2.8.4 DSS - Alternate Budget Model -- Alternate Budget Model

The Alternate Budget Model, which is utilized by DMS staff in budget preparation, reports the generated monthly paid claims and utilization data by state category of service (COS) with a split on KCHIP Phase.

There are 2 tabs in this report:

A. Alternate Budget Model Report

B. Report Notes tab describing the conditions used to create the report.

2.8.4.1 Technical Name

DSS - Alternate Budget Model

2.8.4.2 Alternate Budget Model Layout

Run Date: 8/9/2007

Run Time: 4:01:15 PM

User ID: rztdly

Cabinet for Health and Family Services

Department for Medicaid Services

Alternate Budget Model

Payment Date Range: 5/1/2007 - 5/31/2007

Paid Date	State COS Code	Member KCHIP Phase	Paid Amount Sum	Distinct Utilizers
05/0007	03	2	$205,485.06	31
05/0007	03	3	$83,856.15	13
05/0007	03		$2,899,916.82	481
05/0007	04		$2,433,312.66	1,125
05/0007	07		$585,685.25	44
05/0007	08	2	$33,883.08	3
05/0007	08	3	$35,549.76	3
05/0007	08		$2,044,804.13	173

End of Report

Report Notes

Report Description

The Alternate Budget Model, which is utilized by DMS staff in budget preparation, reports the generated monthly paid claims and utilizer data by category of service (COS).

The Member KCHIP Phase is based in the following criteria:
Phase II - Member program code is "I ", "P ", or "KC" and program status is "P5", "P6", "M5", or "M6"
Phase III - Member program code is "I ", "P ", or "KC" and program status is "P7" or "M7"

Search Criteria

Payment Date Range - Payment date range entered in the prompt
FFS Claims Only - Fee for Service filter
Paid Claims Only filter

2.8.4.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Distinct Utilizers	A count of distinct member utilizers of service, not total members, reported.	12	Char	T_CA_ICN	ID_MEDICAID
Member KCHIP Phase	If aid category is 'I', 'P' or 'KC" and member status code is 'M4' or 'P4' then KCHIP flag is 1 else if member status code is 'M5', 'M6', 'P5', or 'P6' then flag is 2 else if member status is 'M7' or 'P7' then flag is 3.	2	Char	Calculated	N/A

Field	Description	Length	Data Type	DB Table	DB Attributes
Paid Amount	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Paid Date	The month in which a payment was generated from the claim transaction in MM/CCYY format.	7	Date (MM/CCYY)	T_CA_ICN	DTE_PAID
State COS Code	A code defining the billing provider's category of service for the service rendered.	52	Char	T_CA_CLAIM_KEY,T_CDE_COS_VALUES	CDE_COS_ST || DSC_COS_VALUES

2.8.4.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.4.5 Associated Requirements

ID
30.050.015.002.6

2.8.4.6 Change Orders

ID	Name	Description
1441	Alternate Budget Model	Develop the Alternate Budget Model Report according to specifications.

2.8.5 DSS - Ancillary Verifications with Names -- Ancillary Verifications with Names

The Ancillary Verifications with Names report generates a history of Ancillary claims for a given Provider(s) and Revenue Code during a specific date of service range. It is requested when verification of paid claim for ancillary therapy is requested.

2.8.5.1 Technical Name

DSS - Ancillary Verifications with Names

2.8.5.2 Ancillary Verifications with Names Layout

Run Date: 09/20/2006
Run Time: 2:59:23 PM

User ID: tztsbl

Cabinet for Health and Family Services

Department for Medicaid Services

Ancillary Verification - Names

Billing Provider Number(s):
Revenue Code Range: 0120 - 9999
From Date of Service Range: 07/11/2000 - 08/01/2006

ICN	Billed Amount	Member ID	Member Full Name (L,FM)	Revenue From Date of Service	Revenue To Date of Service	Revenue Code & Description
	$1,266.66			07/01/2004	07/18/2004	Diagnositc X Ray

No Data This Report Run

Report Notes

Report Description

The Ancillary Verifications with Names report generates a history of Ancillary claims for a given Provider(s) and Revenue Code during a specific date of service range. It is requested when verification of paid claim for ancillary therapy is requested.

Search Criteria

From Date of Service Range per user input
Latest Claims only
Paid Claims only
Fee for Service Claims only
Billing Provider ID per user input
Revenue Code per user input
Type of Bill between 891 and 894

2.8.5.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Amount	A charge for an individual procedure, treatment or service item as submitted by the provider.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
Revenue From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_HDR_DTL	DTE_FIRST_SVC
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence	13	Char	T_CA_ICN	NUM_ICN

Field	Description	Length	Data Type	DB Table	DB Attributes
	number				
Revenue To Date of Service	This is the line item last date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_HDR_DTL	DTE_LAST_SVC
Member ID	The first Identification number assigned to a member upon initial certification for participation in the Medicaid program.	12	Char	T_CA_ICN	ID_MEDICAID
Member Full Name (L, F, M)	The member's full name.	30	Char	T_RE_BASE	NAM_FIRST,NAM_LAST ,NAM_MID_INIT
Revenue Code Description	The line item revenue code billed on the UB-92 claim (describes the service performed).	74	Number	T_CA_HDR_DTL, T_REVENUE_COD E	CDE_REVENUE || DSC_REV_CODE

2.8.5.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.5.5 Associated Requirements

ID
30.050.015.002.6

2.8.5.6 Change Orders

ID	Name	Description
1431	Ancillary Verifications-Names	Develop Ancillary Verification - Names Report according to specifications.
4266	Ancillary Verification Report	This defect covers all issues related to the Ancillary Verification Report - CO 1431

2.8.6 DSS - Ancillary per Revenue Code -- Ancillary per Revenue Code

The Ancillary per Revenue Code report generates a history of billed Nursing Facility ancillary claims during a specific date of service range.

2.8.6.1 Technical Name

DSS - Ancillary per Revenue Code

2.8.6.2 Ancillary per Revenue Code Layout

Run Date: 07/17/2007
Run Time: 9:53:03 AM

User ID: tztsbl

Cabinet for Health and Family Services

Department for Medicaid Services

Ancillary Per Revenue Code

Revenue Code(s): 0320

From Date of Service Range: 01/01/2006 - 01/31/2006

Billing Provider Numbers	Member ID	Member Full Name (L,FM)	Revenue Code & Desc	ICN	Billed Revenue Amount Sum	Ancillary Total Paid Amount
			0320 - RADIOLOGY DIAGNOSTIC		$620.88	$0.00

End of Report

Report Notes

Report Description

The Ancillary per Revenue Code report generates a history of billed Nursing Facility ancillary claims during a specific date of service range

Search Criteria

Paid Claims only
Latest Claims only
Fee for Service Claims only
Revenue Code per user input
Bill Provider Type equal to 12
Type of Bill between 891 and 894
From Date of Service Range per user input

2.8.6.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Amount	A charge for an individual procedure, treatment or service item as submitted by the provider. The report returns all provider numbers, NPI, Base and Medicaid ID.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in the Medicaid program.	9	Char	T_CA_ICN	ID_PROV_BILL
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	CDE_ICN

Field	Description	Length	Data Type	DB Table	DB Attributes
Member Full Name (L,FM)	The member's full name.	19	Char	T_RE_BASE	NAM_FIRST,NAM_LAST,NAM_MID_INIT
Member ID	The first Identification number assigned to a member upon initial certification for participation in the Medicaid program.	12	Char	T_CA_ICN	ID_MEDICAID
Ancillary Total Paid Amount	The amount a Long Term Facility is paid.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Revenue Code & Description	The line item revenue code billed on the UB-92 claim (describes the service performed).	4	Number	T_CA_HDR_DTL_DN	CDE_REVENUE_1

2.8.6.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.6.5 Associated Requirements

ID
30.050.015.002.6

2.8.6.6 Change Orders

ID	Name	Description
1432	Ancillary per Revenue Code	Develop Ancillary per Revenue Code Report according to specifications.

2.8.7 DSS - Bed Days for Nursing Homes -- Bed Days for Nursing Homes

The Bed Days for Nursing Homes report generates the number of covered Bed Days for a given Provider(s) during a specific date of service range. It is requested when verification of Bed Days are requested for certain Nursing Facilities.

2.8.7.1 Technical Name

DSS - Bed Days for Nursing Homes

2.8.7.2 Bed Days for Nursing Homes Layout

Run Date: 09/20/2006
Run Time: 2:58:02 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: tztsbl

Bed Days for Nursing Homes

Billing Provider Numbers(s):
From Date of Service Range: 01/01/2000 - 01/01/2006

Billing Provider Numbers	Covered Days	Billing Provider Name
	23	

No Data This Report Run

Report Notes

Report Description

The Bed Days for Nursing Homes report generates the number of covered Bed Days for a given Provider(s) during a specific date of service range. It is requested when verification of Bed Days are requested for certain Nursing Facilities.

Search Criteria

From Date of Service Range per user input
Latest Claims only
Paid Claims only
Fee for Service only
Bill Provider ID per user input
Type of Bill between 891 and 894

2.8.7.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in the Medicaid program. The report returns the Provider Base number, the Medicaid provider ID and the provider ID.	9	Char	T_CA_ICN	ID_PROV_BILL
Billing Provider Name	The full name of the Medicaid provider on file.	50	Char	T_PR_SVC_LOC	NAME
Covered Days	This field is computed by the system using the FROM and TO dates of service. Indicates the total number of days for this claim.	5	Number	T_CA_ICN	NUM_DAYS_COVD

2.8.7.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.7.5 Associated Requirements

ID
30.050.015.002.6

2.8.7.6 Change Orders

ID	Name	Description
1433	Bed Days for Nursing Homes	Develop the Bed Days for Nursing Homes Report according to specifications.

2.8.8 DSS - Breast and Cervical Cancer Member -- Breast and Cervical Cancer Member

The Breast and Cervical Cancer Member report generates a listing of the distinct members in the Breast and Cervical Cancer Program by Federal Fiscal Year.

This report has 2 tabs:

A. Breast & Cervical Cancer Member.

B. Report Notes tab describing the conditions used to create the report.

2.8.8.1 Technical Name

DSS - Breast and Cervical Cancer Member

2.8.8.2 Breast and Cervical Cancer Member Layout

Run Date: 6/8/2007 **Cabinet for Health and Family Services** User ID: tztsbl

Run Time: 2:03:43 PM

Department for Medicaid Services

Breast and Cervical Cancer Member

Member Eligibility Date Range: 6/1/2005 - 6/30/2005

Member ID	Last Name	First Name	Middle Initial	Current Address County Description
				006 - Bath
				012 - Bracken
				016 - Butler
				022 - Carter

End of Report

Report Notes

Report Description

This report generates the distinct members in the Breast and Cervical Cancer Program by Federal Fiscal Year.

Search Criteria

Aid Eligibility Date Range - Beginning and Endinging date range entered in the prompt
Aid Code - equal to 'X' (DSS Adm MA Chld Title IV-E PAY)

2.8.8.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Member Eligibility Date Range	Aid Eligibility effective date range	10	Date (MM/DD/CCYY)	T_RE_AID_ELIG_DN	DTE_END
Current Address County Description	The county code & description the member resided in at the time the medical service was performed.	22	Char	T_RE_BASE_DN,T_COUNTRY	CDE_COUNTY || DSC_COUNTY
First Name	The member's first name.	15	Char	T_RE_BASE_DN	NAM_FIRST
Last Name	The member's last name.	20	Char	T_RE_BASE_DN	NAM_LAST
Member ID	The first Identification number assigned to a member upon initial certification for participation in the	12	Char	T_RE_BASE_DN	ID_MEDICAID

Field	Description	Length	Data Type	DB Table	DB Attributes
	Medicaid program.				
Middle Initial	The member's middle initial.	1	Char	T_RE_BASE_DN	NAM_MID_INIT

2.8.8.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.8.5 Associated Requirements

ID
30.050.015.002.6

2.8.8.6 Change Orders

ID	Name	Description
1442	Breast and Cervical Cancer Memb	Develop the Breast and Cervical Cancer Member Report according to specifications.

2.8.9 DSS - BusinessObjects Report Template -- BusinessObjects Report Template

The BusinessObjects Report Template report is used by all DSS reports generated out of BusinessObjects. The report template gives a custom and consistent view to all reports generated out of BusinessObjects. The template is available in portrait and landscape mode.

2.8.9.1 Technical Name

DSS - BusinessObjects Report Template

2.8.9.2 BusinessObjects Report Template Layout

Run Date: 05/09/2006
Run Time: 08:52:41 AM

User ID: nzjq02

Cabinet for Health and Family Services

Department for Medicaid Services

Report Title

Dates of Service Range: 01/01/2005 - 02/01/2005

Column Header 1	Column Header 2	Column Header 3	Column Header 4	Column Header 5	Column Header 6	Column Header 7	Column Header 8
Totals:							

End of Report

DSSProfiler iCE Landscape.rep Page 1 of 1

2.8.9.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Cabinet for Health and Family Services	Main Agency name.	38	Character	N/A	N/A
Claim Type Code	First report column contained within the body of the report. This is just a place holder column in the report template. This column is substituted with the actual report columns in the report applying the template.	15	Character	N/A	N/A
Department for Medicaid Services	Department name.	32	Character	N/A	N/A
End of Report	End of report label.	13	Character	N/A	N/A
Page:	Page number the report.	5	Number	N/A	N/A
Paid Claim Count	Second report column contained within the body of the report. This is just a place holder column in the report template. This column is substituted with the actual report columns in the report applying the template.	15	Character	N/A	N/A
Report Title Here	Report title.	50	Character	N/A	N/A
Run Date:	Date the report was last executed.	8	Date (MM/DD/CCYY)	N/A	N/A
Run Time:	Time the report was last executed. (HH:MM:SS)	6	Character	N/A	N//A

2.8.9.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.9.5 Associated Requirements

ID
30.050.015.002.6

2.8.9.6 Change Orders

ID	Name	Description
No associated Change Orders found.		

2.8.10 DSS - CMHC Monthly Summary -- CMHC Monthly Summary

The CMHC Monthly Summary report generates totals of Community Mental Health claims paid during the reporting period that have specifically designated procedure codes. Effective with DOS 10/16/2003 and after, reports totals of Community Mental Health claims paid during the reporting period that have procedure codes submitted in conjunction with a `UD' modifier.

Note: The following Procedure codes (H0001, H0006, H0015, H0024, H0025, H0031, H0036, H0047, H2012, 90801, 90804, 90847, 90853, 90887, 96150, 90862) and `UD' denote substance abuse program services.There are 2 tabs in this report:

A. CMHC Monthly Summary Report.

B. Report Notes tab describing the conditions used to create the report.

2.8.10.1 Technical Name

DSS - CMHC Monthly Summary

2.8.10.2 CMHC Monthly Summary Layout

Run Date: 04/27/2007
Run Time: 4:11:03 PM

User ID: czvtpc

Cabinet for Health and Family Services

Department for Medicaid Services

CMHC Monthly Summary Report

From Date of Service Range: 01/16/2006 - 12/31/2006

Billing Provider Numbers	Billing Provider Name	Procedure Code & Desc	First Modifier Code & Desc	Second Modifier Code & Desc	Third Modifier Code & Desc	Fourth Modifier Code & Desc	Member Undup Count	Billed Quantity Sum	Paid Amount Sum
		90804 - Psytx, Office, 20-30 Min	U5 - M/CAID CARE LEV 5 STATE DEF	UD - M/CAID CARE LEV 13 STATE DEF	- AUDIT NO MODIFIER	- AUDIT NO MODIFIER	2	3	$87.90
		H0024 - Alcohol And/Or Drug Preventi	U5 - M/CAID CARE LEV 5 STATE DEF	UD - M/CAID CARE LEV 13 STATE DEF	- AUDIT NO MODIFIER	- AUDIT NO MODIFIER	1	8	$50.40
						Provider Total:	**3**	**11**	**$138.30**
		90853 - Group Psychotherapy	U5 - M/CAID CARE LEV 5 STATE DEF	UD - M/CAID CARE LEV 13 STATE DEF	- AUDIT NO MODIFIER	- AUDIT NO MODIFIER	1	12	$63.72
		H0001 - Alcohol And/Or Drug Assess	U5 - M/CAID CARE LEV 5 STATE DEF	UD - M/CAID CARE LEV 13 STATE DEF	- AUDIT NO MODIFIER	- AUDIT NO MODIFIER	1	2	$34.76
		H0001 - Alcohol And/Or Drug Assess	U6 - M/CAID CARE LEV 6 STATE DEF	UD - M/CAID CARE LEV 13 STATE DEF	- AUDIT NO MODIFIER	- AUDIT NO MODIFIER	1	5	$86.90
						Provider Total:	**3**	**19**	**$185.38**

End of Report

Report Notes

Report Description

The CMHC Monthly Summary report generates totals of Community Mental Health claims paid during the reporting period that have procedure codes listed below. Effective with DOS 10/16/2003 and after, reports totals of Community Mental Health claims paid during the reporting period that have procedure codes submitted in conjunction with a `UD' modifier. Note: Procedure codes below and `UD' denote substance abuse program services.

Search Criteria

From Date of Service - Begin & end date of service entered in the user prompt
Billing Provider Type Code - equal to 30 (Community Mental Health)
Paid Claims Only filter
Latest Claims Only filter
Procedure Code Modifiers - equal to 'UD' (Substance abuse program services)
Primary Procedure Code - in list (H0001, H0006, H0015, H0024, H0025, H0031, H0036, H0047, H2012, 90801, 90804, 90847, 90853, 90862, 90887, 96150)
Claim Type - equal M (Medical)
Fee for Service Only filer

2.8.10.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	Quantity of units billed	12	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in the Medicaid program. The report returns all provider numbers, NPI, Base	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
	and Medicaid ID				
Billing Provider Name	Provider full name	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
First Modifier Code & Description	Modifier 1 and description	42	Char	T_CA_ICN, T_CDE_MODIFIER	CDE_MODIFIER_1 || DSC_MODIFIER
Forth Modifier Code & Description	Modifier 4 and description	42	Char	T_CA_ICN, T_CDE_MODIFIER	CDE_MODIFIER_4 || DSC_MODIFIER
Member Undup Count	Count of unique members	12	Char	T_CA_ICN	ID_MEDICIAD
Paid Amount	Total amount paid	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Primary Procedure Code & Desc	Primary procedure code and description	46	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC_PRIM || DSC_PROC
Second Modifier Code & Description	Modifier 2 and description	42	Char	T_CA_ICN, T_CDE_MODIFIER	CDE_MODIFIER_2 || DSC_MODIFIER
Third Modifier Code & Description	Modifier 3 and description	42	Char	T_CA_ICN, T_CDE_MODIFIER	CDE_MODIFIER_3 || DSC_MODIFIER

2.8.10.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.10.5 Associated Requirements

ID
30.090.014.003.2

2.8.10.6 Change Orders

ID	Name	Description
1601	CMHC Monthly Summary Report	Reports totals of Community Mental Health claims paid during the reporting period that have specific procedure codes and a modifier of 'UD', effective with DOS 10/16/2003 and after. Note: These Specific procedure codes and modifier `UD' denote substance abuse program services. The frequency of this report is monthly. (KYMC9916-R001)

2.8.11 DSS - CMHC Quarterly Summary -- CMHC Quarterly Summary

The CMHC Quarterly Summary report generates the Community Mental Health Claims paid during the reporting period that have procedure codes equal to (H0001, H0006, H0015, H0024, H0025, H0031, H0036, H0047, H2012, 90801, 90804, 90847, 90853, 90862, 90887, 96150). The frequency of this report is monthly.

There are 2 tabs in this report:

A. CMHC Quarterly Summary Report

B. Report Notes tab describing the conditions used to create the report.

2.8.11.1 Technical Name

DSS - CMHC Quarterly Summary

2.8.11.2 CMHC Quarterly Summary Layout

Run Date: 04/27/2007
Run Time: 4:11:03 PM

User ID: czvtpc

Cabinet for Health and Family Services

Department for Medicaid Services

CMHC Quarterly Summary Report

From Date of Service Range: 01/01/2006 - 3/31/2006

To Date of Service Range: 01/01/2006 - 3/31/2006

Billing Provider Numbers	Billing Provider Name	Procedure Code & Desc	First Modifier Code & Desc	Second Modifier Code & Desc	Third Modifier Code & Desc	Fourth Modifier Code & Desc	Member Undup Count	Billed Quantity Sum	Paid Amount Sum
		90804 - Psytx, Office, 20-30 Min	U5 - M/CAID CARE LEV 5 STATE DEF	UD - M/CAID CARE LEV 13 STATE DEF	- AUDIT NO MODIFIER	- AUDIT NO MODIFIER	1	4	$103.72
						Provider Total:	**1**	**4**	**$103.72**
		90804 - Psytx, Office, 20-30 Min	AJ - CLINICAL SOCIAL WORKER	UD - M/CAID CARE LEV 13 STATE DEF	- AUDIT NO MODIFIER	- AUDIT NO MODIFIER	1	6	$149.28
						Provider Total:	**1**	**6**	**$149.28**
		90853 - Group Psychotherapy	AJ - CLINICAL SOCIAL WORKER	UD - M/CAID CARE LEV 13 STATE DEF	- AUDIT NO MODIFIER	- AUDIT NO MODIFIER	1	12	$89.64
		90853 - Group Psychotherapy	U6 - M/CAID CARE LEV 6 STATE DEF	UD - M/CAID CARE LEV 13 STATE DEF	- AUDIT NO MODIFIER	- AUDIT NO MODIFIER	1	12	$89.64
						Provider Total:	**2**	**24**	**$179.28**
		90853 - Group Psychotherapy	U3 - M/CAID CARE LEV 3 STATE DEF	UD - M/CAID CARE LEV 13 STATE DEF	- AUDIT NO MODIFIER	- AUDIT NO MODIFIER	2	24	$127.44
		H0001 - Alcohol And/Or Drug Assess	U3 - M/CAID CARE LEV 3 STATE DEF	UD - M/CAID CARE LEV 13 STATE DEF	- AUDIT NO MODIFIER	- AUDIT NO MODIFIER	2	10	$173.80
						Provider Total:	**4**	**34**	**$301.24**

End of Report

Report Notes

Report Description

The CMHC Quarterly Summary report generates the Community Mental Health Claims paid during the reporting period that have procedure codes equal to (H0001, H0006, H0015, H0024, H0025, H0031, H0036, H0047, H2012, 90801, 90804, 90847, 90853, 90862, 90887, 96150). The frequency of this report is monthly.

Search Criteria

From Date of Service Range - Begin & end date of service entered in the user prompt
To Date of Service Range - Begin & end date of service entered in the user prompt
Billing Provider Type Code - equal to 30 (Community Mental Health)
Paid Claims Only filter
Latest Claims Only filter
Primary Procedure Code - in list (H0001, H0006, H0015, H0024, H0025, H0031, H0036, H0047, H2012, 90801, 90804, 90847, 90853, 90862, 90887, 96150)
Claim Type - equal to M
Fee for Service Only filter

2.8.11.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	Quantity of units billed	12	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED
Billing Provider Numbers	Billing provider number. The report returns all provider numbers, NPI, Base and Medicaid ID.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Name	Provider full name	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
From Date of Service	Date of first service	10	Char	T_CA_ICN	DTE_FIRST_SVC
Member ID	Medicaid member number	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount	Total amount paid	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Primary Diagnosis Code & Desc	Primary Diagnosis code and description	47	Char	T_CA_ICN,T_DIAGNOSIS	CDE_DIAG_PRIM || DSC_25
Primary Procedure Code & Desc	Primary Procedure code and description	46	Char	T_CA_ICN,T_CDE_PROC	CDE_PROC_PRIM || DSC_PROC
To Date of Service	Date of last service	10	Char	T_CA_ICN	DTE_LAST_SVC

2.8.11.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.11.5 Associated Requirements

ID
30.090.014.003.2

2.8.11.6 Change Orders

ID	Name	Description
1602	CMHC Quarterly Summary Report	Reports Community Mental Health claims paid during the reporting period that have specific identified procedure codes. The frequency of this report is monthly. (KYMC9917-R001)

2.8.12 DSS - Central Baptist Neonatal Claims -- Central Baptist Neonatal Claims

The Central Baptist Neonatal Claims report generates history of Neonatal claims for Central Baptist Hospital.

There are 2 tabs in this report:

A. Central Baptist Neonatal Claims Report

B. Report Notes tab describing the conditions used to create the report.

2.8.12.1 Technical Name

DSS - Central Baptist Neonatal Claims

2.8.12.2 Central Baptist Neonatal Claims Layout

Run Date: 4/11/2007

Run Time: 10:33:55 AM

User ID: tztsbl

Cabinet for Health and Family Services

Department for Medicaid Services

Central Baptist Neonatal Claims

Paid Date Range: 1/1/2000 - 12/31/2006

ICN	Member ID	Admission Date	Paid Amount Sum	Paid Date	DRG Code & Desc	Member Age	Member Date of Birth
		02/09/2005	$0.00	06/10/2005	0386 - EXTREME IMMATURITY	31	06/18/1973
		05/06/2005	$0.00	06/10/2005	0388 - PREMATURITY W/O MAJOR PROBLEMS	34	04/22/1971
		03/23/2006	$0.00	05/05/2006	0386 - EXTREME IMMATURITY	30	07/04/1975
		04/12/2006	$0.00	05/19/2006	0390 - NEONATE W OTHER SIGNIFICANT PROBLEMS	32	06/20/1973
		06/21/2006	$0.00	07/28/2006	0390 - NEONATE W OTHER SIGNIFICANT PROBLEMS	39	06/21/1967
		06/24/2006	$0.00	07/28/2006	0390 - NEONATE W OTHER SIGNIFICANT PROBLEMS	27	07/29/1978

End of Report

Report Notes

Report Description

This report generates history of neonatal claims for Central Baptist Hospital.

Search Criteria

Paid Date - Payment date range entered in the prompt
Billing Provider Medicaid ID - equal to '01012566' (Central Baptist Hosp)
DRG Code - Diagnosis related group # between '0385' and '0390'

2.8.12.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Admission Date	The date upon which a member was admitted to a medical institution.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_ADMISSION
DRG Code & Description	The DRG (Diagnosis Related Group) number assigned to the claim.	136	Char	T_CA_ICN, T_DRG	CD_DRG || DSC_DRG
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN

Field	Description	Length	Data Type	DB Table	DB Attributes
Member Age	The age of the member at the time the service was rendered, taken from the MMIS claim at the time of adjudication.	4	Number	T_CA_ICN	NUM_RECIP_AGE
Member Date of Birth	The date of birth of the member. This is taken from the MMIS member file at the time the claim was adjudicated.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_BIRTH
Member ID	The first Identification number assigned to a member upon initial certification for participation in the Medicaid program.	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Paid Date	The date on which a payment was generated from the MMIS claim transaction.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID

2.8.12.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.12.5 Associated Requirements

ID
30.050.015.002.6

2.8.12.6 Change Orders

ID	Name	Description

ID	Name	Description
1443	Central Baptist Neonatal Claims	Develop the Central Baptist Neonatal Claims Report according to specifications.

2.8.13 DSS - Certification Failures -- Certification Failures

The Certification Failures report generates a history of Nursing Facility claims for a given Provider(s) and Member(s) during a specific date of service range. It is requested when a Nursing Facility fails to call and get a Certification number in a timely manner. Monies paid under an incorrect certification number are requested to be refunded.

2.8.13.1 Technical Name

DSS - Certification Failures

2.8.13.2 Certification Failures Layout

Run Date: 09/20/2006
Run Time: 2:55:10 PM

User ID: tztsbl

Cabinet for Health and Family Services

Department for Medicaid Services

Certification Failures

Billing Provider Number(s):
Member ID(s):
From Date of Service Range: 01/01/2000 - 01/01/2006

Member ID	Member Full Name (L,FM)	Billing Provider Numbers	Billing Provider Name	Paid Amount	From Date of Service	To Date of Service	ICN
				$633.10	04/13/2004	04/13/2004	

No Data This Report Run

Report Notes

Report Description

The Certification Failures report generates a history of Nursing Facility claims for a given Provider(s) and Member(s) during a specific date of service range. It is requested when a Nursing Facility fails to call and get a Certification number in a timely manner. Monies paid under an incorrect certification number are requested to be refunded.

Search Criteria

From Date of Service Range per user input
Latest Claims only
Paid Claims only
Fee for Service Claims only
Billing Provider ID per user input
Member ID per user input
Type of Bill between 891 and 894

2.8.13.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	The Base Id is the high level ID assigned by interChange to the unique instance of a provider without regard to service location. The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs. The Medicaid ID of the provider at the service location.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_BASE || ID_PROVIDER_NPI || ID_PROVIDER_MCAID
Billing Provider Name	Full name of the provider.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER

Field	Description	Length	Data Type	DB Table	DB Attributes
From Date of Service	This is the first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
Member Full Name (L,FM)	The member's full name.	29	Char	T_RE_BASE	NAM_LAST,NAM_FIRST, NAM_MID_INIT
Member ID	The first Identification number assigned to a member upon initial certification for participation in the Medicaid program.	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount	The total reimbursement amount of the claim.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
To Date Of Service	This is the last date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC

2.8.13.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.13.5 Associated Requirements

ID
30.050.015.002.6

2.8.13.6 Change Orders

ID	Name	Description
1434	Certification Failures	Develop the Certification Failures Report according to specifications.

2.8.14 DSS - DRG Retro Review - Claims Rebilled Detail -- DRG Retro Review - Claims Rebilled Detail

The DRG Retro Review - Claims Rebilled Detail report uses the DRG financial adjustments to find the rebilled claims by member /date of service with same provider and report. Totals are by provider with a grand total at the end. The frequency of this report is monthly.

There are 2 tabs in this report:

A. DRG Retro Review - Claims Rebilled Detail

B. Report Notes tab describing the conditions used to create the report.

2.8.14.1 Technical Name

DSS - DRG Retro Review - Claims Rebilled Detail

For readability, this layout appears on the following several page.

2.8.14.2 DRG Retro Review - Claims Rebilled Detail Layout

A

Run Date: 6/27/2007

Run Time: 10:52:07 AM

User ID: qz00tr

Cabinet for Health and Family Services

Department for Medicaid Services

DRG Retro Review - Financial Adjustments - Rebilled Claims Reporting

From Date of Service Range: 5/1/2006 - 5/15/2006

Billing Provider Numbers	Original ICN	Original Paid Amount	New ICN	New Paid Amount	Difference
		$2,488.61		$2,488.61	$0.00
	Totals:	**$2,488.61**		**$2,488.61**	**$0.00**
		$5,340.84		$5,340.84	$0.00
	Totals:	**$5,340.84**		**$5,340.84**	**$0.00**
		$0.00		$877.20	$(877.20)
	Totals:	**$0.00**		**$877.20**	**$(877.20)**
	Grand Total:	**$7,829.45**		**$8,706.65**	**$(877.20)**

End of Report

Report Notes

Report Description

The DRG Retro Review - Claims Rebilled Detail report uses the DRG financial adjustments to find the rebilled claims by member /date of service with same provider and report. Totals are by provider with a grand total at the end.

Search Criteria

Original Claim data provider:

Adjust/Void code - equal to 'N'
From Date of Service Range - user prompt Begin and End date of service
ICN subquery to only capture Adjusted ICNs
Billing Provider Type Code - equal to '01' (General Hospital)
Inpatient Claims Only (Claim Type A & I)
Detail Number - equal to 0
Billing Provider BASE Numbers Excluded (list below)

New Claim data provider:

Adjust/Void code - equal to 'Y'
From Date of Service Range - user prompt Begin and End date of service
Billing Provider Type Code - equal to '01' (General Hospital)
Inpatient Claims Only (Claim Type A & I)
Detail Number - equal to 0
Billing Provider BASE Numbers Excluded (list below)

Supplemental Documentation

Sorted by: (1) Billing Provider Numbers, (2) Payment Date for Adjusted Claim (hidden column)

Data Providers are linked by: (1) Billing Provider Number and (2) ICN (Original Claim) and Adjusted ICN (New Claim)

DRG Claims are only paid at header level.

All Billing Provider Type Code 01's are considered DRG except for some hospitals. Those hospitals, which are excluded from this report, are listed below.
NOTE: If a hospital is added, removed or the BASE provider # is replaced, then that BASE provider number (8 digits) must be edited in the condition in the query.

Psych DPU Facility

Baptist East 92000124
Baptist Regional 92000033
Ephraim McDowell 92000132
Hardin Memorial 92000116
Harlan ARH 92000082
Hazard ARH 92000017
Jane Todd Crawford 92000009
Lake Cumberland Reg 92000066
Lourdes Hospital 92000025
Norton Kosair Childrens 92000108
St. Claire Medical Center 92000140
St. Elizabeth Medical Ctr 92000074
St Luke Hospital West 92000090
Three Rivers Medical 92000041
University of Ky 92000058

Rehab DPU Facility

Baptist East 93000099
Baptist Regional 93000024
Kings Daughters 93000081
Lake Cumberland 93000057
Lourdes 93000016
Methodist Hospital 93000065
Owensboro Medical 93000040
Regional Medical Ctr 93000032
St. Claire Medical Ctr 93000115
Hazard ARH 93000008

Free Standing Rehab Facility

Cardinal Hill Rehab 01021237
Healthsouth Rehab of Central Ky 01022326
Healthsouth Northern Ky Rehab 01022540

Free Standing Psych Facility

CENTRAL STATE 02021293
EASTERN STATE 02020030
FHC CUMBERLAND HALL 02021301
LINCOLN TRAIL 02021244
NORTHKEY COMMUNITY 02021350
RIDGE BEH HEALTH 02021335
RIVENDELL OF KY 02021251
RIVER VALLEY BEH 02021210
TEN BROECK 02020022
TEN BROECK OF DUPONT 02000016
WESTERN STATE 02000008

Long Term Care Accute Hospitals

Kindred Hospital Louisville 01022532
Continuing Care @ St. Joseph East 01000173
Select Speciality Hospital @ Samaritan 01000322
Cardinal Hill Speciality Hospital 01000306
Oak Tree Hosp @ Baptist Regional 01000363

Out of State Critical Access Hospitals

01400480
01330034
01600774

Out of State Ventilator

01621895
01542729
01600691

Southern Ky Rehab (frmly Mediplex) 01000272
Gateway Rehab of Northern KY 01000447 (old #01000173)
Gateway Rehab @ Norton 01000439 (old #01000314)

Critical Asscess Hospitals

Marcum & Wallace 01002526
Garrard County Hospital 01005339 (closed facility)
Nicholas County 01004233
James B. Haggin 01008044
Trigg County Hospital 01002724
Our Lady of the Way 01021930
Union Co. Methodist 01022110
Bluegrass Community 01000140
Morgan Co. ARH 01021773
Carroll Co. Memorial Hosp 01000330 (old #01022458)
Casey County War Mem. 01000280
St. Elizabeth–Grant Co. Hosp. 01022060
New Horizons Medical Center 01000181
Westlake Regional Hospital 01021898
Caverna Memorial Hospital 01016732
Cumberland County Hospital 01015833
Fort Logan Hospital 01000223
Mary Breckinridge Memorial 01021815
The Medical Center of Franklin 01000074
Breckinridge Memorial Hospital 01015932
Livingston County Hospital 01001619
Caldwell County Hospital 01006931
Ohio County Hospital 01022052
Wayne County Hospital 01021781
Jenkins Community Hospital 01022482
Jane Todd Crawford Hospital 01014232
The Medical Ctr @ Scottsville 01000389
Knox County Hospital 01000348
Marshall County Hospital 01015338
Berea Hospital 01009042
Russell County 01000371
McDowell ARH 01014943

2.8.14.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	The provider on the claim. The report returns all provider number, NPI, Base and Medicaid ID.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
Difference	The difference between the original and new claim	13	Number (Decimal)	n/a	calculated
New ICN	The new day claim number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
New Paid Amount	The new day claim paid amount	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Original ICN	The original adjusted claim number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
Original Paid Amt	The original paid amount of the claim	13	Number (Decimal)	T_CA_ICN	AMT_PAID

2.8.14.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.14.5 Associated Requirements

ID
30.090.014.003.2

2.8.14.6 Change Orders

ID	Name	Description
1606	DRG Retro Review-Clms Rebill Dtl	Reports DRG Claims that were rebilled as a result of financial adjustments. Using the DRG financial adjustments, find the rebilled claims by member /dos with same provider and report. Totals are by provider with a grand total at the end. The frequency of this report is monthly. (KYMC9930-R001)
4542	DRG Retro Review - Claims Rebill	This defect covers all issues related to CO 1606 - DRG Retro Review - Claims Rebilled Detail Report

2.8.15 DSS - DRG Retro Review - Claims Rebilled Summary By Provider -- DRG Retro Review - Claims Rebilled Summary By Provider

The DRG Retro Review - Claims Rebilled Summary By Provider report uses the DRG financial adjustments to find the rebilled claims by member /date of service with same provider and report. Report is totaled by provider and A/R setup date, with a grand total at the end. The frequency of this report is monthly.

There are 2 tabs in this report:

A. DRG Retro Review - Claims Rebilled Summary

B. Report Notes tab describing the conditions used to create the report.

2.8.15.1 Technical Name

DSS - DRG Retro Review - Claims Rebilled Summary By Provider

For readability, this layout appears on the following several pages.

2.8.15.2 DRG Retro Review - Claims Rebilled Summary By Provider Layout

A

Run Date: 6/27/2007

Run Time: 10:52:22 AM

User ID: qz00tr

Cabinet for Health and Family Services

Department for Medicaid Services

DRG Retro Review - Financial Adjustments - Rebilled Claims Summary

From Date of Service Range: 5/1/2006 - 5/15/2006

Billing Provider Number	Paid Date	Original Paid Amount	New Paid Amount	Difference
	06/16/2006	$2,488.61	$2,488.61	$0.00
	Totals:	**$2,488.61**	**$2,488.61**	**$0.00**
	06/09/2006	$6,583.19	$6,583.19	$0.00
	Totals:	**$9,358.31**	**$6,583.19**	**$0.00**
	06/16/2006	$5,378.37	$5,378.37	$0.00
	Totals:	**$124,872.09**	**$5,378.37**	**$0.00**
	06/09/2006	$9,311.94	$9,311.94	$0.00
	Totals:	**$36,278.16**	**$9,311.94**	**$0.00**
	Grand Total:	**$172,997.17**	**$23,762.11**	**$0.00**

End of Report

Report Notes

Report Description

The DRG Retro Review - Claims Rebilled Summary By Provider report uses the DRG financial adjustments to find the rebilled claims by member /date of service with same provider and report. Report is totaled by provider and A/R setup date, with a grand total at the end.

Search Criteria

Original Claim data provider:

Adjust/Void code - equal to 'N'
From Date of Service Range - user prompt Begin and End date of service
ICN subquery to only capture Adjusted ICNs
Billing Provider Type Code - equal to '01' (General Hospital)
Inpatient Claims Only (Claim Type A & I)
Detail Number - equal to 0
Billing Provider BASE Numbers Excluded (list below)

New Claim data provider:

Adjust/Void code - equal to 'Y'
From Date of Service Range - user prompt Begin and End date of service
Billing Provider Type Code - equal to '01' (General Hospital)
Inpatient Claims Only (Claim Type A & I)
Detail Number - equal to 0
Billing Provider BASE Numbers Excluded (list below)

Supplemental Documentation

Sorted by: (1) Billing Provider Numbers, (2) Payment Date for Adjusted Claims

Data Providers are linked by: (1) Billing Provider Number and (2) ICN (Original Claim) and Adjusted ICN (New Claim)

DRG Claims are at header level.

All Billing Provider Type Code 01's are considered DRG except for some hospitals. Those hospitals, which are excluded from this report, are listed below.
NOTE: If a hospital is added, removed or the BASE provider # is replaced, then that BASE provider number (8 digits) must be edited in the condition in the query.

