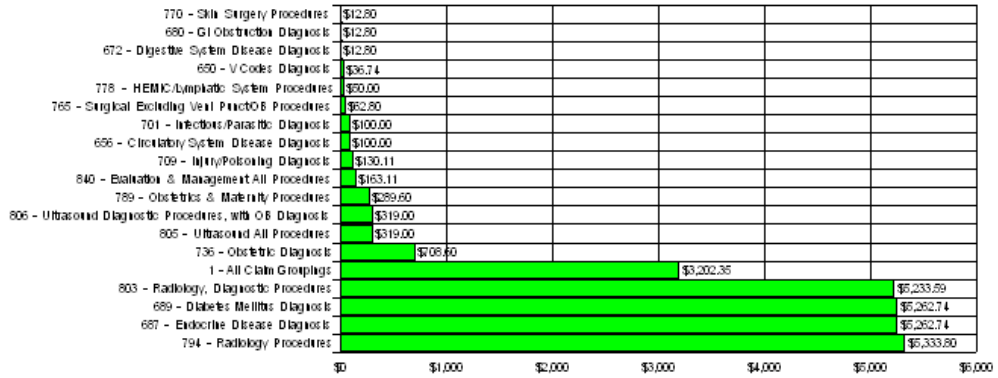



# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:32:08 PM

Outpatient Distribution Analysis
Top 20
For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 20 By Paid Amount per Recipient





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Desktop Intelligence - Outpatient Distribution Analysis.rep - [qzmjbg - @USOLWALVM017.ALMOAD.ALXIX.EDSMH...

File Edit View Insert Format Tools Data Analysis Window Help

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:32:08 PM

## Outpatient Distribution Analysis By Age

For Dates to Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

### Case Type: 1 - All Claim Groupings

| Age Description | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| Age 00 - 05 | 9 | 9 | 5 | $30,291.20 | $10,320.96 | $10,320.96 | $6,058.24 | $2,064.19 | $2,064.19 | 1.80 |
| Age 06 - 17 | 35 | 35 | 17 | $5,866.80 | $1,444.44 | $1,444.44 | $345.11 | $84.97 | $84.97 | 2.06 |
| Age 21 - 34 | 32 | 32 | 13 | $4,275.40 | $1,667.91 | $1,666.41 | $328.88 | $128.30 | $128.19 | 2.46 |
| Age 35 - 64 | 38 | 38 | 11 | $2,262.40 | $353.17 | $342.67 | $205.67 | $32.11 | $31.15 | 3.45 |
| Age 65+ | 12 | 12 | 6 | $129,375.00 | $459.00 | $307.50 | $21,562.50 | $76.50 | $51.25 | 2.00 |
| Sum: | 126 | 126 | 52 | $172,070.80 | $14,245.48 | $14,081.98 | $28,500.40 | $273.95 | $2,359.75 | 11.77 |

### Case Type: 650 - V Codes Diagnosis

| Age Description | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| Age 21 - 34 | 6 | 6 | 3 | $436.80 | $110.22 | $110.22 | $145.60 | $36.74 | $36.74 | 2.00 |
| Sum: | 6 | 6 | 3 | $436.80 | $110.22 | $110.22 | $145.60 | $36.74 | $36.74 | 2.00 |

Outpatient Distribution Summary | TOP 20 | By Age | By Gender | By Age/Gender | Notes

Page 1 1/10 Last Exec: 5/18/2006 4:32 NUM


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File Edit View Insert Format Tools Data Analysis Window Help

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:32:08 PM

## Outpatient Distribution Analysis By Gender

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

### Case Type: 1 - All Claim Groupings

| Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| F | 92 | 92 | 30 | $85,125.80 | $12,886.26 | $12,874.26 | $2,837.53 | $429.54 | $429.14 | 3.07 |
| M | 34 | 34 | 22 | $86,945.00 | $1,359.22 | $1,207.72 | $3,952.05 | $61.78 | $54.90 | 1.55 |
| Sum: | 126 | 126 | 52 | $172,070.80 | $14,245.48 | $14,081.98 | $6,789.57 | $273.95 | $484.04 | 4.61 |

### Case Type: 650 - V Codes Diagnosis

| Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| F | 6 | 6 | 3 | $436.80 | $110.22 | $110.22 | $145.60 | $36.74 | $36.74 | 2.00 |
| Sum: | 6 | 6 | 3 | $436.80 | $110.22 | $110.22 | $145.60 | $36.74 | $36.74 | 2.00 |

Outpatient Distribution Summary | TOP 20 | By Age | By Gender | By Age/Gender | Notes

Page 1 1/8 Last Exec: 5/18/2006 4:32 NUM


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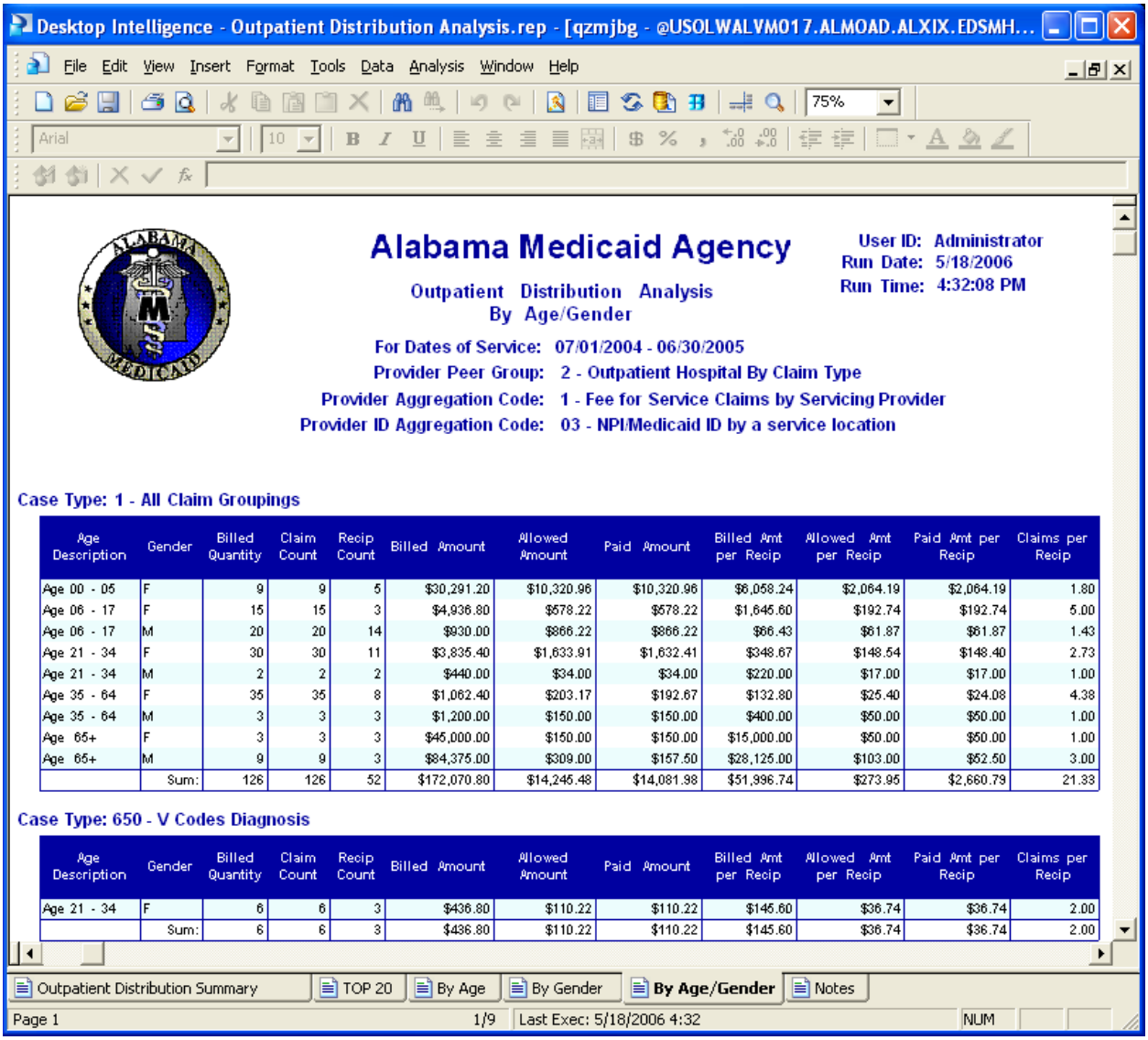


| Age Description | Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Age 00 - 05 | F | 9 | 9 | 5 | $30,291.20 | $10,320.96 | $10,320.96 | $6,058.24 | $2,064.19 | $2,064.19 | 1.80 |
| Age 06 - 17 | F | 15 | 15 | 3 | $4,936.80 | $578.22 | $578.22 | $1,645.60 | $192.74 | $192.74 | 5.00 |
| Age 06 - 17 | M | 20 | 20 | 14 | $930.00 | $866.22 | $866.22 | $66.43 | $61.87 | $61.87 | 1.43 |
| Age 21 - 34 | F | 30 | 30 | 11 | $3,835.40 | $1,633.91 | $1,632.41 | $348.67 | $148.54 | $148.40 | 2.73 |
| Age 21 - 34 | M | 2 | 2 | 2 | $440.00 | $34.00 | $34.00 | $220.00 | $17.00 | $17.00 | 1.00 |
| Age 35 - 64 | F | 35 | 35 | 8 | $1,062.40 | $203.17 | $192.67 | $132.80 | $25.40 | $24.08 | 4.38 |
| Age 35 - 64 | M | 3 | 3 | 3 | $1,200.00 | $150.00 | $150.00 | $400.00 | $50.00 | $50.00 | 1.00 |
| Age 65+ | F | 3 | 3 | 3 | $45,000.00 | $150.00 | $150.00 | $15,000.00 | $50.00 | $50.00 | 1.00 |
| Age 65+ | M | 9 | 9 | 3 | $84,375.00 | $309.00 | $157.50 | $28,125.00 | $103.00 | $52.50 | 3.00 |
| | Sum: | 126 | 126 | 52 | $172,070.80 | $14,245.48 | $14,081.98 | $51,996.74 | $273.95 | $2,660.79 | 21.33 |

| Age Description | Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Age 21 - 34 | F | 6 | 6 | 3 | $436.80 | $110.22 | $110.22 | $145.60 | $36.74 | $36.74 | 2.00 |
| | Sum: | 6 | 6 | 3 | $436.80 | $110.22 | $110.22 | $145.60 | $36.74 | $36.74 | 2.00 |

### 3.5.37.1 DSSProfiler - Outpatient Distribution Analysis Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Case Type Description | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |
| (A) Exception Count | Number of exceptions identified. An exception is defined as two standard deviations from the norm. | 8 | Number (Integer) |
| (A,C,D,E) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A,C,D,E) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,C,D,E) Billed Amount per Recip | Total billed amount divided by the number of recipients. | 12 | Number (Decimal) |
| (A,C,D,E) Billed Quantity | Quantity billed. | 14 | Number (Integer) |
| (A,C,D,E) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (A,C,D,E) Claims per Recip | Total claim count divided by the recipient count. | 4 | Number (Integer) |
| (A-E) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,C,D,E) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A,C,D,E) Paid Amount (Amt) per Recip | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |
| (A,C,D,E) Recip Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (A-E) Provider Aggregation Code | Aggregation Code and Description. | 100 | Character |
| (A-E)Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-E) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (B) Top 20 By Number of Recipients | Graph shows Top 20 exceptions by number of recipients. | 1 | Character |
| (B) Top 20 By Paid Amount per Recipient | Graph shows Top 20 exceptions by paid amount per recipient. | 1 | Character |
| (B) Top 20 Exceptions | Graph shows Top 20 exceptions. | 1 | Character |
| (C,D,E) Allowed Amt Per Recip | Total allowed amount divided by the number of recipients. | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (C,E) Age Description | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (D,E) Gender | Recipient's gender. | 1 | Character |


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### 3.5.38 DSSProfiler - Outpatient Exception Quarterly

The Outpatient Exception Quarterly report is produced for a selected provider, provider peer group and aggregation code. The report displays the number of high exceptions for case groups that occur during each reporting period. Case group calculations that are above the exception high value are marked as exceptions.

**Alabama Medicaid Agency**

Outpatient Exception Quarterly

For Dates of Service: 10/01/2004 - 09/30/2005

User ID: [redacted]
Run Date: 8/28/2006
Run Time: 10:46:36 AM

Provider Service Location Information:
NPI ID: [redacted]
Mcaid ID: [redacted]
Base ID: [redacted]
Name: TIM J BEAL
Type: 31 - Physician
Specialty: 318 - General Practitioner
Address: PO BOX 3466

SALEM, OR 97501

Peer Group Code: 228 - 318 GENERAL PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| | 20051 | |
|---|---|---|
| 710 - Excessive Outpatient Hospital/ER Visits; H: 002 L: 000 | 2.00 | |
| 720 - Excessive Outpatient Hospital/ER Visits per Recipient; H: 002 L: 000 | 2.00 | |

End of Report

#### 3.5.38.1 DSSProfiler - Outpatient Exception Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| Case Type Group Display | Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item. | 4 | Character |
| Exception | This column is marked with a '*' when the case group is above the exception high value. | 1 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients | 20 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | | |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| Provider Service Location Information | Provider's information. This includes the provider name, address, NPI ID, Medicaid ID, and Base ID. | 200 | Character |


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### 3.5.39 DSSProfiler - Outpatient Frequency Distribution

The Outpatient Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one year, this report shows for each outpatient case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.

**Alabama Medicaid Agency**

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:31:51 PM

Outpatient Frequency Distribution

For Dates of Service: 07/01/04 - 06/30/05
Provider Peer Group Code: 2 - Outpatient Hospital By Claim Type
Provider Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type : 650 - V Codes Diagnosis

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 1 | 1 | 1 |

Case Type : 656 - Circulatory System Disease Diagnosis

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 33 | 33 | 33 | 33 | 33 | 33 |

Case Type : 661 - Heart Disease Diagnosis

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 31 | 31 | 31 | 31 | 31 | 31 |

Case Type : 672 - Digestive System Disease Diagnosis

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 1 | 1 | 1 |

#### 3.5.39.1 DSSProfiler - Outpatient Frequency Distribution Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |
| 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Provider Aggregation Code | Aggregation Code and Description. | 100 | Character |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| Provider Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |


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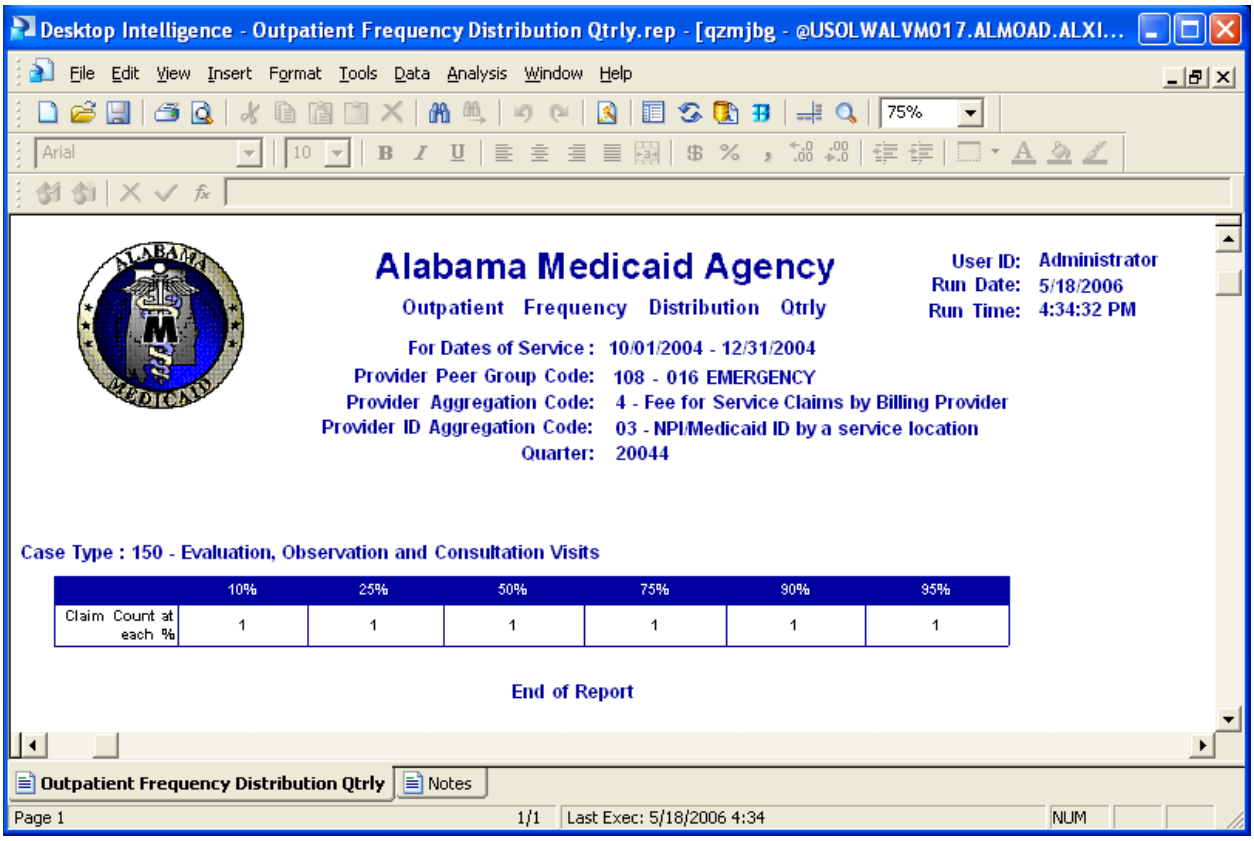
### 3.5.40 DSSProfiler - Outpatient Frequency Distribution Quarterly

The Outpatient Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report shows for each outpatient case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th, and 95th percentiles based on the number of providers reported within a case type, peer grouping.




#### 3.5.40.1 DSSProfiler - Outpatient Frequency Distribution Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |
| 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |
| Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |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| Field | Description | Length | Data Type |
|---|---|---|---|
| Provider Aggregation Code | Aggregation Code and Description. | 100 | Character |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| Provider Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |


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### 3.5.41 DSSProfiler - Outpatient Recipient Case Type Comparison by Peer Group

Outpatient Recipient Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all recipients within a peer group to determine which ones fall outside of service dollar norms for outpatient claims. All information is age and gender adjusted so that differences in patient mix do not affect the results. Individuals who have two standard deviations above the norm for the peer group are highlighted.

There are tabs in this report:

A. Recipient Comparison; and

B. Recipient Grouped by Age/Gender.

A

**Alabama Medicaid Agency**

**Outpatient Recipient Case Type Comparison by Peer Group**
**Recipient Comparison**
**For Dates of Service: 01/01/2006 - 12/31/2006**

**User ID:**
**Run Date: 9/20/2007**
**Run Time: 3:31:40 PM**

**Case Type: 385 - AL Hospice RT Procedures**
**Recipient Peer Group: 925 - 11 Aged-SSI-full Medicaid coverage**
**Aggregation Code: 7 - Fee For Service Claims by Recipient**

| Rank | Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference From Expected | Exception |
|---|---|---|---|---|---|---|---|---|
| 2 | | | $7,206.88 | $7,206.88 | $7,206.88 | $5,189.46 | $2,017.42 | |
| 1 | | | $16,089.00 | $10,237.44 | $10,237.44 | $10,237.44 | $0.00 | |
| 3 | | | $7,183.36 | $7,183.36 | $7,183.36 | $7,402.99 | $(219.63) | |
| 4 | | | $2,941.64 | $2,941.64 | $2,941.64 | $6,911.81 | $(3,970.17) | |
| | | | | | | 2 STD DEV | $4,324.43 | |


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B

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 9/20/2007
Run Time: 3:31:40 PM

Outpatient Recipient Case Type Comparison by Peer Group

Recipient Grouped by Age/Gender

For Dates of Service: 01/01/2006 - 12/31/2006

Case Type: 385 - AL Hospice RT Procedures

Recipient Peer Group: 925 - 11 Aged-SSI-full Medicaid coverage

Aggregation Code: 7 - Fee For Service Claims by Recipient

Age 65+

Gender: F

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| [redacted] | [redacted] | $7,206.88 | $7,206.88 | $7,206.88 |
| [redacted] | [redacted] | $7,183.36 | $7,183.36 | $7,183.36 |
| | | | Sum: | $14,390.24 |

Gender: M

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| [redacted] | [redacted] | $2,941.64 | $2,941.64 | $2,941.64 |
| [redacted] | [redacted] | $16,089.00 | $10,237.44 | $10,237.44 |
| | | | Sum: | $13,179.08 |

### 3.5.41.1 DSSProfiler - Outpatient Recipient Case Type Comparison by Peer Group Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Dollar Difference from Expected | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates recipients who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Number (Integer) |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Rank | Recipient's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A,B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A,B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A,B) Recipient Full Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID | Recipient Medicaid Number. | 12 | Character |
| (A,B) Recipient Peer Group | Recipient Peer Group Code and Description. | 40 | Character |
| (A-B) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-B) Billed Amount | Amount the provider billed for the service. | 13 | Number (Decimal) |


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### 3.5.42 DSSProfiler - Outpatient Recipient Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all providers within a peer group to determine which recipients fall outside of service dollar norms on a user specified case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

There are tabs in this report:

A. Recipient Comparison; and

B. Recipient Grouped by Age/Gender.

**A**

**Alabama Medicaid Agency**

**Outpatient Recipient Case Type Comparison By Peer Group Qtrly**

User ID: [redacted]
Run Date: 9/20/2007
Run Time: 8:34:22 AM

**Recipient Comparison**

**For Dates of Service: 04/01/2006 - 06/30/2006**

**Case Type: 1090 - AL Number of Drug Poison Diagnoses**
**Peer Group Code: 826 - 30 MLIF-Child + full Mcaid**
**Aggregation Code: 7 - Fee For Service Claims by Recipient**
**Quarter: 20062**

| Rank | Expected Rank | Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | [redacted] | [redacted] | $529.00 | $72.29 | $72.29 | $72.12 | $0.17 | |
| 3 | 3 | [redacted] | [redacted] | $82.40 | $38.36 | $38.36 | $38.36 | $0.00 | |
| 3 | 3 | [redacted] | [redacted] | $465.30 | $38.36 | $38.36 | $38.36 | $0.00 | |
| 2 | 1 | [redacted] | [redacted] | $719.15 | $71.94 | $71.94 | $72.12 | $(0.18) | |
| | | | | | | | 2 STD DEV | $0.25 | |

**End of Report**


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**B**

**Alabama Medicaid Agency**

**Outpatient Recipient Case Type Comparison By Peer Group Qtrly**

**Recipients Grouped by Age/Gender**
**For Dates of Service: 04/01/2006 - 06/30/2006**

**User ID:** [redacted]
**Run Date:** 9/20/2007
**Run Time:** 8:34:22 AM

**Case Type:** 1090 - AL Number of Drug Poison Diagnoses
**Peer Group Code:** 826 - 30 MLIF-Child + full Mcaid
**Aggregation Code:** 7 - Fee For Service Claims by Recipient
**Quarter:** 20062

**Age 00 - 05**

**Gender: F**

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| [redacted] | [redacted] | $719.15 | $71.94 | $71.94 |
| [redacted] | [redacted] | $529.00 | $72.29 | $72.29 |
| | | | Sum: | $144.23 |

**Gender: M**

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| [redacted] | [redacted] | $465.30 | $38.36 | $38.36 |
| | | | Sum: | $38.36 |

### 3.5.42.1 DSSProfiler - Outpatient Recipient Case Type Comparison by Peer Group Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Recipient's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group. | 3 | Number (Decimal) |
| (A) Rank | Recipient's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A,B) Aggregation Code | Aggregation Code and Description. | 100 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A,B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B) Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A,B) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A,B) Recipient Full Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID | Recipient identification number. | 8 | Character |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |


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### 3.5.43 DSSProfiler - Outpatient Provider Profile

The Outpatient Provider Profile report is created in the DSSProfiler. Based on the user-entered date range of one year, this report flags any category or case type that exceeds the accepted norm within the outpatient provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and genders adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Outpatient Services - Tab B has two sections. The first section of this report contains a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

**Report Prompts (Search Criteria):**

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - The peer group to which the profiled provider is being compared; and
- Aggregation Code is the code to which the profiled provider is being compared.


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A

# Alabama Medicaid Agency

User ID:
Run Date: 10/4/2007
Run Time: 12:36:38 PM

**Outpatient Provider Profile**
**Provider Summary**

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 449 - 315 EMERGENCY MEDICINE PRACTITIOI
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

## Provider Information

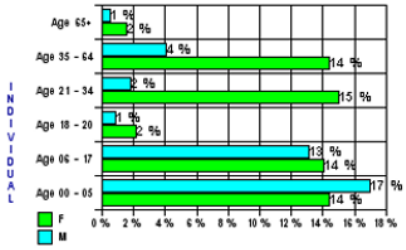
NPI ID:
Mcaid ID:
Base ID:
Name: CORRECT CARE INC - ALL BSE
Type: 31 - Physician
Specialty: 315 - Emergency Medicine Practitioner
Address: 1910 CHEROKEE AVE SW

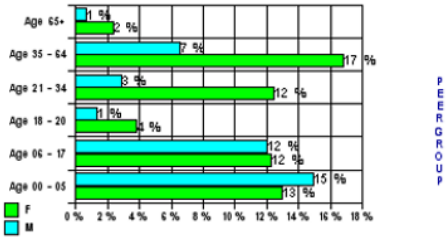
CULLMAN, AL 35055

## Ranks

| | |
|---|---|
| $ Paid Amount Actual | 1 |
| $ Paid Amount Expected | 1 |
| $ Billed Amount Actual | 1 |
| Recipient Rank | 1 |
| # Units Rank | 1 |
| # Claims Rank | 1 |
| Peer Group Size | 1 |

## Patient Age/Gender Breakdown




# Alabama Medicaid Agency

User ID:
Run Date: 10/4/2007
Run Time: 12:36:38 PM

**Outpatient Provider Profile**
**Provider Summary**

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 449 - 315 EMERGENCY MEDICINE PRACTITIOI
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

## Provider's General Service Profile

| Service Type | Recip Count | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|
| 6 - Outpatient Referrals | 311 | $43,940.28 | $316,224.88 | $20,787.14 | $26,466.04 | $(5,678.90) | (21.46) % |

**End of Report**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**B**

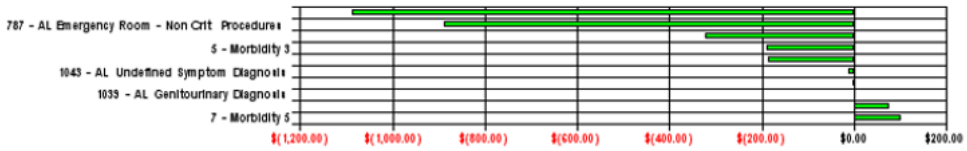
# Alabama Medicaid Agency

User ID:
Run Date: 10/4/2007
Run Time: 12:36:38 PM

Outpatient Provider Profile
Outpatient Services

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 449 - 315 EMERGENCY MEDICINE PRACTITIONER
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Top 10 Case Types: Dollar Difference




# Alabama Medicaid Agency

User ID:
Run Date: 10/4/2007
Run Time: 12:36:38 PM

Outpatient Provider Profile
Outpatient Services

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 449 - 315 EMERGENCY MEDICINE PRACTITIONER
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

| Case Type | Recip Count | Claim Count | Quantity | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|---|
| 7 - Morbidity 5 | 7 | 34 | 34 | $969.78 | $18,989.35 | $947.68 | $846.91 | $100.77 | 11.90 % |
| 804 - AL Surgical Procedures | 1 | 1 | 1 | $258.57 | $1,487.00 | $258.57 | $181.81 | $76.76 | 42.22 % |
| 1039 - AL Genitourinary Diagnosis | 2 | 2 | 2 | $172.00 | $3,440.00 | $0.00 | $0.00 | $0.00 | 0.00 % |
| 1042 - AL Injury Diagnosis | 3 | 3 | 3 | $538.05 | $10,761.15 | $0.00 | $1.17 | $(1.17) | (100.00) % |
| 1043 - AL Undefined Symptom Diagnosis | 5 | 6 | 6 | $862.60 | $17,900.05 | $0.00 | $11.93 | $(11.93) | (100.00) % |
| 880 - AL Lab Procedures | 97 | 317 | 334 | $3,176.05 | $46,602.95 | $3,074.41 | $3,259.77 | $(185.36) | (5.69) % |
| 5 - Morbidity 3 | 41 | 146 | 174 | $3,880.63 | $40,128.58 | $3,775.43 | $3,965.05 | $(189.62) | (4.78) % |
| 831 - AL Respiratory Procedures | 24 | 25 | 25 | $175.61 | $3,740.63 | $175.61 | $498.59 | $(322.98) | (64.78) % |
| 787 - AL Emergency Room - Non Crit Procedures | 296 | 310 | 310 | $11,699.14 | $147,572.02 | $11,592.42 | $12,481.16 | $(888.74) | (7.12) % |
| 794 - AL Radiology Procedures | 118 | 157 | 157 | $3,418.93 | $88,407.32 | $3,244.90 | $4,332.00 | $(1,087.10) | (25.09) % |
| 3 - Morbidity 1 | 137 | 334 | 334 | $8,921.70 | $117,631.40 | $7,806.75 | $8,918.76 | $(1,112.01) | (12.47) % |
| 6 - Morbidity 4 | 52 | 147 | 157 | $4,203.70 | $63,282.11 | $3,188.81 | $5,352.62 | $(2,163.81) | (40.43) % |
| 4 - Morbidity 2 | 74 | 201 | 212 | $5,663.52 | $76,193.44 | $5,068.47 | $7,382.56 | $(2,314.09) | (31.35) % |

End of Report

### 3.5.43.1 DSSProfiler - Outpatient Provider Profile Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Service Type | User defined group based on the service type file. The claim grouping should be specific to the area of service. | 100 | Character |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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-B) Dollar Difference | Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest). | 13 | Number (Decimal) |
| (A-B) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-B) Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A-B) Percent Difference | Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage. | 8 | Number (Decimal) |
| (A-B) Provider ID | Provider identification number. | 15 | Character |
| (A-B) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-B) Recip Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (B) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (B) Quantity | Quantity billed. | 8 | Number (Integer) |


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### 3.5.44 DSSProfiler - Outpatient Provider Profile Quarterly

The Outpatient Provider Profile Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report flags any category or case type that exceeds the accepted norm within the outpatient provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Outpatient Services - Tab B has two sections. The first sections of this report contain a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

**Report Prompts (Search Criteria):**

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - the peer group to which the profiled provider is being compared;
- Aggregation Code is the code to which the profiled provider is being compared; and
- Quarter - Quarter of the provider being profiled in the report.


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A

# Alabama Medicaid Agency

User ID:
Run Date: 9/27/2007
Run Time: 4:09:22 PM

Outpatient Provider Profile Qtrly
Provider Summary
For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 238
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

## Provider Information

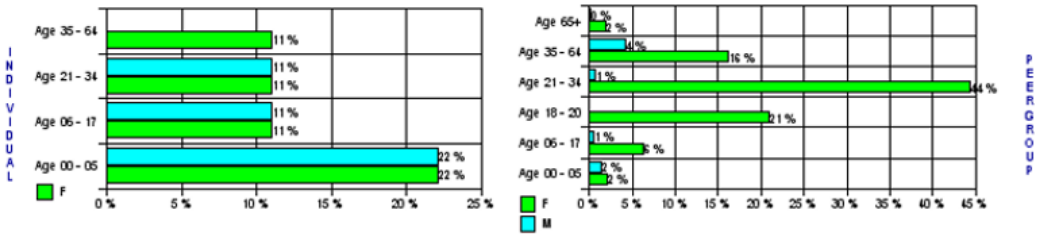
NPI ID:
Mcaid ID:
Base ID:
Name: WALTERS, WILLIAM S
Type: 31 - Physician
Specialty: 328 - Obstetrician/Gynecologist
Address: 2505 HWY 431

BOAZ, AL 35957

## Rank

| | |
|---|---|
| $ Paid Amount Actual | 192 |
| $ Paid Amount Expected | 159 |
| $ Billed Amount Actual | 52 |
| Recipient Rank | 163 |
| # Units Rank | 189 |
| # Claims Rank | 121 |
| Peer Group Size | 606 |

## Patient Age/Gender Breakdown




# Alabama Medicaid Agency

User ID:
Run Date: 11/1/2007
Run Time: 5:00:17 PM

Outpatient Provider Profile Qtrly
Provider Summary
For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 238
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

## Provider's General Service Profile

| Report Category | Recipient Count | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|
| 6 - Outpatient Referrals | 9 | $1,995.99 | $19,290.50 | $1,325.12 | $1,801.55 | $(476.43) | (26.45) % |

End of Report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B

## Alabama Medicaid Agency

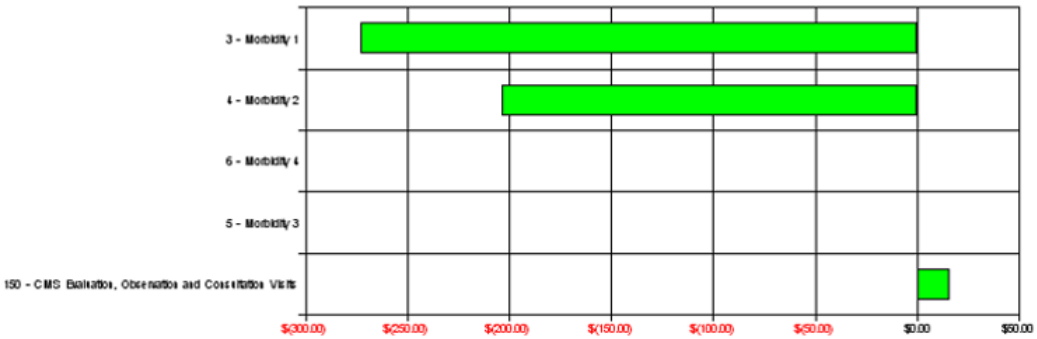
Outpatient Provider Profile Qtrly

Outpatient Services

User ID:
Run Date: 9/27/2007
Run Time: 4:09:22 PM

For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 238 - 328 OBSTETRICIAN/GYNECOLOGIST
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

Top 10 Case Types: Dollar Difference




## Alabama Medicaid Agency

Outpatient Provider Profile Qtrly

Outpatient Services

User ID:
Run Date: 9/27/2007
Run Time: 4:09:22 PM

For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 238 - 328 OBSTETRICIAN/GYNECOLOGIST
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

| Case Type Code & Description | Recipient Count | Claim Count | Billed Quantity | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|---|
| 150 - CMS Evaluation, Observation and Consultation \ | 9 | 9 | 9 | $664.87 | $3,006.50 | $658.87 | $642.86 | $16.01 | 2.49 % |
| 5 - Morbidity 3 | 1 | 11 | 12 | $840.57 | $15,991.50 | $840.57 | $840.57 | $0.00 | 0.00 % |
| 6 - Morbidity 4 | 1 | 2 | 2 | $84.58 | $475.00 | $84.58 | $84.58 | $0.00 | 0.00 % |
| 4 - Morbidity 2 | 2 | 3 | 3 | $92.02 | $638.00 | $89.02 | $292.48 | $(203.46) | (69.56) % |
| 3 - Morbidity 1 | 5 | 12 | 13 | $313.95 | $2,186.00 | $310.95 | $583.92 | $(272.97) | (46.75) % |

### 3.5.44.1 DSSProfiler - Outpatient Provider Profile Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) # Claims Rank | Rank is based on the number of paid claims. | 5 | Number (Integer) |
| (A) # Units Rank | Rank based on the quantity billed. | 5 | Number (Integer) |
| (A) $ Billed Amount Actual | Rank based on the actual money billed by the provider. | 5 | Number (Decimal) |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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) $ Paid Amount Actual | Rank based on the actual money paid by the program in the specific time period. | 5 | Number (Decimal) |
| (A) $ Paid Amount Expected | Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group. | 5 | Number (Decimal) |
| (A) Patient Age/Gender Breakdown | Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve. | 10 | Character |
| (A) Peer Group Size | Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings. | 5 | Number (Integer) |
| (A) Provider Information | Provider's demographic information. This includes the NPI ID, Mcaid ID, Base ID, Name, Type, Specialty and Address. | 200 | Character |
| (A) Recipient Rank | Rank based on the number of eligible recipients the provider served in a specific time period. | 5 | Number (Integer) |
| (A-D) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-D) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Provider ID | Provider identification number. | 13 | Character |
| (A-D) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-D) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A-D) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (B) Report Category | User-defined variables used to categorize case types into service groups. | 21 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (B,D) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (B,D) Dollar Difference | Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest). | 13 | Number (Decimal) |
| (B,D) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (B,D) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (B,D) Percent Difference | Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage. | 8 | Number (Decimal) |
| (B,D) Recipient Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (C) Top 10 Case Types: Dollar Difference | Different in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. | 60 | Character |
| (D) Billed Quantity | Quantity billed. | 14 | Number (Integer) |
| (D) Case Type Code Description | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |
| (D) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (D) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |


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### 3.5.45 DSSProfiler - Pharmacy Case Type Comparison by Peer Group

Based on the user-entered date range of one year, this report displays and compares all pharmacy providers within a peer group to determine which providers fall outside of service dollar norms for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

There are tabs in this report:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender.

**A**

**Alabama Medicaid Agency**

User ID:
Run Date: 11/14/2007
Run Time: 8:24:43 AM

Pharmacy Case Type Comparison by Peer Group

Provider Comparison

For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 3 - Morbidity 1
Provider Peer Group: 454 - 320 GERIATRIC PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

| Rank | Raw Rank | Expected Rank | Provider ID | Provider Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 3 | 4 | | GAVINO, REY S - ALL BSE | $218.71 | $199.33 | $189.33 | $74.62 | $114.71 | |
| 2 | 1 | 1 | | KRISHNASAMI, ZIPPORAH - ALL BSE | $1,076.73 | $840.02 | $796.34 | $695.86 | $100.48 | |
| 3 | 2 | 2 | | RETAN, J WALDEN - ALL BSE | $481.41 | $361.49 | $351.25 | $453.87 | $(102.62) | |
| 4 | 4 | 3 | | UT PHYSICIANS - ALL BSE | $148.82 | $114.53 | $110.53 | $223.11 | $(112.58) | |
| | | | | | | | | 2 STD DEV | $248.89 | |

**B**

**Alabama Medicaid Agency**

User ID:
Run Date: 11/14/2007
Run Time: 8:24:43 AM

Pharmacy Case Type Comparison by Peer Group

Average Amount per Recipient by Age/Gender

For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 3 - Morbidity 1
Provider Peer Group: 454 - 320 GERIATRIC PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

- KRISHNASAMI, ZIPPORAH - ALL BSE

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 00 - 05 | F | 1 | $69.46 |
| Age 00 - 05 | M | 1 | $100.33 |
| Age 06 - 17 | F | 1 | $31.21 |
| Age 18 - 20 | F | 1 | $27.12 |
| Age 35 - 64 | F | 4 | $117.33 |
| Age 35 - 64 | M | 1 | $7.80 |
| Age 65+ | F | 5 | $18.22 |
| | | AVG: | $56.88 |


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C

**Alabama Medicaid Agency**

User ID:
Run Date: 11/14/2007
Run Time: 8:24:43 AM

Pharmacy Case Type Comparison by Peer Group
Average Amount per Recipient All Providers by Selected Age/Gender
For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 3 - Morbidity 1
Provider Peer Group: 454 - 320 GERIATRIC PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Age 00 - 05

Gender: F

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| | UT PHYSICIANS - ALL BSE | $7.25 |
| | RETAN, J WALDEN - ALL BSE | $7.58 |
| | KRISHNASAMI, ZIPPORAH - ALL BSE | $69.46 |
| | AVG: | $22.97 |

Gender: M

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| | RETAN, J WALDEN - ALL BSE | $54.00 |
| | KRISHNASAMI, ZIPPORAH - ALL BSE | $100.33 |
| | AVG: | $77.16 |

### 3.5.45.1 DSSProfiler - Pharmacy Case Type Comparison by Peer Group Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Provider's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group. | 3 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Rank | Provider's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A) Raw Rank | Provider's rank based on the amount Provider was paid. | 3 | Number (Integer) |
| (A-C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,C) Provider ID | Provider identification number. | 15 | Character |
| (A,C) Provider Name | Provider's full name. | 50 | Character |
| (A-C) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-C) Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-C) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-C) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (B) Recipient Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (B) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (B,C) Gender | Recipient’s gender. | 1 | Character |
| (B,C) Paid Amount Per Recipient | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |
| (C) Age | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Number (Integer) |


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### 3.5.46 DSSProfiler - Pharmacy Case Type Comparison by Peer Group Quarterly

The Pharmacy Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar norms on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

There are tabs in this report:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender.

A

**Alabama Medicaid Agency**

User ID:
Run Date: 11/14/2007
Run Time: 8:39:54 AM

Pharmacy Case Type Comparison by Peer Group Qtrly
Provider Comparison

For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 167 - CMS Addictive Drugs by AHFS Class
Provider Peer Group: 255 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

| Rank | Raw Rank | Expected Rank | Provider ID | Provider Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 7 | 15 | | TUTEN, HARRY L - ALL BSE | $91.50 | $53.16 | $53.16 | $26.22 | $26.94 | * |
| 2 | 4 | 5 | | HUNTSVILLE MADISON MH C - ALL BSE | $103.90 | $80.42 | $80.42 | $55.34 | $25.08 | * |
| 3 | 6 | 6 | | ELRICK, WILLIAM A - ALL BSE | $59.30 | $56.05 | $56.04 | $44.26 | $11.78 | |
| 4 | 13 | 20 | | EVANS, ANGIE C - ALL BSE | $32.83 | $23.69 | $23.69 | $14.36 | $9.33 | |
| 5 | 8 | 12 | | ELLIS, DARYL A - ALL BSE | $40.25 | $40.25 | $40.25 | $32.71 | $7.54 | |
| 6 | 2 | 2 | | PEDIATRIC PRACTICE - ALL BSE | $372.03 | $199.65 | $160.55 | $154.70 | $5.85 | |
| 7 | 10 | 13 | | MEDICAL CENTERPHARMACY - ALL BSE | $41.01 | $32.48 | $32.48 | $27.86 | $4.62 | |
| 8 | 15 | 18 | | KAUFMAN, LORI E - ALL BSE | $25.01 | $21.76 | $21.76 | $17.29 | $4.47 | |
| 9 | 18 | 17 | | PILKINTON, JAMES C - ALL BSE | $27.19 | $18.06 | $18.06 | $18.06 | $0.00 | |
| 10 | 21 | 22 | | DECARLO, DAWN - ALL BSE | $12.99 | $12.61 | $12.61 | $12.61 | $0.00 | |


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**B**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 8:39:54 AM

**Pharmacy Case Type Comparison by Peer Group Qtrly**
**Average Amount per Recipient by Age/Gender**

For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 167 - CMS Addictive Drugs by AHFS Class
Provider Peer Group: 255 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

[redacted] - BARKSDALE, NANCY L - ALL BSE

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 35 - 64 | F | 9 | $24.86 |
| Age 35 - 64 | M | 2 | $17.61 |
| Age 65+ | F | 3 | $19.14 |
| Age 65+ | M | 1 | $14.42 |
| | | AVG: | $22.05 |

**C**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 8:39:54 AM

**Pharmacy Case Type Comparison by Peer Group Qtrly**
**Average Amount per Recipient All Providers by Selected Age/Gender**

For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 167 - CMS Addictive Drugs by AHFS Class
Provider Peer Group: 255 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

Age 00 - 05

Gender: F

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| [redacted] | ELLIS, DARYL A - ALL BSE | $33.46 |
| [redacted] | JEFFERSON COUNTY DEPT OF HLT | $10.80 |
| [redacted] | MEDICAL CENTERPHARMACY - ALL | $32.48 |
| [redacted] | ELRICK, WILLIAM A - ALL BSE | $56.04 |
| [redacted] | ASSAAD, SAMER - ALL BSE | $17.02 |
| [redacted] | MORGAN, LEATHA B - ALL BSE | $32.48 |
| [redacted] | BRIGHTSTARTS PEDIATRICS PC - A | $9.11 |
| | AVG: | $24.36 |


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### 3.5.46.1 DSSProfiler - Pharmacy Case Type Comparison by Peer Group Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the service. | 13 | Number (Decimal) |
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group. | 3 | Number (Integer) |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Rank | Provider's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A) Raw Rank | Provider's rank based on the amount Provider was paid. | 3 | Number (Integer) |
| (A,B,C) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A,B,C) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B,C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B,C) Provider ID | Provider identification number. | 15 | Character |
| (A,B,C) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations | 40 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | and 03 NPI/Medicaid ID by service location. | | |
| (A,B,C) Provider Name | Provider's full name. | 50 | Character |
| (A,B,C) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A.B.C) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (B) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Number (Integer) |
| (B,C) Gender | Recipient's gender. | 1 | Character |
| (B,C) Paid Amount per Recipient | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |
| (B) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (C) Age | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Number (Integer) |


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### 3.5.47 DSSProfiler - Pharmacy Claim Details by Provider

This report lets the user drill down to the detail level for all pharmacy case types for a given provider and service location and billing provider ID. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

There are tabs in this report:

A. Pharmacy Claim Details;

B. Recipient Listing; and

C. NDC Listing.

A

**Alabama Medicaid Agency**

Pharmacy Claim Details By Provider
Pharmacy Claim Details

For Dates of Service: 10/01/2007 - 09/30/2008
Provider Base, Medicaid or NPI ID: [redacted]

User ID: [redacted]
Run Date: 2/25/2009
Run Time: 12:14:47 PM

For Claim Types: P and Q

| ICN | C T | Dtl # | Dispensed Dte | NDC | NDC Desc | DEA | GPI | GCN | AHFS | AHFS Therapeutic Class Desc | Recip ID | Recip Name | Age | POt | Dispense Qty | Billed Amt | Alwd Amt | Paid Amt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] | P | 1 | | 65162056650 | IBUPROFEN | 0 | 1 | 35742 | 28000492 | OTHER NONSTEROIDAL ANTI-INFLAM. AGENTS | | | | 00 | 30.000 | $13.75 | $6.73 | $6.73 |
| [redacted] | P | 1 | | 00406053205 | OXYCODONE-ACETAMIN OPHEN | 2 | 1 | 70600 | 28000600 | OPIATE AGONISTS | | | | 00 | 30.000 | $19.86 | $12.14 | $12.14 |
| [redacted] | P | 1 | | 00182402810 | FERROUS SULFATE | 0 | 1 | 04695 | 20040400 | IRON PREPARATIONS | | | | 00 | 60.000 | $4.26 | $4.26 | $4.26 |
| [redacted] | P | 1 | | 55370000107 | AMPICILLIN TRIHYDRATE | 0 | 1 | 39272 | 08121608 | AMINOPENICILLINS | | | | 00 | 28.000 | $19.60 | $11.55 | $11.55 |
| [redacted] | P | 1 | | 66992014616 | LUSONAL | 0 | 2 | 23377 | 48160000 | EXPECTORANTS | | | | 00 | 120.000 | $23.37 | $19.89 | $19.89 |
| [redacted] | P | 1 | | 00093415573 | AMOXICILLIN | 0 | 2 | 39683 | 08121608 | AMINOPENICILLINS | | | | 00 | 100.000 | $13.02 | $7.66 | $7.66 |
| [redacted] | P | 1 | | 53014046356 | DELSYM | 0 | 2 | 17742 | 48000000 | ANTITUSSIVES | | | | 00 | 90.000 | $13.20 | $11.04 | $11.04 |
| [redacted] | P | 1 | | 59702081901 | SUDAL 12 | 0 | 2 | 98129 | 04042000 | PROPYLAMINE DERIVATIVES | | | | 00 | 60.000 | $96.24 | $80.74 | $80.74 |
| [redacted] | P | 1 | | 51991045758 | POLYETHYLENE GLYCOL | 0 | 1 | 86212 | 56120000 | CATHARTICS AND LAXATIVES | | | | 00 | 255.000 | $28.50 | $22.46 | $22.46 |
| [redacted] | P | 1 | | 59762313001 | AZITHROMYCIN | 0 | 1 | 61199 | 08121292 | OTHER MACROLIDES | | | | 00 | 22.500 | $42.92 | $32.59 | $32.59 |
| [redacted] | P | 1 | | 00066853302 | CIPRODEX | 0 | 2 | 20188 | 52040400 | ANTIBACTERIALS (EENT) | | | | 00 | 7.500 | $122.43 | $103.62 | $103.62 |
| [redacted] | P | 1 | | 00781164366 | AMOX TR-POTASSIUM CLAVULANATE | 0 | 2 | 67077 | 08121608 | AMINOPENICILLINS | | | | 00 | 20.000 | $28.92 | $66.45 | $61.85 |
| [redacted] | P | 1 | | 00006011754 | SINGULAIR | 0 | 2 | 94444 | 48102400 | LEUKOTRIENE MODIFIERS | | | | 00 | 30.000 | $131.53 | $106.17 | $111.57 |
| [redacted] | P | 1 | | 00006011754 | SINGULAIR | 0 | 2 | 94444 | 48102400 | LEUKOTRIENE MODIFIERS | | | | 00 | 30.000 | $131.53 | $106.17 | $111.57 |
| [redacted] | P | 1 | | 45802025735 | MOMETASONE FUROATE | 0 | 1 | 45860 | 84060000 | ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS) | | | | 00 | 30.000 | $63.49 | $21.99 | $27.39 |
| [redacted] | P | 1 | | 59702081901 | SUDAL 12 | 0 | 2 | 98129 | 04042000 | PROPYLAMINE DERIVATIVES | | | | 00 | 60.000 | $117.24 | $93.69 | $89.09 |
| [redacted] | P | 1 | | 50383059016 | BROMETANE DX | 0 | 1 | 96136 | 48000000 | ANTITUSSIVES | | | | 00 | 240.000 | $28.60 | $12.57 | $12.57 |
| [redacted] | P | 1 | | 63304051504 | AMOXICILLIN | 0 | 2 | 39651 | 08121608 | AMINOPENICILLINS | | | | 00 | 21.000 | $17.72 | $9.50 | $9.50 |
| [redacted] | P | 1 | | 10702001001 | HYDROXYZINE HCL | 0 | 2 | 13941 | 28249200 | ANXIOLYTICS, SEDATIVES & HYPNOTICS MISC | | | | 00 | 30.000 | $28.01 | $14.59 | $19.99 |
| [redacted] | P | 1 | | 66993010702 | FEXOFENADINE HCL | 0 | 1 | 46693 | 04060000 | SECOND GENERATION ANTIHISTAMINES | | | | 00 | 60.000 | $93.91 | $69.64 | $75.04 |
| [redacted] | P | 1 | | 00168033230 | FLUTICASONE PROPIONATE | 0 | 1 | 43951 | 84060000 | ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS) | | | | 00 | 60.000 | $78.35 | $53.37 | $58.77 |
| [redacted] | P | 1 | | 63717003412 | HYLIRA | 0 | 1 | 25484 | 94000000 | DEVICES | | | | 00 | 340.000 | $122.50 | $96.26 | $103.66 |
| [redacted] | P | 1 | | 00168033230 | FLUTICASONE PROPIONATE | 0 | 1 | 43951 | 84060000 | ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS) | | | | 00 | 60.000 | $78.35 | $53.37 | $58.77 |


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B

# Alabama Medicaid Agency

User ID:
Run Date: 2/25/2009
Run Time: 12:14:47 PM

Pharmacy Claim Details By Provider
Recipient Listing
For Dates of Service: 10/01/2007 - 09/30/2008
Provider Base, Medicaid or NPI ID:
VACCA DISCOUNT DRUGS
For Claim Types: P and Q

| Recipient ID | Recipient Full Name |
|---|---|
| | |

PHI has been covered


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C

**Alabama Medicaid Agency**

Pharmacy Claim Details By Provider

NDC Listing

For Dates of Service: 10/01/2007 - 09/30/2008

Provider Base, Medicaid or NPI ID: [redacted]

VACCA DISCOUNT DRUGS

For Claim Types: P and Q

User ID: [redacted]
Run Date: 2/25/2009
Run Time: 12:14:47 PM

| NDC Code & Desc | ICN Count | Recipient Count |
|---|---|---|
| ########### - | 1 | 1 |
| 00002322830 - STRATTERA | 5 | 1 |
| 00002322930 - STRATTERA | 6 | 1 |
| 00002323730 - CYMBALTA | 18 | 4 |
| 00002323830 - STRATTERA | 4 | 2 |
| 00002323930 - STRATTERA | 7 | 1 |
| 00002325030 - STRATTERA | 6 | 1 |
| 00002751001 - HUMALOG | 6 | 1 |
| 00002821501 - HUMULIN R | 2 | 2 |
| 00002831501 - HUMULIN N | 2 | 2 |
| 00002850101 - HUMULIN R | 1 | 1 |
| 00002871501 - HUMULIN 70-30 | 8 | 3 |
| 00004018682 - BONIVA | 2 | 1 |
| 00004080085 - TAMIFLU | 3 | 3 |
| 00004081095 - TAMIFLU | 18 | 18 |
| 00006003144 - FOSAMAX | 3 | 1 |

### 3.5.47.1 DSSProfiler - Pharmacy Claim Details by Provider Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) NDC | The national drug code for the drug dispensed. | 11 | Character |
| (A) AHFS | Identifies the pharmacological therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification systems. | 8 | Number |
| (A) AHFS Therapeutic Class Description | Text description of the American Hospital Formulary Service (AHFS) classification | 55 | Character |
| (A) Age | The age of the recipient on the From Date of Service rounded down to a full year. | 4 | Number |
| (A) Allowed Amount | The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Claim Type (CT) | Shows what type of claim was submitted. | 1 | Character |
| (A) DEA | Drug Enforcement Administration Code denotes the degree of potential abuse and Federal control of a drug. It is subject to change by Federal regulation. The current code list is: 0, 1, 2, 3, 4, 5. | 1 | Number |
| (A) Detail Number (Dtl#) | Detail number on the claim. | 4 | Number (Integer) |
| (A) Dispense Qty | Number of units of a drug dispensed to a member. The type of unit is expressed in Drug Form Code. | 10 | Number |
| (A) Dispensed Dte | Date the prescription was dispensed by the provider. | 10 | Date (MM/DD/CCYY) |
| (A) GCN | Generic Code Number (GCN) is a unique 5 digit number representing the generic formulation. The GCN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GCN is the same across manufacturers and/or package sizes. The number by itself has no significance, but is useful for online computer applications such as generic substitution. | 5 | Character |
| (A) GPI | Generic Product Indicator (GPI) distinguishes a product either as a generic drug product (1) or a more expensive branded drug product (2). | 5 | Character |
| (A) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A) NDC Description | Description/name of the prescription dispensed. | 35 | Character |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient ( | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Place of Service (POS) | Place of Service code for where services were rendered. | 2 | Number |
| (A,B) Recipient Full Name (Recip Name) | Concatenates the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID (Recip ID) | Recipient Medicaid Number. | 12 | Character |
| (A-C) Provider Base, Medicaid or NPI ID | Provider's ID. | 13 | Character |
| (A-C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (C)Diagnosis 1 - Code & Desc | Concatenates the National Drug Code (NDC) and the description. | 63 | Character |
| (C) ICN Count | Unduplicated count of claims for NDC listed. | 8 | Number (Integer) |
| (C) NDC Code & Desc | National Drug Code. and NDC Name/Description | 49 | Character |
| (C) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |


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### 3.5.48 DSSProfiler - Pharmacy Claim Details by Provider Quarterly

This report lets the user drill down to the detail level for all pharmacy case types for a given provider and service location. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

There are tabs in this report:

A. Pharmacy Claim Details;

B. Recipient Listing; and

C. NDC Listing.

A

**Alabama Medicaid Agency**

Pharmacy Claim Details By Provider Qtrly

Pharmacy Claim Details

For Dates of Service: 10/01/2007 - 09/30/2008

Provider Base, Medicaid or NPI ID: [redacted]

For Claim Types: P and Q

Quarter: 20083

User ID: [redacted]
Run Date: 2/25/2009
Run Time: 12:03:34 PM

| ICN | CT | Dtl # | Dispensed Dte | NDC | NDC Desc | DEA | GPI | GCN | AHFS | AHFS Therapeutic Class Desc | Recip ID | Recip Name | Age | POS | Dispense Qty | Billed Amt | Alwd Amt | Paid Amt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] | P | 1 | | 60047029101 | SCOPOHIST-PE | 0 | 9 | 19297 | 04042000 | PROPYLAMINE DERIVATIVES | | | | 00 | 60.000 | $24.66 | $15.79 | $20.19 |
| [redacted] | P | 1 | | 00472163016 | PROMETHAZINE-DM | 0 | 9 | 13975 | 48000000 | ANTITUSSIVES | | | | 00 | 180.000 | $13.14 | $3.48 | $8.38 |
| [redacted] | P | 1 | | 00781107710 | ALPRAZOLAM | 4 | 9 | 14261 | 28240000 | BENZODIAZEPINES (ANXIOLYTIC,SEDATIVE/HYP) | | | | 00 | 60.000 | $49.37 | $3.21 | $8.11 |
| [redacted] | P | 1 | | 00065401303 | VIGAMOX | 0 | 9 | 19542 | 52040400 | ANTIBACTERIALS (EENT) | | | | 00 | 3.000 | $74.43 | $60.66 | $66.06 |
| [redacted] | P | 1 | | 00168000031 | HYDROCORTISONE | 0 | 9 | 30943 | 84060000 | ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS) | | | | 00 | 30.000 | $16.02 | $3.60 | $9.00 |
| [redacted] | P | 1 | | 00182506651 | TRIAMCINOLONE ACETONIDE | 0 | 2 | 31244 | 84060000 | ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS) | | | | 00 | 15.000 | $10.89 | $3.01 | $8.41 |
| [redacted] | P | 1 | | 00182506651 | TRIAMCINOLONE ACETONIDE | 0 | 2 | 31244 | 84060000 | ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS) | | | | 00 | 15.000 | $10.89 | $3.01 | $8.41 |
| [redacted] | P | 1 | | 65224054501 | ALDEX-CT | 0 | 2 | 26967 | 04040400 | ETHANOLAMINE DERIVATIVES | | | | 00 | 14.000 | $24.20 | $23.91 | $29.31 |
| [redacted] | P | 1 | | 64679071203 | CEFPROZIL | 0 | 1 | 29271 | 08120608 | SECOND GENERATION CEPHALOSPORINS | | | | 00 | 20.000 | $62.61 | $34.85 | $40.25 |
| [redacted] | P | 1 | | 00006011731 | SINGULAIR | 0 | 9 | 94444 | 48102400 | LEUKOTRIENE MODIFIERS | | | | 00 | 30.000 | $126.54 | $106.18 | $111.58 |
| [redacted] | P | 1 | | 63402051001 | XOPENEX HFA | 0 | 9 | 24422 | 12120812 | SELECTIVE BETA-2-ADRENERGIC | | | | 00 | 15.000 | $59.67 | $47.76 | $53.16 |
| [redacted] | P | 1 | | 65224054501 | ALDEX-CT | 0 | 9 | 26967 | 04040400 | ETHANOLAMINE DERIVATIVES | | | | 00 | 14.000 | $24.20 | $23.91 | $29.31 |
| [redacted] | P | 1 | | 65224054501 | ALDEX-CT | 0 | 9 | 26967 | 04040400 | ETHANOLAMINE DERIVATIVES | | | | 00 | 14.000 | $41.50 | $23.91 | $29.31 |
| [redacted] | P | 1 | | 51672129602 | KETOCONAZOLE | 0 | 2 | 31850 | 84040000 | AZOLES (SKIN & MUCOUS MEMBRANE) | | | | 00 | 30.000 | $14.78 | $14.78 | $3.00 |
| [redacted] | P | 1 | | 00168009630 | KETOCONAZOLE | 0 | 2 | 31850 | 84040000 | AZOLES (SKIN & MUCOUS MEMBRANE) | | | | 00 | 30.000 | $24.78 | $21.64 | $3.00 |
| [redacted] | P | 1 | | 00093001256 | PANTOPRAZOLE SODIUM | 0 | 1 | 40120 | 56253600 | PROTON-PUMP INHIBITORS | | | | 00 | 30.000 | $127.62 | $107.22 | $109.62 |
| [redacted] | P | 1 | | 60505003406 | GEMFIBROZIL | 0 | 1 | 25540 | 24060600 | FIBRIC ACID DERIVATIVES | | | | 00 | 60.000 | $76.23 | $16.59 | $20.99 |
| [redacted] | P | 1 | | 00091053510 | METFORMIN HCL | 0 | 1 | 10857 | 68200400 | BIGUANIDES | | | | 00 | 60.000 | $91.71 | $26.86 | $30.26 |
| [redacted] | P | 1 | | 64764045124 | ACTOS | 0 | 2 | 93011 | 68202900 | THIAZOLIDINEDIONES | | | | 00 | 30.000 | $240.39 | $205.62 | $208.02 |
| [redacted] | P | 1 | | 00172206380 | HYDROCHLOROTHIAZIDE | 0 | 2 | 34824 | 40202000 | THIAZIDE DIURETICS | | | | 00 | 30.000 | $8.99 | $1.34 | $6.24 |
| [redacted] | P | 1 | | 65597010430 | BENICAR | 0 | 2 | 17256 | 24320600 | ANGIOTENSIN II RECEPTOR ANTAGONISTS | | | | 00 | 30.000 | $81.18 | $66.50 | $68.90 |
| [redacted] | P | 1 | | 00169183711 | NOVOLIN 70-30 | 0 | 2 | 50001 | 68200000 | INSULINS | | | | 00 | 20.000 | $93.78 | $27.55 | $29.95 |
| [redacted] | P | 1 | | 00881609331 | MONOJECT INSULIN SYRINGE | 0 | 0 | 94200 | 94000000 | DEVICES | | | | 00 | 100.000 | $29.07 | $21.51 | $24.91 |
| [redacted] | P | 1 | | 65162062711 | TRAMADOL HCL | 0 | 1 | 07221 | 28000000 | OPIATE AGONISTS | | | | 00 | 24.000 | $25.02 | $4.92 | $9.32 |
| [redacted] | P | 1 | | 11523723404 | MIRALAX | 0 | 1 | 86212 | 56120000 | CATHARTICS AND LAXATIVES | | | | 00 | 510.000 | $23.76 | $16.84 | $21.24 |
| [redacted] | P | 1 | | 00472135832 | CONSTULOSE | 0 | 2 | 10167 | 40100000 | AMMONIA DETOXICANTS | | | | 00 | 4,730.000 | $332.28 | $80.69 | $83.09 |

PHI has been covered


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**B**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 2/25/2009
Run Time: 12:03:34 PM

Pharmacy Claim Details By Provider Qtrly
Recipient Listing
For Dates of Service: 10/01/2007 - 09/30/2008
Provider Base, Medicaid or NPI ID: [redacted]
DOWNEY DRUG ALEXANDRIA
For Claim Types: P and Q
Quarter: 20083

| Recipient ID | Recipient Full Name |
|---|---|
| | |

PHI has been covered

**C**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 2/25/2009
Run Time: 12:03:34 PM

Pharmacy Claim Details By Provider Qtrly
NDC Listing
For Dates of Service: 10/01/2007 - 09/30/2008
Provider Base, Medicaid or NPI ID: [redacted]
DOWNEY DRUG ALEXANDRIA
For Claim Types: P and Q
Quarter: 20083

| NDC Code & Desc | ICN Count | Recipient Count |
|---|---|---|
| ########### - | 1 | 1 |
| 00002322830 - STRATTERA | 5 | 1 |
| 00002322930 - STRATTERA | 6 | 1 |
| 00002323730 - CYMBALTA | 18 | 4 |
| 00002323830 - STRATTERA | 4 | 2 |
| 00002323930 - STRATTERA | 7 | 1 |
| 00002325030 - STRATTERA | 6 | 1 |
| 00002751001 - HUMALOG | 6 | 1 |
| 00002821501 - HUMULIN R | 2 | 2 |


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### 3.5.48.1 DSSProfiler - Pharmacy Claim Details by Provider Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) NDC | The national drug code for the drug dispensed. | 11 | Character |
| (A) AHFS | Identifies the pharmacological therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification systems. | 8 | Number |
| (A) AHFS Therapeutic Class Description | Text description of the American Hospital Formulary Service (AHFS) classification | 55 | Character |
| (A) Age | The age of the recipient on the From Date of Service rounded down to a full year. | 4 | Number |
| (A) Allowed Amount | The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Claim Type (CT) | Shows what type of claim was submitted. | 1 | Character |
| (A) DEA | Drug Enforcement Administration Code denotes the degree of potential abuse and Federal control of a drug. It is subject to change by Federal regulation. The current code list is: 0, 1, 2, 3, 4, 5. | 1 | Number |
| (A) Detail Number (Dtl#) | Detail number on the claim. | 4 | Number (Integer) |
| (A) Dispense Qty | Number of units of a drug dispensed to a member. The type of unit is expressed in Drug Form Code. | 10 | Number |
| (A) Dispensed Dte | Date the prescription was dispensed by the provider. | 10 | Date (MM/DD/CCYY) |
| (A) GCN | Generic Code Number (GCN) is a unique 5 digit number representing the generic formulation. The GCN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GCN is the same across manufacturers and/or package sizes. The number by itself has no significance, but is useful for online computer applications such as generic substitution. | 5 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) GPI | Generic Product Indicator (GPI) distinguishes a product either as a generic drug product (1) or a more expensive branded drug product (2). | 5 | Character |
| (A) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A) NDC Description | Description/name of the prescription dispensed. | 35 | Character |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Place of Service (POS) | Place of Service code for where services were rendered. | 2 | Number |
| (A,B) Recipient Full Name (Recip Name) | Concatenates the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID (Recip ID) | Recipient Medicaid Number. | 12 | Character |
| (A-C) Provider Base, Medicaid or NPI ID | Provider's ID. | 13 | Character |
| (A-C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-C) Quarter | The quarter for which the report is being run. | 5 | Number |
| (C)Diagnosis 1 - Code & Desc | Concatenates the National Drug Code (NDC) and the description. | 63 | Character |
| (C) ICN Count | Unduplicated count of claims for NDC listed. | 8 | Number (Integer) |
| (C) NDC Code & Desc | National Drug Code and its Name/Description | 49 | Character |
| (C) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |


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### 3.5.49 DSSProfiler - Pharmacy Disease Quick View

This report is created in the DSSProfiler. This report displays recipient utilization services for selected case types with totals broken out by the number of services received. This report can be used for disease management.

There are tabs in this report:

A. Pharmacy Disease; and

B. Pharmacy Disease by Peer Group.

**A**

**Alabama Medicaid Agency**

**Pharmacy Disease Quick View**

**Pharmacy Disease**

**For Dates of Service: 10/01/2004 - 09/30/2005**

**Case Type: 1 - All Claim Groupings**

**Aggregation Code: 7 - Fee for Service Claims by Recipient**

**User ID:** [redacted]
**Run Date:** 8/6/2006
**Run Time:** 9:47:58 PM

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 7 | 1 | 0 | 7 | $0.00 | $0.00 | $0.00 |
| 3 | 2 | 0 | 6 | $0.00 | $0.00 | $0.00 |
| 1 | 3 | 0 | 3 | $0.00 | $0.00 | $0.00 |
| 2 | 5 | 0 | 10 | $0.00 | $0.00 | $0.00 |
| 1 | 9 | 0 | 9 | $0.00 | $0.00 | $0.00 |
| 1 | 12 | 0 | 12 | $0.00 | $0.00 | $0.00 |
| 1 | 14 | 0 | 14 | $0.00 | $0.00 | $0.00 |
| 1 | 14 | 0 | 14 | $0.00 | $0.00 | $0.00 |
| 1 | 14 | 0 | 14 | $0.00 | $0.00 | $0.00 |
| 1 | 14 | 0 | 14 | $0.00 | $0.00 | $0.00 |
| 1 | 14 | 0 | 14 | $0.00 | $0.00 | $0.00 |
| 1 | 14 | 0 | 14 | $0.00 | $0.00 | $0.00 |
| 1 | 14 | 0 | 14 | $0.00 | $0.00 | $0.00 |
| Totals: | | | 61 | $0.00 | $0.00 | $0.00 |


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B

# Alabama Medicaid Agency

User ID:
Run Date: 8/6/2006
Run Time: 9:47:58 PM

**Pharmacy Disease Quick View**
**Pharmacy Disease By Peer Group**

**For Dates of Service: 10/01/2004 - 09/30/2005**
**Case Type: 1 - All Claim Groupings**
**Aggregation Code: 7 - Fee for Service Claims by Recipient**

**Peer Group: 516 - Public Assistance, Blind**

| Each Recipient Had XX Claims | Unduplicated Recipients | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 1 | 1 | 0 | 1 | $0.00 | $0.00 | $0.00 |
| 2 | 1 | 0 | 2 | $0.00 | $0.00 | $0.00 |
| Totals: | | | 3 | $0.00 | $0.00 | $0.00 |

**Peer Group: 519 - Public Assistance, Disabled**

| Each Recipient Had XX Claims | Unduplicated Recipients | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 1 | 2 | 0 | 2 | $0.00 | $0.00 | $0.00 |
| Totals: | | | 2 | $0.00 | $0.00 | $0.00 |

**Peer Group: 520 - Institutionalized with income less than 300%, Blnd**

| Each Recipient Had XX Claims | Unduplicated Recipients | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 3 | 1 | 0 | 3 | $0.00 | $0.00 | $0.00 |
| 9 | 1 | 0 | 9 | $0.00 | $0.00 | $0.00 |
| Totals: | | | 12 | $0.00 | $0.00 | $0.00 |

### 3.5.49.1 DSSProfiler - Pharmacy Disease Quick View Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-B) Allowed Amount | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-B) Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A-B) Each Recipient Had XX Claims | This field shows us how many claims each of the recipients had. | 4 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-B) Total Claims | This is the total number of claims billed based on the number of recipients and the number of claims each recipient had. | 9 | Character |
| (A-B) Total Quantity Billed | This is the total units billed for this particular claim category. | 9 | Character |
| (A-B) Unduplicated Recipients | This is a count of all recipients that have had a service within this claim grouping. The count is unduplicated, meaning each recipient is only counted once. | 9 | Character |
| (B) Peer Group | Peer Group Code and Description. | 107 | Character |


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### 3.5.50 DSSProfiler - Pharmacy Distribution Analysis

The Pharmacy Distribution Analysis report is created in the DSSProfiler. This report shows totals for all pharmacy case types within the selected peer group. The totals include amount reimbursed; amount billed; and number of unduplicated recipients, claim counts, units and exceptions.

This report provides a rapid method to identify which case types or service categories need to be looked at more closely with other reports within the DSS Profiler.

There are five tabs in this report:

A. Pharmacy Distribution Summary;

B. Top 20;

C. By Age;

D. By Gender; and

E. By Age/Gender.

A

**Alabama Medicaid Agency**

User ID:
Run Date: 11/14/2007
Run Time: 10:15:51 AM

Pharmacy Distribution Analysis
Pharmacy Distribution Summary
For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 4 - Pharmacy By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

| Case Type Description | Billed Quantity | Recip Count | Claim Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amount per Recip | Paid Amount per Recip | Claims per Recip | Exception Count |
|---|---|---|---|---|---|---|---|---|---|---|
| 1060 - AL Duragesic Drug Codes | 690 | 35 | 68 | $36,375.67 | $31,111.75 | $30,907.55 | $1,039.30 | $883.07 | 1.94 | 0 |
| 1061 - AL Adderall Drug Codes | 314,092 | 5989 | 9853 | $1,598,658.05 | $1,145,722.27 | $1,121,202.60 | $266.93 | $187.21 | 1.65 | 14 |
| 1062 - AL Concerta Drug Codes | 239,909 | 4535 | 7571 | $1,153,097.39 | $870,184.87 | $849,200.65 | $254.27 | $187.25 | 1.67 | 15 |
| 1063 - AL Metadate Drug Codes | 87,337 | 1769 | 2354 | $302,148.08 | $221,429.71 | $219,270.13 | $170.80 | $123.95 | 1.33 | 19 |
| 3 - Morbidity 1 | 47,458,893 | 176398 | 470196 | $30,214,563.44 | $20,884,270.38 | $20,170,357.58 | $171.29 | $114.35 | 2.67 | 47 |
| 4 - Morbidity 2 | 55,148,541 | 149731 | 596363 | $54,941,237.79 | $38,237,743.79 | $37,061,531.92 | $366.93 | $247.52 | 3.98 | 28 |
| 5 - Morbidity 3 | 19,953,799 | 55718 | 208398 | $21,200,285.98 | $14,978,295.01 | $14,586,911.86 | $380.49 | $261.80 | 3.74 | 27 |
| 6 - Morbidity 4 | 23,050,986 | 58422 | 220124 | $20,970,986.71 | $14,153,883.30 | $13,856,143.03 | $358.96 | $237.17 | 3.77 | 33 |
| 7 - Morbidity 5 | 4,299,632 | 7380 | 32056 | $3,868,759.58 | $2,739,753.60 | $2,708,409.80 | $524.22 | $366.99 | 4.34 | 41 |
| 945 - AL Oxycontin Drug Codes | 82,058 | 523 | 1311 | $494,717.56 | $333,732.57 | $329,708.18 | $945.92 | $630.42 | 2.51 | 4 |

End of Report


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B

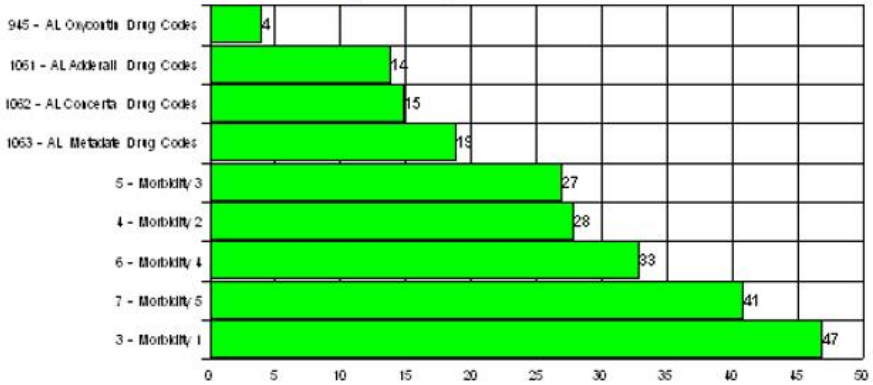
# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 10:15:51 AM

Pharmacy Distribution Analysis
Top 20

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 4 - Pharmacy By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Top 20 Exceptions



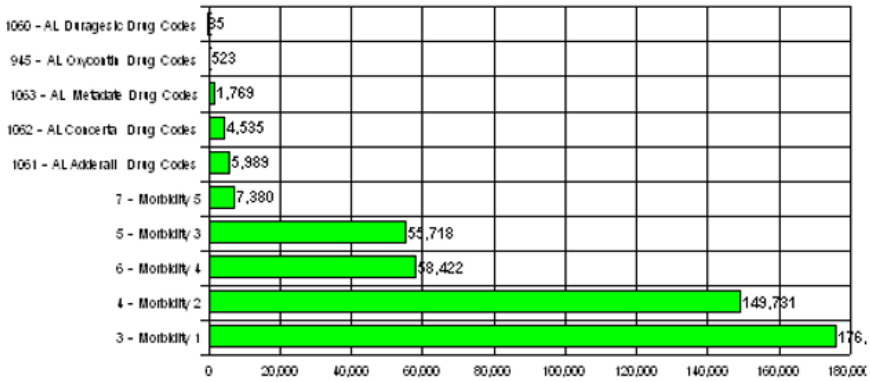

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 10:15:51 AM

Pharmacy Distribution Analysis
Top 20

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 4 - Pharmacy By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Top 20 By Number of Recipients





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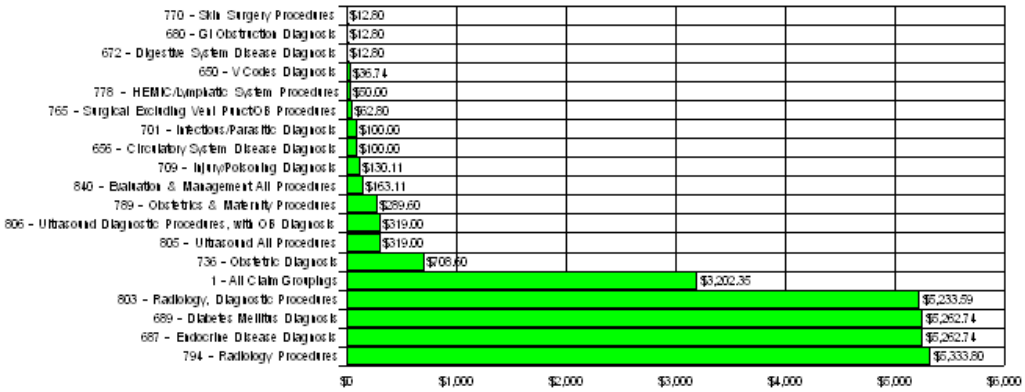
# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:32:08 PM

Outpatient Distribution Analysis
Top 20

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 20 By Paid Amount per Recipient




C

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 10:15:51 AM

Pharmacy Distribution Analysis
By Age

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 4 - Pharmacy By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Case Type: 1060 - AL Duragesic Drug Codes

| Age Description | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amount per Recip | Allowed Amount per Recip | Paid Amount per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| Age 21 - 34 | 90 | 11 | 4 | $4,845.65 | $4,230.62 | $4,197.62 | $1,211.41 | $1,057.66 | $1,049.41 | 2.75 |
| Age 35 - 64 | 580 | 55 | 30 | $30,891.24 | $26,319.60 | $26,154.40 | $1,029.71 | $877.32 | $871.81 | 1.83 |
| Age 65+ | 20 | 2 | 1 | $638.78 | $561.53 | $555.53 | $638.78 | $561.53 | $555.53 | 2.00 |
| Sum: | 690 | 68 | 35 | $36,375.67 | $31,111.75 | $30,907.55 | $2,879.90 | $888.91 | $2,476.75 | 6.58 |

Case Type: 1061 - AL Adderall Drug Codes

| Age Description | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amount per Recip | Allowed Amount per Recip | Paid Amount per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| Age 00 - 05 | 11,099 | 368 | 257 | $57,482.50 | $40,592.49 | $39,567.37 | $223.67 | $157.95 | $153.96 | 1.43 |
| Age 06 - 17 | 287,665 | 9,011 | 5,455 | $1,467,471.59 | $1,049,265.28 | $1,027,642.23 | $269.01 | $192.35 | $188.39 | 1.65 |
| Age 18 - 20 | 7,869 | 239 | 138 | $36,995.69 | $28,632.70 | $27,935.93 | $268.08 | $207.48 | $202.43 | 1.73 |
| Age 21 - 34 | 4,128 | 129 | 80 | $20,043.42 | $15,056.31 | $14,199.58 | $250.54 | $188.20 | $177.49 | 1.61 |
| Age 35 - 64 | 3,331 | 106 | 59 | $16,664.85 | $12,175.49 | $11,857.49 | $282.46 | $206.36 | $200.97 | 1.80 |
| Sum: | 314,092 | 9,853 | 5,989 | $1,598,658.05 | $1,145,722.27 | $1,121,202.60 | $1,293.76 | $191.30 | $923.25 | 8.22 |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D

**Alabama Medicaid Agency**

Pharmacy Distribution Analysis
By Gender

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 10:15:51 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 4 - Pharmacy By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Case Type: 1060 - AL Duragesic Drug Codes

| Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amount per Recip | Allowed Amount per Recip | Paid Amount per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| F | 480 | 48 | 25 | $25,185.74 | $21,231.46 | $21,087.26 | $1,007.43 | $849.26 | $843.49 | 1.92 |
| M | 210 | 20 | 10 | $11,189.93 | $9,880.29 | $9,820.29 | $1,118.99 | $988.03 | $982.03 | 2.00 |
| Sum: | 690 | 68 | 35 | $36,375.67 | $31,111.75 | $30,907.55 | $2,126.42 | $888.91 | $1,825.52 | 3.92 |

Case Type: 1061 - AL Adderall Drug Codes

| Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amount per Recip | Allowed Amount per Recip | Paid Amount per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| F | 88,843 | 2,848 | 1,769 | $462,128.35 | $324,401.67 | $316,112.99 | $255.58 | $183.38 | $178.70 | 1.61 |
| M | 225,249 | 7,005 | 4,220 | $1,146,529.70 | $821,320.60 | $805,089.61 | $271.69 | $194.63 | $190.78 | 1.66 |
| Sum: | 314,092 | 9,853 | 5,989 | $1,598,658.05 | $1,145,722.27 | $1,121,202.60 | $527.27 | $191.30 | $369.48 | 3.27 |

E

**Alabama Medicaid Agency**

Pharmacy Distribution Analysis
By Age/Gender

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 10:15:51 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 4 - Pharmacy By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Case Type: 1060 - AL Duragesic Drug Codes

| Age Description | Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amount per Recip | Allowed Amount per Recip | Paid Amount per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Age 21 - 34 | F | 50 | 5 | 2 | $2,601.70 | $2,269.69 | $2,254.69 | $1,300.85 | $1,134.85 | $1,127.35 | 2.50 |
| Age 21 - 34 | M | 40 | 6 | 2 | $2,243.95 | $1,960.93 | $1,942.93 | $1,121.98 | $980.47 | $971.47 | 3.00 |
| Age 35 - 64 | F | 410 | 41 | 22 | $21,945.26 | $18,400.24 | $18,277.04 | $997.51 | $836.37 | $830.77 | 1.86 |
| Age 35 - 64 | M | 170 | 14 | 8 | $8,945.98 | $7,919.36 | $7,877.36 | $1,118.25 | $989.92 | $984.67 | 1.75 |
| Age 65+ | F | 20 | 2 | 1 | $638.78 | $561.53 | $555.53 | $638.78 | $561.53 | $555.53 | 2.00 |
| | Sum: | 690 | 68 | 35 | $36,375.67 | $31,111.75 | $30,907.55 | $5,177.36 | $888.91 | $4,469.78 | 11.11 |

### 3.5.50.1 DSSProfiler - Pharmacy Distribution Analysis Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Case Type Description | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |
| (A) Exception Count | Number of exceptions identified. An exception is defined as two standard deviations from the norm. | 8 | Number (Integer) |
| (A,C,D,E) Allowed Amount | The amount of money allowed to the Medicaid program billed on this particular | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | grouping of claims for this specific recipient. | | |
| (A,D) Average Billed Amount per Recip | Total billed amount divided by the number of recipients. | 12 | Number (Decimal) |
| (AD) Average Claims per Recip | Total claim count divided by the recipient count. | 4 | Number (Integer) |
| (A,D) Average Paid Amount per Recip | Total reimbursed amount divided by the number of recipients. | 12 | Number (Decimal) |
| (A,C,D,E) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A,C,D,E) Billed Quantity | Quantity billed. | 14 | Number (Integer) |
| (A,C,D,E) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (A,C,D,E) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A,C,D,E) Recip Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (A-E) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-E) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-E) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-E) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (B) Top 20 By Number of Recipients | Graph shows Top 20 exceptions by number of recipients. | 1 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (B) Top 20 By Paid Amount per Recipient | Graph shows Top 20 exceptions by paid amount per recipient. | 1 | Character |
| (B) Top 20 Exceptions | Graph shows Top 20 exceptions. | 1 | Character |
| (C,D,E) Allowed Amt Per Recip | Total allowed amount divided by the number of recipients. | 13 | Number (Decimal) |
| (C,E) Age Description | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (C,E) Billed Amount Per Recip | Total billed amount divided by the number of recipients. | 13 | Number (Decimal) |
| (C,E) Claims Per Recip | Total claim count divided by the recipient count. | 4 | Number (Integer) |
| (C,E) Paid Amount Per Recip | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |
| (D,E) Gender | Recipient's gender. | 1 | Character |


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### 3.5.51 DSSProfiler - Pharmacy Exception Quarterly

The Pharmacy Exception Quarterly report is produced for a selected provider, provider peer group and aggregation code. The report displays the number of high exceptions for case groups that occur during each reporting period. The case groups whose calculations that are above the exception high value are marked as exceptions.

**Alabama Medicaid Agency**

User ID: Administrator
Run Date: 5/18/2006
Run Time: 5:06:36 PM

Pharmacy Exception Quarterly

For Dates of Service: 07/01/2004 - 06/30/2005

Provider Service Location Information:
NPI ID:
Mcaid ID:
Base ID:
Name: MICKEY A DALLES
Type: 24 - Pharmacy
Specialty: 240 - Pharmacy
Address: PO BOX 6042
MAIL STOP 10427
PORTLAND, OR 97501

Peer Group Code: 195 - 240 PHARMACY
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| | 20043 | |
|---|---|---|
| 800 - Unusual Dispensing of Compounded Drugs; H: 002 L: 000 | 5.00 | * |
| 820 - Unusual Prescribing Practices; H: 002 L: 000 | 5.00 | * |
| 840 - Excessive Dispensing of Small Quantity Prescriptions; H: 000 L: 010 | 0.00 | * |

End of Report

#### 3.5.51.1 DSSProfiler - Pharmacy Exception Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| Case Type Group Display | Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item. | 4 | Number (Integer) |
| Exception | This column is marked with a '*' when the case group is above the exception high value. | 1 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The | 20 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | most common recipient peer grouping is the recipient aid category. | | |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| Provider Service Location Information | Provider's information. This includes the provider name, address, NPI ID, Medicaid ID, and Base ID. | 200 | Character |
| Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |


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### 3.5.52 DSSProfiler - Pharmacy Frequency Distribution

The Pharmacy Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one year, this report shows for each pharmacy case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.

**Alabama Medicaid Agency**

**Pharmacy Frequency Distribution**

User ID: [redacted]
Run Date: 5/9/2006
Run Time: 5:32:12 PM

For Dates of Service: 07/01/04 - 06/30/05
Provider Peer Group: 346 - 071 MANAGED CARE ORGANIZATION
Provider Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type : 935 - 7600 Oxytocics

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 3 | 3 | 3 | 3 | 3 | 3 |

End of Report

#### 3.5.52.1 DSSProfiler - Pharmacy Frequency Distribution Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |
| 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |
| Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Provider Aggregation Code | Aggregation Code and Description. | 100 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |


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### 3.5.53 DSSProfiler - Pharmacy Frequency Distribution Quarterly

The Pharmacy Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report shows for each pharmacy case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.

**Alabama Medicaid Agency**

Pharmacy Frequency Distribution Qtrly

User ID:
Run Date: 5/12/2006
Run Time: 10:30:01 AM

For Dates of Service: 01/01/2005 - 03/31/2005
Provider Peer Group Code: 4 - Pharmacy By Claim Type
Provider Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20051

Case Type : 165 - Compounded Drugs

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 6 | 6 | 6 | 8 | 8 | 8 |

Case Type : 166 - Non-Compounded Drugs

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 7 | 7 | 14 | 77 | 105 | 105 |

End of Report

#### 3.5.53.1 DSSProfiler - Pharmacy Frequency Distribution Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |
| 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |
| Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Provider Aggregation Code | Aggregation Code and Description. | 100 | Character |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| Provider Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |


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### 3.5.54 DSSProfiler - Pharmacy Recipient Case Type Comparison by Peer Group

The Pharmacy Recipient Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all recipients within a peer group to determine which providers fall outside of service dollar norms on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Recipients who have two standard deviations above or below the "norm" for the peer group are highlighted. This report provides a rapid method to find which recipients need to be analyzed more closely at a case type level by utilizing other reports within the DSSProfiler. This report makes it easy to see, for example, which recipients are the recipients of asthma services who fall outside of the accepted norm within the peer group.

There are two tabs in this report:

A. Recipient Comparison; and

B. Recipients Grouped by Age/Gender

A

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 9/25/2007
Run Time: 9:16:18 AM

Pharmacy Recipient Case Type Comparison by Peer Group
Recipient Comparison

For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 6 - Morbidity 4
Recipient Peer Group: 941 - 25 Blind-SSI-full Medicaid with QMB Plus
Aggregation Code: 7 - Fee For Service Claims by Recipient

| Rank | Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference From Expected | Exception |
|---|---|---|---|---|---|---|---|---|
| 1 | [redacted] | [redacted] | $250.38 | $217.59 | $209.59 | $52.08 | $157.51 | * |
| 2 | [redacted] | [redacted] | $163.98 | $86.79 | $80.79 | $52.08 | $28.71 | |
| 3 | [redacted] | [redacted] | $108.70 | $77.76 | $72.76 | $57.86 | $14.90 | |
| 6 | [redacted] | [redacted] | $193.35 | $29.61 | $28.11 | $13.43 | $14.68 | |
| 5 | [redacted] | [redacted] | $103.89 | $40.93 | $38.43 | $31.76 | $6.67 | |
| 7 | [redacted] | [redacted] | $48.74 | $27.09 | $25.09 | $31.76 | $(6.67) | |
| 13 | [redacted] | [redacted] | $6.00 | $5.68 | $5.18 | $13.43 | $(8.25) | |
| 4 | [redacted] | [redacted] | $427.88 | $45.95 | $42.95 | $57.86 | $(14.91) | |
| 8 | [redacted] | [redacted] | $288.64 | $25.85 | $23.85 | $52.08 | $(28.23) | |
| 9 | [redacted] | [redacted] | $25.50 | $19.86 | $18.86 | $52.08 | $(33.22) | |
| 10 | [redacted] | [redacted] | $91.44 | $12.38 | $11.38 | $52.08 | $(40.70) | |
| 11 | [redacted] | [redacted] | $12.68 | $11.36 | $10.36 | $52.08 | $(41.72) | |
| 12 | [redacted] | [redacted] | $27.87 | $10.76 | $9.76 | $52.08 | $(42.32) | |
| | | | | | | 2 STD DEV | $101.58 | |


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**B**

# Alabama Medicaid Agency

User ID:
Run Date: 9/25/2007
Run Time: 9:16:18 AM

**Pharmacy Recipient Case Type Comparison by Peer Group**

**Recipient Grouped by Age/Gender**

**For Dates of Service: 01/01/2006 - 12/31/2006**

**Case Type: 6 - Morbidity 4**

**Recipient Peer Group: 941 - 25 Blind-SSI-full Medicaid with QMB Plus**

**Aggregation Code: 7 - Fee For Service Claims by Recipient**

**Age 35 - 64**

**Gender: F**

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| | | $250.38 | $217.59 | $209.59 |
| | | $288.64 | $25.85 | $23.85 |
| | | $27.87 | $10.76 | $9.76 |
| | | $25.50 | $19.86 | $18.86 |
| | | $12.68 | $11.36 | $10.36 |
| | | $163.98 | $86.79 | $80.79 |
| | | $91.44 | $12.38 | $11.38 |
| | | | Sum: | $364.59 |

**Gender: M**

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| | | $6.00 | $5.68 | $5.18 |
| | | $193.35 | $29.61 | $28.11 |
| | | | Sum: | $33.29 |

### 3.5.54.1 DSSProfiler - Pharmacy Recipient Case Type Comparison by Peer Group Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Dollar Difference from Expected | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates recipients who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Rank | Recipient's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A,B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Allowed Amount | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A,B) Billed Amount | Amount the provider billed for the service. | 13 | Number (Decimal) |
| (A,B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A,B) Recipient Full Name | Recipient's full name. | 50 | Character |
| (A,B) Recipient ID | Recipient Medicaid Number. | 12 | Character |
| (A,B) Recipient Peer Group | Recipient Peer Group Code and Description. | 40 | Character |
| (B) Age | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Number (Integer) |
| (B) Gender | Recipient's gender. | 1 | Character |


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### 3.5.55 DSSProfiler - Pharmacy Recipient Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all providers within a peer group to determine which recipients fall outside of service dollar norms on a user specified case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

There are two tabs in this report:

A. Recipient Comparison; and

B. Recipients Grouped by Age/Gender

A

**Alabama Medicaid Agency**

User ID: Administrator
Run Date: 5/22/2006
Run Time: 9:11:47 AM

Pharmacy Recipient Case Type Comparison
By Peer Group Qtrly
Recipient Comparison
For Dates of Service: 01/01/2005 - 03/31/2005
Case Type: 1 - All Claim Groupings
Recipient Peer Group: 302 - Medical Assistance, Categorically Needy, TANF
Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20051

| Rank | Expected Rank | Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|
| 2 | 2 | [redacted] | [redacted] | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | |
| 2 | 2 | [redacted] | [redacted] | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | |
| 1 | 1 | [redacted] | [redacted] | $0.00 | $0.00 | $25.00 | $25.00 | $0.00 | |
| | | | | | | | 2 STD DEV | $0.00 | |

End of Report


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B

**Alabama Medicaid Agency**

Pharmacy Recipient Case Type Comparison
By Peer Group Qtrly

User ID: Administrator
Run Date: 5/22/2006
Run Time: 9:11:47 AM

Recipients Grouped by Age/Gender
For Dates of Service: 01/01/2005 - 03/31/2005
Case Type: 1 - All Claim Groupings
Recipient Peer Group: 302 - Medical Assistance, Categorically Needy, TANF
Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20051

Age 06 - 17

Gender: F

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| [redacted] | [redacted] | $0.00 | $0.00 | $25.00 |
| | | | Sum: | $25.00 |

Gender: M

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| [redacted] | [redacted] | $0.00 | $0.00 | $0.00 |
| | | | Sum: | $0.00 |

### 3.5.55.1 DSSProfiler - Pharmacy Recipient Case Type Comparison by Peer Group Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Recipient's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group. | 3 | Number (Integer) |
| (A) Rank | Recipient's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A,B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Allowed Amount | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A,B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A,B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A,B) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A,B) Recipient Full Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID | Recipient Medicaid Number. | 12 | Character |
| (A,B) Recipient Peer Group | Recipient Peer Group Code and Description. | 40 | Character |
| (B) Age | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Number (Integer) |
| (B) Gender | Recipient's gender. | 1 | Character |


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### 3.5.56 DSSProfiler - Pharmacy Provider Profile

The Pharmacy Provider Profile report is created in the DSSProfiler. Based on the user-entered date range of one year, this report flags any category or case type that exceeds the accepted norm within the pharmacy provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Pharmacy Facility Services - Tab B has two sections. The first section of this report contains a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

**Report Prompts (Search Criteria):**

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - the peer group to which the profiled provider is being compared; and
- Aggregation Code is the code to which the profiled provider is being compared.


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A

# Alabama Medicaid Agency

User ID:
Run Date: 9/25/2007
Run Time: 2:41:33 PM

## Pharmacy Provider Profile

### Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 479 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

### Provider Information

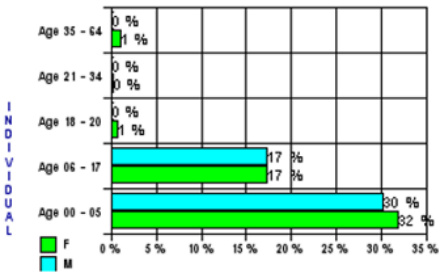
NPI ID:
Mcaid ID:
Base ID:
Name: NORTHEAST ALABAMA PEDIATRICS - ALL BSE
Type: 31 - Physician
Specialty: 345 - General Pediatrician
Address: 829 RIVERBEND DR

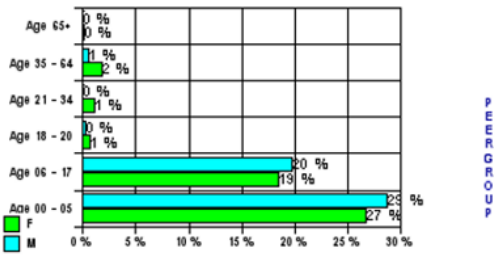
GADSDEN, AL 35901

### Ranks

| | |
|---|---|
| $ Paid Amount Actual | 1 |
| $ Paid Amount Expected | 1 |
| $ Billed Amount Actual | 1 |
| Recipient Rank | 1 |
| # Units Rank | 1 |
| # Claims Rank | 1 |
| Peer Group Size | 1 |

### Patient Age/Gender Breakdown




# Alabama Medicaid Agency

User ID:
Run Date: 11/1/2007
Run Time: 10:16:50 AM

## Pharmacy Provider Profile

### Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 479 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

### Provider's General Service Profile

| Service Type | Recip Count | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|
| 4 - Pharmacy Services | 547 | $58,451.33 | $88,190.39 | $56,089.29 | $82,105.91 | $(26,016.62) | (31.69) % |

End of Report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**Alabama Medicaid Agency**

**Pharmacy Provider Profile**
**Pharmacy Facility Services**

User ID: [redacted]
Run Date: 9/25/2007
Run Time: 2:41:33 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 479 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

| Case Type | Recip Count | Claim Count | Quantity | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|---|
| 7 - Morbidity 5 | 10 | 18 | 1,259 | $3,978.40 | $4,892.15 | $3,978.40 | $4,045.68 | $(67.28) | (1.66) % |
| 1061 - AL Adderall Drug Codes | 1 | 1 | 30 | $109.90 | $244.66 | $109.90 | $203.44 | $(93.54) | (45.98) % |
| 1062 - AL Concerta Drug Codes | 2 | 3 | 67 | $246.61 | $282.71 | $246.61 | $343.32 | $(96.71) | (28.17) % |
| 1063 - AL Metadate Drug Codes | 3 | 3 | 90 | $231.84 | $336.67 | $231.84 | $356.87 | $(125.03) | (35.04) % |
| 6 - Morbidity 4 | 95 | 229 | 15,881 | $11,084.31 | $15,922.00 | $11,057.01 | $13,700.50 | $(2,643.49) | (19.29) % |
| 5 - Morbidity 3 | 29 | 107 | 9,508 | $4,820.27 | $5,653.83 | $3,484.67 | $7,585.39 | $(4,100.72) | (54.06) % |
| 3 - Morbidity 1 | 326 | 821 | 66,612 | $28,916.57 | $48,881.50 | $28,527.79 | $37,325.78 | $(8,797.99) | (23.57) % |
| 4 - Morbidity 2 | 87 | 225 | 17,022 | $9,063.43 | $12,840.91 | $9,041.42 | $19,448.49 | $(10,407.07) | (53.51) % |

**End of Report**

### 3.5.56.1 DSSProfiler - Pharmacy Provider Profile Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Service Type | User defined group based on the service type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-B) Dollar Difference | Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest). | 13 | Number (Decimal) |
| (A-B) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A,B) For Dates of Service | Starting and Ending range of service date selection criteria. | 10 | Date (MM/DD/CCYY) |
| (A-B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-B) Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Percent Difference | Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage. | 8 | Number (Decimal) |
| (A-B) Provider ID | Provider identification number. | 15 | Character |
| (A-B) Recip Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (A-B) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (B) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (B) Quantity | Quantity billed. | 8 | Number (Integer) |


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### 3.5.57 DSSProfiler - Pharmacy Provider Profile Quarterly

The Pharmacy Provider Profile Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report flags any category or case type that exceeds the accepted norm within the pharmacy provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown on recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Pharmacy Services - Tab B has two sections. The first sections of this report contain a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

**Report Prompts (Search Criteria):**

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - The peer group to which the profiled provider is being compared;
- Aggregation Code - The code to which the profiled provider is being compared; and
- Quarter - Quarter of the provider being profiled in the report.


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A

# Alabama Medicaid Agency

User ID:
Run Date: 5/31/2006
Run Time: 10:49:09 AM

Pharmacy Provider Profile Qtrly

Provider Summary

For Dates: 07/01/2004 - 06/30/2005
Provider ID:
Provider Peer Group: 122 - 050 HOME HEALTH AGENCY
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20051

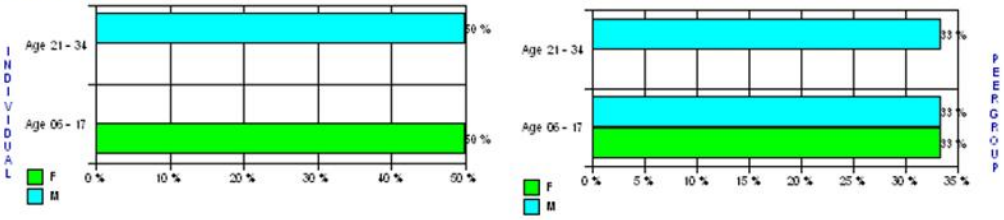
## Provider Information

NPI ID:
Mcaid ID:
Base ID:
Name: NW GENERAL - ALL NPI
Type: 07 - Capitation Provider
Specialty: 071 - Managed Care Organization (MCO
Address: 3463 NE 1ST ST
MAIL STOP 9203
PORTLAND, OR 97501

## Rank

| | |
|---|---|
| $ Paid Amount Actual | 3 |
| $ Paid Amount Expected | 3 |
| $ Billed Amount Actual | 3 |
| Recipient Rank | 2 |
| # Units Rank | 3 |
| # Claims Rank | 2 |
| Peer Group Size | 6 |

## Patient Age/Gender Breakdown




# Alabama Medicaid Agency

User ID:
Run Date: 8/10/2006
Run Time: 3:12:06 PM

Pharmacy Provider Profile Qtrly

Provider Summary

For Dates: 10/01/2004 - 09/30/2005
Provider ID:
Provider Peer Group: 122 - 071 MANAGED CARE ORGANIZATION
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20051

## Provider's General Service Profile

| Report Category | Recipient Count | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|
| 9 - Pharmacy Services by Billing Provider | 3 | $0.00 | $0.00 | $0.00 | $25.00 | $(25.00) | (100.00) % |

End of Report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B

**Alabama Medicaid Agency**

User ID:
Run Date: 1/0/1900
Run Time: 10:49:09 AM

Pharmacy Provider Profile Qtrly
Pharmacy Services
For Dates: 07/01/2004 - 06/30/2005
Provider ID:
Provider Peer Group: 122 - 050 HOME HEALTH AGENCY
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20051

Top 10 Case Types: Dollar Difference

**Alabama Medicaid Agency**

User ID:
Run Date: 8/10/2006
Run Time: 3:12:06 PM

Pharmacy Provider Profile Qtrly
Pharmacy Services
For Dates: 10/01/2004 - 09/30/2005
Provider ID:
Provider Peer Group: 122 - 071 MANAGED CARE ORGANIZATION
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20051

| Case Type | Recipient Count | Claim Count | Billed Quantity | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|---|
| 166 - Non-Compounded Drugs | 3 | 3 | 0 | $0.00 | $0.00 | $0.00 | $25.00 | $(25.00) | (100.00) % |
| 1 - All Claim Groupings | 3 | 3 | 0 | $0.00 | $0.00 | $0.00 | $25.00 | $(25.00) | (100.00) % |

End of Report

## DSSProfiler - Pharmacy Provider Profile Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) # Claims Rank | Rank is based on the number of paid claims. | 5 | Number (Integer) |
| (A) # Units Rank | Rank based on the quantity billed. | 5 | Number (Integer) |
| (A) $ Billed Amount Actual | Rank based on the actual money billed by the provider. | 5 | Number (Decimal) |
| (A) $ Paid Amount Actual | Rank based on the actual money paid by the program in the specific time period. | 5 | Number (Decimal) |
| (A) $ Paid Amount Expected | Rank based on the amount the provider should have received based on the | 5 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group. | | |
| (A) Patient Age/Gender Breakdown | Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve. | 10 | Character |
| (A) Peer Group Size | Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings. | 5 | Number (Integer) |
| (A) Provider Information | Provider's demographic information. This includes the provider type, specialty, name, street address, city, state, zip code, and telephone number. | 200 | Character |
| (A) Recipient Rank | Rank based on the number of eligible recipients the provider served in a specific time period. | 5 | Number (Integer) |
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-B) Billed Quantity | Quantity billed. | 14 | Number (Integer) |
| (A-B) Dollar Difference | Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest). | 13 | Number (Decimal) |
| (A-B) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A-B) For Dates | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-B) Percent Difference | Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the | 8 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | expected value to the actual value in a percentage. | | |
| (A-B) Provider ID | Provider identification number. | 15 | Character |
| (A-B) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-B) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A-B) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A-B) Recipient Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (B) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (B) Top 10 Case Types: Dollar Difference | Difference in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference. | 60 | Character |


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### 3.5.58 DSSProfiler - Professional Case Type Comparison by Peer Group

Based on the user-entered date range of one year, this report displays and compares all professional providers within a peer group to determine which providers fall outside of service dollar norm for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

There are three tabs in this report:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender

A

**Alabama Medicaid Agency**

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:25:34 PM

Professional Case Type Comparison by Peer Group

Provider Comparison

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

| Rank | Raw Rank | Expected Rank | Provider ID | Provider Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 4 | [redacted] | TIM J BEAL - ALL NPI | $9,003.93 | $7,921.39 | $7,474.73 | $1,380.92 | $6,093.81 | * |
| 2 | 2 | 2 | [redacted] | COUNTRY MEDICAL CLINIC - ALL NPI | $6,980.00 | $2,930.57 | $3,054.05 | $2,163.55 | $890.50 | |
| 3 | 3 | 17 | [redacted] | JILL E JANES - ALL NPI | $15,000.00 | $1,100.41 | $1,100.41 | $331.35 | $769.06 | |
| 4 | 11 | 27 | [redacted] | TRAVIS FAMILY HEALTH CENTER - ALL NPI | $290.00 | $124.95 | $124.95 | $52.33 | $72.62 | |
| 5 | 7 | 20 | [redacted] | NANCY T CRANE - ALL NPI | $220.00 | $220.00 | $220.00 | $153.90 | $66.10 | |
| 6 | 16 | 28 | [redacted] | JOHN D SMITH - ALL NPI | $77.00 | $77.00 | $77.00 | $41.53 | $35.47 | |
| 7 | 18 | 28 | [redacted] | TRAVIS FAMILY HEALTH CENTER - ALL NPI | $111.00 | $91.10 | $51.10 | $41.53 | $9.57 | |
| 8 | 24 | 28 | [redacted] | DONALD B JONES - ALL NPI | $400.00 | $26.22 | $26.22 | $41.53 | $(15.31) | |
| 9 | 20 | 22 | [redacted] | NW GENERAL - ALL NPI | $300.00 | $39.33 | $39.33 | $55.95 | $(16.62) | |
| 10 | 22 | 22 | [redacted] | COUNTRY MEDICAL CLINIC - ALL NPI | $210.00 | $36.22 | $36.22 | $55.95 | $(19.73) | |
| 11 | 22 | 22 | [redacted] | BEN I CLEAVER - ALL NPI | $210.00 | $36.22 | $36.22 | $55.95 | $(19.73) | |


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B

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:25:34 PM

Professional Case Type Comparison by Peer Group

Average Amount per Recipient by Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

[redacted] - COUNTRY MEDICAL CLINIC - ALL NPI

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 00 - 05 | F | 1 | $51.25 |
| Age 06 - 17 | F | 2 | $13.11 |
| Age 06 - 17 | M | 1 | $20.00 |
| Age 21 - 34 | F | 2 | $19.00 |
| Age 35 - 64 | F | 1 | $199.00 |
| | | SUM: | $47.78 |

[redacted] - JILL E JANES - ALL NPI

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 21 - 34 | F | 1 | $49.00 |
| | | SUM: | $49.00 |

C

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:25:34 PM

Professional Case Type Comparison by Peer Group

Average Amount per Recipient All Providers by Selected Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Age 00 - 05

Gender: F

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| [redacted] | COUNTRY MEDICAL CLINIC - ALL NPI | $51.25 |
| [redacted] | TRINA O ROBERTS - ALL NPI | $0.00 |
| [redacted] | COUNTRY MEDICAL CLINIC - ALL NPI | $18.50 |
| | SUM: | $23.25 |

### 3.5.58.1 DSSProfiler - Professional Case Type Comparison by Peer Group Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Allowed Amount | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Provider's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group. | 3 | Number (Integer) |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Rank | Provider's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A) Raw Rank | Provider's rank based on the amount Provider was paid. | 3 | Number (Integer) |
| (A-C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-C) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-C) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A-C) Provider ID | Provider identification number. | 15 | Character |
| (A-C) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-C) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are | 20 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | | |
| (A-C) Provider Name | Provider's full name. | 50 | Character |
| (B,C) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (B,C) Paid Amount per Recipient | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |
| (B) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (B,C) Gender | Recipient's gender. | 1 | Character |


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### 3.5.59 DSSProfiler - Professional Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range for one quarter, this report displays and compares all providers within a peer group to determine which providers range appears outside of the service dollar norms for a case type. All information is age and gender adjusted so that different patient mixes do not affect the results. Providers with two standard deviations above or below the norm for the peer group are highlighted.

There are three tabs in this report:

A. Provider Comparison shows providers who fall outside the norm for the peer group;

B. Average Amount per Recipient by Age/Gender shows the age break out for the recipients; and

C. Average Amount per Recipient All Providers by Selected Age/Gender shows the recipients for each age group

A

**Alabama Medicaid Agency**

User ID: Administrator
Run Date: 5/19/2006
Run Time: 2:09:34 PM

Professional Case Type Comparison by Peer Group Qtrly
Provider Comparison
For Dates of Service: 10/01/2004 - 12/31/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 6 - Dental By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20044

| Rank | Raw Rank | Expected Rank | Provider ID | Provider Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 1 | [redacted] | JOHN G TALYLOR | $1,871.00 | $1,690.46 | $1,690.46 | $1,243.18 | $447.28 | |
| 2 | 2 | 3 | [redacted] | TRAVIS FAMILY HEALTH CENTER | $715.57 | $713.08 | $713.08 | $366.43 | $346.65 | |
| 3 | 5 | 8 | [redacted] | MARK S NEWLAND | $39.56 | $39.56 | $39.56 | $37.19 | $2.37 | |
| 4 | 3 | 2 | [redacted] | GEORGE F WILSON | $1,000.00 | $1,000.00 | $713.00 | $713.00 | $0.00 | |
| 5 | 6 | 7 | [redacted] | GRACE COMMUNITY PHYSICAL THERAPY | $100.00 | $26.37 | $26.37 | $79.55 | $(53.18) | |
| 6 | 4 | 5 | [redacted] | MICKEY A DALLES | $180.00 | $180.00 | $180.00 | $294.17 | $(114.17) | |
| 7 | 8 | 5 | [redacted] | CLAY R MILLER | $11.87 | $11.87 | $11.87 | $294.17 | $(282.30) | |
| 8 | 7 | 3 | [redacted] | MICKEY A DALLES | $35.00 | $19.78 | $19.78 | $366.43 | $(346.65) | |
| | | | | | | | | 2 STD DEV | $517.66 | |

End of Report


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**B**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/2/2006
Run Time: 9:32:39 PM

Professional Case Type Comparison by Peer Group Qtrly
Average Amount per Recipient by Age/Gender

For Dates of Service: 10/01/2004 - 12/31/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 6 - Dental By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20044

[redacted] - GRACE COMMUNITY PHYSICAL THERAPY

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 65+ | M | 1 | $26.37 |
| | | AVG: | $26.37 |

[redacted] - JOHN G TALYLOR

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 00 - 05 | M | 1 | $34.82 |
| Age 18 - 20 | M | 2 | $151.71 |
| Age 35 - 64 | F | 1 | $199.00 |
| Age 35 - 64 | M | 3 | $410.55 |
| Age 65+ | M | 2 | $84.21 |
| | | AVG: | $215.25 |

**C**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/2/2006
Run Time: 9:32:39 PM

Professional Case Type Comparison by Peer Group Qtrly
Average Amount per Recipient All Providers by Selected Age/Gender

For Dates of Service: 10/01/2004 - 12/31/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 6 - Dental By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20044

Age 00 - 05

Gender: M

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| [redacted] | JOHN G TALYLOR | $34.82 |
| [redacted] | CLAY R MILLER | $11.87 |
| [redacted] | MARK S NEWLAND | $39.56 |
| | AVG: | $28.75 |

Age 06 - 17

Gender: M

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| [redacted] | MICKEY A DALLES | $19.78 |
| [redacted] | TRAVIS FAMILY HEALTH CENTER | $713.08 |
| | AVG: | $366.43 |


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### 3.5.59.1 DSSProfiler - Professional Case Type Comparison by Peer Group Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Allowed Amount | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Provider's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group. | 3 | Number (Integer) |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Rank | Provider's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A) Raw Rank | Provider's rank based on the amount Provider was paid. | 3 | Number (Integer) |
| (A,B,C) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A,B,C) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B,C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B,C) Provider ID | Provider identification number. | 8 | Character |
| (A,B,C) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations | 40 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | and 03 NPI/Medicaid ID by service location. | | |
| (A,B,C) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A,B,C) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A,C) Provider Name | Provider's full name. | 50 | Character |
| (B,C) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (B,C) Gender | Recipient's gender. | 1 | Character |
| (B,C) Paid Amount Per Recipient | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |
| (B) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |


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### 3.5.60 DSSProfiler - Professional Claim Details by Provider - FFS

Based on the user-entered date range of one year, this report allows the user to move down to the detail level for all case type categories within the system for a given provider and service location. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients that received medical care.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

There are four tabs in this report:

A. Professional Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

**Alabama Medicaid Agency**

**Professional Claim Details By Provider - FFS**

**Professional Claim Details**

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

For Claim Types: M FITZGERALD-PERRETT CLINIC

User ID: [redacted]
Run Date: 9/8/16
Run Time: 12:58:58 PM

| ICN | CT | POS | DB # | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | ICD | Diag 2 | Diag 2 Desc | Proc | Proc Desc | MD1 | MD1 Desc | MD2 | MD2 Desc | MD3 | MD3 Desc | Bill Qty | Billed Amt | Alwd Amt | Paid Amt | Wrap Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] | M | 11 | 1 | 12345678901 2 | XXXXXXXX XXXXXXXX XXXX, XXXXXXXX XXXXXXX, X | 10/25/1964 | 50 | 9/4/2015 | 9/4/2015 | 9 | 4011 | BENIGN ESSENTIAL HYPERTENSION | 9 | 78062 | OTHER HYPOXEMIA | 99214 | Office Outpatient Vist Est | | | | | | | 1 | $110.00 | $80.72 | $76.62 | Y |
| [redacted] | M | 11 | 2 | 12345678901 2 | XXXXXXXX XXXXXXXX XXXX, XXXXXXXX XXXXXXX, X | 11/29/1958 | 56 | 9/3/2015 | 9/3/2015 | 9 | 7862 | COUGH | 9 | [redacted] | Unknown or Not Appl. | 70210 | X-Ray, Exam Of Sinuses | | | | | | | 1 | $65.00 | $21.00 | $21.00 | Y |

**End of Report**


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**B**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/25/2013
Run Time: 1:46:01 PM

## Professional Claim Details By Provider

Recipient Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

WIREGRASS WELLNESS CENTER LLC

For Claim Types: M;B

| Recipient ID | Recipient Full Name | ICN Count |
|---|---|---|
| [redacted] | [redacted] | 1 |
| [redacted] | [redacted] | 1 |
| [redacted] | [redacted] | 1 |
| [redacted] | [redacted] | 1 |
| [redacted] | [redacted] | 1 |

End of Report

PHI has been covered

**C**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/25/2013
Run Time: 1:46:01 PM

## Professional Claim Details By Provider

Diagnosis Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

WIREGRASS WELLNESS CENTER LLC

For Claim Types: M;B

| ICD | Diagnosis 1 - Code & Desc | ICD | Diagnosis 2 - Code & Desc | ICD | Diagnosis 3 - Code & Desc | ICN Count | Recipient Count |
|---|---|---|---|---|---|---|---|
| 9 | 29630 - MAJOR DEPRESSIVE AFFECTIVE DISORDER, REC | # | ####### - | # | ####### - | 4 | 4 |
| 9 | 29690 - UNSPECIFIED AFFECTIVE PSYCHOSIS | # | ####### - | # | ####### - | 1 | 1 |

End of Report


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D

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 10/25/2013
Run Time: 1:46:01 PM

**Professional Claim Details By Provider**

Procedure Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

WIREGRASS WELLNESS CENTER LLC

For Claim Types: M;B

| Procedure Code & Description | ICN Count | Recipient Count |
|---|---|---|
| 99213 - Office/Outpatient Visit Est | 5 | 5 |

End of Report

### 3.5.60.1 DSSProfiler - Professional Claim Details by Provider - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age | The age of the recipient on the From Date of Service rounded down to a full year. | 4 | Number (Integer) |
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Bill Qty | Quantity billed for the service rendered. | 2 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Claim Type (CT) | Shows what type of claim was submitted. | 1 | Character |
| (A) DOB | Recipient's Date of Birth | 10 | Date (MM/DD/CCYY) |
| (A) Detail Number (Dtl#) | Claim line number. | 4 | Number (Integer) |
| (A) Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag Desc | The primary ICD-CM diagnosis code description. | | |
| (A) Diag 2 | The secondary ICD-CM diagnosis code. | 60 | Character |
| (A) Diag 2 Desc | The secondary ICD-CM diagnosis code description. | 7 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) From Date of Service (FDOS) | Claim's first date of service. | 60 | Character |
| (A) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 10 | Date (MM/DD/CCYY) |
| (A) MD1 | First Modifier code for the procedure code billed. | 13 | Character |
| (A) MD1 Desc | Description for the First Modifier code of the procedure code billed. | 2 | Character |
| (A) MD2 | Second Modifier code for the procedure code billed. | 40 | Character |
| (A) MD2 Desc | Description for the Second Modifier code of the procedure code billed. | 2 | Character |
| (A) MD3 | Third Modifier code for the procedure code billed. | 40 | Character |
| (A) MD3 Desc | Description for the Third Modifier code of the procedure code billed. | 2 | Character |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient (sent by the RCO). | 40 | Character |
| (A) Place of Service (POS) | Place of Service code for where services were rendered. | 13 | Number (Decimal) |
| (A) Proc | Procedure Code for the detail. | 2 | Number (Decimal) |
| (A) Proc Desc | Procedure Code description for the detail. | 6 | Character |
| (A) To Date of Service (TDOS) | Date on which the statement period on the claim ended | 40 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Wrap Ind | Wrap Payment Indicator | 1 | Character |
| (A,B) Recipient Full Name (Recip Name) | The recipient last name and first name. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID (Recip ID) | Recipient Medicaid Number. | 12 | Character |
| (A,C) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A,C) ICD Version for Diagnosis 2 | The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A-D) Claim Types (prompt) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |
| (A-D) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-D) Run Time | The time that the report was executed. | 11 | Character |
| (A-D) User ID | The user that created the report. | 50 | Character |
| (A-D) Provider Base, Medicaid or NPI ID (prompt) | Lists the NPI, Medicaid, and Base ID for the attending Provider. | 63 | Character |
| (B) ICN Count | Unduplicated count of claims for the recipient within that provider. | 8 | Number (Integer) |
| (C) Diagnosis 1 - Code & Desc | The primary ICD-CM diagnosis code and its description. | 70 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (C) Diagnosis 2 - Code & Desc | The secondary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 3 - Code & Desc | The third ICD-CM diagnosis code and its description. | 70 | Character |
| (C) ICD Version for Diagnosis 3 | The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (C) ICN Count | Unduplicated count of claims for Diagnosis codes. | 8 | Number (Integer) |
| (C,D) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (D) ICN Count | Unduplicated count of claims for procedure code. | 8 | Number (Integer) |
| (D) Procedure Code & Description | Concatenate procedure code and description into one object. | 47 | Character |
| | | | |


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### 3.5.61 DSSProfiler - Professional Claim Details by Provider Quarterly - FFS

The Professional Details by Provider reports are created in the DSSProfiler. Based on the user-entered date range of one quarter, this report lets the user tab down to the detail level for all professional case type categories within the system. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served. The DSSProfiler has similar reports that drill down for Professional Referrals, Inpatient, Outpatient, Nursing Facility and Pharmacy claims activity.