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Baptist Regional 92000033
Ephraim McDowell 92000132
Hardin Memorial 92000116
Harlan ARH 92000082
Hazard ARH 92000017
Jane Todd Crawford 92000009
Lake Cumberland Reg 92000066
Lourdes Hospital 92000025
Norton Kosair Childrens 92000108
St. Claire Medical Center 92000140
St. Elizabeth Medical Ctr 92000074
St Luke Hospital West 92000090
Three Rivers Medical 92000041
University of Ky 92000058

Rehab DPU Facility

Baptist East 93000099
Baptist Regional 93000024
Kings Daughters 93000081
Lake Cumberland 93000057
Lourdes 93000016
Methodist Hospital 93000065
Owensboro Medical 93000040
Regional Medical Ctr 93000032
St. Claire Medical Ctr 93000115
Hazard ARH 93000008

Free Standing Rehab Facility

Cardinal Hill Rehab 01021237
Healthsouth Rehab of Central Ky 01022326

Free Standing Psych Facility

CENTRAL STATE 02021293
EASTERN STATE 02020030
FHC CUMBERLAND HALL 02021301
LINCOLN TRAIL 02021244
NORTHKEY COMMUNITY 02021350
RIDGE BEH HEALTH 02021335
RIVENDELL OF KY 02021251
RIVER VALLEY BEH 02021210
TEN BROECK 02020022
TEN BROECK OF DUPONT 02000016
WESTERN STATE 02000008

Long Term Care Accute Hospitals

Kindred Hospital Louisville 01022532
Continuing Care @ St. Joseph East 01000173
Select Speciality Hospital @ Samaritan 01000322
Cardinal Hill Speciality Hospital 01000306
Oak Tree Hosp @ Baptist Regional 01000363

Out of State Critical Access Hospitals

01400480
01330034
01600774

Out of State Ventilator

01621895
01542729
01600691

Southern Ky Rehab (frmly Mediplex) 01000272
Gateway Rehab of Northern KY 01000447 (old #01000173)
Gateway Rehab @ Norton 01000439 (old #01000314)

Critical Asscess Hospitals

Marcum & Wallace 01002526
Garrard County Hospital 01005339 (closed facility)
Nicholas County 01004233
James B. Haggin 01008044
Trigg County Hospital 01002724
Our Lady of the Way 01021930
Union Co. Methodist 01022110
Bluegrass Community 01000140
Morgan Co. ARH 01021773
Carroll Co. Memorial Hosp 01000330 (old #01022458)
Casey County War Mem. 01000280
St. Elizabeth–Grant Co. Hosp. 01022060
New Horizons Medical Center 01000181
Westlake Regional Hospital 01021898
Caverna Memorial Hospital 01016732
Cumberland County Hospital 01015833
Fort Logan Hospital 01000223
Mary Breckinridge Memorial 01021815
The Medical Center of Franklin 01000074
Breckinridge Memorial Hospital 01015932
Livingston County Hospital 01001619
Caldwell County Hospital 01006931
Ohio County Hospital 01022052
Wayne County Hospital 01021781
Jenkins Community Hospital 01022482
Jane Todd Crawford Hospital 01014232
The Medical Ctr @ Scottsville 01000389
Knox County Hospital 01000348
Marshall County Hospital 01015338
Berea Hospital 01009042
Russell County 01000371
McDowell ARH 01014943

2.8.15.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	The provider on the claim. The rerport returns all provider numbers, NPI, Base and Medicaid ID.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
Difference	The difference between the original and new claim	13	Number (Decimal)	n/a	calculated
New Paid Amount	The new day claim paid amount of all claims for the same provider/setup date	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Original Paid Amount	The original paid amount of all claims for the same provider/setup date	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Payment Date	FFS claims - date claim was paid; converted FFS claims - adjudication date; encounter claims - date claim was accepted by DPW	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID

2.8.15.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.15.5 Associated Requirements

ID
30.090.014.003.2

2.8.15.6 Change Orders

ID	Name	Description
1607	DRG Retro Review-Clms Summary	DRG Claims that were rebilled as a result of financial adjustments. Using the DRG financial adjustments, find the rebilled claims by member /dos with same provider and report. Report is totaled by provider and A/R setup date, with a grand total at the end. The frequency of this report is monthly. (KYMC9930-R002)
4543	DRG Retro Rev-Claims Rebill Summary	This defect covers all issues related to CO 1607 - DRG Retro Review - Claims Rebilled Summary by Provider Report

2.8.16 DSS - Dental Access -- Dental Access

The Dental Access Report presents the availability of dental access to members by county, population, and practicing/licensed/enrolled dentists.

There are 2 tabs in this report:

A. Dental Access Report

B. Report Notes tab describing the conditions used to create the report.

Note: The GIF file was too wide for this report so it has been split into 2 parts for Tab A. The report columns that are under the first set are actually displayed along with the first set in the landscape format in the actual report.

2.8.16.1 Technical Name

DSS - Dental Access

For readability, this layout appears on the following several pages.

2.8.16.2 Dental Access Layout

A

Run Date: 7/24/2007

Run Time: 10:43:25 AM

Cabinet for Health and Family Services

Department for Medicaid Services

Dental Access Report

County	Total Population	# Licensed Dentists	Enrolled Denists	Biling Dentists	Total Eligible Members	Client/Provider Ratio	U 21 Rec'v Dental Care Spec.56	U 21 Rec'v Dental Care Spec.08	U 21 Rec'v Dental Care Spec.80	U 21 Rec'v Dental Care Spec.88	21 & over Rec'v Dental Care other than Spec.56	21 & over Rec'v Dental Care Spec.56
001 - Adair	17575	5	4	2	3,880	1,940.00	8	108	0	3	45	2
002 - Allen	18541	5	3	3	3,325	1,108.33	6	106	1	4	19	11
003 - Anderson	20099	7	3	2	1,961	980.50	3	44	14	4	24	5
004 - Ballard	8295	1	1	1	1,270	1,270.00	0	19	17	0	7	1
005 - Barren	39473	16	12	9	7,623	847.00	8	193	0	2	94	6
006 - Bath	11538	1	2	1	3,160	3,160.00	2	55	0	2	30	6
007 - Bell	29672	11	9	7	10,637	1,519.57	9	268	22	2	147	18
Sum:	**145,193**	**46**	**34**	**25**	**31,856**		**36**	**793**	**54**	**17**	**366**	**49**

End of Report

User ID: tztsbl

From Date of Service Range: 06/01/2006 - 06/30/2006

Date For Age Calculation: 06/30/2006

Eligible Members under 21	Undup Members Under 21 Rec'v Care	% of Members under 21 rec'v Care	Eligible Members 21 and older	Undup Members 21 & Over Rec'v Care	% of Members 21 & Over Rec'v Care
2,048	1	0.05%	1,832	80	4.37%
1,897	1	0.05%	1,428	80	5.60%
1,253	0	0.00%	708	44	6.21%
724	0	0.00%	546	39	7.14%
4,076	0	0.00%	3,547	269	7.58%
1,606	0	0.00%	1,554	70	4.50%
5,059	0	0.00%	5,578	158	2.83%
16,663	**2**		**15,193**	**740**	

B

Report Notes

Report Description

This report generates dental access to members by county, population, and practicing/licensed/enrolled dentists.

Search Criteria

From Date of Service - Begin and end date range entered in the prompt
Billing Provider Types - in list (60,61,64) and Speciality Code - in list (56,08,80,88)
Member Age - less than or greater than 21
FFS Claims Only - Fee for Service filter
Latest Claims only filter - will give you only the latest version of a claim even if it was previously adjusted.
Paid Claims only filter - claim is not denied

2.8.16.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
# Licensed Dentists	The number of licensed dentists in a particular county.	12	Char	T_RE_BASE_DN	ID_MEDICAID
% of Members 21 and Over Rec'v	The percentage of members who are 21 and over and are receiving dental care.	3	Number	N/A	CALCULATED

Field	Description	Length	Data Type	DB Table	DB Attributes
Care					
% of Members under 21 rec'v Care	The percentage of members under the age of 21 receiving dental care.	3	Number	N/A	CALCULATED
21 & Over Rec'v Dental Care Other Than Spec 56	The number of members that are 21 and older that are receiving dental care from the provider with a provider specialty other than 56.	12	Char	T_CA_ICN	ID_MEDICAID
21 & Over Rec'v Dental Care Spec 56	The number of members that are 21 and older that are receiving dental care from the provider with a provider specialty of 56.	12	Char	T_CA_ICN	ID_MEDICAID
Billing Dentists	The number of billing dentists in a particular county.	9	Number	T_CA_PROV_KEY	SAK_PROV
Client/Provider Ratio	The number of provider to clients ratio.	4	Number	N/A	CALCULATED
County Code and Description	The code and name of the county.	22	Char	T_RE_BASE_DN, T_COUNTY	CDE_COUNTY || DSC_COUNTY
Eligible Members 21 and Older	The number of eligible members that are 21 and older.	12	Char	T_RE_BASE_DN	ID_MEDICAID
Eligible Members under 21	The number of eligible members under that age of 21.	12	Char	T_RE_BASE_DN	ID_MEDICAID
Enrolled Dentists	The number of enrolled dentists in a particular county.	15	Char	T_PR_SVC_LOC_DN	ID_PROVIDER_MCAID

Field	Description	Length	Data Type	DB Table	DB Attributes
Total Eligible Members	The number of enrolled members in a particular county.	12	Char	T_RE_BASE_DN	ID_MEDICAID
Total Population	The total number of members in a particular county.	9	Number	T_PR_SVC_LOC_DN	SAK_PROV
U 21 Rec'v Dental Care Spec. 08	The number of members under the age of 21 who are receiving dental care from a provider with a specialty code of 08.	12	Char	T_CA_ICN	ID_MEDICAID
U 21 Rec'v Dental Care Spec. 56	The number of members under the age of 21 who are receiving dental care from a provider with a specialty code of 56.	12	Char	T_CA_ICN	ID_MEDICAID
U 21 Rec'v Dental Care Spec. 80	The number of members under the age of 21 who are receiving dental care from a provider with a specialty code of 80.	12	Char	T_CA_ICN	ID_MEDICAID
U 21 Rec'v Dental Care Spec. 88	The number of members under the age of 21 who are receiving dental care from a provider with a specialty code of 88.	12	Char	T_CA_ICN	ID_MEDICAID
Undup Member 21 & Over Rec'v Care	The number of unduplicated/unique members that are 21 and older receiving care.	12	Char	T_CA_ICN	ID_MEDICAID
Undup Members Under 21 Rec'v Care	The number of unduplicated/unique members under the age of 21 receiving care.	12	Char	T_CA_ICN	ID_MEDICAID

2.8.16.4 Associated Programs

Program	Description

Program	Description
No associated Programs found.	

2.8.16.5 Associated Requirements

ID
30.050.015.002.6

2.8.16.6 Change Orders

ID	Name	Description
1456	Dental Access Report	Develop the Dental Access Report according to specifications.

2.8.17 DSS - Dental Medicaid Expenditure by Proc Code and Age

The dental expenditures per Proc Code and Age group brings total expenditures by Procedure group, per age group for Paid and Denied Claims in previous quarter.

2.8.17.1 Technical Name

DSS - Dental Medicaid Expenditure by Proc Code and Age Group

2.8.17.2 Dental Medicaid Expenditure by Proc Code and Age Group Layout

A

Run Date: 10/29/2007
KYMM7200-R002

Cabinet for Health and Family Services

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Department of Medicaid Services

Dental Medicaid Expenditures By Proc Code and Age Group

For QTR Ending 9/30/2007

PROCEDURE CODE DIAGNOSTIC D0100-D0999	TOTAL # OF PROC	# DENIED	0-6	7-13	14-20	21-64	65+	TOTAL EXPEND	TOTAL %
D0120	4	3	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0.000 %
D0140	4,269	0	$11,699.50	$19,673.30	$17,681.00	$84,079.92	$3,305.00	$136,958.72	0.665 %
D0150	55,193	0	$400,311.07	$505,242.00	$239,576.85	$260,553.55	$18,986.00	$1,425,734.47	6.920 %
D0210	2,456	0	$15,807.90	$27,409.30	$34,443.30	$57,985.50	$1,176.00	$136,899.00	0.664 %
D0220	19,482	18	$39,888.80	$45,051.90	$34,064.20	$58,893.93	$2,224.00	$181,675.63	0.882 %
D0230	16,953	7	$21,169.52	$18,008.60	$11,579.30	$14,867.00	$672.00	$119,789.32	0.581 %
D0270	248	0	$343.70	$504.40	$458.60	$699.00	$0.00	$2,012.70	0.010 %
D0272	20,137	1	$96,407.90	$179,694.00	$48,220.20	$28,679.10	$951.00	$354,050.20	1.718 %
D0274	11,044	0	$8,728.40	$87,808.90	$109,666.10	$91,004.00	$1,863.00	$299,162.40	1.452 %
D0330	20,859	0	$63,497.00	$296,336.90	$181,605.00	$260,698.40	$6,807.00	$809,763.30	3.930 %
D0340	164	0	$0.00	$7,133.50	$2,743.40	$94.00	$0.00	$9,970.90	0.048 %
SUBTOTAL:	150,809	29	$657,853.79	$1,186,862.80	$680,037.95	$857,554.40	$35,984.00	$3,476,016.64	16.871 %

B

Report Notes

Report Description

The Dental Expenditures per Proc Code and Age Group brings total expenditures by Procedure group, per Age group for Paid and Denied claims in previous quarter.

Search Criteria

The paid date is between previous quarter begin and end for denied and paid claims.

Fee For Service

Procedure Codes starting with D

2.8.17.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
# Denied	Total number of Procedure Codes for Denied Claims	10	Number	T_CA_ICN	CDE_PROC_PRIM
0-6	Paid Amount for that Age Group	10	Number (Decimal)	T_CA_ICN	AMT_PAID

Field	Description	Length	Data Type	DB Table	DB Attributes
14-20	Paid Amount for that Age Group	10	Number (Decimal)	T_CA_ICN	AMT_PAID
21-64	Paid Amount for that Age Group	10	Number (Decimal)	T_CA_ICN	AMT_PAID
65+	Paid Amount for that Age Group	10	Number (Decimal)	T_CA_ICN	AMT_PAID
7-13	Paid Amount for that Age Group	10	Number (Decimal)	T_CA_ICN	AMT_PAID
Procedure Code Diagnostic	Procedure Code	5	Char	T_CA_ICN	CDE_PROC_PRIM
Total # Of Proc	Total number of Procedure Codes for that County	10	Number	T_CA_ICN	CDE_PROC_PRIM
Total %	Paid Dollar amount percentage for the all the age group listed	10	Number (Decimal)	T_CA_ICN	AMT_PAID
Total Expend	Paid Dollar amount for the all the age group listed	10	Number (Decimal)	T_CA_ICN	AMT_PAID

2.8.17.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.17.5 Associated Requirements

ID
No associated Requirements found.

2.8.17.6 Change Orders

ID	Name	Description
No associated Change Orders found.		

2.8.18 DSS - Dental Medicaid Expenditures By Proc Code and Age GroupR001 -- Dental Medicaid Expenditures By Proc Code and Age GroupR001

The Dental Expenditures per Proc Code and Age Group brings total expenditures by Procedure group, per Age group for Paid and Denied claims in previous quarter.

2.8.18.1 Technical Name

DSS - Dental Medicaid Expenditures By Proc Code and Age GroupR001

2.8.18.2 Dental Medicaid Expenditures By Proc Code and Age GroupR001 Layout

A

Run Date: 10/30/2007
KYMM7200-R002

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Cabinet for Health and Family Services

Department of Medicaid Services

Dental Medicaid Expenditures By Proc Code and Age Group

For QTR Ending: 9/30/2007

PROCEDURE CODES	TOTAL # OF PROC	# DENIED	0-6	7-13	14-20	21-64	65+	TOTAL EXPEND	TOTAL %
D0000'S	151,411	29,925	$657,767.99	$1,186,770.80	$679,920.95	$857,488.40	$35,984.00	$3,476,016.64	16.871 %
D1000'S	76,020	17,665	$814,565.84	$1,144,851.90	$436,777.90	$201,070.10	$8,539.00	$2,624,009.14	12.736 %
D1351 SEALANTS	13,748	3,105	$13,263.50	$61,658.15	$13,479.50	$0.00	$0.00	$263,527.15	1.279 %
D2000'S	85,299	15,486	$763,676.63	$1,094,117.06	$955,026.00	$843,965.48	$26,126.00	$5,788,395.77	28.095 %
D3000'S	5,887	1,282	$107,114.30	$169,031.15	$354,534.00	$67.60	$0.00	$757,058.95	3.675 %
D4000'S	10,230	4,836	$101.40	$5,249.80	$58,766.00	$220,987.30	$4,355.50	$831,526.60	4.036 %
D5000'S	64	120	$6,071.60	$3,064.60	$10,913.20	$0.00	$0.00	$20,049.40	0.097 %
D6000'S	0	130	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0.000 %
D7000'S	51,272	11,570	$90,304.80	$256,920.60	$486,585.60	$857,931.40	$32,593.00	$3,489,034.70	16.935 %
D8000'S	4,241	1,132	$2,234.00	$1,990,748.39	$1,166,835.57	$0.00	$0.00	$3,159,817.96	15.337 %

B

Report Notes

Report Description

The Dental Expenditures per Proc Code and Age Group brings total expenditures by Procedure group, per Age group for Paid and Denied claims.

Search Criteria

The paid date is between previous quarter begin and end for denied and paid claims.

Fee For Service

Procedure Codes starting with D and between 00000 and 09999

2.8.18.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
# Denied	Total number of Procedure Codes for Denied Claims	10	Number	T_CA_ICN	CDE_PROC_PRIM
0-6	Paid Amount for that Age Group	10	Number (Decimal)	T_CA_ICN	AMT_PAID

Field	Description	Length	Data Type	DB Table	DB Attributes
14-20	Paid Amount for that Age Group	10	Number (Decimal)	T_CA_ICN	AMT_PAID
21-64	Paid Amount for that Age Group	10	Number (Decimal)	T_CA_ICN	AMT_PAID
65+	Paid Amount for that Age Group	10	Number (Decimal)	T_CA_ICN	AMT_PAID
7-13	Paid Amount for that Age Group	10	Number (Decimal)	T_CA_ICN	AMT_PAID
Procedure Code Diagnostic	Procedure Code	5	Char	T_CA_ICN	CDE_PROC_PRIM
Total # Of Proc	Total number of Procedure Codes for that County	10	Number	T_CA_ICN	CDE_PROC_PRIM
Total %	Paid Dollar amount percentage for the all the age group listed	10	Number (Decimal)	T_CA_ICN	AMT_PAID
Total Expend	Paid Dollar amount for the all the age group listed	10	Number (Decimal)	T_CA_ICN	AMT_PAID

2.8.18.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.18.5 Associated Requirements

ID
No associated Requirements found.

2.8.18.6 Change Orders

ID	Name	Description
No associated Change Orders found.		

2.8.19 DSS - Drug Utilization -- Drug Utilization

The Drug Utilization Report generates history of paid claims for a given Drug Code during a specific date of service. It is used to see how pharmacy claims are billed.

There are 2 tabs in this report:

A. Drug Utilization Report

B. Report Notes tab describing the conditions used to create the report.

2.8.19.1 Technical Name

DSS - Drug Utilization

2.8.19.2 Drug Utilization Layout

Run Date: 10/26/2006
Run Time: 9:06:11 AM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services
Drug Utilization

Billing Provider Number(s):
Drug Code(s): 50962070057
00045152550
Payment Date Range: 8/1/2000 - 8/1/2006

NDC Code & Description	Billing Provider Numbers	Member ID	From Date of Service	Payment Date	Quantity Dispensed	Billed Amount	Paid Amount	ICN	Prescription Number	Days Supply	TPL Amount
00045152550 - LEVAQUIN			11/01/2004	07/13/2006	101.000	$25.00	$0.00		7413258	35	$0.00
00045152550 - LEVAQUIN			01/05/2005	07/13/2006	5.000	$130.00	$0.00		31953	5	$0.00
00045152550 - LEVAQUIN			01/06/2005	07/13/2006	5.000	$132.81	$0.00		7418523	5	$0.00
00045152550 - LEVAQUIN			01/06/2005	07/27/2006	5.000	$132.81	$0.00		7418523	5	$0.00
50962070057 - CARBIDOPA/LEVODOPA			01/01/2005	07/13/2006	120.000	$1,200.00	$0.00		32167	120	$0.00

End of Report

Report Notes

Report Description

This report generates history of paid claims for a given drug code during a specific date of service for only non-adjusted claims. It is used to see how pharmacy claims are billed.

Search Criteria

Payment Date - Payment date range entered in the prompt
Billing Provider Number(s) - Provider Base, Medicaid or NPI Number(s) entered in the prompt, separated by a semi-colon
Drug Code(s) - list of drug codes entered in the prompt, separated by a semi-colon

2.8.19.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Amount	The total paid amount for the claim.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in the Medicaid program. The report returns all provider numbers, NPI, Base and Medicaid ID.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
Days Supply	The number of days of supply for a drug for this claim.	9	Number	T_CA_DRUG	NUM_DAY_SUPPLY
From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC

Field	Description	Length	Data Type	DB Table	DB Attributes
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
Member ID	The first Identification number assigned to a member upon initial certification for Participation in the program.	12	Char	T_CA_ICN	ID_MEDICAID
NDC Code and Description	The National Drug Code (NDC) and description identifying the drug.	46	Char	T_CA_ICN, T_DRUG_DN	CDE_NDC || DSC_NDC
Paid Amount	The total paid amount of the line item for paid claims.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Payment Date	The date on which a payment was generated from the MMIS claim transaction.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID
Payment Date Range	The date of payment date range.	23	Date (CCYY/MM/DD)	T_CA_ICN	DTE_PAID
Prescription Number	The prescription number related to the drug code billed on this claim.	7	Char	T_CA_DRUG	NUM_PRSCRIP
Quantity Dispensed	Number of units of a drug dispensed to a member.	14	Number (Decimal)	T_CA_DRUG	QTY_DISPENSE

Field	Description	Length	Data Type	DB Table	DB Attributes
TPL Amount	The line item amount paid by a third party.	13	Number (Decimal)	T_CA_ICN	AMT_TPL

2.8.19.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.19.5 Associated Requirements

ID
30.050.015.002.6

2.8.19.6 Change Orders

ID	Name	Description
1444	Drug Utilization Report	Develop the Drug Utilization Report according to specifications.
4544	Drug Utilization Report	This defect covers all issues related to CO 1444 - Drug Utilization Report

2.8.20 DSS - Encounter Transportation -- Encounter Transportation

The Encounter Transportation report generates history of Encounter Transportation Claims.

There are 2 tabs in this report:

A. Encounter Transportation Report

B. Report Notes tab describing the conditions used to create the report.

2.8.20.1 Technical Name

DSS - Encounter Transportation

2.8.20.2 Encounter Transportation Layout

Run Date: 5/8/2007
Run Time: 2:33:56 PM

User ID: tztsbl

Cabinet for Health and Family Services

Department for Medicaid Services

Encounter Transportation

From Date of Service Range: 1/1/2000 - 12/31/2005

Member County Code & Desc	Billing Provider Specialty Code & Desc	Billing Provider Type Code & Desc	Encounter Amount Sum
001 - Adair	260 - Ambulance	55 - Emergency Transportation	$913.64
001 - Adair	262 - Bus	56 - Non-Emergency Transportation	$428.40
001 - Adair	263 - Taxi	56 - Non-Emergency Transportation	$47,136.06
001 - Adair	264 - Common Carrier (Ambulatory)	56 - Non-Emergency Transportation	$19,388.20
001 - Adair	265 - Common Carrier (Non-ambulatory)	56 - Non-Emergency Transportation	$20,296.70
001 - Adair	266 - Family Member / Private Auto	56 - Non-Emergency Transportation	$1,522.52
002 - Allen	260 - Ambulance	55 - Emergency Transportation	$0.09
002 - Allen	262 - Bus	56 - Non-Emergency Transportation	$63.00
002 - Allen	263 - Taxi	56 - Non-Emergency Transportation	$12,302.00
002 - Allen	264 - Common Carrier (Ambulatory)	56 - Non-Emergency Transportation	$1,238.97
002 - Allen	265 - Common Carrier (Non-ambulatory)	56 - Non-Emergency Transportation	$22,454.90
002 - Allen	266 - Family Member / Private Auto	56 - Non-Emergency Transportation	$33.32

End of Report

Report Notes

Report Description

This report generates history of encounter transportation claims by waiver eligibility code.

Search Criteria

From Date of Service - Begin and end date range entered in the prompt
Billing Provider Types - equal to 55, 56, 57 and 58
Encounter Claims Only filter
Latest Claims Only filter - will give you only the latest version of a claim even if it was previously adjusted

2.8.20.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Specialty Code & Desc	A code used to indicate the medical specialty of a physician.	53	Char	T_CA_PROV_KEY	CDE_PROV_SPEC_PRIM ||DSC_PROV_SPEC
Billing Provider Type Code & Desc Description	A code used to indicate the provider's type.	52	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM ||DSC_PROV_TYPE
Encounter Amount	The total paid amount of the line item for encounter claims.	13	Number (Decimal)	T_CA_ICN	AMT_ENCOUNTER
Member County Code & Description	The code which indicates the county in which the Member resides.	35	Char	T_CA_RECIP_KEY	CDE_RECIP_COUNTY ||DSC_RECIP_COUNTY

2.8.20.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.20.5 Associated Requirements

ID
30.050.015.002.6

2.8.20.6 Change Orders

ID	Name	Description
1440	Encounter Transportation	Develop the Encounter Transportation Report according to specifications.
4545	Encounter Transportation Rpt	This defect covers all issues related to CO - 1440 - Encounter Transportation Report

2.8.21 DSS - Hospice Total Days -- Hospice Total Days

The Hospice Total Days report generates history of claims for a given Hospice Provider(s) with certain Revenue Codes during a specific date of service range. It is used to Determine 80/20 Rule in Hospice Billing.

There are 2 tabs in this report:

A. Hospice Total Days Report

B. Report Notes tab describing the conditions used to create the report.

2.8.21.1 Technical Name

DSS - Hospice Total Days

2.8.21.2 Hospice Total Days Layout

Run Date: 5/14/2007

Run Time: 9:32:43 AM

User ID: tztsbl

Cabinet for Health and Family Services

Department for Medicaid Services

Hospice Total Days

From Date of Service Range: 6/1/2006 - 6/30/2006

Revenue Code & Desc	Billing Provider Numbers	Billed Quantity	Paid Amount	Encounter Amount	ICN	From Date of Service	To Date of Service	Member ID
0155 - ROOM & BOARD WARD-HOSPICE		58	$7,127.76	$0.00		06/02/2006	06/30/2006	
0155 - ROOM & BOARD WARD-HOSPICE		28	$3,871.15	$0.00		06/03/2006	06/30/2006	
0155 - ROOM & BOARD WARD-HOSPICE		2	$262.95	$0.00		06/04/2006	06/05/2006	

End of Report

Report Notes

Report Description

This report generates history of claims for a given Hospice Provider(s) with certain Revenue Codes during a specific date of service range. It is used to Determine 80/20 Rule in Hospice Billing.

Search Criteria

From Date of Service Range - From beginning and ending date range entered in the prompt
Revenue Code - in list (0651,0652,0655,0656,0155,0183,0185,0182,0184)
Billing Provider Type Code - equal to 44(Hospice)
Latest Claims only filter - will give you only the latest version of a claim even if it was previously adjusted
Home Health Claims Only filter - claim type equal to 'H'
Paid claims only

2.8.21.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	The number of units administered for the procedure code billed on this line item.	9	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in the Medicaid program. The report returns all provider numbers, NPI, Base and	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
	Medicaid ID.				
Encounter Amount	Amount the claim would have paid if an Encounter claims processed through the system as a Fee-for-Service (FFS) claim.	13	Number (Decimal)	T_CA_ICN	AMT_ENCOUNTER
From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
Member ID	The first Identification number assigned to a member upon initial certification for Participation in the program.	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Revenue Code & Description	The line item revenue code and description billed on the UB-92 claim (describes the service performed).	74	Char	T_CA_HDR_DTL, T_CDE_REVENUE	CDE_REVENUE || DSC_REVENUE
To Date of Service	This is the line item through date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC

2.8.21.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.21.5 Associated Requirements

ID
30.050.015.002.6

2.8.21.6 Change Orders

ID	Name	Description
1446	Hospice Total Days	Develop the Hospice Total Days Report according to specifications.
4547	Hospice Total Days Report	This defect covers all issues related to CO 1446 - Hospice Total Days Report

2.8.22 DSS - Hospice Total Dual Eligibles -- Hospice Total Dual Eligibles

The Hospice Total Dual Eligibles report generates detail Hospice claim information for dual recipients. The indicator is calculated using the member's programs, status, age, and Medicare ID.

There are 2 tabs in this report:

A. Hospice Total Dual Eligibles Report

B. Report Notes tab describing the conditions used to create the

2.8.22.1 Technical Name

DSS - Hospice Total Dual Eligibles

2.8.22.2 Hospice Total Dual Eligibles Layout

Run Date: 5/1/2007
Run Time: 3:24:12 PM

Cabinet for Health and Family Services

Department for Medicaid Services

Hospice Total Dual Eligibles

User ID: tztsbl

From Date of Service Range: 1/1/2006 - 6/30/2006

Revenue Code & Desc	Billing Provider Numbers	Billed Quantity Sum	Paid Amount Sum	From Date of Service	To Date of Service	Member ID	ICN
0656 - HOSPICE SERVICES GENERAL INPATIENT CARE		1	$0.00	01/09/2006	01/09/2006		
0656 - HOSPICE SERVICES GENERAL INPATIENT CARE		1	$0.00	01/10/2006	01/10/2006		
0656 - HOSPICE SERVICES GENERAL INPATIENT CARE		1	$0.00	01/11/2006	01/11/2006		
0656 - HOSPICE SERVICES GENERAL INPATIENT CARE		1	$0.00	01/12/2006	01/12/2006		

End of Report

Report Notes

Report Description

The Hospice Total Dual Eligibles report displays a dual eligibility indicator for all members. The indicator is calculated using the member's programs, status, age, and medicare ID.

Search Criteria

From date of service range entered in the prompt
Revenue Code - in list (0655,0656)
Billing Provider Type Code - equal to 44(Hospice)
Dual Eligibility Indicator - equal to 'Y'
Latest Claims Only filter - will give you only the latest version of a claim even if it was previously adjusted
Home Health Claims Only filter - claim type equal to 'H'
Paid claims only

2.8.22.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	Units of services billed for payment.	12	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in the Medicaid program. The report returns all provider numbesr, NPI, Base and Medicaid ID.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
From Date of Service	Date of service was incurred.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
Member ID	The member's Medicaid ID	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Revenue Code & Desc	The line item revenue code and description billed on the UB-92 claim (describes the service performed).	74	Char	T_CA_ICN,T_CDE_REVENUE	CDE_REVENUE || DSC_REVENUE
To Date of Service	Date on which the statement period on the claim ended.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC

2.8.22.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.22.5 Associated Requirements

ID
30.050.015.002.6

2.8.22.6 Change Orders

ID	Name	Description
1468	Hospice Total Dual Eligibles	Develop the Hospice Total Dual Eligibles Report according to specifications.

2.8.23 DSS - Hospice Total Inpatient Days -- Hospice Total Inpatient Days

The Hospice Total Inpatient Days report generates history of inpatient claims for a given Hospice Provider(s) with certain Revenue Codes during a specific date of service range. It is used to determine the 80/20 Rule in Hospice Billing.

There are 2 tabs in this report:

A. Hospice Total Inpatient Days Report

B. Report Notes tab describing the conditions used to create the report.

2.8.23.1 Technical Name

DSS - Hospice Total Inpatient Days

2.8.23.2 Hospice Total Inpatient Days Layout

Run Date: 5/2/2007

Run Time: 8:15:10 AM

User ID: tztsbl

Cabinet for Health and Family Services

Department for Medicaid Services

Hospice Total Inpatient Days

From Date of Service Range: 1/1/2006 - 6/30/2006

Revenue Code & Desc	Billing Provider Numbers	Billed Quantity	Paid Amount	ICN
0655 - HOSPICE SERVICES INPATIENT RESPITE CARE		1	$124.86	
0656 - HOSPICE SERVICES GENERAL INPATIENT CARE		35	$14,376.23	

End of Report

Report Notes

Report Description

This report generates history of claims for a given Hospice Provider(s) with certain Revenue Codes during a specific date of service range. It is used to Determine 80/20 Rule in Hospice Billing.

Search Criteria

From Date(s) of Service - Beginning date(s) entered in the prompt
Revenue Code - in list (0655,0656)
Billing Provider Type Code - equal to 44(Hospice)
Latest Claims only filter - will give you only the latest version of a claim even if it was previously adjusted
Home Health Claims Only filter - claim type equal to 'H'
Paid claims only

2.8.23.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	The number of units administered for the procedure code billed on this line item.	12	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in the Medicaid program. The report returns all provider numbesr, NPI, Base and Medicaid ID.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
Paid Amount	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Revenue Code & Desc	The line item revenue code and description billed on the UB-92 claim (describes the service performed).	74	Char	T_CA_HDR_DTL, T_CDE_REVENUE	CDE_REVENUE || DSC_REVENUE

2.8.23.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.23.5 Associated Requirements

ID
30.050.015.002.6

2.8.23.6 Change Orders

ID	Name	Description
1445	Hospice Total Inpatient Days	Develop the Hospice Total Inpatient Days Report according to specifications.

2.8.24 DSS - Hospital Inpatient Paid Days -- Hospital Inpatient Paid Days

The Hospital Inpatient Paid Days report generates the sum number of covered days for a given Provider(s).

There are 2 tabs in this report:

A. Hospital Inpatient Paid Days Report

B. Report Notes tab describing the conditions used to create the report.

2.8.24.1 Technical Name

DSS - Hospital Inpatient Paid Days

2.8.24.2 Hospital Inpatient Paid Days Layout

A

Run Date: 9/19/2006
Run Time: 1:15:50 PM

User ID: qz00tr

Cabinet for Health and Family Services
Department for Medicaid Services

Hospital Inpatient Paid Days

Billing Provider Number(s): 10024183; 10067265; 20030636
From Date of Service Range: 1/1/2000 - 12/31/2005

Billing Provider Numbers	Covered Days
NPI ID: 1000000513 Medicaid ID: 100241829C Base ID: 10024183	0

End of Report

B

Report Notes

Report Description

This report generates the sum number of covered days for a given Provider(s).

Search Criteria

From Date of Service Range - Begin and end date range entered in the prompt
Billing Provider Numbers - Billing Provider BASE, Medicaid or NPI Number(s) - entered in the prompt, separated by a semi-colon
Billing Provider Type - in list (01,02)
Type of Bill Code - not equal to 110
Claim Type - equal to I (Inpatient)
FFS Claims Only
Latest Claims Only filter
Paid Claims Only filter

2.8.24.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in the Medicaid program. The report returns all provider numbesr, NPI, Base and Medicaid ID.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
Covered Days	The sum of the total number of days for this claim.	9	Number	T_CA_ICN	NUM_DAYS_COVD

2.8.24.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.24.5 Associated Requirements

ID
30.050.015.002.6

2.8.24.6 Change Orders

ID	Name	Description
1457	Hospital Inpatient Paid Days	Develop the Hospital Inpatient Paid Days Report according to specifications.

2.8.25 DSS - IMPACT DCBS -- IMPACT DCBS

The IMPACT Department for Community Based Services (DCBS) report generates history of paid claims for a given DCBS and Department for Mental Health/Mental Retardation (DMH/MR) impact provider during a specific paid date range.

There are 2 tabs in this report:

A. IMPACT DCBS Report

B. Report Notes tab describing the conditions used to create the report.

2.8.25.1 Technical Name

DSS - IMPACT DCBS

2.8.25.2 IMPACT DCBS Layout

A

Run Date: 3/22/2007
Run Time: 11:03:11 AM

Cabinet for Health and Family Services
Department for Medicaid Services
IMPACT DCBS

User ID: rztdly

Paid Date(s): 1/4/2002
Billing Provider Number(s): 1234567893

Billing Provider Numbers	Paid Amount Sum	Paid Date
NPI: 1234567893 Medicaid Number: 65901423 Base Number: 500009887	$362.20	01/04/2002

End of Report

B

Report Notes

Report Description

The IMPACT Department for Community Based Services (DCBS) report generates history of paid claims for a given DCBS and Department for Mental Health/Mental Retardation (DMH/MR) IMPACT provider during a specific paid date range.

Search Criteria

Paid Date - Payment date range entered in the prompt
Billing Provider Numbers - Provider Base, Medicaid or NPI Number(s) entered in the prompt, separated by a semi-colon

2.8.25.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in the Medicaid program. The report returns all provider numbesr, NPI, Base and Medicaid ID.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
Paid Amount	The total paid amount for a claim.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Payment Date	The date on which a payment was generated from the MMIS claim transaction.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID

2.8.25.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.25.5 Associated Requirements

ID
30.050.015.002.6

2.8.25.6 Change Orders

ID	Name	Description
1448	IMPACT DCBS	Develop the IMPACT DCBS Report according to specifications.

2.8.26 DSS - KenPAC Member History -- KenPAC Member History

The KenPAC Member History report generates a detail history of Claims for a given member bsaed on input from the user.

There are 2 tabs in this report:

A. KenPAC Member History Report

B. Report Notes tab describing the conditions used to create the report.

2.8.26.1 Technical Name

DSS - KenPAC Member History

For readability, this layout appears on the following two pages.

2.8.26.2 KenPAC Member History Layout

Run Date: 9/19/2006

Run Time: 3:00:56 PM

User ID: qz00tr

Cabinet for Health and Family Services

Department for Medicaid Services

Kenpac Member History

Member County Code(s): 24; 25

Primary Diagnosis Code(s): 25000; 3458

Billing Provider Number(s): 10021851; 20030526

Member ID(s): 000001346; 000001381

Billing Provider Type Code(s): 64; 54

From Date of Service Range: 1/1/2000 - 12/31/2005

Member County Code & Description	ICN	Claim Type	Claim Indicator	Billing Provider Name	Primary Procedure Code & Desc	State COS Code & Description	Referring Provider Name	Member SSN	Member Full Name FML	Member Date of Birth	Member Phone Number	Member Full Address	NDC Co Descrip	Primary Diagnosis Code & Desc	Secondary Diagnosis Code & Desc	Claim Date	Payment Date	Phone Number	Billing Provider Full Address	Paid Amount	Billed Amount
24 - Garfield	2005073250053	H	F	COUNTRY MEDICAL CLINIC	###### - Unknown	16 - Impact Plus	ANDERSON PHARMACY	446-08-9190	ZELDA B MARTIN	01/01/1969	(999)551-1047	847 NE 2ND ST SALEM, KY 97501 - 1046	#########	25000 - IABETES UNCOMPL TYPE II DI	####### -	10/04/2004	03/15/2005	(999) 551-1073	3079 NE 1ST ST PORTLAND, KY 97501-8011	$0.00	$200.00
24 - Garfield	2005080250004	H	F	COUNTRY MEDICAL CLINIC	###### - Unknown	16 - Impact Plus	ANDERSON PHARMACY	446-08-9190	ZELDA B MARTIN	01/01/1969	(999)551-1047	847 NE 2ND ST SALEM, KY 97501 - 1046	#########	25000 - IABETES UNCOMPL TYPE II DI	####### -	03/04/2005	03/22/2005	(999) 551-1073	3079 NE 1ST ST PORTLAND, KY 97501-8011	$188.80	$200.00
24 - Garfield	2005091250018	H	F	COUNTRY MEDICAL CLINIC	###### - Unknown	16 - Impact Plus	ANDERSON PHARMACY	446-08-9190	ZELDA B MARTIN	01/01/1969	(999)551-1047	847 NE 2ND ST SALEM, KY 97501 - 1046	#########	25000 - IABETES UNCOMPL TYPE II DI	####### -	12/24/2004	04/04/2005	(999) 551-1073	3079 NE 1ST ST PORTLAND, KY 97501-8011	$0.00	$200.00
24 - Garfield	2005108250068	H	F	COUNTRY MEDICAL CLINIC	###### - Unknown	16 - Impact Plus	ANDERSON PHARMACY	446-08-9190	ZELDA B MARTIN	01/01/1969	(999)551-1047	847 NE 2ND ST SALEM, KY 97501 - 1046	#########	25000 - IABETES UNCOMPL TYPE II DI	####### -	04/18/2005	04/22/2005	(999) 551-1073	3079 NE 1ST ST PORTLAND, KY 97501-8011	$0.00	$1,000.00

A

B

Report Notes

Report Description

This report generates history of KenPAC claims for a given county and date of service range.