The detail reports are very helpful for additional analysis on exceptions or comparing the provider's claims with the medical records.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The tabs on this report include:

A. Professional Claim Details - Shows all the claims the provider submitted;

B. Recipient Listing - Lists the individual recipients;

C. Diagnosis Listing - Lists the diagnosis codes on all claims reported; and

D. Procedure Listing - Lists the individual procedure, number of ICNs and number of recipients.

A

**Alabama Medicaid Agency**

**Professional Claim Details By Provider Qtrly - FFS**

**Professional Claim Details**

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [illegible]

Billing Provider Name: SHERMAN L ARMSTRONG JR

For Claim Types: M

Quarter: 20162

User ID: [illegible]
Run Date: 9/8/16
Run Time: 1:08:54 PM

| ICN | CT | POS | DB # | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | ICD | Diag 2 | Diag 2 Desc | Proc | Proc Desc | MD1 | MD1 Desc | MD2 | MD2 Desc | MD3 | MD3 Desc | Bill Qty | Billed Amt | Alwd Amt | Paid Amt | Wrap Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [illegible] | M | 11 | 1 | 123456789012 | XXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X | 4/25/2000 | 16 | 5/1/2016 | 5/1/2016 | 0 | E1100 | TYPE 2 DIAB W HYPROSM W/O NONKET HYPRGLYHYPROS COMA (NONHC) | # | ####### | Unknown or Not Appl. | 99394 | Prev Visit Est Age 12-17 | EP | MEDICAID EPSDT PROGR AM SVC | | | | | 1 | $40.00 | $5.00 | $5.00 | N |
| [illegible] | M | 11 | 1 | 123456789012 | XXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X | 3/14/1991 | 25 | 4/5/2016 | 4/5/2016 | 0 | E1010 | TYPE 1 DIABETES MELLITUS WITH KETOACIDOSIS WITHOUT COMA | # | ####### | Unknown or Not Appl. | 99211 | Office Outpatient Visit Est | | | | | | | 1 | $50.00 | $17.00 | $15.70 | N |
| [illegible] | M | 11 | 1 | 123456789012 | XXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X | 9/15/2001 | 14 | 4/15/2016 | 4/15/2016 | 0 | E1100 | TYPE 2 DIAB W HYPROSM W/O NONKET HYPRGLYHYPROS COMA (NONHC) | # | ####### | Unknown or Not Appl. | 99394 | Prev Visit Est Age 12-17 | EP | MEDICAID EPSDT PROGR AM SVC | | | | | 1 | $40.00 | $40.00 | $40.00 | N |
| [illegible] | M | 11 | 1 | 123456789012 | XXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X | 12/15/1997 | 18 | 4/17/2016 | 4/17/2016 | 0 | E1010 | TYPE 1 DIABETES MELLITUS WITH KETOACIDOSIS WITHOUT COMA | # | ####### | Unknown or Not Appl. | 99211 | Office Outpatient Visit Est | | | | | | | 1 | $60.00 | $0.00 | $0.00 | N |

End of Report

PHI has been removed


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**B**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/28/2013
Run Time: 8:35:24 AM

## Professional Claim Details By Provider Qtrly

Recipient Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

WIREGRASS WELLNESS CENTER LLC

For Claim Types: M;B

Quarter: 20131

| Recipient ID | Recipient Full Name | ICN Count |
|---|---|---|
| [redacted] | [redacted] | 1 |
| [redacted] | [redacted] | 1 |
| [redacted] | [redacted] | 1 |
| [redacted] | [redacted] | 1 |
| [redacted] | [redacted] | 1 |

End of Report

PHI has been covered

**C**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/28/2013
Run Time: 8:35:24 AM

## Professional Claim Details By Provider Qtrly

Diagnosis Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

WIREGRASS WELLNESS CENTER LLC

For Claim Types: M;B

Quarter: 20131

| ICD | Diagnosis 1 - Code & Desc | ICD | Diagnosis 2 - Code & Desc | ICD | Diagnosis 3 - Code & Desc | ICN Count | Recipient Count |
|---|---|---|---|---|---|---|---|
| 9 | 29630 - MAJOR DEPRESSIVE AFFECTIVE DISORDER, REC | # | ####### - | # | ####### - | 4 | 4 |
| 9 | 29690 - UNSPECIFIED AFFECTIVE PSYCHOSIS | # | ####### - | # | ####### - | 1 | 1 |

**D**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/28/2013
Run Time: 8:35:24 AM

## Professional Claim Details By Provider Qtrly

Procedure Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

WIREGRASS WELLNESS CENTER LLC

For Claim Types: M;B

Quarter: 20131

| Procedure Code & Description | ICN Count | Recipient Count |
|---|---|---|
| 99213 - Office/Outpatient Visit Est | 5 | 5 |


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#### 3.5.61.1 DSSProfiler - Professional Claim Details by Provider Quarterly - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age | The age of the recipient on the From Date of Service rounded down to a full year. | 4 | Number (Integer) |
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Bill Qty | Quantity billed for the service rendered. | 2 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Claim Type (CT) | Shows what type of claim was submitted. | 1 | Character |
| (A) DOB | Recipient's Date of Birth | 10 | Date (MM/DD/CCYY) |
| (A) Detail Number (Dtl#) | Claim line number. | 4 | Number (Integer) |
| (A) Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag Desc | The primary ICD-CM diagnosis code description. | 60 | Character |
| (A) Diag 2 | The secondary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag 2 Desc | The secondary ICD-CM diagnosis code description. | 60 | Character |
| (A) From Date of Service (FDOS) | Claim's first date of service. | 10 | Date (MM/DD/CCYY) |
| (A) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A) MD1 | First Modifier code for the procedure code billed. | 2 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) MD1 Desc | Description for the First Modifier code of the procedure code billed. | 40 | Character |
| (A) MD2 | Second Modifier code for the procedure code billed. | 2 | Character |
| (A) MD2 Desc | Description for the Second Modifier code of the procedure code billed. | 40 | Character |
| (A) MD3 | Third Modifier code for the procedure code billed. | 2 | Character |
| (A) MD3 Desc | Description for the Third Modifier code of the procedure code billed. | 40 | Character |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Place of Service (POS) | Place of Service code for where services were rendered. | 2 | Number (Decimal) |
| (A) Proc | Procedure Code for the detail. | 7 | Character |
| (A) Proc Desc | Procedure Code description for the detail. | 40 | Character |
| (A) To Date of Service (TDOS) | Claim's last date of service. | 10 | Date (MM/DD/CCYY) |
| (A) Wrap Ind | Wrap Payment Indicator | 1 | Character |
| (A,B) Recipient Full Name (Recip Name) | The recipient last name and first name. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID (Recip ID) | Recipient Medicaid Number. | 12 | Character |
| (A,C) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A,C) ICD Version for Diagnosis 2 | The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A-D) Claim Types (prompt) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-D) Quarter (prompt) | The quarter for which the report is being run for. | 5 | Number (Integer) |
| (A-D) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-D) Run Time | The time that the report was executed. | 11 | Character |
| (A-D) User ID | The user that created the report. | 50 | Character |
| (A-D) Provider Base, Medicaid or NPI ID (prompt) | Lists the NPI, Medicaid, and Base ID for the attending Provider. | 63 | Character |
| (B) ICN Count | Unduplicated count of claims for the recipient within that provider. | 8 | Number (Integer) |
| (C) Diagnosis 1 - Code & Desc | The primary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 2 - Code & Desc | The secondary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 3 - Code & Desc | The third ICD-CM diagnosis code and its description. | 70 | Character |
| (C) ICD Version for Diagnosis 3 | The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (C) ICN Count | Unduplicated count of claims for Diagnosis codes. | 8 | Number (Integer) |
| (C,D) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (D) ICN Count | Unduplicated count of claims for procedure code. | 8 | Number (Integer) |
| (D) Procedure Code & Description | Concatenate procedure code and description into one object. | 47 | Character |


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### 3.5.62 DSSProfiler - Professional Disease Global View

This set of reports is created in DSSProfiler.

This report allows you to view the services that recipients received from a selected case type. For example, you can observe diabetic or asthmatic recipients and view the associated services that they received.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-G in the layout below. The field names have the corresponding letter in front, identifying the tab it can be located. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports.

The seven tabs in this report are:

A. General Health Demographics shows the age and gender mix;

B. Other Professional Services shows the general health demographics;

C. Other Inpatient Services shows other professional services;

D. Other Outpatient Services shows other inpatient services;

E. Other Pharmacy Services shows other pharmacy services;

F. Other Nursing Facility Services shows other nursing facility services; and

G. Recipients shows the list of recipients by age groups

A

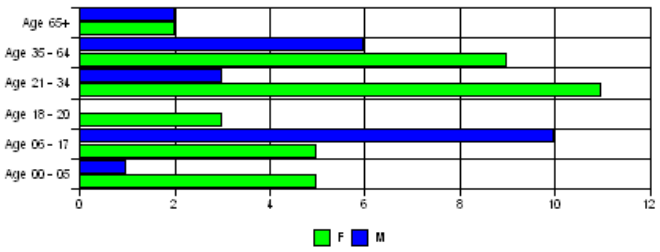
**Alabama Medicaid Agency**

Professional Disease Global View
General Health Demographics

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:32:46 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Age/Gender Mix





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# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:32:46 PM

## Professional Disease Global View
### General Health Demographics

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

| Case Type Description | Billed Amount | Allowed Amount | Paid Amount | Recipient Count | Percent of Recipients |
|---|---|---|---|---|---|
| 1 - All Claim Groupings | $55,503.64 | $23,388.89 | $23,388.89 | 57 | 100.00 % |

End of Report

B

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 8/4/2006
Run Time: 10:50:53 AM

## Professional Disease Global View
### Other Professional Services

For Dates of Service: 10/01/2004 - 09/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

| Case Type Description | Billed Amount | Allowed Amount | Paid Amount | Recipient Count | Percent of Recipients |
|---|---|---|---|---|---|
| 1 - All Claim Groupings | $56,513.64 | $24,075.97 | $22,166.76 | 58 | 100.00 % |
| 300 - FQHC Encounter Procedures | $33,593.34 | $11,888.98 | $10,916.72 | 33 | 56.90 % |
| 381 - Evaluation & Management All Procedures | $4,072.00 | $399.88 | $587.63 | 15 | 25.86 % |
| 237 - Infectious/Parasitic Diagnosis | $9,519.00 | $7,660.60 | $6,907.67 | 14 | 24.14 % |
| 243 - STD, Sexual Transmitted Disease Diagnosis | $9,361.00 | $7,502.60 | $6,750.67 | 12 | 20.69 % |
| 245 - Injury/Poisoning Diagnosis | $2,956.00 | $583.97 | $460.00 | 10 | 17.24 % |
| 223 - Endocrine Disease Diagnosis | $1,560.00 | $442.35 | $431.35 | 9 | 15.52 % |
| 225 - Diabetes Mellitus Diagnosis | $540.00 | $291.25 | $280.25 | 8 | 13.79 % |
| 304 - Surgical Excluding Veni Punct/OB Procedures | $7,465.00 | $6,804.07 | $6,563.59 | 8 | 13.79 % |
| 352 - Pathology All Procedures | $258.00 | $146.08 | $80.00 | 7 | 12.07 % |
| 402 - Dental - C Dental Resin | $10,009.00 | $4,569.82 | $4,569.82 | 7 | 12.07 % |
| 405 - Dental - F Dental Scalant | $824.25 | $192.71 | $192.71 | 6 | 10.34 % |
| 298 - Drugs Excluding Pharmacy Procedures | $530.00 | $331.25 | $150.25 | 5 | 8.62 % |
| 312 - Musculoskeletal Procedures | $1,710.00 | $1,610.41 | $1,605.41 | 4 | 6.90 % |


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**C**

# Alabama Medicaid Agency

**Professional Disease Global View**

**Other Inpatient Services**

**For Dates of Service: 10/01/2004 - 09/30/2005**

**Case Type: 1 - All Claim Groupings**

**Aggregation Code: 7 - Fee for Service Claims by Recipient**

**User ID:** [redacted]
**Run Date:** 8/4/2006
**Run Time:** 10:50:53 AM

| Case Type Description | Billed Amount | Allowed Amount | Paid Amount | Recipient Count | Percent of Recipients |
|---|---|---|---|---|---|
| 1 - All Claim Groupings | $274,510.00 | $177,679.68 | $120,550.42 | 11 | 18.97 % |
| 454 - Admissions Excluding MH/SA/OB | $274,510.00 | $177,679.68 | $120,550.42 | 11 | 18.97 % |
| 626 - Discharged Home codes(01 - 01) | $113,810.00 | $40,004.00 | $39,555.00 | 10 | 17.24 % |
| 631 - Readmissions codes(01 - 04) | $113,810.00 | $40,004.00 | $39,555.00 | 10 | 17.24 % |
| 510 - Injury/Poisoning Diagnosis | $214,420.00 | $153,467.78 | $96,613.52 | 7 | 12.07 % |
| 489 - Endocrine Disease Diagnosis | $5,600.00 | $10,442.50 | $10,167.50 | 3 | 5.17 % |
| 491 - Diabetes Mellitus Diagnosis | $5,600.00 | $10,442.50 | $10,167.50 | 3 | 5.17 % |
| 419 - ACS-All Ambulatory Care Sensor Conditions | $8,800.00 | $4,818.00 | $4,815.00 | 2 | 3.45 % |
| 437 - ACS-Chronic | $4,400.00 | $2,407.50 | $2,407.50 | 2 | 3.45 % |
| 447 - ACS-Diabetes without Complication | $4,400.00 | $2,407.50 | $2,407.50 | 2 | 3.45 % |
| 456 - V Codes Diagnosis | $41,245.00 | $6,369.75 | $6,369.75 | 2 | 3.45 % |
| 502 - Infectious/Parasitic Diagnosis | $13,245.00 | $7,399.65 | $7,399.65 | 2 | 3.45 % |

**End of Report**

**D**

# Alabama Medicaid Agency

**Professional Disease Global View**

**Other Outpatient Services**

**For Dates of Service: 07/01/2004 - 06/30/2005**

**Case Type: 1 - All Claim Groupings**

**Aggregation Code: 7 - Fee for Service Claims by Recipient**

**User ID:** Administrator
**Run Date:** 5/12/2006
**Run Time:** 1:32:46 PM

| Case Type Description | Billed Amount | Allowed Amount | Paid Amount | Recipient Count | Percent of Recipients |
|---|---|---|---|---|---|
| 1 - All Claim Groupings | $15,786.80 | $2,383.42 | $1,658.74 | 8 | 14.04 % |
| 687 - Endocrine Disease Diagnosis | $4,466.20 | $1,301.93 | $724.33 | 5 | 8.77 % |
| 689 - Diabetes Mellitus Diagnosis | $4,466.20 | $1,301.93 | $724.33 | 5 | 8.77 % |
| 656 - Circulatory System Disease Diagnosis | $10,600.00 | $927.19 | $780.11 | 4 | 7.02 % |
| 848 - Provider Type - Home Health Agency | $3,515.00 | $1,319.40 | $745.80 | 4 | 7.02 % |
| 661 - Heart Disease Diagnosis | $9,600.00 | $827.19 | $680.11 | 3 | 5.26 % |
| 701 - Infectious/Parasitic Diagnosis | $105.60 | $9.90 | $9.90 | 1 | 1.75 % |
| 707 - STD, Sexual Transmitted Disease Diagnosis | $105.60 | $9.90 | $9.90 | 1 | 1.75 % |
| 722 - Neoplasm Diagnosis | $115.00 | $94.40 | $94.40 | 1 | 1.75 % |
| 736 - Obstetric Diagnosis | $500.00 | $50.00 | $50.00 | 1 | 1.75 % |

**End of Report**


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E

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:32:46 PM

Professional Disease Global View
Other Pharmacy Services

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

| Case Type Description | Billed Amount | Allowed Amount | Paid Amount | Recipient Count | Percent of Recipients |
|---|---|---|---|---|---|
| 1 - All Claim Groupings | $0.00 | $0.00 | $0.00 | 11 | 19.30 % |

End of Report

F

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:32:46 PM

Professional Disease Global View
Other Nursing Facility Services

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

| Case Type Description | Billed Amount | Allowed Amount | Paid Amount | Recipient Count | Percent of Recipients |
|---|---|---|---|---|---|
| 1 - All Claim Groupings | $16,680.00 | $0.00 | $9,792.19 | 3 | 5.26 % |

End of Report

G

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:32:46 PM

Professional Disease Global View
Recipients

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Age 00 - 05

| Recipient Id | Recipient Full Name |
|---|---|
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |

Age 06 - 17

| Recipient Id | Recipient Full Name |
|---|---|
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |
| [illegible] | [illegible] |


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#### 3.5.62.1 DSSProfiler - Professional Disease Global View Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age/Gender Mix | Bar graph that illustrates the number of recipients for each age group and gender mix. This graph shows the distribution of recipients based on age and gender. | 0 | Character |
| (A-F) Allowed Amount | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-F) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-F) Case Type Description | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |
| (A-F) Paid Amount | Amount the program paid on the claim grouping of recipients in the predefined diagnosis group. | 13 | Number (Decimal) |
| (A-F) Percent of Recipients | Percentage of recipients in the pre-defined diagnosis group that also fall under these specific claim groupings. | 8 | Character |
| (A-F) Recipient Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Character |
| (A-G) Aggregation Code | Aggregation Code and Description. | 107 | Character |
| (A-G) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A-G) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (G) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64 and 65+. | 24 | Character |
| (G) Recipient Full Name | Recipient's full name. | 22 | Character |
| (G) Recipient ID | Recipient Medicaid Number. | 12 | Character |


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### 3.5.63 DSSProfiler - Professional Disease Quick View

This report is created in the DSSProfiler. This report displays recipient utilization services for selected case types with totals listed by the number of services received. This report can also be used for disease management. The first row gives the totals for each column.

There are two tabs in this report:

A. Professional Disease shows recipient utilization for the case type; and

B. Professional Disease by Peer Group shows recipient utilization for each peer group.

A

**Alabama Medicaid Agency**

Professional Disease Quick View
Professional Disease

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:38:08 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 22 | 1 | 24 | 22 | $2,352.41 | $126.04 | $1,438.44 |
| 15 | 2 | 30 | 30 | $18,243.13 | $300.00 | $2,593.46 |
| 3 | 3 | 9 | 9 | $684.69 | $26.04 | $250.14 |
| 3 | 4 | 12 | 12 | $119.48 | $10.00 | $87.48 |
| 1 | 5 | 5 | 5 | $860.00 | $0.00 | $786.82 |
| 3 | 6 | 18 | 18 | $1,337.00 | $652.83 | $1,238.34 |
| 2 | 7 | 14 | 14 | $1,083.00 | $21.37 | $289.95 |
| 2 | 9 | 18 | 18 | $1,170.00 | $20.20 | $422.44 |
| 1 | 10 | 602 | 10 | $6,200.00 | $50.00 | $2,912.98 |
| 1 | 14 | 806 | 14 | $1,231.00 | $10.00 | $750.00 |
| 1 | 19 | 25 | 19 | $1,718.00 | $200.00 | $456.73 |
| 1 | 40 | 40 | 40 | $4,044.00 | $713.08 | $1,360.59 |


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**B**

# Alabama Medicaid Agency

User ID: [illegible]
Run Date: 8/12/2006
Run Time: 12:00:12 PM

**Professional Disease Quick View**

**Professional Disease By Peer Group**
**For Dates of Service: 10/01/2004 - 09/30/2005**
**Case Type: 1 - All Claim Groupings**
**Aggregation Code: 7 - Fee for Service Claims by Recipient**

**Peer Group: 504 - Blank Aid Category**

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 1 | 2 | 2 | 2 | $200.00 | $0.00 | $7.50 |
| Totals: | | | 2 | $200.00 | $0.00 | $7.50 |

**Peer Group: 516 - Public Assistance, Blind**

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 2 | 1 | 2 | 2 | $250.00 | $126.04 | $124.04 |
| 1 | 2 | 2 | 2 | $715.57 | $713.08 | $713.08 |
| Totals: | | | 4 | $965.57 | $839.12 | $837.12 |

**Peer Group: 519 - Public Assistance, Disabled**

| Unduplicated Recipients | Each Recipient Had XX Claims | Total Quantity Billed | Total Claims | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|---|
| 1 | 1 | 2 | 1 | $300.00 | $300.00 | $290.00 |
| 1 | 2 | 2 | 2 | $14.00 | $14.00 | $14.00 |

### 3.5.63.1 DSSProfiler - Professional Disease Quick View Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-B) Allowed Amount | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A-B) Each Recipient Had XX Claims | This field shows us how many claims each of the recipients had. | 4 | Character |
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-B) Paid Amount | This is the total amount paid by the program for the specific claim grouping. | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Total Claims | This is the total number of claims billed based on the number of recipients and the number of claims each recipient had. | 9 | Number (Integer) |
| (A-B) Total Quantity Billed | This is the total units billed for this particular claim category. | 9 | Number (Integer) |
| (A-B) Unduplicated Recipients | This is a count of all recipients that have had a service within this claim grouping. The count is unduplicated, meaning each recipient is only counted once. | 9 | Number (Integer) |
| (B) Peer Group | Peer Group Code and Description. | 107 | Character |


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### 3.5.64 DSSProfiler - Professional Distribution Analysis

The Professional Distribution Analysis reports are created in the DSSProfiler. This report provides the totals for all professional case types within the selected peer group. The totals include amount paid, number of unduplicated recipients, claim counts, units and exceptions. The report also provides a rapid method to identify which case types or service categories need to be observed more closely with other reports within the DSSProfiler.

The tabs in this report include:

A. Professional Distribution Summary shows professional distribution summary for different case types;

B. Professional Services Distribution top 20 shows the top 20 case types with exceptions, by number of recipients and by paid amount per recipient;

C. Professional Services Distribution by Age shows information for the age groups for each case type;

D. Professional Services Distribution by Gender shows information for the gender for each case type; and

E. Professional Services Distribution by Age/Gender shows information for the gender and age groups for each case type.

**Alabama Medicaid Agency**

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:46:10 PM

Professional Distribution Analysis
Professional Distribution Summary

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

| Case Type Description | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Paid Amt per Recip | Claims per Recip | Exception Count |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 - All Claim Groupings | 3 | 3 | 1 | $218.00 | $0.00 | $0.00 | $218.00 | $0.00 | 3.00 | 1 |
| 300 - FQHC Encounter Procedures | 3 | 3 | 1 | $218.00 | $0.00 | $0.00 | $218.00 | $0.00 | 3.00 | 1 |
| 352 - Pathology All Procedures | 1 | 1 | 1 | $88.00 | $0.00 | $0.00 | $88.00 | $0.00 | 1.00 | 1 |
| 381 - Evaluation & Management All Procedures | 2 | 2 | 1 | $130.00 | $0.00 | $0.00 | $130.00 | $0.00 | 2.00 | 1 |

End of Report

Professional Distribution Summary | TOP 20 | By Age | By Gender | By Age/Gender | Notes


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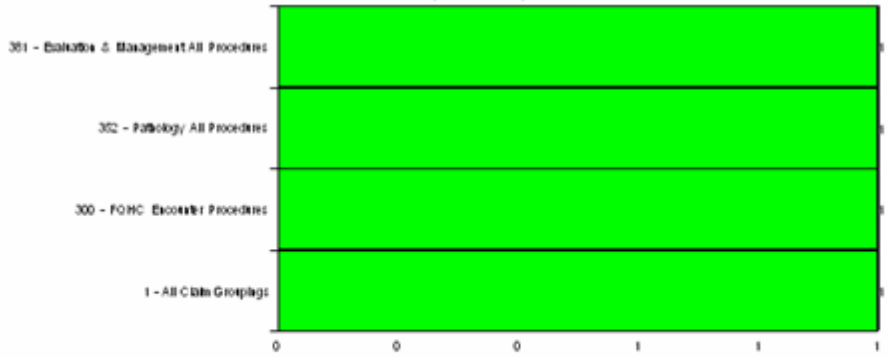
# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:46:10 PM

Professional Distribution Analysis
Top 20

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Top 20 Exceptions




Professional Distribution Summary | TOP 20 | By Age | By Gender | By Age/Gender | Notes

# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:46:10 PM

Professional Distribution Analysis
By Age

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Case Type: 1 - All Claim Groupings

| Age Description | Billed Quantity | Claim Count | Recip Count | Billed Amount | Paid Amount | Billed Amount per Recip | Allowed Amount per Recip | Paid Amount per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|
| Age 65+ | 3 | 3 | 1 | $218.00 | $0.00 | $218.00 | $0.00 | $0.00 | 3.00 |
| Sum: | 3 | 3 | 1 | $218.00 | $0.00 | $218.00 | $0.00 | $0.00 | 3.00 |

Case Type: 300 - FQHC Encounter Procedures

| Age Description | Billed Quantity | Claim Count | Recip Count | Billed Amount | Paid Amount | Billed Amount per Recip | Allowed Amount per Recip | Paid Amount per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|
| Age 65+ | 3 | 3 | 1 | $218.00 | $0.00 | $218.00 | $0.00 | $0.00 | 3.00 |
| Sum: | 3 | 3 | 1 | $218.00 | $0.00 | $218.00 | $0.00 | $0.00 | 3.00 |

Professional Distribution Summary | TOP 20 | By Age | By Gender | By Age/Gender | Notes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# Alabama Medicaid Agency

Professional Distribution Analysis
By Gender

User ID: [redacted]
Run Date: 5/12/2006
Run Time: 12:46:10 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Case Type: 1 - All Claim Groupings

| Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Paid Amount | Billed Amount per Recip | Allowed Amount per Recip | Paid Amount per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|
| M | 3 | 3 | 1 | $218.00 | $0.00 | $218.00 | $0.00 | $0.00 | 3.00 |
| Sum: | 3 | 3 | 1 | $218.00 | $0.00 | $218.00 | $0.00 | $0.00 | 3.00 |

Case Type: 300 - FQHC Encounter Procedures

| Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Paid Amount | Billed Amount per Recip | Allowed Amount per Recip | Paid Amount per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|
| M | 3 | 3 | 1 | $218.00 | $0.00 | $218.00 | $0.00 | $0.00 | 3.00 |
| Sum: | 3 | 3 | 1 | $218.00 | $0.00 | $218.00 | $0.00 | $0.00 | 3.00 |

E

# Alabama Medicaid Agency

Professional Distribution Analysis
By Age/Gender

User ID: [redacted]
Run Date: 5/12/2006
Run Time: 12:46:10 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Case Type: 1 - All Claim Groupings

| Age Description | Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| Age 65+ | M | 3 | 3 | 1 | $218.00 | $0.00 | $218.00 | $0.00 | $0.00 | 3.00 |
| | Sum: | 3 | 3 | 1 | $218.00 | $0.00 | $218.00 | $0.00 | $0.00 | 3.00 |

Case Type: 300 - FQHC Encounter Procedures

| Age Description | Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| Age 65+ | M | 3 | 3 | 1 | $218.00 | $0.00 | $218.00 | $0.00 | $0.00 | 3.00 |
| | Sum: | 3 | 3 | 1 | $218.00 | $0.00 | $218.00 | $0.00 | $0.00 | 3.00 |

Case Type: 352 - Pathology All Procedures

| Age Description | Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| Age 65+ | M | 1 | 1 | 1 | $88.00 | $0.00 | $88.00 | $0.00 | $0.00 | 1.00 |
| | Sum: | 1 | 1 | 1 | $88.00 | $0.00 | $88.00 | $0.00 | $0.00 | 1.00 |


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### 3.5.64.1 DSSProfiler - Professional Distribution Analysis Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,C,D,E) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims. | 13 | Number (Decimal) |
| (A) Case Type Description | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |
| (A) Exception Count | Number of exceptions identified. An exception is defined as two standard deviations from the norm. | 8 | Number (Integer) |
| (C,D,E) Allowed Amt Per Recipient | Total allowed amount divided by the number of recipients. | 13 | Number (Decimal) |
| (A,C,D,E) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A,C,D,E) Billed Amount per Recip | Total billed amount divided by the number of recipients. | 12 | Number (Decimal) |
| (A,C,D,E) Billed Quantità | Quantity billed. | 14 | Number (Integer) |
| (A,C,D,E) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (A,C,D,E) Claims per Recip | Total claim count divided by the recipient count. | 4 | Number (Integer) |
| (A,C,D,E) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A,C,D,E) Paid Amount per Recip | Total paid amount divided by the number of recipients. | 12 | Number (Decimal) |
| (A,C,D,E) Recip Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (A-E) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-E) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-E) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-E) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (B) Top 20 By Number of Recipients | Graph shows Top 20 exceptions by number of recipients. | 1 | Character |
| (B) Top 20 By Paid Amount per Recipient | Graph shows Top 20 exceptions by paid amount per recipient. | 1 | Character |
| (B) Top 20 Exceptions | Graph shows Top 20 exceptions. | 1 | Character |
| (A,C,D,E) Case Type &Description | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |
| (C,E) Age Description | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (D,E) Gender | Recipient's gender. | 1 | Character |


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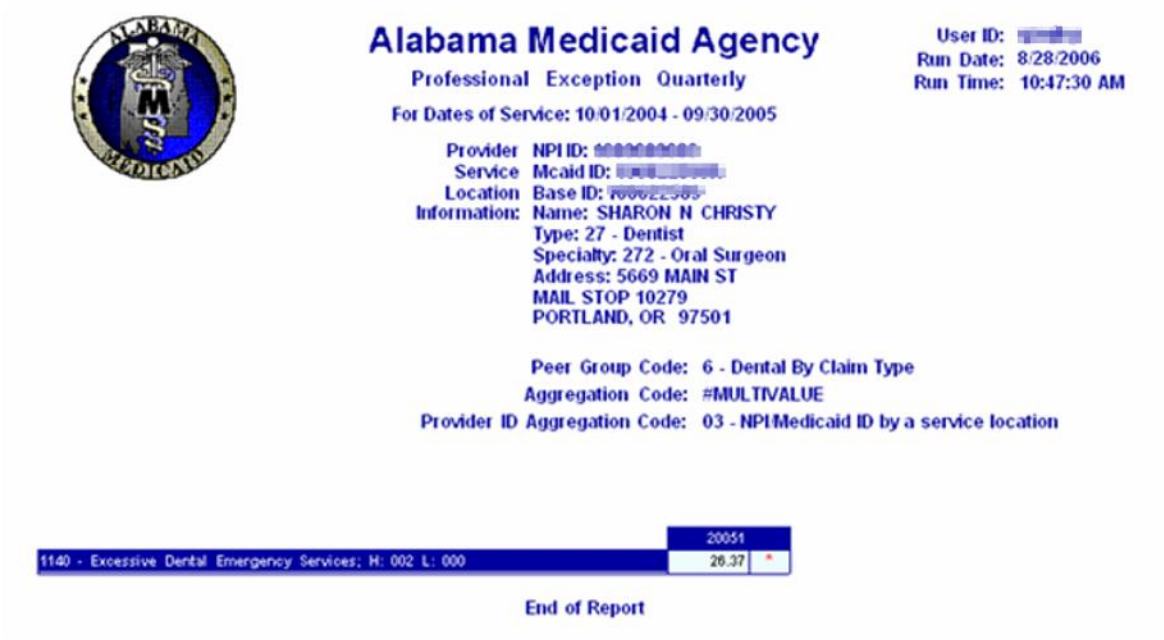
### 3.5.65 DSSProfiler - Professional Exception Quarterly

The Professional Exception Quarterly report is produced for a selected provider, provider peer group and aggregation code. The report displays the number of high exceptions for case groups that occur during each reporting period. The case groups whose calculations are above the high value are marked as exceptions.



Alabama Medicaid Agency

Professional Exception Quarterly

For Dates of Service: 10/01/2004 - 09/30/2005

User ID: [redacted]
Run Date: 8/28/2006
Run Time: 10:47:30 AM

Provider NPI ID: [redacted]
Service Mcaid ID: [redacted]
Location Base ID: [redacted]
Information: Name: SHARON N CHRISTY
Type: 27 - Dentist
Specialty: 272 - Oral Surgeon
Address: 5669 MAIN ST
MAIL STOP 10279
PORTLAND, OR 97501

Peer Group Code: 6 - Dental By Claim Type
Aggregation Code: #MULTIVALUE
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| | 20051 | |
|---|---|---|
| 1140 - Excessive Dental Emergency Services; H: 002 L: 000 | 26.37 | * |

End of Report

#### 3.5.65.1 DSSProfiler - Professional Exception Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| Calculation | Calculation to find case groups above the exception high. | 14 | Number (Decimal) |
| Case Type Group Display | Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item. | 4 | Number (Integer) |
| Exception | This column is marked with a '*' when the case group is above the exception high value. | 1 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer | 20 | Character |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| Field | Description | Length | Data Type |
|---|---|---|---|
| | group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | | |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| Provider Service Location Information | Provider's information. This includes the provider name, address, NPI ID, Medicaid ID, and Base ID. | 200 | Character |


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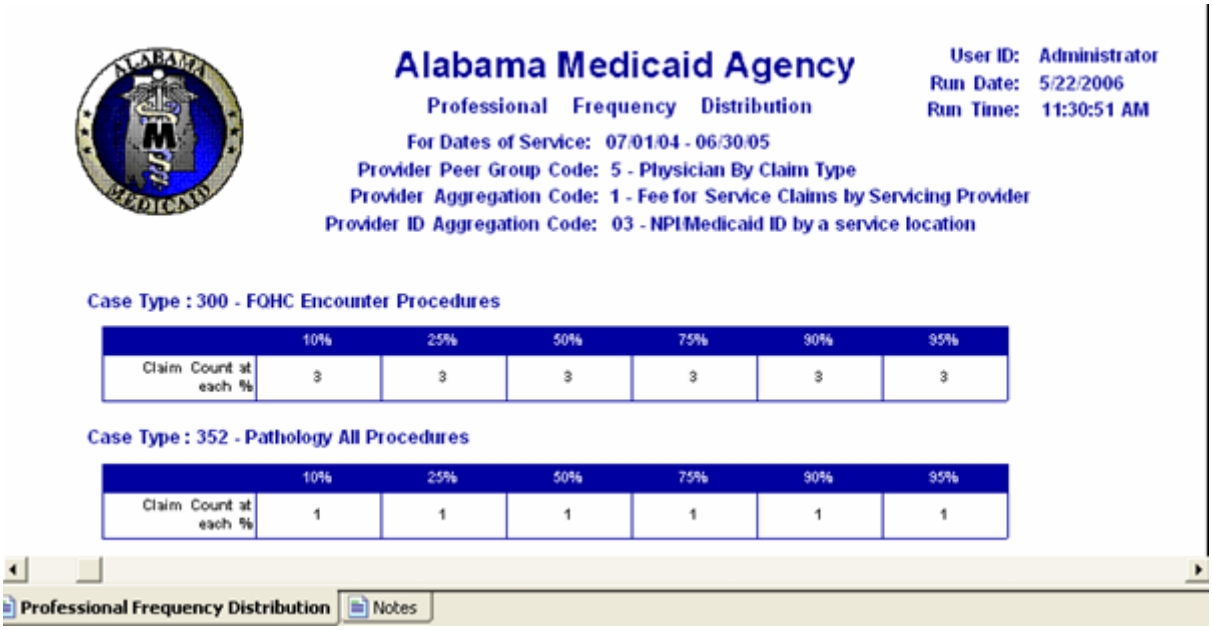
### 3.5.66 DSSProfiler - Professional Frequency Distribution

The Professional Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one year, this report shows for each professional case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.



Alabama Medicaid Agency

Professional Frequency Distribution

User ID: Administrator
Run Date: 5/22/2006
Run Time: 11:30:51 AM

For Dates of Service: 07/01/04 - 06/30/05
Provider Peer Group Code: 5 - Physician By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type : 300 - FQHC Encounter Procedures

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 3 | 3 | 3 | 3 | 3 | 3 |

Case Type : 352 - Pathology All Procedures

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 1 | 1 | 1 |

Professional Frequency Distribution | Notes

#### 3.5.66.1 DSSProfiler - Professional Frequency Distribution Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |
| 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |
| Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Provider Aggregation Code | Aggregation Code and Description. | 100 | Character |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 | 40 | Character |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| Field | Description | Length | Data Type |
|---|---|---|---|
| | - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | | |
| Provider Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |


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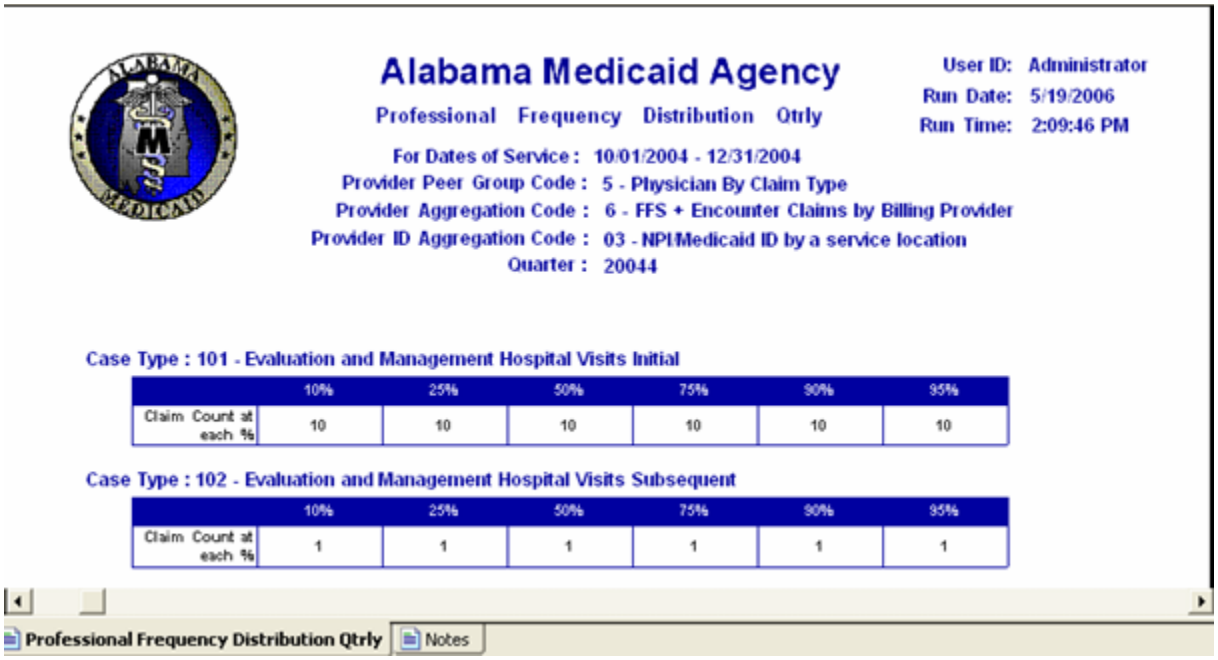
### 3.5.67 DSSProfiler - Professional Frequency Distribution Quarterly

The Professional Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range for one quarter, this report shows each professional case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.



Alabama Medicaid Agency

Professional Frequency Distribution Qtrly

User ID: Administrator
Run Date: 5/19/2006
Run Time: 2:09:46 PM

For Dates of Service : 10/01/2004 - 12/31/2004
Provider Peer Group Code : 5 - Physician By Claim Type
Provider Aggregation Code : 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code : 03 - NPI/Medicaid ID by a service location
Quarter : 20044

Case Type : 101 - Evaluation and Management Hospital Visits Initial

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 10 | 10 | 10 | 10 | 10 | 10 |

Case Type : 102 - Evaluation and Management Hospital Visits Subsequent

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 1 | 1 | 1 |

Professional Frequency Distribution Qtrly | Notes

#### 3.5.67.1 DSSProfiler - Professional Frequency Distribution Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |
| 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |
| Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Provider Aggregation Code | Aggregation Code and Description. | 100 | Character |
| Provider Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other | 20 | Character |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| Field | Description | Length | Data Type |
|---|---|---|---|
| | providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | | |
| Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |


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### 3.5.68 DSSProfiler - Professional Recipient Case Type Comparison by Peer Group

The Professional Recipient Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all recipients within a peer group to determine which recipients fall outside of service dollar norm on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

This report provides a rapid method to find which recipients need to be analyzed more closely at a case type level, utilizing other reports within the DSSProfiler. This report makes it easy to see, for example, which recipients are the recipients of asthma services who fall outside of the accepted norm within the peer group.

The tabs in this report include:

A. Recipient Comparison shows which recipients fall outside the norm for the peer group; and

B. Recipients Grouped by Age/Gender shows recipients for the gender and age groups.

A

**Alabama Medicaid Agency**

Professional Recipient Case Type Comparison by Peer Group

Recipient Comparison

For Dates of Service: 01/01/2006 - 12/31/2006

Case Type: 1071 - AL Hypertension Diagnosis

Recipient Peer Group: 959 - 38 MLIF Elig Cert by Medicaid-Adult-No Money

Aggregation Code: 7 - Fee For Service Claims by Recipient

User ID: [redacted]
Run Date: 10/26/2007
Run Time: 9:59:35 AM

| Rank | Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference From Expected | Exception |
|---|---|---|---|---|---|---|---|---|
| 1 | [redacted] | [redacted] | $160.00 | $136.00 | $134.00 | $50.17 | $83.83 | * |
| 3 | [redacted] | [redacted] | $86.00 | $87.00 | $66.00 | $37.00 | $29.00 | |
| 3 | [redacted] | [redacted] | $80.00 | $67.00 | $66.00 | $43.00 | $23.00 | |
| 2 | [redacted] | [redacted] | $65.00 | $73.77 | $72.77 | $72.77 | $0.00 | |
| 8 | [redacted] | [redacted] | $42.00 | $32.00 | $31.00 | $31.00 | $0.00 | |
| 5 | [redacted] | [redacted] | $50.00 | $43.00 | $42.00 | $50.17 | $-8.17 | |
| 5 | [redacted] | [redacted] | $138.00 | $42.00 | $42.00 | $50.17 | $-8.17 | |
| 7 | [redacted] | [redacted] | $56.00 | $42.00 | $41.00 | $50.17 | $-9.17 | |
| 9 | [redacted] | [redacted] | $48.00 | $31.00 | $30.00 | $50.17 | $-20.17 | |
| 10 | [redacted] | [redacted] | $85.00 | $20.00 | $20.00 | $43.00 | $-23.00 | |
| 12 | [redacted] | [redacted] | $27.00 | $8.00 | $8.00 | $37.00 | $-29.00 | |
| 11 | [redacted] | [redacted] | $28.60 | $12.00 | $12.00 | $50.17 | $-38.17 | |
| | | | | | | 2 STD DEV | $65.64 | |

End of Report


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B

**Alabama Medicaid Agency**

Professional Recipient Case Type Comparison by Peer Group

Recipients Grouped by Age/Gender

For Dates of Service: 01/01/2006 - 12/31/2006

Case Type: 1071 - AL Hypertension Diagnosis

Recipient Peer Group: 959 - 38 MLIF Elig Cert by Medicaid-Adult-No Money

Aggregation Code: 7 - Fee For Service Claims by Recipient

User ID:
Run Date: 10/26/2007
Run Time: 9:59:35 AM

Age 35 - 64

Gender: F

| Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|
| | | $80.00 | $67.00 | $66.00 |
| | | $85.00 | $73.77 | $72.77 |
| | | $85.00 | $20.00 | $20.00 |
| | | | Sum: | $158.77 |

### 3.5.68.1 DSSProfiler - Professional Recipient Case Type Comparison by Peer Group Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Dollar Difference from Expected | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates recipients who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Number (Integer) |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Rank | Recipient's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A,B) Aggregation Code | Classification of the provider rendering health and medical services as approved under the state plan. | 50 | Character |
| (A,B) Allowed Amount | The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A,B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A,B) Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient ( | 13 | Number (Decimal) |
| (A,B) Recipient Full Name | Recipient's full name. | 50 | Character |
| (A,B) Recipient ID | Recipient Medicaid Number. | 12 | Character |
| (A,B) Recipient Peer Group | Recipient Peer Group Code and Description. | 40 | Character |
| (B) Age | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Number (Integer) |
| (B) Gender | Recipient's gender. | 1 | Character |


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### 3.5.69 DSSProfiler - Professional Recipient Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all recipients within a peer group to determine which recipients fall outside of service dollar norms on a user specified case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

There are two tabs in this report:

A. Recipient Comparison shows recipients that fall outside the norm for the peer group; and

B. Recipients Grouped by Age/Gender shows recipients by gender and age groups.

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### 3.5.69.1 DSSProfiler - Professional Recipient Case Type Comparison by Peer Group Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Recipient's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group. | 3 | Number (Integer) |
| (A) Rank | Recipient's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A,B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A,B) Allowed Amount | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A,B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A,B) Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A,B) Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A,B) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Recipient Full Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A,B) Recipient ID | Recipient identification number. | 8 | Character |
| (B) Age | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Number (Integer) |
| (B) Gender | Recipient's gender. | 1 | Character |


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### 3.5.70 DSSProfiler - Professional Provider Profile

The Professional Provider Profile report is created in the DSSProfiler. Based on the user-entered date range of one year, this report flags any category or case type that exceeds the accepted norm within the professional provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown on recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Professional Services - Tab B has two sections. The first sections of this report contain a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

**Report Prompts (Search Criteria):**

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - The peer group to which the profiled provider is being compared; and
- Aggregation Code - The code to which the profiled provider is being compared.


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A

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 9/25/2007
Run Time: 3:06:33 PM

## Professional Provider Profile

### Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

### Provider Information

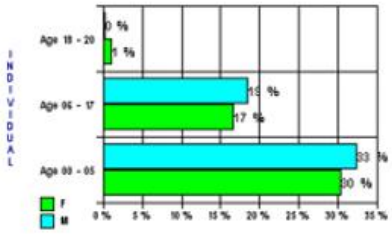
NPI ID: [redacted]
Mcaid ID: [redacted]
Base ID: [redacted]
Name: [redacted]
Type: 13 - Public Health Agency
Specialty: 345 - General Pediatrician
Address: 2817 30TH AVE NORTH

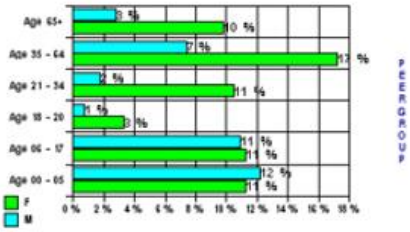
BIRMINGHAM, AL 35207

### Ranks

| | |
|---|---|
| $ Paid Amount Actual | 1 |
| $ Paid Amount Expected | 1 |
| $ Billed Amount Actual | 1 |
| Recipient Rank | 1 |
| # Units Rank | 1 |
| # Claims Rank | 1 |
| Peer Group Size | 1 |

### Patient Age/Gender Breakdown




# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/1/2007
Run Time: 11:42:15 AM

## Professional Referral Provider Profile

### Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

### Provider's General Service Profile

| Service Type | Recip Count | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|
| 2 - Professional Referrals | 256 | $111,828.75 | $64,074.81 | $44,595.28 | $57,768.08 | $(13,172.80) | (22.80) % |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**B**

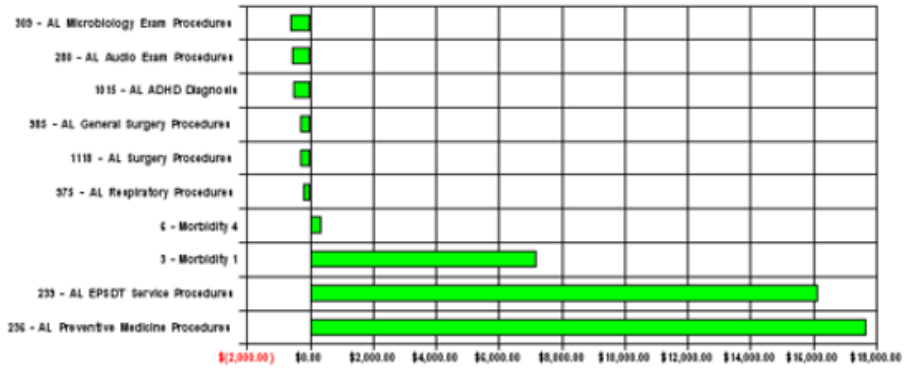
## Alabama Medicaid Agency

Professional Provider Profile
Professional Services

User ID:
Run Date: 9/25/2007
Run Time: 3:06:33 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 10 Case Types: Dollar Difference




## Alabama Medicaid Agency

Professional Provider Profile
Professional Services

User ID:
Run Date: 9/25/2007
Run Time: 3:06:33 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| Case Type | Recip Count | Claim Count | Quantity | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|---|
| 236 - AL Preventive Medicine Procedures | 254 | 271 | 271 | $36,858.00 | $36,858.00 | $40,898.92 | $23,209.53 | $17,689.39 | 76.22 % |
| 239 - AL EPSDT Service Procedures | 249 | 265 | 265 | $36,030.00 | $36,030.00 | $40,026.92 | $23,892.75 | $16,134.17 | 67.53 % |
| 3 - Morbidity 1 | 238 | 640 | 643 | $28,613.66 | $30,136.73 | $28,556.66 | $21,372.12 | $7,184.54 | 33.62 % |
| 6 - Morbidity 4 | 124 | 471 | 474 | $21,046.66 | $21,761.00 | $21,046.66 | $20,681.48 | $365.18 | 1.77 % |
| 975 - AL Respiratory Procedures | 27 | 40 | 62 | $576.00 | $1,777.00 | $0.00 | $224.22 | $(224.22) | (100.00) % |
| 1118 - AL Surgery Procedures | 3 | 3 | 3 | $78.00 | $78.00 | $0.00 | $281.35 | $(281.35) | (100.00) % |

### 3.5.70.1 DSSProfiler - Professional Provider Profile Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) $ Billed Amount Actual | Rank based on the actual money billed by the provider. | 5 | Number (Decimal) |
| (A) # Claims Rank | Rank is based on the number of paid claims. | 5 | Number (Integer) |
| (A) # Units Rank | Rank based on the quantity billed. | 5 | Number (Integer) |
| (A) $ Paid Amount Actual | Rank based on the actual money paid by the program in the specific time period. | 5 | Number (Decimal) |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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) $ Paid Amount Expected | Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group. | 5 | Number (Decimal) |
| (A) Patient Age/Gender Breakdown | This section compares the providers to their specialty peer group based similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve. | 10 | Character |
| (A) Peer Group Size | Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings. | 5 | Number (Integer) |
| (A) Provider Information | Provider's demographic information. This includes the provider type, specialty name, street address, city, state, zip code, and telephone number. | 200 | Character |
| (A) Recipient Rank | Rank based on the number of eligible recipients the provider served in a specific time period. | 5 | Number (Integer) |
| (A) Service Type | User defined group based on the service type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A,B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A,B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A,B) Dollar Difference | Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest). | 13 | Number (Decimal) |
| (A,B) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A,B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A,B) Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping | 20 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | | |
| (A,B) Percent Difference | The percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage. | 8 | Number (Decimal) |
| (A,B) Provider ID | Provider identification number. | 15 | Character |
| (A,B) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A,B) Recip Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (B) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (B) Quantity | Quantity billed. | 8 | Number (Integer) |
| (B) Top 10 Case Type: Dollar Difference | Different in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference. | 60 | Character |


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### 3.5.71 DSSProfiler - Professional Provider Profile Quarterly

The Professional Provider Profile Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report flags any category or case type that exceeds the accepted norm within the professional provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B Professional Services - Tab B has two sections. The first sections of this report contain a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

**Report Prompts (Search Criteria):**

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - the peer group to which the profiled provider is being compared;
- Aggregation Code - the code to which the profiled provider is being compared; and
- Quarter - Quarter of the provider being profiled in the report.


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**A**

# Alabama Medicaid Agency

User ID:
Run Date: 9/27/2007
Run Time: 5:02:49 PM

**Professional Provider Profile Qtrly**

**Provider Summary**

For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 207 - 271 GENERAL DENTISTRY PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

## Provider Information

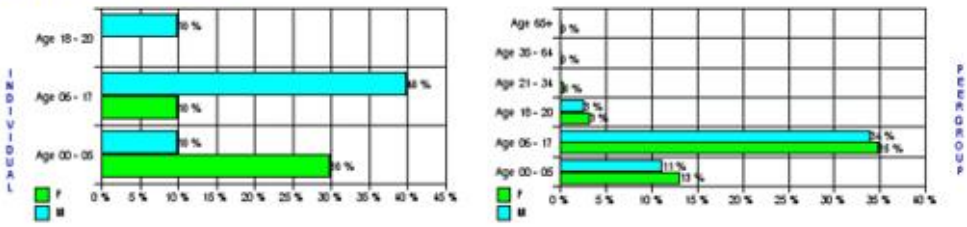
NPI ID:
Mcaid ID:
Base ID:
Name:
Type: 27 - Dentist
Specialty: 271 - General Dentistry Practitioner
Address: 1320 SUMMIT PLACE

BIRMINGHAM, AL 35243

## Rank

| | |
|---|---|
| $ Paid Amount Actual | 132 |
| $ Paid Amount Expected | 83 |
| $ Billed Amount Actual | 89 |
| Recipient Rank | 65 |
| # Units Rank | 170 |
| # Claims Rank | 91 |
| Peer Group Size | 593 |

## Patient Age/Gender Breakdown




# Alabama Medicaid Agency

User ID:
Run Date: 11/1/2007
Run Time: 5:37:35 PM

**Professional Provider Profile Qtrly**

**Provider Summary**

For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 207 - 271 GENERAL DENTISTRY PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

## Provider's General Service Profile

| Report Category | Recipient Count | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|
| 1 - Professional Services | 10 | $1,263.00 | $2,046.00 | $948.00 | $1,483.16 | $-535.16 | -36.08 % |

End of Report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**B**

**Alabama Medicaid Agency**

Professional Provider Profile Qtrly
Professional Services
For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 207 - 271 GENERAL DENTISTRY PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

User ID:
Run Date: 9/27/2007
Run Time: 5:02:49 PM

Top 10 Claim Types: Dollar Difference

**Alabama Medicaid Agency**

Professional Provider Profile Qtrly
Professional Services
For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 207 - 271 GENERAL DENTISTRY PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

User ID:
Run Date: 9/27/2007
Run Time: 5:02:49 PM

| Case Type | Recipient Count | Claim Count | Billed Quantity | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|---|
| 4 - Morbidity 2 | 1 | 2 | 2 | $119.00 | $190.00 | $118.00 | $169.96 | $-51.96 | -30.57 % |
| 3 - Morbidity 1 | 6 | 10 | 10 | $845.00 | $1,334.00 | $682.00 | $853.20 | $-71.20 | -10.90 % |
| 5 - Morbidity 3 | 1 | 5 | 5 | $174.00 | $304.00 | $174.00 | $325.33 | $-151.33 | -46.52 % |
| 6 - Morbidity 4 | 2 | 4 | 4 | $126.00 | $218.00 | $74.00 | $334.66 | $-260.66 | -77.89 % |

### 3.5.71.1 DSSProfiler - Professional Provider Profile Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) # Claims Rank | Rank is based on the number of paid claims. | 5 | Number (Integer) |
| (A) # Units Rank | Rank based on the quantity billed. | 5 | Number (Integer) |
| (A) $ Billed Amount Actual | Rank based on the actual money billed by the provider. | 5 | Number (Decimal) |
| (A) $ Paid Amount Actual | Rank based on the actual money paid by the program in the specific time period. | 5 | Number (Decimal) |
| (A) $ Paid Amount Expected | Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group. | 5 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Patient Age/Gender Breakdown | This section is similar to the health status section. It compares the providers to their specialty peer group based on the beneficiaries they serve. | 10 | Character |
| (A) Peer Group Size | Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings. | 5 | Number (Integer) |
| (A) Provider Information | Provider's demographic information. This includes the provider type, specialty, name, street address, city, state, zip code, and telephone number. | 200 | Character |
| (A) Recipient Rank | Rank based on the number of eligible recipients the provider served in a specific time period. | 5 | Number (Integer) |
| (A,B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A,B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A,B) Dollar Difference | Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest). | 13 | Number (Decimal) |
| (A,B) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A,B) For Dates | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A,B) Percent Difference | The percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage. | 8 | Number (Decimal) |
| (A,B) Provider ID | Provider identification number. | 15 | Character |
| (A,B) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A,B) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A,B) Recipient Count | Number of eligible recipients the provider served for this particular claim grouping. | 6 | Number (Integer) |
| (B) Billed Quantity | Quantity billed. | 14 | Number (Integer) |
| (B) Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |
| (B) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (B) Top 10 Claim Types: Dollar Difference | Difference in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference | 60 | Character |


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### 3.5.72 DSSProfiler - Professional Referrals Case Type Comparison by Peer Group

The Professional Referrals Case Type Comparison by Peer Group report is created within the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar norm on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

There are three tabs in this report.

A. Provider Comparison shows providers that fall outside the norm for the peer group;

B. Average Amount per Recipient by Age/Gender shows averages and recipient count for the gender and age groups for each provider; and

C. Average Amount per Recipient All Providers by Selected Age/Gender shows a lists of providers within the gender and age groups.