Search Criteria

From Date of Service Range- Begin and end date range enter in the prompt
Billing Provider BASE, Medicaid or NPI Number(s) - enter in the prompt, separated by a semi-colon
Billing Provider Type Code(s) - enter in prompt, separated by a semi-colon
Member ID(s) - enter in prompt, separated by a semi-colon
Primary Diagnosis Code(s) - enter in prompt, separated by a semi-colon
Member County Code(s) - enter in prompt, separated by a semi-colon
Latest Claims only filter - will give you only the latest version of a claim even if it was previously adjusted

2.8.26.3 ield Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Amount	The sum of all charges associated with an individual claim.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
Billing Provider Full	The street number and street name	101	Char	T_CA_PROV_KEY	ADR_BILL_<*>,

Field	Description	Length	Data Type	DB Table	DB Attributes
Address	of a KenPAC provider's address.				*=STRT1, STRT2,CITY,STATE,ZIP,ZIP4
Billing Provider Name	Billing Provider Name	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
Claim Date	The date a provider enters on a claim indicating when it was prepared.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_BILLED
Claim Indicator	Indicates whether the claim is Fee-for-Service or Encounter claim	1	Char	T_CA_ICN	IND_CLAIM
Claim Type	Code to indicate type of medical assistance.	1	Char	T_CA_CLAIM_KEY	CDE_CLM_TYPE
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
Member County & Description	The name of the county.	50	Character	T_CA_RECIP_KEY	CDE_RECIP_COUNTY ||DSC_COUNTY
Member County Code(s)	Prompt value for the county code for the billing provider	2	Char	T_CA_RECIP_KEY	CDE_RECIP_COUNTY

Field	Description	Length	Data Type	DB Table	DB Attributes
Member Date of Birth	The member's date of birth.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_BIRTH
Member Full Address	The address from the MMIS member master file includes city, state, and zip code.	89	Char	T_RE_BASE_DN	ADR_STREET_1,ADR_STREET_2,ADR_CITY,ADR_STATE,ADR_ZIP_CODE
Member Full Name FML	The member's full name.	36	Char	T_RE_BASE_DN	NAM_FIRST,NAM_MID_INIT,NAM_LAST
Member Phone Number	The member's telephone number and area code.	10	Char	T_RE_BASE_DN	NUM_PHONE
Member SSN	This field contains member social security number.	9	Char	T_RE_BASE_DN	NUM_SSN
NDC Code & Description	The NDC code, description, and official nomenclature for a drug accepted by the state.	46	Char	T_CA_ICN, T_DRUG_DN	CDE_NDC || DSC_NDC
Paid Amount	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Payment Date	The date on which a payment was generated from the MMIS claim transaction	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID
Phone Number	The phone number on file at which the provider may be contacted.	14	Char	T_CA_PROV_KEY	ADR_BILL_PHONE || ADR_BILL_PHO_EXT

Field	Description	Length	Data Type	DB Table	DB Attributes
Primary Diagnosis Code & Desc	Primary diagnosis code and description from the claim.	47	Char	T_CA_ICN, T_DIAGNOSIS	CD_DIAG_PRIM || DSC_25
Primary Diagnosis Code & Desc	Prompt value for the primary diagnosis code and description.	47	Char	T_CA_ICN	CDE_PROC_PRM
Primary Procedure Code & Desc	The primary procedure code, description, and generally accepted nomenclature for medical, surgical, dental, and so on, procedure.	64	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC_PRM || DSC_PROC
Referring Provider Name	The name of the KenPAC provider.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
Secondary Diagnosis Code & Description	Secondary diagnosis description	47	Char	T_CA_ICN, T_DIAGNOSIS	CDE_DIAG_2 || DSC_25
State COS Code & Description	The type of service provided by the KenPAC provider.	52	Char	T_CA_CLAIM_KEY,T_CDE_COS_VALUES	CDE_COS_ST||DSC_COS_VALUE

2.8.26.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.26.5 Associated Requirements

ID
30.050.015.002.6

2.8.26.6 Change Orders

ID	Name	Description
1458	KenPAC Member History	Develop the KenPAC Member History Report according to specifications.

2.8.27 DSS - KenPAC Utilization Data -- KenPAC Utilization Data

The KenPAC Utilization Data report lists KenPAC utilization data for the reporting period. The frequency of this report is monthly.

There are 2 tabs in this report:

- Tab A. KenPAC Utilization Data By Provider
- Tab B. KenPAC Utilization Data Statewide - By Specialty Group

2.8.27.1 Technical Name

DSS - KenPAC Utilization Data

For readability, this layout appears on the following two pages.

2.8.27.2 KenPAC Utilization Data Layout

Run Date: 10/2/2006
Run Time: 12:06:28 PM

User ID: czv6vp

Cabinet for Health and Family Services

Department for Medicaid Services

KenPAC Utilization Data

KenPAC Utilization Data By Provider

For Month of Service: June 2006

Provider Name: ANDERSON PHARMACY

Your Rates Per 100 Enrollees:

Provider Numbers	E.R. A Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits	Average Cost Per Enrollee
NPI: 1000000398 Medicaid Number: 100219309A Base Number: 10021931	45.00	0.00	0.00	0.00	18.00	0.00	9.00	9.00	949.00
Percentile:	45	0	0	0	18	0	9	9	949

Your County Per 100 Enrollees:

County Code and Description	E.R. A Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits	Average Cost Per Enrollee
073 - McCracken	45.00	0.00	0.00	0.00	18.00	0.00	9.00	9.00	949.00

Your Specialty Per 100 Enrollees:

Provider Specialty Code	E.R. A Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits	Average Cost Per Enrollee
316 - Family Practitioner	1.19	0.00	0.00	0.00	15.38	0.00	7.69	7.69	52.72

Your Specialty Group Per 100 Enrollees:

Specialty Group	E.R. A Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits	Average Cost Per Enrollee
General/Family Practice	27.78	0.00	0.00	0.00	11.11	0.00	5.56	5.56	15.31

End of Report

Run Date: ########
Run Time: 12:06:28 PM

User ID: czv6vp

Cabinet for Health and Family Services

Department for Medicaid Services

KenPAC Utilization Data

KenPAC Utilization Data State Wide

For Month of Service: June 2006

State Wide Per 100 Enrollees:

Specialty Group	E.R. A Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits	Average Cost Per Enrollee
General/Family Practice	27.78	0.00	0.00	0.00	11.11	0.00	5.56	5.56	15.31
Internal Medicine	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Large Clinics (3000 + Enrollees)	0.03	0.00	0.00	0.03	0.06	0.00	0.03	0.03	0.02
OB/GYN	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Pediatrics	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other Specialty Groups	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
All Specialties:	**1.19**	**0.00**	**0.00**	**0.03**	**0.52**	**0.00**	**0.26**	**0.26**	**0.27**

End of Report

Report Notes

Report Description

The KenPAC Utilization Data All Providers report lists cumulative KenPAC utilization data for each KenPAC provider for the reporting period by their County,Specialty and Specialty Groupings. The frequency of this report is monthly. There is a 90 Day lag on the Claims data for every period.

Search Criteria

Utilization rate per 100 enrollees for all KenPAC providers for specific types of service.

Types of Services:
1.E.R.A Visits: Based on the total number of emergency room visits (Revenue Code 450) using Patient Manager's Authorization Number.
2.Physician Referrals: Based on referrals to other physicians excluding Anesthesia, Radiology and Laboratory Services.
3.Hospital Admissions: Based on the total number of admissions using patient manager's Authorization.
4.Lab Services: Based on total number of Laboratory procedures performed using the patient Manager's Authorization.
5.Radiology Services: Based on the total number of procedure codes 70010 - 79999 billed using the patient Manager's Authorization number as the referring provider.
6.Anesthesia Services: Based on anesthesia details paid by provider types 31, 35, 64, 65 and 74 using the patient Manager's Authorization as the referring provider.
7.Pharmacy Services: Based on total number of prescriptions paid.
8.Office Visits: Based on procedure codes 99201 - 99215 and 99381 - 99397 billed by patient managers for their assigned kenpac patients.
9.Average Cost Per Enrollee: Based on total paid claims billed or authorized by patient managers and converted to an average medicaid expenditure per each assigned member.

Supplemental Documentation

Formula for Utilization Rate = (Paid Claims Count) / (Total Enrollees/100)

2.8.27.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Anesth Services	The rate (per 100 enrollees) of anesthesiology service utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Average Cost Per Enrollee	The average cost per enrollee for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
County Code and Description	County Code and Description	10	Char	T_COUNTY	CDE_COUNTY
E.R. A Vistits	The rate (per 100 enrollees) of emergency room visit utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Hospital Admissions	The rate (per 100 enrollees) of hospital admission utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Lab Services	The rate (per 100 enrollees) of lab service utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Office Visits	The rate (per 100 enrollees) of office visit utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Pharmacy Services	The rate (per 100 enrollees) of pharmacy service utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
Physician Referrals	The rate (per 100 enrollees) of physician referral utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Provider Name	Provider Name	50	Char	T_PR_SVC_LOC	NAME
Provider Numbers	Provider Number	45	Char	T_KENPAC	ID_PROVIDER_NPI, ID_PROVIDER_BASE, ID_PROVIDER_MCAID
Provider Specialty Code	Provider Specialty	3	Char	T_PR_SPEC_CDE	CDE_PROV_SPEC
Radiology Services	The rate (per 100 enrollees) of radiology service utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Specialty Group	Specialty Group	32	Char	T_KENPAC	SPECIALTY_GROUP

2.8.27.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.27.5 Associated Requirements

ID
30.090.012.003.3A

2.8.27.6 Change Orders

ID	Name	Description
1609	DSS - KenPAC Utilization Data	The DSS - KenPAC Utilization Data report lists KenPAC utilization data for the reporting period. The frequency of this report is monthly. DSS - KenPAC Utilization Data

2.8.28 DSS - KenPAC Utilization Data All Providers -- KenPAC Utilization Data All Providers

The KenPAC Utilization Data All Providers report lists cumulative KenPAC utilization data for all KenPAC providers by their specialty group for the reporting period. The frequency of this report is monthly.

2.8.28.1 Technical Name

DSS - KenPAC Utilization Data All Providers

2.8.28.2 KenPAC Utilization Data All Providers Layout

Run Date: 10/2/2006
Run Time: 11:23:18 AM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services
KenPAC Utilization Data All Providers
For Month of Service: June 2006

All Providers:

Specialty Group	E.R. A Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits	Average Cost Per Enrollee
General/Family Practice	27.78	0.00	0.00	0.00	11.11	0.00	5.56	5.56	15.31
Internal Medicine	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Large Clinics (3000 + Enrollees)	0.03	0.00	0.00	0.03	0.06	0.00	0.03	0.03	0.02
OB/GYN	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Pediatrics	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other Specialty Groups	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
All Specialties	**1.19**	**0.00**	**0.00**	**0.03**	**0.52**	**0.00**	**0.26**	**0.26**	**0.27**

End of Report

Report Notes

Report Description

The KenPAC Utilization Data All Providers report lists cumulative KenPAC utilization data for all KenPAC providers for the reporting period by Specialty Groupings. The frequency of this report is monthly. The report is based on a 90 day lag on the Claims data for every period.

Search Criteria

Utilization rate per 100 enrollees for all KenPAC providers for specific types of service.

Types of Services:
1.E.R.A Visits: Based on the total number of emergency room visits (Revenue Code 450) using Patient Manager's Authorization Number.
2.Physician Referrals: Based on referrals to other physicians excluding Anesthesia, Radiology and Laboratory Services.
3.Hospital Admissions: Based on the total number of admissions using patient manager's Authorization.
4.Lab Services: Based on total number of Laboratory procedures performed using the patient Manager's Authorization.
5.Radiology Services: Based on the total number of procedure codes 70010 - 79999 billed using the patient Manager's Authorization number as the referring provider.
6.Anesthesia Services: Based on anesthesia details paid by provider types 31, 35, 64, 65 and 74 using the patient Manager's Authorization as the referring provider.
7.Pharmacy Services: Based on total number of prescriptions paid.
8.Office Visits: Based on procedure codes 99201 - 99215 and 99381 - 99397 billed by patient managers for their assigned kenpac patients.
9.Average Cost Per Enrollee: Based on total paid claims billed or authorized by patient managers and converted to an average medicaid expenditure per each assigned member.

Supplemental Documentation

Formula for Utilization Rate = (Paid Claims Count) / (Total Enrollees/100)

2.8.28.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Anesth Services	The rate (per 100 enrollees) of anesthesiology service utilization for all KenPAC providers and the specialty groupings being reported.	9	Number (Decimal)	N/A	Calculated
Avg Cost Per Enrollee	The average cost per enrollee for all KenPAC providers and the specialty groupings being reported.	9	Number (Decimal)	N/A	Calculated
E.R. Visits - A	The rate (per 100 enrollees) of emergency room visit utilization for the all KenPAC providers and the specialty groupings being reported.	9	Number (Decimal)	N/A	Calculated
Hospital Admissions	The rate (per 100 enrollees) of hospital admission utilization for all KenPAC providers and the specialty groupings being reported.	9	Number (Decimal)	N/A	Calculated
Lab Services	The rate (per 100 enrollees) of lab service utilization for all KenPAC providers and the specialty groupings being reported.	9	Number (Decimal)	N/A	Calculated
Office Visits	The rate (per 100 enrollees) of office visit utilization for all KenPAC providers and the specialty groupings being reported.	9	Number (Decimal)	N/A	Calculated
Pharmacy Services	The rate (per 100 enrollees) of pharmacy service utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Physician Referrals	The rate (per 100 enrollees) of physician	9	Number (Decimal)	N/A	Calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
	referral utilization for all KenPAC providers and the specialty groupings being reported.				
Radiology Services	The rate (per 100 enrollees) of radiology service utilization for all KenPAC providers and the specialty groupings being reported.	9	Number (Decimal)	N/A	Calculated
Specialty Group	Specialty Group of the Provider	32	Char	T_KENPAC	SPECIALTY_GROUP

2.8.28.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.28.5 Associated Requirements

ID
30.090.012.003.3A

2.8.28.6 Change Orders

ID	Name	Description
1610	DSS - KenPAC Utilizatn Data All	The DSS - KenPAC Utilization Data All Providers report lists cumulative KenPAC utilization data for all KenPAC providers for the reporting period. The frequency of this report is monthly.

2.8.29 DSS - KenPAC Utilization Review Detail -- KenPAC Utilization Review Detail

The KenPAC Utilization Review Detail report lists KenPAC utilization review detail data for the reporting period. The frequency of this report is monthly.

2.8.29.1 Technical Name

DSS - KenPAC Utilization Review Detail

2.8.29.2 KenPAC Utilization Review Detail Layout

Run Date: 10/2/2006
Run Time: 10:56:08 AM

User ID: czv6vp

Cabinet for Health and Family Services

Department for Medicaid Services

KenPAC Utilization Review Detail

For Month of Service: June 2006

County Code & Description: 073 - McCracken

Provider Numbers	Provider Name	Total Enrollees	Per 100 Enrollees: E.R. A Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits
NPI: 1000000398 Medicaid Number: 100219309A Base Number: 10021931	ANDERSON PHARMACY	100	45.00	0.00	0.00	0.00	18.00	0.00	9.00	9.00

End of Report

Report Notes

Report Description

The KenPAC Utilization Review Detail Report generates a list of KenPAC Utilization review details data for each KenPAC provider that fall within the reporting period for their types of services. The frequency of this report is monthly. The report is based on a 90 day lag on the Claims data for every period.

Search Criteria

Utilization rate per 100 enrollees for all KenPAC providers for specific types of service.

Types of Services:
1.E.R.A Visits: Based on the total number of emergency room visits (Revenue Code 450) using Patient Manager's Authorization Number.
2.Physician Referrals: Based on referrals to other physicians excluding Anesthesia, Radiology and Laboratory Services.
3.Hospital Admissions: Based on the total number of admissions using patient manager's Authorization.
4.Lab Services: Based on total number of Laboratory procedures performed using the patient Manager's Authorization.
5.Radiology Services: Based on the total number of procedure codes 70010 - 79999 billed using the patient Manager's Authorization number as the referring provider.
6.Anesthesia Services: Based on anesthesia details paid by provider types 31, 35, 64, 65 and 74 using the patient Manager's Authorization as the referring provider.
7.Pharmacy Services: Based on total number of prescriptions paid.
8.Office Visits: Based on procedure codes 99201 - 99215 and 99381 - 99397 billed by patient managers for their assigned kenpac patients.

Supplemental Documentation

Formula for Utilization Rate = (Paid Claims Count) / (Total Enrollees/100)

2.8.29.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Anesth Services	The rate (per 100 enrollees) of anesthesiology service utilization for the provider being reported.	6	Number	n/a	calculated
County Code and Description	County Code and Description	10	Char	T_COUNTY	CDE_COUNTY
E.R. A Visits	The rate (per 100 enrollees) of emergency room visit utilization for the provider being reported.	6	Number (Decimal)	n/a	calculated
Hospital Admissions	The rate (per 100 enrollees) of hospital admission utilization for the provider being reported.	6	Number (Decimal)	n/a	calculated
Lab Services	The rate (per 100 enrollees) of lab service utilization for the provider being reported.	6	Number (Decimal)	n/a	calculated
Office Visits	The rate (per 100 enrollees) of office visit utilization for the provider being reported.	6	Number (Decimal)	n/a	calculated
Pharmacy Services	The rate (per 100 enrollees) of pharmacy service utilization for the provider being reported.	6	Number (Decimal)	n/a	calculated
Physician Referrals	The rate (per 100 enrollees) of physician referral utilization for the provider being reported.	6	Number	n/a	calculated
Provider Name	The name of the provider being reported.	50	Char	T_PR_SVC_LOCN	NAME

Field	Description	Length	Data Type	DB Table	DB Attributes
Provider Numbers	The provider number of the provider being reported. The report returns all provider numbesr, NPI, Base and Medicaid ID.	10	Char	T_CA_ICN	NUM_PROV_BILL
Radiology Services	The rate (per 100 enrollees) of radiology service utilization for the provider being reported.	6	Number (Decimal)	n/a	calculated
Total Enrollees	The number of enrollees for the provider being reported.	10	Number (Integer)	T_CA_ICN	ID_MEDICAID

2.8.29.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.29.5 Associated Requirements

ID
30.090.012.003.3A

2.8.29.6 Change Orders

ID	Name	Description
1611	DSS - KenPAC Utilization Detail	This report lists KenPAC utilization review detail data for the reporting period. The frequency of this report is monthly.

2.8.30 DSS - KenPAC Utilization Review Exception -- KenPAC Utilization Review Exception

The KenPAC Utilization Review Exception report lists any provider that has any type of service with a ratio over or under two standard deviations from the statewide average. The frequency of this report is monthly.

2.8.30.1 Technical Name

DSS - KenPAC Utilization Review Exception

2.8.30.2 KenPAC Utilization Review Exception Layout

Run Date: 10/2/2006
Run Time: 11:03:53 AM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services
KenPAC Utilization Review Exception
For Month of Service: June 2006

County Code & Description: 073 - McCracken

			Per 100 Enrollees:							
Provider Numbers	Provider Name	Total Enrollees	E.R. A Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits
NPI: 1000000398 Medicaid Number: 100219309A Base Number: 10021931	ANDERSON PHARMACY	100	OVER			UNDER	OVER		OVER	OVER

End of Report

Report Notes

Report Description

The KenPAC Utilization Review Exception report lists any provider that has any type of service with a ratio over or under two standard deviations from the statewide average. The frequency of this report is monthly. The report is based on a 90 day lag on the Claims data for every period.

Search Criteria

Utilization rate per 100 enrollees for all KenPAC providers for specific types of service.

Types of Services:
1.E.R.A Visits: Based on the total number of emergency room visits (Revenue Code 450) using Patient Manager's Authorization Number.
2.Physician Referrals: Based on referrals to other physicians excluding Anesthesia, Radiology and Laboratory Services.
3.Hospital Admissions: Based on the total number of admissions using patient manager's Authorization.
4.Lab Services: Based on total number of Laboratory procedures performed using the patient Manager's Authorization.
5.Radiology Services: Based on the total number of procedure codes 70010 - 79999 billed using the patient Manager's Authorization number as the referring provider.
6.Anesthesia Services: Based on anesthesia details paid by provider types 31, 35, 64, 65 and 74 using the patient Manager's Authorization as the referring provider.
7.Pharmacy Services: Based on total number of prescriptions paid.
8.Office Visits: Based on procedure codes 99201 - 99215 and 99381 - 99397 billed by patient managers for their assigned kenpac patients.

Supplemental Documentation

Formulas:

1.Utilization Rate = (Paid Claims Count) / (Total Enrollees/100)

2.OVER = Utilization Rate > (Statewide Average of Utilization Rate + 2*Standard Deviation of Utilization Rate)

3.UNDER = Utilization Rate < (Statewide Average of Utilization Rate - 2*Standard Deviation of Utilization Rate)

2.8.30.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Anesth Services	The over or under deviation (per 100 enrollees) of anesthesiology service utilization for the provider being reported.	6	Number	n/a	calculated
E.R. A Visits	The over or under deviation (per 100 enrollees) of emergency room visit utilization for the provider being reported.	6	Number (Decimal)	n/a	calculated
Hospital Admissions	The over or under deviation (per 100 enrollees) of hospital admission utilization for the provider being reported.	6	Number (Decimal)	n/a	calculated
Lab Services	The over or under deviation (per 100 enrollees) of lab service utilization for the provider being reported.	6	Number (Decimal)	n/a	calculated
Office Visits	The over or under deviation (per 100 enrollees) of office visit utilization for the provider being reported.	6	Number (Decimal)	n/a	calculated
Pharmacy Services	The over or under deviation (per 100 enrollees) of pharmacy service utilization for the provider being reported.	6	Number (Decimal)	n/a	calculated
Physician Referrals	The over or under deviation (per 100 enrollees) of physician referral utilization for the provider being reported.	6	Number	n/a	calculated
Provider Name	The name of the provider being reported.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER

Field	Description	Length	Data Type	DB Table	DB Attributes
Provider Numbers	The provider number of the provider being reported. The report returns all provider numbesr, NPI, Base and Medicaid ID.	10	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
Radiology Services	The over or under deviation (per 100 enrollees) of radiology service utilization for the provider being reported.	6	Number (Decimal)	n/a	calculated
Total Enrollees	The total number of members enrolled.	10	Number	n/a	Calculated

2.8.30.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.30.5 Associated Requirements

ID
30.090.012.003.3A

2.8.30.6 Change Orders

ID	Name	Description
1612	DSS - KenPAC Utilization Exceptn	The DSS - KenPAC Utilization Review Exception report lists any provider that has any type of service with a ratio over or under two standard deviations from the statewide average. The frequency of this report is monthly.

2.8.31 DSS - KenPAC Utilizers By Provider Type of Service -- KenPAC Utilizers By Provider Type of Service

The KenPAC Utilizers By Provider Type of Service report lists KenPAC utilizer data by provider type of service for the reporting period. KenPAC data is pulled from the Data Warehouse and staged in T_KP_KENPAC table for use in this and related reports. The frequency of this report is monthly.

2.8.31.1 Technical Name

DSS - KenPAC Utilizers By Provider Type of Service

For readability, this layout appears on the following two pages.

2.8.31.2 KenPAC Utilizers By Provider Type of Service Layout

Run Date: 10/2/2006
Run Time: 11:16:37 AM

User ID: czv6vp

Cabinet for Health and Family Services

Department for Medicaid Services

KenPAC Utilizers By Provider Type of Service

For Month of Service: June 2006

Provider Numbers: NPI: 1000000398
Medicaid Number: 100219309A
Base Number: 10021931

Provider Name: ANDERSON PHARMACY

Type of Service: E.R.A Visits

Member Full Name	Member ID	Billing Provider Numbers	Billing Provider Name	From Date of Service	Units	Over Utilized
MARTIN, ZELDA B	000001346	NPI: 1000000397 Medicaid Number: 100218509E Base Number: 10021851	COUNTRY MEDICAL CLINIC	06/11/2006	2	*
MARTIN, ZELDA B	000001346	NPI: 1000000397 Medicaid Number: 100218509E Base Number: 10021851	COUNTRY MEDICAL CLINIC	06/20/2006	1	*
PRITCHARD, HANK W	000001261	NPI: 1000000397 Medicaid Number: 100218509E Base Number: 10021851	COUNTRY MEDICAL CLINIC	06/15/2006	2	*
RAY-SAMUELS, TIM J	000040075	NPI: 1000000397 Medicaid Number: 100218509E Base Number: 10021851	COUNTRY MEDICAL CLINIC	06/01/2006	4	*

End of Report

Report Notes

Report Description

This report lists KenPAC Utilizers By Provider Type of Service for the reporting period. The frequency of this report is monthly. The report is based on a 90 day lag on the Claims data for every period.

Over Utilized = * means - Your KenPAC caseload utilization rate for this measure was greater than +2 standard deviations from the statewide average rate. This report lists the members, billing providers and dates of service used by our system to compute the greater than 2+standard deviation rate from the statewide average. This information is being provided to assist you in analysing your KenPAC caseload experience. Please contact the KenPAC program staff if you have any questions pertaing to this report or if you require additional information.

Search Criteria

Utilization rate per 100 enrollees for all KenPAC providers for specific types of service.

Types of Services:
1.E.R.A Visits: Based on the total number of emergency room visits (Revenue Code 450) using Patient Manager's Authorization Number.
2.Physician Referrals: Based on referrals to other physicians excluding Anesthesia, Radiology and Laboratory Services.
3.Hospital Admissions: Based on the total number of admissions using patient manager's Authorization.
4.Lab Services: Based on total number of Laboratory procedures performed using the patient Manager's Authorization.
5.Radiology Services: Based on the total number of procedure codes 70010 - 79999 billed using the patient Manager's Authorization number as the referring provider.
6.Anesthesia Services: Based on anesthesia details paid by provider types 31, 35, 64, 65 and 74 using the patient Manager's Authorization as the referring provider.
7.Pharmacy Services: Based on total number of prescriptions paid.
8.Office Visits: Based on procedure codes 99201 - 99215 and 99381 - 99397 billed by patient managers for their assigned kenpac patients.

Supplemental Documentation

Formulas:

1.Utilization Rate = (Paid Claims Count) / (Total Enrollees/100)

2.OVER = Utilization Rate > (Statewide Average of Utilization Rate + 2*Standard Deviation of Utilization Rate)

2.8.31.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Name	The name of the provider who billed the service.	50	Char	T_CA_PROV_KEY	NAM_FIRST,NAM_LAST,NAM_MID_INIT
From Date of Service Date of Service	The date of service.	10	Date (CCYY/MM/DD)	T_CA_ICN	DTE_FIRST_SVC
Member Full Name	Full member name.	30	Char	T_RE_BASE	NAM_FIRST,NAM_LAST,NAM_MID_INIT
Member ID	The member Medicaid identification number.	9	Char	T_RE_BASE	ID_MEDICAID
Over Utilized	The units that are over utilized.	1	Char	Derived	Derived
Provider Name	The name of the provider who rendered the service.	50	Char	T_PR_SVC_LOC	NAME
Provider Numbers	The numbers of the provider who rendered the service. The report returns all provider numbesr, NPI, Base and Medicaid ID.	45	Char	T_PR_SVC_LOC_DN	ID_PROV_NPI
Type of Service	Types of services.	2	Char	T_KENPAC	TYPE_OF_SERVICE
Units	The number of units	7	Number	T_CA_ICN	QTY_UNITS_BILLED

2.8.31.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.31.5 Associated Requirements

ID
30.090.012.003.3A

2.8.31.6 Change Orders

ID	Name	Description
1613	DSS - KenPAC Utilizers-Prov Spc	The DSS -KenPAC Utilizers By Provider Specialty report lists KenPAC utilizer data by provider specialty for the reporting period. The frequency of this report is monthly. (KYMN1500-R001)

2.8.32 DSS - Measures of Success - Nursing -- Measures of Success - Nursing

The function of this report is the monitor the success of the Nursing facility Initiative in reducing KyHealth Choices dollars.

There are 2 tabs in this report:

A. Measures of Success - Nursing Report

B. Report Notes tab describing the conditions used to create the report.

2.8.32.1 Technical Name

DSS - Measures of Success – Nursing

For readability, this layout appears on the following two pages.

2.8.32.2 Measures of Success - Nursing Layout

A

Run Date: 9/21/2006
Run Time: 1:58:20 PM

Kentucky

Cabinet for Health and Family Services

User ID: qz00tr

Department for Medicaid Services

Measures of Success - Nursing Facility Initiative

Billing Provider Number(s): 10075275; 10075341

From Date of Service Range: 1/1/2003 - 12/31/2006

From Date of Service Month	Total Expenditures	Total XIX Covered Days	Laboratory Revenue Codes 0300-0314 Billed Quantity	X-Ray Revenue Code 0320 Billed Quantity	Oxygen Revenue Code 0410 Billed Quantity	Respitory Therapy Revenue Code 0412 Billed Quantity	Respitory Therapy Supplies Revenue Code 0419 Billed Quantity	Physical Therapy Revenue Codes 0420-0424 Billed Quantity	Occupational Therapy Revenue Codes 0430-0433 Billed Quantity	Speech Therapy Revenue Codes 0440-0444 Billed Quantity	Member Undup Count	Total Medicare Cost Sharing Expenditures
200407	$452.45	0	0	0	0	0	0	0	0	0	5	$0.0
200409	$574.90	0	0	0	0	0	0	0	0	0	1	$0.0
Sum:	$1,027.35	0	0	0	0	0	0	0	0	0		$0.0

End of Report

B

Report Description

The function of this report is the monitor the successfulness of the Nursing facility Initiative in reducing Medicaid dollars.

Search Criteria

Query 1 - (T_CA_HDR_DTL table when applicable)

Billing Provider Numbers - enter in user prompt, separated by semi-colons
From Date of Service Range
Billing Provider Type Code = 12(Nursing)
(Claim Type = A (Inpatient Crossover)) or (Claim Type = L (Long Term Care) and Header or Detail Paid Indicator = H)
Type of Bill Code - in list (891,892,893,894)
Latest Claims Only
Paid Claims Only
Fee for Service Only
Revenue Code = see below

Union Query 2 - (T_CA_ICN table)

Billing Provider Numbers - enter in user prompt, separated by semi-colons
From Date of Service Range
Billing Provider Type Code = 12(Nursing)
Claim Type = L (Long Term Care) and Header or Detail Paid Indicator = D
Type of Bill Code - in list (891,892,893,894)
Latest Claims Only
Paid Claims Only
Fee for Service Only
Revenue Code = see below

There are 9 data providers, all with same queries as above, but with different Revenue Code conditions:

Laboratory - Revenue Codes 0300-0314
X-Ray - Revenue Code 0320
Oxygen - Revenue Code 0410
Inhalation Service - Revenue Code 0412
Other Respitory Services - Revenue Code 0419
Physical Therapy - Revenue Codes 0420-0424
Occupational Therapy - Revenue Codes 0430-0433
Speech Therapy - Revenue Codes 0440-0444
Total - no filters on Revenue Codes

Supplemental Documentation

Total Expenditures = Total Amount Paid for all revenue codes (not just codes listed above).
Total XIX Covered Days = Covered Days for all revenue codes (not just codes listed above).
Total Medicare Cost Sharing Expenditures = Medicaid Paid Amount for Claim Type A only.

2.8.32.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
From Date of Service Month	Month of the first date of service (format is CCYYMM)	6	Date (CCYY/MM/DD)	T_CA_TIME_KEY	DTE_MO
Laboratory Revenue Code 0300-0314 Billed Quantity	Laboratory revenue code 0300 - 0314 billed quantity.	12	Number (Decimal)	T_CA_ICN,T_CA_HDR_DTL	QTY_UNITS_BILLED
Member Undup Count	The unduplicated number of members.	10	Number	T_CA_ICN	Calculated
Occupational Therapy Revenue Code 0430-0433 Billed Quantity	Occupational therapy revenue codes 0300 - 0314 billed quantity.	12	Number (Decimal)	T_CA_ICN,T_CA_HDR_DTL	QTY_UNITS_BILLED
Oxygen Revenue Code 0410 Billed Quantity	The Oxygen revenue code 0410 billed quantity.	12	Number	T_CA_ICN,T_CA_HDR_DTL	QTY_UNITS_BILLED
Physical Therapy Revenue Code 0420-0424 Billed Quantity	Physical therapy revenue codes 0420 - 0424 billed quantity.	12	Number (Decimal)	T_CA_ICN,T_CA_HDR_DTL	QTY_UNITS_BILLED
Respitory Therapy Revenue Code 0412 Billed Quantity	Respiratory therapy revenue code 0412 billed quantity.	12	Number (Decimal)	T_CA_ICN,T_CA_HDR_DTL	QTY_UNITS_BILLED
Respitory	Respiratory therapy supplies	12	Number (Decimal)	T_CA_ICN,T_CA_HDR_DTL	QTY_UNITS_BILLE

Field	Description	Length	Data Type	DB Table	DB Attributes
Therapy Supplies Revenue Code 0419 Billed Quantity	revenue code 0419 billed quantity.				D
Speech Therapy Revenue Code 440 - 444 Billed Quantity	Speech therapy revenue codes 0440 - 0444 billed quantity.	12	Number (Decimal)	T_CA_ICN,T_CA_HDR_DTL	QTY_UNITS_BILLED
Total Expenditures	Total amount paid	13	Number (Decimal)	T_CA_ICN,T_CA_HDR_DTL	AMT_PAID
Total Medicare Cost Sharing Expenditures	Total Medicare Cost Savings Expenditures for claim type A only.	12	Number (Decimal)	T_CA_ICN,T_CA_HDR_DTL	AMT_PAID
Total Number Utilizers	Total number of utilizers (unduplicated members).	12	Character	T_CA_ICN	ID_MEDICAID
Total XIX Covered Days	Total number of Title XIX (Medicaid) covered days.	9	Number	T_CA_ICN	NUM_DAYS_COVD
X-Ray Revenue Code 0320 Billed Quantity	X-ray revenue code 0320 billed quantity.	12	Number (Decimal)	T_CA_ICN,T_CA_HDR_DTL	QTY_UNITS_BILLED

2.8.32.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.32.5 Associated Requirements

ID
No associated Requirements found.

2.8.32.6 Change Orders

ID	Name	Description
2197	Measures of Success - Nursing	Create the Measures of Success - Nursing Facility Initiative according to specifications.

2.8.33 DSS - Medicaid Eligible Children -- Medicaid Eligible Children

The Medicaid Eligible Children report generates a count of children for a specific eligibility begin and end date range.

There are 2 tabs in this report:

A. Medicaid Eligible Children Report

B. Report Notes tab describing the conditions used to create the report.

2.8.33.1 Technical Name

DSS - Medicaid Eligible Children

2.8.33.2 Medicaid Eligible Children Layout

A

Run Date: 7/18/2006
Run Time: 3:05:29 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: qz00tr

Medicaid Eligible Children Per Month

Member Aid Eligibility Begin Date: 1/1/2000
Member Aid Eligibility End Date: 12/31/2005
Aid Code(s): A;M;I

Race Description	Current Age	KCHIP Indicator	Member Count
A - Asian or Pacific Islander	4	N	4
A - Asian or Pacific Islander	6	N	20
A - Asian or Pacific Islander	7	N	4
A - Asian or Pacific Islander	13	N	2
A - Asian or Pacific Islander	14	N	2
A - Asian or Pacific Islander	16	N	2

End of Report

B

Report Notes

Report Description

This report generates a count of children for a specific eligibility begin and end date range.

Search Criteria

Member Aid Eligibility Begin Date - The date, entered in the prompt, that the member becomes eligible for the corresponding aid category
Member Aid Eligibility End Date - The date, entered in the prompt, that the member is no longer eligible for the corresponding aid categor
Member Age - Current age less than or equal 18
Aid Code(s) - Member's aid category code(s) entered in the prompt

2.8.33.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Current Age	The age of the member.	10	Date (MM/DD/CCYY)	T_RE_BASE_DN	DTE_BIRTH
KCHIP Indicator	The KCHIP indicator. Valid values are 'Y' or 'N'	1	Char	Calculated	NA
Member Count	Total number of members.	12	Char	T_RE_BASE_DN	ID_MEDICAID
Race Description	The code & description which indicates the member's race.	102	Char	T_RE_BASE_DN	CDE_RACE || DSC_RACE

2.8.33.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.33.5 Associated Requirements

ID
30.050.015.002.6

2.8.33.6 Change Orders

ID	Name	Description
1450	Medicaid Eligible Children	Develop the Medicaid Eligible Children Report according to specifications.

2.8.34 DSS - Medicaid Member History Request -- Medicaid Member History Request

The Medicaid Member History Request report generates a history of claims for a given member(s) during a specific date of service range.

There are 2 tabs in this report:

A. Medicaid Member History Request Report.

B. Report Notes tab describing the conditions used to create the report.

2.8.34.1 Technical Name

DSS - Medicaid Member History Request

2.8.34.2 Medicaid Member History Request Layout

A

Run Date: 8/8/2006
Run Time: 11:14:07 AM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: qz00tr

Medicaid Member History Request

Member ID(s): 000001869
From Date of Service Range: 09/01/2004 - 09/30/2005

ICN	Phone Number	Billing Provider Name	Billing Provider Full Address	From Date of Service	Revenue Code & Description	Primary Procedure Code & Desc	Primary Diagnosis Code & Desc	Claim Date	Billed Amount	Paid Amount	Payment Date
2005090000010	(999) 551-3747	NEWLAND, MARK S	6027 NE 1ST ST SALEM, KY 97501-8008	09/01/2004	0120 - Semi-Private Room	###### -	95901 - EAD INJURY UNSPEC UN	11/01/2004	$1,245.00	$700.00	03/31/2005
2005090000010	(999) 551-3747	NEWLAND, MARK S	6027 NE 1ST ST SALEM, KY 97501-8008	09/01/2004	0250 - Pharmacy	###### -	95901 - EAD INJURY UNSPEC UN	11/01/2004	$1,245.00	$700.00	03/31/2005
2005112000033	(999) 551-3747	NEWLAND, MARK S	6027 NE 1ST ST SALEM, KY 97501-8008	09/04/2004	0130 - Room-Board/3&4 Bed	###### -	95901 - EAD INJURY UNSPEC UN	11/01/2004	$1,245.00	$700.00	04/22/2005
2005112000033	(999) 551-3747	NEWLAND, MARK S	6027 NE 1ST ST SALEM, KY 97501-8008	09/04/2004	0250 - Pharmacy	###### -	95901 - EAD INJURY UNSPEC UN	11/01/2004	$1,245.00	$700.00	04/22/2005

End of Report

B

Report Notes

Report Description

This report generates a history of claims for a given Member(s) during a specific date of service range.

Search Criteria

From Date of Service - Begin and end date range entered in the prompt
Member ID(s) - Member ID(s) entered in the prompt, separated by a semi-colon
FFS Claims Only - Fee for Service filter
Latest Claims only - will give you only the latest version of a claim even if it was previously adjusted
Paid Claims only - claim is not denied

2.8.34.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Amount	The sum of all charges associated with an individual claim.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
Billing Provider Full Address	Provider address including city, state, and zip code.	101	Char	T_CA_PROV_KEY	ADR_BILL_<*>, *= STRT1,STRT2,CITY,STATE,ZIP,ZIP4
Billing Provider Name	The name of the provider.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
Claim Date	The date a provider enters on a claim indicating when it was prepared.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_BILLED
From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
Paid Amount	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Payment Date	The date on which a payment was generated from the MMIS claim transaction.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID

Field	Description	Length	Data Type	DB Table	DB Attributes
Phone Number	The phone number on file at which the provider may be contacted	14	Char	T_CA_PROV_KEY	ADR_BILL_PHONE || ADR_BILL_PHO_EXT
Primary Diagnosis Code & Desc	The name or English description of the diagnosis code	74	Char	T_CA_ICN, T_DIAGNOSIS	CDE_DIAG_PRIM || DSC_25
Primary Procedure Code & Desc	The generally accepted nomenclature for medical, surgical, dental, and so on, procedure.	64	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC_PRIM || DSC_PROC
Revenue Code & Description	Code & description detailing the medical procedure performed for this claim detail.	74	Char	T_CA_HDR_DTL, T_CDE_REVENUE	CDE_REVENUE || DSC_REVENUE

2.8.34.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.34.5 Associated Requirements

ID
30.050.015.002.6

2.8.34.6 Change Orders

ID	Name	Description
1455	Medicaid Member History Request	Develop the Medicaid Member History Request Report according to specifications.

2.8.35 DSS - Medicare Crossover Part B Repricing -- Medicare Crossover Part B Repricing

The Medicare Crossover Part B Repricing report displays savings from pricing changes to crossover claims made in DCR 00715. The frequency of this report is monthly.

There are 2 tabs in this report:

A. Medicare Crossover Part B Reprice Report

B. Report Notes tab describing the conditions used to create the report.

2.8.35.1 Technical Name

DSS - Medicare Crossover Part B Repricing

2.8.35.2 Medicare Crossover Part B Repricing Layout

A

Run Date: 8/30/2006
Run Time: 5:04:40 PM

User ID: qz00tr

Cabinet for Health and Family Services

Department for Medicaid Services

Medicare Crossover Part B Repricing

From Date of Service Range: 9/1/2000 - 05/1/2006

Provider Type	Billing Provider Type Description	Distinct Members	ICN Undup Count	Medicare Co-Insurance	Medicare Deductible	Medicaid Paid Amount	Savings Difference
37	Independant Labratory	17	253	$983.00	$367.00	$0.00	$1,350.00
77	Optometrist	1	1	$0.00	$0.00	$0.00	$0.00
95	Physician Assistant	3	11	$24.00	$15.00	$11.00	$28.00
	Total:	**21**	**265**	**$1,007.00**	**$382.00**	**$11.00**	**$1,378.00**
90	DME Supplier	5	10	$0.00	$850.00	$524.00	$326.00
54	Pharmacy	2	635	$15,870.00	$15,950.00	$57.00	$31,763.00
	Total:	**7**	**645**	**$15,870.00**	**$16,800.00**	**$581.00**	**$32,089.00**
	Grand Total:	**28**	**910**	**$16,877.00**	**$17,182.00**	**$592.00**	**$33,467.00**

End of Report

B

Report Notes

Report Description

The Medicare Crossover Part B Repricing report displays savings from pricing changes to crossover claims made in DCR 00715. The frequency of this report is monthly.

Search Criteria

From Date of Service Range - Begin and end date range entered in the prompt
Claim Type - equal to B (Professional Crossover) & C (Outpatient Crossover)
Billing Provider Type - in list (30,37,50,52,54,60,61,64,65,70,72,74,77,78,80,85,90,95)
FFS Claims Only
Latest Claims only
Paid Claims Only

2.8.35.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Type Description	Billing provider type description.	50	Char	T_CA_PROV_KEY	DSC_PROV_TYPE
Distinct Members	Count of unique Medicaid member IDs.	10	Number	T_CA_ICN	ID_MEDICAID
ICN Undup Count	Count of unique claim internal control numbers.	10	Number	T_CA_ICN	NUM_ICN
Medicaid Paid Amount	Total of Medicaid paid amount.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Medicare Co-Insurance	Total of Medicare coinsurance amounts.	11	Number (Decimal)	T_CA_XOVER	AMT_COINSURANCE
Medicare Deductible	Total of Medicare deductible amounts.	13	Number (Decimal)	T_CA_XOVER	AMT_DEDUCT
Provider Type	Billing provider type code.	2	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM
Savings Difference	(Medicare co-insurance + Medicare deductible) - Medicaid paid amount.	13	Number (Decimal)	n/a	calculated

2.8.35.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.35.5 Associated Requirements

ID
30.090.014.003.2

2.8.35.6 Change Orders

ID	Name	Description
No associated Change Orders found.		

2.8.36 DSS - Member Claim Detail - eKasper -- Member Claim Detail - eKasper

The function of this report is to monitor member utilization patterns and avoid over utilization of KyHealth Choices benefits, therefore reducing program dollars.

This report has 3 tabs:

A. Member Claim Detail Prescriber - eKasper (with Prescriber Provider Numbers, Name and DEA#)

B. Member Claim Detail Dispenser - eKasper (with Dispenser Provider Numbers, Name and DEA#)

C. Report Notes tab describing the conditions used to create the report

2.8.36.1 Technical Name

DSS - Member Claim Detail – eKasper

2.8.36.2 Member Claim Detail - eKasper Layout

Run Date: 9/26/2006

Run Time: 4:08:52 PM

Cabinet for Health and Family Services

Department for Medicaid Services

User ID: qz00tr

Member Claim Detail - eKASPER

Member ID: 888800043

From Date of Service Range: 1/1/2004 - 12/31/2004

Dispensed Date: 3/14/2003

Member County/Case Record Number	Member ID	Member Full Name (L, FM)	Member Date of Birth	Member Gender Code & Description	Member Full Address	Member County Code & Description	ICN	From Date of Service	Payment Date	Paid Amount	Billed Amount	Billed Quantity	Prescriber Provider Numbers	Prescriber Full Name	Primary Diagnosis Code & Desc	Secondary Diagnosis Code & Desc	Claim Type & Description	NDC Code & Description	Days Supplied	Dispensed Date	Prescriber DEA Number
888800043	888800043	SKAGGS, CAROL	07/03/1949	F - Female	518 MAIN ST. STROUD, OK 74079 - 0000	19 - Creek	2005138300039	11/30/2004	05/19/2005	$489.09	$1.00	1	NPI ID: Medicaid ID: Base ID:	John	####### -	####### -	P - PHARMACY CLAIMS	406035901 - IMITREX	16	03/14/2003	BG4789042

End of Report

A

B

Run Date: 9/26/2006
Run Time: 4:08:52 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: qz00tr

Member Claim Detail - eKASPER

Member ID: 888800043
From Date of Service Range: 1/1/2004 - 12/31/2004
Dispensed Date: 3/14/2003

Member County/Case Record Number	Member ID	Member Full Name (L, FM)	Member Date of Birth	Member Gender Code & Description	Member Full Address	Member County Code & Description	ICN	From Date of Service	Payment Date	Paid Amount	Billed Amount	Billed Quantity	Dispenser Provider Numbers	Dispenser Full Name	Primary Diagnosis Code & Desc	Secondary Diagnosis Code & Desc	Claim Type & Description	NDC Code & Description	Days Supplied	Dispensed Date	Dispenser DEA Number
888800043	888800043	SKAGGS, CAROL	07/03/1949	F - Female	518 MAIN ST. STROUD, OK 74079 - 0000	19 - Creek	2005138300039	11/30/2004	05/19/2005	$489.09	$1.00	1	NPI ID: 1000000473 Medicaid ID: 100236279A Base ID: 10023628	Wal-Mart Pharmacy 10-1426	####### -	####### -	P - PHARMACY CLAIMS	406035901 - IMITREX	16	03/14/2003	BW5497020

End of Report

c

Report Notes

Report Description

The function of this report is to monitor members utilization patterns and avoid over utilization of Medicaid benefits, therefore reducing Medicaid dollars.

Search Criteria

From Date of Service Range - Begin and end date range in user prompt
Dispensed Date - enter date filled in user prompt
Member ID - enter in user prompt
Paid Claims only filter
Fee For Service only filter - claim indicator = F & H

2.8.36.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Prescriber DEA Number	The prescriber provider DEA number.	9	Char	T_EK_RECIP_PROV	NUM_PROV_DEA
(A) Prescriber Full Name	The prescriber provider name.	58	Char	T_EK_RECIP_PROV	NAM_PROV_FULL
(A) Prescriber Provider Numbers	The prescriber provider number.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID ||

Field	Description	Length	Data Type	DB Table	DB Attributes
					ID_PROVIDER_BASE
(A,B) Billed Amount	Amount billed.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
(A,B) Billed Quantity	Number of units that were billed.	12	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED
(A,B) Claim Type & Description	Claim type and description.	51	Char	T_CA_ICN, T_CLAIM_TYPE	CDE_CLM_TYPE || DSC_CLM_TYP
(A,B) Days Supplied	The number of days supply of the drug.	3	Number	T_EK_RECIP_PROV	NUM_DAYS_SUPPLIED
(A,B) Dispensed Date	The date the prescription was filled.	10	Date (MM/DD/CCYY)	T_EK_RECIP_PROV	DATE_FILLED
(A,B) From Date of Service	The first date of service for this claim.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
(A,B) ICN	The transaction control number.	13	Char	T_CA_ICN	NUM_ICN
(A,B) Member County Code & Description	The member's county of residence.	35	Char	T_CA_RECIP_KEY	CDE_RECIP_COUNTY || DSC_RECIP_COUNTY
(A,B) Member County/Case Record Number	Member case number.	12	Char	T_CA_ICN	NUM_CASE

Field	Description	Length	Data Type	DB Table	DB Attributes
(A,B) Member Date of Birth	The member's date of birth.	10	Date (MM/DD/CCYY)	T_EK_RECIP_PROV	DTE_MEMBER_DOB
(A,B) Member Full Address	The member's full mailing address.	93	Char	T_RE_BASE_DN	ADR_STREET_1,ADR_STREET_2,ADR_CITY, ADR_STATE,ADR_ZIP_CODE,
(A,B) Member Full Name (L,FM)	The members full name (last, first, middle initial).	45	Char	T_EK_RECIP_PROV	NAM_MEMBER_LAST, NAM_MEMBER_FIRST, NAM_MEMBER_MI
(A,B) Member Gender Code & Description	The member's sex code.	21	Char	T_CA_RECIP_KEY	CDE_SEX || DSC_SEX
(A,B) Member ID	The member's Medicaid identification number.	12	Char	T_EK_RECIP_PROV	ID_MEDICAID
(A,B) NDC Code and Description	The National Drug Code and description.	46	Char	T_EK_RECIP_PROV, T_DRUG_DN	CDE_NDC || DSC_NDC
(A,B) Paid Amount	Amount paid on claim.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
(A,B) Payment Date	Date the claim was paid.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID
(A,B) Primary Diagnosis Code &	The code and description for the primary diagnosis.	32	Char	T_CA_ICN, T_DIAGNOSI	CDE_DIAG_PRIM || DSC_25

Field	Description	Length	Data Type	DB Table	DB Attributes
Desc				S	
(A,B) Secondary Diagnosis Code & Desc	The code and description for the secondary diagnosis.	32	Char	T_CA_ICN, T_DIAGNOSIS	CDE_DIAG_2 || DSC_25
(B) Dispenser DEA Number	The dispenser provider DEA number.	9	Char	T_EK_RECIP_PROV	NUM_DISP_DEA
(B) Dispenser Full Name	The dispenser provider name.	40	Char	T_EK_RECIP_PROV	NAM_DISP_FULL
(B) Dispenser Provider Numbers	The dispenser (pharmacy) provider's assigned numbers.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE

2.8.36.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.36.5 Associated Requirements

ID
No associated Requirements found.

2.8.36.6 Change Orders

ID	Name	Description
2233	Member Claim Detail - eKasper	Develop the Member Claim Detail - eKasper report according to specifications

2.8.37 Member History Request

The Member History Request report generates the Total Amount Paid per claim for a given Member(s).

There are 2 tabs in this report:

A. Member History Report

B. Report Notes tab describing the conditions used to create the report.

2.8.37.1 Technical Name

DSS - Member History Request

2.8.37.2 Member History Request Report Layout

A

Run Date: 8/25/2006
Run Time: 3:35:53 PM

User ID: qz00tr

Cabinet for Health and Family Services
Department for Medicaid Services

Member History Request

Member ID(s): 000001326
From Date of Service Range: 1/1/2002 - 12/31/2005

Member County/Case Record Number	Member ID	Member Full Name (L,FM)	From Date of Service	Paid Amount
D092889	000001326	COX, HANK	03/20/2002	$3,115.19
			09/01/2004	$2,714.70
			10/01/2004	$150.00
			11/01/2004	$150.00
			Sum:	**$6,129.89**

End of Report

B

Report Notes

Report Description

The Member History Request report generates the Total Amount Paid per claim for a given Member(s).

Search Criteria

From Date of Service - Begin and end date range entered in the prompt
Member ID(s) - entered in prompt, separated by a semi-colon
Paid Claims only filter
Fee for Service only filter

2.8.37.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
Member County/Case Record Number	Group Identification number of the member	12	Number	T_CA_ICN	NUM_CASE
Member Full Name (L,FM)	The member's full name	36	Char	T_RE_CASE	NAM_LAST,NAM_FIRST,NAM_MID_INIT
Member ID	The current Identification number assigned to a member	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount	The total paid amount for the claim.	13	Number (Decimal)	T_CA_ICN	AMT_PAID

2.8.37.4 Associated Programs

Program	DESCRIPTION
No associated programs found	

2.8.37.5 Associated Requirements

ID
30.050.015.002.6

2.8.37.6 Change Orders

ID	TYPE	NAME	DESCRIPTION	Current Status
1463	Change Order	Member History Request	Develop the Member History Request Report according to specifications.	Prod Implemented
4269	Defect	Member History Request Report	This defect will cover all issues related to: CO 1463 - Member History request Report	Prod Implemented

2.8.38 DSS - NF Initiative Ancillary Paid -- NF Initiative Ancillary Paid

The NF Initiative Ancillary Paid report generates a history of paid Nursing Facility claims for given procedure(s) during a specific date of service range. It is used for budgeting the Nursing Facility KyHealth Choices dollars and an initiative called 'Measures of Success'.

2.8.38.1 Technical Name

DSS - NF Initiative Ancillary Paid

2.8.38.2 NF Initiative Ancillary Paid Layout

Run Date: 08/10/2006
Run Time: 9:07:04 AM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: tztsbl

A

NF Initiative Ancillary Paid

From Date of Service Range: 1/1/2000 - 8/1/2006

From Date of Service	Billing Provider IDs	Billing Provider Name	Covered Days	Total Accom Paid Amount	Ancillary Paid Amount	Net Patient Paid Amount	Other Insurance Paid Amount	Paid Amount	Crossover Paid Amount	Paid Amount + Crossover Paid Amount
03/2001	NPI ID: 1000000624 Medicaid ID: 100407159A Base ID: 10040716		42	$1,900.29	$0.00	$1,350.00	$0.00	$2,171.76	$0.00	$2,171.76
03/2002	NPI ID: 1000000624 Medicaid ID: 100407159A Base ID: 10040716		14	$0.00	$633.43	$0.00	$0.00	$1,266.86	$0.00	$1,266.86
07/2004	NPI ID: 1000000624 Medicaid ID: 100407159A Base ID: 10040716		14	$633.43	$0.00	$1,266.86	$0.00	$0.00	$0.00	$0.00

End of Report

B

Report Notes

Report Description

The NF Initiative Ancillary Paid report generates a history of paid Nursing Facility claims for given procedure(s) during a specific date of service range. It is used for budgeting the Nursing Facility Medicaid dollars and an initiative called Measures of Success.

Search Criteria

First Date of Service Range per user input
FFS Claims only
Bill Provider Type equal to 12 (Nursing Home)
Latest Claims only
Paid Claims only
Claim Type equal to L (LTC) or A (Institutional Crossover)

Supplemental Documentation

Accommodation paid amounts are defined as having revenue codes between 100 and 219. All other revenue codes are treated as ancillary.

2.8.38.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Ancillary Paid Amount	The total amount paid for ancillary charges on the claim.	13	Number (Decimal)	n/a	Calculated
Billing Provider IDs	A unique number assigned by the state to each provider of services participating in the Medicaid program.	9	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
Billing Provider Name	The full name of a provider.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
Covered Days	Indicates the number of days covered for the statement period of the claim.	5	Number	T_CA_ICN	NUM_DAYS_COVD
Crossover Paid Amount	The total paid amount of the line item for encounter claims.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
From Date of Service	This is the line item first date of service for the particular claim detail.	7	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
Net Patient Paid Amount	The amount received by the provider from the member. This excludes copay. This is the amount that has been determined to be available from the member as partial payment of the cost of care.	13	Number (Decimal)	T_CA_ICN	AMT_PAT_LIAB
Other Insurance Paid Amount	The amount of payment received by the provider from a third party source.	13	Number (Decimal)	T_CA_ICN	AMT_TPL

Field	Description	Length	Data Type	DB Table	DB Attributes
Paid Amount	The total paid amount of the line item for encounter claims.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Paid Amount + Crossover Paid Amount	The total sum of encounter claims payment amount and the amount paid by Medicare	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Total Accom Paid Amount	The total paid amount of the line item accommodations charges.	13	Number (Decimal)	n/a	Calculated

2.8.38.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.38.5 Associated Requirements

ID
30.050.015.002.6

2.8.38.6 Change Orders

ID	Name	Description
1435	NF Initiative Ancillary Paid	Develop the NF Initiative Ancillary Paid Report according to specifications.

2.8.39 DSS - NF Initiative Ancillary Units -- NF Initiative Ancillary Units

The NF Initiative Ancillary Units report generates a history of Nursing Facility claims for given procedure(s) during a specific date of service range. It is used for budgeting the Nursing Facility KyHealth Choices dollars and an initiative called 'Measures of Success'.

2.8.39.1 Technical Name

DSS - NF Initiative Ancillary Units

2.8.39.2 NF Initiative Ancillary Units Layout

A

Run Date: 08/04/2006
Run Time: 2:31:40 PM

User ID: tztsbl

Cabinet for Health and Family Services

Department for Medicaid Services

NF Initiative Ancillary Units

From Date of Service Range: 01/01/2001 - 01/01/2006

Revenue From Date of Service	Revenue Code & Description	Billed Revenue Amount	Billed Revenue Quantity	Member Undup Count	ICN Undup Count
07/01/2004	0320 - Diagnostic X Ray	$633.43	7	1	1

End of Report

B

Report Notes

Report Description

The NF Initiative Ancillary Units report generates a history of Nursing Facility claims for given procedure(s) during a specific date of service range. It is used for budgeting the Nursing Facility Medicaid dollars and an initiative called Measures of Success.

Search Criteria

From Date of Service per user input
FFS Claims only
Bill Provider Type equal to 12 (Nursing Home)
Type of Bill between 891 and 894
Latest Claims only
Paid Claims only
Covered Charges only (Patient liability = $0)
Revenue Code in (0320, 0410, 0412, 0419) or Revenue Code between 0300 and 0314 or Revenue Code between 0420 and 0424 or Revenue Code between 0430 and 0433 or Revenue Code between 0440 and 0444

2.8.39.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Revenue Amount	The total of submitted charges.	13	Number (Decimal)	T_CA_HDR_DTL	AMT_BILLED
Billed Revenue Quantity	The total units billed.	7	Number	T_CA_HDR_DTL	QTY_BILLED
ICN Undup Count	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	10	Number	T_CA_ICN	NUM_ICN
Member Undup Count	Total count of unique original member identifications.	10	Number	T_CA_ICN	ID_MEDICAID
Revenue Code & Description	The line item revenue code billed on the UB-92 claim (describes the service performed).	45	Char	T_CA_HDR_DTL	CDE_REVENUE
Revenue From Date of Service	This is the line item first date of service for the particular claim detail. Format is YYYY/MM.	7	Date (MM/DD/CCYY)	T_CA_HDR_DTL	DTE_FIRST_SVC

2.8.39.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.39.5 Associated Requirements

ID

ID
30.050.015.002.6

2.8.39.6 Change Orders

ID	Name	Description
1436	NF Initiative Ancillary Units	Develop the NF Initiative Ancillary Units Report according to specifications.

2.8.40 DSS - Non Actual Budget Model -- Non Actual Budget Model

The Non Actual Budget Model report generates a Budget Model in conjunction with the Non Actual Budget Model. The report layout varies based on what is requested.

There are 2 tabs in this report:

A. Non Actual Budget Model Report.

B. Report Notes tab describing the conditions used to create the report.

2.8.40.1 Technical Name

DSS - Non Actual Budget Model

2.8.40.2 Non Actual Budget Model Layout

A

Run Date: 10/26/2006
Run Time: 10:15:23 AM

Cabinet for Health and Family Services

User ID: czv6vp

Department for Medicaid Services

Non Actual Budget Model

Payment Date Range: 1/1/2000 - 12/31/2006

State COS Code & Description	Paid Amount	Member Undup Count
24 - Comm For Chldrn w/Spec Hlth Care Needs (CSHC)	$4,954.79	8

End of Report

B

Report Notes

Report Description

The Non Actual Budget Model report generates a Budget Model in conjunction with the Non Actual Budget Model. The report layout varies based on what is requested.

Search Criteria

Payment Date - Payment date range entered in the prompt
State Category of Service Code - in list (24,26,29) - Type of provider rendering service
FFS Claims Only - Fee for Service filter

2.8.40.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Member Undup Count	A unique count of first identification number assigned to a member upon initial certification for participation in the program.	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount	A unique count of the amount paid by Medicaid for the line item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Payment Date Range	Prompt value for payment date range	10	Date (CCYY/MM/DD)	T_CA_ICN	DTE_PAID
State COS Code & Description	A code and description defining the category of service rendered (for example: inpatient, pharmacy, physician, home health).	52	Char	T_CA_CLAIM_KEY	CDE_COS_ST || DSC_COS

2.8.40.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.40.5 Associated Requirements

ID
30.050.015.002.6

2.8.40.6 Change Orders

ID	Name	Description

ID	Name	Description
1451	Non Actual Budget Model	Develop the Non Actual Budget Estimate Report according to specifications.
4270	Non Actual Budget Model	This defect covers all issues related to : CO 1451 - Non Actual Budget Model

2.8.41 DSS - Number of Dental Providers Per county Treating Specific Age -- Number of Dental Providers Per county Treating Specific Age

The Dental Providers by County treating specific Age group bring back the number of providers for specific county treating specific age group for that previous quarter.

2.8.41.1 Technical Name

DSS - Number of Dental Providers Per county Treating Specific Age

2.8.41.2 Number of Dental Providers Per county Treating Specific Age Layout

A

Run Date: 10/30/2007
KYMM7100-R002

Page 1

Cabinet for Health and Family Services

Department for Medicaid Services

Number of Dental Providers Per county Treating Specific Age

For QTR Ending: 9/30/2007

County	Total # Providers	0-6	7-13	14-20	Sub Total	21-64	65+	Total Recips
001 - Adair	2	36	91	65	192	49	11	251
002 - Allen	3	249	101	18	366	13	1	380
003 - Anderson	2	21	82	58	160	78	3	241
004 - Ballard	1	12	22	13	47	1	0	48
005 - Barren	11	163	310	198	668	209	21	898
006 - Bath	1	18	18	26	62	32	2	96
007 - Bell	7	195	331	224	742	363	20	1,125
008 - Boone	12	399	423	244	1,064	359	20	1,442
009 - Bourbon	4	157	194	88	439	158	13	609
010 - Boyd	9	457	689	324	1,468	289	11	1,768
011 - Boyle	9	467	477	222	1,165	251	13	1,429
012 - Bracken	2	31	47	40	117	18	2	137
013 - Breathitt	4	94	168	133	394	190	7	591
014 - Breckinridge	0	0	9	5	14	3	4	21
015 - Bullitt	0	0	0	5	5	0	0	5
016 - Butler	2	33	74	45	151	48	4	203
017 - Caldwell	2	64	75	72	210	87	3	300
018 - Calloway	6	212	326	263	797	289	19	1,104
019 - Campbell	6	74	103	77	254	96	7	357
020 - Carlisle	1	20	39	19	77	13	2	92
022 - Carter	4	122	157	142	421	210	13	642
023 - Casey	1	89	96	36	220	59	2	281
024 - Christian	4	189	372	175	732	117	16	864

B

Report Notes

Report Description

The Dental Providers by County treating specific Age group bring back the number of providers for specific county treating specific age group for that previous quarter.

Search Criteria

The paid date is between previous quarter begin and end for paid claims.

Fee For Service

Dental Providers 60 and 61.

2.8.41.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
0-6	Number of Members visited in that county	5	Number	T_CA_ICN	ID_Medicaid
14-20	Number of Members visited in that county	5	Number	T_CA_ICN	ID_Medicaid

Field	Description	Length	Data Type	DB Table	DB Attributes
21-64	Number of Members visited in that county	5	Number	T_CA_ICN	ID_Medicaid
65+	Number of Members visited in that county	5	Number	T_CA_ICN	ID_Medicaid
7-13	Number of Members visited in that county	5	Number	T_CA_ICN	ID_Medicaid
County	County Description	20	Char	T_CA_PROV_KEY	CDE_SVC_COUNTY and DSC_SVC_COUNTY
SubTotal	Number of Members visited for the above listed age groups	5	Number	T_CA_ICN	ID_Medicaid
Total # Providers	Total Number of Providers	5	Number	T_CA_PROV_KEY	SAK_PROV
Total Recips	Total Number of Members visited for all the above listed age groups	5	Number	T_CA_ICN	ID_Medicaid

2.8.41.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.41.5 Associated Requirements

ID
No associated Requirements found.

2.8.41.6 Change Orders

ID	Name	Description

ID	Name	Description
No associated Change Orders found.		

2.8.42 DSS - Number of Dental Providers Seeing Unduplicated Recipients -- Number of Dental Providers Seeing Unduplicated Recipients

Dental Providers seeing unduplicated members brings backnumber os unduplicated members a provider sees in the previous quarter by county.

2.8.42.1 Technical Name

DSS - Number of Dental Providers Seeing Unduplicated Recipients

2.8.42.2 Number of Dental Providers Seeing Unduplicated Recipients Layout

A

REPORT ID: KYMM7100-R001
RUN DATE: 11/20/2007

Page 1

Cabinet for Health and Family Services

Department For Medicaid Services

Number of Dental Providers Seeing Unduplicated Recipients

For QTR ENDING: 9/30/2007

Number of Providers Seeing Specific Numbers Of Members

COUNTY	1-49	50-99	100-149	150-199	200-299	300-399	400+	TOTAL
001 - Adair	1	0	1	0	1	0	0	3
002 - Allen	2	0	0	0	0	1	0	3
003 - Anderson	0	1	0	0	1	0	0	2
004 - Ballard	0	1	0	0	0	0	0	1
005 - Barren	7	1	1	0	2	1	0	12
006 - Bath	0	0	1	0	0	0	0	1
007 - Bell	2	0	2	0	3	1	0	8
008 - Boone	6	3	0	1	4	1	0	15
009 - Bourbon	1	1	1	0	0	0	1	4
010 - Boyd	9	2	1	0	1	1	1	15
011 - Boyle	7	5	0	0	2	1	1	16
012 - Bracken	1	0	1	0	0	0	0	2
013 - Breathitt	1	0	0	1	1	1	0	4
014 - Breckinridge	3	0	0	0	0	0	0	3
015 - Bullitt	2	0	0	0	0	0	0	2
016 - Butler	0	1	0	1	0	0	0	2
017 - Caldwell	1	0	0	0	0	1	0	2
018 - Calloway	2	2	1	0	1	1	1	8
019 - Campbell	6	0	0	2	0	0	0	8
020 - Carlisle	0	1	0	0	0	0	0	1
022 - Carter	0	1	1	1	0	1	0	4
023 - Casey	0	0	0	0	0	1	0	1

B

Report Notes

Report Description

Dental Providers seeing unduplicated members brings backnumber os unduplicated members a provider sees in the previous quarter by county.

Search Criteria

The paid date is between previous quarter begin and end for paid claims.

Fee For Service

Dental Providers 60 and 61.

2.8.42.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
1-49	Number of Unduplicated recipients visited in that county	5	Number	T_CA_RPOV_KEY	ID_Medicaid

Field	Description	Length	Data Type	DB Table	DB Attributes
100-149	Number of Unduplicated recipients visited in that county	5	Number	T_CA_PROV_KEY	ID_Medicaid
150-199	Number of Unduplicated recipients visited in that county	5	Number	T_CA_PROV_KEY	ID_Medicaid
200-249	Number of Unduplicated recipients visited in that county	5	Number	T_CA_PROV_KEY	ID_Medicaid
250-299	Number of Unduplicated recipients visited in that county	5	Number	T_CA_PROV_KEY	ID_Medicaid
300-399	Number of Unduplicated recipients visited in that county	5	Number	T_CA_PROV_KEY	ID_Medicaid
400+	Number of Unduplicated recipients visited in that county	5	Number	T_CA_PROV_KEY	ID_Medicaid
50-99	Number of Unduplicated recipients visited in that county	5	Number	T_CA_PROV_KEY	ID_Medicaid
County	County Description	20	Char	T_CA_PROV_KEY	CDE_SVC_COUNTY and DSC_SVC_COUNTY

2.8.42.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.42.5 Associated Requirements

ID
No associated Requirements found.

2.8.42.6 Change Orders

ID	Name	Description
No associated Change Orders found.		

2.8.43 DSS - Paid Claims DME Providers For Procedure E1399 -- Paid Claims DME Providers For Procedure E1399

The Paid Claims DME Providers For Procedure E1399 report provides a listing of all providers having paid claims with procedure code E1399 and a paid amount of $300.00 or less. The frequency of this report is monthly.

There are 2 tabs in this report:

A. DME Provider Monthly Report

B. Report Notes tab describing the conditions used to create the report.

2.8.43.1 Technical Name

DSS - Paid Claims DME Providers For Procedure E1399

2.8.43.2 Paid Claims DME Providers For Procedure E1399 Layout

A

Run Date: 9/19/2006
Run Time: 5:45:13 PM

Cabinet for Health and Family Services

User ID: qz00tr

Department for Medicaid Services

DME Provider Monthly Report

Paid Claims for DME Providers Billing $300.00 or Less For Procedure E1399

Payment Month: 200504

Billing Provider Numbers	ICN	Billed Amount	Paid Amount	From Date of Service
	Report Totals:	**$0.00**	**$0.00**	

No Data This Report Run

B

Report Notes

Report Description

The Paid Claims DME Providers For Procedure E1399 report provides a listing of all providers having paid claims with procedure code E1399 and a paid amount of $300.00 or less. The frequency of this report is monthly.

Search Criteria

Billing Provider Type - equal to 90 (DME Supplier)
Claim Type - equal to M (Professional)
Primary Procedure Code - equal to E1399 (Durable Medical Equipment)
Paid Amount - less than or equal to $300.00
Payment Month - enter in user prompt [yyyymm]
Latest Claims Only
Paid Claims Only

2.8.43.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Amount	The amount billed by the provider on the claim.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
Billing Provider Numbers	The Medicaid provider number assigned to the provider.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
From Date of Service	The from date of service on the claim	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
Paid Amount	The amount paid to the provider on the claim record	13	Number (Decimal)	T_CA_ICN	AMT_PAID

2.8.43.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.43.5 Associated Requirements

ID
30.090.014.003.2

2.8.43.6 Change Orders

ID	Name	Description
1604	Paid Claims DME Prov Proc E1399	This report provides a listing of all providers having paid claims with procedure code E1399 and a paid amount of $300.00 or less. The frequency of this report is monthly. (KYMC9927-R001)

2.8.44 DSS - Paid Claims Hi - Low -- Paid Claims Hi - Low

The Paid Claims Hi - Low report lists the 100 highest paid and 100 lowest paid physician claims, the 25 highest and lowest paid non-institutional/other claims, and the 50 highest and lowest paid claims for each of the other claim types. The frequency of this report is weekly.

2.8.44.1 Technical Name

DSS - Paid Claims Hi – Low

For readability, this layout appears on the following pages.

2.8.44.2 Paid Claims Hi - Low Layout

A Run Date: 4/2/2007
Run Time: 3:25:32 PM

User ID: tztsbl

Cabinet for Health and Family Services

Department for Medicaid Services

Paid Claims Hi-Low

Highest Paid Claims

Paid date range: 6/1/2006- 6/30/2006

Claim Type: A - INST XOVER CLAIMS

ICN	Detail Num	Billing Provider Numbers	Member ID	Billed Amount	Allowed Amount	Paid Amount	TPL Amount	Medicare Paid Amount	From Date of Service	To Date of Service	Procedure Code & Desc	Admission Date	Discharge Date	Covrd Days	Place of Service Code & Desc
	0			$33,596.60	$4,998.18	$4,998.18	$0.00	$1,346.29	3/8/2006	3/24/2006	###### -Unknown or Not Applicable	3/8/2006	3/24/2006	16	21 - Inpatient Hospital
	0			$33,934.20	$4,189.41	$4,189.41	$0.00	$5,757.54	12/29/2005	1/14/2006	###### -Unknown or Not Applicable	12/29/2005	1/14/2006	16	21 - Inpatient Hospital
	0			$203,707.76	$3,808.00	$3,808.00	$0.00	$49,259.66	2/7/2006	3/9/2006	###### -Unknown or Not Applicable	2/7/2006	3/9/2006	30	21 - Inpatient Hospital

Claim Type: I - INPATIENT CLAIMS

ICN	Detail Num	Billing Provider Numbers	Member ID	Billed Amount	Allowed Amount	Paid Amount	TPL Amount	Medicare Paid Amount	From Date of Service	To Date of Service	Procedure Code & Desc	Admission Date	Discharge Date	Covrd Days	Place of Service Code & Desc
	0			$459,273.40	$117,012.85	$117,012.85	$0.00	$0.00	3/20/2006	5/23/2006	###### -Unknown or Not Applicable	3/20/2006	5/23/2006	64	21 - Inpatient Hospital
	0			$297,035.27	$115,575.75	$115,575.75	$0.00	$0.00	12/12/2005	1/11/2006	###### -Unknown or Not Applicable	12/12/2005	1/11/2006	30	21 - Inpatient Hospital
	0			$11,858.74	$108,675.18	$108,675.18	$0.00	$0.00	12/9/2005	12/11/2005	###### -Unknown or Not Applicable	12/9/2005	12/11/2005	2	21 - Inpatient Hospital
	0			$27,697.10	$108,675.18	$108,675.18	$0.00	$0.00	4/16/2006	4/20/2006	###### -Unknown or Not Applicable	4/16/2006	4/20/2006	4	21 - Inpatient Hospital

B Run Date: 4/2/2007
Run Time: 3:25:32 PM

User ID: tztsbl

Cabinet for Health and Family Services

Department for Medicaid Services

Paid Claims Hi-Low

Lowest Paid Claims

Paid date range: 6/1/2006- 6/30/2006

Claim Type: A - INST XOVER CLAIMS

ICN	Detail Num	Billing Provider Numbers	Member ID	Billed Amount	Allowed Amount	Paid Amount	TPL Amount	Medicare Paid Amount	From Date of Service	To Date of Service	Procedure Code & Desc	Admission Date	Discharge Date	Covrd Days	Place of Service Code & Desc
	0			$6,524.55	$0.13	$0.13	$0.00	$1,827.24	4/4/2006	4/6/2006	###### - Unknown or Not Applicable	4/4/2006	4/6/2006	2	21 - Inpatient Hospital
	0			$23.48	$0.33	$0.33	$0.00	$93.92	4/26/2006	4/28/2006	97532 - Cognitive Skills Development	4/26/2006	4/28/2006	0	21 - Inpatient Hospital
	0			$0.39	$0.39	$0.39	$0.00	$19.87	12/1/2005	12/31/2005	36415 - Routine Venipuncture	6/5/2004	12/31/2299	0	21 - Inpatient Hospital
	0			$0.39	$0.39	$0.39	$0.00	$56.17	6/1/2005	6/30/2005	81001 - Urinalysis, Auto W/Scope	1/13/2004	12/31/2299	0	21 - Inpatient Hospital

Claim Type: I - INPATIENT CLAIMS

ICN	Detail Num	Billing Provider Numbers	Member ID	Billed Amount	Allowed Amount	Paid Amount	TPL Amount	Medicare Paid Amount	From Date of Service	To Date of Service	Procedure Code & Desc	Admission Date	Discharge Date	Covrd Days	Place of Service Code & Desc
	0			$3,025.00	$12.32	$12.32	$2,750.00	$0.00	10/1/2005	10/12/2005	###### - Unknown or Not Applicable	12/14/2004	10/12/2005	11	21 - Inpatient Hospital
	0			$3,152.37	$13.61	$13.61	$2,475.00	$0.00	3/22/2006	3/24/2006	###### - Unknown or Not Applicable	3/22/2006	3/24/2006	2	21 - Inpatient Hospital
	0			$2,601.21	$26.06	$26.06	$2,080.98	$0.00	4/8/2006	4/10/2006	###### - Unknown or Not Applicable	4/8/2006	4/10/2006	2	21 - Inpatient Hospital

C

Report Notes

Report Description

This report displays the 100 highest paid and lowest paid claims by claim type for the specified claim type(s). Highest paid claims are sorted from highest paid amounts to lowest. Lowest paid claims are sorted from lowest paid amount to hightest.

Report Tabs

A. Highest Paid Claims
B. Lowest Paid Claims

Search Criteria:

Latest claims only
Paid claims only
Paid amount > 0
Paid date range as specified in the user prompt
Claim types as specified in the user prompt

Report Location:

This report can be retrieved from the 'DSS Reports' folder or 'DSS Reports\Legacy DSS Reports" category.

2.8.44.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A,B) Allowed Amount	Amount approved to pay for services provided to a member.	10	Number (Decimal)	T_CA_ICN	AMT_ALWD
(A,B) Billed	Amount billed	13	Number (Decimal)	T_CA_ICN	AMT_BILLED

Field	Description	Length	Data Type	DB Table	DB Attributes
Amount					
(A,B) Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in the Medicaid program.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
(A,B) Blood Deduct	The blood deductible amount from the UB claim form.	8	Number (Decimal)	T_CA_XOVER	AMT_DEDUCT_BLOOD
(A,B) Claim Type	A code to indicate the type of medical assistance invoice used by the provider to bill for the rendered service.	1	Char	T_CA_OCCUR	CDE_CLM_TYPE
(A,B) Dtl Number	The claim detail number.	4	Number (Integer)	T_CA_ICN	NUM_DTL
(A,B) From Date of Service	First date of service.	10	Date (CCYY/MM/DD)	T_CA_ICN	DTE_FIRST_SVC
(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	Char	T_CA_ICN	NUM_ICN

Field	Description	Length	Data Type	DB Table	DB Attributes
(A,B) Medicare Coinsurance Amount	The Medicare coinsurance amount for the claim.	8	Number (Decimal)	T_CA_XOVER	AMT_COINSURANCE
(A,B) Medicare Paid Amount	Amount paid by Medicare.	10	Number (Decimal)	T_CA_XOVER	AMT_MCARE_PAID
(A,B) Member ID	The unique number assigned to the member.	12	Char	T_CA_ICN	ID_MEDICAID
(A,B) Paid Amount	Amount that is applied toward the check amount.	13	Number	T_CA_ICN	AMT_PAID

2.8.44.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.44.5 Associated Requirements

ID
30.090.014.003.2

2.8.44.6 Change Orders

ID	Name	Description
1593	Paid Claim Hi/Low Report	Lists the 100 highest paid and 100 lowest paid physician claims. Lists the 25 highest and lowest paid non-institutional/other claims. Lists the 50 highest and lowest paid claims for each of the other claim types. The frequency of this report is weekly. (KYMC8700-R001)

ID	Name	Description
4272	Paid Claims Hi - Low Report	This defect covers all issues related to: CO 1593 - Paid Claims Hi - Low

2.8.45 DSS - Paid Claims History -- Paid Claims History

The Paid Claims History report generates a history of paid claims for a given Member(s) during a specific date of service range.

There are 2 tabs in this report:

A. Paid Claims History Report

B. Report Notes tab describing the conditions used to create the report.

2.8.45.1 Technical Name

DSS - Paid Claims History

2.8.45.2 Paid Claims History Layout

A

Run Date: 8/24/2006
Run Time: 4:43:04 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: qz00tr

Paid Claims History

Member ID(s): 000001869
From Date of Service Range: 9/1/2004 - 9/30/2004

Billing Provider Name	Billing Provider Full Address	From Date of Service	To Date of Service	Medicare Submitted	Primary Diagnosis Code & Desc	Primary Procedure Code & Desc	Paid Amount	Payment Date
NEWLAND, MARK S	6027 NE 1ST ST SALEM, KY 97501-8008	09/01/2004	09/02/2004	Y	95901 - EAD INJURY UNSPEC UN	###### -	$700.00	03/31/2005
NEWLAND, MARK S	6027 NE 1ST ST SALEM, KY 97501-8008	09/04/2004	09/05/2004	Y	95901 - EAD INJURY UNSPEC UN	###### -	$700.00	04/22/2005

End of Report

B

Report Notes

Report Description

The Paid Claims History report generates a history of paid claims for a given Member(s) during a specific date of service range.

Search Criteria

From Date of Service - Begin and end date range entered in the prompt
Member ID(s) - Member ID(s) entered in the prompt, separated by a semi-colon
FFS Claims Only - Fee for Service filter
Latest Claims only - will give you only the latest version of a claim even if it was previously

Supplemental Documentation

Medicare Submitted is Claim Types = Crossover codes (A, B or C) then Yes Else No.