**A**

**Alabama Medicaid Agency**

**Professional Referrals Case Type Comparison by Peer Group**
**Provider Comparison**

User ID:
Run Date: 10/10/2007
Run Time: 3:20:02 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 3 - Morbidity 1
Provider Peer Group: 587 - 720 PRIMARY CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

| Rank | Raw Rank | Expected Rank | Provider ID | Provider Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dol Diff | Exception |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 2 | | NORTHERN HEALTH, CENTER - ALL BSE | $96,345.21 | $71,803.45 | $71,476.46 | $66,549.15 | $4,927.31 | |
| 2 | 1 | 1 | | JEFFERSON COUNTY DEPT OF HLT - ALL BSE | $553,726.45 | $443,619.74 | $439,927.21 | $444,858.78 | $(4,931.57) | |
| | | | | | | | | 2 STD DEV | $13,942.56 | |

End of Report


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**B**

# Alabama Medicaid Agency

User ID:
Run Date: 10/10/2007
Run Time: 3:20:02 PM

**Professional Referrals Case Type Comparison by Peer Group**
**Average Amount per Recipient by Age/Gender**

For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 3 - Morbidity 1
Provider Peer Group: 587 - 720 PRIMARY CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

- NORTHERN HEALTH, CENTER - ALL BSE

| Age Group | Gender | Recipient Count | Paid Amount per Recipient |
|---|---|---|---|
| Age 00 - 05 | F | 110 | $175.53 |
| Age 00 - 05 | M | 109 | $134.45 |
| Age 06 - 17 | F | 119 | $123.31 |
| Age 06 - 17 | M | 114 | $138.14 |
| Age 18 - 20 | F | 14 | $139.81 |
| Age 18 - 20 | M | 4 | $97.75 |
| Age 21 - 34 | F | 17 | $222.66 |
| Age 35 - 64 | F | 4 | $229.37 |
| Age 35 - 64 | M | 1 | $41.00 |
| | | AVG: | $145.28 |

**C**

# Alabama Medicaid Agency

User ID:
Run Date: 10/10/2007
Run Time: 3:20:02 PM

**Professional Referrals Case Type Comparison by Peer Group**
**Average Amount per Recipient All Providers by Selected Age/Gender**

For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 3 - Morbidity 1
Provider Peer Group: 587 - 720 PRIMARY CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Age 00 - 05

Gender: F

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| | NORTHERN HEALTH, CENTER - ALL BSE | $175.53 |
| | JEFFERSON COUNTY DEPT OF HLT - ALL BSE | $138.79 |
| | AVG: | $143.11 |

Gender: M

| Provider ID | Provider Name | Paid Amount per Recipient |
|---|---|---|
| | NORTHERN HEALTH, CENTER - ALL BSE | $134.45 |
| | JEFFERSON COUNTY DEPT OF HLT - ALL BSE | $143.19 |
| | AVG: | $142.25 |


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#### 3.5.72.1 DSSProfiler - Professional Referrals Case Type Comparison by Peer Group Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Allowed Amount | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Doll Diff | Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Expected Rank | Provider's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group. | 3 | Number (Integer) |
| (A-C) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A) Rank | Provider's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A) Raw Rank | Provider's rank based on the amount Provider was paid. | 3 | Number (Integer) |
| (A,C) Provider Name | Provider's full name. | 50 | Character |
| (A-C) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-C) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A-C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (B-C) Paid Amount (Per Recipient) | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |
| (A-C) Provider ID | Provider identification number. | 15 | Character |
| (A-C) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (B-C) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (B) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (B-C) Gender | Recipient's gender. | 1 | Character |


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### 3.5.73 DSSProfiler - Professional Referrals Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar norm for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

There are three tabs in this report:

A. Provider Comparison shows providers that fall outside the norm for the peer group;

B. Average Amount per Recipient by Age/Gender shows averages and recipient count for the gender and age groups for each provider; and

C. Average Amount per Recipient All Providers by Age/Gender shows a lists of providers within the gender and age groups.


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### 3.5.73.1 DSSProfiler - Professional Referrals Case Type Comparison by Peer Group Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific provider. | 13 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Expected Rank | Provider's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group. | 3 | Number (Integer) |
| (A) Paid Amount | Actual amount the provider was paid. | 13 | Character |
| (A) Rank | Provider's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A) Raw Rank | Provider's rank based on the amount Provider was paid. | 3 | Number (Integer) |
| (A,B,C) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A,B,C) Case Type | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |
| (A.B,C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A,B,C) Provider ID | Provider identification number. | 15 | Character |
| (A,B,C) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A,B,C) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A,B,C) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A,C) Provider Name | Provider's full name. | 50 | Character |
| (B) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (B,C) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64 and 65+. | 24 | Character |
| (B,C) Gender | Recipient's gender. | 1 | Character |
| (B,C) Paid Amount per Recipient | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |


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### 3.5.74 DSSProfiler - Professional Referral Claim Details by Provider - FFS

The Professional Referral Claim Details by Provider report is created in the DSSProfiler. Based on the user-entered date range of one year, this report lets the user drill down to the detail level for all case type categories within the system. The Professional Referrals report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The tabs in this report include:

A. Professional Referral Claim Details - Shows all the claims the provider submitted;

B. Recipient Listing - Lists the individual recipient ID and names;

C. Diagnosis Listing - Lists the primary, secondary, and tertiary diagnosis codes; and

D. Procedure Listing – Lists the individual procedure, number of ICNs and number of recipients.

A

**Alabama Medicaid Agency**

**Professional Referral Claim Details By Provider - FFS**

**Professional Claim Details**

For Dates of Service: 07/01/2015 - 06/30/2016
Provider Base, Medicaid or NPI ID:
Billing Provider Name: SOUTHERN HEAD & NECK SRGY AL
For Claim Types: M

User ID:
Run Date: 9/8/16
Run Time: 1:14:22 PM

| ICN | CTS | POS | DB # | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | ICD | Diag 2 | Diag 2 Desc | Proc | Proc Desc | MD 1 | MD1 Desc | MD 2 | MD2 Desc | MD 3 | MD3 Desc | Bill Qty | Billed Amt | Alwd Amt | Paid Amt | Wrap Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] | M | 11 | 1 | 1234567890 12 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 7/6/1999 | 16 | 8/27/2015 | 8/27/2015 | 9 | 4779 | ALLERGIC RHINITIS, CAUSE UNSPECIFIED | 9 | 4770 | ALLERGIC RHINITIS DUE TO POLLEN | 99213 | Office Outpatient Vst Est | 25 | B/S S&P OBN SERV SAME HO DAY | | | | | 1 | $80.00 | $34.40 | $34.40 | Y |
| [redacted] | M | 11 | 2 | 1234567890 12 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 7/6/1999 | 16 | 8/27/2015 | 8/27/2015 | 9 | 4616 | OTHER ACUTE SINUSITIS | 9 | ******** | | J0702 | Betamethasone Inj, Acetate Phosp | | | | | | | 1 | $15.00 | $6.92 | $6.92 | Y |
| [redacted] | M | 11 | 3 | 1234567890 12 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 7/6/1999 | 16 | 8/27/2015 | 8/27/2015 | 9 | 4616 | OTHER ACUTE SINUSITIS | 9 | ******** | | 96372 | Ther/Prophy/Diag Inj Sc/Im | 59 | DISTINCT PROCEDURAL SERVICE | | | | | 1 | $29.00 | $10.00 | $10.00 | Y |
| [redacted] | M | 11 | 1 | 1234567890 12 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 8/25/1978 | 37 | 9/14/2015 | 9/14/2015 | 9 | 4779 | ALLERGIC RHINITIS, CAUSE UNSPECIFIED | 9 | 38181 | DISFUNCTION OF EUSTACHIAN TUBE | 99213 | Office Outpatient Vst Est | 25 | B/S S&P OBN SERV SAME HO DAY | 24 | UNRELATED SERV SAME HO PROVIDER | | | 1 | $80.00 | $34.40 | $31.80 | Y |
| [redacted] | M | 11 | 2 | 1234567890 12 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 8/25/1978 | 37 | 9/14/2015 | 9/14/2015 | 9 | 4738 | OTHER CHRONIC SINUSITIS | 9 | ******** | | J0702 | Betamethasone Inj, Acetate Phosp | | | | | | | 1 | $15.00 | $6.92 | $6.92 | Y |
| [redacted] | M | 11 | 3 | 1234567890 12 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 8/25/1978 | 37 | 9/14/2015 | 9/14/2015 | 9 | 4738 | OTHER CHRONIC SINUSITIS | 9 | ******** | | 96372 | Ther/Prophy/Diag Inj Sc/Im | 59 | DISTINCT PROCEDURAL SERVICE | | | | | 1 | $29.00 | $10.00 | $10.00 | Y |
| [redacted] | M | 11 | 5 | 1234567890 12 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X | 8/25/1978 | 37 | 9/14/2015 | 9/14/2015 | 9 | 38181 | DISFUNCTION OF EUSTACHIAN TUBE | 9 | 3829 | UNSPECIFIED OTITIS MEDIA | 92567 | Tympanometry | | | | | | | 1 | $30.00 | $11.20 | $11.20 | Y |

End of Report

PHI has been removed


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B

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/18/16
Run Time: 10:52:25 AM

## Professional Referral Claim Details By Provider - FFS

Recipient Listing
For Dates of Service: 04/01/2015 - 03/31/2016
Provider Base, Medicaid or NPI ID: [redacted]
Billing Provider Name: ST CLAIR CO HLTH DEPT.-PELL
For Claim Types: M

| Recipient ID | Recipient Full Name | ICN Count |
|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX, X | 205 |

End of Report

PHI has been removed

C

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/18/16
Run Time: 10:52:25 AM

## Professional Referral Claim Details By Provider - FFS

Diagnosis Listing
For Dates of Service: 04/01/2015 - 03/31/2016
Provider Base, Medicaid or NPI ID: [redacted]
Billing Provider Name: ST CLAIR CO HLTH DEPT.-PELL
For Claim Types: M

| ICD | Diagnosis 1 - Code & Desc | ICD | Diagnosis 2 - Code & Desc | ICD | Diagnosis 3 - Code & Desc | ICN Count | Recipient Count |
|---|---|---|---|---|---|---|---|
| 0 | C07 - MALIGNANT NEOPLASM OF PAROTID GLAND | # | ####### - Unknown or Not Appl. | # | ####### - Unknown or Not Appl. | 3 | 2 |
| 0 | E1010 - TYPE 1 DIABETES MELLITUS WITH KETOACIDOSIS WITHOUT COMA | # | ####### - Unknown or Not Appl. | # | ####### - Unknown or Not Appl. | 60 | 7 |
| 0 | E109 - TYPE 1 DIABETES MELLITUS WITHOUT COMPLICATIONS | # | ####### - Unknown or Not Appl. | # | ####### - Unknown or Not Appl. | 5 | 2 |
| 0 | E1100 - TYPE 2 DIAB W HYPROSM W/O NONKET HYPRGLY-HYPROS COMA (NKHHC) | # | ####### - Unknown or Not Appl. | # | ####### - Unknown or Not Appl. | 62 | 16 |
| 0 | E1142 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY | # | ####### - Unknown or Not Appl. | # | ####### - Unknown or Not Appl. | 1 | 1 |


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D

**Alabama Medicaid Agency**

**Professional Referral Claim Details By Provider - FFS**

**Procedure Listing**

**For Dates of Service: 04/01/2015 - 03/31/2016**

**Provider Base, Medicaid or NPI ID:** [redacted]

**Billing Provider Name: ST CLAIR CO HLTH DEPT.-PELL**

**For Claim Types: M**

**User ID:** [redacted]
**Run Date: 7/18/16**
**Run Time: 10:52:25 AM**

| Procedure Code & Description | ICN Count | Recipient Count |
|---|---|---|
| 11450 - Removal Sweat Gland Lesion | 1 | 1 |
| 11750 - Removal Of Nail Bed | 8 | 3 |
| 11920 - Correct Skin Color 6.0 Cm/< | 1 | 1 |
| 26010 - Drainage Of Finger Abscess | 1 | 1 |
| 27599 - Leg Surgery Procedure | 2 | 1 |
| 29130 - Application Of Finger Splint | 12 | 1 |
| 59410 - Obstetrical Care | 1 | 1 |

### 3.5.74.1 DSSProfiler - Professional Referrals Claim Details by Provider - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age | The age of the recipient on the From Date of Service rounded down to a full year. | 4 | Number (Integer) |
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Bill Qty | Quantity billed for the service rendered. | 2 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Claim Type (CT) | Shows what type of claim was submitted. | 1 | Character |
| (A) DOB | Recipient's Date of Birth | 10 | Date (MM/DD/CCYY) |
| (A) Detail Number (Dtl#) | Claim line number. | 4 | Number (Integer) |
| (A) Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag Desc | The primary ICD-CM diagnosis code description. | 60 | Character |
| (A) Diag 2 | The secondary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag 2 Desc | The secondary ICD-CM diagnosis code description. | 60 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) From Date of Service (FDOS) | Claim's first date of service. | 10 | Date (MM/DD/CCYY) |
| (A) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A) MD1 | First Modifier code for the procedure code billed. | 2 | Character |
| (A) MD1 Desc | Description for the First Modifier code of the procedure code billed. | 40 | Character |
| (A) MD2 | Second Modifier code for the procedure code billed. | 2 | Character |
| (A) MD2 Desc | Description for the Second Modifier code of the procedure code billed. | 40 | Character |
| (A) MD3 | Third Modifier code for the procedure code billed. | 2 | Character |
| (A) MD3 Desc | Description for the Third Modifier code of the procedure code billed. | 40 | Character |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Place of Service (POS) | Place of Service code for where services were rendered. | 2 | Number (Decimal) |
| (A) Proc | Procedure Code for the detail. | 7 | Character |
| (A) Proc Desc | Procedure Code description for the detail. | 40 | Character |
| (A) To Date of Service (TDOS) | Claim's last date of service. | 10 | Date (MM/DD/CCYY) |
| (A) Wrap Ind | Wrap Payment Indicator | 1 | Character |
| (A,B) Recipient Full Name (Recip Name) | The recipient last name and first name. The format of the name will be in: last name, first name. | 22 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Recipient ID (Recip ID) | Recipient Medicaid Number. | 12 | Character |
| (A,C) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A,C) ICD Version for Diagnosis 2 | The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A-D) Claim Types (prompt) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |
| (A-D) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-D) Run Time | The time that the report was executed. | 11 | Character |
| (A-D) User ID | The user that created the report. | 50 | Character |
| (A-D) Provider Base, Medicaid or NPI ID (prompt) | Lists the NPI, Medicaid, and Base ID for the attending Provider. | 63 | Character |
| (B) ICN Count | Unduplicated count of claims for the recipient within that provider. | 8 | Number (Integer) |
| (C) Diagnosis 1 - Code & Desc | The primary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 2 - Code & Desc | The secondary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 3 - Code & Desc | The third ICD-CM diagnosis code and its description. | 70 | Character |
| (C) ICD Version for Diagnosis 3 | The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (C) ICN Count | Unduplicated count of claims for Diagnosis codes. | 8 | Number (Integer) |
| (C,D) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (D) ICN Count | Unduplicated count of claims for procedure code. | 8 | Number (Integer) |
| (D) Procedure Code & Description | Concatenate procedure code and description into one object. | 47 | Character |


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### 3.5.75 DSSProfiler - Professional Referral Claim Details by Provider Quarterly - FFS

The Professional Referral Claims Detail by Provider Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report lets the user drill down to the detail level for all case type categories within the system. The Professional Referrals report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The tabs in this report include:

A. Professional Referral Claim Details - Shows all the claims the provider submitted;

B. Recipient Listing - Lists the individual recipient ID and names;

C. Diagnosis Listing - Lists the primary, secondary diagnosis as well as diagnosis 3; and

D. Procedure Listing - Lists the individual procedure, number of ICNs and number of recipients.

A

**Alabama Medicaid Agency**

**Professional Referral Claim Details By Provider Qtrly - FFS**

**Professional Claim Details**

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: SOUTHERN HEAD & NECK SRGY AL

For Claim Types: M

Quarter: 20153

User ID: [redacted]
Run Date: 9/8/16
Run Time: 1:18:25 PM

| ICN | CT | POS | DB # | Recip ID | Recip Name | DOB | Age | FDOS | TDOS | ICD | Diag | Diag Desc | ICD | Diag 2 | Diag 2 Desc | Proc | Proc Desc | MD 1 | MD1 Desc | MD 2 | MD2 Desc | MD 3 | MD3 Desc | Bill Qty | Billed Amt | Allwd Amt | Paid Amt | Wrap Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] | M | 11 | 1 | 12345678912 | XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X | 7/6/1999 | 16 | 9/27/2015 | 9/27/2015 | 9 | 4779 | ALLERGIC RHINITIS, CAUSE UNSPECIFIED | 9 | 4770 | ALLERGIC RHINITIS DUE TO POLLEN | 99213 | Other Outpatient Visit Est | 2 3 | B/S SKP CBN SKIN SKHS VID DAY | | | | | 1 | $80.00 | $34.40 | $34.40 | N |
| [redacted] | M | 11 | 2 | 12345678912 | XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X | 7/6/1999 | 16 | 9/27/2015 | 9/27/2015 | 9 | 4616 | OTHER ACUTE SINUSITIS | 9 | [redacted] | | J0702 | Betamethasone Acet&Sod Phosp | | | | | | | 1 | $15.00 | $6.92 | $6.92 | N |
| [redacted] | M | 11 | 3 | 12345678912 | XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X | 7/6/1999 | 16 | 9/27/2015 | 9/27/2015 | 9 | 4616 | OTHER ACUTE SINUSITIS | 9 | [redacted] | | 96372 | Ther/Prph/Diag Inj Subcu | 5 9 | DISTINCT PROCEDURAL SERVICE | | | | | 1 | $29.00 | $10.00 | $10.00 | N |
| [redacted] | M | 11 | 1 | 12345678912 | XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X | 8/25/1978 | 37 | 9/14/2015 | 9/14/2015 | 9 | 4779 | ALLERGIC RHINITIS, CAUSE UNSPECIFIED | 9 | 38181 | DISFUNCTION OF EUSTACHIAN TUBE | 99213 | Other Outpatient Visit Est | 2 3 | B/S SKP CBN SKIN SKHS VID DAY | 0 4 | UNRELATED SKIN SKHS VID POSTOP | | | 1 | $80.00 | $34.40 | $31.80 | N |
| [redacted] | M | 11 | 2 | 12345678912 | XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X | 8/25/1978 | 37 | 9/14/2015 | 9/14/2015 | 9 | 4738 | OTHER CHRONIC SINUSITIS | 9 | [redacted] | | J0702 | Betamethasone Acet&Sod Phosp | | | | | | | 1 | $15.00 | $6.92 | $6.92 | N |
| [redacted] | M | 11 | 3 | 12345678912 | XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X | 8/25/1978 | 37 | 9/14/2015 | 9/14/2015 | 9 | 4738 | OTHER CHRONIC SINUSITIS | 9 | [redacted] | | 96372 | Ther/Prph/Diag Inj Subcu | 5 9 | DISTINCT PROCEDURAL SERVICE | | | | | 1 | $29.00 | $10.00 | $10.00 | N |
| [redacted] | M | 11 | 5 | 12345678912 | XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X | 8/25/1978 | 37 | 9/14/2015 | 9/14/2015 | 9 | 38181 | DISFUNCTION OF EUSTACHIAN TUBE | 9 | 3829 | UNSPECIFIED OTITIS MEDIA | 92567 | Tympanometry | | | | | | | 1 | $30.00 | $11.20 | $11.20 | N |

End of Report

Pill has been removed


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B

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/18/16
Run Time: 10:54:44 AM

**Professional Referral Claim Details By Provider Qtrly - FFS**

Recipient Listing
For Dates of Service: 04/01/2015 - 03/31/2016
Provider Base, Medicaid or NPI ID: [redacted]
Billing Provider Name: ST CLAIR CO HLTH DEPT.-PELL
For Claim Types: M
Quarter: 20162

| Recipient ID | Recipient Full Name | ICN Count |
|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X | 203 |

End of Report

PHI has been removed

C

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/18/16
Run Time: 10:54:44 AM

**Professional Referral Claim Details By Provider Qtrly - FFS**

Diagnosis Listing
For Dates of Service: 04/01/2015 - 03/31/2016
Provider Base, Medicaid or NPI ID: [redacted]
Billing Provider Name: ST CLAIR CO HLTH DEPT.-PELL
For Claim Types: M
Quarter: 20162

| ICD | Diagnosis 1 - Code & Desc | ICD | Diagnosis 2 - Code & Desc | ICD | Diagnosis 3 - Code & Desc | ICN Count | Recipient Count |
|---|---|---|---|---|---|---|---|
| 0 | C07 - MALIGNANT NEOPLASM OF PAROTID GLAND | # | ####### - Unknown or Not Appl. | # | ####### - Unknown or Not Appl. | 3 | 2 |
| 0 | E1010 - TYPE 1 DIABETES MELLITUS WITH KETOACIDOSIS WITHOUT COMA | # | ####### - Unknown or Not Appl. | # | ####### - Unknown or Not Appl. | 60 | 7 |
| 0 | E109 - TYPE 1 DIABETES MELLITUS WITHOUT COMPLICATIONS | # | ####### - Unknown or Not Appl. | # | ####### - Unknown or Not Appl. | 5 | 2 |
| 0 | E1100 - TYPE 2 DIAB W HYPROSM W/O NONKET HYPRGLY-HYPROS COMA (NKHHC) | # | ####### - Unknown or Not Appl. | # | ####### - Unknown or Not Appl. | 60 | 16 |
| 0 | E1142 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY | # | ####### - Unknown or Not Appl. | # | ####### - Unknown or Not Appl. | 1 | 1 |


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D

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 7/18/16
Run Time: 10:54:44 AM

**Professional Referral Claim Details By Provider Qtrly - FFS**

Procedure Listing

For Dates of Service: 04/01/2015 - 03/31/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: ST CLAIR CO HLTH DEPT.-PELL

For Claim Types: M

Quarter: 20162

| Procedure Code & Description | ICN Count | Recipient Count |
|---|---|---|
| 11450 - Removal Sweat Gland Lesion | 1 | 1 |
| 11750 - Removal Of Nail Bed | 8 | 3 |
| 11920 - Correct Skin Color 6.0 Cm/< | 1 | 1 |
| 26010 - Drainage Of Finger Abscess | 1 | 1 |
| 27599 - Leg Surgery Procedure | 2 | 1 |

### 3.5.75.1 DSSProfiler - Professional Referrals Claim Details by Provider Quarterly - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age | The age of the recipient on the From Date of Service rounded down to a full year. | 4 | Number (Integer) |
| (A) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A) Bill Qty | Quantity billed for the service rendered. | 2 | Number (Decimal) |
| (A) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A) Claim Type (CT) | Shows what type of claim was submitted. | 1 | Character |
| (A) DOB | Recipient's Date of Birth | 10 | Date (MM/DD/CCYY) |
| (A) Detail Number (Dtl#) | Claim line number. | 4 | Number (Integer) |
| (A) Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag Desc | The primary ICD-CM diagnosis code description. | 60 | Character |
| (A) Diag 2 | The secondary ICD-CM diagnosis code. | 7 | Character |
| (A) Diag 2 Desc | The secondary ICD-CM diagnosis code description. | 60 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) From Date of Service (FDOS) | Claim's first date of service. | 10 | Date (MM/DD/CCYY) |
| (A) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A) MD1 | First Modifier code for the procedure code billed. | 2 | Character |
| (A) MD1 Desc | Description for the First Modifier code of the procedure code billed. | 40 | Character |
| (A) MD2 | Second Modifier code for the procedure code billed. | 2 | Character |
| (A) MD2 Desc | Description for the Second Modifier code of the procedure code billed. | 40 | Character |
| (A) MD3 | Third Modifier code for the procedure code billed. | 2 | Character |
| (A) MD3 Desc | Description for the Third Modifier code of the procedure code billed. | 40 | Character |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A) Place of Service (POS) | Place of Service code for where services were rendered. | 2 | Number (Decimal) |
| (A) Proc | Procedure Code for the detail. | 6 | Character |
| (A) Proc Desc | Procedure Code description for the detail. | 40 | Character |
| (A) To Date of Service (TDOS) | Claim's last date of service. | 10 | Date (MM/DD/CCYY) |
| (A) Wrap Ind | Wrap Payment Indicator | 1 | Character |
| (A,B) Recipient Full Name (Recip Name) | The recipient last name and first name. The format of the name will be in: last name, first name. | 22 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Recipient ID (Recip ID) | Recipient Medicaid Number. | 12 | Character |
| (A,C) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A,C) ICD Version for Diagnosis 2 | The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (A-D) Claim Types (prompt) | The code indicating the type of claim record the provider used for billing the rendered service. | 1 | Character |
| (A-D) Quarter (prompt) | The quarter for which the report is being run for. | 5 | Number (Integer) |
| (A-D) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-D) Run Time | The time that the report was executed. | 11 | Character |
| (A-D) User ID | The user that created the report. | 50 | Character |
| (A-D) Provider Base, Medicaid or NPI ID (prompt) | Lists the NPI, Medicaid, and Base ID for the attending Provider. | 63 | Character |
| (B) ICN Count | Unduplicated count of claims for the recipient within that provider. | 8 | Number (Integer) |
| (C) Diagnosis 1 - Code & Desc | The primary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 2 - Code & Desc | The secondary ICD-CM diagnosis code and its description. | 70 | Character |
| (C) Diagnosis 3 - Code & Desc | The third ICD-CM diagnosis code and its description. | 70 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (C) ICD Version for Diagnosis 3 | The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A) | 1 | Character |
| (C) ICN Count | Unduplicated count of claims for Diagnosis codes. | 8 | Number (Integer) |
| (C,D) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (D) ICN Count | Unduplicated count of claims for procedure code. | 8 | Number (Integer) |
| (D) Procedure Code & Description | Concatenate procedure code and description into one object. | 47 | Character |


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### 3.5.76 DSSProfiler - Professional Referral Distribution Analysis

This report shows totals for all professional referral case types within the selected peer group. The totals include amount paid, number of unduplicated recipients, claim counts, units and exceptions. The report also provides a rapid method to identify which case types, or service categories, need to be looked at more closely with other reports within the DSSProfiler. The exception count is the count of distinct providers who have more than two standard deviations from the norm compared to their peers.

There are five tabs in this report:

A. Professional Referral Distribution Summary shows professional distribution summary for different case types;

B. TOP 20 shows the top 20 case types with exceptions, by number of recipients and by paid amount per recipient;

C. By Age shows information for the age groups for each case type;

D. By Gender shows information for the gender for each case type; and

E. By Age/Gender shows information for the gender and age groups for each case type.

A

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 9/14/2007
Run Time: 10:42:34 AM

**Professional Referral Distribution Analysis**
**Professional Referral Distribution Summary**
**For Dates of Service: 01/01/2006 - 12/31/2006**
**Provider Peer Group: 587 - 720 PRIMARY CARE**
**Aggregation Code: 1 - Fee for Service Claims by Servicing Provider**
**Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location**

| Case Type Description | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Paid Amt per Recip | Claims per Recip | Exception Count |
|---|---|---|---|---|---|---|---|---|---|---|
| 1000 - AL Dormicilla Procedures | 2 | 2 | 2 | $154.00 | $91.33 | $91.33 | $77.00 | $45.67 | 1.00 | 0 |
| 1002 - AL Biospy Procedures | 9 | 9 | 9 | $4,359.25 | $2,202.00 | $1,798.00 | $484.36 | $199.78 | 1.00 | 0 |
| 1003 - AL Wire Removal with Surgery | 1 | 1 | 1 | $500.00 | $500.00 | $500.00 | $500.00 | $500.00 | 1.00 | 1 |
| 1005 - AL Open Reduction Procedures | 6 | 6 | 4 | $15,146.72 | $5,621.50 | $5,366.50 | $3,786.68 | $1,341.63 | 1.50 | 0 |
| 1007 - AL Retinal Procedures | 1 | 1 | 1 | $1,225.00 | $504.00 | $504.00 | $1,225.00 | $504.00 | 1.00 | 1 |
| 1008 - AL Psychiatric Evaluation Procedures | 426 | 355 | 151 | $39,439.00 | $32,187.00 | $27,553.00 | $261.19 | $182.47 | 2.35 | 0 |
| 1010 - AL Group Therapy Procedures | 14 | 6 | 4 | $189.00 | $189.00 | $81.00 | $47.25 | $20.25 | 1.50 | 3 |


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B

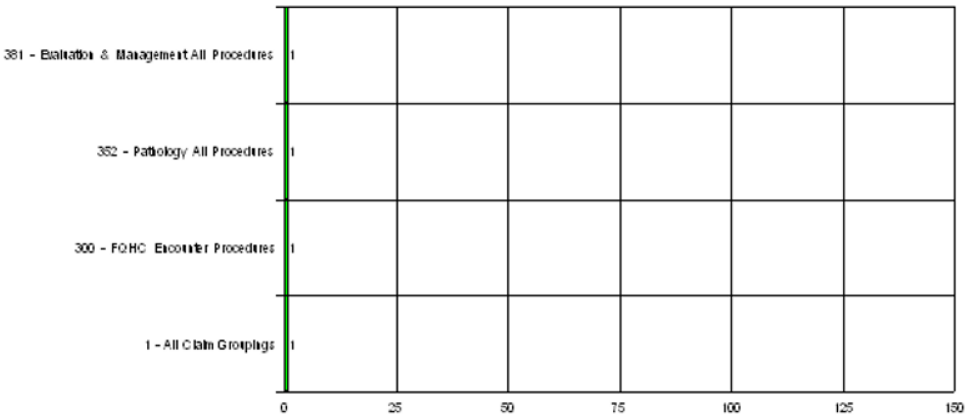
# Alabama Medicaid Agency

User ID:
Run Date: 5/22/2006
Run Time: 11:31:57 AM

Professional Referral Distribution Analysis
Top 20

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Top 20 Exceptions



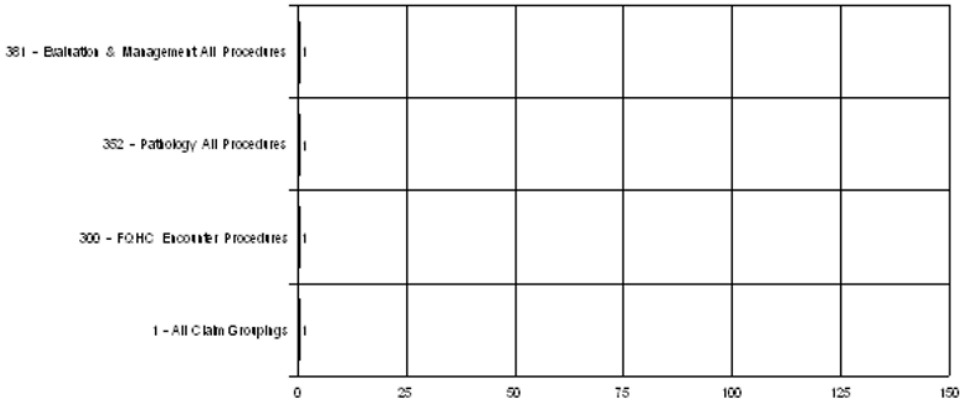

# Alabama Medicaid Agency

User ID:
Run Date: 5/22/2006
Run Time: 11:31:57 AM

Professional Referral Distribution Analysis
Top 20

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Top 20 By Number of Recipients





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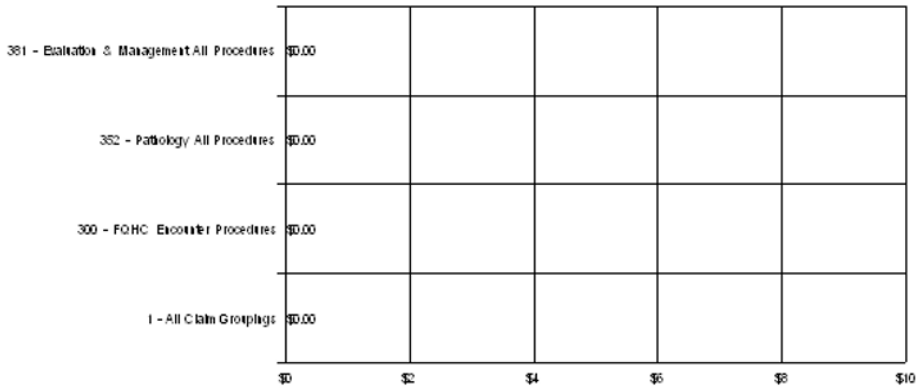
# Alabama Medicaid Agency

Professional Referral Distribution Analysis
Top 20

User ID:
Run Date: 5/22/2006
Run Time: 11:31:57 AM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Top 20 By Paid Amount per Recipient




C

# Alabama Medicaid Agency

Professional Referral Distribution Analysis
By Age

User ID:
Run Date: 9/14/2007
Run Time: 10:42:34 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 587 - 720 PRIMARY CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type: 1000 - AL Dormicilla Procedures

| Age Description | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| Age 35 - 64 | 2 | 2 | 2 | $154.00 | $91.33 | $91.33 | $77.00 | $45.67 | $45.67 | 1.00 |
| Sum: | 2 | 2 | 2 | $154.00 | $91.33 | $91.33 | $77.00 | $45.67 | $45.67 | 1.00 |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D

**Alabama Medicaid Agency**

User ID:
Run Date: 9/14/2007
Run Time: 10:42:34 AM

Professional Referral Distribution Analysis
By Gender

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 587 - 720 PRIMARY CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type: 1000 - AL Dormicilla Procedures

| Gender | Billed Quantity | Claim Count | Recip Count | Billed Amount | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|
| F | 2 | 2 | 2 | $154.00 | $91.33 | $91.33 | $77.00 | $45.67 | $45.67 | 1.00 |
| Sum: | 2 | 2 | 2 | $154.00 | $91.33 | $91.33 | $77.00 | $45.67 | $45.67 | 1.00 |

E

**Alabama Medicaid Agency**

User ID:
Run Date: 9/14/2007
Run Time: 10:42:34 AM

Professional Referral Distribution Analysis
By Age/Gender

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 587 - 720 PRIMARY CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type: 1000 - AL Dormicilla Procedures

| Age Description | Gender | Quantity Billed | Claim Count | Recip Count | Billed Amt | Allowed Amount | Paid Amount | Billed Amt per Recip | Allowed Amt per Recip | Paid Amt per Recip | Claims per Recip |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Age 35 - 64 | F | 2 | 2 | 2 | $154.00 | $91.33 | $91.33 | $77.00 | $45.67 | $45.67 | 1.00 |
| | Sum: | 2 | 2 | 2 | $154.00 | $91.33 | $91.33 | $77.00 | $45.67 | 45.67 | 1.00 |

### 3.5.76.1 DSSProfiler - Professional Referrals Distribution Analysis Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Case Type Description | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |
| (A) Exception Count | Number of exceptions identified. An exception is defined as two standard deviations from the norm. | 8 | Number (Integer) |
| (A,C,D,E) Allowed Amount | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A,C,D,E) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A,C,D,E) Billed Amount per Recip | Total billed amount divided by the number of recipients. | 12 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,C,D,E) Billed Quantity | Quantity billed. | 14 | Number (Integer) |
| (A,C,D,E) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (A,C,D,E) Claims per Recip | Total claim count divided by the recipient count. | 4 | Number (Integer) |
| (A,C,D,E) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A,C,D,E) Paid Amount per Recip | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |
| (A,C,D,E) Recip Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (A-E) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-E) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-E) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-E) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| B) Top 20 By Number of Recipients | Graph shows Top 20 exceptions by number of recipients. | 1 | Character |
| (B) Top 20 By Paid Amount per Recipient | Graph shows Top 20 exceptions by paid amount per recipient. | 1 | Character |
| (B) Top 20 Exceptions | Graph shows Top 20 exceptions. | 1 | Character |
| (C,D,E) Allowed Amt Per Recip | Total allowed amount divided by the number of recipients. | 13 | Number (Decimal) |
| (C,D,E) Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (C,E) Age Description | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (D,E) Gender | Recipient's gender. | 1 | Character |


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### 3.5.77 DSSProfiler - Professional Referral Exception Quarterly

The Professional Referral Exception Quarterly report is produced for a selected provider, provider peer group and aggregation code. This report displays the number of high exceptions for case groups that occur during each reporting period. The case groups whose calculations are above the exception high value are marked as exceptions.

**Alabama Medicaid Agency**

Professional Referral Exception Quarterly

User ID: Administrator
Run Date: 5/19/2006
Run Time: 3:07:24 PM

For Dates of Service: 07/01/2004 - 06/30/2005

Provider Service Location Information:
NPI ID: [redacted]
Mcaid ID: [redacted]
Base ID: [redacted]
Name: GRACE COMMUNITY PHYSICAL THERAPY
Type: 27 - Dentist
Specialty: 273 - Orthodontist
Address: 3097 MAIN ST

SALEM, OR 97501

Peer Group: 6 - Dental By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| | 20044 | |
|---|---|---|
| 123 - Dental Emergencies; H: 002 L: 000 | 26.37 | * |

End of Report

#### 3.5.77.1 DSSProfiler - Professional Referrals Exception Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| Calculation | Calculation to find case groups above the exception high. | 14 | Number (Decimal) |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Peer Group | Peer Group Code and Description. | 4 | Number (Integer) |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| Provider Service Location Information | Provider's information. This includes the provider name, address, NPI ID, Medicaid ID, and Base ID. | 200 | Character |
| NPI ID | National provider identification number. | 13 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| Mcaid ID | Medicaid provider identification number. | 13 | Character |
| Base ID | Provider identification number. | 13 | Character |
| Name | The provider's name. | 45 | Character |
| Type | The provider type for the provider id. | 15 | Character |
| Specialty | The provider specialty for the provider identification number. | 15 | Character |
| Provider Service Location Information | The provider address to include street address, city, state, zip code, and telephone number. | 200 | Character |


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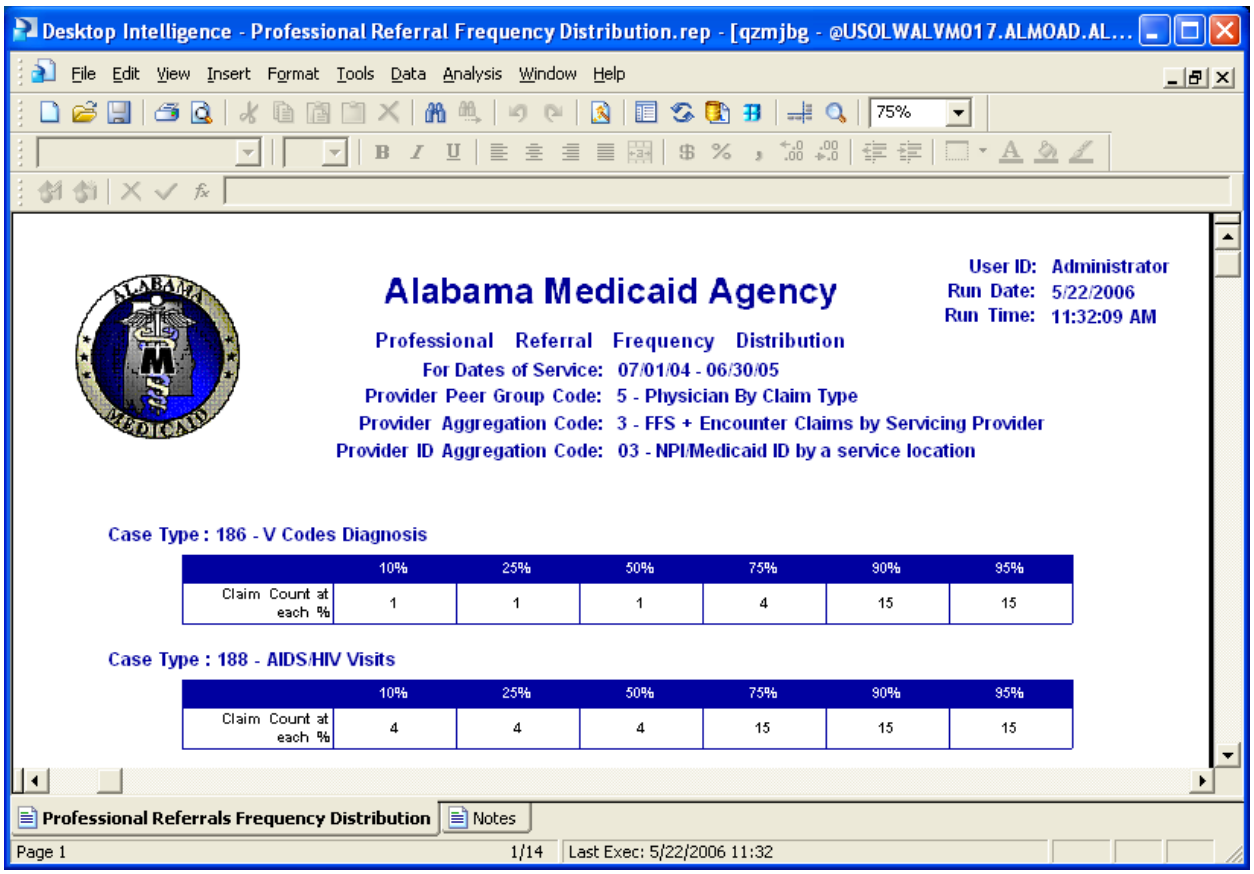
### 3.5.78 DSSProfiler - Professional Referral Frequency Distribution

The Professional Referral Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one year, this report shows for each professional referral case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.




#### 3.5.78.1 DSSProfiler - Professional Referrals Frequency Distribution Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |
| 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |
| Case Type | A user defined group based on the case mix file. The claim grouping should be specific to the area of service. | 100 | Character |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| Field | Description | Length | Data Type |
|---|---|---|---|
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Provider Aggregation Code | Aggregation Code and Description. | 100 | Character |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |


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### 3.5.79 DSSProfiler - Professional Referral Frequency Distribution Quarterly

Based on the user-entered date range of one quarter, this report displays provider claim counts for professional referral services by percentile for the selected peer group and aggregation type. Each percentile represents a percentage of the number of providers within the specific claim grouping. The percentile groups are determined by ordering providers, by the number of paid claims each has for the case type, and then grouping the providers into the percentiles starting with the provider with the least number of claims. The claim count displayed for each percentile represents the maximum number of claims for any provider falling in the percentile.

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 9/27/2007
Run Time: 10:43:10 AM

Professional Referral Frequency Distribution Qtrly

For Dates of Service: 01/01/2006 - 03/31/2006
Provider Peer Group Code: 5 - Physician By Claim Type
Provider Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20061

Case Type : 1006 - AL Cateract Procedures

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 1 | 1 | 1 |

Case Type : 101 - CMS Eval and Mgmt Hospital Visits Initial

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 2 | 3 | 5 |

#### 3.5.79.1 DSSProfiler - Professional Referrals Frequency Distribution Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |
| 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Provider Aggregation Code | Aggregation Code and Description. | 100 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| Provider Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |


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### 3.5.80 DSSProfiler - Professional Referral Provider Profile

The Professional Referral Provider Profile report is created in the DSSProfiler. Based on the user-entered date range of one year, this report flags any category or case type that exceeds the accepted norm within the professional provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B Professional Referral - Tab B has two sections. The first sections of this report contain a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

**Report Prompts (Search Criteria):**

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - The peer group to which the profiled provider is being compared; and
- Aggregation Code - The code to which the profiled provider is being compared.


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A

# Alabama Medicaid Agency

User ID:
Run Date: 9/26/2007
Run Time: 8:44:02 AM

**Professional Referral Provider Profile**
**Provider Summary**

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 479 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

**Provider Information**

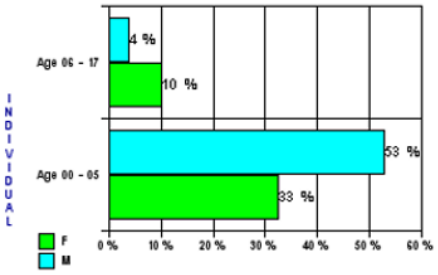
NPI ID:
Mcaid ID:
Base ID:
Name:
Type: 31 - Physician
Specialty: 345 - General Pediatrician
Address: 1022 FIRST ST NORTH #102

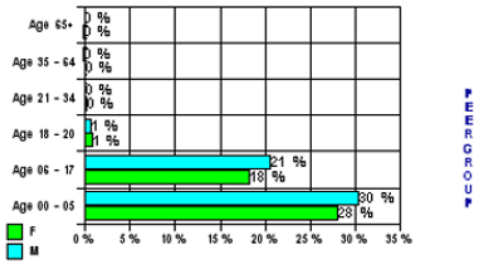
ALABASTER, AL 35007

**Ranks**

| | |
|---|---|
| $ Paid Amount Actual | 1 |
| $ Paid Amount Expected | 1 |
| $ Billed Amount Actual | 1 |
| Recipient Rank | 1 |
| # Units Rank | 1 |
| # Claims Rank | 1 |
| Peer Group Size | 1 |

**Patient Age/Gender Breakdown**




# Alabama Medicaid Agency

User ID:
Run Date: 11/1/2007
Run Time: 1:10:21 PM

**Professional Referral Provider Profile**
**Provider Summary**

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

**Provider's General Service Profile**

| Service Type | Recip Count | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|
| 2 - Professional Referrals | 665 | $462,484.75 | $242,297.56 | $172,776.75 | $195,600.28 | $(22,823.53) | (11.67) % |

End of Report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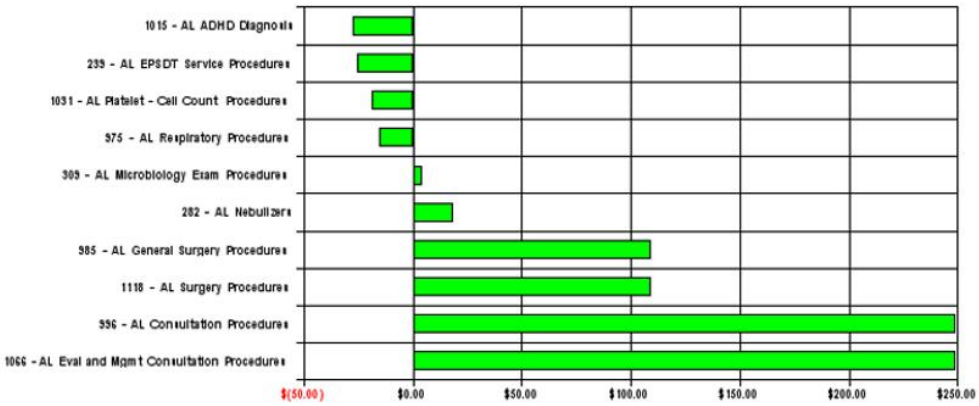
**B**

## Alabama Medicaid Agency

User ID: [redacted]
Run Date: 9/26/2007
Run Time: 8:44:02 AM

Professional Referral Provider Profile
Professional Referral
For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 479 - 345 GENERAL PEDIATR
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 10 Case Types: Dollar Difference




## Alabama Medicaid Agency

User ID: [redacted]
Run Date: 9/26/2007
Run Time: 8:44:02 AM

Professional Referral Provider Profile
Professional Referral
For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 479 - 345 GENERAL PEDIATR
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

| Case Type | Recip Count | Claim Count | Quantity | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|---|
| 1066 - AL Eval and Mgmt Consultation Procedures | 5 | 5 | 5 | $877.00 | $1,098.00 | $935.00 | $686.04 | $248.96 | 36.29 % |
| 996 - AL Consultation Procedures | 5 | 5 | 5 | $877.00 | $1,098.00 | $935.00 | $686.04 | $248.96 | 36.29 % |
| 1118 - AL Surgery Procedures | 2 | 2 | 2 | $331.00 | $822.00 | $331.00 | $221.86 | $109.14 | 49.19 % |
| 985 - AL General Surgery Procedures | 2 | 2 | 2 | $331.00 | $822.00 | $331.00 | $221.86 | $109.14 | 49.19 % |
| 282 - AL Nebulizers | 1 | 1 | 1 | $138.16 | $150.00 | $159.13 | $140.54 | $18.59 | 13.23 % |
| 309 - AL Microbiology Exam Procedures | 3 | 4 | 5 | $48.00 | $96.00 | $14.00 | $9.85 | $4.15 | 42.13 % |
| 975 - AL Respiratory Procedures | 1 | 1 | 1 | $9.00 | $30.00 | $0.00 | $15.05 | $(15.05) | (100.00) % |
| 1031 - AL Platelet - Cell Count Procedures | 2 | 2 | 2 | $20.00 | $43.00 | $0.00 | $18.82 | $(18.82) | (100.00) % |

### 3.5.80.1 DSSProfiler - Professional Referral Provider Profile Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Service Type | User defined group based on the service type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A-B) # Claims Rank | Rank is based on the number of paid claims. | 5 | Number (Integer) |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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) # Units Rank | Rank based on the quantity billed. | 5 | Number (Integer) |
| (A-B) $ Billed Amount Actual | Rank based on the actual money billed by the provider. | 5 | Number (Integer) |
| (A-B) $ Paid Amount Actual | Rank based on the actual money paid by the program in the specific time period. | 5 | Number (Integer) |
| (A-B) $ Paid Amount Expected | Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group. | 5 | Number (Integer) |
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-B) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Integer) |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-B) Dollar Difference | Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest). | 13 | Number (Decimal) |
| (A-B) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-B) Patient Age/Gender Breakdown | Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve. | 10 | Character |
| (A-B) Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Peer Group Size | Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings. | 5 | Number (Integer) |
| (A-B) Percent Difference | Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage. | 8 | Number (Decimal) |
| (A-B) Provider ID | Provider identification number. | 15 | Character |
| (A-B) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-B) Provider Information | Provider's demographic information. This includes the provider name, street address, city, state, zip code, and telephone number. | 200 | Character |
| (A-B) Recip Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (A-B) Recipient Rank | Rank based on the number of eligible recipients the provider served in a specific time period. | 5 | Number (Integer) |
| (B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (B) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (B) Quantity | Quantity billed. | 8 | Number (Integer) |
| (B) Top 10 Case Types | Different in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference. | 60 | Character |
| (A) NPI ID | National provider identification number. | 13 | Character |
| (A) Mcaid ID | Medicaid provider identification number. | 13 | Character |
| (A) Base ID | Provider identification number. | 13 | Character |
| (A) Name | The provider's name. | 45 | Character |
| (A) Type | The provider type for the provider identification number. | 15 | Character |
| (A) Specialty | The provider specialty for the provider identification number. | 15 | Character |


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### 3.5.81 DSSProfiler - Professional Referral Provider Profile Quarterly

The Professional Referral Provider Quarterly Profile report is created in the DSSProfiler. This report flags any category or case type that exceeds the accepted norm within the professional provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B Professional Referral - Tab B has two sections. The first sections of this report contain a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

**Report Prompts (Search Criteria):**

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - The peer group to which the profiled provider is being compared;
- Aggregation Code - The code to which the profiled provider is being compared; and
- Quarter - Quarter of the provider being profiled in the report.


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A

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/8/2007
Run Time: 8:05:42 PM

**Professional Referral Provider Profile Qtrly**
**Provider Summary**

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: 1[redacted]
Provider Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

## Provider Information

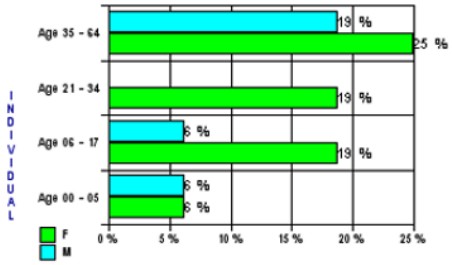
NPI ID: 1508874512
Mcaid ID: 009957890
Base ID: 10846
Name: SANDERS, STEVE M - ALL BSE
Type: 31 - Physician
Specialty: 316 - Family Practitioner
Address: 1026 GOODYEAR AVE STE 100

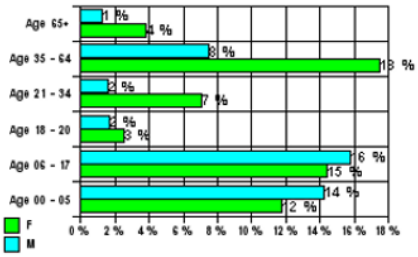
GADSDEN, AL 35903

## Ranks

| | |
|---|---|
| $ Paid Amount Actual | 1 |
| $ Paid Amount Expected | 1 |
| $ Billed Amount Actual | 1 |
| Recipient Rank | 1 |
| # Units Rank | 1 |
| # Claims Rank | 1 |
| Peer Group Size | 1 |

## Patient Age/Gender Breakdown




# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/8/2007
Run Time: 8:05:42 PM

**Professional Referral Provider Profile Qtrly**
**Provider Summary**

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Provider Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

## Provider's General Service Profile

| Report Category | Recipient Count | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|
| 2 - Professional Referrals | 16 | $6,764.72 | $24,037.97 | $5,003.30 | $3,439.14 | $1,564.16 | 45.48 % |

End of Report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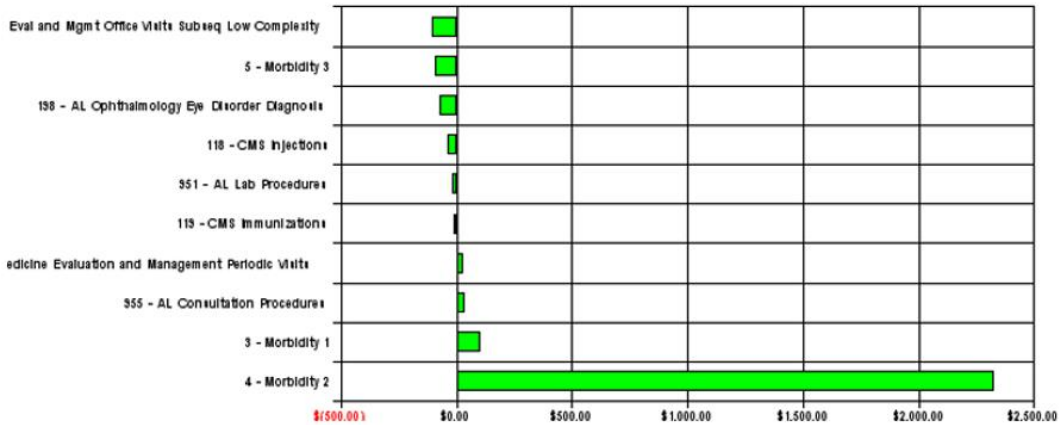
**B**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/8/2007
Run Time: 8:05:42 PM

Professional Referral Provider Profile Qtrly
Professional Referrals
For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Provider Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

Top 10 Case Types: Dollar Difference




# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/8/2007
Run Time: 8:05:42 PM

Professional Referral Provider Profile Qtrly
Professional Referrals
For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Provider Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

| Case Type | Recipient Count | Claim Count | Quantity | Allowed Amount | Billed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|---|
| 4 - Morbidity 2 | 6 | 35 | 38 | $3,704.60 | $20,464.71 | $3,607.60 | $1,278.30 | $2,329.30 | 182.22 % |
| 3 - Morbidity 1 | 4 | 9 | 9 | $496.70 | $1,119.50 | $495.70 | $390.63 | $105.07 | 26.90 % |
| 955 - AL Consultation Procedures | 2 | 2 | 2 | $278.00 | $583.00 | $326.00 | $285.60 | $40.40 | 14.15 % |
| 121 - CMS Comprehensive Preventive Medicine Evaluation and Management Periodic Visits | 2 | 2 | 2 | $126.00 | $140.00 | $166.00 | $132.34 | $33.66 | 25.43 % |
| 119 - CMS Immunizations | 2 | 5 | 5 | $40.00 | $282.00 | $0.00 | $10.92 | $(10.92) | (100.00) % |
| 951 - AL Lab Procedures | 1 | 1 | 1 | $10.00 | $22.00 | $51.00 | $66.50 | $(15.50) | (23.31) % |
| 118 - CMS Injections | 2 | 5 | 5 | $40.00 | $282.00 | $0.00 | $38.91 | $(38.91) | (100.00) % |
| 198 - AL Ophthalmology Eye Disorder Diagnosis | 1 | 3 | 3 | $114.00 | $248.00 | $41.00 | $112.26 | $(71.26) | (63.48) % |
| 5 - Morbidity 3 | 1 | 1 | 1 | $100.00 | $112.00 | $99.00 | $190.14 | $(91.14) | (47.93) % |
| 107 - CMS Eval and Mgmt Office Visits Subseq Low Complexity | 3 | 3 | 3 | $127.00 | $173.00 | $83.00 | $191.65 | $(108.65) | (56.69) % |
| 108 - CMS Eval and Mgmt Office Visits Subseq High Complexity | 5 | 5 | 5 | $369.00 | $533.00 | $366.00 | $520.97 | $(154.97) | (29.75) % |
| 125 - CMS Over the Counter Medical Supplies | 2 | 3 | 5 | $179.01 | $234.47 | $84.60 | $241.44 | $(156.84) | (64.96) % |
| 224 - AL Ophthalmology ILL Defined Diagnosis | 3 | 7 | 7 | $159.00 | $888.50 | $135.00 | $562.84 | $(427.84) | (76.01) % |
| 112 - CMS Surgeries | 1 | 1 | 1 | $51.00 | $90.00 | $11.00 | $758.82 | $(747.82) | (98.55) % |
| 6 - Morbidity 4 | 5 | 19 | 20 | $970.41 | $2,341.76 | $801.00 | $1,580.07 | $(779.07) | (49.31) % |

End of Report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#### 3.5.81.1 DSSProfiler - Professional Referring Provider Profile Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) # Claims Rank | Rank is based on the number of paid claims. | 5 | Number (Integer) |
| (A) # Units Rank | Rank based on the quantity billed. | 5 | Number (Integer) |
| (A) $ Billed Amount Actual | Rank based on the actual money billed by the provider. | 5 | Number (Decimal) |
| (A) $ Paid Amount Actual | Rank based on the actual money paid by the program in the specific time period. | 5 | Number (Decimal) |
| (A) $ Paid Amount Expected | Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group. | 5 | Number (Decimal) |
| (A) Base ID | Provider identification number. | 13 | Character |
| (A) Mcaid ID | Medicaid provider identification number. | 13 | Character |
| (A) Name | The provider's name. | 45 | Character |
| (A) NPI ID | National provider identification number. | 13 | Character |
| (A) Patient Age/Gender Breakdown | Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve. | 10 | Character |
| (A) Peer Group Size | Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings. | 5 | Number (Integer) |
| (A) Provider Information | Provider's demographic information. This includes the provider name, street address, city, state, zip code, and telephone number. | 200 | Character |
| (A) Recipient Rank | Rank based on the number of eligible recipients the provider served in a specific time period. | 5 | Number (Integer) |
| (A) Report Category | User-defined variables used to categorize case types into service groups. | 21 | Character |
| (A) Specialty | The provider specialty for the provider identification number. | 15 | Character |
| (A) Type | The provider type for the provider id. | 15 | Character |
| (A-B) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Integer) |
| (A-B) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-B) Dollar Difference | Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest). | 13 | Number (Decimal) |
| (A-B) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-B) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-B) Percent Difference | Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage. | 8 | Number (Decimal) |
| (A-B) Provider ID | Provider identification number. | 15 | Character |
| (A-B) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-B) Provider Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A-B) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A-B) Recipient Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (B ) Quantity | The quantity billed. | 14 | Number (Integer) |
| (B) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (B) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (B) Top 10 Case Types: Dollar Difference | Different in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference. | 60 | Character |


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### 3.5.82 DSSProfiler - Provider Peer Group Comparison

The Peer Group Comparison report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar norm. All information is age and gender adjusted so that differences in patient mix do not affect the results. This report can look at professional service totals, professional referral totals, inpatient totals, outpatient referral totals and pharmacy totals. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

This report provides a rapid method to find which providers need to be analyzed more closely utilizing other reports within the DSSProfiler. The tabs in this report include:

A. Compare by Dollar Difference - contains information that is essential in comparing providers within the same specialty group;

B. Compare by Percent Difference - similar to the previous, except the difference is expressed as a percent;

C. Data - shows the raw data for all of the equations used in the compare by dollar difference report and the compare by percent difference report; and

D. Other Rankings - shows four rankings for the providers in this particular specialty group.

**Report Prompts (Search Criteria):**

- Provider Peer Group - The peer group to which the profiled provider is being compared;
- Aggregation Code - Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. Claims can be further aggregated by billing or servicing provider where the servicing provider is the performing, referring, attending or prescribing provider, depending on the claim type; and
- Report Category - User-defined variables used to categorize case types into service groups.

**Alabama Medicaid Agency**

Provider Peer Group Comparison
Compare by Dollar Difference

User ID: [redacted]
Run Date: 5/12/2006
Run Time: 12:35:13 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Report Category: 8 - Inpatient Services by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

| Rank | Raw Rank | Exp Rank | Provider ID | Provider Name | Dollar Difference from Expected | Number of Standard Deviations | Each * represent a $5000 Difference From Center Line. Rows in red indicate a Dollar Difference that is more that 2 standard deviations from the norm. 2 Standard Deviations = $62,640.94 |
|---|---|---|---|---|---|---|---|
| 1 | 1 | 1 | [redacted] | NW GENERAL - ALL NPI | $57,744.67 | 1.99 | ********** |
| 2 | 5 | 5 | [redacted] | NW GENERAL - ALL NPI | $5,098.90 | 0.18 | * |
| 3 | 6 | 7 | [redacted] | SEAMORE X-RAY CLINIC - ALL NPI | $0.00 | 0.00 | |
| 4 | 7 | 6 | [redacted] | SEAMORE X-RAY CLINIC - ALL NPI | $(4,213.91) | -0.15 | * |
| 5 | 2 | 4 | [redacted] | SEAMORE X-RAY CLINIC - ALL NPI | $(24,086.50) | -0.83 | ***** |
| 6 | 3 | 3 | [redacted] | MEMORIAL VALLEY MEDICAL - ALL NPI | $(28,661.61) | -0.99 | ****** |
| 7 | 4 | 2 | [redacted] | BAILY MEDICAL SUPPLIES - ALL NPI | $(35,034.14) | -1.21 | ******** |

End of Report


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# Alabama Medicaid Agency

User ID:
Run Date: 5/12/2006
Run Time: 12:35:13 PM

Provider Peer Group Comparison

Compare by Percent Difference

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Report Category: 8 - Inpatient Services by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

| Rank | Raw Rank | Exp Rank | Provider ID | Provider Name | Percent Difference from Expected | Number of Standard Deviations | Each * represent a 10% Difference From Center Line | |
|---|---|---|---|---|---|---|---|---|
| 1 | 5 | 5 | | NW GENERAL - ALL NPI | 83.95 % | 1.38 | | * * * * * * * * * |
| 2 | 1 | 1 | | NW GENERAL - ALL NPI | 35.43 % | 0.58 | | * * * * |
| 3 | 6 | 7 | | SEAMORE X-RAY CLINIC - ALL NPI | 0.00 % | 0.00 | | |
| 4 | 2 | 4 | | SEAMORE X-RAY CLINIC - ALL NPI | -60.89 % | -1.00 | * * * * * * * | |
| 5 | 3 | 3 | | MEMORIAL VALLEY MEDICAL - ALL NPI | -68.35 % | -1.12 | * * * * * * * | |
| 6 | 4 | 2 | | BAILY MEDICAL SUPPLIES - ALL NPI | -74.35 % | -1.22 | * * * * * * * * | |
| 7 | 7 | 6 | | SEAMORE X-RAY CLINIC - ALL NPI | -89.58 % | -1.47 | * * * * * * * * * | |

End of Report

# Alabama Medicaid Agency

User ID:
Run Date: 5/12/2006
Run Time: 12:35:13 PM

Provider Peer Group Comparison
Data

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Report Category: 8 - Inpatient Services by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

| Rank | Raw RANK | Exp Rank | Provider ID | Provider Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference | Recip Count | Exception |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 1 | | NW GENERAL - ALL NPI | $467,755.00 | $234,006.54 | $220,740.55 | $162,995.88 | $57,744.67 | 35.43 % | 26 | |
| 2 | 5 | 5 | | NW GENERAL - ALL NPI | $3,459.38 | $11,172.43 | $11,172.43 | $6,073.53 | $5,098.90 | 83.95 % | 2 | |
| 3 | 6 | 7 | | SEAMORE X-RAY CLINIC - ALL NPI | $584.69 | $2,436.84 | $2,436.84 | $2,436.84 | $0.00 | 0.00 % | 1 | |
| 4 | 7 | 6 | | SEAMORE X-RAY CLINIC - ALL NPI | $26,745.00 | $739.00 | $490.00 | $4,703.91 | $(4,213.91) | -89.58 % | 2 | |
| 5 | 2 | 4 | | SEAMORE X-RAY CLINIC - ALL NPI | $101,700.00 | $72,153.69 | $15,473.43 | $39,559.93 | $(24,086.50) | -60.89 % | 5 | |
| 6 | 3 | 3 | | MEMORIAL VALLEY MEDICAL - ALL NPI | $12,235.00 | $15,957.00 | $13,271.50 | $41,933.11 | $(28,661.61) | -68.35 % | 5 | |
| 7 | 4 | 2 | | BAILY MEDICAL SUPPLIES - ALL NPI | $32,285.00 | $14,886.56 | $12,086.56 | $47,120.70 | $(35,034.14) | -74.35 % | 7 | |


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**Alabama Medicaid Agency**

Provider Peer Group Comparison
Other Rankings

User ID: [redacted]
Run Date: 5/12/2006
Run Time: 12:35:13 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Report Category: 8 - Inpatient Services by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

| Provider ID | Provider Name | Raw Rank | Claim Rank | Recip Rank | Quantity Rank | Dollar Difference | Number of Standard Deviations |
|---|---|---|---|---|---|---|---|
| [redacted] | NW GENERAL - ALL NPI | 1 | 1 | 1 | 1 | $57,744.67 | 1.99 |
| [redacted] | NW GENERAL - ALL NPI | 5 | 6 | 5 | 6 | $5,098.90 | 0.18 |
| [redacted] | SEAMORE X-RAY CLINIC - ALL NPI | 6 | 7 | 7 | 7 | $0.00 | 0.00 |
| [redacted] | SEAMORE X-RAY CLINIC - ALL NPI | 7 | 3 | 5 | 3 | $(4,213.91) | -0.15 |
| [redacted] | SEAMORE X-RAY CLINIC - ALL NPI | 2 | 5 | 3 | 5 | $(24,086.50) | -0.83 |
| [redacted] | MEMORIAL VALLEY MEDICAL - ALL NPI | 3 | 4 | 3 | 4 | $(28,661.61) | -0.99 |
| [redacted] | BAILY MEDICAL SUPPLIES - ALL NPI | 4 | 2 | 2 | 2 | $(35,034.14) | -1.21 |

End of Report

### 3.5.82.1 DSSProfiler - Provider Peer Group Comparison Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Dollar Difference from Expected | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology). | 13 | Number (Integer) |
| (A-B) Each * 10% difference | Each * represents a 10% Difference From Center Line. | 1 | Character |
| (A-B,D) Number of Standard Deviations | Represents the number of standard deviations that the provider's dollar difference was from the expected. | 8 | Number (Integer) |
| (A-C) Rank | Recipient's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A-C) Exp Rank | Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group. | 3 | Number (Integer) |
| (A-D) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-D) Report Category | User-defined variables used to categorize case types into service groups. | 21 | Character |
| (A-D) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-D) For Date of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Provider ID | Provider identification number. | 15 | Character |
| (A-D) Provider Name | Provider's full name. | 50 | Character |
| (A-D) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A-D) Raw Rank | Provider's rank based on the amount Provider was paid. | 3 | Number (Integer) |
| (A-D) Report Category | User-defined variables used to categorize case types into service groups. | 50 | Character |
| (B) Percent Difference from Expected | Percentage number that is the difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology). | 7 | Number (Integer) |
| (C) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Integer) |
| (C)Billed Amount | Amount the provider billed for the services. | 13 | Number (Integer) |
| (C) Dollar Difference | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology). | 13 | Number (Integer) |
| (C) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (C) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (C) Percent Difference | Percent number representing the difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology). | 8 | Number (Decimal) |
| (C) Recip Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (D) Claim Rank | Number of claims rank is based on Number of claims provider billed. | 3 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (D) Dollar Difference | Difference in the actual amount Provider was paid and the amount Provider was expected to receive (based on the ACG adjustment methodology). | 13 | Character |
| (D) Quantity Rank | Rank based on quantity billed. | 3 | Number (Decimal) |
| (D) Recip Rank | Recipient rank is a rank based on Number of eligible recipients Provider serves in a specific time period. | 3 | Number (Decimal) |


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### 3.5.83 DSSProfiler - Provider Peer Group Comparison Quarterly

The Peer Group Comparison Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar norm. All information is age and gender adjusted so that differences in patient mix do not affect the results. This report can look at professional service totals, professional referral totals, inpatient totals, outpatient referral totals and pharmacy totals. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

This report provides a rapid method to find which providers need to be analyzed more closely utilizing other reports within the DSSProfiler. The tabs in this report include:

A. Compare by Dollar Difference - contains information that is essential in comparing providers within the same specialty group;

B. Compare by Percent Difference - similar to the previous, except the difference is expressed as a percent;

C. Data - shows the raw data for all of the equations used in the compare by dollar difference report and the compare by percent difference report; and

D. Other Rankings - shows four rankings for the providers in this particular specialty group.

**Report Prompts (Search Criteria):**

- Provider Peer Group - The peer group to which the profiled provider is being compared;
- Aggregation Code - Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. Claims can be further aggregated by billing or servicing provider where the servicing provider is the performing, referring, attending or prescribing provider, depending on claim type;
- Report Category - User-defined variables used to categorize case types into service groups; and
- Quarter - The quarter for which the report is being run. In the field description section, the fields are listed according to which tab they are found.