2.8.45.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Full Address	Provider address including city, state, and zip code.	101	Char	T_PR_ADR	ADR_BILL_STRT1,*_STRT2, *_CITY,*_STATE,*_ZIP,*_ZIP4
Billing Provider Name	The name of the provider of Medicaid services as used on official state records	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
Medicare Submitted	The Line item total bill charged to Medicare. Claim types equal to crossover.	1	Char	N/A	calculation
Paid Amount	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Payment Date	The date on which a payment was generated from the MMIS claim transaction.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID
Primary Diagnosis Code & Desc	The name or English description of the diagnosis code.	47	Char	T_CA_ICN, T_DIAGNOSIS	CDE_DIAG_PRIM || DSC_25
Primary Procedure Code & Desc	The generally accepted nomenclature for medical, surgical, dental, and so on, procedure.	46	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC_PRIM || DSC_PROC

Field	Description	Length	Data Type	DB Table	DB Attributes
To Date of Service	This is the line item through date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC

2.8.45.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.45.5 Associated Requirements

ID
30.050.015.002.6

2.8.45.6 Change Orders

ID	Name	Description
1459	Paid Claims History	Develop the Paid Claims History Report according to specifications.
4273	Paid Claims History Report	This defect covers all issues related to: CO 1459 - Paid Claims History

2.8.46 DSS - Performance Report Card -- Performance Report Card

The Performance Report Card report lists requirements that have been measured and the associated status for each month.

2.8.46.1 Technical Name

DSS - Performance Report Card

2.8.46.2 Performance Report Card Layout

Run Date: 10/05/2005 **Cabinet for Health and Family Services** Run Time: 1:15:36 PM

Department for Medicaid Services

Performance Report Card

Performance Requirement: XXXXXXXXXX

Status Date (YYYY/MM): 2005/01
2005/02
2005/03

Performance Requirement	Requirement Description	Status Date	Status
XXXXXXXXXX		2005/01	
XXXXXXXXXX		2005/02	
XXXXXXXXXX		2005/03	

End of Report

2.8.46.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Performance Requirement	Performance requirement to be measured.	20	Char	T_RC_DETAIL	CDE_REQ

Field	Description	Length	Data Type	DB Table	DB Attributes
Requirement Description	Description of the performance requirement to be measured.	250	Char	T_RC_DETAIL	DSC_REQ
Status	Status for the performance requirement. Status can be 1 (Met), 2 (Not Met), and 3 (N/A).	1	Char	T_RC_DETAIL	CDE_STATUS
Status Date	Month and year that status was given for the performance requirement (YYYY/MM).	7	Char	T_RC_DETAIL	DTE_STATUS

2.8.46.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.46.5 Associated Requirements

ID
30.050.015.002.6

2.8.46.6 Change Orders

ID	Name	Description
1619	DSS - Performance Report Card	Produce the Performance Report card according to specifications.

2.8.47 DSS - Preventive Health Payments - DOS -- Preventive Health Payments - DOS

The Preventive Health Payments - DOS report generates a history of preventive health claims during a specific date of service range. It determines preventive health payments for reimbursement.

2.8.47.1 Technical Name

DSS - Preventive Health Payments – DOS

2.8.47.2 Preventive Health Payments - DOS Layout

Run Date: 08/09/2006
Run Time: 3:19:59 PM

Cabinet for Health and Family Services

User ID: tztsbl

Department for Medicaid Services

Preventive Health Payments - DOS

A

From Date of Service Range: 2/1/2005 - 3/31/2006

From Date of Service	Primary Procedure Code & Desc	Paid Amount	Billed Quantity	ICN Undup Count
02/07/2005	E0618 -	$14.50	1	1
02/11/2005	56620 -	$230.00	2	1
03/06/2005	A4250 -	$0.00	1	1
03/07/2005	E0618 -	$14.50	1	1
04/07/2005	E0618 -	$14.50	1	1

End of Report

B

Report Notes

Report Description

The Preventive Health Payments - DOS report generates a history of preventive health claims during a specific date of service range. It determines preventive health payments for reimbursement.

Selection Criteria

From Date of Service per user input
Bill Provider Type equal to 20 (Preventive & Remedial Public Health)
Fee for Service Claims only
Paid Claims only
Latest Claims only

2.8.47.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	The number of units administered for the procedure code billed on this line item.	7	Number	T_CA_ICN	QTY_UNITS_BILLED
From Date of Service	This is the first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
ICN Undup Count	Count of unique ICNs	10	Number	T_CA_ICN	NUM_ICN
Paid Amount	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Primary Procedure Code & Desc	Code detailing the medical procedure performed for this claim detail.	46	Char	T_CA_HDR_DTL	CDE_PROC || DSC_PROC

2.8.47.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.47.5 Associated Requirements

ID
30.050.015.002.6

2.8.47.6 Change Orders

ID	Name	Description
1439	Preventive Health Payments-DOS	Develop the Preventive Health Payments - DOS Report according to specifications.

2.8.48 DSS - Primary Care Rural Health Crossover Cost Savings -- Primary Care Rural Health Crossover Cost Savings

The Primary Care Rural Health Crossover Cost Savings report presents Primary Care and Rural Health Care crossover reimbursement by provider type and provider number; the amount actually paid by KyHealth Choices; the amount that would have been paid prior to the pricing change effective 7/1/02 and after; and the difference between the two amounts. The frequency of this report is monthly.

There are 2 tabs in this report:

A. Primary Care Rural Health Crossover Cost Savings.

B. Report Notes tab describing the conditions used to create the report.

2.8.48.1 Technical Name

DSS - Primary Care Rural Health Crossover Cost Savings

2.8.48.2 Primary Care Rural Health Crossover Cost Savings Layout

Run Date: 11/04/2005 Run Time: 3:40:06 PM

Cabinet for Health and Family Services

Department for Medicaid Services

Primary Care/Rural Health Crossover Cost Savings

For Month Ending: 99/99/9999

Provider Number	Provider Name	Actual Paid Amt	Computed Paid Amt	Cost Containment
9999999999	XXXXXXXXXXXXXXXXXXXXXXXX	$99,999,999.99	$99,999,999.99	$99,999,999.99
9999999999	XXXXXXXXXXXXXXXXXXXXXXXX	$99,999,999.99	$99,999,999.99	$99,999,999.99
9999999999	XXXXXXXXXXXXXXXXXXXXXXXX	$99,999,999.99	$99,999,999.99	$99,999,999.99
	Provider Type 31 Totals:	$99,999,999.99	$99,999,999.99	$99,999,999.99
	Provider Type 35 Totals:	$99,999,999.99	$99,999,999.99	$99,999,999.99

End of Report

2.8.48.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Computed Paid Amount	The amount that would have been paid by Medicaid using pricing logic effective prior to 7/1/02.	13	Number (Decimal)	n/a	calculated
Cost Containment	The difference between the actual paid amount and computed paid amount.	13	Number (Decimal)	n/a	calculated
Paid Amount	The amount paid to the provider by Medicaid.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Provider Name	The provider name of the billing provider.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
Provider Numbers	The provider number.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
Provider Type Code 31 Totals	The grand totals for provider type 31 & description	52	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM || DSC_PROV_TYPE
Provider Type Code 35 Totals	The grand totals for provider type 35 & description.	52	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM || DSC_PROV_TYPE

2.8.48.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.48.5 Associated Requirements

ID
30.090.014.003.2

2.8.48.6 Change Orders

ID	Name	Description
No associated Change Orders found.		

2.8.49 DSS - Provider Denial Rates Above 50 Percent -- Provider Denial Rates Above 50 Percent

The Provider Denial Rates Above 50 Percent report lists providers who have 50% of the claims submitted denied. The frequency of this report is monthly.

2.8.49.1 Technical Name

DSS - Provider Denial Rates Above 50 Percent

2.8.49.2 Provider Denial Rates Above 50 Percent Layout

A

Run Date: 8/3/2006
Run Time: 3:21:43 PM

User ID: qzndgg

Cabinet for Health and Family Services
Department for Medicaid Services

Provider Denial Rates Above 50%

Billing Provider IDs	Denied Claim Count	Denied Percentage
NPI ID: 0101256600 Medicaid ID: 100217209C Base ID: 10021721	11	100.00 %
NPI ID: 1000000023 Medicaid ID: 100000359A Base ID: 10000036	5	100.00 %
NPI ID: 1000000055 Medicaid ID: 100006669A Base ID: 10000667	6	100.00 %
NPI ID: 1000000055 Medicaid ID: 100006669B Base ID: 10000667	1	100.00 %

End of Report

B

Report Notes

Report Description

This report lists providers who have 50% of the claims submitted denied. The frequency of this report is monthly.

Search Criteria

Select providers where # of denied claims > # paid claims for the reporting period.

2.8.49.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Denial Percentage	The percentage of denied claims for the month.	5	Number (Decimal)	N/A	Calculated
Denied Claim Count	The number of denied claims for the month.	6	Number (Decimal)	T_CA_ICN	CNT_CLAIMS_DENIED
Billing Provider Numbers	Provider Number	9	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE

2.8.49.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.49.5 Associated Requirements

ID
30.090.014.003.2

2.8.49.6 Change Orders

ID	Name	Description
1594	Provider Denial Rates	Lists providers who have 50% of the claims submitted denied. The frequency of this report is monthly. (KYMC9300-R001)
4274	Provider Denial Rate Report	This defect covers all issues related to: CO 1594 - Provider Denial Rates Above 50 Percent

2.8.50 DSS - Provider History -- Provider History

The Provider History Report generates a history of claims for a given Provider(s). It is used in billing reviews to determine any overpayments made by the KyHealth Choices program.

There are 2 tabs in this report:

A. Provider History Report.

B. Report Notes tab describing the conditions used to create the report.

2.8.50.1 Technical Name

DSS - Provider History

2.8.50.2 Provider History Layout

A

Run Date: 8/28/2006
Run Time: 3:13:41 PM

Cabinet for Health and Family Services

User ID: qz00tr

Department for Medicaid Services

Provider History

Billing Provider Number(s): 10023628
Member ID(s): 000001346
From Date of Service Range: 1/1/2000 - 12/31/2006

Billing Provider Numbers: NPI ID: 1000000473
Medicaid ID: 100236279A - DALLES, MICKEY A
Base ID: 10023628

Member ID: 000001346 - WATERS, ZELDA B

ICN	Detail Number	Primary Procedure Code & Desc	From Date of Service	To Date of Service	Paid Amount	Billed Quantity
2005087300043	0	####### -	01/01/2005	01/01/2005	$0.00	1
2005076300037	0	####### -	02/01/2005	02/01/2005	$100.00	1
2005080300085	0	####### -	02/01/2005	02/01/2005	$25.30	1
2005077300006	0	####### -	02/15/2005	02/15/2005	$20.46	1
2005087130019	0	####### -	02/15/2005	02/15/2005	$0.00	1
2005077130001	0	####### -	03/01/2005	03/01/2005	$65.00	1
2005080300086	0	####### -	03/15/2005	03/15/2005	$0.00	1
2005086300080	0	####### -	03/15/2005	03/15/2005	$17.46	1

B

Report Notes

Report Description

The Provider History Report generates a history of claims for a given Provider(s). It is used in billing reviews to determine any overpayments made by the Medicaid Program.

Search Criteria

From Date of Service Range - From begin & end date range of service entered in the user prompt
Member ID(s) - Member ID(s) separated by a semi-colon in the user prompt
Billing Provider Number(s) - Billing Provider NPI, Medicaid or Base Number(s) separated by a semi-colon in the user prompt
FFS Claims Only - Fee for Service filter
Latest Claims Only filter

2.8.50.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	The sum of all charges associated with an individual claim.	12	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED
Billing Provider Name	Provider Name	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in the Medicaid program.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
Detail Number	Number of Detail on Claim	4	Number	T_CA_ICN	NUM_DTL
From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
Member ID	The first Identification number assigned to a member upon initial certification for participation in the Medicaid program and the member's full name.	12	Char	T_CA_ICN, T_RE_BASE_DN	ID_MEDICAID, NAM_LAST||NAM_FIRST||N

Field	Description	Length	Data Type	DB Table	DB Attributes
Paid Amount	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Primary Procedure Code & Desc	Code detailing the medical procedure performed for this claim detail.	46	Char	T_CA_ICN,T_CDE_PROC	CDE_PROC_PRIM || DSC_PROC
To Date of Service	This is the line item last date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC

2.8.50.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.50.5 Associated Requirements

ID
30.050.015.002.6

2.8.50.6 Change Orders

ID	Name	Description
1460	Provider History	Develop the Provider History Report according to specifications.
4275	Provider History Report	This defect covers all issues related to: CO 1460 - Provider History Report

2.8.51 DSS - Provider Type 55-56 (16) Ex by Proc -- Provider Type 55-56 (16) Transportation Expenditures by Procedure

The Provider Type 55-56 (016) Transportation Expenditures by Procedure report lists summary totals by procedure code by provider type 55 and 56 providers with a specialty of (016) and report totals. The Report is split into claim types N and B. The frequency of this report is monthly.

8/22/06, During Development, claim type N (Professional) is now M.

There are 2 tabs in this report:

A. Provider Type 55-56(Spec016) Trans Exp by Procedure Report

B. Report Notes tab describing the conditions used to create the report.

2.8.51.1 Technical Name

DSS - Provider Type 55-56 (16) Ex by Proc

2.8.51.2 Provider Type 55-56 (16) Transportation Expenditures by Procedure Layout

A

Run Date: 8/22/2006
Run Time: 12:53:26 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: qz00tr

Provider Type 55 and 56 (Spec 016)
Transportation Expenditures by Procedure

Payment Date Range: 4/1/2000 - 4/30/2006

Claim Type & Description: B - HCFA 1500 XOVER CLAIMS

Primary Procedure Code & Desc	Total Claim Count	Denied Claim Count	Paid Amount	Average Paid Amount Per Procedure
###### -	2	2	$0.00	$0.00
71020 -	2	2	$0.00	$0.00
99171 -	1	1	$0.00	$0.00
99211 -	2	2	$0.00	$0.00
99212 -	1	1	$0.00	$0.00
99213 -	1	1	$0.00	$0.00
99271 -	3	2	$37.00	$37.00
99371 -	2	2	$0.00	$0.00
A6219 -	3	3	$0.00	$0.00
Claim Type B Totals:	**17**	**16**	**$37.00**	**$37.00**

Claim Type & Description: M - HCFA 1500 CLAIMS

Primary Procedure Code & Desc	Total Claim Count	Denied Claim Count	Paid Amount	Average Paid Amount Per Procedure
###### -	10	10	$0.00	$0.00

B

Report Notes

Report Description

The Provider Type 55-56 (016) Transportation Expenditures by Procedure report lists summary totals by procedure code by provider type 55 and 56 providers with a specialty of (016) and report totals. The Report is split into claim types M and B. The frequency of this report is monthly. Average Paid Amount Per Procedure equals (Paid Amount/Total Paid Amount).

Search Criteria

Billing Provider Type Code - equal to 55 (Emergency Transporation)
Billing Provider Type Code - equal to 56 (Non-Emergency Transportation) with Billing Provider Specialty Code 016 (Emergency)
Payment Date Range - begin and end payment range entered in user prompt
Latest Claims Only
Professional Claims Only - Claim Type = M (Professional) and B (Professional Crossover)

2.8.51.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Average to Paid Amount Per Procedure	The average expenditure on the given procedure code.	9	Number (Decimal)	n/a	calculated
Claim Type & Description	Type of claim & description being reported.	51	Char	T_CA_CLAIM_KEY	CDE_CLM_TYPE || DSC_CLM_TYPE
Denied Claim Count	The denied claim count for the procedure code for the provider.	9	Number (Integer)	T_CA_ICN	CNT_CLAIMS_DENIED
Paid Amount	The total amount paid for the procedure code listed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Paid Claims Count	The paid claim count for the procedure code.	9	Number (Integer)	T_CA_ICN	CNT_CLAIMS_PAID
Primary Procedure Code & Desc	The procedure code from the claim.	46	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC_PRIM || DSC_PROC
Total Claim Count	Total claims submitted with the procedure code listed.	9	Number (Integer)	T_CA_ICN	CNT_CLAIMS_PAID + CNT_CLAIMS_DENIED

2.8.51.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.51.5 Associated Requirements

ID
30.090.014.003.2

2.8.51.6 Change Orders

ID	Name	Description
1597	Provider Type 55-56 Ex by Proc	This report lists summary totals by procedure code by provider type 55 and 56 providers with a specialty of (16) and report totals. The Report is split into claim types N and B. The frequency of this report is monthly. (KYMC9911-R001)

2.8.52 DSS - Provider Type 55-56 (16) Transportation Expenditures by County -- Provider Type 55-56 (16) Transportation Expenditures by County

The Provider Type 55-56 (16) Transportation Expenditures by County report generates financial participation data to assist in planning and controlling program cost. The claims payment amounts are presented by county for select Transportation Providers. The frequency of this report is monthly.

There are 2 tabs in this report:

A. Prov Type 55 and 56(spec016) by County

B. Report Notes tab describing the conditions used to create the report.

2.8.52.1 Technical Name

DSS - Provider Type 55-56 (16) Transportation Expenditures by County

2.8.52.2 Provider Type 55-56 (16) Transportation Expenditures by County Layout

A

Run Date: 8/22/2006
Run Time: 10:37:30 AM

User ID: qz00tr

Cabinet for Health and Family Services
Department for Medicaid Services

Provider Type 55 and 56 (Spec 016)
Transportation Expenditures by County

Payment Date Range: 4/1/2000 - 4/30/2006

County Name	55 - Emergency Transportation	Total
055 - Jackson	$210.00	$210.00

End of Report

B

Report Notes

Report Description

The Provider Type 55-56 (016) Transportation Expenditures by County report generates financial participation data to assist in planning and controlling program cost. The claims payment amounts are presented by county for select Transportation Providers. The frequency of this report is monthly.

Search Criteria

Billing Provider Type Code - equal to 55 (Emergency Tranpsoration)
Billing Provider Type Code - equal to 56 (Non-Emergency Transportation) with Billing Provider Specialty Code 016 (Emergency)
Payment Date Range - begin and end payment range entered in user prompt
Latest Claims Only

2.8.52.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
County Name	The county name and county code.	60	Char	T_CA_PROV_KEY	CDE_SVC_COUNTY ‖DSC_SVC_COUNTY
Total	The total amount of money expended for Provider types 55 and 56 (16) for the county given.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Type 55 - Emergency Transportation	The total amount expended for Provider type 55 in the county listed given.	13	Number (Decimal)	T_CA_ICN	AMT_PAID

2.8.52.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.52.5 Associated Requirements

ID
30.090.014.003.2

2.8.52.6 Change Orders

ID	Name	Description
1598	Provider Type 55-56 Ex by County	To provide financial participation data to assist in planning and controlling program cost. The claims payment amounts are presented by county for select Transportation Providers. The frequency of this report is monthly. (KYMC9911-R002)

2.8.53 DSS - Q6 Modifier Claims Billed for 60 Consecutive Days -- Q6 Modifier Claims Billed for 60 Consecutive Days

The Q6 Modifier Claims Billed for 60 Consecutive Days report generates claims that have billed over 60 consecutive days using the Q6 modifier. The frequency of this report is monthly.

2.8.53.1 Technical Name

DSS - Q6 Modifier Claims Billed for 60 Consecutive Days

2.8.53.2 Q6 Modifier Claims Billed for 60 Consecutive Days Layout

A

Run Date: 8/11/2006
Run Time: 2:50:08 PM

User ID: qzndgg

Cabinet for Health and Family Services
Department for Medicaid Services

Q6 Modifier Claims Billed for 60 Consecutive Days

From Date(s) of Service: 1/1/2004 - 12/31/2004

Billing Provider IDs	Billing Provider Name	From Date of Service	To Date of Service	ICN exceeding 60 days
NPI ID: 1000000204 Medicaid ID: 100102759A Base ID: 10010276	SMITH, JOHN D	04/05/2004	07/05/2004	2205090600012

Billing Provider IDs	Billing Provider Name	From Date of Service	To Date of Service	ICN exceeding 60 days
NPI ID: 1000001203 Medicaid ID: 100692969C Base ID: 10069297	TERRY, SCOTT C	05/12/2004	08/12/2004	2003142600687
		05/12/2004	08/12/2004	2003161600819

B

Report Notes

Report Description

To report Claims that have billed over 60 consecutive days using the Q6 modifier. The frequency of this report is monthly.

Search Criteria

Select claims that have billed over 60 consecutive days using the Q6 modifier.

2.8.53.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Name	The full name of the billing provider	50	Char	T_PR_SVC_LOC	NAME
Billing Provider Number	The ID of the billing provider	10	Char	T_CA_ICN	ID_PROV_BILL
From Date of Service	The first date of service	10	Date (CCYY/MM/DD)	T_CA_ICN	DTE_FIRST_SVC
ICN Exceeding 60 Days	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
To Date of Service	The to date of service	10	Date (CCYY/MM/DD)	T_CA_ICN	DTE_LAST_SVC

2.8.53.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.53.5 Associated Requirements

ID
30.090.014.003.2

2.8.53.6 Change Orders

ID	Name	Description
1595	Q6-Modifier Claims Billed	To report Claims that have billed over 60 consecutive days using the Q6 modifier. The frequency of this report is monthly. (KYMC9515-R001)
4277	Q6 Modifier Claims Billed Report	This defect covers all issues related to:CO 1595 - Q6 Modifier Claims Billed for 60 Consec Days Report

2.8.54 DSS - QIO Monitoring -- QIO Monitoring

The QIO Monitoring report generates a history of claims for a given provider(s) during a specific date of service range. It is utilized to produce monitoring ad hocs for the Quality Improvement Organization (QIO) - first three months of the year.

There are 2 tabs in this report:

A. QIO Monitoring Report.

B. Report Notes tab describing the conditions used to create the report.

2.8.54.1 Technical Name

DSS - QIO Monitoring

2.8.54.2 QIO Monitoring Layout

A

Run Date: 3/22/2007
Run Time: 10:22:39 AM

User ID: tztsbl

Cabinet for Health and Family Services
Department for Medicaid Services
QIO Monitoring

Billing Provider Number(s): ########
From Date of Service Range: 1/1/2005 - 12/31/2006
To Date of Service Range: 1/1/2005 - 12/31/2006

Revenue Code & Desc	Billed Amount Sum	Billed Quantity Sum	ICN	From Date of Service	To Date of Service	Member Case Name (L,FM)	Member ID	Billing Provider Numbers	Paid Amount Sum
0270 - MEDICAL SUPPLIES GENERAL CLASSIFICATION	$103.38	128	4005129049230	03/03/2005	03/03/2005	XXXXXXXXXXXXXX, XXXXX X	##########	NPI: Medicaid Number: ######## Base Number: #########	$51.69
0550 - SKILLED NURSING GERERAL CLASSIFICATION	$240.00	1	4005129049230	03/03/2005	03/03/2005	XXXXXXXXXXXXXX, XXXXX X	##########	NPI: Medicaid Number: ######## Base Number: #########	$83.00
0550 - SKILLED NURSING GERERAL CLASSIFICATION	$240.00	1	4005129049230	03/10/2005	03/10/2005	XXXXXXXXXXXXXX, XXXXX X	##########	NPI: Medicaid Number: ######## Base Number: #########	$83.00
0550 - SKILLED NURSING GERERAL CLASSIFICATION	$240.00	1	4005129049230	03/17/2005	03/17/2005	XXXXXXXXXXXXXX, XXXXX X	##########	NPI: Medicaid Number: ######## Base Number: #########	$83.00

End of Report

B

Report Notes

Report Description

This report generates a history of claims for a given Provider(s) during a specific date of service range. It is utilized to produce monitoring ad hocs for the QIO - first three months of the year.

Search Criteria

From Date of Service Range - From begin & end date range of service entered in the prompt
To Date of Service Range - To begin & end date range of service entered in the prompt
Billing Provider BASE, Medicaid or NPI Number(s) entered in the prompt, separated by semi-colon
FFS Claims Only filter
Latest Claims Only filter

2.8.54.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Amount Sum	The amount billed for the procedure.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
Billed Quantity	The number of units administered for the procedure code billed on this line item.	13	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in the Medicaid program.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
Member Case Name (L,FM)	The member's full name, as it appears in Medicaid case files.	36	Char	T_RE_CASE	NAM_LAST||NAM_FIRST|| NAM_MID_INIT
Member ID	The first Identification number assigned to a member upon initial certification for Participation in the	12	Char	T_CA_ICN	ID_MEDICAID

Field	Description	Length	Data Type	DB Table	DB Attributes
	program.				
Paid Amount Sum	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Revenue Code & Description	The line item revenue code and description billed on the UB-92 claim (describes the service performed).	74	Char	T_CA_HDR_DTL, T_CDE_REVENUE	CDE_REVENUE || DSC_REVENUE
To Date of Service	This is the line item through date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC

2.8.54.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.54.5 Associated Requirements

ID
30.050.015.002.6

2.8.54.6 Change Orders

ID	Name	Description
1447	QIO Monitoring	Develop the QIO Monitoring Report according to specifications.
4546	PRO Monitoring Rpt	This defect covers all issues related to CO 1447 - PRO Monitoring Report

2.8.55 DSS - Ranking of Prov Type 60 and 61 by Total Paid Dollar -- Ranking of Prov Type 60 and 61 by Total Paid Dollar

Ranking of Prov Type 60 and 61 by total Paid Dollar ranks all the provider falling under 60 and 61 by their total paid dollar amount for previous quarter.

2.8.55.1 Technical Name

DSS - Ranking of Prov Type 60 and 61 by Total Paid Dollar

2.8.55.2 Ranking of Prov Type 60 and 61 by Total Paid Dollar Layout

A

Run Date: 10/31/2007

KYMM7200-R005

Page 1

Cabinet for Health and Family Services

Department for Medicaid Services

Ranking of Prov Type 60 and 61 by Total Paid Dollar

For QTR Ending: 9/30/2007

Rank	Provider ID	Billing Provider Specialty Code & Desc	Total Paid Amount
1	60052388	273 - Orthodontist	$526,314.00
2	60039286	273 - Orthodontist	$485,485.30
3	60070075	274 - Pediatric Dentist	$283,980.91
4	60062635	273 - Orthodontist	$282,521.00
5	60053303	273 - Orthodontist	$256,907.64
6	61942827	273 - Orthodontist	$240,305.50
7	60057825	271 - General Dentistry Practitioner	$203,967.80
8	60066883	271 - General Dentistry Practitioner	$191,090.10
9	61941274	272 - Oral Surgeon	$185,349.70
10	61900593	271 - General Dentistry Practitioner	$163,656.20
11	61942801	610 - Multi Specialty Group - Dental	$162,881.70
12	60063591	271 - General Dentistry Practitioner	$159,679.50
13	60002300	272 - Oral Surgeon	$151,773.20
14	60053196	271 - General Dentistry Practitioner	$151,447.40
15	60037165	273 - Orthodontist	$148,973.00
16	61900700	271 - General Dentistry Practitioner	$146,341.30
17	61942892	271 - General Dentistry Practitioner	$137,096.60
18	60050770	271 - General Dentistry Practitioner	$132,673.70
19	60072360	271 - General Dentistry Practitioner	$131,827.90
20	60049392	272 - Oral Surgeon	$128,881.30
21	60054665	274 - Pediatric Dentist	$124,471.50
22	60066834	271 - General Dentistry Practitioner	$124,073.00
23	60043189	273 - Orthodontist	$122,269.00

B

Report Notes

Report Description

Ranking of Prov Type 60 and 61 by total Paid Dollar ranks all the provider falling under 60 and 61 by their total paid dollar amount for previous quarter.

Search Criteria

The paid date is between previous quarter begin and end for paid claims.

Fee For Service

Provider Type 60 and 61

2.8.55.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Speciality Code and Description	Billing Provider Speciality Code and Description	100	Char	T_CA_PROV_KEY	CDE_PROV_SPEC_PRIM and DSC_PROV_SPEC
Provider ID	Provider Medicaid Number	10	Number	T_CA_ICN	ID_Provider_Mcaid
Rank	Ranks the Provider based on the Paid amount	3	Number	T_CA_ICN	amt_paid

Field	Description	Length	Data Type	DB Table	DB Attributes
Total Paid Amount	Total Paid Amount for that specific Provider	10	Number (Decimal)	T_CA_ICN	amt_paid

2.8.55.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.55.5 Associated Requirements

ID
No associated Requirements found.

2.8.55.6 Change Orders

ID	Name	Description
No associated Change Orders found.		

2.8.56 DSS - Ranking of Provider Type 55 and 56 (16) -- Ranking of Provider Type 55 and 56 (16)

The Ranking of Provider Type 55 and 56 (16) report separately groups provider types 55 and 56, with a specialty of 16, by amount expended per provider. The frequency of this report is monthly.

There are 2 tabs in this report:

A. Rank of Provider Type 55 and 56 (Spec 016) Report.

B. Report Notes tab describing the conditions used to create the report.

2.8.56.1 Technical Name

DSS - Ranking of Provider Type 55 and 56 (16)

2.8.56.2 Ranking of Provider Type 55 and 56 (16) Layout

A

Run Date: 8/18/2006
Run Time: 11:34:55 AM

User ID: qz00tr

Cabinet for Health and Family Services
Department for Medicaid Services

Ranking of Provider Type 55 and Provider Type 56 (Spec 016)

Payment Date Range: 4/1/2005 - 4/30/2005

Provider Type & Description: 55 - Emergency Transportation

Rank	Billing Provider IDs	Total Claim Count	Paid Claim Count	Denied Claim Count	Paid Amount
1	NPI ID: 1000000305 Medicaid ID: 100179699B Base ID: 10017970	9	9	0	$210.00
	Prov Type 55 Totals:	**9**	**9**	**0**	**$210.00**

	Grand Total:	**9**	**9**	**0**	**$210.00**

End of Report

B

Report Notes

Report Description

The Ranking of Provider Type 55 and 56 (16) report groups provider types 55 and 56 with a specialty of 16 separately by amount expended per provider. The frequency of this report is monthly.

Search Criteria

Billing Provider Type Code - equal to 55 (Emergency Transportation)
Billing Provider Type Code - equal to 56 (Non-Emergency Transportation) with Billing Provider Specialty Code 016 (Emergency)
Payment Date Range - Begin and end payment date range in user prompt
Rank Billing Provider Numbers by Paid Amount
Latest Claims Only

2.8.56.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider IDs	The provider identification number used by the provider.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
Denied Claim Count	Total claims denied to the provider.	9	Number (Integer)	T_CA_ICN	CNT_CLAIMS_DENIED
Paid Amount	Total paid to provider.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Paid Claim Count	Total claims paid to the provider	9	Number (Integer)	T_CA_ICN	CNT_CLAIMS_PAID
Provider Type & Description	The billing provider's type and description.	52	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM
Rank	The relative rank of provider per paid amount	6	Number (Integer)	N/A	Calculated
Total Claim Count	Total claims submitted by the provider.	9	Number (Integer)	T_CA_ICN	CNT_CLAIMS_PAID,CNT_CLAIMS_DENIED

2.8.56.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.56.5 Associated Requirements

ID

ID
30.090.014.003.2

2.8.56.6 Change Orders

ID	Name	Description
1599	Ranking of Providers	This report ranks provider types 55, and 56 with a specialty of 16, by amount paid. The frequency of this report is monthly. (KYMC9911-R003)

2.8.57 DSS - Ray Prior Auth -- Ray Prior Auth

The Ray Prior Auth report generates a list of all SCL providers and original Member IDs during a specific date of service range. The output of this report is fed into a monthly incident report that covers all of the SCL providers.

There are 2 tabs in this report:

A. Ray Prior Auth Report.

B. Report Notes tab describing the conditions used to create the report.

2.8.57.1 Technical Name

DSS - Ray Prior Auth

2.8.57.2 Ray Prior Auth Layout

A

Run Date: 9/20/2006
Run Time: 9:35:19 AM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: qz00tr

Ray Prior Auth

Authorization End Date: 1/31/2000

Authorization Prior Auth End Date	Requesting Provider Medicaid Number	Member ID
06/01/2001	100015999A	000001265
06/02/2001		
06/03/2001		
06/06/2001		
06/11/2001		
07/30/2001		

End of Report

B

Report Notes

Report Description

This report generates a list of all SCL providers and original Member IDs during a specific date of service range. The output of this report is feed into a monthly Incident Report that covers all of the SCL Providers.

Search Criteria

Authorization End Date - Authorized Prior Authorization stop date entered in the prompt
Assignment code = 50 (Waiver SCL)

2.8.57.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Authorizaton Prior Auth End Date	The ending effective date of a service/prior authorization.	10	Date (MM/DD/CCYY)	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Member ID	The first identification number assigned to a member upon initial certification for participation in the program.	12	Char	T_RE_BASE_DN	ID_MEDICAID
Requesting Provider Medicaid Number	A unique number assigned by the state to each provider of services participating in the Medicaid program.	15	Char	T_CA_PROV_KEY	ID_PROV_MCAID

2.8.57.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.57.5 Associated Requirements

ID
30.050.015.002.6

2.8.57.6 Change Orders

ID	Name	Description
1452	Ray Prior Auth	Develop the Ray Prior Authorization Report according to specifications.

2.8.58 DSS - SCL 2005 -- SCL 2005

The SCL 2005 report generates the year-to-date unduplicated individuals served and the total number of units paid by KyHealth Choices. It is sorted by procedure code. The outputs of this report are placed in a spreadsheet that is used by management to monitor the expenditures and number of individuals served in the waiver program.

There are 2 tabs in this report:

A. SCL 2005.

B. Report Notes tab describing the conditions used to create the report.

2.8.58.1 Technical Name

DSS - SCL 2005

2.8.58.2 SCL 2005 Layout

A

Run Date: 8/8/2006
Run Time: 10:53:15 AM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: qz00tr

SCL 2005

From Date of Service Range: 1/1/1998 - 12/31/2005

Paid Amount	Member Undup Count	Primary Procedure Code & Desc	Revenue Code & Description	Billed Quantity
$161.21	24	99271 -	-	92
$26.07	1	99271 -	0150 - Room-Board/Ward	1
$0.00	1	99271 -	0155 - Hospice/Ward	1
$0.00	1	99271 -	0652 - Hospice Services/Continuous Home Care	1
$0.00	1	99271 -	0656 - Hospice Services/General Inpatient Care	1
$236.25	9	99271 -	#### - Unknown or Not Applicable	650

End of Report

B

Report Notes

Report Description

This report generates the year to date unduplicated individuals served and the total number of units paid by Medicaid sorted by procedure code. The outputs of this report are placed in a spreadsheet that is used by management to monitor the expenditures and number of individuals served in the waiver program.

Search Criteria

From Date of Service - Begin and End date range entered in the prompt
Bill Provider Type - Type of provider rendering service equal to 33 (SCL)

2.8.58.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	The sum of the number of units administered for the procedure code billed on this line item.	11	Number	T_CA_ICN	QTY_UNITS_BILLED
Member Undup Count	The unique count of the first Identification number assigned to a member upon initial certification for Participation in the program.	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Primary Procedure Code & Desc	Code & description detailing the medical procedure performed for this claim detail.	46	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC_PRIM || DSC_PROC
Revenue Code & Description	The line item revenue code & description billed on the UB-92 claim (describes the service performed).	74	Char	T_CA_HDR_DTL, T_CDE_REVENUE	CDE_REVENUE || DSC_REVENUE

2.8.58.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.58.5 Associated Requirements

ID
30.050.015.002.6

2.8.58.6 Change Orders

ID	Name	Description
1453	SCL 2005	Develop the SCL 2005 Report according to specifications.

2.8.59 DSS - SCL Hi Intensity Summary -- SCL Hi Intensity Summary

The SCL Hi Intensity Summary report generates paid claim data for SCL members with a 'hi intensity' indicator of "Y" on the SNAP Data File. The frequency of this report is monthly.

There are 2 tabs in this report:

A. SCL Hi Intensity Summary Report.

B. Report Notes tab describing the conditions used to create the report.

2.8.59.1 Technical Name

DSS - SCL Hi Intensity Summary

2.8.59.2 SCL Hi Intensity Summary Layout

Run Date: 11/8/2006

Run Time: 12:09:59 PM

User ID: tztsbl

Cabinet for Health and Family Services

Department for Medicaid Services

SCL Hi Intensity Summary

For Cycle Ending: 07/28/2006

Member ID	Member Full Name (L,FM)	Waiver Days	Hi Days	Hi Intnsty	Billing Provider Numbers	Billing Provider Name	New Ind	Primary Procedure Code & Desc	Paid Amount	Billed Qty	Projected Yearly Cost

Report Notes

Report Description

This report will identify members that show up on the SNAP file and have SCL waiver. SNAP was developed to provide a reliable method for determining the level or intensity of needs for a person with developmental disabilities.

Report Columns:
Member ID - Member ID
Member Full Name - Member name
Waiver Days - Days between the effective date of SCL Waiver and the latest cycle end date.
Hi Days - Days between the SNAP effective date and the SNAP end date or the latest cycle end date, whichever is less
Hi Intsty - High intensity indicator from SNAP file
Billing Provider Numbers - Billing provider Base, NPI, and Medicaid numbers
Billing Provider Name - Billing provider name
New Ind - Indicator set to 'Y' if the claim provider enrollment date >= 1/1/2000, otherwise set to 'N'
Primary Procedure Code & Description - The procedure from the claim
Paid Amount - Paid amount from the claim
Billed Qty - Number of items billed from the claim
Projected Yearly Cost - Paid Amount / Number of Hi Intensity Days truncated to 2 decimal places then multiplied by 365

Selection Criteria

Paid claims only
Latest claims only
From date of service is between SNAP effective and end dates
From date of service is during current fiscal year
Member has SCL Waiver program
Medical claims only (Claim type 'M' and 'B')

Note: From date of service for detail billed claims is defined as the earliest from date of service of all the details on the claim.

2.8.59.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	The total units of service for the service being reported.	12	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED
Billing Provider Name	The name of the provider who submitted the claim.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
Billing Provider Numbers	The provider number of the provider who submitted the claim.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
Hi Days	The number of days the member has been Hi-intensity.	5	Number (Integer)	n/a	Calculated
Hi Intensity	High intensity indicator from snap file.	1	Char	T_RE_SNAP_STATE	IND_INTENSITY
Member Full Name (L,FM)	Member name.	36	Char	T_RE_BASE_DN	NAM_FIRST,NAM_LAST, NAM_MID_INIT
Member ID	Member Medicaid identification number.	12	Char	T_CA_ICN	ID_MEDICAID
New Ind	Indicates if the provider is considered a 'new' provider.	1	Char	n/a	Calculated
Paid Amount	The paid amount for the service being reported.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Primary Procedure	The procedure code and description of	46	Char	T_CA_ICN,T_CD	CDE_PROC_PRIM ||

Field	Description	Length	Data Type	DB Table	DB Attributes
Code & Desc	the service being reported.			E_PROC	DSC_PROC
Projected Yearly Cost	The projected yearly cost for the service being reported.	13	Number (Decimal)	N/A	Calculated
Waiver Days	The number of days the member has been SCL-eligible.	5	Number (Integer)	n/a	Calculated

2.8.59.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.59.5 Associated Requirements

ID
30.090.014.003.2

2.8.59.6 Change Orders

ID	Name	Description
1603	SCL Hi Intensity Summary	Reports paid claim data for SCL members with a `hi intensity' indicator of 'Y' on the SNAP Data File. The frequency of this report is monthly. (KYMC9919-R001)

2.8.60 DSS - School Based Procedure Code Summary -- School Based Procedure Code Summary

The School Based Procedure Code Summary report list procedure codes, Modifier and Total Claim Paid Amounts for the reporting quarter for School Based claims (provider type 21). The frequency of this report is quarterly.

There are 2 tabs in this report:

A. School Based Procedure Code Summary report.

B. Report Notes tab describing the conditions used to create the report.

2.8.60.1 Technical Name

DSS - School Based Procedure Code Summary

2.8.60.2 School Based Procedure Code Summary Layout

A

Run Date: 9/15/2006
Run Time: 10:11:47 AM

User ID: qz00tr

Cabinet for Health and Family Services
Department for Medicaid Services

School Based Procedure Code Summary

Payment Date Range: 8/1/2004 - 11/30/2005

Primary Procedure Code & Desc	First Modifier Code & Description	Second Modifier Code & Description	Third Modifier Code & Description	Fourth Modifier Code & Description	Paid Amount
63030 - Laminotomy (Hemilaminectomy), For Decomp	## - Unknown	## - Unknown	## - Unknown	## - Unknown	$1,160.00
	80 - ASSISTANT SURGEON	## - Unknown	## - Unknown	## - Unknown	$747.75
	50 - BILATERAL PROCEDURE	## - Unknown	## - Unknown	## - Unknown	$124.00
				Procedure Total:	**$2,031.75**
				Report Total:	**$2,031.75**

End of Report

B

Report Notes

Report Description

The School Based Procedure Code Summary report list Procedure Codes, Modifier and Total Claim Paid Amounts for the reporting quarter for School Based claims (provider type 21) The frequency of this report is quarterly.

Search Criteria

Billing Provider Type Code = 21 (School Based Claims)
Payment Date - Payment begin and end date entered in user prompt
Latest Claims Only
Paid Claims Only
FFS Only
Claim Type = M (Professional)

2.8.60.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
First Modifier Code & Description	The procedure code modifier from the claim.	42	Char	T_CA_ICN,T_MODIFIER	CDE_MODIFIER_1 || DSC_MODIFIER
First Procedure Code & Desc	The code and description of the procedure code on the claim.	46	Char	T_CA_ICN,T_CDE_PROC	CDE_PROC_PRIM || DSC_PROC
Forth Modifier Code & Desc	Fourth procedure code modifier from the claim.	42	Char	T_CA_ICN,T_MODIFIER	CDE_MODIFIER_4 || DSC_MODIFIER
Paid Amount	The total claim paid amount for the procedure code.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Second Modifier Code & Description	Second procedure code modifier from the claim.	42	Char	T_CA_ICN,T_MODIFIER	CDE_MODIFIER_2 || DSC_MODIFIER
Third Modifier Code & Desc	Third procedure code modifier from the claim.	42	Char	T_CA_ICN,T_MODIFIER	CDE_MODIFIER_3 || DSC_MODIFIER

2.8.60.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.60.5 Associated Requirements

ID
30.090.014.003.2

2.8.60.6 Change Orders

ID	Name	Description
1600	School Based Procedure Code Summ	This report list procedure codes, Modifier and Total Claim Paid Amounts for the reporting quarter for School Based claims (provider type 21). The frequency of this report is quarterly. (KYMC9912-R001)

2.8.61 DSS - Support for Community Living Member -- Support for Community Living Member

The Support for Community Living Member report generates a list of members with current and original ID for a given provider(s). It is used in billing reviews to determine any overpayments made by the KyHealth Choices program.

There are 2 tabs in this report:

A. Support for Community Living Member report.

B. Report Notes tab describing the conditions used to create the report.

2.8.61.1 Technical Name

DSS - Support for Community Living Member

2.8.61.2 Support for Community Living Member Layout

A

Run Date: 9/19/2006
Run Time: 5:10:49 PM

User ID: qz00tr

Cabinet for Health and Family Services

Department for Medicaid Services

Support for Community Living Member

Billing Provider Number(s): 10006879; 10009707
From Date of Service Range: 1/1/1998 - 12/31/2005
Payment Date Range: 1/1/2000 - 12/31/2005

Billing Provider Numbers	Billing Provider Name	Member ID	Member Full Name (L,FM)
NPI ID: 1000000124 Medicaid ID: 100068789A Base ID: 10006879	THOMAS, JANE D	000041369	CHILDERS, ISABELLA
Member ID Count: 1			
NPI ID: 1000000184 Medicaid ID: 100097069A Base ID: 10009707	TALYLOR, JOHN G	000002483	HUGULEY, TIM S
Member ID Count: 1			

End of Report

B

Report Notes

Report Description

The Support for Community Living Member report generates a list of Members with Current and Original ID for a given Provider(s). It is used in billing reviews to determine any overpayments made by the Medicaid Program.

Search Criteria

Billing Provider Numbers - Billing Provider Base, Medicaid or NPI Numbers entered in the user prompt, separated by semicolon
From Date of Service Range - Begin and end date range entered in the user prompt
Payment Date Range - Begin and end date range entered in the user prompt
Latest Claims Only
Billing Provider Type Code = 33 (Support Community Living)

2.8.61.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Name	The name of the provider.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in the Medicaid program	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
Member Full Name (L, FM)	The name of the member.	36	Char	T_RE_BASE_DN	NAM_LAST,NAM_FIRST, NAM_MID_INIT
Member ID	The first Identification number assigned to a member upon initial certification for Participation in the program.	12	Char	T_CA_ICN	ID_MEDICAID

2.8.61.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.61.5 Associated Requirements

ID
30.050.015.002.6

2.8.61.6 Change Orders

ID	Name	Description
1461	Support for Comm Living Member	Develop the Support for Community Living Member Report according to specifications.

2.8.62 DSS - Unduplicated Members -- Unduplicated Members

The Unduplicated Members report generates a grand total unduplicated count of KyHealth Choices members for whom nursing facilities have filed claims during a specific date of service range. This is primarily used for a budgeting initiative called 'Measures of Success'.

2.8.62.1 Technical Name

DSS - Unduplicated Members

2.8.62.2 Unduplicated Members Layout

Run Date: 08/10/2006
Run Time: 9:05:32 AM

A

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: tztsbl

Unduplicated Members

From Date of Service Range: 01/01/2000 - 08/01/2006

Nursing Home Member Count: 1

End of Report

B

Report Notes

Report Description

The Unduplicated Members report generates a grand total unduplicated count of Medicaid members that Nursing Facilities have filed claims during a specific date of service range. This is primarily used for a budgeting initiative called the Measures of Success.

Search Criteria

From Date of Service per user input
Latest Claims only
Paid Claims only
Fee for Service only
Bill Provider Type equal to 12 (Nursing Home)

2.8.62.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Nursing Home Member Count	The number of unique/distinct original member IDs.	12	Char	T_CA_ICN	ID_MEDICAID

2.8.62.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.62.5 Associated Requirements

ID
30.050.015.002.6

2.8.62.6 Change Orders

ID	Name	Description
1437	Unduplicated Members/Month	Develop the Unduplicated Members/Month Report according to specifications.
4278	Unduplicated Members Report	This defect covers all issues related to: CO 1437 - Unduplicated Members Report

2.8.63 DSS - University of Louisville Providers -- University of Louisville Providers Billing Under FEIN 611014882

The University of Louisville Providers Billing Under FEIN 611014882 report lists all physician clinic billing under FEIN 611014882 giving month to date and year to date totals. The frequency of this report is monthly.

2.8.63.1 Technical Name

DSS - University of Louisville Providers

2.8.63.2 University of Louisville Providers Billing Under FEIN 611014882 Layout

A

Run Date: 8/17/2006
Run Time: 2:53:21 PM

User ID: qzndgg

Cabinet for Health and Family Services
Department for Medicaid Services

University of Louisville Providers Billing Under FEIN 611014882

For Month: February 2005

Billing Provider IDs	Billing Provider Name	MTD Paid	YTD Paid
NPI ID: 1000001933 Medicaid ID: 100814699A Base ID: 10081470	UNIVERSITY OF LOUISVILLE	$0.00	$0.00
NPI ID: 1000001934 Medicaid ID: 100817659A Base ID: 10081766	UNIVERSITY OF LOUISVILLE LEXINGTON	$0.00	$0.00
NPI ID: 1000002244 Medicaid ID: 200309550A Base ID: 20030955	UNIVERSITY OF LOUISVILLE, KENTUCKY	$1,971.00	$1,971.00

End of Report

B

Report Notes

Report Description

This report lists all physician clinic billing under FEIN 611014882 giving month to date and year to date totals. The frequency of this report is monthly.

Search Criteria

Select paid claim amounts for providers billing under FEIN 611014882.

2.8.63.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider IDs	Billing provider number	10	Char	T_CA_ICN	ID_PROV_BILL
Billing Provider Name	Billing provider full name	50	Char	T_PR_SVC_LOC	NAME
MTD Paid	Month to date paid amount	13	Number (Decimal)	T_CA_ICN	AMT_PAID
YTD Paid	Year to date paid amount	13	Number (Decimal)	T_CA_ICN	AMT_PAID

2.8.63.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.63.5 Associated Requirements

ID
30.090.014.003.2

2.8.63.6 Change Orders

ID	Name	Description
1596	University of Louisville Provs	This report lists all physician clinic billing under FEIN 611014882 giving month to date and year to date totals. The frequency of this report is monthly. (KYMC9901-R001)
4279	U of L Provs Report	This defect covers all issues related to: CO 1596 - U of L Provs Billing under FEIN 611014882 Report

2.8.64 DSSDM - EIS - Dashboard Measures -- DSSDM - EIS - Dashboard Measures

The executive level Dashboard Measures report provides a broad view of KyHealth Choices program status. The dashboard consists of the following analytics:

Durable Medical Goods

This dashboard analytic displays the quarterly and fiscal year to date amount paid out for durable medical equipment services.

- Initiatives

This dashboard analytic displays a set of speedometers showing paid amounts and member counts for the following initiatives:

- Diabetes - A view of adult members over the age of eighteen receiving diabetes treatment.
- Pediatric Asthma - A view of pediatric members between the ages of five (5) through seventeen (17) with a diagnosis of asthma.
- Pediatric Obesity - A view of pediatric members between the ages of 5-12 with a diagnosis of obesity.
- Cardiac Heart Failure - A view of adult members with a diagnosis of Cardiac.

KCHIP Member Counts

This analytic counts the number of children enrolled in KyHealth Choices and KCHIP. The data is broken down by KCHIP Phase III, KCHIP Phase II, and Non KCHIP KyHealth Choices children

Nursing Facility and ICF/MR Paid Claims

This analytic shows paid amounts for nursing facility and ICF/MR claims along with ancillary paid amounts for nursing facility claims. Monthly and State fiscal year to date amounts are available.

Waiver Paid Claims

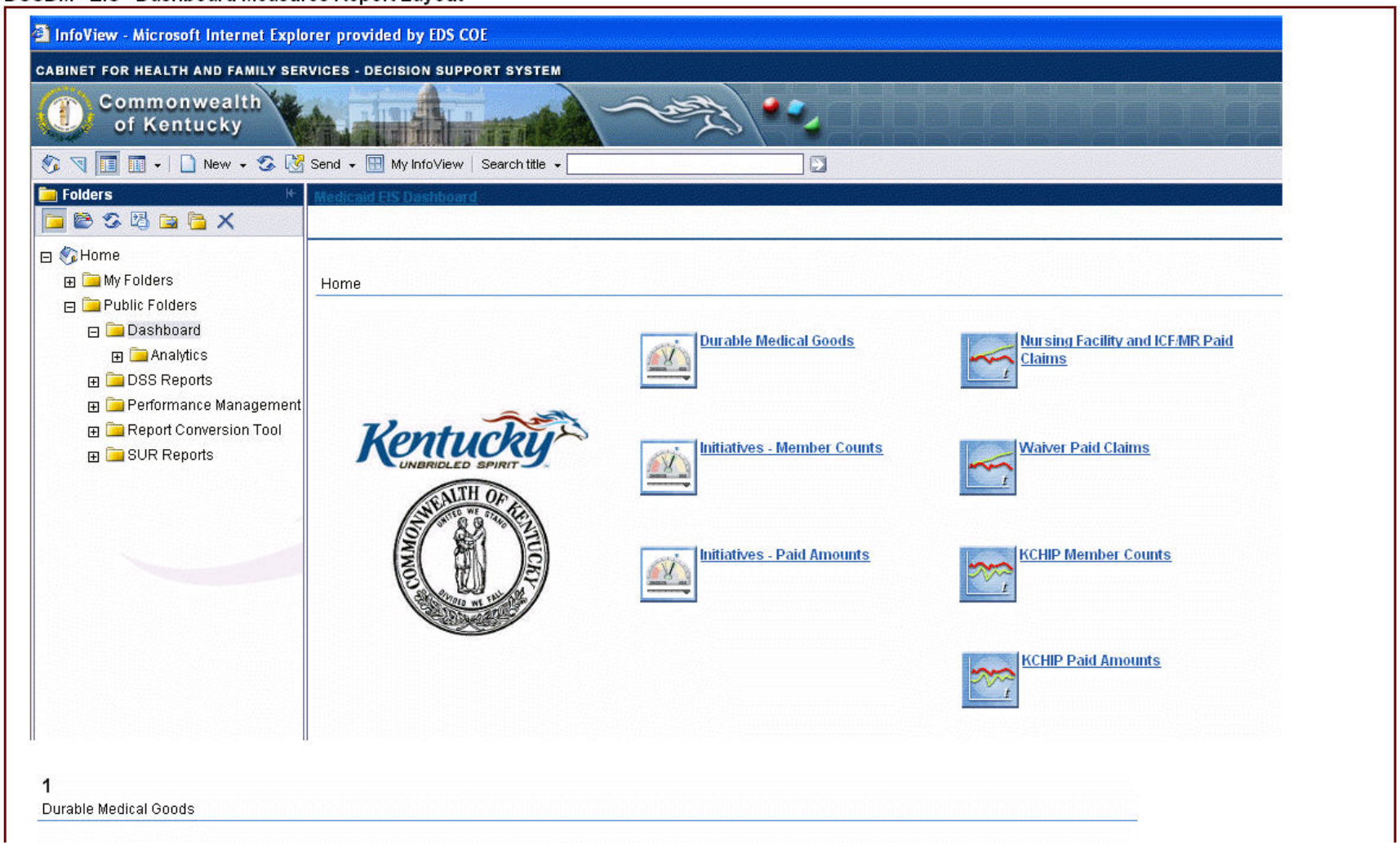
This analytic shows paid amounts for waiver programs along with ancillary paid amounts. Monthly and State fiscal year to date amounts are available.

2.8.64.1 Technical Name

DSSDM - EIS - Dashboard Measures

2.8.64.2 DSSDM - EIS - Dashboard Measures Layout

DSSDM - EIS - Dashboard Measures Report Layout



I

2

Heart Failure Member Count
Provider County
1,336
36,020
33,662
Feb-07
Adult Diabetes Member Count
Provider County
0
5,403
4,502
Feb-07
Pediatric Asthma Member Count
Provider County
862
18,580
14,555
Feb-07
Pediatric Obesity Member Count
Provider County
142
2,955
1,774
Feb-07
Notes
Initiatives - Paid Amounts
Home

2.1

Initiatives Member Counts Analytic Notes

Analytic Description

The cardiac speedemoter gives a count of adult members with a diagnosis of Cardiac. The pediatric obesity speedometer gives a count or members between the ages of 5-12 with a diagnosis of obesity. The pediatric asthma speedometer gives a count of members between the ages of five (5) through seventeen (17) with a diagnosis of asthma. The adult diabetes speedometer gives a count of diabetic members of the age of 18.

Analytic Selection Criteria

- Paid Claims Only
- Latest ClaimOnly

Adult Diabetes Initiative

- Age 18 and older
- Recives one or more of the following drugs:
  - Specific Therapeutic Class = C4G - INSULINS

Cardiac Initiative

- Recives one or more of the following drugs:
  - Specific Therapeutic Class = A4D - HYPOTENSIVES, ACE INHIBITORS
  - Specific Therapeutic Class = R1M - LOOP DIURETICS
  - Specific Therapeutic Class = R1H - POTASSIUM SPARING DIURETICS
  - Specific Therapeutic Class = R1L - POTASSIUM SPARING DIURETICS IN COMBINATION
  - Specific Therapeutic Class = R1F - THIAZIDE AND RELATED DIURETICS
  - Specific Therapeutic Class = J7C - BETA-ADRENERGIC BLOCKING AGENTS
- Or is diagnosed with one of the following
  - 40201 MAL HYPERT HRT DIS W HT FAIL
  - 40211 BENIGN HYP HRT DIS W HT FAIL
  - 40291 HYPERTEN HEART DIS W HT FAIL
  - 40491 UNS HRT/KID HTN W HT FAIL
  - 4280 CONGESTIVE HEART FAILURE UNS
  - 4281 LEFT HEART FAILURE
  - 4282 SYSTOLIC HEART FAILURE
  - 4283 DIASTOLIC HEART FAILURE
  - 4284 SYS/DIASTOLIC HEART FAILURE
  - 4289 HEART FAILURE UNSPEC

Pediatric Asthma Initiative

- Age between 5 and 17
- Recives one or more of the following drugs:
  - AHFS Therapeutic Class = 48120400 - ADRENERGIC AGENTS
  - AHFS Therapeutic Class = 48120000 - BRONCHODILATORS
  - AHFS Therapeutic Class = 48080000 - ANTITUSSIVES
- Or is diagnosed with one of the following
  - 466 AC BRONCHITIS/BRONCHIOLITIS
  - 490 BRONCHITIS UNSPECIFIED
  - 491 CHRONIC BRONCHITIS
  - 4930 EXTRINSIC ASTHMA
  - 49300 EXTRINSIC ASTHMA UNSPEC
  - 49301 EXT ASTHMA W STATUS ASTH
  - 49310 INTRINSIC ASTHMA UNSPEC
  - 49311 INT ASTHMA W STATUS ASTH
  - 49312 INTRINSIC ASTHMA W EXAC
  - 4932 CHRONIC OBSTRUCTIVE ASTHMA
  - 49320 CHR OBSRUCTIVE ASTHMA UNSP
  - 49321 CHR OBS ASTHMA W STAT ASTH
  - 49322 CHR OBSTRUCT ASTHMA W EXAC
  - 4939 ASTHMA UNSPECIFIED
  - 49391 ASTHMA W STATUS ASTHMAT
  - 49392 ASTHMA UNSPEC W EXACERBAT
  - 78602 ORTHOPNEA
  - 78607 WHEEZING

Pediatric Obesity Initiative

- Age between 5 and 17
- Recives one or more of the following drugs:
  - AHFS Therapeutic Class = 24080000 - HYPOTENSIVE AGENTS
  - Specific Therapeutic Class = C4G - INSULINS
  - Specific Therapeutic Class = M4G - HYPERGLYCEMICS
- Or is diagnosed with one of the following
  - 25000 DIABETES UNCOMPL TYPE II
  - 2724 HYPERLIPIDEMIA OT/UNSPEC
  - 2780 OVERWEIGHT AND OBESITY
  - 2781 LOCALIZED ADIPOSITY
  - 4019 HYPERTENSION UNSPEC
  - 7012 ACQ ACANTHOSIS NIGRICANS
  - 7831 ABNORMAL WEIGHT GAIN
  - 7836 POLYPHAGIA
  - V651 PERSON CONSULT FOR ANOTH
  - V653 DIETARY SURVEIL/COUNSEL
  - V6549 OTHER COUNSELING

2.2

Notes

Initiatives - Member Counts

Home

2.3

Initiatives Paid Amounts Analytic Notes

Analytic Description

The cardiac speedemoter gives a sum of paid claim amounts for members with a diagnosis of Cardiac. The pediatric obesity speedometer gives a sum of paid claim amounts for members between the ages of 5-12 with a diagnosis of obesity. The pediatric asthma speedometer gives a sum of paid claim amounts for members between the ages of five (5) through seventeen (17) with a diagnosis of asthma. The adult diabetes speedometer gives a sum of paid claim amounts for diabetic members of the age of 18.

Analytic Selection Criteria

- Paid Claims Only
- Latest ClaimOnly

Adult Diabetes Initiative

- Age 18 and older
- Recives one or more of the following drugs:
  - Specific Therapeutic Class = C4G - INSULINS

Cardiac Initiative

- Recives one or more of the following drugs:
  - Specific Therapeutic Class = A4D - HYPOTENSIVES, ACE INHIBITORS
  - Specific Therapeutic Class = R1M - LOOP DIURETICS
  - Specific Therapeutic Class = R1H - POTASSIUM SPARING DIURETICS
  - Specific Therapeutic Class = R1L - POTASSIUM SPARING DIURETICS IN COMBINATION
  - Specific Therapeutic Class = R1F - THIAZIDE AND RELATED DIURETICS
  - Specific Therapeutic Class = J7C - BETA-ADRENERGIC BLOCKING AGENTS
- Or is diagnosed with one of the following
  - 40201 MAL HYPERT HRT DIS W HT FAIL
  - 40211 BENIGN HYP HRT DIS W HT FAIL
  - 40291 HYPERTEN HEART DIS W HT FAIL
  - 40491 UNS HRT/KID HTN W HT FAIL
  - 4280 CONGESTIVE HEART FAILURE UNS
  - 4281 LEFT HEART FAILURE
  - 4282 SYSTOLIC HEART FAILURE
  - 4283 DIASTOLIC HEART FAILURE
  - 4284 SYS/DIASTOLIC HEART FAILURE
  - 4289 HEART FAILURE UNSPEC

Pediatric Asthma Initiative

- Age between 5 and 17
- Recives one or more of the following drugs:
  - AHFS Therapeutic Class = 48120400 - ADRENERGIC AGENTS
  - AHFS Therapeutic Class = 48120000 - BRONCHODILATORS
  - AHFS Therapeutic Class = 48080000 - ANTITUSSIVES
- Or is diagnosed with one of the following
  - 466 AC BRONCHITIS/BRONCHIOLITIS
  - 490 BRONCHITIS UNSPECIFIED
  - 491 CHRONIC BRONCHITIS
  - 4930 EXTRINSIC ASTHMA
  - 49300 EXTRINSIC ASTHMA UNSPEC
  - 49301 EXT ASTHMA W STATUS ASTH
  - 49310 INTRINSIC ASTHMA UNSPEC
  - 49311 INT ASTHMA W STATUS ASTH
  - 49312 INTRINSIC ASTHMA W EXAC
  - 4932 CHRONIC OBSTRUCTIVE ASTHMA
  - 49320 CHR OBSRUCTIVE ASTHMA UNSP
  - 49321 CHR OBS ASTHMA W STAT ASTH
  - 49322 CHR OBSTRUCT ASTHMA W EXAC
  - 4939 ASTHMA UNSPECIFIED
  - 49391 ASTHMA W STATUS ASTHMAT
  - 49392 ASTHMA UNSPEC W EXACERBAT
  - 78602 ORTHOPNEA
  - 78607 WHEEZING

Pediatric Obesity Initiative

- Age between 5 and 17
- Recives one or more of the following drugs:
  - AHFS Therapeutic Class = 24080000 - HYPOTENSIVE AGENTS
  - Specific Therapeutic Class = C4G - INSULINS
  - Specific Therapeutic Class = M4G - HYPERGLYCEMICS
- Or is diagnosed with one of the following
  - 25000 DIABETES UNCOMPL TYPE II
  - 2724 HYPERLIPIDEMIA OT/UNSPEC
  - 2780 OVERWEIGHT AND OBESITY
  - 2781 LOCALIZED ADIPOSITY
  - 4019 HYPERTENSION UNSPEC
  - 7012 ACQ ACANTHOSIS NIGRICANS
  - 7831 ABNORMAL WEIGHT GAIN
  - 7836 POLYPHAGIA
  - V651 PERSON CONSULT FOR ANOTH
  - V653 DIETARY SURVEIL/COUNSEL
  - V6549 OTHER COUNSELING

3
KCHIP Member Counts

3.1
Notes

KCHIP Member Counts Analytic Notes

Analytic Description

This dashboard will count the number of children enrolled in Medicaid and KCHIP and will be used as a monitoring and analysis tool.

Analytic Selection Criteria

- Paid Claims Only
- Fee For Service Only
- Latest ClaimOnly
- Claim Source Code not Capitation Transaction

KCHIP Phase III

- Aid Category Code is 'I', 'P', or 'KC
- Program Status Code is 'P7'

KCHIP Phase II

- Aid Category Code is 'I', 'P', or 'KC
- Program Status Code is 'P5' or P6'

Non KCHIP Medicaid Children

- Aid Category Code is NOT 'I', 'P', or 'KC
- Program Status Code is NOT 'P5', 'P6', or 'P7' for KCHIP IIII
- Age 17 or Less

ei Press Backspace key to return to previous page

3.2

KCHIP Paid Amounts Notes

Home

KCHIP Member Counts

3.3

KCHIP Paid Amounts Notes

KCHIP Paid Amounts Analytic Notes

Analytic Description

This dashboard will measure expenditure activity for children enrolled in Medicaid and KCHIP and will be used as a monitoring and analysis tool.

Analytic Selection Criteria

- Paid Claims Only
- Fee For Service Only
- Latest ClaimOnly
- Claim Source Code not Capitation Transaction

KCHIP Phase III

- Aid Category Code is 'I', 'P', or 'KC
- Program Status Code is 'P7'

KCHIP Phase II

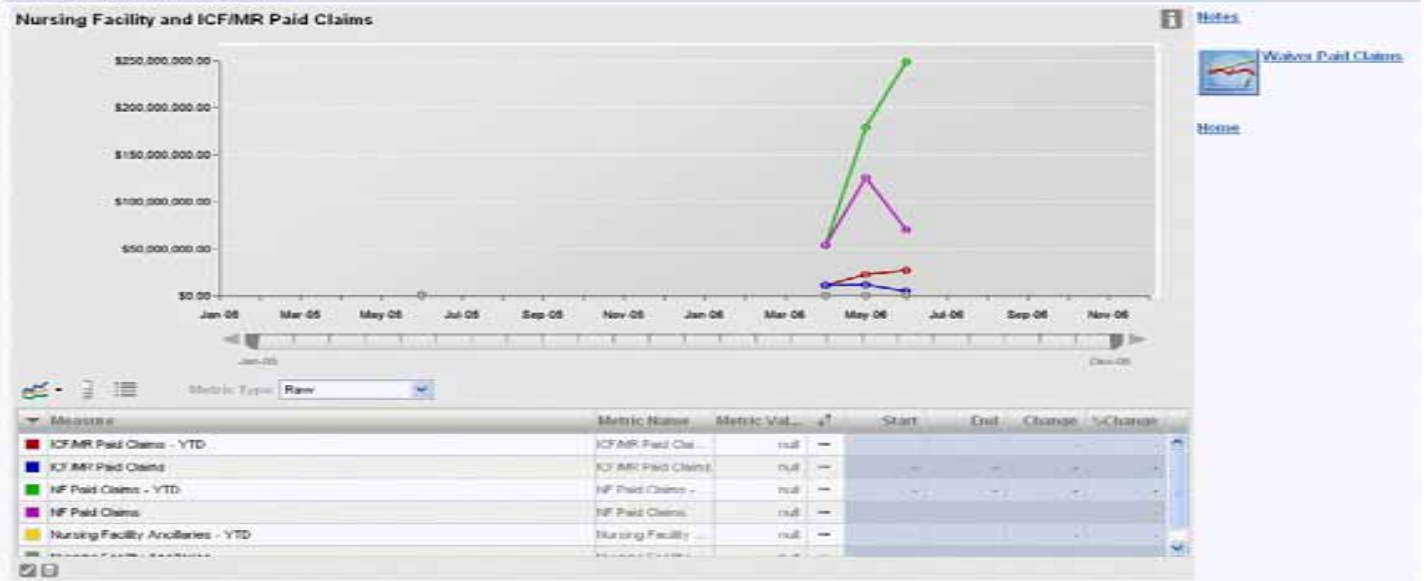
- Aid Category Code is 'I', 'P', or 'KC
- Program Status Code is 'P5' or P6'

Non KCHIP Medicaid Childrenl

- Aid Category Code is NOT 'I', 'P', or 'KC
- Program Status Code is NOT 'P5', 'P6', or 'P7' for KCHIP IIII
- Age 17 or Less

Press backspace key to return to previous page

4
Nursing Facility and ICF/MR Paid Claims



4.1
Nursing Facility and ICF/MR Paid Claims Notes

Nursing Facility and ICF/MR Paid Claims Analytic Notes

Analytic Description

This dashboard will show paid amounts for nursing facility and ICF/MR claims along with ancillary paid amounts for nursing facility claims. Monthly and State fiscal year to date amounts are available.

Analytic Selection Criteria

ICF/MR Paid Claims:

- Paid Claims Only
- Latest ClaimOnly
- Billing provider type is ICF/MR (11)

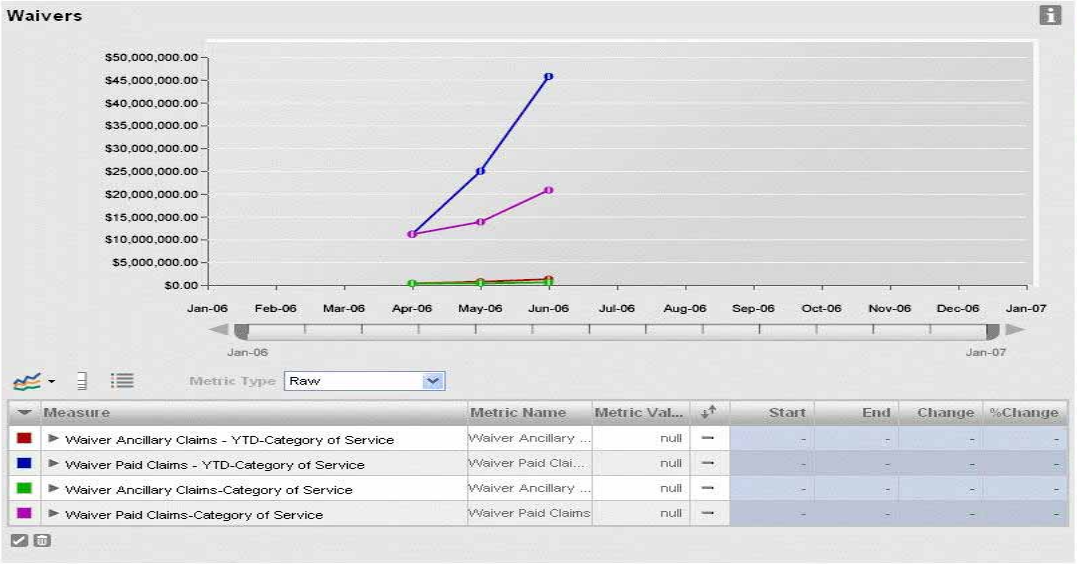
Nursing Facility Paid Claims:

- Paid Claims Only
- Latest ClaimOnly
- Billing provider type is Nursing Facility (12)

Nursing Facility Ancillary PT/OT, Oxygen, or Speech Paid Claims:

- Paid Claims Only
- Latest ClaimOnly
- Billing provider type is Nursing Facility (12)
- Procedure code in 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', or 92508
- or revenue code in '0979', '0440', '0441', '0442', '0443', '0444', '0449', '0277', '0644', '0413', or '0240'

5
Waiver Paid Claims



Notes

Nursing Facility and ICF/MR Paid Claims

Home

5.1
Waiver Paid Claims Analytic Notes

Waiver Paid Claims Analytic Notes

Analytic Description

This dashboard will show paid amount for waiver programs along with ancillary paid amounts. Monthly and State fiscal year to date amounts are available.

Analytic Selection Criteria

- Paid Claims Only
- Latest ClaimOnly

Waiver Paid Claims:

- Catagory of Service is ABI (60) and procedure code in '97535', T1005', 'T2022', 'H0039', 'H0004', '97530','92507', 'S5165', 'S5135', 'H2017', '90853', '97537', 'E1399', 'H0043', or 'T2016'
- Catagory of Service is SCL (50) and procedure code in 'T1005', 'T2022', 'H0039', 'H0004', '90804', '97530', '92507', '97110', 'S5126', 'T2016', 'H0043', 'S5140', 'T2021', 'H2021', 'T1028', '97535', 'E1399', 'H0002', 'H0032'
- Catagory of Service is HCBS (52) and provider type is Home and Community Based Waiver (42) and revenue code in '0590', '0551', '0552', '0581', '0582', '0580', '0660', or '0290'
- Catagory of Service is HCBS (52) and provider type is Adult Day Care (43) and procedure code in 'S5150', 'S5125', 'S5130', 'S5135', or 'T2022'
- Catagory of Service is ADC (53) and procedure code in '97001', '97002', '97110', '97003', '97004', '92506', '92506', 'T1005', 'T1028', 'T1016', or 'S5165'
- Catagory of Service is Model 2 (07) and revenue code in '0552', '0559', or '0410'

Waiver Ancillaries:

- Catagory of Service is SCL (50), ABI (60), or ADC (53)
- Procedure code in '97530', '92507', or '97110'

Press backspace key to return to previous page

2.8.64.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
TBD	N/A	0	Character	N/A	N/A

2.8.64.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.64.5 Associated Requirements

ID
30.090.015.002.16

2.8.64.6 Change Orders

ID	Name	Description
1639	DSSDM - Medicaid EIS Dashboard	Produce the new Kentucky Medicaid Dashboard.

2.8.65 DSSMeasureBase - All Measure Summary -- DSSMeasureBase - All Measure Summary

The All Measures Summary report is created in the DSSMeasureBase. This report displays all pre-defined measures with the number and percentage of the population meeting the criteria of each measure.

There are three tabs on this report. For documentation only, the tabs are lettered A through C. The letters do not display on the actual report.

The tabs on this report are:

A. Measure Summary -- Displays each measure and the number and percentage of the population meeting the criteria of each measure.

B. Measure List -- Displays a listing of each measure source and measure description found on tab A.

C. Report Notes -- Report Notes tab describing the conditions used to create the report.

2.8.65.1 Technical Name

DSSMeasureBase - All Measure Summary

For readability, this layout appears on the following two pages.

2.8.65.2 DSSMeasureBase - All Measure Summary Layout

Run Date: 9/11/2006
Run Time: 4:33:59 PM

User ID: czv6vp

Cabinet for Health and Family Services

Department for Medicaid Services

DSSMeasureBase
Summary of All Measures

Measure Summary

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code and Description	Measure Domain	Measure Source	Measure Code Long Description	Percent Meeting Measure Criteria	Percent Not Meeting Measure Criteria	Numerator Count	Denominator Count	Measure Calculation Type Code and Description	Minimum Performance Standard	Target Value
10 - ADOLESCENT IMMUNIZATIONS - Combination 1	EFFECTIVENESS OF CARE	HEDIS 2005	The percentage of enrolled adolescents 13 years of age, who had a second dose of MMR, and three hepatitis B by their 13TH birthday.	0.00 %	100.00 %	0	2	A - Percentage	0.00 %	0.00 %
11 - ADOLESCENT IMMUNIZATIONS - Combination 2	EFFECTIVENESS OF CARE	HEDIS 2005	The percentage of enrolled adolescents 13 years of age, who had a second dose of MMR, three hepatitis B and 1 VZT by their 13TH birthday.	0.00 %	100.00 %	0	2	A - Percentage	0.00 %	0.00 %
12 - ADOLESCENT IMMUNIZATIONS - MMR	EFFECTIVENESS OF CARE	HEDIS 2005	The percentage of enrolled adolescents 13 years of age, who had a second dose of MMR.	0.00 %	100.00 %	0	2	A - Percentage	0.00 %	0.00 %
13 - ADOLESCENT IMMUNIZATIONS - Hep B	EFFECTIVENESS OF CARE	HEDIS 2005	The percentage of enrolled adolescents 13 years of age, who had Hep B Vaccinations.	0.00 %	100.00 %	0	2	A - Percentage	0.00 %	0.00 %

Run Date: 9/11/2006
Run Time: 4:33:59 PM

User ID: czv6vp

Cabinet for Health and Family Services

Department for Medicaid Services

DSSMeasureBase
Summary of All Measures

Measure List

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code and Description	Measure Source
10 - ADOLESCENT IMMUNIZATIONS - Combination 1	HEDIS 2005
11 - ADOLESCENT IMMUNIZATIONS - Combination 2	HEDIS 2005
12 - ADOLESCENT IMMUNIZATIONS - MMR	HEDIS 2005
13 - ADOLESCENT IMMUNIZATIONS - Hep B	HEDIS 2005
14 - ADOLESCENT IMMUNIZATIONS - VZT	HEDIS 2005
17 - BREAST CANCER SCREENING	HEDIS 2005
18 - CERVICAL CANCER SCREENING	HEDIS 2005
36 - FLU SHOT FOR ADULTS AGE 50-64	HEDIS 2005
37 - FLU SHOT FOR ADULTS AGE 65Plus	HEDIS 2005
38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE	HEDIS 2005
39 - CHILDREN AND ADOLESCENTS ACCESS TO PRIMARY CARE P	HEDIS 2005
40 - CHILDREN AND ADOLESCENTS ACCESS TO PRIMARY CARE P	HEDIS 2005

DSSMeasureBase Reports DSSMeasureBase - All Measure Summary.rep Page 1 of 5

c

Report Notes

Report Description

This report displays all pre-defined measures with the number and percentage of the population meeting the criteria of each measure.
The tabs on this report are:
A. Measure Summary -- Displays each measure and the number and percentage of the population meeting the criteria of each measure.
B. Measure List -- Displays a listing of each measure source and measure description found on tab A.

Search Criteria

None

2.8.65.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Denominator Count	The number of members meeting the high level selection criteria.	6	Number	T_MB_CALC	CNT_DEN
(A) Measure Calculation Type Code and Description	Describes the method of calculation.	20	Char	T_MB_CALC	CDE_CALC_TYPE
(A) Measure Code Long Description	Specific description of the measurement including high level selection parameters.	700	Char	T_MB_DESC	DSC_LONG
(A) Measure Domain	Indicates the generalized area the measurement is evaluating.	50	Char	T_MB_DESC	DSC_MEASURE_DOMAIN
(A) Minimum Performance Standard	The minimum performance standard for the measure.	4	Number	T_MB_DESC	MIN_PERF_STD
(A) Numerator Count	The number of members that received services defined in the measure criteria.	6	Number	T_MB_CALC	CNT_NUM
(A) Percent Meeting Measure Criteria	The percentage of members meeting the high level selection criteria that also received services defined in measure criteria.	5	Number	N/A	calculated
(A) Percent Not Meeting Measure Criteria	The percentage of members meeting the high level selection criteria that did not receive services defined in the measure criteria.	5	Number	N/A	calculated
(A) Target Value	The desired target value for the measurement criteria.	4	Number	T_MB_DESC	TARGET_VAL

Field	Description	Length	Data Type	DB Table	DB Attributes
(A, B) Measure Code and Description	Short description of the measurement.	200	Char	T_MB_CALC	MEASURE_CODE
(A, B) Measure Source	Indicates the source for the measurement criteria.	50	Char	T_MB_DESC	DSC_MEASURE_SOURCE

2.8.65.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.65.5 Associated Requirements

ID
30.090.015.002.20

2.8.65.6 Change Orders

ID	Name	Description
1620	DSSMeasureBase - All Measure	Install the DSSMeasureBase - All Measures Summary Report.
4553	MBase All Measures Summary	This defect covers all issues related to CO 1620 - MBase All Measures Summary

2.8.66 DSSMeasureBase - Denominator Details -- DSSMeasureBase - Denominator Details

The Denominator Details report is created in the DSSMeasureBase. This report provides member detail for denominator members who meet the criteria of the selected measure. The Denominator Details report allows for review of the underlying detail that supports a member meeting the measurement criteria.

There are two tabs on this report. For documentation only, the tabs are lettered A through B. The letters do not display on the actual report.

The tabs on this report are:

A. Denominator Details - Displays all Denominator details for the selected measure.

B. Report Notes - Describing the conditions used to create the report.

2.8.66.1 Technical Name

DSSMeasureBase - Denominator Details

2.8.66.2 DSSMeasureBase - Denominator Details Layout

Run Date: 10/17/2006
Run Time: 10:12:04 AM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Denominator Details
Denominator Members

Measure: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Member ID	Member Name	Member Age	Member County Code and Description	Member Race Code and Description	Member Gender Code	Member Aid Category Code and Description	Member Program Status Code and Description
000001267	HOLLON, EDDIE D	29	055 - Jackson	O - White (Non-Hispanic)	F	A - Aged Indiv 65 and over who receive SSI	AA - AA
000001297	NELSON, YANCY C	31	016 - Butler	B - Black	F	M - Disabled persons	AA - AA
000040540	HARNEY, DEBBIE J	59	041 - Grant	O - White (Non-Hispanic)	F	GP - Blind Indiv who receive State Supp	AA - AA
000041416	RAMIREZ, SAM	51	055 - Jackson	O - White (Non-Hispanic)	F	GP - Blind Indiv who receive State Supp	AA - AA

End of Report

Report Notes

Report Description

This report provides Denominator details information of members who meet the criteria of the selected measure. The Denominator Details report allows for review of the underlying detail that supports a member meeting the measurement criteria.

Search Criteria

Measure Code as specified in the user prompt.