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# Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/22/2006
Run Time: 11:13:07 AM

Provider Peer Group Comparison Qtrly
Compare By Dollar Difference

For Dates of Service: 07/01/2004 - 09/30/2004
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Report Category: 5 - Nursing Facility Services
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20043

| Rank | Raw Rank | Exp Rank | Provider ID | Provider Name | Dollar Difference from Expected | Number of Standard Deviations | Each * represent a $5000 Difference From Center Line. Rows in red indicate an Dollar Difference that is more than 2 standard deviations from the norm. 2 Standard Deviations = $10,827.26 | |
|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 1 | [redacted] | JOHN D SMITH - ALL BSE | $8,667.93 | 1.79 | | * |
| 2 | 3 | 4 | [redacted] | NEW HORIZON REHAB CLINIC - ALL BSE | $1,069.90 | 0.22 | | |
| 3 | 5 | 4 | [redacted] | GRACE COMMUNITY PHYSICAL THERAPY - ALL BSE | $(1,069.90) | -0.22 | | |
| 4 | 2 | 2 | [redacted] | COUNTRY MEDICAL CLINIC - ALL BSE | $(3,275.53) | -0.68 | | |
| 5 | 4 | 2 | [redacted] | WEST HILLS MEMORIAL - ALL BSE | $(5,392.41) | -1.11 | * | |

End of Report

# Alabama Medicaid Agency

User ID: Administrato
Run Date: 5/22/2006
Run Time: 11:13:07 AM

Provider Peer Group Comparison Qtrly
Compare By Percent Difference

For Dates of Service: 07/01/2004 - 09/30/2004
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Report Category: 5 - Nursing Facility Services
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20043

| Rank | Raw Rank | Exp Rank | Provider ID | Provider Name | Percent Difference from Expected | Number of Standard Deviations | Each * represents a 10% Difference From Center Line | |
|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 1 | [redacted] | JOHN D SMITH - ALL BSE | 86.91 % | 1.27 | | * * * * * * * * |
| 2 | 3 | 4 | [redacted] | NEW HORIZON REHAB CLINIC - ALL BSE | 65.05 % | 0.95 | | * * * * * * |
| 3 | 2 | 2 | [redacted] | COUNTRY MEDICAL CLINIC - ALL BSE | -45.17 % | -0.66 | * * * * | |
| 4 | 5 | 4 | [redacted] | GRACE COMMUNITY PHYSICAL THERAPY - ALL E | -65.05 % | -0.95 | * * * * * * | |
| 5 | 4 | 2 | [redacted] | WEST HILLS MEMORIAL - ALL BSE | -74.37 % | -1.09 | * * * * * * * | |

End of Report


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**Alabama Medicaid Agency**

Provider Peer Group Comparison Qtrly
Data

User ID: Administrator
Run Date: 5/22/2006
Run Time: 11:13:07 AM

For Dates of Service: 07/01/2004 - 09/30/2004
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Report Category: 5 - Nursing Facility Services
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20043

| Rank | Raw RANK | Exp Rank | Provider ID | Provider Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference | Recipient Count | Exception |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | 1 | 1[illegible] | JOHN D SMITH - ALL BSE | $17,500.00 | $19,932.57 | $18,641.57 | $9,973.64 | $8,667.93 | 86.91 % | 2 | |
| 2 | 3 | 4 | 1[illegible] | NEW HORIZON REHAB CLINIC - ALL BSE | $2,714.70 | $2,714.70 | $2,714.70 | $1,644.80 | $1,069.90 | 65.05 % | 1 | |
| 3 | 5 | 4 | 1[illegible] | GRACE COMMUNITY PHYSICAL THERAPY - ALL BSE | $1,004.90 | $1,004.90 | $574.90 | $1,644.80 | $(1,069.90) | -65.05 % | 1 | |
| 4 | 2 | 2 | 1[illegible] | COUNTRY MEDICAL CLINIC - ALL BSE | $2,000.00 | $3,975.60 | $3,975.60 | $7,251.13 | $(3,275.53) | -45.17 % | 1 | |
| 5 | 4 | 2 | 1[illegible] | WEST HILLS MEMORIAL - ALL BSE | $3,167.15 | $3,167.15 | $1,858.72 | $7,251.13 | $(5,392.41) | -74.37 % | 1 | |

End of Report

**Alabama Medicaid Agency**

Provider Peer Group Comparison Qtrly
Other Rankings

User ID: Administrator
Run Date: 5/22/2006
Run Time: 11:13:07 AM

For Dates of Service: 07/01/2004 - 09/30/2004
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Report Category: 5 - Nursing Facility Services
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20043

| Provider ID | Provider Name | Raw Rank | Claim Rank | Recip Rank | Quantity Rank | Dollar Difference | Number of Standard Deviations | Exception |
|---|---|---|---|---|---|---|---|---|
| [illegible] | JOHN D SMITH - ALL BSE | 1 | 1 | 1 | 1 | $8,667.93 | 1.79 | |
| [illegible] | NEW HORIZON REHAB CLINIC - ALL BSE | 3 | 3 | 2 | 3 | $1,069.90 | 0.22 | |
| [illegible] | GRACE COMMUNITY PHYSICAL THERAPY - ALL BSE | 5 | 3 | 2 | 3 | $(1,069.90) | -0.22 | |
| [illegible] | COUNTRY MEDICAL CLINIC - ALL BSE | 2 | 3 | 2 | 3 | $(3,275.53) | -0.68 | |
| [illegible] | WEST HILLS MEMORIAL - ALL BSE | 4 | 2 | 2 | 2 | $(5,392.41) | -1.11 | |

End of Report

### 3.5.83.1 DSSProfiler - Provider Peer Group Comparison Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Dollar Difference from Expected | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology). | 13 | Number (Decimal) |
| (B) Each * 10% difference | Each * represents a 10% Difference From Center Line. | 1 | Character |
| (A) Each * $ 5000 difference | Each * represents a $5000 Difference From Center Line. Rows in red represent a Dollar Difference that is more than 2 standard | 1 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | deviations from norm. 2 Standard Deviations = $ 10,827.26 | | |
| (A-B,D) Number of Standard Deviations | Represents the number of standard deviations that the provider's dollar difference was from the expected. | 8 | Number (Integer) |
| (A-C) Exp Rank | Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group. | 3 | Number (Integer) |
| (A-C) Rank | Recipient's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A-D) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-D) For Date of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Provider ID | Provider identification number. | 15 | Character |
| (A-D) Provider ID Aggregation Code | This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location. | 40 | Character |
| (A-D) Provider Name | Provider's full name. | 50 | Character |
| (A-D) Provider Peer Group | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A-D) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A-D) Raw Rank | Provider's rank based on the amount Provider was paid. | 3 | Number (Integer) |
| (A-D) Report Category | User-defined variables used to categorize case types into service groups. | 21 | Character |
| (B) Percent Difference from Expected | Percentage number that is the difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology). | 7 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (C) Allowed Amount | The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (C) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (C) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (C) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (C) Percent Difference | Percent number representing the difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology). | 8 | Number (Decimal) |
| (C) Recipient Count | An unduplicated count of recipients. | 6 | Number (Integer) |
| (C-D) Dollar Difference | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology). | 13 | Number (Decimal) |
| (C-D) Exception | This column is marked with a '*' when the case group is above the exception high value. | 1 | Character |
| (D) Claim Rank | Number of claims rank is based on Number of claims provider billed. | 3 | Number (Integer) |
| (D) Quantity Rank | Rank based on quantity billed. | 3 | Number (Integer) |
| (D) Recip Rank | Recipient rank is a rank based on Number of eligible recipients Provider serves in a specific time period. | 3 | Number (Integer) |


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### 3.5.84 DSSProfiler – Recipient Claim Details - FFS

Based on the user-entered date range of one year, this report shows claim details for a recipient who has been profiled. The detailed claims information is categorized by the individual case types applied to the recipient's claims. Additionally, procedures and diagnoses are displayed, as well as a list of billing and performing providers.

The detail reports are very helpful for additional analysis on individual recipients.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The report contains five tabs:

A. The Inpatient Details tab holds claim details for inpatient claims;

B. The Professional Details tab holds claim details for professional and dental claims;

C. The Nursing Facility Details tab holds claim details for nursing facility claims;

D. The Pharmacy Details tab holds claim details for pharmacy claims; and

E. The Outpatient Details tab holds claim details for outpatient claims.

**Search criteria:**

- Recipient ID as specified in the user prompt; and
- Claims Indicator as specified in the user prompt.

A

**Alabama Medicaid Agency**

Recipient Claim Details - FFS

Inpatient Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016

Recipient ID: 123456789012

Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X

User ID:

Run Date: 7/7/16

Run Time: 1:19:45 PM

| ICN | CT | DB # | FDOS | TDOS | Proc Cde | Proc Desc | Rev Cde | Rev Desc | ICD | Prim Diag | Diag Desc | Billing Provider IDs | Billing Provider Name | POS | Billed Qty | Billed Amt | Allwd Amt | Paid Amount | DRG Code & Desc | DRG Relative Weight | DRG Service Adjuster |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1234567890123 | I | 1 | 08/12/2015 | 08/15/2015 | ##### | Unknown or Not Applicable | 0120 | Room and board/semi-private | 9 | 486 | PNEUMONIA, ORGANISM UNSPECIFIED | NPI ID: Medicaid ID: Base ID: | UNIVERSITY OF ALABAMA | 21 | 3 | $12,322.89 | $4,011.28 | $4,011.28 | 0481 - Nerve Disorders | 0.59 | 1 |
| 1234567890123 | I | 2 | 08/12/2015 | 08/15/2015 | ##### | Unknown or Not Applicable | 0250 | Pharmacy | 9 | 486 | PNEUMONIA, ORGANISM UNSPECIFIED | NPI ID: Medicaid ID: Base ID: | UNIVERSITY OF ALABAMA | 21 | 10 | $1,324.22 | $0.00 | $0.00 | 0481 - Nerve Disorders | 0.59 | 1 |

PHI has been removed

End of Report


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B

## Alabama Medicaid Agency

**Recipient Claim Details - FFS**
**Professional Claim Details**
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X

User ID:
Run Date: 8/19/16
Run Time: 9:57:57 AM

| ICN | CT | Dtl # | FDOS | TDOS | Proc Cde | Proc Desc | TOS | Rev Cde | Rev Desc | ICD | Prim Diag | Diag Desc | Billing Provider IDs | Billing Provider Name | POS | Billed Qty | Billed Amt | Allwd Amt | Paid Amt | Wrap Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1234567890123 | M | 1 | 10/6/2015 | 10/6/2015 | H0032 | Mh Svc Plan Dev By Non-Md | 9 | #### | Unknown or Not Applicable | 0 | F200 | PARANOID SCHIZOPHRENIA | NPI ID: Medicaid ID: Base ID: | DEPT OF MNTL HLTH & MNTL RTR | 11 | 1 | $22.00 | $22.00 | $22.00 | Y |

End of Report

PHI has been removed

C

## Alabama Medicaid Agency

**Recipient Claim Details - FFS**
**Nursing Facility Claim Details**
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X

User ID:
Run Date: 7/11/16
Run Time: 4:54:34 PM

| ICN | CT | Dtl # | FDOS | TDOS | Proc Cde | Proc Desc | TOS | Rev Cde | Rev Desc | ICD | Prim Diag | Diag Desc | Billing Provider Ids | Billing Provider Name | POS | Billed Qty | Billed Amt | Allwd Amt | Paid Amt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1234567890123 | L | 1 | 1/1/2016 | 1/31/2016 | ###### | Unknown or Not Applicable | # | 0101 | All Incl Room And Board | 0 | M6281 | MUSCLE WEAKNESS (GENERALIZED) | NPI ID: Medicaid ID: Base ID: | RIVER CITY CARE AND REHABILITATIO N CENTER | 31 | 31 | $1,064.22 | $5,541.56 | $4,739.56 |
| 1234567890123 | L | 1 | 4/1/2016 | 4/30/2016 | ###### | Unknown or Not Applicable | # | 0101 | All Incl Room And Board | 0 | M6281 | MUSCLE WEAKNESS (GENERALIZED) | NPI ID: Medicaid ID: Base ID: | RIVER CITY CARE AND REHABILITATIO N CENTER | 31 | 30 | $1,064.22 | $5,362.80 | $4,560.80 |
| 1234567890123 | L | 1 | 9/25/2015 | 9/30/2015 | ###### | Unknown or Not Applicable | # | 0101 | All Incl Room And Board | 9 | V5789 | CARE INVOLVING OTHER SPECIFIED REHABILIT | NPI ID: Medicaid ID: Base ID: | RIVER CITY CARE AND REHABILITATIO N CENTER | 31 | 6 | $1,064.22 | $1,064.22 | $903.82 |

PHI has been removed

End of Report

D

## Alabama Medicaid Agency

**Recipient Claim Details - FFS**
**Pharmacy Claim Details**
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X

User ID:
Run Date: 7/11/16
Run Time: 5:26:05 PM

| ICN | CT | Dtl # | Dispense Date | NDC | NDC Desc | DEA | GPI | AHFS | AHFS Desc | Billing Provider IDs | Billing Provider Name | POS | Dispense Qty | Billed Amt | Allwd Amt | Paid Amt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1234567890123 | P | 1 | 01/12/2016 | 51672403201 | WARFARIN SODIUM | 0 | 1 | 2012040 | COUMARIN DERIVATIVES | NPI ID: Medicaid ID: Base ID: | CITY PHARMACY | 00 | 30.000 | $23.65 | $10.60 | $14.59 |
| 1234567890123 | P | 1 | 01/12/2016 | 51672403201 | HYDROCODONE-ACETAMINOPHEN | 3 | 1 | 2808080 | OPIATE AGONISTS | NPI ID: Medicaid ID: Base ID: | CITY PHARMACY | 00 | 30.000 | $19.10 | $10.64 | $14.63 |

End of Report

PHI has been removed


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E

**Alabama Medicaid Agency**

**Recipient Claim Details - Encounters**
**Outpatient Claim Details**
**For Dates of Service: 07/01/2015 - 06/30/2016**
**Recipient ID: 123456789012**
**Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXX**

**User ID:**
**Run Date: 7/7/16**
**Run Time: 11:25:20 AM**

| ICN | CT | Dtl # | FDOS | TDOS | Proc Cde | Proc Desc | TOS | Rev Cde | Rev Desc | ICD | Prim Diag | Diag Desc | Billing Provider IDs | Billing Provider Name | POS | Billed Qty | Billed Amt | Alwd Amt | Paid Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1234567890123 | O | 1 | 6/1/2016 | 6/1/2016 | J0690 | Cefazolin Sodium Injection | 1 | 0636 | Drugs-Detail Coding | 0 | R5600 | SIMPLE FEBRILE CONVULSIONS | NPI ID: Medicaid ID: Base ID: | UNIVERSITY OF ALABAMA | 22 | 2 | $615.00 | $1.78 | $1.78 |
| 1234567890123 | O | 1 | 6/1/2016 | 6/1/2016 | J1885 | Ketorolac Tromethamine Inj | 1 | 0636 | Drugs-Detail Coding | 0 | R5600 | SIMPLE FEBRILE CONVULSIONS | NPI ID: Medicaid ID: Base ID: | UNIVERSITY OF ALABAMA | 22 | 4 | $510.00 | $1.96 | $1.96 |
| 1234567890123 | O | 1 | 6/1/2016 | 6/1/2016 | J2250 | Inj Midazolam Hydrochloride | 1 | 0636 | Drugs-Detail Coding | 0 | R5600 | SIMPLE FEBRILE CONVULSIONS | NPI ID: Medicaid ID: Base ID: | UNIVERSITY OF ALABAMA | 22 | 2 | $337.50 | $0.26 | $0.26 |

**End of Report**

PHI has been removed

### 3.5.84.1 DSSProfiler – Recipient Claim Details - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-C,E) Billed Qty | Quantity billed. | 4 | Number (Integer) |
| (A-C,E) Diag Desc | The primary ICD-CM diagnosis code description. | 60 | Character |
| (A-C,E) FDOS | Claim's first date of service. | 10 | Date (MM/DD/CCYY) |
| (A-C,E) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. | 1 | Character |
| (A-C,E) POS | Place of Service code for where service is rendered. | 2 | Number (Integer) |
| (A-C,E) Prim Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A-C,E) Proc Cde | Procedure code on the detail. | 6 | Character |
| (A-C,E) Proc Desc | Description of the Procedure code on the detail. | 40 | Character |
| (A-C,E) Rev Cde | Revenue Code on the detail. | 5 | Character |
| (A-C,E) Rev Desc | Description of the Revenue code on the detail. | 70 | Character |
| (A-C,E) TDOS | Claim's last date of service. | 10 | Date (MM/DD/CCYY) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-E) Dates of Service | The Profiler dates of services. | 20 | Date (MM/DD/CCYY) |
| (A-D) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-D) Run Time | The time that the report was executed. | 11 | Character |
| (A-D) User ID | The user that created the report. | 50 | Character |
| (A-E) Allwd Amnt | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-E) Billed Amt | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-E) Billing Provider IDs | Lists the NPI, Medicaid, and Base ID for the billing Provider. | 63 | Character |
| (A-E) Billing Provider Name | Billing Provider name. | 63 | Character |
| (A-E) CT | Shows what type of claim was submitted. | 2 | Character |
| (A-E) Dtl # | Claim line number. | 4 | Number (Integer) |
| (A-E) DRG Code and Description | Diagnosis Related Group Number assigned to the claim, and its description. | 60 | Character |
| (A-E) DRG Relative Weight | Relative weight for pricing DRG | 5 | Number (Decimal) |
| (A-E) DRG Service Adjuster | This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor | 3 | Number (Decimal) |
| (A-E) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A-E) Paid Amt | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-E) Recipient Full Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A-E) Recipient ID | Recipient Medicaid Number | 12 | Character |
| (A) Wrap Ind | Wrap Payment Indicator | 1 | Character |
| (B,CE) TOS | Claim Type of Service. | 4 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (D) AHFS | Therapeutic class code. | 8 | Number (Integer) |
| (D) AHFS Desc | Description of the therapeutic class code. | 55 | Character |
| (D) DEA | Drug Enforcement Agency (DEA) Code | 3 | Character |
| (D) Dispense Date | Date the prescription was dispensed by the provider. | 20 | Date (MM/DD/CCYY) |
| (D) Dispense Qty | Number of units of a drug dispensed to a member. | 10 | Number (Integer) |
| (D) GPI | Generic Product Indicator (GPI) distinguishes a product either as a generic drug product (1) or a more expensive branded drug product (2). | 1 | Number (Integer) |
| (D) NDC | National Drug Code | 11 | Number (Integer) |
| (D) NDC Description | National Drug Code (NDC) description/name. | 35 | Character |


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### 3.5.85 DSSProfiler – Recipient Claim Details Quarterly - FFS

Based on the user-entered date range of one quarter, this report shows claim details for a recipient who has been profiled. The claims are broken out by claim type and case type. The Professional Details tab includes claim details for professional or dental claims. The Outpatient Details tab included outpatient claim details. The Inpatient Details tab includes inpatient claim details. The Pharmacy Details tab includes drug claim details. Nursing Facility tab includes nursing facility claim details.

The detail reports are very helpful for additional analysis on individual recipients.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The report contains five tabs:

A. The Professional Details tab holds claim details for professional and dental claims;

B. The Outpatient Details tab holds claim details for outpatient claims;

C. The Inpatient Details tab holds claim details for inpatient claims;

D. The Pharmacy Details tab holds claim details for pharmacy claims; and

E. The Nursing Facility Details tab holds claim details for nursing facility claims.

**Search criteria:**

- Recipient ID as specified in the user prompt; and
- Claims Indicator as specified in the user prompt.

A

**Alabama Medicaid Agency**

Recipient Claim Details Qtrly - FFS
Inpatient Claim Details
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X
Quarter: 20162

User ID:
Run Date: 7/7/16
Run Time: 1:19:45 PM

| ICN | CT | DB # | FDOS | TDOS | Proc Cde | Proc Desc | Rev Cde | Rev Desc | ICD | Prim Diag | Diag Desc | Billing Provider IDs | Billing Provider Name | POS | Billed Qty | Billed Amt | Allwd Amt | Paid Amount | DRG Code & Desc | DRG Relative Weight | DRG Service Adjuster |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 123456789012 | I | 1 | 08/12/2015 | 08/15/2015 | ##### | Unknown or Not Applicable | 0120 | Room and board/semi-private | 9 | 486 | PNEUMONIA, ORGANISM UNSPECIFIED | NPI ID: Medicaid ID: Base ID: 1 | UNIVERSITY OF ALABAMA | 21 | 3 | $12,322.89 | $4,011.26 | $4,011.26 | 0481 - Nerve Disorders | 0.59 | 1 |
| 123456789012 | I | 2 | 08/12/2015 | 08/15/2015 | ##### | Unknown or Not Applicable | 0250 | Pharmacy | 9 | 486 | PNEUMONIA, ORGANISM UNSPECIFIED | NPI ID: Medicaid ID: Base ID: | UNIVERSITY OF ALABAMA | 21 | 10 | $1,324.22 | $0.00 | $0.00 | 0481 - Nerve Disorders | 0.59 | 1 |

PHI has been removed

End of Report


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B

## Alabama Medicaid Agency

**Recipient Claim Details Qtrly - FFS**
**Pharmacy Claim Details**
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X
Quarter: 20161

User ID:
Run Date: 7/11/16
Run Time: 5:26:05 PM

| ICN | CT | Dtl # | Dispense Date | NDC | NDC Desc | DEA | GPI | AHFS | AHFS Desc | Billing Provider IDs | Billing Provider Name | POS | Dispense Qty | Billed Amt | Allwd Amt | Paid Amt | Wrap Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1234567890123 | P | 1 | 01/12/2016 | 51672403201 | WARFARIN SODIUM | D | 1 | 2012040 | COUMARIN DERIVATIVES | NPI ID: Medicaid ID: Base ID: | CITY PHARMACY | 00 | 30.000 | $23.65 | $10.60 | $14.59 | Y |
| 1234567890123 | P | 1 | 01/12/2016 | 51672403201 | HYDROCODONE-ACETAMINOPHEN | 3 | 1 | 2808080 | OPIATE AGONISTS | NPI ID: Medicaid ID: Base ID: | CITY PHARMACY | 00 | 30.000 | $19.10 | $10.64 | $14.63 | N |

End of Report

PHI has been removed

C

## Alabama Medicaid Agency

**Recipient Claim Details Qtrly - FFS**
**Nursing Facility Claim Details**
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X
Quarter: 20161

User ID:
Run Date: 7/11/16
Run Time: 5:26:05 PM

| ICN | CT | Dtl # | FDOS | TDOS | Proc Cde | Proc Desc | TOS | Rev Cde | Rev Desc | ICD | Prim Diag | Diag Desc | Billing Provider Ids | Billing Provider Name | POS | Billed Qty | Billed Amt | Allwd Amt | Paid Amt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1234567890123 | L | 1 | 1/1/2016 | 1/31/2016 | ###### | Unknown or Not Applicable | # | 0101 | All Incl Room And Board | 0 | M6281 | MUSCLE WEAKNESS (GENERALIZED) | NPI ID: Medicaid ID: Base ID: 1 | RIVER CITY CARE AND REHABILITATIO N CENTER | 31 | 31 | $1,064.22 | $5,541.56 | $4,739.56 |

PHI has been removed

End of Report

D

## Alabama Medicaid Agency

**Recipient Claim Details Qtrly - FFS**
**Pharmacy Claim Details**
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X
Quarter: 20161

User ID:
Run Date: 7/11/16
Run Time: 5:26:05 PM

| ICN | CT | Dtl # | Dispense Date | NDC | NDC Desc | DEA | GPI | AHFS | AHFS Desc | Billing Provider IDs | Billing Provider Name | POS | Dispense Qty | Billed Amt | Allwd Amt | Paid Amt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1234567890123 | P | 1 | 01/12/2016 | 51672403201 | WARFARIN SODIUM | D | 1 | 2012040 | COUMARIN DERIVATIVES | NPI ID: Medicaid ID: Base ID: | CITY PHARMACY | 00 | 30.000 | $23.65 | $10.60 | $14.59 |
| 1234567890123 | P | 1 | 01/12/2016 | 51672403201 | HYDROCODONE-ACETAMINOPHEN | 3 | 1 | 2808080 | OPIATE AGONISTS | NPI ID Medicaid ID: Base ID: | CITY PHARMACY | 00 | 30.000 | $19.10 | $10.64 | $14.63 |

End of Report

PHI has been removed


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**Alabama Mediciad Agency**

**Recipient Claim Details Qtrly - FFS**
**Outpatient Claim Details**
**For Dates of Service: 07/01/2015 - 06/30/2016**
**Recipient ID: 123456789012**
**Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXX**

**User ID:**
**Run Date: 7/7/16**
**Run Time: 1:19:45 PM**

| ICN | CT | Dtl # | FDOS | TDOS | Proc Cde | Proc Desc | TOS | Rev Cde | Rev Desc | ICD | Prim Diag | Diag Desc | Billing Provider IDs | Billing Provider Name | POS | Billed Qty | Billed Amt | Allwd Amt | Paid Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1234567890123 | O | 1 | 6/1/2016 | 6/1/2016 | J0690 | Cefazolin Sodium Injection | 1 | 0636 | Drugs-Detail Coding | 0 | R5600 | SIMPLE FEBRILE CONVULSIONS | NPI ID: Medicaid ID: Base ID | UNIVERSITY OF ALABAMA | 22 | 2 | $615.00 | $1.78 | $1.78 |
| 1234567890123 | O | 1 | 6/1/2016 | 6/1/2016 | J1885 | Ketorolac Tromethamine Inj | 1 | 0636 | Drugs-Detail Coding | 0 | R5600 | SIMPLE FEBRILE CONVULSIONS | NPI ID: Medicaid ID: Base ID: | UNIVERSITY OF ALABAMA | 22 | 4 | $510.00 | $1.96 | $1.96 |
| 1234567890123 | O | 1 | 6/1/2016 | 6/1/2016 | J2250 | Inj Midazolam Hydrochloride | 1 | 0636 | Drugs-Detail Coding | 0 | R5600 | SIMPLE FEBRILE CONVULSIONS | NPI ID: Medicaid ID: Base ID: | UNIVERSITY OF ALABAMA | 22 | 2 | $337.50 | $0.26 | $0.26 |

PHI has been removed

**End of Report**

### 3.5.85.1 DSSProfiler – Recipient Claim Details Quarterly - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-C,E) Billed Qty | Quantity billed. | 4 | Number (Integer) |
| (A-C,E) Diag Desc | The primary ICD-CM diagnosis code description. | 60 | Character |
| (A-C,E) FDOS | Claim's first date of service. | 10 | Date (MM/DD/CCYY) |
| (A-C,E) ICD Version for Diagnosis 1 | The ICD Version code for the primary ICD-CM payment level diagnosis code. | 1 | Character |
| (A-C,E) POS | Place of Service code for where service is rendered. | 2 | Number (Integer) |
| (A-C,E) Prim Diag | The primary ICD-CM diagnosis code. | 7 | Character |
| (A-C,E) Proc Cde | Procedure code on the detail. | 5 | Character |
| (A-C,E) Proc Desc | Description of the Procedure code on the detail. | 40 | Character |
| (A-C,E) Rev Cde | Revenue Code on the detail. | 5 | Character |
| (A-C,E) Rev Desc | Description of the Revenue code on the detail. | 70 | Character |
| (A-C,E) TDOS | Claim's last date of service. | 10 | Date (MM/DD/CCYY) |
| (A-E) Dates of Service | The Profiler dates of services. | 20 | Date (MM/DD/CCYY) |
| (A-D) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-D) Run Time | The time that the report was executed. | 11 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-D) User ID | The user that created the report. | 50 | Character |
| (A-E) Allwd Amnt | The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-E) Billed Amt | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-E) Billing Provider IDs | Lists the NPI, Medicaid, and Base ID for the billing Provider. | 63 | Character |
| (A-E) Billing Provider Name | Billing Provider name. | 63 | Character |
| (A-E) CT | Shows what type of claim was submitted. | 2 | Character |
| (A-E) Dtl # | Claim line number. | 4 | Number (Integer) |
| (A-E) DRG Code and Description | Diagnosis Related Group Number assigned to the claim, and its description. | 60 | Character |
| (A-E) DRG Relative Weight | Relative weight for pricing DRG | 5 | Number (Decimal) |
| (A-E) DRG Service Adjuster | This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor | 3 | Number (Decimal) |
| (A-E) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| (A-E) Paid Amt | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-E) Recipient Full Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A-E) Quarter (prompt) | The quarter for which the report is being run for. | 5 | Number (Integer) |
| (A-E) Recipient ID | Recipient Medicaid Number | 12 | Character |
| (B) Wrap Ind | Wrap Payment Indicator | 1 | Character |
| (B,CE) TOS | Claim Type of Service. | 4 | Number (Integer) |
| (D) AHFS | Therapeutic class code. | 8 | Number (Integer) |
| (D) AHFS Desc | Description of the therapeutic class code. | 55 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (D) DEA | Drug Enforcement Agency (DEA) Code | 3 | Character |
| (D) Dispense Date | Date the prescription was dispensed by the provider. | 20 | Date (MM/DD/CCYY) |
| (D) Dispense Qty | Number of units of a drug dispensed to a member. | 10 | Number (Integer) |
| (D) GPI | Generic Product Indicator (GPI) distinguishes a product either as a generic drug product (1) or a more expensive branded drug product (2). | 1 | Number (Integer) |
| (D) NDC | National Drug Code | 11 | Number (Integer) |
| (D) NDC Description | National Drug Code (NDC) description/name. | 35 | Character |


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### 3.5.86 DSSProfiler - Recipient Exception Quarterly

The Recipient Exception Profile QTR report is created in the DSSProfiler. This report shows recipient exception trending for a period of 12 months by quarter.

The report contains six tabs:

A. The Inpatient tab holds claim details for inpatient claims;

B. The Nursing Facility tab holds claim details for nursing facility claims;

C. The Outpatient tab holds claim details for outpatient claims;

D. The Pharmacy tab holds claim details for pharmacy claims;

E. The Professional tab holds claim details for professional and dental claims; and

F. The Professional Referrals tab holds claim details for professional referral related claims.

A

**Alabama Medicaid Agency**

Recipient Exception Quarterly

Inpatient

For Dates of Service: 01/01/2006 - 12/31/2006

Recipient:

735 GABLE DRIVE
BIRMINGHAM, AL 35215-0000
37 - Jefferson

User ID:
Run Date: 11/5/2007
Run Time: 1:27:50 PM

Peer Group Code: 865 - 52 SOBRA Child(KB) with no money ! 133%FP + full Mcaid
Aggregation Code: 8 - Encounter Claims by Recipient

| | 20062 |
|---|---|
| 1835 - AL Number of Drug Poison Diagnosis H: 003 L: 000 | 8.00 |

End of Report


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**B**

# Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 3:01:01 PM

Recipient Exception Quarterly
Nursing Home
For Dates of Service: 01/01/2006 - 12/31/2006
Recipient:
DECATUR HEALTH/REHAB
P O BOX 1821
DECATUR, AL 35602-0000
52 - Morgan
Peer Group Code: 805 - 16 Aged-D.O. with no money + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

| | 20061 | | 20062 | | 20064 | |
|---|---|---|---|---|---|---|
| 1824 - AL Number of Syncope and Collapse H: 003 L: 000 | 1.00 | | 2.00 | | 2.00 | |

End of Report

**C**

# Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 3:05:56 PM

Recipient Exception Quarterly
Outpatient
For Dates of Service: 01/01/2006 - 12/31/2006
Recipient:
8810 4TH AVE N
BIRMINGHAM, AL 35206-2126

37 - Jefferson
Peer Group Code: 846 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

| | 20061 | |
|---|---|---|
| 1710 - CMS Number of Emergency Room Visits H: 002 L: 000 | 1.00 | |
| 1720 - CMS Average Number of ER Visits per Provider H: 005 L: 000 | 1.00 | |


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**D**

## Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/5/2007
Run Time: 3:09:11 PM

Recipient Exception Quarterly
Pharmacy

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient: [redacted]
P O BOX 581
BREWTON, AL 36427-0000

27 - Escambia
Peer Group Code: 864 - 51 SOBRA Child(KM) with no money ! 100%FP + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

| | 20064 | |
|---|---|---|
| 1610 - CMS Amount Paid for Narcotic Drugs H: 005 L: 000 | 36.83 | * |
| 1620 - CMS Amount Paid for Antibiotic Drugs H: 005 L: 000 | 9.07 | * |
| 1770 - CMS Amount Paid for All Drugs H: 005 L: 000 | 45.90 | * |
| 1790 - CMS Number of Prescriptions Filled H: 005 L: 000 | 6.00 | * |

End of Report

**E**

## Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/5/2007
Run Time: 3:21:49 PM

Recipient Exception Quarterly
Professional

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient: [redacted]
510 N 3RD AVE
HARTFORD, AL 36344-1904

31 - Geneva
Peer Group Code: 804 - 15 Aged-SSI with OMB Plus + full Mcaid OMB
Aggregation Code: 7 - Fee For Service Claims by Recipient

| | 20061 | |
|---|---|---|
| 1833 - AL Number of Headache Diagnosis H: 004 L: 000 | 1.00 | |

End of Report


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F

**Alabama Medicaid Agency**

Recipient Exception Quarterly
Professional Referrals
For Dates of Service: 01/01/2006 - 12/31/2006
Recipient: [redacted]
880 FREEMAN DRIVE
DADEVILLE, AL 36853-2116

62 - Tallapoosa
Peer Group Code: 832 - 36 MLIF-Adult with no money + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

User ID: [redacted]
Run Date: 11/5/2007
Run Time: 3:33:49 PM

| | 20062 |
|---|---|
| 1710 - CMS Number of Emergency Room Visits H: 002 L: 000 | 1.00 |
| 1720 - CMS Average Number of ER Visits per Provider H: 005 L: 000 | 1.00 |
| 1829 - AL Number of Malaise and Fatigue H: 006 L: 000 | 1.00 |

End of Report

### 3.5.86.1 DSSProfiler - Recipient Exception Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-F) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-F) Calculation | Calculation to find case groups above the exception high. | 14 | Number (Decimal) |
| (A-F) Case Type Group Display | Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item. | 4 | Number (Integer) |
| (A-F) Exception | This column is marked with a '*' when the case group is above the exception high value. | 1 | Character |
| (A-E) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-F) Peer Group Code | User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category. | 20 | Character |
| (A-F) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A-F) Recipient | Unique identifier for the recipient. | 12 | Character |


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### 3.5.87 DSSProfiler - Recipient Frequency Distribution

The Recipient Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one year, this report shows for each inpatient, pharmacy, nursing facility, professional services, professional referrals and outpatient case types, peer grouping, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of recipients reported within a case type, peer grouping.

The report contains five tabs:

A. The Inpatient tab holds claim details for inpatient claims;

B. The Pharmacy tab holds claim details for pharmacy claims;

C. The Nursing Facility tab holds claim details for nursing facility claims;

D. The Professional Services tab holds claim details for professional and dental claims;

E. The Professional Referrals tab holds claim details for professional referrals; and

F. The Outpatient tab holds claim details for outpatient claims.

**A**

**Alabama Medicaid Agency**

**Recipient Frequency Distribution**
**Inpatient**
**For Dates of Service: 01/01/06 - 12/31/06**
**Recipient Peer Group Code: 971 - 41 Disabled-SSI- full Mcaid**
**Recipient Aggregation Code: 7 - Fee For Service Claims by Recipient**

**User ID:** [redacted]
**Run Date:** 9/27/2007
**Run Time:** 11:19:51 AM

**Case Type : 1054 - AL Drug Poison Diagnosis**

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 1 | 1 | 1 |

**Case Type : 3 - Morbidity 1**

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 1 | 1 | 1 |


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**B**

## Alabama Medicaid Agency

User ID:
Run Date: 9/27/2007
Run Time: 11:19:58 AM

Recipient Frequency Distribution
Pharmacy

For Dates of Service: 01/01/06 - 12/31/06
Recipient Peer Group Code: 971 - 41 Disabled-SSI- full Mcaid
Recipient Aggregation Code: 7 - Fee For Service Claims by Recipient

Case Type : 1060 - AL Duragesic Drug Codes

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 2 | 3 | 3 | 4 |

Case Type : 1061 - AL Adderall Drug Codes

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 2 | 3 | 3 | 4 |

**C**

## Alabama Medicaid Agency

User ID:
Run Date: 9/27/2007
Run Time: 11:23:35 AM

Recipient Frequency Distribution
Nursing Facility
For Dates of Service: 01/01/06 - 12/31/06
Recipient Peer Group Code: 971 - 41 Disabled-SSI- full Mcaid
Recipient Aggregation Code: 7 - Fee For Service Claims by Recipient

Case Type : 3 - Morbidity 1

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 2 | 3 | 3 | 6 | 7 |

Case Type : 4 - Morbidity 2

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 2 | 3 | 3 | 5 | 6 |


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**D**

# Alabama Medicaid Agency

User ID:
Run Date: 9/27/2007
Run Time: 11:23:38 AM

**Recipient Frequency Distribution**

**Professional Services**

**For Dates of Service: 01/01/06 - 12/31/06**

**Recipient Peer Group Code: 971 - 41 Disabled-SSI- full Mcaid**

**Recipient Aggregation Code: 7 - Fee For Service Claims by Recipient**

**Case Type : 1000 - AL Dormicilla Procedures**

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 2 | 3 | 4 | 5 |

**Case Type : 1002 - AL Biospy Procedures**

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 1 | 1 | 2 |

**E**

# Alabama Medicaid Agency

User ID
Run Date: 9/27/2007
Run Time: 11:34:51 AM

**Recipient Frequency Distribution**

**Professional Referrals**

**For Dates of Service: 01/01/06 - 12/31/06**

**Recipient Peer Group Code: 971 - 41 Disabled-SSI- full Mcaid**

**Recipient Aggregation Code: 7 - Fee For Service Claims by Recipient**

**Case Type : 1000 - AL Dormicilla Procedures**

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 2 | 3 | 4 | 4 |

**Case Type : 1002 - AL Biospy Procedures**

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 1 | 1 | 2 |


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F

**Alabama Medicaid Agency**

Recipient Frequency Distribution
Outpatient

For Dates of Service: 01/01/06 - 12/31/06
Recipient Peer Group Code: 971 - 41 Disabled-SSI- full Mcaid
Recipient Aggregation Code: 7 - Fee For Service Claims by Recipient

User ID:
Run Date: 9/27/2007
Run Time: 11:21:26 AM

Case Type : 1039 - AL Genitourinary Diagnosis

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 2 | 3 | 4 |

Case Type : 1040 - AL Maternity Diagnosis

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 3 | 3 | 3 |

### 3.5.87.1 DSSProfiler - Recipient Frequency Distribution Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-F) 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| (A-F) 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| (A-F) 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| (A-F) 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |
| (A-F) 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| (A-F) 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |
| (A-F) Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| (A-F) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-F) Recipient Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-F) Recipient Peer Group Code | Recipient Peer Group Code. | 40 | Character |


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### 3.5.88 DSSProfiler - Recipient Frequency Distribution Quarterly

Based on the user-entered date range of one quarter, this report displays recipient claim counts for each claim type service by percentile for the selected peer groups and aggregation types. Each percentile represents a percentage of the number of recipients with claims in the specific case type grouping. The percentile groups are determined by ordering recipients by the number of paid claims each has for the case type and then grouping the recipients into the percentiles starting with the recipient with the least number of claims. The claim count displayed for each percentile represents the maximum number of claims for any recipient falling in the percentile.

The report contains six tabs:

A. The Inpatient tab holds claim details for inpatient claims;

B. The Pharmacy tab holds claim details for pharmacy claims;

C. The Nursing Facility tab holds claim details for nursing facility claims;

D. The Professional Services tab holds claim details for professional and dental claims;

E. The Professional Referrals tab holds claims details for professional referral related claims; and

F. The Outpatient tab holds claim details for outpatient claims.

A

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 11/5/2007
Run Time: 9:18:05 AM

Recipient Frequency Distribution Qtrly
Inpatient
For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group Code: 800 - 11 Aged-SSI-full Medicaid coverage
Recipient Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20061

Case Type: 3 - Morbidity 1

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 8 | 8 | 9 | 9 | 11 | 11 |

Case Type: 4 - Morbidity 2

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 13 | 13 | 14 | 23 | 23 | 23 |

Case Type: 5 - Morbidity 3

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 29 | 29 | 29 | 29 | 29 | 29 |


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B

# Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 9:18:44 AM

Recipient Frequency Distribution Qtrly
Pharmacy
For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group Code: 800 - 11 Aged-SSI-full Medicaid coverage
Recipient Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20061

Case Type: 176 - CMS Narcotic Drugs

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 3 | 4 | 4 |

Case Type: 3 - Morbidity 1

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 4 | 4 | 4 | 4 | 4 | 4 |

Case Type: 4 - Morbidity 2

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 4 | 4 | 4 |

C

# Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 9:18:50 AM

Recipient Frequency Distribution Qtrly
Nursing Facility
For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group Code: 800 - 11 Aged-SSI-full Medicaid coverage
Recipient Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20061

Case Type: 4 - Morbidity 2

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 2 | 2 | 2 |

Case Type: 5 - Morbidity 3

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 3 | 3 | 3 | 3 | 3 | 3 |

End of Report


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D

# Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 9:18:51 AM

Recipient Frequency Distribution Qtrly
Professional Services
For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group Code: 800 - 11 Aged-SSI-full Medicaid coverage
Recipient Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20061

Case Type: 1078 - AL Number of Dizziness and Giddiness Diagnoses

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 2 | 2 | 2 | 2 | 2 | 2 |

Case Type: 1079 - AL Number of Syncope and Collapse Diagnoses

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 1 | 4 | 4 |

Case Type: 1080 - AL Number of Abdominal Pain Diagnoses

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 2 | 2 | 3 | 3 |

E

# Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 9:18:56 AM

Recipient Frequency Distribution Qtrly
Professionals Referral
For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group Code: 800 - 11 Aged-SSI-full Medicaid coverage
Recipient Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20061

Case Type: 1082 - AL Number of Office Visits

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 1 | 2 | 2 |

Case Type: 3 - Morbidity 1

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 1 | 1 | 1 |

Case Type: 4 - Morbidity 2

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 1 | 2 | 8 | 8 |


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F

# Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 9:18:48 AM

Recipient Frequency Distribution Qtrly
Outpatient
For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group Code: 800 - 11 Aged-SSI-full Medicaid coverage
Recipient Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20061

Case Type : 1079 - AL Number of Syncope and Collapse Diagnoses

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 17 | 17 | 17 | 17 | 17 | 17 |

Case Type : 1082 - AL Number of Office Visits

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 1 | 1 | 2 | 2 | 2 | 2 |

Case Type : 1085 - AL Number of Malaise and Fatigue Diagnoses

| | 10% | 25% | 50% | 75% | 90% | 95% |
|---|---|---|---|---|---|---|
| Claim Count at each % | 19 | 19 | 19 | 19 | 19 | 19 |

### 3.5.88.1 DSSProfiler - Recipient Frequency Distribution Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| 10% | Distribution of services within 10th percentile. | 4 | Number (Decimal) |
| 25% | Distribution of services within 25th percentile. | 4 | Number (Decimal) |
| 50% | Distribution of services within 50th percentile. | 4 | Number (Decimal) |
| 75% | Distribution of services within 75th percentile. | 4 | Number (Decimal) |
| 90% | Distribution of services within 90th percentile. | 4 | Number (Decimal) |
| 95% | Distribution of services within 95th percentile. | 4 | Number (Decimal) |
| Case Type | User defined group based on the case type file. The claim grouping should be specific to the area of service. | 100 | Character |
| Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Recipient Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| Recipient Peer Group Code | Recipient Peer Group Code. | 40 | Character |


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### 3.5.89 DSSProfiler - Recipient Peer Group Comparison

The Recipient Peer Group Comparison report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all recipients within a peer group to determine which recipients fall outside of service dollar norms. All information is age and gender adjusted so that differences in patient mix do not affect the results. This report can look at professional service totals, professional referral totals, inpatient referral totals, outpatient referrals and pharmacy totals. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

This report provides a rapid method to find which recipients need to be analyzed more closely utilizing other reports within the DSSProfiler.

The tabs in this report include:

A. Compare by Dollar Difference - Contains information that is essential in comparing recipients within the same group;

B. Compare by Percent Difference - Similar to the previous, except the difference is expressed as a percent; and

C. Data - Shows the raw data for all of the equations used in the compare by dollar difference report and the compare by percent difference report.

A

**Alabama Medicaid Agency**

Recipient Peer Group Comparison
Compare by Dollar Difference

User ID:
Run Date: 10/4/2007
Run Time: 11:26:50 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient Peer Group: 961 - 3A Breast and Cervical Cancer + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Report Category: 1 - Professional Services

| Line # | Raw Rank | Recipient ID | Recipient Full Name | Dollar Difference From Expected | Number of Standard Deviations | Each * represent a $5000 Difference From Center Line. Rows in red indicate a Dollar Difference that is more that 2 standard deviations from the norm. 2 Standard Deviations = $8,755.09 |
|---|---|---|---|---|---|---|
| 1 | 1 | | | $45,075.51 | 10.30 | ********** |
| 2 | 2 | | | $24,111.37 | 5.51 | ***** |
| 3 | 4 | | | $20,218.57 | 4.62 | ***** |
| 4 | 5 | | | $18,811.99 | 4.30 | **** |
| 5 | 6 | | | $16,550.78 | 3.78 | **** |
| 6 | 7 | | | $15,220.94 | 3.48 | **** |
| 7 | 8 | | | $14,082.30 | 3.22 | *** |
| 8 | 9 | | | $11,818.07 | 2.70 | *** |
| 9 | 10 | | | $11,528.42 | 2.63 | *** |
| 10 | 3 | | | $11,048.73 | 2.52 | *** |
| 11 | 14 | | | $9,284.16 | 2.12 | ** |
| 12 | 12 | | | $9,232.77 | 2.11 | ** |
| 13 | 13 | | | $9,174.25 | 2.10 | ** |
| 14 | 11 | | | $9,126.66 | 2.08 | ** |
| 15 | 16 | | | $8,178.65 | 1.87 | ** |
| 16 | 15 | | | $8,050.32 | 1.84 | ** |
| 17 | 18 | | | $7,772.09 | 1.78 | ** |
| 18 | 20 | | | $7,075.36 | 1.62 | ** |


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**B**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/4/2007
Run Time: 11:26:50 AM

**Recipient Peer Group Comparison**
**Compare by Percent Difference**

**For Dates of Service: 01/01/2006 - 12/31/2006**

**Recipient Peer Group: 961 - 3A Breast and Cervical Cancer + full Mcaid**
**Aggregation Code: 7 - Fee For Service Claims by Recipient**
**Report Category: 1 - Professional Services**

| Line # | Raw Rank | Recipient ID | Recipient Full Name | Percent Difference from Expected | Number of Standard Deviations | Each * represent a 10% Difference From Center Line |
|---|---|---|---|---|---|---|
| 1 | 1 | [redacted] | [redacted] | 2033.31 % | 10.74 | ********** |
| 2 | 2 | [redacted] | [redacted] | 1087.64 % | 5.75 | ********** |
| 3 | 4 | [redacted] | [redacted] | 912.04 % | 4.82 | ********** |
| 4 | 5 | [redacted] | [redacted] | 848.59 % | 4.48 | ********** |
| 5 | 7 | [redacted] | [redacted] | 686.60 % | 3.63 | ********** |
| 6 | 99 | [redacted] | [redacted] | 608.84 % | 3.22 | ********** |
| 7 | 9 | [redacted] | [redacted] | 533.10 % | 2.82 | ********** |
| 8 | 10 | [redacted] | [redacted] | 520.04 % | 2.75 | ********** |
| 9 | 6 | [redacted] | [redacted] | 479.95 % | 2.54 | ********** |
| 10 | 8 | [redacted] | [redacted] | 442.94 % | 2.34 | ********** |
| 11 | 14 | [redacted] | [redacted] | 418.80 % | 2.21 | ********** |
| 12 | 56 | [redacted] | [redacted] | 373.70 % | 1.97 | ********** |
| 13 | 16 | [redacted] | [redacted] | 368.93 % | 1.95 | ********** |
| 14 | 18 | [redacted] | [redacted] | 350.59 % | 1.85 | ********** |

**C**

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/4/2007
Run Time: 11:26:50 AM

**Recipient Peer Group Comparison**
**Data**

**For Dates of Service: 01/01/2006 - 12/31/2006**

**Recipient Peer Group: 961 - 3A Breast and Cervical Cancer + full Mcaid**
**Aggregation Code: 7 - Fee For Service Claims by Recipient**
**Report Category: 1 - Professional Services**

| Raw RANK | Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|
| 1 | [redacted] | [redacted] | $105,675.80 | $47,297.36 | $47,292.36 | $2,216.85 | $45,075.51 | 2033.31 % |
| 2 | [redacted] | [redacted] | $68,817.70 | $26,332.22 | $26,328.22 | $2,216.85 | $24,111.37 | 1087.64 % |
| 3 | [redacted] | [redacted] | $77,986.04 | $28,604.16 | $25,780.92 | $14,732.19 | $11,048.73 | 75.00 % |
| 4 | [redacted] | [redacted] | $51,806.97 | $22,503.42 | $22,435.42 | $2,216.85 | $20,218.57 | 912.04 % |
| 5 | [redacted] | [redacted] | $78,276.60 | $21,144.84 | $21,028.84 | $2,216.85 | $18,811.99 | 848.59 % |
| 6 | [redacted] | [redacted] | $49,916.80 | $20,002.23 | $19,999.23 | $3,448.45 | $16,550.78 | 479.95 % |
| 7 | [redacted] | [redacted] | $55,121.00 | $17,444.79 | $17,437.79 | $2,216.85 | $15,220.94 | 686.60 % |
| 8 | [redacted] | [redacted] | $58,547.40 | $17,372.49 | $17,261.58 | $3,179.28 | $14,082.30 | 442.94 % |
| 9 | [redacted] | [redacted] | $28,704.00 | $14,035.92 | $14,034.92 | $2,216.85 | $11,818.07 | 533.10 % |
| 10 | [redacted] | [redacted] | $33,908.26 | $14,229.27 | $13,745.27 | $2,216.85 | $11,528.42 | 520.04 % |
| 11 | [redacted] | [redacted] | $16,713.12 | $12,578.11 | $12,575.11 | $3,448.45 | $9,126.66 | 264.66 % |
| 12 | [redacted] | [redacted] | $19,580.48 | $12,447.05 | $12,412.05 | $3,179.28 | $9,232.77 | 290.40 % |
| 13 | [redacted] | [redacted] | $41,604.00 | $26,369.16 | $12,353.53 | $3,179.28 | $9,174.25 | 288.56 % |


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### 3.5.89.1 DSSProfiler - Recipient Peer Group Comparison Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Dollar Difference from Expected | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology). | 13 | Number (Decimal) |
| (A,B) Each * Represents | (A) Each * represents a $5000 Dollar Difference From Center Line. Rows in red indicate a Dollar Difference that is more than 2 standard deviations from the norm.<br>(B) Each * represents a 10% Difference From Center Line. | 8 | Number (Decimal) |
| (A,B) Number of Standard Deviation | Represents the number of standard deviations that the provider's dollar difference was from the expected. | 8 | Number (Integer) |
| (A,B) Line # | Line number on the report. | 3 | Number (Integer) |
| (A-C) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-C) Raw Rank | Provider's rank based on the amount Provider was paid. | 3 | Number (Decimal) |
| (A-C) Recipient Full Name | Recipient's full name. | 50 | Character |
| (A-C) Recipient ID | Recipient Medicaid Number. | 12 | Character |
| (A-C) Recipient Peer Group | Recipient Peer Group Code and Description. | 40 | Character |
| (A-C) Report Category | User-defined variables used to categorize case types into service groups. | 21 | Character |
| (B) Percent Difference from Expected | Percentage number that is the difference in the actual amount recipient was paid and the amount recipient was expected to receive (based on the ACG adjustment methodology). | 7 | Number (Decimal) |
| (C) Allowed Amount | The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (C) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (C) Dollar Difference | Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology). | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (C) Expected Amount | Amount provider was expected to receive. | 13 | Number (Decimal) |
| (C) Paid Amount | Actual amount provider was paid. | 13 | Number (Decimal) |
| (C) Percent Difference | Percent number representing the difference in the actual amount recipient was paid and the amount recipient was expected to receive (based on the ACG adjustment methodology). | 8 | Number (Decimal) |


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### 3.5.90 DSSProfiler - Recipient Peer Group Comparison Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all recipients within a peer group to determine which recipients fall outside of service dollar norms. All information is age and gender adjusted so that differences in patient mix do not affect the results. This report can look at professional service, inpatient referrals, outpatient referrals and pharmacy totals. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

The tabs in this report include:

A. Compare by Dollar Difference - Contains information that is essential in comparing recipients within the same group;

B. Compare by Percent Difference - Similar to the previous, except the difference is expressed as a percent; and

C. Individual Recipient Information - Shows the raw data for all of the equations used in the compare by dollar difference report and the compare by percent difference report.

A

**Alabama Medicaid Agency**

**Recipient Peer Group Comparison Qtrly**

**Compare By Dollar Difference**

User ID: [redacted]
Run Date: 10/4/2007
Run Time: 11:47:04 AM

For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group: 904 - R1 Retro-Full Elig + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Report Category: 1 - Professional Services
Quarter: 20061

| Line # | Raw Rank | Recipient ID | Recipient Full Name | Dollar Difference From Expected | Number of Standard Deviations | Each * represent a $5000 Difference From Center Line. Rows in red indicate a Dollar Difference that is more that 2 standard deviations from the norm. 2 Standard Deviations = $1,359.03 |
|---|---|---|---|---|---|---|
| 1 | 3 | [redacted] | [redacted] | $4,623.80 | 6.80 | |
| 2 | 2 | [redacted] | [redacted] | $3,960.18 | 5.83 | |
| 3 | 8 | [redacted] | [redacted] | $3,472.56 | 5.11 | |
| 4 | 1 | [redacted] | [redacted] | $3,408.00 | 5.02 | |
| 5 | 5 | [redacted] | [redacted] | $3,354.95 | 4.94 | |
| 6 | 3 | [redacted] | [redacted] | $3,054.24 | 4.49 | |
| 7 | 9 | [redacted] | [redacted] | $2,797.07 | 4.12 | |
| 8 | 6 | [redacted] | [redacted] | $2,614.31 | 3.85 | |
| 9 | 7 | [redacted] | [redacted] | $2,177.24 | 3.20 | |
| 10 | 15 | [redacted] | [redacted] | $1,846.30 | 2.72 | |
| 11 | 10 | [redacted] | [redacted] | $1,687.21 | 2.48 | |
| 12 | 17 | [redacted] | [redacted] | $1,514.24 | 2.23 | |
| 13 | 13 | [redacted] | [redacted] | $1,481.00 | 2.18 | |
| 14 | 12 | [redacted] | [redacted] | $1,435.21 | 2.11 | |
| 15 | 11 | [redacted] | [redacted] | $1,324.21 | 1.95 | |
| 16 | 16 | [redacted] | [redacted] | $1,224.58 | 1.80 | |
| 17 | 14 | [redacted] | [redacted] | $1,090.80 | 1.61 | |
| 18 | 18 | [redacted] | [redacted] | $964.39 | 1.42 | |


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B

# Alabama Medicaid Agency

User ID:
Run Date: 10/4/2007
Run Time: 11:47:04 AM

## Recipient Peer Group Comparison Qtrly
## Compare By Percent Difference

For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group: 904 - R1 Retro-Full Elig + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Report Category: 1 - Professional Services
Quarter: 20061

| Line # | Raw Rank | Recipient ID | Recipient Full Name | Percent Difference from Expected | Number of Standard Deviations | Each * represent a 10% Difference From Center Line |
|---|---|---|---|---|---|---|
| 1 | 3 | | | 1525.00 % | 10.36 | ********** |
| 2 | 15 | | | 780.02 % | 5.30 | ********** |
| 3 | 8 | | | 739.72 % | 5.02 | ********** |
| 4 | 30 | | | 630.81 % | 4.28 | ********** |
| 5 | 9 | | | 552.79 % | 3.75 | ********** |
| 6 | 17 | | | 511.98 % | 3.48 | ********** |
| 7 | 109 | | | 441.92 % | 3.00 | ********** |
| 8 | 121 | | | 441.35 % | 3.00 | ********** |
| 9 | 5 | | | 405.41 % | 2.75 | ********** |
| 10 | 24 | | | 397.35 % | 2.70 | ********** |
| 11 | 2 | | | 376.52 % | 2.56 | ********** |
| 12 | 80 | | | 277.13 % | 1.88 | ********** |
| 13 | 26 | | | 260.43 % | 1.77 | ********** |
| 14 | 146 | | | 227.28 % | 1.54 | ********** |
| 15 | 177 | | | 224.48 % | 1.52 | ********** |


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C

**Alabama Medicaid Agency**

User ID: [redacted]
Run Date: 10/4/2007
Run Time: 11:47:04 AM

Recipient Peer Group Comparison Qtrly
Individual Recipient Information

For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group: 904 - R1 Retro-Full Elig + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Report Category: 1 - Professional Services
Quarter: 20061

| Raw Rank | Recipient ID | Recipient Full Name | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference | Exception |
|---|---|---|---|---|---|---|---|---|---|
| 3 | [redacted] | [redacted] | $4,927.00 | $4,927.00 | $4,927.00 | $303.20 | $4,623.80 | 1525.00 % | * |
| 2 | [redacted] | [redacted] | $35,267.00 | $5,011.97 | $5,011.97 | $1,051.79 | $3,960.18 | 376.52 % | * |
| 8 | [redacted] | [redacted] | $3,942.00 | $3,942.00 | $3,942.00 | $469.44 | $3,472.56 | 739.72 % | * |
| 1 | [redacted] | [redacted] | $5,130.00 | $3,762.00 | $5,769.00 | $2,361.00 | $3,408.00 | 144.35 % | * |
| 5 | [redacted] | [redacted] | $8,278.35 | $4,182.50 | $4,182.50 | $827.55 | $3,354.95 | 405.41 % | * |
| 3 | [redacted] | [redacted] | $4,927.00 | $4,927.00 | $4,927.00 | $1,872.76 | $3,054.24 | 163.09 % | * |
| 9 | [redacted] | [redacted] | $18,325.00 | $3,303.05 | $3,303.05 | $505.99 | $2,797.07 | 552.79 % | * |
| 6 | [redacted] | [redacted] | $8,794.00 | $4,085.00 | $4,085.00 | $1,470.69 | $2,614.31 | 177.76 % | * |
| 7 | [redacted] | [redacted] | $4,222.00 | $4,050.00 | $4,050.00 | $1,872.76 | $2,177.24 | 116.26 % | * |
| 15 | [redacted] | [redacted] | $6,726.80 | $2,083.00 | $2,083.00 | $236.70 | $1,846.30 | 780.02 % | * |
| 10 | [redacted] | [redacted] | $5,956.00 | $2,868.00 | $2,868.00 | $1,180.79 | $1,687.21 | 142.89 % | * |
| 17 | [redacted] | [redacted] | $2,505.00 | $1,810.00 | $1,810.00 | $295.76 | $1,514.24 | 511.98 % | * |
| 13 | [redacted] | [redacted] | $5,329.00 | $2,254.50 | $2,254.50 | $773.50 | $1,481.00 | 191.47 % | * |
| 12 | [redacted] | [redacted] | $4,516.00 | $2,487.00 | $2,487.00 | $1,051.79 | $1,435.21 | 136.45 % | * |
| 11 | [redacted] | [redacted] | $5,457.00 | $2,506.00 | $2,505.00 | $1,180.79 | $1,324.21 | 112.15 % | |
| 16 | [redacted] | [redacted] | $2,390.00 | $1,932.00 | $1,932.00 | $707.42 | $1,224.58 | 173.11 % | |
| 14 | [redacted] | [redacted] | $2,800.00 | $2,124.00 | $2,124.00 | $1,033.20 | $1,090.80 | 105.57 % | |
| 18 | [redacted] | [redacted] | $2,593.75 | $1,561.17 | $1,561.17 | $596.78 | $964.39 | 161.60 % | |

### 3.5.90.1 DSSProfiler - Recipient Peer Group Comparison Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,C) Dollar Difference from Expected | Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A-B) Each * Represents | Each * represent a $5000 Difference From Center Line. Rows in red indicate an Dollar Difference that is more that 2 standard deviations from the norm. | 8 | Number (Decimal) |
| (A-B) Number of Standard Deviations | Represents the number of standard deviations that the provider's dollar difference was from the expected. | 8 | Number (Integer) |
| (A-C) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-C) Line # | Line number on the report. | 3 | Number (Integer) |
| (A-C) First Dates of Service | Starting and Ending range of service date selection criteria. | 11 | Date (MM/DD/CCYY) |
| (A-C) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-C) Raw Rank | Recipient's rank based on the actual money paid by the program. | 3 | Number (Integer) |
| (A-C) Recipient Full Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A-C) Recipient ID | Recipient Medicaid Number. | 12 | Character |
| (A-C) Recipient Peer Group | Recipient Peer Group Code and Description. | 40 | Character |
| (A-C) Report Category | User-defined variables used to categorize case types into service groups. | 21 | Character |
| (B,C) Percent Difference from Expected | Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (C) Allowed Amount | The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (C) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (C) Exception | Indicates providers who are 2 standard deviations above or below the "norm" for the peer group. | 1 | Character |
| (C) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (C) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |


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### 3.5.91 DSSProfiler - Recipient Profile

This report is created in the DSSProfiler. Based on the user-entered date range of one year, the Recipient Profile displays the aggregated case type categories for the selected recipients. This report makes it easier to see the types of services that a recipient is utilizing without the need for looking at the claim detail level. This report shows all case types including professional, inpatient, outpatient, nursing facility and pharmacy services.