2.8.66.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Member Age	Age of Member	3	Number	T_MB_DEN_RECIP	AGE
Member Aid category Code and Description	Aid Category of member	52	Character	T_MB_DEN_RECIP	CDE_AID_CATEGORY
Member County Code and Description	County code of the Member	10	Character	T_MB_DEN_RECIP	CDE_RECIP_COUNTY
Member Eligible Months	Eligible Months of Member	8	Number	T_ELIGCNT	NUM_CONT_MTH_ELIG
Member Gender Code	Gender Code	21	Character	T_MB_DEN_RECIP	CDE_SEX
Member ID	Member ID and name of Denominator members	12	Number	T_MB_DEN_RECIP	ID_MEDICAID
Member Name	Member Name of Denominator members	90	Character	T_MB_DEN_RECIP	NAME
Member Program Status Code and Description	Program Status of Member	52	Character	T_MB_DEN_RECIP	CDE_PGM_STATUS
Member Race Code and Description	Race code of Member	2	Character	T_MB_DEN_RECIP	CDE_RACE

2.8.66.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.66.5 Associated Requirements

ID
30.090.015.002.20

2.8.66.6 Change Orders

ID	Name	Description
4139	DSSMeasureBase - Denominator Rep	Install the DSSMeasurebase - Denominator Details Report.

2.8.67 DSSMeasureBase - Measure Detail -- DSSMeasureBase - Measure Detail

The Measure Details report is created in the DSSMeasureBase. This report displays the count and percentage of members meeting the criteria of a selected measure. The information is calculated and displayed by several different criteria, including county, age, race, gender, and aid category.

There are multiple tabs on this report. For documentation only, the tabs are lettered A through I. The letters do not display on the actual report.

The tabs on this report are:

A. Measure Summary -- Displays the measure and the number and percentage of members meeting the criteria of the measure;
B. Measure Summary Graphics -- Displays measure information in chart format by gender and aid category;
C. County Analysis -- Displays measure information by county;
D. Age Analysis -- Displays measure information by age;
E. Race Analysis -- Displays measure information by race;
F. Gender Analysis -- Displays measure information by gender;
G. Aid Category -- Displays measure information by aid category;
H. Program Status -- Displays measure information by Program status;
I. Report Notes-- Report Notes tab describing the conditions used to create the report.

2.8.67.1 Technical Name

DSSMeasureBase - Measure Detail

For readability, this layout appears on the following several pages.

2.8.67.2 DSSMeasureBase - Measure Detail Layout

A

Run Date: 9/13/2006
Run Time: 2:54:20 PM

Cabinet for Health and Family Services

Department for Medicaid Services

User ID: czv6vp

DSSMeasureBase
Measure Detail

Measure Summary

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Measure Code and Description	Measure Domain	Measure Source	Measure Code Long Description	Percent Meeting Measure Criteria	Percent Not Meeting Measure Criteria	Numerator Count	Denominator Count	Measure Calculation Type Code and Description	Minimum Performance Standard	Target Value
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA	USE OF SERVICES	HEDIS 2005	This measure summarizes utilization of acute inpatient services in the following categories: All inpatient discharges	0.0000	N/A	0	4	B - Per 1000	0.00 %	0.00 %

End of Report

B

Run Date: 9/13/2006
Run Time: 2:54:20 PM

User ID: czv6vp

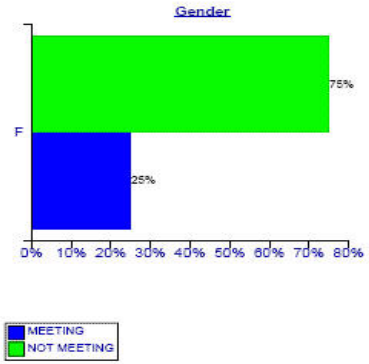
Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Measure Detail

Measure Summary Graphics

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

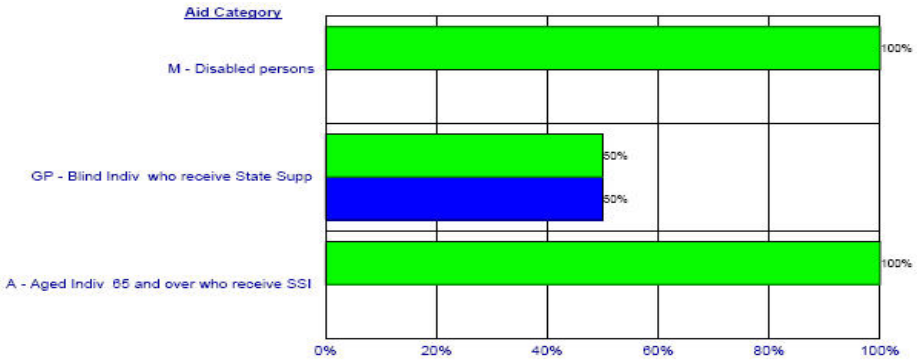
Measure Code: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA



Run Date: 9/13/2006
Run Time: 2:54:20 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services



End of Report

C

Run Date: 9/13/2006
Run Time: 2:54:20 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Measure Detail
County Analysis

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Member County Code and Description	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
016 - Butler	0	1	0.00 %	25.00 %	0.00 %	100.00 %
041 - Grant	0	1	0.00 %	25.00 %	0.00 %	100.00 %
055 - Jackson	1	2	100.00 %	50.00 %	50.00 %	50.00 %
Totals:	1	4	100.00 %	100.00 %	25.00 %	75.00 %

End of Report

D

Run Date: 9/13/2006
Run Time: 2:54:20 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Measure Detail
Age Analysis

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Member Age	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
29	0	1	0.00 %	25.00 %	0.00 %	100.00 %
31	0	1	0.00 %	25.00 %	0.00 %	100.00 %
51	1	1	100.00 %	25.00 %	100.00 %	0.00 %
59	0	1	0.00 %	25.00 %	0.00 %	100.00 %
Totals:	1	4	100.00 %	100.00 %	25.00 %	75.00 %

End of Report

E

Run Date: 9/13/2006
Run Time: 2:54:20 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Measure Detail

Race Analysis

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Member Race Code and Description	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
B - Black	0	1	0.00 %	25.00 %	0.00 %	100.00 %
O - White (Non-Hispanic)	1	3	100.00 %	75.00 %	33.33 %	66.67 %
Totals:	1	4	100.00 %	100.00 %	25.00 %	75.00 %

End of Report

F

Run Date: 9/13/2006
Run Time: 2:54:20 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Measure Detail

Gender Analysis

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Member Gender Code	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
F	1	4	100.00 %	100.00 %	25.00 %	75.00 %
Totals:	1	4	100.00 %	100.00 %	25.00 %	75.00 %

End of Report

G

Run Date: 9/13/2006
Run Time: 2:54:20 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Measure Detail

Aid Category Analysis

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Member Aid Category Code and Description	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
A - Aged Indiv 65 and over who receive SSI	0	1	0.00 %	25.00 %	0.00 %	100.00 %
GP - Blind Indiv who receive State Supp	1	2	100.00 %	50.00 %	50.00 %	50.00 %
M - Disabled persons	0	1	0.00 %	25.00 %	0.00 %	100.00 %
Totals:	1	4	100.00 %	100.00 %	25.00 %	75.00 %

End of Report

H

Run Date: 9/13/2006
Run Time: 2:54:20 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Measure Detail

Program Status Analysis

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Member Program Status Code and Description	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
AA - AA	1	4	100.00 %	100.00 %	25.00 %	75.00 %
	0	4	0.00 %	100.00 %	0.00 %	100.00 %
Totals:	1	4	100.00 %	100.00 %	25.00 %	75.00 %

End of Report

I

Report Notes

Report Description

This report displays the count and percentage of members meeting the criteria of a selected measure. The information is calculated and displayed by several different criteria, including county, age, race, gender, aid category.
The tabs on this report are:
A. Measure Summary -- Displays the measure and the number and percentage of members meeting the criteria of the measure.
B. Measure Summary Graphics -- Displays measure information in chart format by gender and aid category.
C. County Analysis -- Displays measure information by county.
D. Age Analysis -- Displays measure information by age.
E. Race Analysis -- Displays measure information by race.
F. Gender Analysis -- Displays measure information by gender.
G. Aid Category Analysis-- Displays measure information by aid category.
H. Program Status Analysis-- Displays measure information by Program Status.

Search Criteria

Measure Code as specified in the user prompt.

2.8.67.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Denominator Count	The number of members meeting the high level selection criteria	6	Number (Integer)	T_MB_CALC	CNT_DEN
(A) Measure Calculation Type	Describes the method of calculation	20	Char	T_MB_CALC	CDE_CALC_TYPE

Field	Description	Length	Data Type	DB Table	DB Attributes
Code and Description					
(A) Measure Code and Description	Code and short description of the measurement.	200	Char	T_MB_DESC	MEASURE_CODE
(A) Measure Code and Long Description	Specific description of the measurement including high level selection parameters.	100	Char	T_MB_DESC	DSC_LONG
(A) Measure Domain	Indicates the generalized area the measurement is evaluating.	50	Char	T_MB_DESC	DSC_MEASURE_DOMAIN
(A) Measure Source	Indicates the source for the measurement criteria.	50	Char	T_MB_DESC	DSC_MEASURE_SOURCE
(A) Minimum Performance Standard	The minimum performance standard for the measure.	4	Number (Integer)	T_MB_DESC	MIN_PERF_STD
(A) Numerator Count	The number of members that received services defined in the measure criteria	6	Number (Integer)	T_MB_CALC	CNT_NUM
(A) Percent Meeting Measure Criteria	The percentage of members meeting the high level selection criteria that also received services defined in measure criteria.	5	Number (Decimal)	N/A	calculated
(A) Percent Not Meeting Measure	The percentage of members meeting the high level selection criteria that did	5	Number (Decimal)	N/A	calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
Criteria	not receive services defined in the measure criteria. The percentage of members meeting the high level selection criteria that did not receive services defined in the measure criteria.				
(A) Target value	The desired target value for the measurement criteria.	4	Number (Integer)	T_MB_DESC	TARGET_VAL
(C) Member County Code and Description	The county name	40	Char	T_MB_NUM_RECIP	CDE_RECIP_COUNTY
(C-H) All Members For This Measure	The number of members meeting the high level selection criteria.	6	Number (Integer)	N/A	calculated
(C-H) Members Meeting Criteria	The number of members that received services defined in the measure criteria.	6	Number (Integer)	N/A	calculated
(C-H) Percent Meeting	The percentage of members meeting the high level selection criteria that also received services defined in measure criteria.	5	Number (Decimal)	N/A	calculated
(C-H) Percent Not Meeting	The percentage of members meeting the high level selection criteria that did not receive services defined in the measure criteria.	5	Number (Decimal)	N/A	calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
(C-H) Percent Of All Members	The percentage of the total number of members meeting the high level criteria. That is, the percentage of the total for column "All Members For This Measure".	5	Number (Decimal)	N/A	calculated
(C-H) Percent Of All Members Meeting	The percentage of the total number of members meeting the measure criteria. That is, the percentage of the total for column "Members Meeting Criteria".	5	Number (Decimal)	N/A	calculated
(D) Member Age	The age of the members as of the end of the reporting period.	3	Number (Integer)	T_MB_NUM_RECIP	AGE
(E) Member Race Code and Description	The race of the members.	20	Char	T_MB_NUM_RECIP	CDE_RACE
(F) Member Gender Code	The gender of the members	20	Char	T_MB_NUM_RECIP	CDE_SEX
(G) Member Aid Category Code and Description	The aid category of the members as of the end of the reporting period.	40	Char	T_MB_NUM_RECIP	CDE_AID_CATEGORY
(H) Program Status Code and Description	The Programs status of the members as of the end of the reporting period.	40	Char	T_MB_NUM_RECIP	CDE_PGM_STATUS

2.8.67.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.67.5 Associated Requirements

ID
30.090.015.002.20

2.8.67.6 Change Orders

ID	Name	Description
1621	DSSMeasureBase - Measure Detail	Install the DSSMeasureBase - Measure Detail report.
4552	MBase Measure Detail	This defect covers all issues related to Co 1621 - MBase Measure Detail

2.8.68 DSSMeasureBase - Members Not Meeting -- DSSMeasureBase - Members Not Meeting

The Members Not Meeting report is created in the DSSMeasureBase. This report displays names and addresses of the members who do not meet the measure criteria, but do meet the high level selection criterion of the selected measure. The high level criterion is the measure denominator and identifies the population to whom the measure could apply. It allows the user to develop a mailing list for these members.

There are multiple tabs on this report. For workbook documentation only, the tabs are lettered A, B, and so on. Each field name in the Field Descriptions section has a corresponding letter, identifying the tab on which it can be found. The letters do not appear on the actual report.

The tabs on this report are:

A. All Members - Displays all members included in the report.
B. Members by Race - Displays members for a selected race code within the selected measure.
C. Members by County - Displays members for a selected county code within the selected measure.
D. Report Notes - Report Notes tab describing the conditions used to create the report.

2.8.68.1 Technical Name

DSSMeasureBase - Members Not Meeting

For readability, this layout appears on the two several pages.

2.8.68.2 DSSMeasureBase - Members Not Meeting Layout

A

Run Date: 9/13/2006
Run Time: 4:07:10 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Members Not Meeting
All Members
For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Member ID and Name	Member Mailing Address
000001267 - HOLLON, EDDIE D	HOLLON, EDDIE D 1952 ST CHARLES AVE SALEM, KY 97
000001297 - NELSON, YANCY C	NELSON, YANCY C 1281 MAIN ST SALEM, KY 97501-
000040540 - HARNEY, DEBBIE J	HARNEY, DEBBIE J 1516 ST CHARLES AVE PORTLAND, K
3	

End of Report

B

Run Date: 9/13/2006
Run Time: 4:07:10 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Members Not Meeting
Members By Race
For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA
Race Code: All

Member ID and Name	Member Mailing Address
000001267 - HOLLON, EDDIE D	HOLLON, EDDIE D 1952 ST CHARLES AVE SALEM, KY 97
000001297 - NELSON, YANCY C	NELSON, YANCY C 1281 MAIN ST SALEM, KY 97501-
000040540 - HARNEY, DEBBIE J	HARNEY, DEBBIE J 1516 ST CHARLES AVE PORTLAND, K
3	

End of Report

C

Run Date: 9/13/2006
Run Time: 4:07:10 PM

User ID: czv8vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Members Not Meeting
Members By County

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA
County Code: 016 - Butler

Member ID and Name	Member Mailing Address
000001297 - NELSON, YANCY C	NELSON, YANCY C 1281 MAIN ST SALEM, KY 97501-
1	

End of Report

D

Report Notes

Report Description

This report displays names and addresses of the members who do not meet the measure criteria, but do meet the high level selection criteria of the selected measure. The high level criteria is the measure denominator and identifies the population to whom the measure could apply. It allows the user to develop a mailing list for these members.
The tabs on this report are:
A. All Members - Displays all members included in the report.
B. Members by Race - Displays members for a selected race code within the selected measure.
C. Members by County - Displays members for a selected county code within the selected measure.

Search Criteria

Measure Code as specified in the user prompt.

2.8.68.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A-C) Member ID and Name	The ID and name of the member.	50	Char	T_MB_DEN_RECIP	NAM_LAST,NAM_FIRST,NAM_MID_INIT,ID_MEDICAID
(A-C) Member Mailing Address	The ID, name, and full address of the member.	200	Char	T_MB_DEN_RECIP	ADR_STREET_1,ADR_STREET_2, ADR_CITY,ADR_STATE,ADR_ZIP_CODE
(B) Race Code	The race of the members.	20	Char	T_MB_DEN_RECIP	CDE_RACE
(A,B,C) Measure Code	Measure Code and Description Code and short description of the measurement.	200	Char	T_MB_DESC	MEASURE_CODE
(C) County Code	The county of the members.	20	Char	T_MB_DEN_RECIP	CDE_COUNTY

2.8.68.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.68.5 Associated Requirements

ID
30.090.015.002.20

2.8.68.6 Change Orders

ID	Name	Description
1622	DSSMeasureBase - Members not Mtg	Install the DSSMeasurebase - Members Not Meeting Report.
4551	MBase Members not meeting	This defect covers all issues related to CO 1622 - MBase Members not Meeting

2.8.69 DSSMeasureBase - Multiple Measure Details -- DSSMeasureBase - Multiple Measure Details

The Multiple Measure Details report is created in the DSSMeasureBase. This report displays the count and percentage of members meeting the criteria of multiple selected measures. The information is calculated and displayed by several different criteria, including county, age, race, gender, aid category, programs status. This report is very similar to the Measure Details report except it reports on multiple measures that are related, instead of just one measure.

There are multiple tabs on this report. For documentation only, the tabs are lettered A through I. The letters do not display on the actual report.

The tabs on this report are:

A. Measure Summary -- Displays the selected measures and the number and percentage of members meeting the criteria of the selected measures;
B. Measure Summary Graphics -- Displays measure information in chart format by gender and aid category;
C. County Analysis -- Displays measure information by selected county;
D. Age Analysis -- Displays measure information by selected age;
E. Race Analysis -- Displays measure information by selected race;
F. Gender Analysis -- Displays measure information by selected gender;
G. Aid Category -- Displays measure information by selected aid category;
H. Programs Status -- Displays measure information by selected programs status;
I. Report Notes -- Report Notes tab describing the conditions used to create the report.

2.8.69.1 Technical Name

DSSMeasureBase - Multiple Measure Details

For readability, this layout appears on the following several pages.

2.8.69.2 DSSMeasureBase - Multiple Measure Details Layout

A

Run Date: 9/13/2006
Run Time: 2:44:36 PM

User ID: czv6vp

Cabinet for Health and Family Services

Department for Medicaid Services

DSSMeasureBase
Multiple Measure Detail
Measure Summary

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code: 38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Measure Code and Description	Measure Domain	Measure Source	Measure Code Long Description	Percent Meeting Measure Criteria	Percent Not Meeting Measure Criteria	Numerator Count	Denominator Count	Measure Calculation Type Code and Description	Minimum Performance Standard	Target Value
38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE	ACCESS/AVAILABILITY OF CARE	HEDIS 2005	The number of outpatient services for recipients during the measurement year.	0.65 %	99.35 %	1	155	A - Percentage	0.00 %	0.00 %
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA	USE OF SERVICES	HEDIS 2005	This measure summarizes utilization of acute inpatient services in the following categories: All inpatient discharges	0.0000	N/A	0	4	B - Per 1000	0.00 %	0.00 %

End of Report

B

Run Date: 9/13/2006
Run Time: 2:44:38 PM

User ID: ozv6vp

Cabinet for Health and Family Services

Department for Medicaid Services

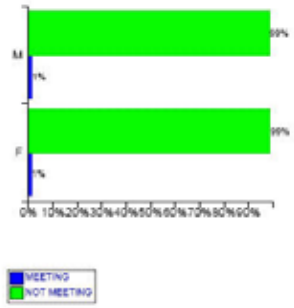
DSSMeasureBase
Multiple Measure Detail

Measure Summary Graphics

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure Code: 38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Gender



Run Date: 9/13/2006
Run Time: 2:44:38 PM

User ID: ozv6vp

Cabinet for Health and Family Services

Department for Medicaid Services

Aid Category

End of Report

C

Run Date: 9/13/2006
Run Time: 2:44:36 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Multiple Measure Detail

County Analysis

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

County: All
Measure Code: 38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Measure Code and Description	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE	1	155	100.00 %	100.00 %	0.65 %	99.35 %
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA	1	4	100.00 %	100.00 %	25.00 %	75.00 %
Totals:	2	159	100.00 %	100.00 %	1.26 %	98.74 %

End of Report

D

Run Date: 9/13/2006
Run Time: 2:44:36 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Multiple Measure Detail

Age Analysis

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Age: All
Measure Code: 38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Measure Code and Description	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE	1	155	100.00 %	100.00 %	0.65 %	99.35 %
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA	1	4	100.00 %	100.00 %	25.00 %	75.00 %
Totals:	2	159	100.00 %	100.00 %	1.26 %	98.74 %

End of Report

G

Run Date: 9/13/2006
Run Time: 2:44:36 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Multiple Measure Detail

Aid Category Analysis

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Aid Category: All
Measure Code: 38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Measure Code and Description	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE	1	155	100.00 %	100.00 %	0.65 %	99.35 %
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA	1	4	100.00 %	100.00 %	25.00 %	75.00 %
Totals:	2	159	100.00 %	100.00 %	1.26 %	98.74 %

End of Report

H

Run Date: 9/13/2006
Run Time: 2:44:36 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Multiple Measure Detail

Program Status Analysis

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Program Status: AA
Measure Code: 38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Measure Code and Description	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE	1	155	100.00 %	100.00 %	0.65 %	99.35 %
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA	1	4	100.00 %	100.00 %	25.00 %	75.00 %
Totals:	2	159	100.00 %	100.00 %	1.26 %	98.74 %

End of Report

G

Run Date: 9/13/2006
Run Time: 2:44:36 PM

Kentucky

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Multiple Measure Detail

Aid Category Analysis

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Aid Category: All
Measure Code: 38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Measure Code and Description	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE	1	155	100.00 %	100.00 %	0.65 %	99.35 %
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA	1	4	100.00 %	100.00 %	25.00 %	75.00 %
Totals:	2	159	100.00 %	100.00 %	1.26 %	98.74 %

End of Report

H

Run Date: 9/13/2006
Run Time: 2:44:36 PM

Kentucky

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Multiple Measure Detail

Program Status Analysis

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Program Status: AA
Measure Code: 38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Measure Code and Description	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE	1	155	100.00 %	100.00 %	0.65 %	99.35 %
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA	1	4	100.00 %	100.00 %	25.00 %	75.00 %
Totals:	2	159	100.00 %	100.00 %	1.26 %	98.74 %

End of Report

I

Report Notes

Report Description

This report displays the count and percentage of members meeting the criteria of a selected measure. The information is calculated and displayed by several different criteria, including county, age, race, gender, aid category.
The tabs on this report are:
A. Measure Summary -- Displays the measure and the number and percentage of members meeting the criteria of the measure.
B. Measure Summary Graphics -- Displays measure information in chart format by gender and aid category.
C. County Analysis -- Displays measure information by county.
D. Age Analysis -- Displays measure information by age.
E. Race Analysis -- Displays measure information by race.
F. Gender Analysis -- Displays measure information by gender.
G. Aid Category Analysis-- Displays measure information by aid category.
H. Program Status Analysis-- Displays measure information by Program Status.

Search Criteria

Measure Code as specified in the user prompt.

2.8.69.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Denominator Count	The number of members meeting the high level selection criteria	6	Number	T_MB_CALC	CNT_DEN
(A) Measure Code and Description	Code and short description of the measurement.	200	Char	T_MB_DESC	MEASURE_CODE

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Measure Code and Long Description	Specific description of the measurement including high level selection parameters.	700	Char	T_MB_DESC	DSC_LONG
(A) Measure Domain	Indicates the generalized area the measurement is evaluating.	50	Char	T_MB_DESC	DSC_MEASURE_DOMAIN
(A) Measure Source	Indicates the source for the measurement criteria.	50	Char	T_MB_DESC	DSC_MEASURE_SOURCE
(A) Minimum Performance Standard	The minimum performance standard for the measure.	4	Number	T_MB_DESC	MIN_PERF_STD
(A) Numerator Count	The number of members that received services defined in the measure criteria	6	Number	T_MB_CALC	CNT_NUM
(A) Percent Meeting Measure Criteria	The percentage of members meeting the high level selection criteria that also received services defined in measure criteria.	5	Number	N/A	calculated
(A) Percent Not Meeting Measure Criteria	The percentage of members meeting the high level selection criteria that did not receive services defined in the measure criteria.	5	Number	N/A	calculated
(A) Target Value	The desired target value for the measurement criteria.	4	Number	T_MB_DESC	TARGET_VAL
(B) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all counties.	5	Number	N/A	calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
(B) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all counties.	5	Number	N/A	calculated
(B-J) All Members For This Measure	The number of members meeting the high level selection criteria.	6	Number	N/A	calculated
(B-J) Measure Code and Description	Short description of the measurement.	200	Char	T_MB_DESC	MEASURE_CODE
(B-J) Members Meeting Criteria	The number of members that received services defined in the measure criteria.	6	Number	N/A	calculated
(B-J) Percent Meeting	The percentage of members meeting the high level selection criteria that also received services defined in measure criteria.	5	Number	N/A	calculated
(B-J) Percent Not Meeting	The percentage of members meeting the high level selection criteria that did not receive services defined in the measure criteria.	5	Number	N/A	calculated
(C) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all ages.	5	Number	N/A	calculated
(C) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all ages.	5	Number	N/A	calculated
(D) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all	5	Number	N/A	calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
	races.				
(D) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all races.	5	Number	N/A	calculated
(E) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all genders.	5	Number	N/A	calculated
(E) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all genders.	5	Number	N/A	calculated
(F) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all eligibility categories.	5	Number	N/A	calculated
(F) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all eligibility categories.	5	Number	N/A	calculated
(G) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all beneficiary categories.	5	Number	N/A	calculated
(G) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all beneficiary categories.	5	Number	N/A	calculated
(H) Percent Of All	The percentage of the total number of members meeting the high level selection criteria for all	5	Number	N/A	calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
Members	geographic service areas.				
(H) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all geographic service areas.	5	Number	N/A	calculated
(I) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all funding sources.	5	Number	N/A	calculated
(I) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all funding sources.	5	Number	N/A	calculated
(J) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all health plans.	5	Number	N/A	calculated
(J) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all health plans.	5	Number	N/A	calculated

2.8.69.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.69.5 Associated Requirements

ID
30.090.015.002.20

2.8.69.6 Change Orders

ID	Name	Description
1623	DSSMeasureBase - Multi Measure	Install the DSSMeasurebase - Multiple Measure Details Report
4550	MBase Multi Measure	This defect covers all issues related to CO 1623 - MBase Multi Measure

2.8.70 DSSMeasureBase - Numerator Details -- DSSMeasureBase - Numerator Details

The Numerator Details report is created in the DSSMeasureBase. This report provides claim level detail for members who meet the criteria of the selected measure. The Numerator Details report allows for review of the underlying detail that supports a member meeting the measurement criteria. The report includes claim level information such as billing provider, servicing provider, diagnosis, procedure code, and so on.

There are multiple tabs on this report. For documentation only, the tabs are lettered A through D. The letters do not display on the actual report.

The tabs on this report are:

A. Numerator Details - Displays all numerator details for the selected measure.
B. Summary by Servicing Provider - Displays summary of numerator details by servicing provider.
C. Summary by Member - Displays summary of numerator details by member.
D. Report Notes - Describes the report and the conditions used to create the report.

2.8.70.1 Technical Name

DSSMeasureBase - Numerator Details

For readability, this layout appears on the following several pages.

2.8.70.2 DSSMeasureBase - Numerator Details Layout

A

Run Date: 10/23/2006
Run Time: 3:48:11 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Numerator Details

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Claim Number	Claim Type & Description	Member ID	Member Full Name	Age	Aid Category Code & Desc	Program Status Code & Desc	Primary Diagnosis Code & Desc
2006193600237	M - HCFA 1500 CLAIMS	000041416	COX, SAM	48	GP - Blind indiv who rec State Suppl	-	V581 - CHEMOTHERAPY

Billing Provider Numbers	Billing Provider Name	Servicing Provider Numbers	Servicing Provider Name
NPI: 1000000176 Medicaid Number: 100094589A Base Number: 100094589	ROBERTS, TRINA O	NPI: 1000000176 Medicaid Number: 100094589A Base Number: 100094589	ROBERTS, TRINA O

Detail Number	From Date of Service	To Date of Service	Billed Amount	Allowed Amount	Paid Amount	Procedure Code & Desc
1	03/25/2004	03/25/2004	$0.00	$0.00	$0.00	99282 - Emergency Department Visit For The Evalu
2	03/26/2004	03/26/2004	$200.00	$0.00	$0.00	99212 - Office Or Other Outpatient Visit For The

Claim Number	Claim Type & Description	Member ID	Member Full Name	Age	Aid Category Code & Desc	Program Status Code & Desc	Primary Diagnosis Code & Desc
5605125250001	A - UB92 INST XOVER CLAIMS	000001346	WATERS, ZELDA B	35	L - Chldrn and their caretaker rel	-	95901 - HEAD INJURY, UNSPECIFIED

Billing Provider Numbers	Billing Provider Name	Servicing Provider Numbers	Servicing Provider Name
NPI: 1000000359 Medicaid Number: 100195369B Base Number: 100195369	SEAMORE X-RAY CLINIC	NPI: ############## Medicaid Number: ############### Base Number: ##############	

Detail Number	From Date of Service	To Date of Service	Billed Amount	Allowed Amount	Paid Amount	Procedure Code & Desc
1	08/01/2004	08/01/2004	$1,000.00	$0.00	$0.00	#### -
2	08/01/2004	08/01/2004	$50.00	$0.00	$0.00	72010 - Radiologic Examination, Spine, Entire, S

Total Members:	2
Total Claim/Encounters:	2
Total Billed:	$1,250.00
Total Allowed:	$0.00
Total Paid:	$0.00

B

Run Date: 10/23/2006
Run Time: 3:48:11 PM

User ID: czv8vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Numerator Details
Summary by Servicing Provider

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Servicing Provider Numbers	Servicing Provider Name	Billed Amount	Allowed Amount	Paid Amount	Member Count
NPI: 1000000176 Medicaid Number: 100094589A Base Number: 100094589	ROBERTS, TRINA O	$200.00	$0.00	$0.00	1
NPI: ############## Medicaid Number: ############### Base Number: ##############		$1,050.00	$0.00	$0.00	1
	Sum:	$1,250.00	$0.00	$0.00	2

End of Report

C

Run Date: 10/23/2006
Run Time: 3:48:11 PM

User ID: czv8vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Numerator Details
Summary by Member

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA

Member ID and Name	Billed Amount	Allowed Amount	Paid Amount	Member Count
000001346 - WATERS, ZELDA B	$1,050.00	$0.00	$0.00	1
000041416 - COX, SAM	$200.00	$0.00	$0.00	1
Sum:	$1,250.00	$0.00	$0.00	2

End of Report

D

Report Notes

Report Description

This report provides claim level detail for members who meet the criteria of the selected measure. The Numerator Details report allows for review of the underlying detail that supports a member meeting the measurement criteria. The report includes claim level information such as billing provider, servicing provider, diagnosis, procedure code, etc.
The tabs on this report are:
A. Numerator Details - Displays all numerator claim details for the selected measure.
B. Summary by Servicing Provider - Displays summary of numerator details by servicing provider.
C. Summary by Member - Displays summary of numerator details by member.

Search Criteria

Measure Code as specified in the user prompt.

2.8.70.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Age	The age of the member.	3	Number	T_CA_ICN	NUM_RECIP_AGE
(A) Aid Category Code & Desc	The member's aid category code.	52	Char	T_CA_RECIP_KEY	CDE_AID_CATEGORY, DSC_AID_CATEGORY
(A) Billing Provider Numbers	The billing provider number and type of provider.	50	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) CLaim Type & Description	The claim type from the claim.	51	Char	T_CA_CLAIM_KEY	CDE_CLM_TYPE
(A) Claim Number	The ICN or specific number assigned a claim to allow tracking of claim.	13	Number	T_CA_ICN	NUM_ICN
(A) Detail Number	The line number of the claim.	3	Number	T_CA_ICN	NUM_DTL
(A) From Date of Service	From date of service.	10	Date (CCYY/MM/DD)	T_CA_ICN	DTE_FIRST_SVC
(A) Member Full Name	The full member name.	50	Char	T_RE_BASE	NAM_LAST, NAM_FIRST, NAM_MID_INIT
(A) Member ID	The member prime ID.	12	Char	T_RE_BASE	ID_MEDICAID
(A) Primary Diagnosis Code & Desc	The Primary Diagnosis Code	50	Char	T_CA_ICN	CDE_DIAG_PRIM
(A) Procedure Code & Desc	The Procedure Code and description	50	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC_PRIM, DSC_PROC
(A) To Date of Service	To date of service	10	Date (CCYY/MM/DD)	T_CA_ICN	DTE_LAST_SVC
(A)Billing Provider Name	Name of the provider. This can be a personal or business name.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER

Field	Description	Length	Data Type	DB Table	DB Attributes
(A)Program Status Code & Desc	The member's eligibility category code.	52	Char	T_CA_RECIP_KEY	CDE_PGM_STATUS, DSC_PGM_STATUS
(A)Servicing Provider Numbers	Name of the provider. This can be a personal or business name.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
(A)Total Allowed	The total allowed amount for the selected Measure.	10	Number	N/A	Calculated
(A)Total Billed	The total billed amount for the selected Measure.	10	Number	N/A	Calculated
(A)Total Claim/Encounters	The total number of claims/encounters for the selected Measure.	10	Number	N/A	Calculated
(A)Total Members	The total number of members for the selected Measure.	10	Number	N/A	Calculated
(A)Total Paid	The total paid amount for the selected measure.	10	Number	N/A	Calculated
(A,B,C) Measure	Measure Code and Description Code and short description of the measurement.	200	Char	T_MB_DESC	MEASURE_CODE
(A-C) Servicing Provider Numbers	The servicing provider number and type of provider.	50	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
(B-C) Allowed	The amount allowed for services.	13	Number	T_CA_ICN	AMT_ALWD

Field	Description	Length	Data Type	DB Table	DB Attributes
Amount					
(B-C) Billed Amount	The amount billed for services.	13	Number	T_CA_ICN	AMT_BILLED
(B-C) Member Count	The number of unduplicated members.	6	Number	n/a	calculated
(B-C) Paid Amount	The amount paid for services.	13	Number	T_CA_ICN	AMT_PAID
(C) Member ID & Name	The member ID and name.	50	Char	T_RE_BASE	NAM_LAST, NAM_FIRST, NAM_MID_INIT

2.8.70.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.70.5 Associated Requirements

ID
30.090.015.002.20

2.8.70.6 Change Orders

ID	Name	Description
1624	DSSMeasureBase - Numerator Dtl	Install the DSSMeasurebase - Numerator Details Report.
4549	MBase Numerator Details	This defect covers all issues related to CO 1624 - MBAse Numerator Details

2.8.71 DSSMeasureBase - Numerator Members -- DSSMeasureBase - Numerator Members

The Numerator Members report is created in the DSSMeasureBase. This report displays names and addresses of all members who meet the criteria of the selected measure. It allows the user to develop a mailing list for these members.

There are multiple tabs on this report. For documentation only, the tabs are lettered A through D. The letters do not display on the actual report.

The tabs on this report are:

A. All Members - Displays all members for the selected measure
B. Members by Race - Displays members for a selected race code within the selected measure.
C. Members by County - Displays members for a selected county code within the selected measure.
D. Report Notes - Report Notes tab describing the conditions used to create the report.

2.8.71.1 Technical Name

DSSMeasureBase - Numerator Members

For readability, this layout appears on the following two pages.

2.8.71.2 DSSMeasureBase - Numerator Members Layout

B

Run Date: 9/13/2006
Run Time: 4:07:49 PM

User ID: czv6vp

Cabinet for Health and Family Services
Department for Medicaid Services

DSSMeasureBase
Numerator Members
Members By Race

For Dates of Service (Core Measure Year): 1/1/2004 - 12/31/2004

Measure : 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA
Race : O - White (Non-Hispanic)

Member ID and Name	Member Mailing Address
000041416 - RAMIREZ, SAM	RAMIREZ, SAM 2597 MAIN ST PORTLAND, KY 975
1	

End of Report

2.8.71.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A-C) Member Mailing Address	The ID, name, and full address of the member.	200	Char	T_MB_NUM_RECIP	ADR_STREET_1,ADR_STREET_2,ADR_CITY,ADR_STATE,ADR_ZIP_CODE
A-C) Member ID and Name	The ID and name of the member.	50	Char	T_MB_NUM_RECIP	NAM_LAST,NAM_FIRST,NAM_MID_INIT,ID_MEDICAID
(B) Race	The race of the members.	20	Char	T_MB_NUM_RECIP	CDE_RACE
(A,B,C) Measure	Measure Code and Description Code and short description of the measurement.	200	Char	T_MB_DESC	MEASURE_CODE

2.8.71.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.71.5 Associated Requirements

ID
30.090.015.002.20

2.8.71.6 Change Orders

ID	Name	Description
1625	DSSMeasureBase - Numerator Memb	Install the DSSMeasurebase - Numerator Members Report.
4548	MBase Numerator Members	This defect covers all issues related to CO 1625 - MBAse Numerator Members

2.8.72 EIS - Drug Company File Listing -- EIS - Drug Company File Listing

The EIS - Drug Company File Listing report contains two tabs:

A. Drug Company File Listing By Name which sorts manufacturers in alphabetical order.
B. Drug Company File Listing By Code which sorts by manufacturer code.

2.8.72.1 Technical Name

EIS - Drug Company File Listing

2.8.72.2 EIS - Drug Company File Listing Layout

A

Run Date: 08/29/2006
Run Time: 4:59:41 PM

Cabinet for Health and Family Services

User ID: wzrdmh

Department For Medicaid Services

Drug Company File Listing

Drug Company File Listing By Code

Labeler Code	Labeler Name
00003	E.R. SQUIBB & SONS, INC.
00004	HOFFMANN-LA ROCHE
00005	LEDERLE LABORATORIES
00006	MERCK & CO., INC.
00007	NOVARTIS
00008	WYETH LABORATORIES
00009	PFIZER, INC
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS
00013	PFIZER, INC.
00014	PHARMACIA CORPORATION

B

Run Date: 08/29/2006
Run Time: 4:59:41 PM

Cabinet for Health and Family Services

User ID: wzrdmh

Department For Medicaid Services

Drug Company File Listing By Name

Labeler Name	Labeler Code
ABLE LABORATORIES INC.	53265
ABRIKA PHARMACEUTICALS, LLLP	67767
ACCUMED PHARMACEUTICALS, INC.	60876
ACORDA THERAPEUTICS, INC.	10144
ACTELION PHARMACEUTICALS	66215
ADAMS LABORATORIES, INC.	63824
ADH HEALTH PRODUCTS, INC.	60142
ADVANCED NUTRITIONAL BANNER PHARMACAPS	10888
ADVANCED REMEDIES INCORPORATED	57685
ADVANCED VISION RESEARCH	58790
ADVANCE PHARMACEUTICALS, INC.	17714
ADVANCIS PHARMACEUTICAL CORPORATION	11042

Report Notes

Report Description

This report will contain two tabs. The first (Drug Company File Listing By Code) will sort by manufacturer code. The second (Drug Company File Listing By Name) will sort manufacturers in alphabetical order.

2.8.72.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A-B)Labeler Code	This code is used to uniquely identify the labeler of a drug. This code is assigned by CMS and is used as the first 5 characters of the labeler's NDCs.	5	Char	T_DRUG_LBLR	CDE_LABELER
(A-B)Labeler Name	The name of the drug labeler.	39	Char	T_DRUG_LBLR	NAME

2.8.72.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.72.5 Associated Requirements

ID
30.050.015.002.6

2.8.72.6 Change Orders

ID	Name	Description
1699	EIS - Drug Company File Listing	The EIS - Drug Company File Listing report contain two tabs. The first (Drug Company File Listing By Name) sorts manufacturers in alphabetical order. The second (Drug Company File Listing By Code) sorts by manufacturer code.

2.8.73 EIS - Member History -- EIS - Member History

The EIS - Member History report contains seven tabs:

A. ICN Information - represents the detailed information of the ICN for a specific member.
B. Summary of Medical Visits- shows the medical visits that a member has made.
C. Summary of ER Visits - shows the ER visits that a member has made.
D. Summary of Prescriptions - shows a summary of the prescriptions for a member.
E. Medical Provider Address Listing - shows the medical provider address listing for a specific member.
F. Outpatient Provider Address Listing - shows the outpatient provider address listing for a specific member.
G. Pharmacy Provider Address Listing - shows the pharmacy provider address listing for a specific member.

2.8.73.1 Technical Name

EIS - Member History

For readability, this layout appears on the following several pages.