There are multiple tabs on this report. For workbook documentation only, the different tabs have been lettered A-F in the layout below. The field names have the corresponding letter in front identifying the tab it can be found on. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

The six tabs in this report are:

A. Recipient Demographics/Totals;

B. Professional Services;

C. Inpatient Services;

D. Outpatient Services;

E. Pharmacy Services; and

F. Nursing Facility Services.

A

**Alabama Medicaid Agency**

**Recipient Profile**
**Recipient Demographics/Totals**

User ID:
Run Date: 12/12/2007
Run Time: 1:37:54 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient ID:
Recipient Peer Group: 971 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

Recipient County:
Birth Date:
Age Group:
Gender:

| Report Category Description | Claim Count | Quantity | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|
| 1 - Professional Services | 1 | 1 | $156.00 | $37.00 | $37.00 | $705.16 | $(668.16) | -95.00 % |
| 4 - Pharmacy Services | 12 | 1,346 | $518.67 | $515.70 | $515.70 | $868.95 | $(353.25) | -41.00 % |
| 5 - Nursing Facility Services | 3 | 89 | $14,493.13 | $14,493.13 | $14,493.13 | $11,942.66 | $2,550.47 | 21.00 % |

**End of Report**


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**B**

## Alabama Medicaid Agency

Recipient Profile
Professional Services

User ID: [redacted]
Run Date: 12/12/2007
Run Time: 1:37:54 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient ID: [redacted]
Recipient Peer Group: 971 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

| Case Type Description | Claim Count | Quantity | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|
| 4 - Morbidity 2 | 1 | 1 | $156.00 | $37.00 | $37.00 |
| 956 - AL Radiology Procedures - All | 1 | 1 | $156.00 | $37.00 | $37.00 |

End of Report

**C**

## Alabama Medicaid Agency

Recipient Profile
Inpatient Services

User ID: [redacted]
Run Date: 12/12/2007
Run Time: 1:37:54 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient ID: [redacted]
Recipient Peer Group: 971 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

| Case Type Description | Claim Count | Quantity | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|

No Data This Report Run

**D**

## Alabama Medicaid Agency

Recipient Profile
Outpatient Services

User ID: [redacted]
Run Date: 12/12/2007
Run Time: 1:37:54 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient ID: [redacted]
Recipient Peer Group: 971 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

| Case Type Description | Claim Count | Quantity | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|
| 4 - Morbidity 2 | 6 | 6 | $1,345.92 | $199.37 | $199.37 |
| 794 - AL Radiology Procedures | 2 | 2 | $968.73 | $137.38 | $137.38 |
| 880 - AL Lab Procedures | 4 | 4 | $377.19 | $61.99 | $61.99 |

End of Report


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E

**Alabama Medicaid Agency**

Recipient Profile
Pharmacy Services

User ID: [redacted]
Run Date: 12/12/2007
Run Time: 1:37:54 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient ID: [redacted]
Recipient Peer Group: 971 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

| Case Type Description | Claim Count | Quantity | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|
| 4 - Morbidity 2 | 12 | 1,346 | $518.67 | $515.70 | $515.70 |

End of Report

F

**Alabama Medicaid Agency**

Recipient Profile
Nursing Facility Services

User ID: [redacted]
Run Date: 12/12/2007
Run Time: 1:37:54 PM

Date of Service: 01/01/2006 - 12/31/2006
Recipient ID: [redacted]
Recipient Peer Group: 971 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

| Case Type Description | Claim Count | Quantity | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|
| 4 - Morbidity 2 | 3 | 89 | $14,493.13 | $14,493.13 | $14,493.13 |

End of Report

### 3.5.91.1 DSSProfiler - Recipient Profile Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age Group | Six age groups are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+. | 24 | Character |
| (A) Birth Date | Recipient's date of birth. | 8 | Date (MM/DD/CCYY) |
| (A) Dollar Difference | Difference in the actual amount recipient was paid and the amount recipient was expected to receive (based on the ACG adjustment methodology). | 13 | Number (Decimal) |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Gender | Recipient's gender. | 7 | Character |
| (A) Percent Difference | Percent number representing the difference in the actual amount recipient was paid and the | 8 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | amount recipient was expected to receive (based on the ACG adjustment methodology). | | |
| (A) Recipient County | Recipient's county of residence. | 20 | Character |
| (A) Report Category Description | User-defined variables used to categorize case types into service groups. | 52 | Character |
| (A-F) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-F) Allowed Amount | The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-F) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-F) Claim Count | Number of claims the provider filed in the particular claim group for the recipient. | 8 | Character |
| (A-F) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-F) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-F) Quantity | Quantity billed. | 8 | Number (Integer) |
| (A-F) Recipient ID | Recipient Medicaid Number (plus Recipient's name). | 20 | Character |
| (A-F) Recipient Peer Group | Recipient Peer Group Code and Description. | 40 | Character |
| (B-F) Case Type Description | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |


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### 3.5.92 DSSProfiler - Recipient Profile Quarterly

Based on the user-entered date range of one quarter, this report shows a claim summary for a recipient that has been profiled. The first tab shows totals by claim type. There are also tabs for each claim type which show totals by case type.

The six tabs in this report are:

A. Recipient Demographics/Totals;

B. Professional Services;

C. Inpatient Services;

D. Outpatient Services;

E. Pharmacy Services; and

F. Nursing Facility Services.


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**A**

## Alabama Medicaid Agency

User ID: [illegible]
Run Date: 12/12/2007
Run Time: 2:44:21 PM

Recipient Profile Qtrly
Recipient Demographics/Totals
For Dates of Service: 10/01/2006 - 12/31/2006
Recipient ID: [illegible]
Aggregation Code: 7 - Fee For Service Claims by Recipient
Recipient Peer Group: 846 - 41 Disabled-SSI- full Mcaid
Quarter: 20064

Recipient ID: [illegible]
Recipient Name: [illegible]
Birth Date: 02/13/1997
Age Group: Age 06 - 17
Gender: F

| Report Category Code & Description | Claim Count | Quantity | Billed Amount | Allowed Amount | Paid Amount | Expected Amount | Dollar Difference | Percent Difference |
|---|---|---|---|---|---|---|---|---|
| 6 - Outpatient Referrals | 6 | 6 | $1,264.10 | $94.27 | $94.27 | $171.99 | $(77.72) | -45.00 % |
| 4 - Pharmacy Services | 10 | 417 | $511.70 | $377.14 | $377.14 | $500.29 | $(123.15) | -25.00 % |
| 1 - Professional Services | 5 | 5 | $314.00 | $171.00 | $171.00 | $546.39 | $(375.39) | -69.00 % |

End of Report

**B**

## Alabama Medicaid Agency

User ID: [illegible]
Run Date: 12/12/2007
Run Time: 2:44:21 PM

Recipient Profile Qtrly
Professional Services
For Dates of Service: 10/01/2006 - 12/31/2006
Recipient ID: [illegible]
Aggregation Code: 7 - Fee For Service Claims by Recipient
Recipient Peer Group: 846 - 41 Disabled-SSI- full Mcaid
Quarter: 20064

| Case Type Description | Claim Count | Quantity | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|
| 184 - AL Number of Emergency Room Visits | 1 | 1 | $185.00 | $42.00 | $42.00 |
| 4 - Morbidity 2 | 5 | 5 | $314.00 | $171.00 | $171.00 |

End of Report

**C**

## Alabama Medicaid Agency

User ID: [illegible]
Run Date: 12/12/2007
Run Time: 2:44:21 PM

Recipient Profile Qtrly
Inpatient Services
For Dates of Service: 10/01/2006 - 12/31/2006
Recipient ID: [illegible]
Aggregation Code: 7 - Fee For Service Claims by Recipient
Recipient Peer Group: 846 - 41 Disabled-SSI- full Mcaid
Quarter: 20064

| Case Type Description | Claim Count | Quantity | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|

No Data This Report Run


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**D**

# Alabama Medicaid Agency

User ID:
Run Date: 12/12/2007
Run Time: 2:44:21 PM

Recipient Profile Qtrly
Outpatient Services
For Dates of Service: 10/01/2006 - 12/31/2006
Recipient ID:
Aggregation Code: 7 - Fee For Service Claims by Recipient
Recipient Peer Group: 846 - 41 Disabled-SSI- full Mcaid
Quarter: 20064

| Case Type Description | Claim Count | Quantity | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|
| 184 - AL Number of Emergency Room Visits | 1 | 1 | $440.45 | | $38.36 |
| 4 - Morbidity 2 | 6 | 6 | $1,264.10 | | $94.27 |

End of Report

**E**

# Alabama Medicaid Agency

User ID:
Run Date: 12/12/2007
Run Time: 2:44:21 PM

Recipient Profile Qtrly
Pharmacy Services
For Dates of Service: 10/01/2006 - 12/31/2006
Recipient ID:
Aggregation Code: 7 - Fee For Service Claims by Recipient
Recipient Peer Group: 846 - 41 Disabled-SSI- full Mcaid
Quarter: 20064

| Case Type Description | Claim Count | Quantity | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|
| 176 - CMS Narcotic Drugs | 9 | 400 | $176.00 | $363.56 | $363.56 |
| 4 - Morbidity 2 | 10 | 417 | $4.00 | $377.14 | $377.14 |

End of Report

**F**

# Alabama Medicaid Agency

User ID:
Run Date: 12/12/2007
Run Time: 2:44:21 PM

Recipient Profile Qtrly
Nursing Facility Services
For Dates of Service: 10/01/2006 - 12/31/2006
Recipient ID:
Aggregation Code: 7 - Fee For Service Claims by Recipient
Recipient Peer Group: 846 - 41 Disabled-SSI- full Mcaid
Quarter: 20064

| Case Type Description | Claim Count | Quantity | Billed Amount | Allowed Amount | Paid Amount |
|---|---|---|---|---|---|

No Data This Report Run


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### 3.5.92.1 DSSProfiler - Recipient Profile Quarterly Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Age Group | Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+. | 24 | Character |
| (A) Birth Date | Recipient's date of birth. | 8 | Date (MM/DD/CCYY) |
| (A) Dollar Difference | Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Expected Amount | Amount provider was expected to receive based on the peer group adjustment methodology. | 13 | Number (Decimal) |
| (A) Gender | Recipient's gender. | 1 | Character |
| (A) Percent Difference | Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology). | 13 | Number (Decimal) |
| (A) Recipient Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A) Report Category Code Description | User-defined variables used to categorize case types into service groups. | 50 | Character |
| (A-F) Claim Count | Number of claims the provider filed for the particular claim group. | 8 | Number (Integer) |
| (A-F) Quantity | Quantity billed in the particular claim group for the recipient. | 8 | Number (Integer) |
| (A-F) Aggregation Code | Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. | 50 | Character |
| (A-F) Allowed Amount | The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient. | 13 | Number (Decimal) |
| (A-F) Billed Amount | Amount the provider billed for the services. | 13 | Number (Decimal) |
| (A-F) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-F) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (A-F) Quarter | The quarter for which the report is being run. | 5 | Date (CCYYQ) |
| (A-F) Recipient ID | Recipient Medicaid Number. | 12 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-F) Recipient Peer Group | Recipient Peer Group Code and Description. | 40 | Character |
| (B-F) Case Type Description | Claims groupings that were billed on the recipients within the predefined group. | 100 | Character |


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### 3.5.93 ETG Descriptions

This ETG Descriptions report contains code values and descriptions for ETG major practice categories, ETG number, and ETG episode types. This is a static report based on the code table values, and other than any ETG software changes, the data in this report will not change.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-C in the layout below. The field names have the corresponding letter in front, identifying the tab on which it can be found. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

The eight tabs in this report are:

A. ETGs By Major Processing Category;

B. ETGs By ETG Number & Description; and

C. ETG Episode Types.

A

**Alabama Medicaid Agency**

**ETG Descriptions**

**ETG's By Major Processing Category**

User ID: [redacted]
Run Date: 5/13/2014
Run Time: 11:23:54 AM

**Major Processing Category: 01 - INFECTIOUS DISEASES**

| ETG Number | Episode Treatment Group Description |
|---|---|
| 130100 | 130100 - AIDS, with complication, with comorbidity, with surgery |
| 130100 | 130100 - AIDS, with complication, with comorbidity, w/o surgery |
| 130100 | 130100 - AIDS, with complication, w/o comorbidity, with surgery |
| 130100 | 130100 - AIDS, with complication, w/o comorbidity, w/o surgery |
| 130100 | 130100 - AIDS, w/o complication, with comorbidity, with surgery |
| 130100 | 130100 - AIDS, w/o complication, with comorbidity, w/o surgery |
| 130100 | 130100 - AIDS, w/o complication, w/o comorbidity, with surgery |
| 130100 | 130100 - AIDS, w/o complication, w/o comorbidity, w/o surgery |
| 130200 | 130200 - HIV sero-positive w/o AIDS, with surgery |
| 130200 | 130200 - HIV sero-positive w/o AIDS, w/o surgery |
| 130400 | 130400 - Septicemia, with complication, with surgery |
| 130400 | 130400 - Septicemia, with complication, w/o surgery |
| 130400 | 130400 - Septicemia, w/o complication, with surgery |
| 130400 | 130400 - Septicemia, w/o complication, w/o surgery |
| 130600 | 130600 - Other infectious diseases, with complication, with comorbidity, with surgery |
| 130600 | 130600 - Other infectious diseases, with complication, with comorbidity, w/o surgery |
| 130600 | 130600 - Other infectious diseases, with complication, w/o comorbidity, with surgery |
| 130600 | 130600 - Other infectious diseases, with complication, w/o comorbidity, w/o surgery |

Episode Treatment Grouper (ETG) ETG Descriptions.rep Page 1 of 89


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B

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 5/13/2014
Run Time: 11:23:54 AM

## ETG Descriptions

### ETG's by ETG Number & Description

| ETG Number | Episode Treatment Group Description |
|---|---|
| 130100 | 130100 - AIDS, with complication, with comorbidity, with surgery |
| 130100 | 130100 - AIDS, with complication, with comorbidity, w/o surgery |
| 130100 | 130100 - AIDS, with complication, w/o comorbidity, with surgery |
| 130100 | 130100 - AIDS, with complication, w/o comorbidity, w/o surgery |
| 130100 | 130100 - AIDS, w/o complication, with comorbidity, with surgery |
| 130100 | 130100 - AIDS, w/o complication, with comorbidity, w/o surgery |
| 130100 | 130100 - AIDS, w/o complication, w/o comorbidity, with surgery |
| 130100 | 130100 - AIDS, w/o complication, w/o comorbidity, w/o surgery |
| 130200 | 130200 - HIV sero-positive w/o AIDS, with surgery |
| 130200 | 130200 - HIV sero-positive w/o AIDS, w/o surgery |
| 130400 | 130400 - Septicemia, with complication, with surgery |
| 130400 | 130400 - Septicemia, with complication, w/o surgery |
| 130400 | 130400 - Septicemia, w/o complication, with surgery |
| 130400 | 130400 - Septicemia, w/o complication, w/o surgery |
| 130600 | 130600 - Other infectious diseases, with complication, with comorbidity, with surgery |
| 130600 | 130600 - Other infectious diseases, with complication, with comorbidity, w/o surgery |
| 130600 | 130600 - Other infectious diseases, with complication, w/o comorbidity, with surgery |

Episode Treatment Grouper (ETG) ETG Descriptions.rep Page 1 of 91


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# Alabama Medicaid Agency

User ID:
Run Date: 5/13/2014
Run Time: 11:23:54 AM

## ETG Descriptions

### ETG Episode Types

| Episode Type | Episode Type Description |
|---|---|
| 0 | 0 - Complete Episode. |
| 1 | 1 - A full year episode which has at least one anchor record within the episode's clean period from the end of the claims data range. |
| 2 | 2 - A full year episode which has at least one anchor record within the episode's clean period from the beginning of the claims data range. |
| 3 | 3 - A full year episode which has both an anchor record within the episode clean period from the beginning of the database, and another anchor record within the clean period from the end of the claims data range. |
| 4 | 4 - An episode < 1 year with a clean start. |
| 5 | 5 - An episode < 1 year with a clean finish. |
| 6 | 6 - An episode < 1 year with neither a clean start nor a clean finish. |
| 7 | 7 - Incomplete annual episode, only applies to chronic episodes. |
| 8 | 8 - A record which was not grouped to an episode. This includes records with "Ongoing Rx Therapy" and Ungroupable ETG. This value may also occur for some pregnancy records. |
| 9 | 9 - Orphan ancillary service, not grouped to an episode. |

**End of Report**


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### 3.5.93.1 ETG Descriptions Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Major Processing Category | The concatenation of The Major Practice Category and its description.<br>The Major Practice Category - This is a high level ETG specific classification for specific disease conditions.<br>The Major Practice Category Description. - This is a high level ETG specific classification for specific disease conditions. | 105 | Character |
| (A-B) ETG Number | The ETG identifier assigned to the episode that further identifies a disease condition. | 6 | Character |
| (A-B) Episode Treatment Group Description | The description of the ETG number. | 234 | Character |
| (C) Episode Type | This field indicates the Episode type. | 2 | Character |
| (C) Episode Type Description | This is the episode type and description. | 230 | Character |


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### 3.5.94 ETG Details - FFS

The ETG Details report breaks the Episode Treatment Groups (ETGs) down to the major category levels. It displays the average episode cost, the average amount per recipient, total episodes, total recipients and total dollars.

This report contains a prompt that allows the report user to enter a specific warrant date or a range of warrant dates to extract the claim's data.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-H in the layout below. The field names have the corresponding letter in front, identifying the tab on which it can be found. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The eight tabs in this report are:

A. Details By ETG;

B. Details By Recipient;

C. Details By Servicing Provider;

D. Recipient Totals;

E. Provider Totals;

F. Procedure Totals;

G. Diagnosis Totals; and

H. NDC Totals.

A

**Alabama Medicaid Agency**

**ETG Details - FFS**
Details By ETG
For Dates of Service: 07/01/2014 - 06/30/2016
ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

User ID:
Run Date: 7/26/16
Run Time: 3:42:35 PM

Subclass: 000
Subclass Description: Bursitis & tendinitis - foot & ankle, w/o surgery

| Claim ICN | Claim Type Code & Description | Episode Type & Description | Recipient ID | Recipient Full Name | Recip Age | Recip County Description | Claim Indicator | Program Code Description | Provider ID - Billing | Provider ID - Referring/ Attending/ Prescribing | ICD | Primary Diagnosis Code & Description | Buyin Medicare A | Buyin Medicare B | DRG Code & Description | DRG Relative Weight | DRG Service Adjuster |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M - PROFESSIONAL CLAIMS | 0 - Complete Episode. | 1234567890 | XXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX | 17 | 22 - Cullman | F | 41 - Disabled-SSI-full Medicaid coverage | NPI ID: Medicaid ID: Base ID: | NPI ID: Medicaid ID: Base ID: | 9 | 72671 - ACHILLES BURSITIS OR TENDINITIS | | N | N | - | |

| Detail Number | Claim Detail Status | Date First Service | Date Last Service | NDC & Description | Procedure Code & Description | Billed Amount | Allowed Amount | Paid Amount | Provider ID - Rendering | Revenue Code & Description | Wrap Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | P | 8/27/2015 | 8/27/2015 | ########### - | 99213 - Office/ Outpatient Visit Est | $75.00 | $34.40 | $34.40 | NPI ID: Medicaid ID: Base ID: | #### - Unknown or Not Applicable | N |

End of Report

PHI has been removed


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B

## Alabama Medicaid Agency

**ETG Details - FFS**
Details By Recipient

For Dates of Service: 07/01/2014 - 06/30/2016
ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

User ID:
Run Date: 7/26/16
Run Time: 3:42:35 PM

123456789012

| Claim ICN | Claim Type Code & Description | Episode Type & Description | Recip Age | Recipient County Description | Claim Indicator | Program Code Description | Provider ID - Billing | Provider ID - Referring/Attending/ Prescribing | I C D | Primary Diagnosis Code & Description | Buyin Medicare A | Buyin Medicare B | DRG Code & Description | DRG Relative Weight | DRG Service Adjuster |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M - PROFESSIONAL CLAIMS | 0 - Complete Episode. | 34 | 16 - Coffee | F | 36 - MLIF-Adult-No Money-full Medicaid coverage | NPI ID: Medicaid ID: Base ID: | NPI ID: Medicaid ID: Base ID: | 9 | 72672 - TIBIALIS TENDINITIS | N | N | | - | |

| Detail Number | Claim Detail Status | Date First Service | Date Last Service | NDC & Description | Procedure Code & Description | Billed Amount | Allowed Amount | Paid Amount | Provider ID - Rendering | Revenue Code & Description | Wrap Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | P | 8/25/2015 | 8/25/2015 | ########### - | 99214 - Office/ Outpatient Visit Est | $150.00 | $68.00 | $64.10 | NPI ID: Medicaid ID: Base ID: | #### - Unknown or Not Applicable | Y |

**End of Report**

C

## Alabama Medicaid Agency

**ETG Details - FFS**
Details By Servicing Provider

For Dates of Service: 07/01/2014 - 06/30/2016
ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

User ID:
Run Date: 7/26/16
Run Time: 3:42:35 PM

Medicaid ID:

| Claim ICN | Claim Type Code & Description | Episode Type & Description | Recipient ID | Recipient Full Name | Recip Age | Recipient County Description | Claim Indicator | Program Code Description | Provider ID - Billing | Provider ID - Referring/ Attending/ Prescribing | I C D | Primary Diagnosis Code & Description | Buyin Medicare A | Buyin Medicare B | DRG Code & Description | DRG Relative Weight | DRG Service Adjuster |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M - PROFESSIONAL CLAIMS | 0 - Complete Episode. | 123456789012 | XXXXXXXXX XXXXXXXXX XX, XXXXXXXXX XXXXXX, X | 17 | 22 - Cullman | F | 41 - Disabled-SSI-full Medicaid coverage | NPI ID: Medicaid ID: Base ID: | NPI ID: Medicaid ID: Base ID: | 9 | 72671 - ACHILLES BURSITIS OR TENDINITIS | N | N | - | | |

| Detail Number | Claim Detail Status | Date First Service | Date Last Service | NDC & Description | Procedure Code & Description | Billed Amount | Allowed Amount | Paid Amount | Provider ID - Rendering | Revenue Code & Description | Wrap Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | P | 8/27/2015 | 8/27/2015 | ########### - | 99213 - Office/Outpatient Visit Est | $75.00 | $34.40 | $34.40 | NPI ID: Medicaid ID: Base ID: | #### - Unknown or Not Applicable | N |

**End of Report**

PHI has been removed


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D

# Alabama Medicaid Agency

**ETG Details - FFS**
**Recipient Totals**

User ID: [redacted]
Run Date: 7/26/16
Run Time: 3:42:35 PM

For Dates of Service: 07/01/2014 - 06/30/2016
ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 000
Subclass Description: Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 001
Subclass Description: Bursitis & tendinitis - foot & ankle, with surgery

| Recipient ID | Recipient Full Name | Paid Amount |
|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X | $8,075.59 |
| Totals: 76 | | $8,075.59 |

E

# Alabama Medicaid Agency

**ETG Details - FFS**
**Provider Totals**

User ID: [redacted]
Run Date: 7/26/16
Run Time: 3:42:35 PM

For Dates of Service: 07/01/2014 - 06/30/2016
ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 000
Subclass Description: Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 001
Subclass Description: Bursitis & tendinitis - foot & ankle, with surgery

| Provider ID - Billing | Provider ID - Referring/ Attending/Prescribing | Provider ID - Rendering | Paid Amount |
|---|---|---|---|
| NPI ID: [redacted]<br>Medicaid ID: [redacted]<br>Base ID: [redacted] | NPI ID: [redacted]<br>Medicaid ID: [redacted]<br>Base ID: [redacted] | NPI ID: [redacted]<br>Medicaid ID: [redacted]<br>Base ID: [redacted] | $94.13 |
| NPI ID: [redacted]<br>Medicaid ID: [redacted]<br>Base ID: [redacted] | NPI ID:<br>Medicaid ID:<br>Base ID: | NPI ID: [redacted]<br>Medicaid ID: [redacted]<br>Base ID: [redacted] | $42.00 |

**End of Report**


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F

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/26/16
Run Time: 3:42:35 PM

## ETG Details - FFS

### Procedure Totals

For Dates of Service: 07/01/2014 - 06/30/2016

ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 000
Subclass Description: Bursitis & tendinitis - foot & ankle, w/o surgery

| Procedure Code & Description | Number of Providers | Percent of All Providers | Number of Recipients | Percent of All Recipients | Number of Claims | Percent of All Claims | Paid Amount |
|---|---|---|---|---|---|---|---|
| 20550 - Inj Tendon Sheath/Ligament | 1 | 1.25 % | 1 | 1.35 % | 1 | 0.81 % | $47.00 |
| 20605 - Drain/Inj Joint/Bursa W/O Us | 2 | 2.50 % | 2 | 2.70 % | 2 | 1.61 % | $84.00 |
| 29425 - Apply Short Leg Cast | 1 | 1.25 % | 1 | 1.35 % | 1 | 0.81 % | $74.00 |
| 29540 - Strapping Of Ankle And/Or Ft | 2 | 2.50 % | 2 | 2.70 % | 2 | 1.61 % | $50.40 |
| 73590 - X-Ray Exam Of Lower Leg | 2 | 2.50 % | 2 | 2.70 % | 2 | 1.61 % | $44.00 |

End of Report

G

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/26/16
Run Time: 3:42:35 PM

## ETG Details - FFS

### Diagnosis Totals

For Dates of Service: 07/01/2014 - 06/30/2016

ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 000
Subclass Description: Bursitis & tendinitis - foot & ankle, w/o surgery

| ICD | Primary Diagnosis Code & Description | Number of Providers | Percent of All Providers | Number of Recipients | Percent of All Recipients | Number of Claims | Percent of All Claims | Paid Amount |
|---|---|---|---|---|---|---|---|---|
| # | ####### - Unknown or Not Appl. | 16 | 20.00 % | 17 | 22.97 % | 26 | 20.97 % | $375.45 |
| 0 | M2550 - PAIN IN UNSPECIFIED JOINT | 1 | 1.25 % | 1 | 1.35 % | 1 | 0.81 % | $42.40 |
| 0 | M65871 - OTHER SYNOVITIS AND TENOSYNOVITIS, RIGHT ANKLE AND FOOT | 1 | 1.25 % | 1 | 1.35 % | 1 | 0.81 % | $23.00 |
| 0 | M7671 - PERONEAL TENDINITIS, RIGHT LEG | 1 | 1.25 % | 1 | 1.35 % | 1 | 0.81 % | $64.27 |

End of Report


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H

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/26/16
Run Time: 3:42:35 PM

**ETG Details - FFS**

**NDC Totals**

**For Dates of Service: 07/01/2014 - 06/30/2016**

**ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery**

**Subclass: 000**
**Subclass Description: Bursitis & tendinitis - foot & ankle, w/o surgery**

**Subclass: 001**
**Subclass Description: Bursitis & tendinitis - foot & ankle, with surgery**

| NDC & Description | Number of Providers | Percent of All Providers | Number of Recipients | Percent of All Recipients | Number of Claims | Percent of All Claims | Paid Amount |
|---|---|---|---|---|---|---|---|
| ########### - | 74 | 90.24 % | 68 | 89.47 % | 98 | 75.97 % | $7,549.05 |
| 00093014905 - NAPROXEN | 1 | 1.22 % | 1 | 1.32 % | 1 | 0.78 % | $13.73 |
| 00093094801 - DICLOFENAC POTASSIUM | 1 | 1.22 % | 1 | 1.32 % | 1 | 0.78 % | $45.24 |
| 00406012305 - HYDROCODONE-ACETAMINOPHEN | 1 | 1.22 % | 1 | 1.32 % | 1 | 0.78 % | $19.22 |
| 00591544210 - PREDNISONE | 1 | 1.22 % | 1 | 1.32 % | 1 | 0.78 % | $15.94 |

### 3.5.94.1 ETG Details - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-C) Wrap Ind | Wrap Payment Indicator | 1 | Character |
| (A,B,C,G) ICD | The ICD Version code for the primary ICD-CM payment level diagnosis code. | 1 | Character |
| (A,C,D) Recipient Full Name | Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name. | 22 | Character |
| (A,C,D) Recipient ID | The recipient's Medicaid identification number. | 12 | Character |
| (A,D-H) Subclass | This field further describes the ETG number. | 3 | Character |
| (A,D-H) Subclass Description | The description of the subclass; for example: ETG Number 669001 is Skin trauma, subclass 000 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, w/o surgery", and subclass 001 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, *with* surgery". | 225 | Character |
| (A-C) Allowed Amount | The allowed amount for the detail. | 11 | Number (Decimal) |
| (A-C) Billed Amount | The billed amount for the detail. | 11 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-C) Buyin Medicare A | Medicare Buy-in in which recipient is participating in Part A. | 5 | Character |
| (A-C) Buyin Medicare B | Medicare Buy-in in which recipient is participating in Part B. | 5 | Character |
| (A-C) Claim Detail Status | The claim's status code. | 1 | Character |
| (A-C) Claim ICN | The claim's identification number. | 13 | Character |
| (A-C) Claim Indicator | Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim. | 1 | Character |
| (A-C) Claim Type & Description | Shows what type of claim was submitted and the description. | 53 | Character |
| (A-C) Date First Service | The claim's first date of service. | 10 | Date (MM/DD/CCYY) |
| (A-C) Date Last Service | The claim's last date of service. | 10 | Date (MM/DD/CCYY) |
| (A-C) Detail Number | Detail number on the claim. | 3 | Number (Integer) |
| (A-C) DRG Code and Description | Diagnosis Related Group Number assigned to the claim, and its description. | 30 | Character |
| (A-C) DRG Relative Weight | Relative weight for pricing DRG | 5 | Number (Decimal) |
| (A-C) DRG Service Adjuster | This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor | 3 | Number (Decimal) |
| (A-C) Episode Type & Description | Episode Type and the associated description. | 229 | Character |
| (A-H) ETG Number & Description | The selected ETG Number and its description. | 234 | Character |
| (A-C) Program Code & Description | State aid category. | 55 | Character |
| (A-C) Recip Age | The recipient's age. | 3 | Number (Integer) |
| (A-C) Recip County & Description | Recipient's county of residence and the associated description. | 38 | Character |
| (A-C) Revenue Code & Description | The revenue code on a detail and the associated description. | 77 | Character |
| (A-C, E) Provider ID - Referring/Attending/Prescribing | Lists the NPI, Medicaid, and Base ID for the provider. | 63 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-C, E) Provider ID - Billing | Lists the NPI, Medicaid, and Base ID for the provider. | 63 | Character |
| (A-C, E) Provider ID - Rendering | Lists the NPI, Medicaid, and Base ID for the provider. | 63 | Character |
| (A-C, F) Procedure Code & Description | Procedure code on the detail and its description. | 49 | Character |
| (A-C, H) NDC Code & Description | The National Drug Code for a drug claim and its name/description | 49 | Character |
| (A-C,G) Primary Diagnosis Code & Description | Primary diagnosis code and its description. | 70 | Character |
| (A-H) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-H) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient. | 11 | Number (Decimal) |
| (D-H) Total Paid Amount | The paid (warrant) amount including the State share amount. | 11 | Number (Decimal) |
| (F-H) Number of Claims | Unduplicated count of ICNs. | 8 | Number (Integer) |
| (F-H) Number of Providers | The count of providers for the associated line. | 8 | Number (Integer) |
| (F-H) Number of Recipients | Unduplicated count of recipient IDs. | 8 | Number (Integer) |
| (F-H) Percent of All Claims | Count of ICN divided by total of all ICNs. | 8 | Number (Decimal) |
| (F-H) Percent of All Providers | The count of procedures for the provider divided by the count of all providers. | 13 | Number (Integer) |
| (F-H) Percent of All Recipients | Count of recipient id divided by total of all recipients. | 8 | Number (Integer) |


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### 3.5.95


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### ETG Distribution Analysis Episode Type - FFS

The ETG Distribution Analysis Episode Type report provides totals and averages for ETG Episode Types. This includes allowed amount, number of unduplicated recipients, episodes and the number of exceptions for episodes and recipients.

The Episode Type field of each record (also included in the summary record for the episode) indicates the completeness of the record's episode; see Episode Types in the Appendix for more details.

Episode Treatment Groups (ETGs) are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). ETGs provide a medically meaningful statistical unit representing a complete episode of care assessed on a series of clinical and statistical algorithms.

The reports combine routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories. ETGs successfully provide a unit of analysis for creating provider profiling, demand analysis and disease management strategies. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The report contains three tabs:

A. ETG Distribution Analysis by ETG;

B. ETG Distribution Analysis by Major Practice Category (MPC); and

C. ETG Distribution Analysis Episode Type.

A

**Alabama Medicaid Agency**
**ETG Distribution Analysis - FFS**
**By ETG**
**For Dates of Service: 10/01/2011 - 09/30/2013**

**User ID:** [redacted]
**Run Date:** 5/14/2014
**Run Time:** 4:30:02 PM

**ETG Number & Description: 130100 - AIDS, with complication, with comorbidity, with surgery**

| Episode Type Description | Amount Per Recipient | Amount Per Episode | Total Allowed Amount | Total Detail Paid Amount | Total Episodes | Total Recipients | Exceptions based on cost per Episode | Exceptions based on cost per Recipient |
|---|---|---|---|---|---|---|---|---|
| 0 - Complete Episode - Full Year | $13,357.00 | $13,357.00 | $93,500.00 | $93,500.00 | 7 | 7 | 0 | 0 |
| 7 - Unknown Start/Unknown Finish Incomplete Annual | $5,960.00 | $5,960.00 | $59,603.00 | $59,603.00 | 10 | 10 | 1 | 1 |
| | | Totals: | $153,103.00 | $153,103.00 | 17 | 17 | 1 | 1 |


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B

# Alabama Medicaid Agency

**ETG Distribution Analysis - FFS**

**By Major Practicing Category (MPC)**

**For Dates of Service: 10/01/2011 - 09/30/2013**

**User ID:** [redacted]
**Run Date:** 5/14/2014
**Run Time:** 4:30:02 PM

| ETG Number & Description | Episode Type Description | Amount Per Recipient | Amount Per Episode | Total Allowed Amount | Total Detail Paid Amount | Total Episodes | Total Recipients | Exceptions based on cost per Episode | Exceptions based on cost per Recipients |
|---|---|---|---|---|---|---|---|---|---|
| 130100 - AIDS, w/o complication, with comorbidity, w/o surgery | 0 - Complete Episode - Full Year | $5,949.00 | $5,736.00 | $803,055.00 | $803,056.00 | 140 | 135 | 1 | 1 |
| 130100 - AIDS, w/o complication, with comorbidity, w/o surgery | 7 - Unknown Start/Unknown Finish Incomplete Annual | $3,594.00 | $3,513.00 | $779,899.00 | $779,899.00 | 222 | 217 | 1 | 1 |
| 130100 - AIDS, w/o complication, w/o comorbidity, w/o surgery | 0 - Complete Episode - Full Year | $6,389.00 | $5,979.00 | $466,363.00 | $466,363.00 | 78 | 73 | 0 | 1 |
| 130100 - AIDS, w/o complication, w/o comorbidity, w/o surgery | 7 - Unknown Start/Unknown Finish Incomplete Annual | $3,742.00 | $3,611.00 | $516,330.00 | $516,330.00 | 143 | 138 | 0 | 0 |
| 130200 - HIV sero-positive w/o AIDS, w/o surgery | 0 - Complete Episode - Full Year | $6,007.00 | $5,062.00 | $997,184.00 | $997,184.00 | 197 | 166 | 2 | 3 |
| 130200 - HIV sero-positive w/o AIDS, w/o surgery | 7 - Unknown Start/Unknown Finish Incomplete Annual | $2,842.00 | $2,434.00 | $491,613.00 | $491,613.00 | 202 | 173 | 1 | 2 |
| 130400 - Septicemia, with complication, with surgery | 0 - Complete Episode - Full Year | $4,064.00 | $4,064.00 | $8,128.00 | $8,128.00 | 2 | 2 | 0 | 0 |
| 130400 - Septicemia, with complication, with surgery | 1 - Clean Start/Unknown Finish - Full Year | $491.00 | $491.00 | $982.00 | $981.00 | 2 | 2 | 0 | 0 |


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# Alabama Medicaid Agency

**ETG Distribution Analysis - FFS**
**By Episode Type**
**For Dates of Service: 10/01/2011 - 09/30/2013**

**User ID:** [redacted]
**Run Date:** 5/14/2014
**Run Time:** 4:30:02 PM

| ETG Number & Description | Amount Per Recipient | Amt Allowed Per Episode | Total Allowed Amount | Total Detail Paid Amount | Total Episodes | Total Recipients | Exceptions based on cost per Episode | Exceptions based on cost per Recipient |
|---|---|---|---|---|---|---|---|---|
| 163400 - Non-malignant neoplasm of pituitary gland, w/o complication, with surgery | $4,591.00 | $4,591.00 | $27,546.00 | $27,547.00 | 6 | 6 | 0 | 0 |
| 163400 - Non-malignant neoplasm of pituitary gland, w/o complication, w/o surgery | $1,646.00 | $1,204.00 | $390,208.00 | $390,208.00 | 324 | 237 | 2 | 3 |
| 163500 - Hyper-functioning adrenal gland, with surgery | $2,720.00 | $2,720.00 | $2,720.00 | $2,720.00 | 1 | 1 | 0 | 0 |
| 163500 - Hyper-functioning adrenal gland, w/o surgery | $647.00 | $444.00 | $97,634.00 | $97,634.00 | 220 | 151 | 1 | 1 |
| 163600 - Hypo-functioning adrenal gland, w/o surgery | $438.00 | $318.00 | $100,661.00 | $100,661.00 | 317 | 230 | 7 | 7 |
| 163700 - Malignant neoplasm of adrenal gland, with surgery, with active mgmt | $29,468.00 | $29,468.00 | $117,872.00 | $117,873.00 | 4 | 4 | 0 | 0 |
| 163700 - Malignant neoplasm of adrenal gland, with surgery, w/o active mgmt | $2,951.00 | $2,951.00 | $2,951.00 | $2,951.00 | 1 | 1 | 0 | 0 |
| 163700 - Malignant neoplasm of adrenal gland, w/o surgery, with active mgmt | $15,025.00 | $11,071.00 | $210,351.00 | $210,350.00 | 19 | 14 | 1 | 1 |
| 163700 - Malignant neoplasm of adrenal gland, w/o surgery, w/o active mgmt | $752.00 | $550.00 | $36,856.00 | $36,856.00 | 67 | 49 | 2 | 2 |

### 3.5.95.1 ETG Distribution Analysis Episode Type - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) ETG Number & Description | Episode Treatment Group (ETG) and description. | 234 | Character |
| (A,C) Episode Type & Description | Episode Type and the associated description. | 229 | Character |
| (A-B) Amount Per Episode | Total Amount allowed divided by total number of episodes. Calculation: Total Allowed Amount divided by Total Episodes. | 13 | Number (Decimal) |
| (A-C) Amount Per Recipient | Total Amount allowed divided by total number of recipients. Calculation: Total Allowed Amount divided by Total Recipients. | 13 | Number (Decimal) |
| (A-C) Exceptions based on Cost per Episode | Number of episodes whose cost falls two or more standard deviations away from the norm. | 9 | Number (Integer) |
| (A-C) Exceptions based on Cost per Recipient | Number of recipients whose cost falls two or more standard deviations away from the norm. | 9 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-C) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-C) Total Allowed Amount | This is total allowed amount for an episode type. | 11 | Number (Decimal) |
| (A-C) Total Detail Paid Amount | This is the sum of the ancillary inpatient paid, ancillary outpatient paid, facility paid, Medical Services paid, Medicare paid, RX paid, and surgery paid. | 11 | Number (Decimal) |
| (A-C) Total Episodes | Total episodes for the ETG. | 9 | Number (Integer) |
| (A-C) Total Recipients | Total recipients for the ETG. | 9 | Number (Integer) |
| (B) Major Practice Category & Description | Major Practice Category and description. | 50 | Character |
| (C) Amt Allowed Per Episode | Total amount paid per ETG episode. | 13 | Number (Decimal) |


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### 3.5.96 ETG Episode Cross Reference - FFS

The ETG Episode Cross Reference report provides cross reference episode information to determine if one type of disease condition is related to other episode types (for example, do asthmatics have prevalence for diabetes?) Combining episodes provides a comprehensive image of the health of recipients.

Episode Treatment Groups (ETGs) are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). ETGs provide a medically meaningful statistical unit representing a complete episode of care based on a series of clinical and statistical algorithms. The reports combine routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories.

ETGs successfully provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters. This date range is displayed in the header of the report.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The report contains two tabs:

A. ETG Overview - Contains an overview of the top ETGs by recipient count and the top ETGs by episode count; and

B. ETG Episodes - Contains all ETGs with the counts and amounts for each.


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A

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 3/3/16
Run Time: 11:08:02 AM

## ETG Episode Cross Reference - FFS

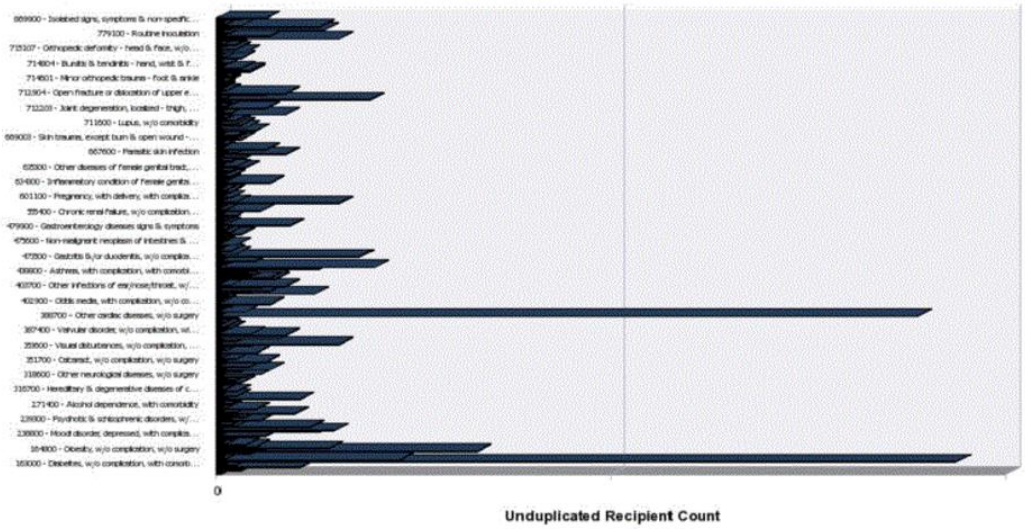
Overview

For Dates of Service: 07/01/2014 - 06/30/2016

ETG Number Entered: 163000

ETG Number Highest: 869900 - Isolated signs, symptoms & non-specific diagnoses or conditions

### Top Episodes by Recipient Count





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B

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 3/3/16
Run Time: 11:08:02 AM

**ETG Episode Cross Reference - FFS**
All Episodes
For Dates of Service: 07/01/2014 - 06/30/2016
ETG Number entered: 163000
ETG Number Highest: 869900 - Isolated signs, symptoms & non-specific diagnoses or conditions

Episode Type & Description: 0 - Complete Episode.

| Episode Count | Recipient Count | Percent of Recipients | Total Amount Paid |
|---|---|---|---|
| 1,527 | 1,191 | 1063.39 % | $992,156.00 |
| Totals: 1,527 | 1,191 | | $992,156.00 |

Episode Type & Description: 1 - A full year episode which has at least one anchor record within the episode's clean period from the end of the claims data range.

| Episode Count | Recipient Count | Percent of Recipients | Total Amount Paid |
|---|---|---|---|
| 7 | 7 | 6.25 % | $13,517.00 |
| Totals: 7 | 7 | | $13,517.00 |

Episode Type & Description: 4 - An episode < 1 year with a clean start.

| Episode Count | Recipient Count | Percent of Recipients | Total Amount Paid |
|---|---|---|---|
| 77 | 77 | 68.75 % | $64,721.00 |
| Totals: 77 | 77 | | $64,721.00 |

### 3.5.96.1 ETG Episode Cross Reference - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Top Episodes by Episode Count: ETG and Episode Description (Y-axis) | The ETG and Episode Description. | 56 | Character |
| (A) Top Episodes by Episode Count: Episode Count (X-axis) | Total episode count for the Episode (highest to lowest). | 7 | Number (Integer) |
| (A) Top Episodes by Recipient Count: ETG and Episode Description (Y-axis) | The ETG and Episode Description | 56 | Character |
| (A) Top Episodes by Recipient Count: Recipient Count (X-axis) | Total recipient count for the Episode (highest to lowest). | 8 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) ETG Number entered (prompt) | The selected Episode Treatment Group (ETG) number. | 6 | Character |
| (A,B) ETG Number Highest & Description | The highest value of an Episode Treatment Group (ETG) number present in the Episode, and its description. | 234 | Character |
| (A,B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (B) Percent of Recipients | Percentage of recipients who had an episode in this ETG. Calculation: The unduplicated Recipient Count divided by the total number of recipients. | 8 | Number (Decimal) |
| (B) Recipient Count | Total recipient count for the ETG. Calculation The unduplicated Recipient Count. | 8 | Number (Integer) |
| (B) Total Amount Paid | Total amount paid for ETG. | 11 | Number (Decimal) |
| (B) Episode Type & Description | Indicates the Episode type. Values Are:<br>0 = Clean Start/Clean End Complete Episode.<br>1 = Clean Start/Unknown End A full year episode which has at least one anchor record within the episode's clean period from the end of the claims data range.<br>2 = Unknown Start/Clean End A full year episode which has at least one anchor record within the episode's clean period from the beginning of the claims data range.<br>3 = Unknown Start/Unknown End A full year episode which has both an anchor record within the episode clean period from the beginning of the database, and another anchor record within the clean period from the end of the of the claims data range.<br>4 = Clean Start/Unknown End An episode < 1 year with a clean start.<br>5 = Unknown Start/Clean End An episode < 1 year with a clean finish.<br>6 = Unknown Start/Unknown End An episode < 1 year with neither a clean start nor a clean finish.<br>7 = Incomplete annual episode, only applies to chronic episodes<br>8 - A record which was not grouped to an episode. This includes records with “Ongoing Rx Therapy” and Ungroupable ETG. This value may also occur for some pregnancy records. | 229 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | 9 = Orphan ancillary service, not grouped to an episode. | | |
| (B) Episode Count | Unduplicated count of episodes. | 8 | Number (Integer) |


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### 3.5.97 ETG Recipient Comparison - FFS

The ETG Recipient Comparison report flags recipients with total cost per episode or per recipient that is two or more standard deviations from the norm for a given episode type. The report provides a comparison of recipient's ETG information by episode type, for a selected ETG.

Episode Treatment Groups (ETGs) are basic illness classifications similar in structure to Diagnosis Related Groupings (DRGs). ETGs provide a medically meaningful statistical unit representing a complete episode of care based on a series of clinical and statistical algorithms. The report combines routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories.

ETGs provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters. The ETG Recipient Comparison report flags recipients with total cost per episode of two or more standard deviations from the norm. The report allows comparing recipients ETG information by episode type for a selected ETG.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

**Alabama Medicaid Agency**

**ETG Recipient Comparison - FFS**

User ID:
Run Date: 2/11/2014
Run Time: 10:03:15 AM

For Dates of Service: 07/01/2011 - 06/30/2013

ETG Number: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

Episode Type & Description: 0 - Complete Episode.

| Recipient ID | Recipient Full Name | Paid Amount Per Episode | Global Paid Amount Per Episode | Difference in Episode Cost 2 std dev = $0 | Episode Count | Paid Amount Per Recipient | Global Paid Amount Per Recipient | Difference in Recipient Cost 2 std dev = $0 |
|---|---|---|---|---|---|---|---|---|
| [illegible] | [illegible] | $242.50 | $2,296.00 | $0.00 | 2 | $485.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $446.50 | $2,296.00 | $0.00 | 2 | $893.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $1,268.00 | $2,296.00 | $0.00 | 1 | $1,268.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $301.50 | $2,296.00 | $0.00 | 2 | $603.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $1,202.00 | $2,296.00 | $0.00 | 2 | $2,404.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $101.00 | $2,296.00 | $0.00 | 1 | $101.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $2,407.00 | $2,296.00 | $0.00 | 1 | $2,407.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $293.00 | $2,296.00 | $0.00 | 1 | $293.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $280.00 | $2,296.00 | $0.00 | 2 | $560.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $1,331.00 | $2,296.00 | $0.00 | 2 | $2,662.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $40.00 | $2,296.00 | $0.00 | 1 | $40.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] A | $1,724.50 | $2,296.00 | $0.00 | 2 | $3,449.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $1,163.00 | $2,296.00 | $0.00 | 2 | $2,326.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] M | $793.00 | $2,296.00 | $0.00 | 2 | $1,586.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $158.50 | $2,296.00 | $0.00 | 2 | $317.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $1,186.50 | $2,296.00 | $0.00 | 2 | $2,373.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $556.50 | $2,296.00 | $0.00 | 2 | $1,113.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $1,200.00 | $2,296.00 | $0.00 | 1 | $1,200.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] F | $2,155.00 | $2,296.00 | $0.00 | 1 | $2,155.00 | $3,121.00 | $0.00 |
| [illegible] | [illegible] | $1,253.00 | $2,296.00 | $0.00 | 2 | $2,506.00 | $3,121.00 | $0.00 |

PHI has been covered


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### 3.5.97.1 ETG Recipient Comparison - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Difference in Episode Cost: 2 std dev = $0 | Difference Episode Cost value which is two standard deviations (2 std dev) from the 'norm'. Provider Amount per Episode minus Global Amt per Episode. Calculation: The amount allowed for a given provider per Episode minus the global amount allowed per provider and Episode. | 11 | Number (Decimal) |
| Difference Recipient Cost: 2 std dev = $0 | Difference Recipient Cost value which is two standard deviations from the 'norm'. Provider Amount per Recipient minus Global Amount per Recipient. Calculation: The amount allowed for a given recipient per Episode minus the global amount allowed per recipient and Episode. 2 Std Dev (Difference Recipient Cost) | 11 | Number (Decimal) |
| Episode Count | Unduplicated count of episodes. | 8 | Number (Integer) |
| Episode Type & Description | Episode Type and description. | 229 | Character |
| ETG Number (prompt) & Description | The selected Episode Treatment Group (ETG) code and its description. | 234 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Global Paid Amount per Episode | Total amount for all providers divided by the number of episodes. | 11 | Number (Decimal) |
| Global Paid Amount per Recipient | The grand total of all paid amount per recipient. | 13 | Number (Decimal) |
| Paid Amount Per Episode | The total paid amount divided by the episode count. | 13 | Number (Decimal) |
| Paid Amount Per Recipient | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |
| Recipient ID | The recipient's identification number. | 12 | Character |
| Recipient Full Name | The recipient's full name. | 43 | Character |
| Subclass | This field further describes the ETG number. | 3 | Character |
| Subclass Description | The description of the subclass; for example: ETG Number 669001 is Skin trauma, subclass 000 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, w/o surgery", and subclass 001 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, *with* surgery". | 225 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| Totals | The sum of episode amounts. | 13 | Number (Decimal) |


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### 3.5.98


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### ETG Recipient Details - FFS

The ETG Recipient Details report shows selected recipient's detail claims information. Episode Treatment Groups (ETGs) are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). ETGs provide a medically meaningful statistical unit representing a complete episode of care based on a series of clinical and statistical algorithms. The report combines routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories. ETGs provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters. The details are grouped into episode types, which provide a method of viewing specific billing patterns and practices of providers that help to determine what steps may be required to improve the health of recipients or reduce the cost of the services.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting.

The report contains eight tabs:

A. Recipient Overview;

B. Details by ETG;

C. Details by Servicing Provider;

D. Provider Totals;

E. ETG Totals;

F. Procedure Totals;

G. Diagnosis Totals; and

H. NDC Totals.


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A

# Alabama Medicaid Agency

**ETG Recipient Details - FFS**

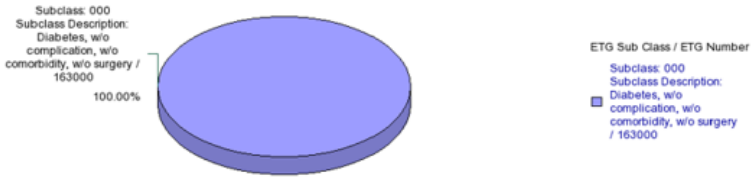
Recipient Overview

For Dates of Service: 07/01/2014 - 06/30/2016

Recipient ID: 123456789012

User ID: [redacted]
Run Date: 7/27/16
Run Time: 2:08:55 PM

Recipient Name: [redacted]
Date of Birth: [redacted]
Recipient Current Age: [redacted]
Gender: [redacted]




PHI has been removed

B

# Alabama Medicaid Agency

**ETG Recipient Details - FFS**

Details By ETG

For Dates of Service: 01/01/2015 - 12/31/2016

Recipient ID: 123456789012

User ID: [redacted]
Run Date: 9/8/16
Run Time: 3:28:44 PM

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

| Claim ICN | Claim Type Code & Description | Episode Type & Description | Recipient Full Name | Recipient Age | Recipient County Description | Claim Indicator | Procedure Code Description | Provider ID - Billing | Provider ID - Referring/ Attending/Prescribing | ICD | Primary Diagnosis Code & Description | Buyin Medicare A | Buyin Medicare B | DRG Code & Description | DRG Relative Weight | DRG Service Adjuster |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] | M - PROFESSIONAL CLAIMS | 7 - Incomplete annual episode, only applies to chronic episodes | XXXXXXXX XXXXXXXX XXXX, XXXXXXXX XXXXXXX, X | 16 | 08 - Calhoun | E | 51 - SOBRA Child(KM)-No$ (<100% FPL)-full Caid coverage | [redacted] | NPI ID: Medicaid ID: Base ID: | 0 | E1165 - TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA | Y | Y | - | | |

| Detail Number | Claim Detail Status | Date First Service | Date Last Service | NDC & Description | Procedure Code & Description | Billed Amount | Allowed Amount | Paid Amount | Provider ID - Rendering | Revenue Code & Description | Wrap Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | P | 4/6/2016 | 4/6/2016 | ########### - | 99214 - Office/Outpatient Visit Est | $130.00 | $0.00 | $50.00 | [redacted] | #### - Unknown or Not Applicable | N |

PHI has been removed

End of Report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C

## Alabama Medicaid Agency

**ETG Recipient Details - FFS**
Details By Servicing Provider
For Dates of Service: 01/01/2015 - 12/31/2016
Recipient ID: 123456789012

User ID:
Run Date: 9/8/16
Run Time: 3:28:44 I

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Servicing Provider ID: NPI ID:
Medicaid ID:
Base ID:

| Claim ICN | Claim Type Code & Description | Episode Type & Description | Recipient Full Name | Recipient Age | Recipient County Description | Claim Indicator | Procedure Code Description | Provider ID - Billing | Provider ID - Referring/ Attending/ Prescribing | ICD | Primary Diagnosis Code & Description | Buyin Medicare A | Buyin Medicare B | DRG Code & Description | DRG Relative Weight | DRG Service Adjuster |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 123456890123 | M - PROFESSIONAL CLAIMS | 7 - Incomplete annual episode, only applies to chronic episodes. | XXXXXXXX XXXXXXXX XXXX, XXXXXXXX XXXXXXX, X | 18 | 09 - Calhoun | E | 31 - SOBRA Child KM)-No$ (<100% FPL)-full Caid coverage | NPI ID: Medicaid ID: 1 Base ID: 100 | NPI ID: Medicaid ID: Base ID: | 9 | E1165 - TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA | Y | Y | - | | |

| Detail Number | Claim Detail Status | Date First Service | Date Last Service | NDC & Description | Procedure Code & Description | Billed Amount | Allowed Amount | Paid Amount | Provider ID - Rendering | Revenue Code & Description | Wrap Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | P | 4/6/2016 | 4/6/2016 | ********** ** - | 99214 - Office/ Outpatient Visit Est | $130.00 | $0.00 | $50.00 | NPI ID: Medicaid ID: 1 Base ID: | **** - Unknown or Not Applicable | N |

PHI has been removed

End of Report

D

## Alabama Medicaid Agency

**ETG Recipient Details - FFS**
Provider Totals
For Dates of Service: 07/01/2014 - 06/30/2016
Recipient ID: 123456789012

User ID:
Run Date: 7/27/16
Run Time: 2:08:55 PM

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

| Provider ID | Paid Amount |
|---|---|
| NPI ID:<br>Medicaid ID:<br>Base ID: | $100.00 |
| Totals: 1 | $100.00 |

End of Report

PHI has been removed


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E

# Alabama Medicaid Agency

**ETG Recipient Details - FFS**

**ETG Totals**

**For Dates of Service: 07/01/2014 - 06/30/2016**
**Recipient ID: 123456789012**

**User ID:** [redacted]
**Run Date: 7/27/16**
**Run Time: 2:08:55 PM**

| ETG Number & Description | Paid Amount |
|---|---|
| 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery | $100.00 |
| Totals: | $100.00 |

**End of Report**

PHI has been removed

F

# Alabama Medicaid Agency

**ETG Recipient Details - FFS**

**Procedure Totals**

**For Dates of Service: 07/01/2014 - 06/30/2016**
**Recipient ID: 123456789012**

**User ID:** [redacted]
**Run Date: 7/27/16**
**Run Time: 2:08:55 PM**

**ETG Number & Description:** **163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery**

**Subclass: 000**
**Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery**

| Procedure Code & Description | Provider Name | Recipient ID | Recipient Full Name | Paid Amount |
|---|---|---|---|---|
| 99214 - Office/Outpatient Visit Est | NPI ID: [redacted]<br>Medicaid ID: [redacted]<br>Base ID: [redacted] | 123456789012 | XXXXXXXXXXXXX XXXXXXX, XXXXXXXXXXXXX XX, X | $100.00 |
| Totals: | 1 | | | $100.00 |

**End of Report**

PHI has been removed


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G

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/27/16
Run Time: 2:08:55 PM

**ETG Recipient Details - FFS**
**Diagnosis Totals**

For Dates of Service: 07/01/2014 - 06/30/2016
Recipient ID: 123456789012

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery
Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

| ICD | Primary Diagnosis Code & Description | Provider Name | Recipient ID | Recipient Full Name | Paid Amount |
|---|---|---|---|---|---|
| 0 | E1165 - TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA | NPI ID: [redacted]<br>Medicaid ID: [redacted]<br>Base ID: [redacted] | 123456789012 | XXXXXXXXXXXXX XXXXXXX, XXXXXXXXXXXXX XX, X | $100.00 |
| | Totals: | 1 | | | $100.00 |

H

# Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/27/16
Run Time: 2:08:55 PM

**ETG Recipient Details - FFS**
**NDC Totals**

For Dates of Service: 07/01/2014 - 06/30/2016
Recipient ID: 123456789012

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

| NDC & Description | Provider Name | Recipient ID | Recipient Full Name | Paid Amount |
|---|---|---|---|---|
| ########### - | NPI ID: [redacted]<br>Medicaid ID: [redacted]<br>Base ID: [redacted] | 123456789012 | XXXXXXXXXXXXXX XXXXX, XXXXXXXXXXXXXX, X | $100.00 |
| Totals: | 1 | | | $100.00 |

### 3.5.98.1 ETG Recipient Details - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Date of Birth | Date of birth for recipient. | 10 | Date (MM/DD/CCYY) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Gender | The sex of the recipient. | 1 | Character |
| (A) Recipient Current Age | The recipient's current age. | 3 | Number (Integer) |
| (A) Recipient Name | Recipient Name. | 12 | Character |
| (A,D,F,G-H) Subclass | This field further describes the ETG number. | 3 | Character |
| (A,D,F,G-H) Subclass Description | The description of the subclass; for example: ETG Number 669001 is Skin trauma, subclass 000 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, w/o surgery", and subclass 001 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, *with* surgery". | 225 | Character |
| (A-H) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-H) Recipient ID | The recipient's Medicaid ID. | 12 | Character |
| (B) Recipient Full Name | Recipient's full name. | 12 | Character |
| (B-C) Allowed Amount | The allowed amount for the detail. | 11 | Number (Decimal) |
| (B-C) Billed Amount | The billed amount for the detail. | 11 | Number (Decimal) |
| (B-C) Claim Detail Status | The claim's status code. | 1 | Character |
| (B-C) Claim ICN | The claim's identification number. | 13 | Character |
| (B-C) Claim Type & Description | Shows what type of claim was submitted and the description. | 63 | Character |
| (B-C) Date First Service | The claim's first date of service. | 10 | Date (MM/DD/CCYY) |
| (B-C) Date Last Service | The claim's last date of service. | 10 | Date (MM/DD/CCYY) |
| (B-C) Detail Number | Detail number on the claim. | 3 | Number (Integer) |
| (B-C) DRG Code and Description | Diagnosis Related Group Number assigned to the claim, and its description. | 30 | Character |
| (B-C) DRG Relative Weight | Relative weight for pricing DRG | 5 | Number (Decimal) |
| (B-C) DRG Service Adjuster | This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor | 5 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (B-C) Episode Type & Description | Episode Type and the associated description. | 229 | Character |
| (B-C) Provider ID - Referring/Attending/Prescribing | Lists the NPI, Medicaid, and Base ID for the provider. | 63 | Character |
| (B-C) Provider ID – Billing | Lists the NPI, Medicaid, and Base ID for the provider. | 63 | Character |
| (B-C) Provider ID – Referring/Attending/Prescribing | Lists the NPI, Medicaid, and Base ID for the provider. | 63 | Character |
| (B-C) Provider ID – Rendering | Lists the NPI, Medicaid, and Base ID for the provider. | 63 | Character |
| (B-C) Recipient Age | The recipient's age. | 3 | Number (Integer) |
| (B-C) Revenue Code & Description | The revenue code on a detail and the associated description. | 63 | Character |
| (B-C) Wrap Ind | Wrap Payment Indicator | 1 | Character |
| (B-C,F) Procedure Code & Description | The procedure code for the detail and the associated description. | 49 | Character |
| (B-C,H) NDC Code & Description | National Drug Code is comprised of a 5-Character numeric labeler code, a 4-Character numeric product code, and a 2-Character numeric package code. It identifies a drug, its labeler, and the package size of a product, and is used for pricing and prior authorization. The description is a combination of the drug name appearing on the package label, the strength description and the dosage form description. | 49 | Character |
| (B-H) ETG Number & Description | The ETG Number and its description. | 234 | Character |
| (B-H) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 11 | Number (Decimal) |
| (D,F,G,H) Provider Name | Name of the provider | 25 | Character |
| (B,C,G) ICD | The ICD Version code for the primary ICD-CM payment level diagnosis code. | 1 | Character |
| (B,C,G) Primary Diagnosis Code & Description | Primary diagnosis code and its description. | 47 | Character |


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### 3.5.99


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### ETG Recipient Summary - FFS

The ETG Recipient Summary report rapidly displays all of the selected recipients' episodes in graphical and numeric format to assist in the identification of anomalies in service or practice. Episode Treatment Groups (ETGS) are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). Based on a series of clinical and statistical algorithms, ETGs provide a medically meaningful statistical unit representing a complete episode of care. ETGs combine all routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories. ETGs successfully provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The Episode Treatment Grouper (or ETG Profiler) allows for reporting on ETGs. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-D in the layout below. The field names have the corresponding letter in front, identifying the tab on which it can be found. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

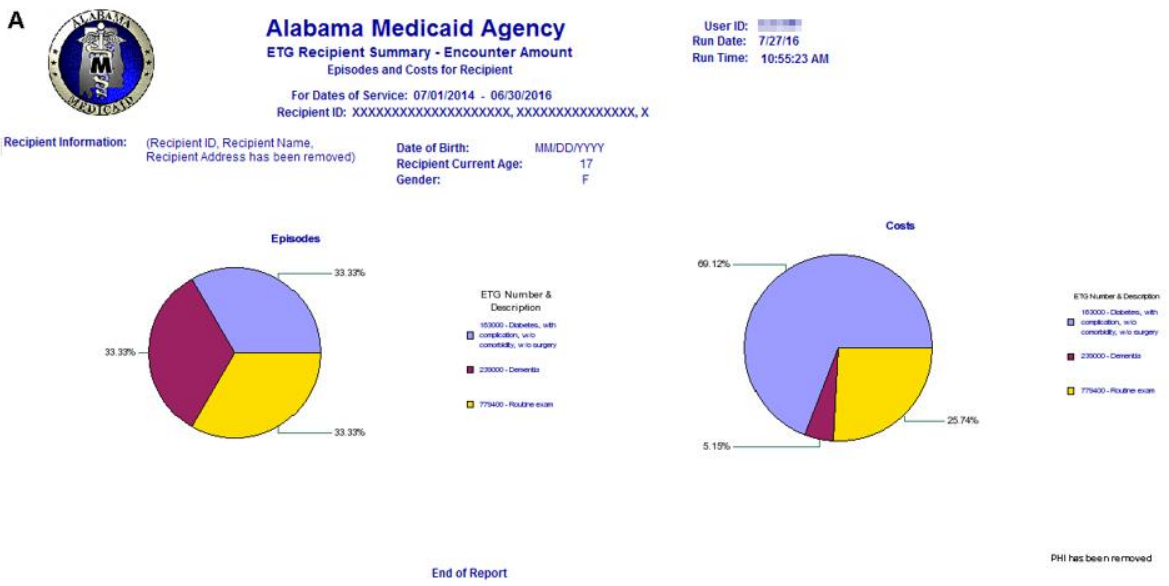
The four tabs in this report are:

A. Episodes and Costs for Recipient;

B. Recipient Summary Global Comparison;

C. Summary by ETG; and

D. Summary ETG Details by Major Practicing Category (MPC).





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B

# Alabama Medicaid Agency

**ETG Recipient Summary- Encounter Amount**

Recipient Summary Global Comparison

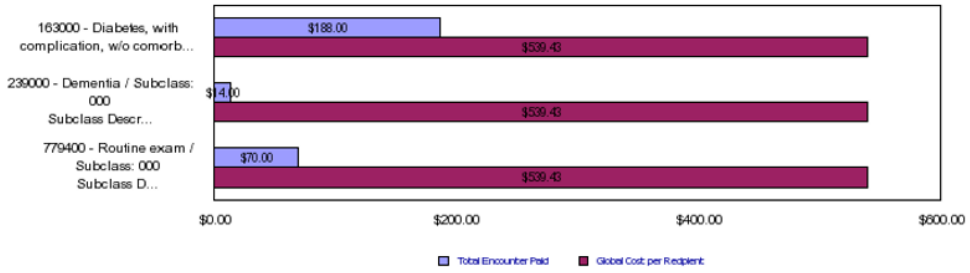
For Dates of Service: 07/01/2014 - 06/30/2016

Recipient ID: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X

User ID: [redacted]
Run Date: 7/27/16
Run Time: 10:55:23 AM

**Recipient Information**

(Recipient ID, Recipient Name,
Recipient Address has been removed)




End of Report

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C

# Alabama Medicaid Agency

**ETG Recipient Summary - Encounter Amount**

Summary By ETG

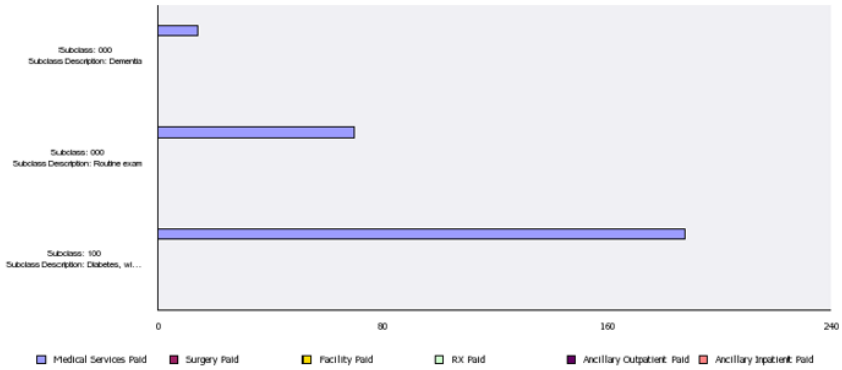
For Dates of Service: 07/01/2014 - 06/30/2016

Recipient ID: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X

User ID: [redacted]
Run Date: 7/27/16
Run Time: 10:55:23 AM

**Recipient Information**

(Recipient ID, Recipient Name, Recipient Address has been rer




| | |
|---|---|
| Average Episode Cost: | $90.67 |
| Average Amount per Recipient: | $90.67 |
| Total Episodes: | 3 |
| Total Recipients: | 3 |
| Total Dollars: | $272.00 |

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D

**Alabama Medicaid Agency**

**ETG Recipient Summary - Encounter Amount**

**Summary ETG Details by Major Practicing Category (MPC)**

**For Dates of Service: 07/01/2014 - 06/30/2016**
**Recipient ID: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X**

**User ID:** [redacted]
**Run Date: 7/27/16**
**Run Time: 10:55:23 AM**

**Recipient Information**
(Recipient ID, Recipient Name, Recipient Address has been removed)

**MPC & Description: 02 - ENDOCRINOLOGY**

| ETG Number & Description | Episode Count | Total Amount Billed | Total Encounter Amount | Global Paid Amount Per Recipient | Dollar Difference | Percent Difference | Ancillary Outpatient Paid | Facility Paid | Medical Services Paid | RX Paid | Surgery Paid | Ancillary Inpatient Paid |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 163000 - Diabetes, with complication, w/o comorbidity, w/o surgery | 1 | $525.00 | $188.00 | $539.43 | $(351.43) | (65.15) % | $0.00 | $0.00 | $188.00 | $0.00 | $0.00 | $0.00 |

PHI has been removed

### 3.5.99.1 ETG Recipient Summary - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Costs | Total amount paid for the provider. | 13 | Number (Decimal) |
| (A) Date of Birth | The recipient's birth date. | 10 | Date (MM/DD/CCYY) |
| (A) Episodes | The count of episodes for the provider. | 8 | Number (Integer) |
| (A) Gender | The sex of the recipient. | 1 | Character |
| (A) Recipient Current Age | The age of the recipient. | 3 | Number (Integer) |
| (A,B,D) Recipient Address (City, State, Zip) | The recipient's city, state, and zip code. | 25 | Character |
| (A,B,D) Recipient Address (Street) | The recipient's street address. | 30 | Character |
| (A,B,D) Recipient Name | The recipient's name. | 43 | Character |
| (A-D) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Recipient ID | Recipient Medicaid Number. | 12 | Character |
| (B) Global Cost Per Recipient | Total amount paid / unduplicated recipient count | 7 | Number (Decimal) |
| (B) Total Amount Paid | The total amount paid for the ETG. | 11 | Number (Decimal) |
| (C) Percentage | Percentage of paid amount identified in the previous report column. | 8 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (C) Average Amount per Recipient | Total amount paid / unduplicated recipient count. | 11 | Number (Decimal) |
| (C) Average Episode Cost | Total amount paid / episode count. | 11 | Number (Decimal) |
| (C) ETG Number | The ETG number/ID. | 6 | Number (Integer) |
| (C) Total Dollars | The summed total of all paid amounts. | 13 | Number (Decimal) |
| (C) Total Episodes | The episode count for the ETG. | 6 | Number (Integer) |
| (C) Total Recipients | The unduplicated recipient count. | 6 | Number (Integer) |
| (C,D) Ancillary Inpatient Paid | Ancillary Inpatient paid amount. | 11 | Number (Decimal) |
| (C,D) Ancillary Outpatient Paid | Ancillary Outpatient paid amount. | 7 | Number (Decimal) |
| (C,D) Facility Paid | Facility paid amount. | 11 | Number (Decimal) |
| (C,D) Medical Services Paid | Medical paid amount. | 11 | Number (Decimal) |
| (C,D) RX Paid | Prescription paid amount. | 11 | Number (Decimal) |
| (C,D) Surgery Paid | Surgery paid amount. | 11 | Number (Decimal) |
| (D) Dollar Difference | The difference between the paid and allowed amount. | 7 | Number (Decimal) |
| (D) Episode Count | Unduplicated count of episodes. | 8 | Number (Integer) |
| (D) ETG Number & Description | The ETG number and its description. | 234 | Character |
| (D) Global Paid Amount Per Recipient | Amount paid per recipient. | 11 | Number (Decimal) |
| (D) MPC & Description | The ETG defined category grouping and description. | 50 | Character |
| (D) Percent Difference | The difference between the paid and allowed amount expressed as a percent. | 3 | Number (Decimal) |
| (D) Total Amount Billed | The total amount billed for the ETG. | 11 | Number (Decimal) |
| (D) Total Amount Paid | The total amount paid for the ETG. | 11 | Number (Decimal) |


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### 3.5.100 ETG Provider Comparison - FFS

The ETG Provider Comparison report flags providers with total cost per episode or per recipient that is two or more standard deviations from the norm for a given episode type. The report provides a comparison of provider's ETG information by episode type for a selected ETG.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

Episode Treatment Groups (ETGs) are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). ETGs provide a medically meaningful statistical unit representing a complete episode of care based on a series of clinical and statistical algorithms. The reports combine routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories. ETGs successfully provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters.

**Alabama Medicaid Agency**

**ETG Provider Comparison - FFS**

**For Dates of Service: 07/01/2011 - 06/30/2013**

**ETG Number: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery**

**User ID:** [redacted]
**Run Date:** 2/11/2014
**Run Time:** 11:15:09 AM

**Subclass: 000**
**Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery**

**Episode Type & Description: 0 - Complete Episode.**

| Provider ID | Provider Full Name | Paid Amount Per Episode | Global Allowed Amount Per Episode | Difference in Episode Cost: 2 std dev = $3,168 | Episode Count | Paid Amount Per Recipient | Global Allowed Amount Per Recipient | Difference Recipient Cost: 2 std dev = $3,941 | Recipient Count |
|---|---|---|---|---|---|---|---|---|---|
| NPI ID: [redacted] Medicaid [redacted] Base ID: [redacted] | DAVID L SMITH | $10,552.00 | $22,853.00 | $(12,301.00) | 1 | $10,552.00 | $26,175.00 | $(15,623.00) | 1 |
| NPI ID: [redacted] Medicaid [redacted] Base ID: [redacted] | BRENDELLA T MONTGOMERY | $10,123.00 | $22,853.00 | $(12,730.00) | 1 | $10,123.00 | $26,175.00 | $(16,052.00) | 1 |
| NPI ID: [redacted] Medicaid [redacted] Base ID: [redacted] | BILLY J GOLDEN | $9,262.00 | $22,853.00 | $(13,591.00) | 2 | $18,524.00 | $26,175.00 | $(7,651.00) | 1 |
| NPI ID: [redacted] Medicaid [redacted]0 Base ID: [redacted] | CHERRIE L WAGNON | $8,349.00 | $22,853.00 | $(14,504.00) | 1 | $8,349.00 | $26,175.00 | $(17,826.00) | 1 |
| NPI ID: [redacted] Medicaid [redacted] Base ID: [redacted] | JAMES O DEVANEY III | $7,682.00 | $22,853.00 | $(15,171.00) | 1 | $7,682.00 | $26,175.00 | $(18,493.00) | 1 |
| NPI ID: [redacted] Medicaid [redacted] Base ID: [redacted] | ANDREW M ALLEN | $7,682.00 | $22,853.00 | $(15,171.00) | 1 | $7,682.00 | $26,175.00 | $(18,493.00) | 1 |
| NPI ID: [redacted] Medicaid [redacted]0 Base ID: [redacted] | JOYCELYN A ATCHISON | $7,504.00 | $22,853.00 | $(15,349.00) | 1 | $7,504.00 | $26,175.00 | $(18,671.00) | 1 |
| NPI ID: [redacted] Medicaid [redacted]5 Base ID: [redacted] | RONNIE T CHU | $7,427.00 | $22,853.00 | $(15,426.00) | 1 | $7,427.00 | $26,175.00 | $(18,748.00) | 1 |


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### 3.5.100.1 ETG Provider Comparison - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Difference in Episode Cost: 2 std dev = $0 | Difference Episode Cost value which is two standard deviations (2 std dev) from the 'norm'. Provider Amount per Episode minus Global Amt per Episode. Calculation: The amount allowed for a given provider per Episode minus the global amount allowed per provider and Episode. | 11 | Number (Decimal) |
| Difference Recipient Cost: 2 std dev = $0 | Difference Recipient Cost value which is two standard deviations from the 'norm'. Provider Amount per Recipient minus Global Amount per Recipient. Calculation: The amount allowed for a given recipient per Episode minus the global amount allowed per recipient and Episode. 2 Std Dev (Difference Recipient Cost) | 11 | Number (Decimal) |
| Episode Count | Unduplicated count of episodes. | 8 | Number (Integer) |
| Episode Type and Description | Episode Type and description. | 229 | Character |
| ETG Number (prompt) & Description | The selected ETG Number and its description. | 234 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Global Allowed Amount per Episode | Paid amount per episode. | 11 | Number (Decimal) |
| Global Allowed Amount per Recipient | The allowed amount per recipient. | 11 | Number (Decimal) |
| Paid Amount Per Episode | The total paid amount divided by the episode count. | 13 | Number (Decimal) |
| Paid Amount Per Recipient | Actual amount the provider was paid per recipient. | 13 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| Provider Full Name | The provider's full name. | 50 | Character |
| Provider ID | The provider's identification number. | 9 | Character |
| Recipient Count | The number of eligible recipients the provider served for this particular claim grouping. | 6 | Number (Integer) |
| Subclass | This field further describes the ETG number. | 3 | Character |
| Subclass Description | The description of the subclass; for example: ETG Number 669001 is Skin trauma, subclass 000 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, w/o surgery", and subclass 001 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, *with* surgery". | 225 | Character |
| Totals | The sum of episode amounts. | 13 | Number (Decimal) |


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### 3.5.101 ETG Provider Details - FFS

The ETG Provider Details report shows detailed information for a selected provider. The details are grouped into episode type, which provides a convenient method of viewing specific billing patterns and practices of the provider. This information helps to determine what steps may be required to improve the health of recipients or reduce the cost of the services. Episode Treatment Groups (ETGs) are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). ETGs provide a medically meaningful statistical unit representing a complete episode of care based on a series of clinical and statistical algorithms.

The report combines routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories. ETGs provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The report contains eight tabs:

A. Provider Overview;

B. Details by ETG;

C. Details by Recipient;

D. Recipient Totals;

E. ETG Totals;

F. Procedure Totals;

G. Diagnosis Totals; and

H. NDC Totals.


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# Alabama Medicaid Agency

**ETG Provider Details - FFS**

**Provider Overview**

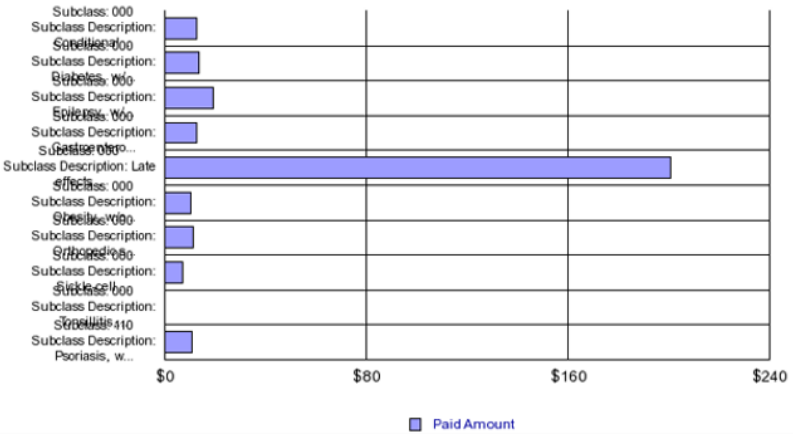
**For Dates of Service: 07/01/2014 - 06/30/2016**

User ID: [redacted]
Run Date: 7/21/16
Run Time: 2:15:35 PM

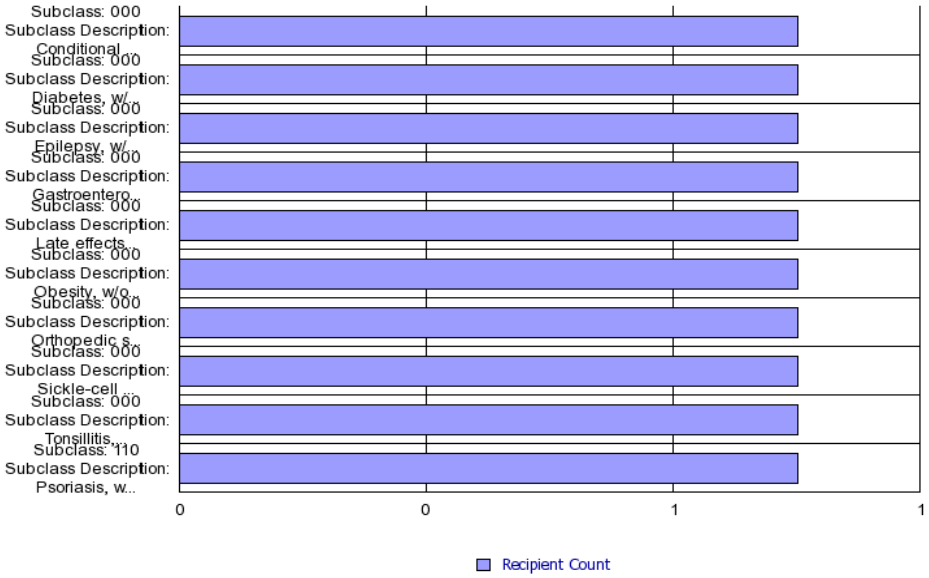
Provider Information:
NPI ID: [redacted]
Medicaid ID: [redacted]
Base ID: [redacted]
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

**Top 10 ETGs based on Paid Amount**




**Top 10 ETGs based on Recipient Count**




**End of Report**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B

## Alabama Medicaid Agency

**ETG Provider Details - FFS**

Details By ETG

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

For Dates of Service: 07/01/2014 - 06/30/2016
Provider Information:
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

ETG Number & Description: 63000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

| Claim ICN | Claim Type Code & Description | Episode Type & Description | Recipient ID | Recipient Full Name | Recip Age | Recipient County Description | Claim Indicator | Program Code Description | Provider ID - Billing | Provider ID - Referring/ Attending/ Prescribing | ICD | Primary Diagnosis Code & Description | Buyin Medicare A | Buyin Medicare B | DRG Code & Description | DRG Relative Weight | DRG Service Adjuster |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Claim Type Code & Description | 0 - Complete Episode. | 123456789012 | XXXXXXXXX XXXXXXXXX XX, XXXXXXXXX XXXXXX, X | 14 | 08 - Calhoun | F | 41 - Disabled-SSI-full Medicaid coverage | NPI ID: Medicaid ID: Base ID: | NPI ID: Medicaid ID: Base ID: | 9 | 25000 - DIABETES UNCOMPL ADULT-TYPE II | N | N | #### - | 0 | 0 |

| Detail Number | Claim Detail Status | Date First Service | Date Last Service | NDC & Description | Procedure Code & Description | Billed Amount | Allowed Amount | Paid Amount | Provider ID - Rendering | Revenue Code & Description | Wrap Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | P | 8/26/2015 | 8/26/2015 | ########### - | 80053 - Comprehen Metabolic Panel | $583.30 | $13.31 | $13.31 | NPI ID: Medicaid ID: Base ID: | 0301 - Lab/ Chemistry | N |

PHI has been removed

C

## Alabama Medicaid Agency

**ETG Provider Details - FFS**

Details By Recipient

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

For Dates of Service: 07/01/2014 - 06/30/2016
Provider Information:
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

Recipient ID: 123456789012

| Claim ICN | Claim Type Code & Description | Episode Type & Description | Recipient Full Name | Recip Age | Recipient County Description | Claim Indicator | Program Code Description | Provider ID - Billing | Provider ID - Referring/Attending/ Prescribing | ICD | Primary Diagnosis Code & Description | Buyin Medicare A | Buyin Medicare B | DRG Code & Description | DRG Relative Weight | DRG Service Adjuster |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M - PROFESSIONAL CLAIMS | 0 - Complete Episode. | XXXXXXXXX XXXXXXXXX XX, XXXXXXXXX XXXXXX, X | 8 | 63 - Tuscaloosa | F | 41 - Disabled-SSI-full Medicaid coverage | NPI ID: Medicaid ID: Base ID: | NPI ID: Medicaid ID: Base ID: | 9 | V421 - HEART REPLACED BY TRANSPLANT | N | N | - | | |

| Detail Number | Claim Detail Status | Date First Service | Date Last Service | NDC & Description | Procedure Code & Description | Billed Amount | Allowed Amount | Paid Amount | Provider ID - Rendering | Revenue Code & Description | Wrap Ind |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | P | 8/31/2015 | 8/31/2015 | ########### - | 93010 - Electrocardiogram Report | $24.00 | $12.69 | $12.69 | NPI ID: Medicaid ID: Base ID: | #### - Unknown or Not Applicable | N |

PHI has been removed

End of Report


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D

# Alabama Medicaid Agency

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

## ETG Provider Details - FFS

### Recipient Totals

For Dates of Service: 07/01/2014 - 06/30/2016

Provider Information:
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

| Recipient ID | Recipient Full Name | ETG Number & Description | Paid Amount |
|---|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXXXX , XXXXXXXXXXXXXX, X | 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery | $13.31 |
| Recipient ID | Recipient Full Name | ETG Number & Description | Paid Amount |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX , XXXXXXXXXXXXXX, X | 164800 - Obesity, w/o complication, w/o surgery | $10.11 |
| Recipient ID | Recipient Full Name | ETG Number & Description | Paid Amount |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX , XXXXXXXXXXXXXX, X | 207400 - Sickle-cell anemia, w/o surgery | $7.05 |

E

# Alabama Medicaid Agency

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

## ETG Provider Details - FFS

### ETG Totals

For Dates of Service: 07/01/2014 - 06/30/2016

Provider Information:
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

| ETG Number & Description | Paid Amount |
|---|---|
| 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery | $13.31 |
| 164800 - Obesity, w/o complication, w/o surgery | $10.11 |
| 207400 - Sickle-cell anemia, w/o surgery | $7.05 |
| 315200 - Epilepsy, w/o complication, w/o comorbidity, w/o surgery | $19.10 |
| 403100 - Tonsillitis, adenoiditis or pharyngitis, w/o complication, w/o comorbidity, w/o surgery | $0.00 |


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F

# Alabama Medicaid Agency

**ETG Provider Details - FFS**

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

**Procedure Totals**

**For Dates of Service: 07/01/2014 - 06/30/2016**

**Provider Information:**
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

**ETG Number & Description:** 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

**Subclass: 000**
**Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery**

| Procedure Code & Description | Recipient ID | Recipient Full Name | Claim ICN | Paid Amount |
|---|---|---|---|---|
| 80053 - Comprehen Metabolic Panel | 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX, X | 2015299045713 | $13.31 |
| Totals: | 1 | | 1 | $13.31 |

PHI has been removed

G

# Alabama Medicaid Agency

**ETG Provider Details - FFS**

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

**Diagnosis Totals**

**For Dates of Service: 07/01/2014 - 06/30/2016**

**Provider Information:**
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

**ETG Number & Description:** 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

**Subclass: 000**
**Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery**

| ICD | Primary Diagnosis Code & Description | Recipient ID | Recipient Full Name | Claim ICN | Paid Amount |
|---|---|---|---|---|---|
| 9 | 25000 - DIABETES UNCOMPL ADULT-TYPE II | 123456789012 | XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXX, X | 2015299045713 | $13.31 |
| | Totals: | 1 | | 1 | $13.31 |

PHI has been removed


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H

**Alabama Medicaid Agency**

**ETG Provider Details - FFS**

**NDC Totals**

**For Dates of Service: 07/01/2014 - 06/30/2016**

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

Provider Information:
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

| NDC & Description | Recipient ID | Recipient Full Name | Claim ICN | Paid Amount |
|---|---|---|---|---|
| ########## - | 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX, X | 2015299045713 | $13.31 |
| Totals: | 1 | | 1 | $13.31 |

End of Report

PHI has been removed

### 3.5.101.1 ETG Provider Details - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Top 10 ETGs based on Paid Amount - ETG Description (X axis) | The Episode Treatment Group (ETG) description for ETGs with the highest paid amounts for this provider. | 0 | Character |
| (A) Top 10 ETGs based on Paid Amount - Paid (Y axis) | The paid amount (high to low) for Episode Treatment Groups with the highest paid amounts for this provider. | 0 | Number (Decimal) |
| (A) Top 10 ETGs based on Recipient Count (Y axis) | The recipient count (high to low) for ETGs with the highest recipient counts for this provider. | 0 | Number (Integer) |
| (A) Top 10 ETGs based on Recipient Count- ETG Description (X axis) | The ETG description for ETGs with the highest recipient counts for this provider. | 0 | Character |
| (A-H) NPI ID | The National Provider Identification number of the provider. | 10 | Character |
| (A-H) Medicaid ID | Medicaid identification number for the provider. | 13 | Character |
| (A-H) Base ID | The Medicaid identification number of the provider. | 13 | Character |
| (B,D,E,F,G,H) ETG Number & Description | The ETG number and its description. | 234 | Character |
| (A-H) Name | The provider's name. | 50 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-H) (Provider) Type | The provider type code and description. | 55 | Character |
| (A-H) (Provider ) Specialty | The specialty and description for the provider. | 56 | Character |
| (A-H) Address (City, State, Zip) | The provider's city, state, and ZIP code. | 46 | Character |
| (A-H) Address (Street) | The provider's street address. | 62 | Character |
| (B) Servicing Provider Address (City, State, Zip) | The servicing provider's city, state, and ZIP code. | 46 | Character |
| (B) Servicing Provider Address (Street) | The servicing provider's street address. | 62 | Character |
| (D,F,G,H) Totals | The sum of episode amounts. | 13 | Number (Integer) |
| (B-H) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| (B-D, F-H) Claim ICN | The claim's identification number. | 13 | Character |
| (B-D, F-H) Recipient Full Name | Recipient Full name, including first, middle initial and last name. | 39 | Character |
| (B-D, F-H) Recipient ID | The recipient's Medicaid identification number. | 11 | Character |
| (B,C,H) NDC & Description | National Drug Code is comprised of a 5-Character numeric labeler code, a 4-Character numeric product code, and a 2-Character numeric package code. It identifies a drug, its labeler, and the package size of a product, and is used for pricing and prior authorization. The description is a combination of the drug name appearing on the package label, the strength description and the dosage form description. | 49 | Character |
| (B,C,F) Procedure Code & Description | The procedure code for the detail and the associated description. | 49 | Character |
| (B,C) Billed Amount | The billed amount for the detail. | 11 | Character |
| (B,C) Allowed Amount | The allowed amount for the detail. | 11 | Character |
| (B,C) Buy-In Medicare A | Medicare Buy-in in which recipient is participating in Part A. | 5 | Character |
| (B,C) Buy-In Medicare B | Medicare Buy-in in which recipient is participating in Part B. | 5 | Character |
| (B,C) DRG Code and Description | Diagnosis Related Group Number assigned to the claim, and its description. | 30 | Character |
| (B,C) DRG Relative Weight | Relative weight for pricing DRG | 5 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (B,C) DRG Service Adjuster | This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor | 3 | Number (Decimal) |
| (B,C) Provider ID-Rendering | Lists the NPI, Medicaid, and Base ID for the rendering provider. | 63 | Character |
| (B,C) Revenue Code & Description | Revenue code and description. | 77 | Character |
| (B,C,G) ICD | The ICD Version code for the primary ICD-CM payment level diagnosis code. | 1 | Character |
| (B,C,G) Primary Diagnosis Code & Description | The primary ICD-CM diagnosis description. | 70 | Character |
| (B,C) Claim Type Code & Description | Shows what type of claim was submitted. | 54 | Character |
| (B,C) Episode Type & Description | Episode Type and the associated description. | 229 | Character |
| (B,C) Recip Age | The recipient's age. | 3 | Number (Integer) |
| (B,C) Recip County Description | Recipient's county of residence and the associated description. | 38 | Character |
| (B,C) Claim Indicator | Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim. | 1 | Character |
| (B,C) Program Code Description | State aid category. | 6 | Character |
| (B,C) Provider ID Billing | Lists the NPI, Medicaid, and Base ID for the billing provider. | 63 | Character |
| (B,C) Provider ID-Referring/Attending/Prescribing | Lists the NPI, Medicaid, and Base ID for the provider. | 63 | Character |
| (B,C) Detail Number | Detail number on the claim. | 2 | Number (Integer) |
| (B,C) Claim Detail Status | The claim's status code. | 1 | Character |
| (B,C) Date First Service | The claim's first date of service. | 10 | Date (MM/DD/CCYY) |
| (B,C) Date Last Service | The claim's last date of service. | 10 | Date (MM/DD/CCYY) |
| (B,C,F,G,H) Subclass | This field further describes the ETG number. | 3 | Character |
| (B,C) Wrap Ind | Wrap Payment Indicator | 1 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (B,C,F,G,H) Subclass Description | The description of the subclass; for example: ETG Number 669001 is Skin trauma, subclass 000 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, w/o surgery", and subclass 001 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, *with* surgery". | 225 | Character |

### 3.5.102 ETG Provider Summary - FFS

This report is run through the Episode Treatment Grouper (ETG). This breaks the ETGs down to the provider level.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-D in the layout below. The field names have the corresponding letter in front, identifying the tab on which it can be found. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

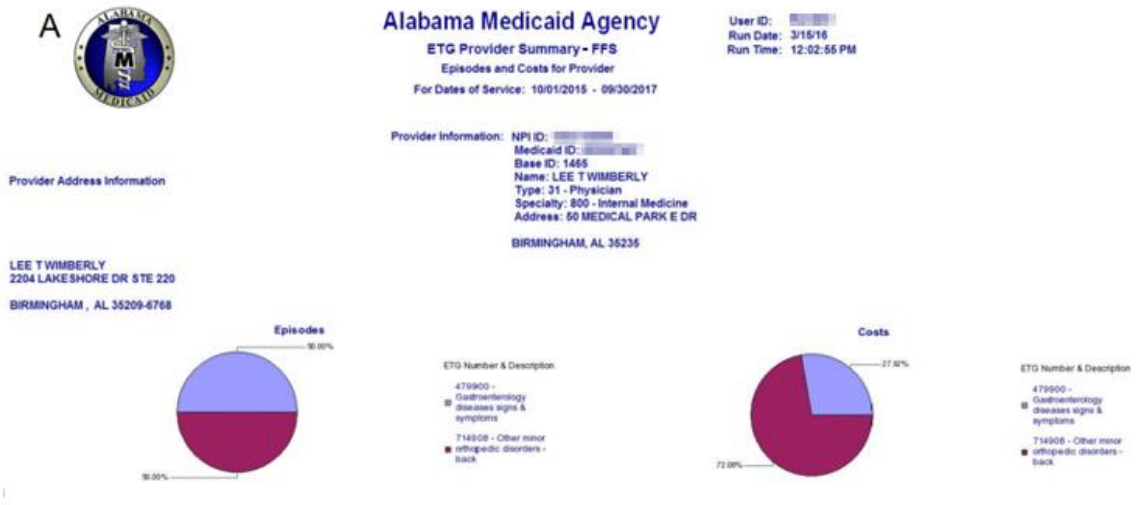
The four tabs in this report are:

A. Episodes and Costs for Provider;

B. Provider Summary Global Comparison;

C. Summary By ETG; and

D. Summary ETG Details By Major Practicing Category (MPC).





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B

# Alabama Medicaid Agency

**ETG Provider Summary - FFS**

**Provider Summary Global Comparison**

**For Dates of Service: 10/01/2015 - 09/30/2017**

User ID:
Run Date: 3/15/16
Run Time: 12:02:55 PM

**Provider Information:**
NPI ID:
Medicaid ID:
Base ID:
Name: LEE T WIMBERLY
Type: 31 - Physician
Specialty: 800 - Internal Medicine
Address: 50 MEDICAL PARK E DR

BIRMINGHAM, AL 35235

**Recipient Information**

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C

# Alabama Medicaid Agency

**ETG Provider Summary - FFS**

**Summary By ETG**

**For Dates of Service: 07/01/2014 - 06/30/2016**

**User ID:** [redacted]
**Run Date:** 7/25/16
**Run Time:** 10:41:51 AM

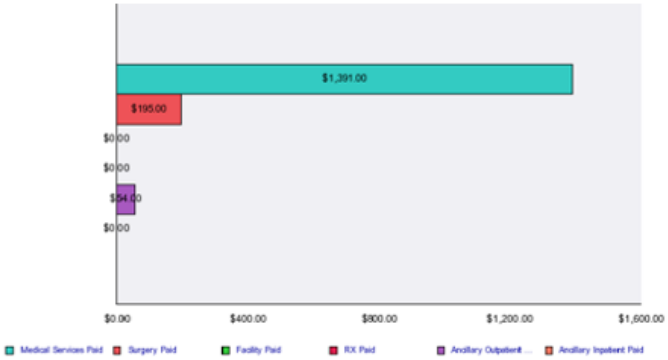
**Provider Information:**
**NPI ID:** [redacted]
**Medicaid ID:** [redacted]
**Base ID:** [redacted]
**Name:** SHERMAN L ARMSTRONG JR
**Type:** 31 - Physician
**Specialty:** 319 - General Surgeon
**Address:** 1722 PINE ST STE 201

MONTGOMERY, AL 36106

**MPC Code & Description:** 02 - ENDOCRINOLOGY

**ETG Number & Description:** 163000 - Diabetes, with complication, w/o comorbidity, w/o surgery

**Episode Type & Description:** 7 - Incomplete annual episode, only applies to chronic episodes.




| | |
|---|---|
| Average Episode Cost: | $102.50 |
| Average Amount per Recipients: | $102.50 |
| Total Episodes: | 16 |
| Total Recipients: | 16 |
| Total Dollars: | $1,640.00 |

| ETG Number | Ancillary Inpatient Paid | Percentage | Ancillary Outpatient Paid | Percentage | Facility Paid | Percentage | Medical Services Paid | Percentage | RX Paid | Percentage | Surgery Paid | Percentage |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 163000 - Diabetes, with complication, w/o comorbidity, w/o surgery | $0.00 | 0.00 % | $54.00 | 3.29 % | $0.00 | 0.00 % | $1,391.00 | 84.82 % | $0.00 | 0.00 % | $195.00 | 11.89 % |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**Alabama Medicaid Agency**

**ETG Provider Summary - FFS**

Summary ETG Details By Major Practicing Category (MPC)

For Dates of Service: 07/01/2011 - 06/30/2013

User ID: [redacted]
Run Date: 2/11/2014
Run Time: 11:42:22 AM

Provider Information: NPI ID: [redacted]
Medicaid ID: [redacted]
Base ID: [redacted]
Name: WILLIAM E TYNDALL
Type: 31 - Physician
Specialty: 315 - Emergency Medicine Practitioner
Address: 600 S 3RD ST

GADSDEN, AL 35901

Provider Address Information
WILLIAM E TYNDALL
PO BOX 538424

ATLANTA , GA 30353-

MPC & Description: 02 - ENDOCRINOLOGY

| ETG Number & Description(Provider) | Recip Count | Episode Count | Total Amount Billed | Total Amount Paid | Provider Average Cost per Recip | Global Allowed Amount Per Recip | Dollar Difference | Percent Difference | Ancillary Outpatient Paid | Facility Paid | Medical Services Paid | RX Paid | Surgery Paid | Ancillary Inpatient Paid |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 163000 - Diabetes, w/o complication, with comorbidity, w/o surgery | 2 | 2 | $17,241.00 | $4,753.00 | $2,376.50 | $1,925.00 | $451.89 | 23.48 % | $2,004.00 | $0.00 | $1,701.00 | $915.00 | $133.00 | $0.00 |

MPC & Description: 05 - CHEMICAL DEPENDENCY

| ETG Number & Description(Provider) | Recip Count | Episode Count | Total Amount Billed | Total Amount Paid | Provider Average Cost per Recip | Global Allowed Amount Per Recip | Dollar Difference | Percent Difference | Ancillary Outpatient Paid | Facility Paid | Medical Services Paid | RX Paid | Surgery Paid | Ancillary Inpatient Paid |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 271200 - Acute alcohol intoxication | 1 | 1 | $3,498.00 | $1,198.00 | $1,198.00 | $359.00 | $838.90 | 233.61 % | $1,132.00 | $0.00 | $66.00 | $0.00 | $0.00 | $0.00 |

### 3.5.102.1 ETG Provider Summary - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-D) (Provider) Specialty | The specialty and description for the provider. | 63 | Character |
| (A-D) (Provider) Type | The provider type code and description. | 50 | Character |
| (A-D) Address (City, State, Zip) | The provider's city, state, and ZIP code. | 25 | Character |
| (A-D) Address (Street) | The provider's street address. | 30 | Character |
| (A-D) Base ID | The Base identification number of the provider. | 13 | Character |
| (A-D) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-D) Medicaid ID | Medicaid identification number for the provider. | 13 | Character |
| (A-D) Name | The provider's name. | 50 | Character |
| (A-D) NPI ID | The National Provider Identification number of the provider. | 10 | Character |
| (B) Global Cost per Recipient | Total amount paid / unduplicated recipient count. | 7 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (B,D) Provider Average Cost per Recipient | Total amount paid per recipient. | 11 | Number (Decimal) |
| (B) Subclass | This field further describes the ETG number. | 3 | Character |
| (B) Subclass Description | The description of the subclass; for example: ETG Number 669001 is Skin trauma, subclass 000 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, w/o surgery", and subclass 001 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, *with* surgery". | 225 | Character |
| (C) Average Episode Cost | Total amount paid /episode cost. | 11 | Number (Decimal) |
| (C) Total Episodes | The episode count for the ETG. | 6 | Number (Integer) |
| (C) Average Amount per Recipient | Total amount paid / unduplicated recipient count. | 11 | Number (Decimal) |
| (C) Total Recipients | The unduplicated recipient count for the ETG. | 6 | Number (Integer) |
| (C) Total Dollars | The summed total of all paid amounts. | 11 | Number (Decimal) |
| (C)Percentage | Percentage of paid amount identified in the previous report column. | 8 | Number (Decimal) |
| (C) ETG Number & Description | The ETG number and its description. | 234 | Character |
| (C,D) Ancillary Inpatient Paid | Ancillary Inpatient paid amount. | 11 | Number (Decimal) |
| (C,D) Ancillary Outpatient Paid | Ancillary Outpatient paid amount. | 11 | Number (Decimal) |
| (C,D) Facility Paid | Facility paid amount. | 11 | Number (Decimal) |
| (C,D) Medical Services Paid | Medical paid amount. | 11 | Number (Decimal) |
| (C,D) RX Paid | Prescription paid amount. | 11 | Number (Decimal) |
| (C,D) Surgery Paid | Surgery paid amount. | 11 | Number (Decimal) |
| (D) Recip Count | Number of eligible recipients the provider served for this particular claim grouping. | 8 | Number (Integer) |
| (D) Episode Count | The episode count for the ETG. | 6 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (D) Total Amount Billed | The total amount billed for the ETG. | 11 | Number (Decimal) |
| (D) Total Amount Paid | The total amount paid for the ETG. | 11 | Number (Decimal) |
| (D) Global Allowed Amount per Recip | The allowed amount per recipient. | 11 | Number (Decimal) |
| (D) Dollar Difference | The difference between the paid and allowed amount. | 7 | Number (Decimal) |
| (D) Percent Difference | The difference between the paid and allowed amount expressed as a percent. | 3 | Number (Decimal) |


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### 3.5.103 ETG Summary - FFS

The ETG Summary report breaks the Episode Treatment Groups (ETGs) down to the major category levels. It displays the average episode cost, the average amount per recipient, total episodes, total recipients and total dollars.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

ETGs are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). Based on a series of clinical and statistical algorithms, ETGs provide a medically meaningful statistical unit representing a complete episode of care. ETGs combine all routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories. ETGs successfully provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The Episode Treatment Grouper (or ETG Profiler) allows for reporting on ETGs. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters.

The ETG Summary report contains two tabs. The first tab contains brief information for every ETG major processing category. The second tab allows the report user to drill down by major processing category, ETG description and episode type to view individual ETGs. The report in the second tab presents the data in chart and tabular format. A report user can select the ETG processing category, ETG description and episode type they want to see by using the drop down boxes at the top of the report.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-B in the layout below. The field names have the corresponding letter in front, identifying the tab on which it can be found. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

The two tabs in this report are:

A. Summary By ETG; and

B. Summary ETG Details By Major Practicing Category (MPC).


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A

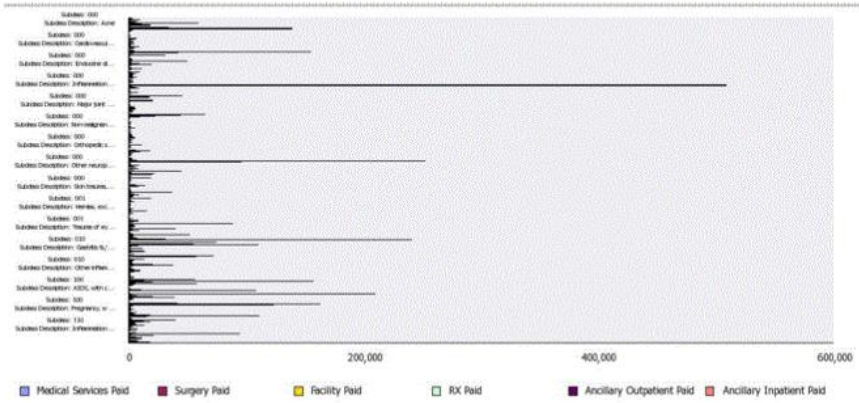
# Alabama Medicaid Agency

**ETG Summary - FFS**

**Summary By ETG**

**For Dates of Service: 10/01/2015 - 09/30/2017**

User ID: [redacted]
Run Date: 3/21/16
Run Time: 2:51:46 PM




| | |
|---|---|
| Average Episode Cost: | $749.50 |
| Average Amount per Recipient: | $891.86 |
| Total Episodes: | 10,061 |
| Total Recipients: | 8,455 |
| Total Dollars: | $7,540,709.00 |

| ETG Number & Description | Ancillary Inpatient Paid | Percentage | Ancillary Outpatient Paid | Percentage | Facility Paid | Percentage | Medical Services Paid | Percentage | RX Paid | Percentage | Surgery Paid | Percentage |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 130100 - AIDS, with complication, with comorbidity, with surgery | $0.00 | 0.00 % | $308.00 | 1.36 % | $0.00 | 0.00 % | $1,654.00 | 7.31 % | $20,433.00 | 90.34 % | $223.00 | 0.99 % |
| 130100 - AIDS, with complication, with comorbidity, w/o surgery | $0.00 | 0.00 % | $13,583.00 | 10.63 % | $0.00 | 0.00 % | $2,084.00 | 1.63 % | $111,033.00 | 86.88 % | $1,095.00 | 0.86 % |
| 130100 - AIDS, with complication, w/o comorbidity, w/o surgery | $0.00 | 0.00 % | $13,419.00 | 18.85 % | $0.00 | 0.00 % | $464.00 | 0.65 % | $57,320.00 | 80.50 % | $0.00 | 0.00 % |
| 130100 - AIDS, w/o complication, with comorbidity, w/o surgery | $0.00 | 0.00 % | $0.00 | 0.00 % | $0.00 | 0.00 % | $0.00 | 0.00 % | $2,459.00 | 100.00 % | $0.00 | 0.00 % |
| 130200 - HIV sero-positive w/o AIDS, w/o surgery | $0.00 | 0.00 % | $248.00 | 71.26 % | $0.00 | 0.00 % | $88.00 | 25.29 % | $12.00 | 3.45 % | $0.00 | 0.00 % |
| 130400 - Septicemia, with complication, w/o surgery | $0.00 | 0.00 % | $77.00 | 14.15 % | $0.00 | 0.00 % | $377.00 | 69.30 % | $90.00 | 16.54 % | $0.00 | 0.00 % |
| 130400 - Septicemia, w/o complication, w/o surgery | $0.00 | 0.00 % | $689.00 | 46.37 % | $0.00 | 0.00 % | $685.00 | 46.10 % | $68.00 | 4.58 % | $44.00 | 2.96 % |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**Alabama Medicaid Agency**

**ETG Summary - FFS**

**Summary ETG Details by Major Practicing Category (MPC)**

**For Dates of Service: 10/01/2014 - 09/30/2016**

**User ID:** [redacted]
**Run Date:** 3/8/16
**Run Time:** 2:50:17 PM

**MPC & Description:** 01 - INFECTIOUS DISEASES

| ETG Number & Description | Unduplicated Recip Count | Episode Count | Ancillary Outpatient Paid | Facility Paid | Medical Services Paid | RX Paid | Surgery Paid | Total Amount Billed | Total Amount Paid |
|---|---|---|---|---|---|---|---|---|---|
| 130100 - AIDS, with complication, with comorbidity, with surgery | 1 | 1 | $308.00 | $0.00 | $1,654.00 | $20,433.00 | $223.00 | $30,058.00 | $22,617.00 |
| 130100 - AIDS, with complication, with comorbidity, w/o surgery | 7 | 10 | $13,583.00 | $0.00 | $2,084.00 | $111,033.00 | $1,095.00 | $191,270.00 | $127,796.00 |
| 130100 - AIDS, with complication, w/o comorbidity, w/o surgery | 2 | 3 | $13,419.00 | $0.00 | $464.00 | $57,320.00 | $0.00 | $87,761.00 | $71,204.00 |
| 130100 - AIDS, w/o complication, with comorbidity, w/o surgery | 1 | 1 | $0.00 | $0.00 | $0.00 | $2,459.00 | $0.00 | $2,975.00 | $2,459.00 |
| 130200 - HIV sero-positive w/o AIDS, w/o surgery | 2 | 2 | $248.00 | $0.00 | $88.00 | $12.00 | $0.00 | $503.00 | $348.00 |
| 130400 - Septicemia, with complication, w/o surgery | 1 | 1 | $77.00 | $0.00 | $377.00 | $90.00 | $0.00 | $3,817.00 | $543.00 |
| 130400 - Septicemia, w/o complication, w/o surgery | 8 | 8 | $689.00 | $0.00 | $685.00 | $68.00 | $44.00 | $9,412.00 | $1,486.00 |
| 130600 - Other infectious diseases, with complication, with comorbidity, w/o surgery | 8 | 8 | $260.00 | $0.00 | $505.00 | $280.00 | $0.00 | $4,680.00 | $1,045.00 |

### 3.5.103.1 ETG Summary - FFS Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Ancillary Inpatient Paid | Ancillary Inpatient paid amount. | 11 | Number (Decimal) |
| (A) Average Amount per Recipient | Total amount paid / unduplicated recipient count. | 11 | Number (Decimal) |
| (A) Average Episode Cost | Total amount paid / episode count. | 11 | Number (Decimal) |
| (A) Percentage | Percentage of paid amount identified in the previous report column. | 8 | Number (Decimal) |
| (A) Total Dollars | The summed total of all paid amounts. | 11 | Number (Decimal) |
| (A) Total Episodes | The total count of all episodes. | 6 | Number (Integer) |
| (A) Total Recipients | The total count of all recipients. | 6 | Number (Integer) |
| (A,B) Ancillary Outpatient Paid | Ancillary Outpatient paid amount. | 11 | Number (Decimal) |
| (A,B) Facility Paid | Facility paid amount. | 11 | Number (Decimal) |
| (A,B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A,B) Medical Services Paid | Medical paid amount. | 11 | Number (Decimal) |
| (A,B) Rx Paid | Prescription paid amount. | 11 | Number (Decimal) |
| (A,B) Surgery Paid | Surgery paid amount. | 11 | Number (Decimal) |
| (A,B) ETG Number & Description | The ETG number and its description. | 234 | Character |
| (B) Episode Count | The episode count for the ETG. | 6 | Number (Integer) |
| (B) Total Amount Billed | The summed total of all billed amounts. | 11 | Number (Decimal) |
| (B) Total Amount Paid | The summed total of all paid amounts. | 11 | Number (Decimal) |
| (B) Unduplicated Recip Count | The unduplicated recipient count for the ETG. | 6 | Number (Integer) |
| (B) MPC & Description | The ETG defined category grouping. | 50 | Character |

### 3.5.104 TQ - Facility Visits Exception

The Facility Visits Exception Report displays the exception professional claims submitted by a provider meeting the defined criteria for the report.

The SURS Certification Requirement met by this report:

- Physicians and other practitioners having instances of frequent multiple visits on a single day to many recipients at the same facility or location. The requirement of 'frequent' is determined by the analyst reviewing the report.

**Search Criteria:**

- Claim Type = M or B;
- Paid Claims Only;
- Latest Claims Only;
- Exclude Wrap Payments;
- Procedure Code between 99221 and 99223 or 99231 and 99233 or 99381 and 99387 or 99391 and 99397;
- Date of Services - Date range specified by the user in the prompt; and
- Multiple Visits - Specified by the user. It is the number of visits per day by a provider to one or more recipients at the same facility or location.


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**Alabama Medicaid Agency**
**Office Visits Exception Report**

From Date of Service: 1/1/16 - 6/26/16
Multiple Visits: 1

User ID:
Run Date: 6/29/2016
Run Time: 13:58:06

Medicaid Provider ID:
Provider Name: ALABAMA COMMUNITY CARE REGION A

| Recipient ID | Recipient Name | From Date of Service Date | To Date of Service Date | Claim Type | District Plan Code | ICN | Primary Procedure Code & Description | Claim Ind | Payment Date | Paid Amount | Encounter Amount | RCO Paid Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXX XX, XXXXXXXXXXXXXXX, X | 4/5/2016 | 4/5/2016 | M | RA1 | | 99201 - OFFICE/OUTPATIENT VISIT NEW | E | 5/9/2016 | $0.00 | $0.00 | $7.00 |
| 123456789012 | XXXXXXXXXXXXXXXXXX XX, XXXXXXXXXXXXXXX, X | 4/5/2016 | 4/5/2016 | M | RA1 | | 99201 - OFFICE/OUTPATIENT VISIT NEW | E | 5/9/2016 | $0.00 | $0.00 | $7.00 |

Medicaid Provider ID:
Provider Name: SHERMAN L ARMSTRONG JR

PHI has been removed

| Recipient ID | Recipient Name | From Date of Service Date | To Date of Service Date | Claim Type | District Plan Code | ICN | Primary Procedure Code & Description | Claim Ind | Payment Date | Paid Amount | Encounter Amount | RCO Paid Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXX XX, XXXXXXXXXXXXXXX, X | 4/1/2016 | 4/1/2016 | M | RA3 | | 99211 - OFFICE/OUTPATIENT VISIT EST | E | 5/17/2016 | $0.00 | $15.70 | $2.00 |

### 3.5.104.1 TQ - Facility Visits Exception Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Billing Provider Medicaid ID | Lists the NPI, Medicaid, and Base ID for the billing Provider. | 13 | Character |
| Billing Provider Name | The name associated with the billing provider ID. | 50 | Character |
| Claim Indicator | Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim. | 1 | Character |
| Claim Type | A code to indicate the type of medical assistance invoice used by the provider to bill OMAP for the rendered service. | 1 | Character |
| District Plan Code | The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid | 3 | Character |
| Encounter Amount | Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount). | 10 | Number (Decimal) |
| Facility Provider Medicaid ID | Lists the NPI, Medicaid, and Base ID for the Provider. | 13 | Character |
| Facility Provider Name | The name associated with the organization or person. | 50 | Character |
| From Date of Service Date | The date the service was incurred. | 10 | Date (MM/DD/CCYY) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| Payment Date | The date the claim was paid. | 10 | Number (Integer) |
| Provider Medicaid ID | Lists the NPI, Medicaid, and Base ID for the provider. | 13 | Character |
| Provider Name | Name of the Provider. | 25 | Character |
| Primary Procedure Code and Description | The primary procedure code and its description. | 49 | Character |
| RCO Paid Amount | Amount sent to a provider for payment for services rendered to a recipient (by RCO). | 10 | Number (Decimal) |
| Recipient ID | The unique number assigned to the recipient. | 12 | Character |
| Recipient Name | Full name of the recipient on the claim. | 32 | Character |
| Multiple Visits | User prompt to enter the limit of visits for the report data to be displayed. | 2 | Character |
| To Date of Service Date | Date on which the statement period on the claim ended. | 10 | Date (MM/DD/CCYY) |


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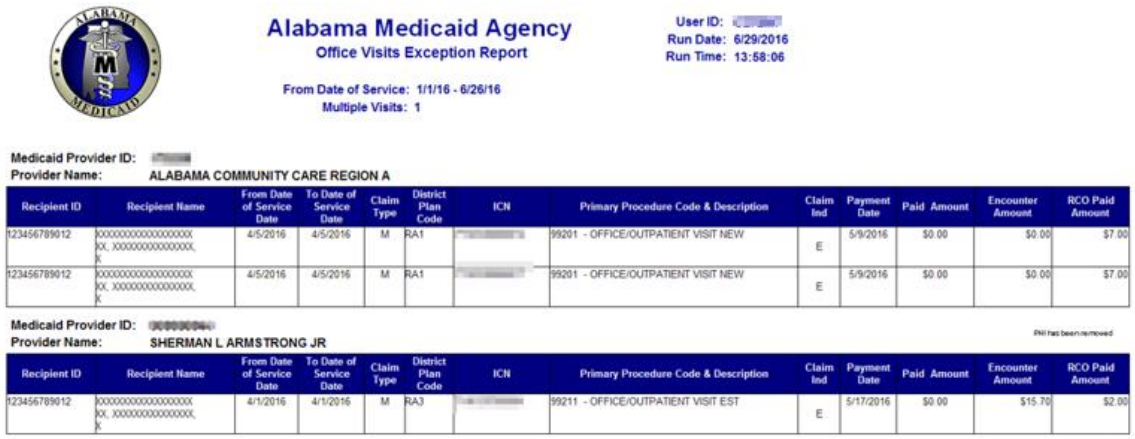
### 3.5.105 TQ - Office Visits Exception

The Office Visits Exception Report displays the exception professional claims submitted by a provider meeting the defined criteria for the report.

**Report criteria:**

- Claim Type = M or B;
- Paid Claims Only;
- Latest Claims Only;
- Exclude Wrap Payments;
- Procedure Code between 99201 and 99205 or 99211 and 99215 or W0061 and W0062;
- Date of Services - Date range specified by the user in the prompt; and
- Multiple Visits - Number of Visits specified by the user in the prompt.



Alabama Medicaid Agency
Office Visits Exception Report

From Date of Service: 1/1/16 - 6/26/16
Multiple Visits: 1

User ID:
Run Date: 6/29/2016
Run Time: 13:58:06

Medicaid Provider ID:
Provider Name: ALABAMA COMMUNITY CARE REGION A

| Recipient ID | Recipient Name | From Date of Service Date | To Date of Service Date | Claim Type | District Plan Code | ICN | Primary Procedure Code & Description | Claim Ind | Payment Date | Paid Amount | Encounter Amount | RCO Paid Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXX XX, XXXXXXXXXXXXXX, X | 4/5/2016 | 4/5/2016 | M | RA1 | | 99201 - OFFICE/OUTPATIENT VISIT NEW | E | 5/9/2016 | $0.00 | $0.00 | $7.00 |
| 123456789012 | XXXXXXXXXXXXXXXXXX XX, XXXXXXXXXXXXXX, X | 4/5/2016 | 4/5/2016 | M | RA1 | | 99201 - OFFICE/OUTPATIENT VISIT NEW | E | 5/9/2016 | $0.00 | $0.00 | $7.00 |

Medicaid Provider ID:
Provider Name: SHERMAN L ARMSTRONG JR

PHI has been removed

| Recipient ID | Recipient Name | From Date of Service Date | To Date of Service Date | Claim Type | District Plan Code | ICN | Primary Procedure Code & Description | Claim Ind | Payment Date | Paid Amount | Encounter Amount | RCO Paid Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXX XX, XXXXXXXXXXXXXX, X | 4/1/2016 | 4/1/2016 | M | RA3 | | 99211 - OFFICE/OUTPATIENT VISIT EST | E | 5/17/2016 | $0.00 | $15.70 | $2.00 |

#### 3.5.105.1 TQ - Office Visits Exception Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Claim Ind | Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim. | 1 | Character |
| Claim Type | Code indicating the type of claim record. | 1 | Character |
| District Plan Code | The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid | 3 | Character |
| Encounter Amount | Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount). | 10 | Number (Decimal) |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| Field | Description | Length | Data Type |
|---|---|---|---|
| From Date of Service | Date on which services were first performed for a recipient. | 10 | Date (MM/DD/CCYY) |
| ICN | Internal control number of the mother claim. | 13 | Character |
| Medicaid Provider ID | Identification of the provider who performed (rendered) the service. | 10 | Character |
| Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| Payment Date | The date the claim was paid. | 10 | Date (MM/DD/CCYY) |
| Primary Procedure Code & Description | The primary procedure code and its description. | 49 | Character |
| Provider Name | Performing Prov Name. | 50 | Character |
| RCO Paid Amount | Amount sent to a provider for payment for services rendered to a recipient (by RCO). | 10 | Number (Decimal) |
| Recipient ID | The unique number assigned to the recipient by the State. | 12 | Character |
| Recipient Name | Recipient Name. | 32 | Number (Decimal) |
| Reimbursed Amount | Amount sent to a provider for payment for services rendered to a recipient | 10 | Date (MM/DD/CCYY) |
| To Date of Service | Date on which services were last performed for a recipient. | 10 | Date (MM/DD/CCYY) |


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### 3.5.106 TQ – Home Hospital Conflict

This report identifies recipients receiving services from different user selected provider types on the same or overlapping dates of service. The user can enter Billing Provider Type code(s) and date of service range.

A - Overlapping Recipient Services Report is sorted by Date of First Service.

A claim is considered to overlap another claim if all of the following criteria are met: Same recipient or dates of service ranges overlap on any day except the admission and discharge date on the inpatient.

Other criteria: No voided claims; Paid Claims only; Exclude Family Planning Claims

**Alabama Medicaid Agency**
**Home Hospital Conflict**
From Date of Service: 1/1/16 - 8/1/16

User ID:
Run Date: 7/29/2016
Run Time: 13:49:31

| Recipient ID | Recipient Name | Performing Provider Base ID (Inpatient) | Performing Provider Name (Inpatient) | Performing Provider Type Code & Description (Inpatient) | Performing Provider Specialty Code & Description (Inpatient) | From Date of Service (Inpatient) | To Date of Service (Inpatient) | Paid Amount (Inpatient) |
|---|---|---|---|---|---|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | | GERALD M MACHEN | 31 - Physician | 316 - Family Practitioner | 08/23/2015 | 08/26/2015 | $1,260.00 |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | | GERALD M MACHEN | 31 - Physician | 316 - Family Practitioner | 08/23/2015 | 08/26/2015 | $1,260.00 |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | | JAMES R MOSS | 31 - Physician | 800 - Internal Medicine | 07/01/2015 | 07/31/2015 | $2,581.10 |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | | OLUDAYO B DAWODU | 31 - Physician | 316 - Family Practitioner | 08/01/2015 | 08/31/2015 | $2,609.96 |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | | BARON C MAZE | 31 - Physician | 800 - Internal Medicine | 10/05/2015 | 10/12/2015 | $8,323.07 |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | | SIMON MCCLURE | 31 - Physician | 339 - Psychiatrist | 07/16/2015 | 08/20/2015 | $1,260.00 |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | | PRAVEEN JETTY | 31 - Physician | 339 - Psychiatrist | 08/12/2015 | 08/25/2015 | $1,260.00 |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | | BHARAT K VAKHARIA | 31 - Physician | 800 - Internal Medicine | 08/12/2015 | 08/18/2015 | $1,260.00 |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | | TY J KREHBIEL | 31 - Physician | 316 - Family Practitioner | 08/27/2015 | 08/28/2015 | $630.00 |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | | FAIZULLAH SYED | 31 - Physician | 800 - Internal Medicine | 08/17/2015 | 08/21/2015 | $1,260.00 |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | | FAIZULLAH SYED | 31 - Physician | 800 - Internal Medicine | 08/18/2015 | 08/21/2015 | $1,210.00 |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | | PRITHVIRAJ R CHAVAN | 31 - Physician | 810 - Orthopedic | 08/18/2015 | 08/20/2015 | $1,260.00 |
| 123456789012 | XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | | PRITHVIRAJ R CHAVAN | 31 - Physician | 810 - Orthopedic | 08/18/2015 | 08/20/2015 | $1,260.00 |

PHI has been removed

| ICN (Inpatient) | Detail Number (Inpatient) | Adjusted ICN (Inpatient) | Adjust/ Void Code (Inpatient) | Claim Type (Inpatient) | Performing Provider Base ID (Waiver) | Claim Indicator (Inpatient) | District Plan Code (Inpatient) | Encounter Amount (Inpatient) | RCO Paid Amount (Inpatient) | Performing Provider Name (Waiver) | Performing Provider Type Code & Description (Waiver) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | | A | A | | F | | $0.00 | $0.00 | GERALD M MACHEN | 31 - Physician |
| | 0 | | A | A | | F | | $0.00 | $0.00 | GERALD M MACHEN | 31 - Physician |
| | 0 | | A | A | | F | | $0.00 | $0.00 | JAMES R MOSS | 31 - Physician |
| | 0 | | A | A | | F | | $0.00 | $0.00 | GREGORY AYERS | 31 - Physician |
| | 0 | | A | I | | F | | $0.00 | $0.00 | BARON C MAZE | 31 - Physician |
| | 0 | | A | A | | F | | $0.00 | $0.00 | SIMON MCCLURE | 31 - Physician |
| | 0 | | A | A | | F | | $0.00 | $0.00 | WILLIAM B SHIRAH | 31 - Physician |
| | 0 | | A | A | | F | | $0.00 | $0.00 | BHARAT K VAKHARIA | 31 - Physician |
| | 0 | | A | A | | F | | $0.00 | $0.00 | SAKINA A KAMAL | 31 - Physician |
| | 0 | | A | A | | F | | $0.00 | $0.00 | GEORGE A EVANS | 31 - Physician |
| | 0 | | A | A | | F | | $0.00 | $0.00 | KARL T HAGLER | 31 - Physician |
| | 0 | | A | A | | F | | $0.00 | $0.00 | GARY M RICHARDSON | 31 - Physician |
| | 0 | | A | A | | F | | $0.00 | $0.00 | STANLEY B WINSLOW | 31 - Physician |


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| Performing Provider Specialty Code & Description (Waiver) | From Date of Service (Waiver) | To Date of Service (Waiver) | Reimbursed Amount (Waiver) | ICN (Waiver) | Detail Number (Waiver) | Adjusted ICN (Waiver) | Adjust/ Void Code (Waiver) | Claim Type (Waiver) | Claim Indicator (Waiver) | District Plan Code (Waiver) | Encounter Amount (Waiver) | RCO Paid Amount (Waiver) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 316 - Family Practitioner | 08/26/2015 | 08/26/2015 | $0.00 | [redacted] | 4 | [redacted] | A | B | F | | $0.00 | $0.00 |
| 316 - Family Practitioner | 08/26/2015 | 08/26/2015 | $0.00 | [redacted] | 5 | [redacted] | A | B | F | | $0.00 | $0.00 |
| 800 - Internal Medicine | 07/31/2015 | 07/31/2015 | $0.00 | [redacted] | 1 | [redacted] | A | B | F | | $0.00 | $0.00 |
| 800 - Internal Medicine | 08/31/2015 | 08/31/2015 | $0.00 | [redacted] | 1 | [redacted] | A | B | F | | $0.00 | $0.00 |
| 800 - Internal Medicine | 10/12/2015 | 10/12/2015 | $58.59 | [redacted] | 1 | [redacted] | A | M | F | C00 | $0.00 | $0.00 |
| 339 - Psychiatrist | 08/20/2015 | 08/20/2015 | $0.00 | [redacted] | 5 | [redacted] | A | B | F | | $0.00 | $0.00 |
| 800 - Internal Medicine | 08/25/2015 | 08/25/2015 | $0.00 | [redacted] | 2 | [redacted] | A | B | F | | $0.00 | $0.00 |
| 800 - Internal Medicine | 08/18/2015 | 08/18/2015 | $0.00 | [redacted] | 7 | [redacted] | A | B | F | | $0.00 | $0.00 |
| 313 - Cardiovascular Surgeon | 08/28/2015 | 08/28/2015 | $16.56 | [redacted] | 1 | [redacted] | A | B | F | | $0.00 | $0.00 |
| 316 - Family Practitioner | 08/21/2015 | 08/21/2015 | $0.00 | [redacted] | 1 | [redacted] | A | B | F | | $0.00 | $0.00 |
| 329 - Oncologist | 08/19/2015 | 08/21/2015 | $0.00 | [redacted] | 2 | [redacted] | A | B | F | | $0.00 | $0.00 |
| 318 - General Practitioner | 08/20/2015 | 08/20/2015 | $2.64 | [redacted] | 2 | [redacted] | A | B | F | | $0.00 | $0.00 |
| 341 - Radiologist | 08/20/2015 | 08/20/2015 | $0.86 | [redacted] | 1 | [redacted] | A | B | F | | $0.00 | $0.00 |

### 3.5.106.1 TQ – Home Hospital Conflict Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Adjust/Void Code (Inpatient) | A code to indicate whether the record is a new day claim (N), adjustment (A=daughter claim) or a void (V). | 1 | Character |
| Adjust/Void Code (Waiver) | A code to indicate whether the record is a new day claim (N), adjustment (A=daughter claim) or a void (V). | 1 | Character |
| Adjusted ICN (Inpatient) | Internal control number of the mother claim. | 13 | Character |
| Adjusted ICN (Waiver) | Internal control number of the mother claim. | 13 | Character |
| Claim Indicator (Inpatient) | Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim. | 1 | Character |
| Claim Indicator (Waiver) | Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim. | 1 | Character |
| Claim Type (Inpatient) | Code indicating the type of claim record. | 1 | Character |
| Claim Type (Waiver) | Code indicating the type of claim record. | 1 | Character |
| Detail Number (Inpatient) | Detail number on the claim. | 22 | Number (Integer) |
| Detail Number (Waiver) | Detail number on the claim. | 22 | Number (Integer) |
| District Plan Code (Inpatient) | The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid | 3 | Character |
| District Plan Code (Waiver) | The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid | 3 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| Encounter Amount (Inpatient) | Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount). | 10 | Number (Decimal) |
| Encounter Amount (Waiver) | Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount). | 10 | Number (Decimal) |
| From Date of Service (Inpatient) | Date on which services were first performed for a recipient. | 10 | Date (MM/DD/CCYY) |
| From Date of Service (Waiver) | Date on which services were first performed for a recipient. | 10 | Date (MM/DD/CCYY) |
| ICN (Inpatient) | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| ICN (Waiver) | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| Paid Amount (Inpatient) | Amount sent to a provider for payment for services rendered to a recipient | 10 | Date (MM/DD/CCYY) |
| Performing Provider Base ID (Inpatient) | Identification of the provider who performed (rendered) the service. | 10 | Character |
| Performing Provider Base ID (Waiver) | Identification of the provider who performed (rendered) the service. | 10 | Character |
| Performing Provider Name (Inpatient) | Performing Inpatient Provider Name. | 50 | Character |
| Performing Provider Name (Waiver) | Performing Waiver Provider Name. | 50 | Character |
| Performing Provider Specialty Code & Description (Inpatient) | Indicates the provider's primary specialty. | 56 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| Performing Provider Specialty Code & Description (Waiver) | Indicates the provider's primary specialty. | 56 | Character |
| Performing Provider Type Code & Description (Inpatient) | Type that a provider is licensed. | 55 | Character |
| Performing Provider Type Code & Description (Waiver) | Type that a provider is licensed. | 55 | Character |
| Recipient ID | The unique number assigned to the recipient by the State. | 10 | Number (Decimal) |
| Recipient Name | Recipient Name. | 10 | Date (MM/DD/CCYY) |
| Reimbursed Amount (Waiver) | Amount sent to a provider for payment for services rendered to a recipient | 10 | Date (MM/DD/CCYY) |
| RCO Paid Amount (Inpatient) | Amount sent to a provider for payment for services rendered to a recipient (by RCO). | 10 | Number (Decimal) |
| RCO Paid Amount (Waiver) | Amount sent to a provider for payment for services rendered to a recipient (by RCO). | 10 | Number (Decimal) |
| To Date of Service (Inpatient) | Date on which services were last performed for a recipient. | 13 | Number (Decimal) |
| To Date of Service (Waiver) | Date on which services were last performed for a recipient. | 10 | Date (MM/DD/CCYY) |


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### 3.5.107 TQ – Physician Office Visits

The Physician Office Visits report shows counts of physician office visits by recipient.

The SURS certification requirement met by this report is:

Excessive medical visits to a single physician or other provider unit by an AFDC family. The tabs on this report include:

A. Sorted by Provider Name

B. Sorted by Number of Visits

**Search Criteria:**

- Recipient Aid Category – Specified by the user
- The From Date of Service range as entered by the user at prompt
- Paid claims only
- Procedure code between 99201 and 99215
- All claims types except Pharmacy
- Exclude Family Planning Claims
- Latest Claims Only
- Exclude Wrap Payments
- Total Visits Per Family no less than number entered by user at prompt


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A

## Alabama Medicaid Agency

### Physician Office Visits

Sorted by Provider Name

For Dates of Service: 04/01/2016 - 06/30/2016

Total visits per family: 2

Aid Category Codes: 36;34;41

User ID:
Run Date: 6/28/16
Run Time: 7:48:11 AM

| Recipient ID | Claim Indicator | District Plan Code | Performing/Attending Provider IDs | Performing/ Attending Provider Name | Performing Provider Specialty Code & Desc | Number of Visits |
|---|---|---|---|---|---|---|
| 123456789012 | E | RB1 | NPI ID:<br>Medicaid ID:<br>Base ID: | ALABAMA ONCOLOGY HEMATOLOGY ASSOCIATES | 329 - Oncologist | 2 |
| 123456789012 | F | | NPI ID:<br>Medicaid ID:<br>Base ID: | DARNITA A HILL | 316 - Family Practitioner | 4 |
| 123456789012 | E | RA1 | NPI ID:<br>Medicaid ID:<br>Base ID: | SHERMAN L ARMSTRONG JR | 319 - General Surgeon | 19 |

PHI has been removed

B

## Alabama Medicaid Agency

### Physician Office Visits

Sorted by Number of Visits

For Dates of Service: 04/01/2016 - 06/30/2016

Total visits per family: 2

Aid Category Codes: 36;34;41

User ID:
Run Date: 6/28/16
Run Time: 7:48:11 AM

| Recipient ID | Claim Indicator | District Plan Code | Performing/Attending Provider IDs | Performing/Attending Provider Name | Performing Provider Specialty Code & Desc | Number of Visits |
|---|---|---|---|---|---|---|
| 123456789012 | E | RB1 | NPI ID:<br>Medicaid ID:<br>Base ID: | TONIA M LONG | 093 - Nurse Practitioner (Other | 100 |
| 123456789012 | E | RA1 | NPI ID:<br>Medicaid ID:<br>Base ID: | SHERMAN L ARMSTRONG JR | 319 - General Surgeon | 19 |
| 123456789012 | F | | NPI ID:<br>Medicaid ID:<br>Base ID: | DARNITA A HILL | 316 - Family Practitioner | 4 |
| 123456789012 | E | RB1 | NPI ID:<br>Medicaid ID:<br>Base ID: | ALABAMA ONCOLOGY HEMATOLOGY ASSOCIATES | 329 - Oncologist | 2 |
| 123456789012 | F | | NPI ID:<br>Medicaid ID:<br>Base ID: | SHERMAN L ARMSTRONG JR | 319 - General Surgeon | 2 |
| | | | | | Sum: | 127 |

PHI has been removed


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### 3.5.107.1 TQ – Physician Office Visits Field Descriptions

| Field | Description | Data Type | Length |
|---|---|---|---|
| (A-B) Recipient ID | The unique number assigned to the recipient. | 12 | Character |
| (A-B) Claim Indicator | “F” for Fee-for-Service, “E” for encounters. | 1 | Character |
| (A-B) District Plan Code | The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid | 3 | Character |
| (A-B) Performing Provider IDs | Identification of the provider who performed (rendered) the service. | 10 | Character |
| (A-B) Performing Provider Name | Performing Provider Name. | 50 | Character |
| (A-B) Performing Provider Specialty Code & Desc | Performing Provider's primary Specialty and Description. | 56 | Character |
| (A-B) Number of Visits | Count of claims for physician office visits for the recipient/case number. | 8 | Number (Integer) |
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-B) Total Visits per Family | User entered value for setting the threshold for Number of Visits column. | 2 | Number (Integer) |
| (A-B) Aid Category Codes | User entered aid category codes for which the report should be run. | 2 | Character |


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### 3.5.108 TQ – Physician Office Visits by Recipient

This report shows counts of physician office visits by recipient. This will help identify excessive medical visits to a single physician or other provider unit.

- Recipient Aid Category – Specified by the user
- The From Date of Service range as entered by the user at prompt
- Paid claims only
- Procedure code between 99201 and 99215
- All claims types except Pharmacy
- Exclude Family Planning Claims
- Latest Claims Only
- Exclude Wrap Payments
- Number of Office Visits no less than number entered by user at prompt

**Alabama Medicaid Agency**
**Physician Office Visits by Recipient**
**For Dates of Service: 04/01/2016 - 06/30/2016**
**Number of Office Visits: 2**

User ID:
Run Date: 7/19/16
Run Time: 11:31:46 AM

| Recipient ID | Claim Indicator | District Plan Code | Recipient Name | Billing Provider IDs | Billing Provider Name | Billing Provider Specialty Code & Description | Paid Claim Count |
|---|---|---|---|---|---|---|---|
| 123456789012 | E | RA1 | XXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | NPI ID:<br>Medicaid ID:<br>Base ID: | SHERMAN L ARMSTRONG JR | 319 - General Surgeon | 6 |
| | | | | | | Sum: | 6 |
| 123456789012 | E | RA2 | XXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | NPI ID:<br>Medicaid ID:<br>Base ID: | SHERMAN L ARMSTRONG JR | 319 - General Surgeon | 4 |
| | | | | | | Sum: | 4 |
| 123456789012 | E | RB1 | XXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | NPI ID:<br>Medicaid ID:<br>Base ID: | CARDIOVASCULAR INSTITUTE OF THE SHOALS PC | 313 - Cardiovascular Surgeon | 45 |
| | | | | | | Sum: | 45 |
| 123456789012 | F | | XXXXXXXXXXXXXXXXXXX, XXXXXXXXXX | NPI ID:<br>Medicaid ID:<br>Base ID: | SHERMAN L ARMSTRONG JR | 319 - General Surgeon | 3 |
| | | | | | | Sum: | 3 |

**End of Report**

#### 3.5.108.1 TQ – Physician Office Visits by Recipient Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Billing Provider IDs | Identification that identifies the provider billing the claim. | 10 | Character |
| Billing Provider Name | The name associated with the organization or person. | 50 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| Billing Provider Specialty Code & Desc | Billing Provider Specialty Code and Description. | 56 | Character |
| Claim Indicator | “F” for Fee-for-Service, “E” for encounters. | 1 | Character |
| District Plan Code | The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid | 3 | Character |
| For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| Number of Office Visits | Count of claims for office visits for the recipient/case number. | 8 | Number (Integer) |
| Paid Claim Count | Counts the financial transaction as a paid claim. | 22 | Number (Decimal) |
| Recipient ID | The unique number assigned to the recipient by the State. | 12 | Character |
| Recipient Name | The name of the recipient. | 32 | Character |

### 3.5.109 TQ – PT OT Daily Overbilling

This report is to identify consumers with more than $250.00 in payments for physical, occupational, or speech therapy services performed in a single day.

**Additional Criteria:**

Claim type is equal to M (medical) or O (outpatient);

Payment amount is greater than zero;

Exclude adjusted claims (If claim has been adjusted, include only the final adjustment. Original claim should be excluded.); and

Procedure code is one of the following: S9129, S9131, S9128, 97001, 97002, 97003, 97004, 97010, 97012, 97014, 97016, 97018, 97020, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97504, 97520, 97530, 97532, 97533, 97535, 97537, 97542, 97545, 97546, 92507, 92508.


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**Alabama Medicaid Agency**

**PT OT Daily Overbilling**

For Dates of Service : 1/1/16 - 8/1/16

User ID:
Run Date: 7/29/16
Run Time: 1:48:30 PM

Billing Provider IDs: NPI ID:
Medicaid ID:
Base ID:

Billing Provider Name: CULLMAN REG MEDICAL CENTER

| Recipient ID | Recipient Full Name | ICN | Claim Indicator | District Plan Code | I C D | Primary Diagnosis Code & Description | Primary Procedure Code & Description | Place of Service Code | From Date of Service | To Date of Service | Payment Date | First Modifier Code | Second Modifier Code | Performing/ Attending Provider IDs | Wrap Ind | Allowed Quantity | Sum of Paid Amount | Encounter Amount | RCO Paid Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 123456789012 | XXXXXXX XXXXXXX XXXXXX. XXXXXXX XXXXXXX K.X | | F | RA2 | 0 | M25512 - PAIN IN LEFT SHOULDER | 97001 - Pt Evaluation | 22 | 6/16/2016 | 6/16/2016 | 6/28/2016 | GP | ## | NPI ID: Medicaid ID: Base ID: | N | 1 | $40.44 | $0.00 | $0.00 |
| 123456789012 | XXXXXXX XXXXXXX XXXXXX. XXXXXXX XXXXXXX K.X | | F | RA2 | 0 | M25512 - PAIN IN LEFT SHOULDER | 97110 - Therapeutic Exercises | 22 | 6/16/2016 | 6/16/2016 | 6/28/2016 | GP | ## | NPI ID: Medicaid ID: Base ID: | N | 3 | $50.55 | $0.00 | $0.00 |
| | | | | | | | | | | | | | | | | Sum: | $90.99 | $0.00 | $0.00 |

End of Report

PHI has been removed

### 3.5.109.1 TQ – PT OT Daily Overbilling Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Allowed Quantity | The units of service approved for payment. | 8 | Number (Decimal) |
| Billing Provider IDs | This object contains the Base, Medicaid and NPI IDs that identify the billing provider. | 45 | Character |
| Billing Provider Name | Name of the billing provider. | 50 | Character |
| Claim Indicator | “F” for Fee-for-Service, “E” for encounters. | 1 | Character |
| District Plan Code | The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid | 3 | Character |
| Encounter Amount | Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount). | 10 | Number (Decimal) |
| First Modifier Code | The first of up to 2 codes that may be used to supplement the procedure-code. | 2 | Character |
| For Dates of Service (prompt) | Selected date range for which claims were selected by date of service. | 23 | Date (MM/DD/CCYY) |
| From Date of Service | The date the service was incurred. | 13 | Character |
| ICD | The ICD Version code for the primary ICD-CM payment level diagnosis code. | 1 | Character |
| ICN | Unique control number assigned to the invoice to indicate its date of receipt. The | 13 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | | |
| Payment Date | The date the claim was paid. | 10 | Date (MM/DD/CCYY) |
| Performing Provider IDs | This object contains the Base, Medicaid and NPI IDs that identify the provider who performed (rendered) the service. | 45 | Character |
| Place of Service Code | A code to indicate where the service was provided. | 2 | Character |
| Primary Diagnosis Code & Description | The primary ICD-CM diagnosis description. | 70 | Character |
| Primary Procedure Code & Description | The code and description associated with the primary procedure code. | 47 | Character |
| RCO Paid Amount | Amount sent to a provider for payment for services rendered to a recipient (by RCO). | 10 | Number (Decimal) |
| Recipient Full Name | This field concatenates the recipient last name, first name and middle initial into one object. | 39 | Character |
| Recipient ID | The unique number assigned to the recipient by the State. | 12 | Character |
| Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| Run Time | The time that the report was executed. | 11 | Character |
| Second Modifier Code | The second of up to 2 codes that may be used to supplement the procedure-code. | 2 | Character |
| Sum | The total paid amount for the recipient. | 13 | Number (Decimal) |
| Sum of Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 10 | Number (Decimal) |
| To Date of Service | Date on which the statement period on the claim ended. | 10 | Date (MM/DD/CCYY) |
| User ID | The id of the user that created the report. | 50 | Character |
| Wrap Ind | Wrap Payment Indicator | 1 | Character |


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### 3.5.110 TQ - Emergency Room Visits

The Emergency Room Visits report displays counts of emergency room visits by the recipients in the family. The number of recipients in the family and the unduplicated number of recipients involved with the visits are shown, along with provider information.

The tabs on this report include:

A. Emergency Room Visits, sorted by Provider Name

B. Emergency Room Visits, sorted By Number of Visits

**Search Criteria:**

- The From Date of Service range as entered by the user at prompt;
- Paid Claims Only;
- Latest Claims Only;
- Exclude Wrap Payments;
- Procedure Code between 99281 and 99288;
- Date of Services - Date range specified by the user in the prompt;
- Minimum Visits Per Family - Specified by the user; and
- Recipient Aid Category – Specified by the user

A

**Alabama Medicaid Agency**

**TQ - Emergency Room Visits**

**Sorted by Provider Name**

**For Dates of Service: 07/01/2016 - 09/30/2016**

**Minimum Visits Per Family: 1**

**Recipient Aid Category: 32**

**User ID:**
**Run Date: 7/21/16**
**Run Time: 8:37:51 AM**

| Recipient ID | Recipient Full Name | Performing/Attending Provider IDs | Performing/Attending Provider Name | Performing Provider Specialty Code & Desc | Number of Visits |
|---|---|---|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXX XXX, XXXXXXXXXXXXXX, X | NPI ID:<br>Medicaid ID:<br>Base ID: | JARVIS E PATTON JR. | 315 - Emergency Medicine Practitioner | 1 |

**End of Report**

PHI has been removed


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B

**Alabama Medicaid Agency**

**TQ - Emergency Room Visits**

**Sorted by Number of Visits**

**For Dates of Service: 07/01/2016 - 09/30/2016**
**Minimum Visits Per Family: 1**
**Recipient Aid Category: 32**

**User ID:**
**Run Date: 7/21/16**
**Run Time: 8:37:51 AM**

| Recipient ID | Recipient Full Name | Performing/Attending Provider Name | Performing Provider Specialty Code & Desc | Performing/ Attending Provider IDs | Number of Visits |
|---|---|---|---|---|---|
| 123456789012 | XXXXXXXXXXXXXXXXX XXX, XXXXXXXXXXXXXXX, X | JARVIS E PATTON JR. | 315 - Emergency Medicine Practitioner | NPI ID:<br>Medicaid ID:<br>Base ID: | 1 |
| | | | | Total Visits: | 1 |

**End of Report**

PHI has been removed

### 3.5.110.1 TQ - Emergency Room Visits Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) For Dates of Service | Starting and Ending range of service date selection criteria. | 20 | Date (MM/DD/CCYY) |
| (A-B) Minimum Visits Per Family | User prompt to enter the limit of visits for the report data to be displayed. | 2 | Number (Integer) |
| (A-B) Number of Visits | Count of claims for emergency room visits for the recipient/case number. | 8 | Number (Integer) |
| (A-B) Recipient ID | The unique number assigned to the recipient by the State. | 12 | Character |
| (A-B) Performing Provider IDs | Identification of the provider who performed (rendered) the service. | 10 | Character |
| (A-B) Performing Provider Name | Performing Provider Name. | 50 | Character |
| (A-B) Performing Provider Specialty Code & Desc | Performing Provider's primary Specialty and Description. | 56 | Character |
| (A-B) Recipient Aid Category | The aid category for the recipient. | 2 | Character |
| (A-B) Recip County Code | County code for the recipient head of household. | 2 | Character |


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### 3.5.111 TQ – Inpatient – Related Readmissions

The Inpatient - Related Readmissions report shows recipients who have been admitted more than once to the same hospital within a seven-day period.

**Alabama Medicaid Agency**

**Inpatient - Related Readmissions**

**Dates of Service within: 1/1/16 – 11/30/16**

**Claims Indicator(s): F**

User ID: [redacted]
Run Date: 11/29/2016
Run Time: 13:55:17

| Billing Provider IDs | | | Billing Provider Name | Recipient ID & Check Digit | Recipient Full Name | | NDC Code & Description | | | Paid Amount | | | Pricing DRG Code & Description | DRG Relative Weight | DRG Service Adjustor |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Claim Indicator | District Plan Code | ICN | Previous ICN | Adjusted ICN | Adjust/Void Code | Claim Type | Detail Number | Admission Date | Discharge Date | Encounter Amount | RCO Paid Amount | | Readmission Alert | | |
| Medicaid ID: [redacted] | | | ORLANDO HEALTH, INC. | [redacted] | | | ########### - | | | | | | $30,254.50#### - | 0.0000 | 0.00 |
| F | | | | | N | I | 0 | 6/11/2016 | 7/6/2016 | $0.00 | $0.00 | | | | |
| Medicaid ID: [redacted] | | | ORLANDO HEALTH, INC. | [redacted] | | | ########### - | | | | | | $7,261.06#### - | 0.0000 | 0.00 |
| F | | | | | N | I | 0 | 7/11/2016 | 7/17/2016 | $0.00 | $0.00 | | Possible Related Readmission! | | |
| Medicaid ID: [redacted] | | | CUMBERLAND HOSPITAL | [redacted] | | | ########### - | | | | | | $22,953.42#### - | 0.0000 | 0.00 |
| F | | | | | N | I | 0 | 2/11/2016 | 12/31/2299 | $0.00 | $0.00 | | | | |
| Medicaid ID: [redacted] | | | CUMBERLAND HOSPITAL | [redacted] | | | ########### - | | | | | | $37,515.58#### - | 0.0000 | 0.00 |
| F | | | | | N | I | 0 | 2/11/2016 | 12/31/2299 | $0.00 | $0.00 | | | | |
| Medicaid ID: [redacted] | | | CUMBERLAND HOSPITAL | [redacted] | | | ########### - | | | | | | $37,515.58#### - | 0.0000 | 0.00 |
| F | | | | | N | I | 0 | 10/20/2015 | 12/31/2299 | $0.00 | $0.00 | | | | |
| Medicaid ID: [redacted] | | | CUMBERLAND HOSPITAL | [redacted] | | | ########### - | | | | | | $35,095.22#### - | 0.0000 | 0.00 |
| F | | | | | N | I | 0 | 10/20/2015 | 12/31/2299 | $0.00 | $0.00 | | | | |
| Medicaid ID: [redacted] | | | CUMBERLAND HOSPITAL | [redacted] | | | ########### - | | | | | | $1,210.18#### - | 0.0000 | 0.00 |
| F | | | | | N | I | 0 | 10/20/2015 | 3/2/2016 | $0.00 | $0.00 | | | | |
| Medicaid ID: [redacted] | | | CUMBERLAND HOSPITAL | [redacted] | | | ########### - | | | | | | $37,515.58#### - | 0.0000 | 0.00 |
| F | | | | | N | I | 0 | 7/28/2015 | 12/31/2299 | $0.00 | $0.00 | | | | |
| Medicaid ID: [redacted] | | | CUMBERLAND HOSPITAL | [redacted] | | | ########### - | | | | | | $35,095.22#### - | 0.0000 | 0.00 |
| F | | | | | N | I | 0 | 7/28/2015 | 12/31/2299 | $0.00 | $0.00 | | | | |
| Medicaid ID: [redacted] | | | CUMBERLAND HOSPITAL | [redacted] | | | ########### - | | | | | | $37,515.58#### - | 0.0000 | 0.00 |

#### 3.5.111.1 TQ – Inpatient – Related Readmissions Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Adjust/Void Code | A code to indicate whether the record is for a debit or credit and adjustment. | 1 | Character |
| Adjusted ICN | Unique control number assigned to a claim when it has been adjusted in the system, blank if this is a non-adjusted claim. | 13 | Number (Integer) |
| Claims Indicator (s) | Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim (E). | 1 | Character |
| Admission Date | Date recipient was admitted. | 10 | Date (MM/DD/CCYY) |
| Claim Type | Shows what type of claim was submitted. | 1 | Character |
| Detail Number | Detail number on the claim. | 63 | Number (Integer) |
| Discharge Date | Date that the recipient was discharged by the provider for inpatient care, outpatient services or start of care. | 10 | Date (MM/DD/CCYY) |
| District Plan Code | The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid | 3 | Character |
| DRG Code and Description | Diagnosis Related Group Number assigned to the claim, and its description. | 60 | Character |
| DRG Relative Weight | Relative weight for pricing DRG | 5 | Number (Decimal) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| DRG Service Adjuster | This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor | 3 | Number (Decimal) |
| Encounter Amount | Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount). | 10 | Number (Decimal) |
| From Dates of Service within | Claim's first date of service. | 13 | Number (Integer) |
| ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Character |
| NDC Code & Description | National Drug Code is comprised of a 5-Character numeric labeler code, a 4-Character numeric product code, and a 2-Character numeric package code. It identifies a drug, its labeler, and the package size of a product, and is used for pricing and prior authorization. The description is a combination of the drug name appearing on the package label, the strength description and the dosage form description. | 49 | Character |
| Paid Amount | Amount sent to a provider for payment for services rendered to a recipient This is the amount paid by Medicaid, after TPL, copay, etc have been subtracted. | 9 | Number (Integer) |
| Previous ICN | ICN from the legacy system | 13 | Character |
| Performing Provider IDs | Lists the NPI, Medicaid, and Base ID for the performing Provider. | 63 | Character |
| Performing Provider Name | Name of the provider. | 25 | Character |
| Readmission Alert | Indicates a possible readmission within 7 days. | 29 | Character |
| RCO Paid Amount | Amount sent to a provider for payment for services rendered to a recipient (by RCO). | 10 | Number (Decimal) |
| Recipient Full Name | Name of the recipient. | 13 | Number (Integer) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| Recipient ID & Check Digit | Number used to verify recipients identification. | 12 | Character |


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### 3.5.112 TQ – Antibiotics 12 Months or Longer

This report is used to identify recipients who have continuously been on any combination of antibiotics for 12 months prior to the date of the end of From Date of Service or longer. The report looks for standard therapeutic class codes 21, 22, 24, 25, 26, and 27.

**Alabama Medicaid Agency**

**Antibiotics 12 Months or Longer**

**From Date of Service: 08/01/2007**

**User ID:** [redacted]
**Run Date: 10/23/2007**
**Run Time: 3:11:49 PM**

| Recipient ID | Recipient Name | Recipient Age | Recipient Gender | ICN | Adjusted ICN | Previous ICN | Prescriber Provider Base ID |
|---|---|---|---|---|---|---|---|
| [redacted] | [redacted] | 34 | F | [redacted] | | | |

| Recipient ID | Recipient Name | Recipient Age | Recipient Gender | ICN | Adjusted ICN | Previous ICN | Prescriber Provider Base ID |
|---|---|---|---|---|---|---|---|
| [redacted] | [redacted] | 65 | F | [redacted] | | | [redacted] |

| Recipient ID | Recipient Name | Recipient Age | Recipient Gender | ICN | Adjusted ICN | Previous ICN | Prescriber Provider Base ID |
|---|---|---|---|---|---|---|---|
| [redacted] | [redacted] | 50 | F | [redacted] | | | [redacted] |

| Recipient ID | Recipient Name | Recipient Age | Recipient Gender | ICN | Adjusted ICN | Previous ICN | Prescriber Provider Base ID |
|---|---|---|---|---|---|---|---|
| [redacted] | [redacted] | 22 | F | [redacted] | | | |
| [redacted] | [redacted] | 22 | F | [redacted] | | | [redacted] |
| [redacted] | [redacted] | 22 | F | [redacted] | | | |
| [redacted] | [redacted] | 23 | F | [redacted] | | | [redacted] |


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# Alabama Medicaid Agency

**Antibiotics 12 Months or Longer**

**From Date of Service: 08/01/2007**

**User ID:** [redacted]
**Run Date: 10/23/2007**
**Run Time: 3:11:49 PM**

| Prescriber Provider Name | Prescriber Provider License | Prescriber Provider Type & Description | NDC Code & Description |
|---|---|---|---|
| Unknown | | ## - Unknown | 00143992701 - CIPROFLOXACIN HCL |

| Prescriber Provider Name | Prescriber Provider License | Prescriber Provider Type & Description | NDC Code & Description |
|---|---|---|---|
| ST JUDE CHILDRENS RESEARCHH | [redacted] | 01 - Hospital | 00009022502 - CLEOCIN HCL |

| Prescriber Provider Name | Prescriber Provider License | Prescriber Provider Type & Description | NDC Code & Description |
|---|---|---|---|
| GWINN III, NELSON S | [redacted] | 31 - Physician | 00781183120 - AMOX TR-POTASSIUM CLAVULANATE |

| Prescriber Provider Name | Prescriber Provider License | Prescriber Provider Type & Description | NDC Code & Description |
|---|---|---|---|
| Unknown | | ## - Unknown | 00603064450 - TRIPLE ANTIBIOTIC |
| PATIENTS CHOICEINC | | 25 - DME/Medical Supply Dealer | 00603064450 - TRIPLE ANTIBIOTIC |
| PATIENTS CHOICEINC | | 25 - DME/Medical Supply Dealer | 00603064450 - TRIPLE ANTIBIOTIC |
| CRENSHAW, ERIKA W | [redacted] | 31 - Physician | 00143992701 - CIPROFLOXACIN HCL |

# Alabama Medicaid Agency

**Antibiotics 12 Months or Longer**

**From Date of Service: 08/01/2007**

**User ID:** [redacted]
**Run Date: 10/23/2007**
**Run Time: 3:11:49 PM**

| AHFS Therapeutic Class Code and Description | Drug Quantity | Days Supply | Control Drug Indicator | Prescription Number | Refill Indicator | From Date of Service | Payment Date | Paid Amount |
|---|---|---|---|---|---|---|---|---|
| 08121800 - QUINOLONES | 30.00 | 30.00 | 0 | 46651 | 00 | 11/2/2006 | 9/11/2007 | $13.01 |

| AHFS Therapeutic Class Code and Description | Drug Quantity | Days Supply | Control Drug Indicator | Prescription Number | Refill Indicator | From Date of Service | Payment Date | Paid Amount |
|---|---|---|---|---|---|---|---|---|
| 08122800 - ANTIBACTERIALS, MISCELL | 30.00 | 30.00 | 0 | 46671 | 00 | 5/7/2007 | 9/27/2007 | $21.54 |

| AHFS Therapeutic Class Code and Description | Drug Quantity | Days Supply | Control Drug Indicator | Prescription Number | Refill Indicator | From Date of Service | Payment Date | Paid Amount |
|---|---|---|---|---|---|---|---|---|
| 08121608 - AMINOPENICILLINS | 30.00 | 30.00 | 0 | 50171 | 00 | 7/7/2007 | 7/9/2007 | $35.00 |

| AHFS Therapeutic Class Code and Description | Drug Quantity | Days Supply | Control Drug Indicator | Prescription Number | Refill Indicator | From Date of Service | Payment Date | Paid Amount |
|---|---|---|---|---|---|---|---|---|
| 84040400 - ANTIBACTERIALS (SKIN & M | 28.00 | 30.00 | 0 | 46638 | 00 | 4/11/2007 | 4/30/2007 | $8.00 |
| 84040400 - ANTIBACTERIALS (SKIN & M | 28.00 | 30.00 | 0 | 46638 | 00 | 5/11/2007 | 8/7/2007 | $8.00 |
| 84040400 - ANTIBACTERIALS (SKIN & M | 28.00 | 30.00 | 0 | 46638 | 00 | 1/11/2007 | 8/16/2007 | $7.50 |
| 08121800 - QUINOLONES | 120.00 | 30.00 | 0 | 1000060 | 00 | 9/6/2007 | 9/11/2007 | $4.90 |


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**Alabama Medicaid Agency**

**Antibiotics 12 Months or Longer**

**From Date of Service: 08/01/2007**

**User ID:**
**Run Date: 10/23/2007**
**Run Time: 3:11:49 PM**

| Billing Provider Base ID | Billing Provider Name | Performing Provider Base ID | Performing Provider Name |
|---|---|---|---|
| | UNION SPRING PHARMA | | UNION SPRING PHARMACY INC |

| Billing Provider Base ID | Billing Provider Name | Performing Provider Base ID | Performing Provider Name |
|---|---|---|---|
| | UNION SPRING PHARMA | | UNION SPRING PHARMACY INC |

| Billing Provider Base ID | Billing Provider Name | Performing Provider Base ID | Performing Provider Name |
|---|---|---|---|
| | ADAMS PHARMACYSERV | | ADAMS PHARMACYSERVICES INC |

| Billing Provider Base ID | Billing Provider Name | Performing Provider Base ID | Performing Provider Name |
|---|---|---|---|
| | UNION SPRING PHARMA | | UNION SPRING PHARMACY INC |
| | UNION SPRING PHARMA | | UNION SPRING PHARMACY INC |
| | UNION SPRING PHARMA | | UNION SPRING PHARMACY INC |
| | NORTHWOOD PHARMAC | | NORTHWOOD PHARMACY |

### 3.5.112.1 TQ – Antibiotics 12 Months or Longer Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Adjusted ICN | Unique control number assigned to a claim when it has been adjusted in the system, blank if this is a non-adjusted claim. | 13 | Character |
| AHFS Therapeutic Class Code and Description | American Hospital Formulary Service (AHFS) classification code and its description, identifying the pharmacological therapeutic category of the drug product. | 68 | Character |
| Billing Provider Base ID | ID which identifies the provider billing the claim. | 9 | Character |
| Billing Provider Name | The name associated with the billing provider ID. | 50 | Character |
| Control Drug Indicator | Indicates whether the drug is a controlled substance. | 1 | Character |
| Days Supply | Number of days the prescription should last. | 9 | Number (Integer) |
| Drug Quantity | Quantity dispensed for the drug claim. | 9 | Number (Integer) |
| From Date of Service | The date the service was incurred. | 10 | Date (MM/DD/CCYY) |
| ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is | 13 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | | |
| NDC Code & Description | National Drug Code is comprised of a 5-Character numeric labeler code, a 4-Character numeric product code, and a 2-Character numeric package code. It identifies a drug, its labeler, and the package size of a product, and is used for pricing and prior authorization. The description is a combination of the drug name appearing on the package label, the strength description and the dosage form description. | 49 | Character |
| Paid Amount | Amount sent to a provider for payment for services rendered to a recipient. This is the amount paid by Medicaid, after TPL, copay, etc have been subtracted. | 9 | Number (Decimal) |
| Payment Date | The date the claim was paid. | 10 | Date (MM/DD/CCYY) |
| Performing Provider Base ID | ID and Service Location which identifies the provider rendering the service. | 9 | Character |
| Performing Provider Name | The name associated with the performing provider ID. | 50 | Character |
| Prescriber Provider Base ID | ID and Service Location which identifies the provider prescribing the service. | 9 | Character |
| Prescriber Provider License | License number used to identify a person who refers recipients to other providers that perform services. | 10 | Character |
| Prescriber Provider Name | The name associated with the Prescriber ID. | 50 | Character |
| Prescriber Provider Type & Description | Provider Type and Description. | 63 | Character |
| Prescription Number | Number assigned to the prescription by the provider. | 7 | Character |
| Previous ICN | ICN from the legacy system. | 22 | Character |
| Recipient Age | Age of the recipient on the From Date of Service rounded down to a full year. | 22 | Character |
| Recipient Gender | Gender of the recipient. | 1 | Character |
| Recipient ID | Recipient's State assigned Medicaid Number or ID. | 12 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| Recipient Name | Full name of the recipient on the claim. | 32 | Character |
| Refill Indicator | Reflects the number of refills. The maximum number of refills is 6. | 2 | Character |


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### 3.5.113 TQ – Delayed Surgery Summary

This report lists all inpatient claims containing a surgical code where the surgical date is greater than the from date of service. This report ranks the claims based on the number of days a surgery was delayed. The delayed surgery count is calculated by determining the days between the from date of service and the surgical procedure date.

The report contains 3 report tabs:

A. The Delayed Surgery Provider List - Displays a list of providers and the delayed surgery claim count. The order is descending by delayed surgery claim count;

B. The Delayed Surgery Detail Report by Provider - Used to view a specific provider found in the Delayed Surgery Provider List. This gives you a quick view (drill) into the claims for a specific provider. Also, if you want to print the report, but don't want to print all of the other providers, use this tab to get only the selected provider; and

C. The Delayed Surgery Detail Report - All Providers displays the claims for all providers found in the Delayed Surgery Provider List tab. Use this report tab when you want to look at all of the providers' claim information at the same time.

This report is used to meet the following SUR Certification Requirement:

- Inpatient Hospitals having instances of: Frequently delayed surgery per recipient; and
- Frequently delayed surgeries are identified for billing providers having more than 3 claims with surgeries being delayed, based on the surgical procedure date, for more than 1 day from the from date of service on the claim.

**Report criteria:**

- Inpatient Claims Only;
- Paid Claims Only;
- From Date of Service Range prompt; and
- Surgical Procedure Date from the From Date of Service greater than 1 (one).


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A

# Alabama Medicaid Agency

## Delayed Surgery Provider List

From Date of Service: 4/1/16 - 6/29/16

Number of days delayed: 1

User ID:
Run Date: 6/29/2016
Run Time:2:52:11 PM

| Billing Provider IDs | Billing Provider Name | Delayed Surgery Claim Count |
|---|---|---|
| NPI ID:<br>Medicaid ID:<br>Base ID: | SACRED HEART HOSPITAL | 153 |
| NPI ID:<br>Medicaid ID:<br>Base ID: | HUNTSVILLE HOSPITAL | 89 |
| NPI ID:<br>Medicaid ID:<br>Base ID: | THE CHILDRENS HOSPITAL OF ALABAMA | 41 |
| NPI ID:<br>Medicaid ID:<br>Base ID: | SOUTHEAST ALABAMA MED CTR | 17 |
| NPI ID:<br>Medicaid ID:<br>Base ID: | JAY HOSPITAL | 6 |
| NPI ID:<br>Medicaid ID:<br>Base ID: | UNIVERSITY OF ALABAMA | 4 |

End of Report

B

# Alabama Medicaid Agency

Delayed Surgery Detail Report by Provider
From Date of Service: 4/1/16 - 6/29/16
Number of days delayed: 1

User ID:
Run Date: 6/29/2016
Run Time: 2:52:11 PM

Billing Provider IDs: NPI ID:
Medicaid ID:
Base ID:

Billing Provider Name: JAY HOSPITAL

| Detail Number | Claim Type | Claim Indicator | District Plan Code | Surgical Procedure Date | Paid Date | I C D | Surgical Procedure Code | Surgical Provider License Number | Paid Amount | Encounter Amount | RCO Paid Amount | Delayed Surgery Days | Pricing DRG Code & Description | DRG Relative Weight | DRG Service Adjustor |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | I | F | | 6/4/2016 | 6/1/2016 | 0 | 02H63JZ | 8022 | $27,421.95 | $0.00 | $0.00 | 3 | 1663 - CORONARY BYPASS W/O CATH | 4.0194 | 1.00 |
| 0 | I | F | RB1 | 6/4/2016 | 6/1/2016 | 0 | 02H63JZ | 8022 | $20,819.92 | $0.00 | $0.00 | 3 | 1662 - CORONARY BYPASS W/O CATH | 3.0517 | 1.00 |
| | | | | | | | | Sum: | $48,241.87 | $0.00 | $0.00 | 6 | | | |

End of Report


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C

**Alabama Medicaid Agency**

**Delayed Surgery Detail Report - All Providers**
From Date of Service: 4/1/16 - 6/29/16
Number of days delayed: 1

User ID:
Run Date: 6/29/2016
Run Time: 2:52:11 PM

Billing Provider IDs: NPI ID:
Medicaid ID:
Base ID:

Billing Provider Name: UNIVERSITY OF ALABAMA

| ICN | Claim Indicator | District Plan Code | Claim Type | ICD | Surgical Procedure Code | Paid Amount | Encounter Amount | RCO Paid Amount | Delayed Surgery Days | Surgical Procedure Date | Paid Date | Pricing DRG Code & Description | DRG Relative Weight | DRG Service Adjustor |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | E | RB1 | I | 0 | H22ZZZZ | $0.00 | $2,000.00 | $2,000.00 | 2 | 4/18/2016 | 5/17/2016 | 7532 - BIPOLAR DIS | 7.1400 | 1.00 |
| | E | RB1 | I | 0 | H22ZZZZ | $0.00 | $0.00 | $2,000.00 | 2 | 4/18/2016 | 5/31/2016 | 7532 - BIPOLAR DIS | 7.1400 | 1.00 |

### 3.5.113.1 TQ – Delayed Surgery Summary Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Delayed Surgery Claim Count | This object will determine the number of days between the surgical procedure date and the from date of service on the inpatient claim. | 9 | Number (Integer) |
| (A-C) Billing Provider IDs | This object contains the Base, Medicaid and NPI IDs that identify a provider. | 45 | Character |
| (A-C) Billing Provider Name | The name associated with the organization or person. | 50 | Character |
| (A-C) From Date of Service (prompt) | The from date of service range entered by the user. | 23 | Date (MM/DD/CCYY) |
| (A-C) Number of days delayed (prompt) | The number of days between the surgical procedure date and the from date of service on the inpatient claim. | 10 | Number (Integer) |
| (A-C) Run Date | The date that the report was executed. | 10 | Date (MM/DD/CCYY) |
| (A-C) Run Time | The time that the report was executed. | 10 | Character |
| (A-C) User ID | The id of the user that created the report. | 50 | Character |
| (B,C) Claim Indicator | Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim. | 1 | Character |
| (B,C) Claim Type | Shows what type of claim was submitted. | 1 | Character |
| (B,C) ICD | The ICD Version code for the surgical procedure code. | 1 | Character |
| (B,C) ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the | 13 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | batch number; and SSS is the sequence number of the invoice within the batch. | | |
| (B,C) Delayed Surgery Days | This object will determine the number of days between the Surgical Procedure Date and the From Date of Service on the Inpatient Claim. | 9 | Number (Integer) |
| (B,C) District Plan Code | The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid | 3 | Character |
| (B,C) DRG Code and Description | Diagnosis Related Group Number assigned to the claim, and its description. | 60 | Character |
| (B,C) DRG Relative Weight | Relative weight for pricing DRG | 5 | Number (Decimal) |
| (B,C) DRG Service Adjuster | This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor | 3 | Number (Decimal) |
| (B,C) Encounter Amount | Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount). | 10 | Number (Decimal) |
| (B,C) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 10 | Number (Decimal) |
| (B,C) RCO Paid Amount | Amount sent to a provider for payment for services rendered to a recipient (by RCO). | 10 | Number (Decimal) |
| (B,C) Paid Date | The date the claim was paid. | 10 | Date(MM/DD/CCYY) |
| (B,C) Surgical Procedure Code | The first ICD-CM code for the service performed for the recipient. | 7 | Character |
| (B,C) Surgical Procedure Date | The date the first surgical procedure was performed. | 10 | Date (MM/DD/CCYY) |
| (B,C) Surgical Provider License Number | The Medicaid physician ID of the surgeon or surgical license. | 10 | Character |


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### 3.5.114 TQ – Drug – Overspending Prescribers

This report shows all prescribers that write at least 50 percent of their prescriptions for scheduled drugs.

The report contains 2 report tabs:

A: Drug - Overspending Prescribers – Drugs; and

B: Prescriber – Specialty Matchup.

**Alabama Medicaid Agency**

Drug - Overspending Prescribers

From Date of Service within: 12/01/2006 - 12/31/2006

User ID: [redacted]
Run Date: 10/31/2007
Run Time: 9:33:16 AM

| Prescriber License | AHFS Therapeutic Class Code & Description | Claims | Paid Amount | Unique Recipients |
|---|---|---|---|---|
| [redacted] | 04040400 - ETHANOLAMINE DERIVATIVES | 3 | $3.00 | 1 |
| [redacted] | 04041200 - PHENOTHIAZINE DERIVATIVES | 7 | $7.00 | 1 |
| [redacted] | 04042000 - PROPYLAMINE DERIVATIVES | 4 | $4.00 | 1 |
| [redacted] | 04049200 - FIRST GEN. ANTIHIST. DERIVATIVES, MISC. | 2 | $2.00 | 1 |
| [redacted] | 04080000 - SECOND GENERATION ANTIHISTAMINES | 15 | $15.00 | 1 |
| [redacted] | 08080000 - ANTHELMINTICS | 1 | $1.00 | 1 |
| [redacted] | 08120604 - FIRST GENERATION CEPHALOSPORINS | 3 | $3.00 | 1 |
| [redacted] | 08120608 - SECOND GENERATION CEPHALOSPORINS | 1 | $1.00 | 1 |
| [redacted] | 08120612 - THIRD GENERATION CEPHALOSPORINS | 3 | $3.00 | 1 |
| [redacted] | 08121292 - OTHER MACROLIDES | 4 | $4.00 | 1 |
| [redacted] | 08121608 - AMINOPENICILLINS | 34 | $32.00 | 1 |
| [redacted] | 08121800 - QUINOLONES | 2 | $2.00 | 1 |
| [redacted] | 08122000 - SULFONAMIDES (SYSTEMIC) | 4 | $4.00 | 1 |
| [redacted] | 08122800 - ANTIBACTERIALS, MISCELLANEOUS | 2 | $2.00 | 1 |
| [redacted] | 08140800 - AZOLES | 4 | $4.00 | 1 |
| [redacted] | 08149200 - ANTIFUNGALS, MISCELLANEOUS | 1 | $1.00 | 1 |
| [redacted] | 08183200 - NUCLEOSIDES AND NUCLEOTIDES | 2 | $2.00 | 1 |
| [redacted] | 08300800 - ANTIMALARIALS | 1 | $1.00 | 1 |
| [redacted] | 08309200 - ANTIPROTOZOALS, MISCELLANEOUS | 1 | $1.00 | 1 |
| [redacted] | 08360000 - URINARY ANTI-INFECTIVES | 2 | $2.00 | 1 |
| [redacted] | 12080800 - ANTIMUSCARINICS/ANTISPASMODICS | 7 | $5.00 | 1 |
| [redacted] | 12120812 - SELECTIVE BETA-2-ADRENERGIC AGONISTS | 41 | $36.00 | 1 |
| [redacted] | 12200400 - CENTRALLY ACTING SKELETAL MUSCLE RELAXNT | 11 | $10.00 | 1 |
| [redacted] | 12201200 - GABA DERIVATIVE SKELETAL MUSCLE RELAXANT | 1 | $1.00 | 1 |
| [redacted] | 20040400 - IRON PREPARATIONS | 5 | $5.00 | 1 |
| [redacted] | 20120408 - COUMARIN DERIVATIVES | 1 | $1.00 | 1 |
| [redacted] | 20121800 - PLATELET-AGGREGATION INHIBITORS | 1 | $1.00 | 1 |
| [redacted] | 24040800 - CARDIOTONIC AGENTS | 2 | $2.00 | 1 |
| [redacted] | 24060600 - FIBRIC ACID DERIVATIVES | 2 | $2.00 | 1 |
| [redacted] | 24060800 - HMG-COA REDUCTASE INHIBITORS | 15 | $15.00 | 1 |
| [redacted] | 24081600 - CENTRAL ALPHA-AGONISTS | 7 | $7.00 | 1 |
| [redacted] | 24120800 - NITRATES AND NITRITES | 1 | $1.00 | 1 |
| [redacted] | 24240000 - BETA-ADRENERGIC BLOCKING AGENTS | 15 | $15.00 | 1 |
| [redacted] | 24280800 - DIHYDROPYRIDINES | 3 | $3.00 | 1 |


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**Alabama Medicaid Agency**

Drug - Overspending Prescribers

Prescriber - Specialty Matchup

From Date of Service within: 12/01/2006 - 12/31/2006

User ID: [illegible]
Run Date: 10/31/2007
Run Time: 9:36:19 AM

| Prescriber License Number | Provider Medicaid ID | Prescriber Name | Prov Primary Specialty Code & Description | Provider Specialty Code & Description |
|---|---|---|---|---|
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 242 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 242 - Pharmacy | 242 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |
| [illegible] | [illegible] | [illegible] | 240 - Pharmacy | 240 - Pharmacy |

### 3.5.114.1 TQ – Drug – Overspending Prescribers Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| (A) Claims | Claim count for prescribing license number. | 5 | Number (Integer) |
| (A) Paid Amount | Amount sent to a provider for payment for services rendered to a recipient ( | 13 | Number (Decimal) |
| (A) AFHS Therapeutic Class Code & Description | Therapeutic class code concatenated with a description of the therapeutic class code. | 40 | Character |
| (A) Unique Recipients | Recipient count for the prescribing license number. | 5 | Number (Integer) |
| (A,B) From Date of Service within | Claim's first date of service. | 20 | Date (MM/DD/CCYY) |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| (A-B) Prescriber License (Number) | License number used to identify a person who refers recipients to other providers that perform services. | 10 | Character |
| (B) Prescriber Name | Name of the prescriber. | 40 | Character |
| (B) Prov Primary Specialty Code & Description | The primary specialty of the provider. | 20 | Character |
| (B) Prov Specialty Code & Description | A specialty of the provider. | 20 | Character |
| (B) Provider Medicaid ID | The identification number for the provider. | 10 | Character |


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### 3.5.115 TQ – Drug – Recipients w-mult Pharmacies-Prescribers

The Drug - Recipients w/mult Pharmacies-Prescribers report shows recipients who visited five or more different pharmacies and obtained prescriptions from five or more prescribers in a given quarter. Note: The report layout displays the report columns being split into multiple sections. This has been done to allow for easy viewing in iTRACE and printing of the Design System Document (DSD). The actual reports in BusinessObjects will be presented in the standard report format.

**Alabama Medicaid Agency**

Drug - Recipients w-mult Pharmacies-Prescribers

From Date of Service Within : 01/01/2007 -03/31/2007

User ID:
Run Date: 10/25/2007
Run Time: 2:09:10 PM

| Recipient ID & Check Digit | Recipient Full Name | Recipient SSN | Recipient Lockin Indicator | Previous ICN | ICN | Detail Number | Adjusted ICN | Adjust/ Void Code | Claim Type | From Date of Service | Performing Provider IDs | Performing Provider Name | Performing Provider County Code & Description |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | N | | | 0 | | N | P | 11/19/2005 | Medicaid ID: | CVS DRUG STORE# 4908 | 45 - Madison |
| | | | N | | | 0 | | N | P | 11/19/2005 | Medicaid ID: | CVS DRUG STORE# 4908 | 45 - Madison |
| | | | N | | | 0 | | N | P | 11/19/2005 | Medicaid ID: | CVS DRUG STORE# 4908 | 45 - Madison |
| | | | N | | | 0 | | N | P | 12/01/2005 | Medicaid ID: | AMBULATORY CLINIC PHARMAC | 45 - Madison |
| | | | N | | | 0 | | N | P | 12/02/2005 | Medicaid ID: | AMBULATORY CLINIC PHARMAC | 45 - Madison |
| | | | N | | | 0 | | N | P | 12/02/2005 | Medicaid ID: | CVS DRUG STORE# 4924 | 45 - Madison |
| | | | N | | | 0 | | N | P | 12/12/2005 | Medicaid ID: | MEDICINE SHOPPE | 45 - Madison |
| | | | N | | | 0 | | N | P | 12/11/2005 | Medicaid ID: | WALGREENS #06430 | 45 - Madison |
| | | | N | | | 0 | | N | P | 12/11/2005 | Medicaid ID: | WALGREENS #06430 | 45 - Madison |
| | | | N | | | 0 | | N | P | 12/11/2005 | Medicaid ID: | WALGREENS #06430 | 45 - Madison |

| Prescribing License | Prescribing Provider ID on Claim | NDC Code & Description | AHFS Therapeutic Class Code & Description |
|---|---|---|---|
| | | 00078033805 - | 28129200 - Anticonvulsants, Miscellaneous |
| | | 00310027460 - SEROQUEL | 28160804 - Atypical Antipsychotics |
| | | 00008083601 - EFFEXOR XR | 28160416 - Sel. Serotonin & Norepi Reuptake Inhibtr |
| | | 00603401928 - IBUPROFEN | 28080492 - Other Nonsteroidal Anti-Inflam. Agents |
| | | 00713052612 - PROMETHEGAN | 04041200 - Phenothiazine Derivatives |
| | | 00008083601 - EFFEXOR XR | 28160416 - Sel. Serotonin & Norepi Reuptake Inhibtr |
| | | 00591033505 - ACYCLOVIR | 08183200 - Nucleosides And Nucleotides |
| | | 00078033805 - | 28129200 - Anticonvulsants, Miscellaneous |
| | | 00173073101 - WELLBUTRIN XL | 28160492 - Antidepressants, Miscellaneous |
| | | 00310027460 - SEROQUEL | 28160804 - Atypical Antipsychotics |

| ICN Region Code & Description | Paid Amount | Quantity Dispensed |
|---|---|---|
| 40 - CONVERTED REGION 05 ELECTRONIC CLAIMS | $154.86 | 40.000 |
| 40 - CONVERTED REGION 05 ELECTRONIC CLAIMS | $300.43 | 40.000 |
| 40 - CONVERTED REGION 05 ELECTRONIC CLAIMS | $37.17 | 10.000 |
| 40 - CONVERTED REGION 05 ELECTRONIC CLAIMS | $5.58 | 12.000 |
| 40 - CONVERTED REGION 05 ELECTRONIC CLAIMS | $10.61 | 6.000 |
| 40 - CONVERTED REGION 05 ELECTRONIC CLAIMS | $103.72 | 30.000 |
| 40 - CONVERTED REGION 05 ELECTRONIC CLAIMS | $24.40 | 90.000 |
| 40 - CONVERTED REGION 05 ELECTRONIC CLAIMS | $231.09 | 60.000 |
| 40 - CONVERTED REGION 05 ELECTRONIC CLAIMS | $129.35 | 30.000 |
| 40 - CONVERTED REGION 05 ELECTRONIC CLAIMS | $449.45 | 60.000 |


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### 3.5.115.1 TQ – Drug – Recipients w-mult Pharmacies-Prescribers Field Descriptions

| Field | Description | Length | Data Type |
|---|---|---|---|
| Adjust/Void Code | A code to indicate whether the record is for a debit or credit and adjustment. | 1 | Character |
| Adjusted ICN | Unique control number assigned to a claim when it has been adjusted in the system, blank if this is a non-adjusted claim. | 13 | Character |
| AHFS Therapeutic Class & Description | American Hospital Formulary Service (AHFS) classification, identifying the pharmacological therapeutic category of the drug product. | 68 | Character |
| Claim Type | Show the type of claim. | 10 | Character |
| Detail Number | Detail number on the claim. | 4 | Number (Integer) |
| Quantity Dispensed | The quantity of the drug that was dispensed to the recipient. | 8 | Number (Integer) |
| From Date of Service | For invoice types 1, the date on which services were first performed for a recipient. For invoice types 3 and 4, the first day of the billing period. | 10 | Date (MM/DD/CCYY |
| From Date of Service Within | For invoice types 1, the date on which services were first performed for a recipient. For invoice types 3 and 4, the first day of the billing period. | 20 | Date (MM/DD/CCYY) |
| ICN | Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch. | 13 | Number (Integer) |
| ICN Region Code & Description | The first two positions of the ICN and associated description. | 40 | Character |
| Previous ICN | ICN from legacy system | 13 | Number (Integer) |
| NDC Code & Description | National Drug Code is comprised of a 5-Character numeric labeler code, a 4-Character numeric product code, and a 2-Character numeric package code. It identifies a drug, its labeler, and the package size of a product, and is used for pricing and prior authorization. The description is combination of the | 49 | Character |


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| Field | Description | Length | Data Type |
|---|---|---|---|
| | drug name appearing on the package label, the strength description, and the dosage form description. | | |
| Paid Amount | Amount sent to a provider for payment for services rendered to a recipient | 13 | Number (Decimal) |
| Performing Provider County Code & Description | County in which the provider's service address is located. Out-of-state providers are also assigned a county code. The county name is associated with the county code. | 30 | Character |
| Performing Provider IDs | Identification number of the provider who performed (rendered) the service. | 46 | Character |
| Performing Provider Name | Name of the provider who performed (rendered) the service. | 64 | Character |
| Prescribing License | License number used to identify a person who refers recipients to other providers that perform services. | 9 | Character |
| Recipient Full Name | Full name of the recipient on the claim. | 22 | Character |
| Recipient ID & Check Digit | Number assigned to the recipient by the State and the recipient check digit assigned by the system with the recipient's Medicaid ID. | 12 | Character |
| Recipient Lockin Indicator | A code to indicate whether the recipient is/was "locked-in" to a specific provider to prevent utilization abuse by the recipient. Blank - No entry found for recipient on Lockin Tables, I - Recipient locked in as of date of service, O - Recipient not locked in as of date of service, but was at one time. | 1 | Character |
| Recipient SSN | Recipient Medicaid Number. | 12 | Character |


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