2.8.73.2 EIS - Member History Layout

A

Run Date: 10/11/2006
Run Time: 12:28:14 PM

User ID: rztdly

Cabinet for Health and Family Services
Department for Medicaid Services

Member History
ICN Information

Member ID: 000001934
From Dates of Service: 01/01/1996 - 12/01/2006

ICN	Claim Type & Description	FDOS	TDOS	Billed Quantity	Billed Amount	Allowed Amount	Reimbursed Amount	Paid Count	Denied Count	Total Claim Count
2003149130003	D - COMPOUND DRUG CLAIMS	03/05/2003	03/05/2003	1	$275.00	$133.74	$231.74	1	0	1
2003238300001	P - PHARMACY CLAIMS	07/16/2002	07/16/2002	1	$35.00	$2,103.00	$13.00	1	0	1
2003147300013	P - PHARMACY CLAIMS	04/01/2003	04/01/2003	1	$25.00	$934.00	$19.00	1	0	1
2003238300001	P - PHARMACY CLAIMS	07/16/2002	07/16/2002	1	$35.00	$2,103.70	$13.00	1	0	1
2003147300013	P - PHARMACY CLAIMS	04/01/2003	04/01/2003	1	$25.00	$934.98	$19.00	1	0	1
2003149130003	Q - COMPOUND DRUG CLAIMS	03/05/2003	03/05/2003	3	$0.00	$133.00	$231.74	3	0	3
2003149130002	Q - COMPOUND DRUG CLAIMS	03/05/2003	03/05/2003	1	$275.00	$0.00	$0.00	0	1	1

B

Run Date: 10/11/2006
Run Time: 12:28:14 PM

User ID: rztdly

Cabinet for Health and Family Services
Department for Medicaid Services

Member History
Summary of Medical Visits

Member ID: 000001934
From Dates of Service: 01/01/1996 - 12/01/2006

FDOS	Billing Provider Numbers	Billing Provider Name	Primary Diagnosis Code & Desc	Primary Procedure Code & Desc
07/16/2002	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	07882 - EPIDEMIC VOMITING SYND	99211 - Office Or Other Outpatient Visit For The
03/05/2003	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	07882 - EPIDEMIC VOMITING SYND	99211 - Office Or Other Outpatient Visit For The
03/05/2003	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	07882 - EPIDEMIC VOMITING SYND	10160 - Puncture Aspiration Of Abscess, Hematoma
03/05/2003	NPI: Medicaid Number: Base Number:		78660 -	71030 - Radiologic Examination, Chest; Complete

C

Run Date: 10/11/2006
Run Time: 12:28:14 PM

User ID: rztdly

Cabinet for Health and Family Services
Department for Medicaid Services
Member History
Summary of ER Visits

Member ID: 000001934
From Dates of Service: 01/01/1996 - 12/01/2006

FDOS	Billing Provider Numbers	Billing Provider Name	Primary Diagnosis Code & Desc	Primary Procedure Code & Desc
08/13/2002	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	1965 - MAL NEO LYMPH-INGUIN/LEG	###### -

Total Billing Providers:	1
Total Number:	1

D

Run Date: 10/11/2006
Run Time: 12:28:14 PM

User ID: rztdly

Cabinet for Health and Family Services
Department for Medicaid Services
Member History
Summary of Prescriptions

Member ID: 000001934
From Dates of Service: 01/01/1996 - 12/0

Dispensed Date	NDC Code & Description	Quantity Dispensed	Days Supply	Prescription Number	Billing Provider Numbers	Billing Provider Name	Prescribing Provider Numbers	Prescribing Pro Name
07/16/2002	00088120865 - ANZEMET	90	30	2368146	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	NPI: 1000000125 Medicaid Number: 10007085 Base Number: 10007086	NEWLAND, MARK
03/05/2003	########### -	10	10	2587113	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	NPI: 1000000125 Medicaid Number: 10007085 Base Number: 10007086	NEWLAND, MARK
03/05/2003	00078024115 - SANDIMMUNE	10	10	2587113	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	NPI: 1000000125 Medicaid Number: 10007085 Base Number: 10007086	NEWLAND, MARK
03/05/2003	00088120865 - ANZEMET	10	10	2587113	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	NPI: 1000000125 Medicaid Number: 10007085 Base Number: 10007086	NEWLAND, MARK

E

Run Date: 10/11/2006
Run Time: 12:28:14 PM

Cabinet for Health and Family Services

User ID: rztdly

Department for Medicaid Services

Member History

Medical Provider Address Listing

Member ID: 000001934

From Dates of Service: 01/01/1996 - 12/01/2006

Billing Provider Numbers	Provider Name	Street Address	City, State and Zip Code	Billing Prov Specialty Code & Desc	Billing Provider Type Code & Desc
NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	3031 NE 1ST ST	PORTLAND, OR 97501-0000	250 - DME/Medical Supply Dealer	25 - DME/Medical Supply Dealer

End of Report

F

Run Date: 10/11/2006
Run Time: 12:28:14 PM

Cabinet for Health and Family Services

User ID: rztdly

Department for Medicaid Services

Member History

Outpatient Provider Address Listing

Member ID: 000001934

From Dates of Service: 01/01/1996 - 12/01/2006

Billing Provider Numbers	Provider Name	Street Address	City, State, Zip Code	Billing Prov Specialty Code & Desc	Billing Provider Type Code & Desc
NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	5996 PARK AVE DROP CODE 10412	SALEM, OR 97501-8184	016 - Emergency	01 - Hospital

End of Report

G

Run Date: 10/11/2006
Run Time: 12:28:14 PM

User ID: rztdly

Cabinet for Health and Family Services

Department for Medicaid Services

Member History

Pharmacy Provider Address Listing

Member ID: 000001934

From Dates of Service: 01/01/1996 - 12/01/2006

Billing Provider Numbers	Billing Provider Name	Street Address	City, State and Zip Code	Billing Prov Specialty Code & Desc	Billing Provider Type Code & Desc
NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	5871 NE 1ST ST MAIL STOP 10351	PORTLAND, KY 97501-	318 - General Practitioner	64 - Physician Individual

H

Report Notes

Report Description

This report contains seven tabs. The first represents the detailed information of the ICN for a specific recipient. The second shows the medical visits that a recipient has done. The third shows the ER visits that a recipient has done. The fourth tab shows the summary prescriptions for a recipient. The fifth shows the medical provider address listing for a specific recipient. The sixth shows the outpatient provider address listing for a specific recipient the last tab shows the Pharmacy Provider Address Listing.

Search Criteria:

Member ID specified by the user in a prompt.

From date of service range specified by the user in a prompt.

2.8.73.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Allowed Amount	Total amount approved to pay for services provided to a member. This is the amount before copay and TPL are taken out.	13	Number	T_CA_ICN	AMT_ALWD
(A) Billed Amount	Amount of money requested for payment by a provider for services rendered to a member.	13	Number	T_CA_ICN	AMT_BILLED
(A) Billed Quantity	The units of service billed for payment.	9	Number	T_CA_ICN	QTY_UNITS_BILLED
(A) Claim Type & Description	Displays the claim type which is a code to indicate the type of medical assistance invoice used by the provider to bill for the rendered service and description of that claim type.	51	Char	T_CA_ICN	CDE_CLM_TYPE, DSC_CLM_TYPE
(A) Denied Count	Counts the claim as a denied claim.	13	Number	T_CA_ICN	CNT_CLAIMS_DENIED
(A) ICN	Unique control number assigned to the invoice to allow tracking through the system. Sort order: (A) 1	13	Char	T_CA_ICN	NUM_ICN
(A) Paid Amount	The computed amount of payment due a provider for a claim or an adjustment transaction.	13	Number	T_CA_ICN	AMT_PAID
(A) Paid Count	Counts the claims as a paid claim.	13	Number	T_CA_ICN	CNT_CLAIMS_PAID
(A) TDOS	Day procedure was finished.	10	Date	T_CA_ICN	DTE_LAST_SVC

Field	Description	Length	Data Type	DB Table	DB Attributes
			(CCYY/MM/DD)		
(A) Total Claim Count	Summarized paid and denied claim counts.	13	Number	n/a	calculated
(A,B,C) FDOS	Day procedure was started. Sort order: (B,C) 1	10	Date (CCYY/MM/DD)	T_CA_ICN	DTE_FIRST_SVC
(B,C) Primary Diagnosis Code & Desc	The primary ICD-9-CM diagnosis description.	40	Char	T_CA_ICN, T_DIAGNOSIS	CDE_DIAG_PRIM, DSC_25
(B,C) Primary Procedure Code & Desc	The description associated with the primary procedure code.	40	Char	T_CA_ICN, T_CDE_PROC	CD_PROC_PRIM, DSC_PROC
(B,C,E,F,G) Billing Provider Name	The name associated with the organization or person.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
(B,C,E,F,G) Billing Provider Numbers	The concatenation of NPI Provider ID, Medicaid Provider ID and Base ID.	10	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI, ID_PROVIDER_MCAID, ID_PROVIDER_BASE
(C) Total Billing Providers	A count of the billing providers on the EIS - Member History Summary of ER Visits.	13	Number	Calculated	N/A
(C) Total Number	A count of the line items on the EIS - Member History Summary of ER Visits.	13	Number	Calculated	N/A

Field	Description	Length	Data Type	DB Table	DB Attributes
(D) Days Supply	The number of days the prescription should last.	9	Number	T_CA_DRUG	NUM_DAY_SUPPLY
(D) Dispensed Date	The date the prescription was filled. Sort order: (D) 1	0	Date (CCYY/MM/DD)	T_CA_DRUG	DTE_DISPENSE
(D) NDC Description	The NDC code and description. Sort order: (D) 2	40	Char	T_CA_DRUG	CDE_NDC, DSC_NDC
(D) Prescribing Provider Name	Name of the prescribing provider. This can be a personal or business name.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
(D) Prescribing Provider Numbers	ID is used to identify a provider who orders or refers specific services for members.	9	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI, ID_PROVIDER_MCAID, ID_PROVIDER_BASE
(D) Prescription Number	The number assigned to the prescription by the provider.	7	Char	T_CA_DRUG	NUM_PRSCRIP
(D) Quantity Dispensed	The quantity of the drug that was dispensed to the member.	9	Character	T_CA_DRUG	QTY_DISPENSE
(E,F,G) Billing Provider Specialty Code & Desc	The provider specialty code and description.	50	Char	T_CA_PROV_KEY	CDE_PROV_SPEC_PRIM, DSC_PROV_SPEC
(E,F,G) Billing Provider Type Code & Desc	The code and description associated with the billing provider type code.	50	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM, DSC_PROV_TYPE

Field	Description	Length	Data Type	DB Table	DB Attributes
(E,F,G) City, State and Zip Code	Concatenates the provider's city, state and zip code address information into one object.	50	Char	T_CA_PROV_KEY	ADR_SVC_CITY, ADR_SVC_STATE, ADR_SVC_ZIP, ADR_SVC_ZIP4
(E,F,G) Street Address	Concatenates the provider's street 1 and street 2 address information.	50	Char	T_CA_PROV_KEY	ADR_SVC_STRT1, ADR_SVC_STRT2

2.8.73.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.73.5 Associated Requirements

ID
30.050.015.002.6
30.090.007.003.25

2.8.73.6 Change Orders

ID	Name	Description
1700	EIS - Member History	The EIS - Member History report contains seven tabs. The first represents the detailed information of the ICN for a specific member. The second shows the medical visits that a member has done. The third shows the ER visits that a member has done. The fourth tab shows the summary prescriptions for a member. The fifth shows the medical provider address listing for a specific member. The sixth shows the outpatient provider address listing for a specific member the last tab shows the Pharmacy Provider Address Listing.

2.8.74 EIS - Monthly Home Health Visits -- EIS - Monthly Home Health Visits

The EIS - Monthly Home Health Visits report lists home health visits and costs by provider.

2.8.74.1 Technical Name

EIS - Monthly Home Health Visits

For readability, this layout appears on the following several pages.

2.8.74.2 EIS - Monthly Home Health Visits Layout

A

Run Date: 10/11/2006
Run Time: 9:07:24 AM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: rztdly

Monthly Home Health Visits

Totals by Procedure Code

From Dates of Service: 01/01/1997 - 12/31/2006

Primary Procedure Code & Desc	Billed Amount	Allowed Amount	Paid Amount
99211 - Office Or Other Outpatient Visit For The	$1,500.00	$17.04	$17.04
99213 - Office Or Other Outpatient Visit For The	$4,500.00	$99.27	$99.27
99271 - Confirmatory Consultation For A New Or E	$750.00	$0.00	$0.00
99341 - Home Visit For The Evaluation And Manage	$100.00	$0.00	$0.00
99347 - Home Visit For The Evaluation And Manage	$400.00	$0.00	$0.00
A0030 - Ambulance Service, Conventional Air Serv	$250.00	$0.00	$0.00
E0163 - Commode Chair , Stationary, With Fixed A	$3,000.00	$152.00	$152.00

End of Report

B

Run Date: 10/11/2006
Run Time: 9:07:24 AM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: rztdly

Monthly Home Health Visits

Totals Per Member

From Dates of Service: 01/01/1997 - 12/31/2006

Member ID	Billed Amount	Allowed Amount	Paid Amount
000001265	$250.00	$0.00	$0.00
000001266	$100.00	$0.00	$0.00
000001283	$250.00	$0.00	$0.00
000001284	$250.00	$0.00	$0.00
000001291	$250.00	$0.00	$0.00
000001293	$300.00	$0.00	$0.00
000001294	$100.00	$0.00	$0.00
000001297	$9,000.00	$268.31	$268.31
Sum:	**$10,500.00**	**$268.31**	**$268.31**

End of Report

C

Run Date: 10/11/2006
Run Time: 9:07:24 AM

User ID: rztdly

Cabinet for Health and Family Services
Department for Medicaid Services

Monthly Home Health Visits
Totals per Provider

From Dates of Service: 01/01/1997 - 12/31/2006

Performing Provider Numbers	Performing Provider Name	Billed Amount	Allowed Amount	Paid Amount
NPI: 1000000474 Medicaid Number: 100236759B Base Number: 10023676	DALLES, MICKEY A	$7,500.00	$251.27	$251.27
NPI: 1000000477 Medicaid Number: 100238249B Base Number: 10023825	JANES, JILL E	$1,000.00	$0.00	$0.00
NPI: 1000000478 Medicaid Number: 100238279A Base Number: 10023828	SMITH, CALEB U	$500.00	$0.00	$0.00
NPI: 1000000478 Medicaid Number: 100238279B Base Number: 10023828	UNITED NURSING ASSISTANCE CENTER	$1,500.00	$17.04	$17.04
	Sum:	**$10,500.00**	**$268.31**	**$268.31**

End of Report

D

Run Date: 10/11/2006
Run Time: 9:07:24 AM

User ID: rztdly

Cabinet for Health and Family Services
Department for Medicaid Services

Monthly Home Health Visits
Totals per Code per Provider

For Dates of Service: 01/01/1997 - 12/31/2006

Provider Numbers: NPI: 1000000474
Medicaid Number: 100236759B
Base Number: 10023676

Provider Name: DALLES, MICKEY A

Primary Procedure Code & Desc	Billed Amount	Allowed Amount	Paid Amount
99213 - Office Or Other Outpatient Visit For The	$4,500.00	$99.27	$99.27
E0163 - Commode Chair , Stationary, With Fixed A	$3,000.00	$152.00	$152.00

End of Report

E

Run Date: 10/11/2006
Run Time: 9:07:24 AM

Cabinet for Health and Family Services

User ID: rztdly

Department for Medicaid Services

Monthly Home Health Visits

Details

For Dates of Service: 01/01/1997 - 12/31/2006

ICN	Performing Provider Numbers	Performing Provider Name	Dtl No	Status	Member ID	Primary Procedure Code & Desc	Performing Provider Type Code & Dsc	Performing Prov Spec Code & Desc	Provider County Code & Desc	Billed Amount	Allowed Amount	Paid Amount
2003142300365	NPI: 1000000471 Medicaid Number: 100235819A Base Number: 10023582	DALLES, MICKEY A	1	P	000001403	99213 - Office Or Other Outpatient Visit For The	64 - Physician Individual	318 - General Practitioner	072 - Lyon	$1,500.00	$33.09	$33.09
2003142300365	NPI: 1000000471 Medicaid Number: 100235819A Base Number: 10023582	DALLES, MICKEY A	1	P	000001403	E0163 - Commode Chair , Stationary, With Fixed A	64 - Physician Individual	318 - General Practitioner	072 - Lyon	$1,500.00	$76.00	$76.00
2003142300365	NPI: 1000000471 Medicaid Number: 100235819A Base Number: 10023582	DALLES, MICKEY A	1	P	000001403	99213 - Office Or Other Outpatient Visit For The	64 - Physician Individual	318 - General Practitioner	072 - Lyon	$1,500.00	$33.09	$33.09
2003142300365	NPI: 1000000471 Medicaid Number: 100235819A Base Number: 10023582	DALLES, MICKEY A	1	P	000001403	E0163 - Commode Chair , Stationary, With Fixed A	64 - Physician Individual	318 - General Practitioner	072 - Lyon	$1,500.00	$76.00	$76.00
2003142300365	NPI: 1000000471 Medicaid Number: 100235819A Base Number: 10023582	DALLES, MICKEY A	1	P	000001403	99213 - Office Or Other Outpatient Visit For The	64 - Physician Individual	318 - General Practitioner	072 - Lyon	$1,500.00	$33.09	$33.09

F

Report Notes

Report Description

This report lists monthly home health visits and costs by provider. There are report totals by Procedure Code, Member, Provider, Code per Provider and Details. The report includes NPI, Medicaid, and Base IDs for each provider.

Search Criteria

Billed date range specified by the user in a prompt.
Provider type 34 (Home Health)
Procedure code on claim not emtpy

2.8.74.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A,D,E)Primary Procedure Code & Desc	Code and description used to identify a medical, dental, or DME procedure. Sort order: (A,D) 1	5	Char	T_CA_ICN, T_CDE_PROC	CD_PROC_PRIM, DSC_PROC
(A-E) Allowed Amount	Total amount approved to pay for services provided to a member. This is the amount before copay and TPL are taken out.	13	Number	T_CA_ICN	AMT_ALWD
(A-E)Billed Amount	The sum of all charges associated with each individual detail on a claim.	9	Number	T_CA_ICN	AMT_BILLED
(A-E)Paid Amount	The computed amount of payment due a provider for a claim or an adjustment transaction.	9	Number	T_CA_ICN	AMT_PAID
(B,E)Member ID	Unique identifier for the member. Sort order: (B) 1	12	Char	T_CA_ICN	ID_MEDICAID
(C,E)Performing Provider Name	The complete name of the provider of Medicaid services as used on official state records.	50	Char	T_PR_SVC_LOC	NAME
(C,E)Performing Provider Numbers	Numbers of the provider who performed (rendered) service. Sort order (E) 1	9	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI, ID_PROVIDER_MCAID, ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
(E) Provider County Code & Desc	Code and description of the provider county.	30	Char	T_CA_PROV_KEY	CDE_SVC_COUNTY, DSC_SVC_COUNTY
(E)Detail No.	The number of the detail on a claim record.	2	Char	T_CA_ICN	NUM_DTL
(E)ICN	Number assigned to a claim processed in the system. This number is used for control purposes. Sort order: (E) 2	13	Char	T_CA_ICN	NUM_ICN
(E)Performing Prov Spec Code & Desc	A description of the provider specialty code.	30	Char	T_CA_PROV_KEY	CDE_PROV_SPEC_PRIM, DSC_PROV_SPEC
(E)Performing Provider Type Code & Dsc	A description of the provider type code.	30	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM, DSC_PROV_TYPE
(E)Status	Indicates the status of the detail in the MMIS system.	1	Char	T_CA_ICN	CDE_DTL_STATUS

2.8.74.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.74.5 Associated Requirements

ID
30.050.015.002.6

2.8.74.6 Change Orders

ID	Name	Description
1701	EIS - Monthly Home Health Visits	The EIS - Monthly Home Health Visits report lists home health visits and costs by provider.
4502	EIS Monthly Home Health Visits	" UNDER tab TOTALS PER CODE PER PROVIDER The report has a field for Provider Name in one table it not long enough - truncating character. Same for field Medicaid Number The heading fields on the second page - only the caption come through - no values first page is fine."

2.8.75 EIS - Nursing Facility Statistics -- EIS - Nursing Facility Statistics

This report contains six tabs containing graphs. The tabs are:

A. Total Expenditures by SFY - It shows the total paid in each year on nursing facility claims.
B.- Total Monthly Expenditures - It shows the total paid each month.
C.- Covered Days by SFY - It shows the number of days covered.
D.- Covered Monthly Days - It shows the number of days covered each month.
E. Average Daily Cost by SFY - It shows the average cost per day, per member.
F. Average Daily Cost by Month - It shows the average cost per day, per member by month.

2.8.75.1 Technical Name

EIS - Nursing Facility Statistics

For readability, this layout appears on the following several pages.

2.8.75.2 EIS - Nursing Facility Statistics Layout

A

Run Date: 9/28/2006
Run Time: 11:44:20 AM

Cabinet for Health and Family Services

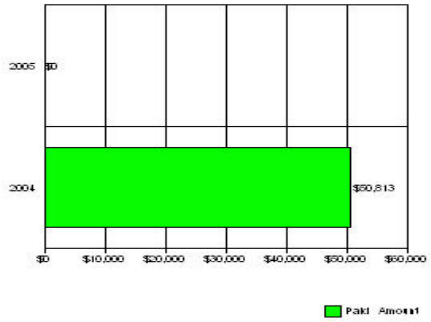
User ID: wzrdmh

Department for Medicaid Services

Nursing Facility Statistics

Total Expenditures by SFY

State Fiscal Year (SFY) Range: 2000 - 2006



End of Report

B

Run Date: 9/28/2006
Run Time: 11:44:20 AM

Cabinet for Health and Family Services

User ID: wzrdmh

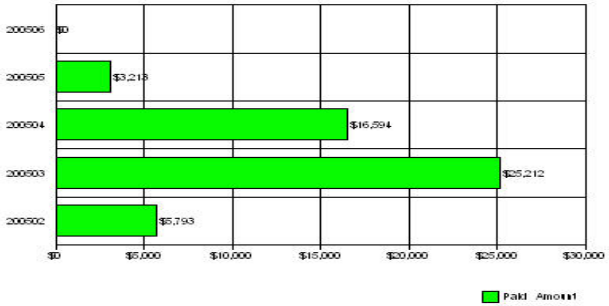
Department for Medicaid Services

Nursing Facility Statistics

Total Monthly Expenditures

State Fiscal Year (SFY) Range: 2000 - 2006

2004



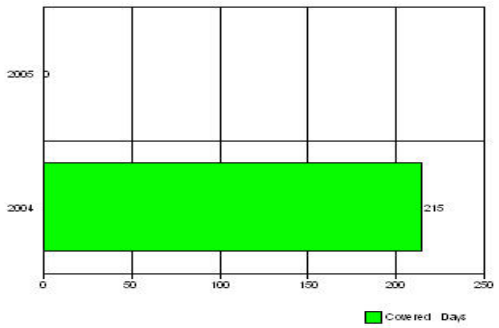
C

Run Date: 9/28/2006
Run Time: 3:59:33 PM

User ID: wzrdmh

Cabinet for Health and Family Services
Department for Medicaid Services
Nursing Facility Statistics
Covered Days by SFY

State Fiscal Year (SFY) Range: 2000 - 2006



End of Report

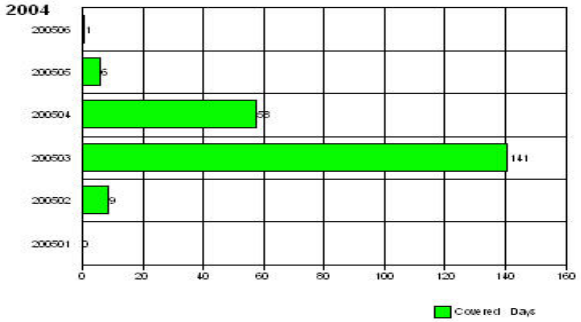
D

Run Date: 9/28/2006
Run Time: 3:59:33 PM

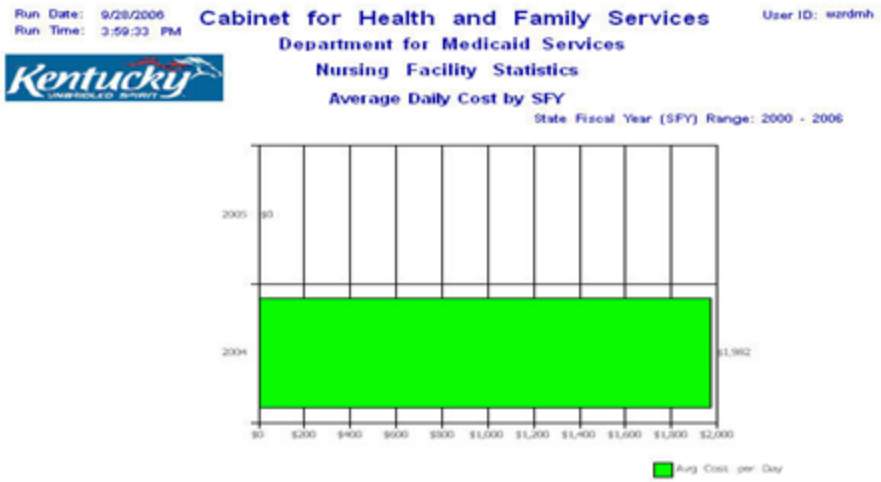
User ID: wzrdmh

Cabinet for Health and Family Services
Department for Medicaid Services
Nursing Facility Statistics
Covered Monthly Days

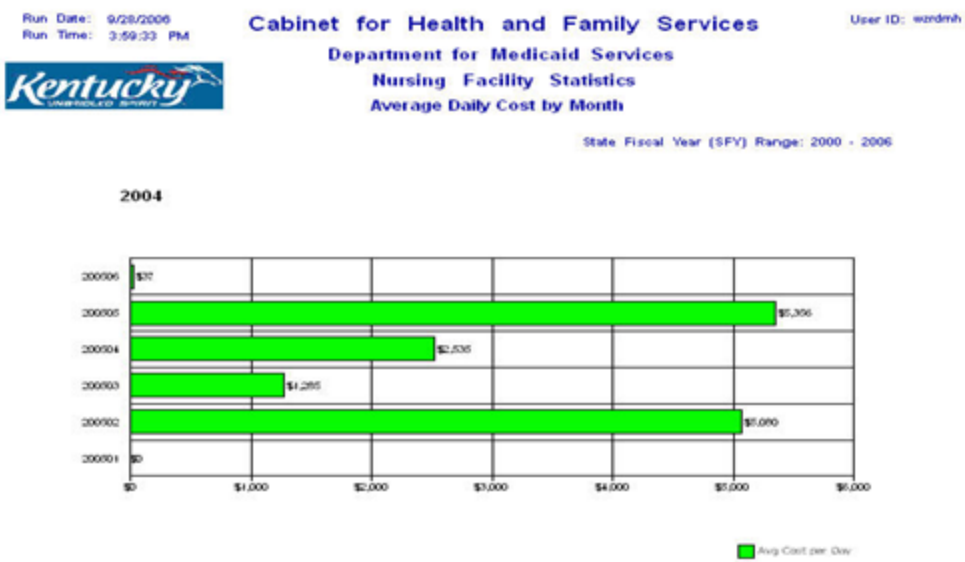
State Fiscal Year (SFY) Range: 2000 - 2006



E


Run Date: 9/28/2006
Run Time: 3:59:33 PM
Cabinet for Health and Family Services
User ID: wzrdmh
Department for Medicaid Services
Nursing Facility Statistics
Average Daily Cost by SFY
State Fiscal Year (SFY) Range: 2000 - 2006
2005
2004
$0
$200
$400
$600
$800
$1,000
$1,200
$1,400
$1,600
$1,800
$2,000
Avg Cost per Day

F


Run Date: 9/28/2006
Run Time: 3:59:33 PM
Cabinet for Health and Family Services
User ID: wzrdmh
Department for Medicaid Services
Nursing Facility Statistics
Average Daily Cost by Month
State Fiscal Year (SFY) Range: 2000 - 2006
2004
$0
$1,000
$2,000
$3,000
$4,000
$5,000
$6,000
Avg Cost per Day

G

Report Notes

Report Description

This report contains six tabs containing graphs.

1.- Total Expenditures by SFY - It represents the total paid in each year on nursing facility claims.
2.- Total Monthly Expenditures - It shows the total paid each month.
3.- Covered Days by SFY - It shows the number of days covered.
4.- Covered Monthly Days - It illustrates the number of days covered each month.
5.- Average Monthly Days by SFY - It denotes the average cost per day as well per recipient.
6.- Average Daily Cost by Month - It shows the average cost per day and per recipient by month.

Search Criteria

Paid date state fiscal year (SFY) range - From begin & end date range (CCYY) of payment entered by the user prompt.
This report shows latest claims only.
The claim type for all graphs equals LTC (Long Term Care).

2.8.75.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Average Cost by SFY	The average cost per day per month.	10	Number	T_CA_ICN	AMT_PAID/NUM_DAYS_COVD
Average Daily Cost by Month	The average cost per day and per member.	10	Number	T_CA_ICN	AMT_PAID/NUM_DAYS_COVD

Field	Description	Length	Data Type	DB Table	DB Attributes
Covered Days by SFY	The total number of covered days.	10	Number	T_CA_ICN	NUM_DAYS_COVD
Covered Monthly Days	The total number of covered days per month.	10	Number	T_CA_ICN	NUM_DAYS_COVD
Total Expenditures by SFY	The total expenditures.	10	Number	T_CA_ICN	AMT_PAID
Total Monthly Expenditures	The total expenditures per month.	10	Number	T_CA_ICN	AMT_PAID

2.8.75.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.75.5 Associated Requirements

ID
30.050.015.002.6

2.8.75.6 Change Orders

ID	Name	Description
1702	EIS - Nursing Facility Stats	The EIS - Nursing Facility Statistics report contains six tabs containing graphs. The first represents the total paid in each year on nursing facility claims. The second shows the total paid each month while the third shows the number of days covered. The fourth tab illustrates the number of days covered each month. The fifth tab denotes the averages cost per day as well as per member. The last tab shows the average cost per day and per member by month.

2.8.76 EIS - Provider History -- EIS - Provider History

The EIS - Provider History report contains nine tabs. The first four tabs represent detailed information on the ICN, diagnosis, procedures and place of services that have been done by a specific provider. The next four tabs show information on all the claims types (inpatient, dental, pharmacy, and physician). The last tab presents report notes.

There are 9 tabs in this report:

A. ICN Information Report
B. Provider Detail Reports by Diagnosis
C. Provider Detail Reports by Procedure
D. Provider Detail Reports by Place of Service
E. Pharmacy Claims
F. Dental Claims
G. UB Claims
H. Physician Claims
I. Report Notes tab describing the conditions used to create the report.

2.8.76.1 Technical Name

EIS - Provider History

For readability, this layout appears on the following several pages.

2.8.76.2 EIS - Provider History Layout

A

Run Date: 9/28/2006
Run Time: 4:50:04 PM

User ID: qz00tr

Cabinet for Health and Family Services
Department for Medicaid Services
Provider History
ICN Information

Provider Information: NPI: 1000000513
Medicaid Number: 1002418291
Base Number: 10024183
Name: FRANCIS MEMORIAL CLINIC
Type: 01 - General hospital
Specialty: 010 - Acute Care
Address: 3999 NE 1ST ST
SUITE 9453
PORTLAND, KY 97501

From Paid Dates: 01/02/2000 - 12/31/2006

ICN	Claim Type Code & Desc	Claim Indicator	To Date of Service	From Date of Service	Billed Quantity	Billed Amount	Allowed Amount	Paid Amount	Paid Claim Count	Denied Claim Count	Total Claim Count
2003142001063	B - HCFA 1500 XOVER CLAIMS	F	12/20/2002	12/20/2002	1	$60.00	$0.00	$0.00	1	0	1
2005101250068	H - HOME HEALTH CLAIMS	F	07/18/2004	07/22/2004	1	$237.00	$236.00	$236.00	1	0	1
2003142130073	O - OUTPATIENT CLAIMS	F	01/25/2002	01/25/2002	1	$17.75	$-100.00	$0.00	0	1	1
2003161130129	O - OUTPATIENT CLAIMS	F	01/25/2002	01/25/2002	1	$17.75	$-100.00	$0.00	0	1	1
2004219130004	O - OUTPATIENT CLAIMS	F	01/25/2002	01/25/2002	1	$17.75	$-100.00	$0.00	0	1	1
				Sum:	5	$350.25	$-64.00	$236.00	2	3	5

End of Report

2.8.76.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Denied Claim Count	Number of denied claims	9	Number	T_CA_ICN	CNT_CLAIM_DENIED
(A) Paid Claim Count	Number of paid claims	9	Number	T_CA_ICN	CNT_CLAIMS_PAID
(A) Total Claim Count	Number of paid claims + number of denied claims.	9	Number	n/a	calc
(A,B,C) Billed Quantity	The units of service billed for payment.	9	Number	T_CA_ICN	QTY_BILLED

Field	Description	Length	Data Type	DB Table	DB Attributes
(A,B,C,D,F) Billed Quantity	The units of service billed for payment. (Sort order 1, (B,C,D))	12	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED
(A,E,F,G,H) Claim Indicator	Fee for Service or Encounter Claim.	1	Char	T_CA_ICN	IND_CLAIM
(A,E,F,G,H) ICN	Unique control number assigned to the invoice to allow tracking through the system. Sort order 1: (E,F,G,H) Sort order 4: (A)	13	Char	T_CA_ICN	NUM_ICN
(A,E,F,GH) Claim Indicator	An indicator identifying a clam as E=Encounter or F=Fee for service claim.	1	Char	T_CA_ICN	IND_CLAIM
(A,F,G,H) From Date of Service	Day procedure was started. (Sort order 2 (A))	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
(A,F,G,H) To Date Of Service	Day procedure was finished. (Sort order 3 (A))	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC
(A,G,H) Claim Type Code & Description	Invoice type code and description (Sort order 1 (A)).	51	Char	T_CA_CLAIM_KEY	CDE_CLM_TYPE || DSC_CLM_TYPE
(A-H) Allowed Amount	Total amount approved to pay for services provided to a member. This is the amount before copay and TPL are taken out.	13	Number (Decimal)	T_CA_ICN	AMT_ALWD
(A-H) Billed Amount	Amount of money requested for payment by a provider for services rendered to a member. (Sort order	13	Number (Decimal)	T_CA_ICN	AMT_BILLED

Field	Description	Length	Data Type	DB Table	DB Attributes
	2, (B,C)				
(A-H) Paid Amount	This is the same as reimbursed amount.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
(B,C,D) Member Count	A distinct count based on the individual member ID.	12	Char	T_CA_ICN	ID_MEDICAID
(B,H) Primary Diagnosis Code & Desc	The primary ICD-9-CM diagnosis code and description.	47	Char	T_CA_ICN, T_DIAGNOSIS	CDE_DIAG_PRIM || DSC_25
(C,F,G,H) Primary Procedure Code & Desc	The primary procedure code and description.	46	Char	T_CA_ICN,T_CDE_PROC	CDE_PROC_PRIM || DSC_PROC
(D) Place Of Service	Code and description to indicate where the service was provided.	52	Char	T_CA_CLAIM_KEY	CDE_POS,DSC_POS
(D,F) Billed Qty	The units of service billed for payment.	9	Number	T_CA_ICN	QTY_BILLED
(E) Dispensed Date	The date the prescription was filled.	10	Date (MM/DD/CCYY)	T_CA_DRUG	DTE_DISPENSE
(E) NDC Code & Description	The National Drug Code and description for the drug dispensed on claim.	46	Character	T_CA_ICN,T_CA_DRUG	CDE_NDC || DSC_NDC
(E) Prescribing Provider Name	The name associated with the referring organization or person.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER

Field	Description	Length	Data Type	DB Table	DB Attributes
(E) Prescribing Provider Numbers	This object contains the referring Base, Medicaid and NPIs that identify a provider.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
(E) Prescribing Provider Specialty Code & Desc	Code and description of referring provider's specialty.	53	Char	T_CA_PROV_KEY	CDE_PROV_SPEC_PRIM || DSC_PROV_SPEC
(E) Prescribing Provider Type Code & Desc	The referring provider's type code and a description of the provider type code.	52	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM || DSC_PROV_TYPE
(E) Prescription Number	The number assigned to the prescription by the provider.	7	Char	T_CA_DRUG	NUM_PRSCRIP
(E,F,G,H) Billing Provider Name	The provider name.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
(E,F,G,H) Billing Provider Number	The provider identification number used by the provider.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
(E,F,G,H) Billing Provider Specialty Code & Desc	Code and description for provider specialty.	53	Char	T_CA_PROV_KEY	CDE_PROV_SPEC_PRIM || DSC_PROV_SPEC
(E,F,G,H) Billing Provider Type & Desc	The billing provider's type code and a description of the provider type code.	52	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM || DSC_PROV_TYPE
(E,F,G,H) Detail	Claim line number from header paid	4	Number	T_CA_ICN	NUM_DTL

Field	Description	Length	Data Type	DB Table	DB Attributes
Number	claims.				
(E,F,G,H) Member ID	The unique Medicaid identification number assigned to the member.	12	Char	T_CA_ICN	ID_MEDICAID
(E,F,G,H) Member Name	Concatenates the member last name, first name and middle initial into one object. The format of the name is in: last name, first name, and middle initial.	36	Char	T_RE_BASE_DN	NAM_LAST,NAM_FIRST ,NAM_MID_INIT
(E,F,H) Age	The age of the member	4	Number	T_CA_ICN	NUM_RECIP_AGE
(F) Tooth Number	Tooth Number and description	42	Char	T_CA_DENTAL,T_T OOTH	CDE_TOOTH_NBR || DSC_TOOTH_NBR
(F,G,H) Paid Date	The date the service was paid.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID
(F,H) Performing Provider Name	The name associated with the performing organization or person.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
(F,H) Performing Provider Number	ID is used to identify a performing provider who orders or refers specific services for members.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
(F,H) Performing Provider Specialty Code & Desc	Code and description for performing provider specialty.	53	Char	T_CA_PROV_KEY	CDE_PROV_SPEC_PRI M || DSC_PROV_SPEC
(F,H) Performing Provider Type Code	The performing provider's type code and a description of the provider	52	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRI

Field	Description	Length	Data Type	DB Table	DB Attributes
& Desc	type code.				M || DSC_PROV_TYPE
(G) Admission Date	Date that the member was admitted by the provider for inpatient care, outpatient services, or start of care.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_ADMISSION
(G) Attending Provider Name	The Referring Provider Name.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
(G) Attending Provider Number	The referring provider ID.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI || ID_PROVIDER_MCAID || ID_PROVIDER_BASE
(G) Attending Provider Specialty Code & Desc	Code and description for the referring provider specialty.	53	Char	T_CA_PROV_KEY	CDE_PROV_SPEC_PRI M || DSC_PROV_SPEC
(G) Attending Provider Type Code & Desc	The referring provider's type code and a description of the provider type code.	52	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRI M || DSC_PROV_TYPE
(G) Revenue Code & Description	Revenue code and description used in subquery for claims paid either header or detail.	74	Char	T_CA_HDR_DTL,T_ CDE_REVENUE	CDE_REVENUE || DSC_REVENUE
(G) Revenue Code & Description	Contains the revenue code and description for header paid claims.	74	Char	T_CA_ICN,T_CDE_R EVENUE	CDE_REVENUE || DSC_REVENUE
(G) Surgical Procedure Code 1 & Desc	The ICD-9-CM code 1 and description for the service performed for the member.	44	Char	T_CA_ICD9_PROC_ DN,T_CDE_PROV	CDE_PROC_ICD9_1 || DSC_PROC

Field	Description	Length	Data Type	DB Table	DB Attributes
(G) Surgical Procedure Code 2 & Desc	The ICD-9-CM code 2 and description for the service performed for the member.	44	Char	T_CA_ICD9_PROC_DN,T_CDE_PROC	CDE_PROC_ICD9_2 || DSC_PROC
(G) Surgical Procedure Code 3 & Desc	The ICD-9-CM code 3 and description for the service performed for the member.	44	Char	T_CA_ICD9_PROC_DN,T_CDE_PROC	CDE_PROC_ICD9_3 || DSC_PROC
(G) Surgical Procedure Code 4 & Desc	The ICD-9-CM code 4 and description for the service performed for the member.	44	Char	T_CA_ICD9_PROC_DN,T_CDE_PROC	CDE_PROC_ICD9_4 || DSC_PROC
(G,H) Detail Number	Detail number used in subquery from header detail table	4	Number	T_CA_HDR_DTL	NUM_DTL
(G,H) Member Aid Category Code & Desc	Code and description that identifies the type of aid for which a member is eligible.	52	Char	T_CA_RECIP_KEY, T_CDE_PROC	CDE_AID_CATEGORY || DSC_AID_CATEGORY
(G,H) Primary Procedure Code & Description	Primary procedure code and description used in subquery from header detail table.	46	Char	T_CA_HDR_DTL,T_CDE_PROC	CDE_PROC || DCS_PROC

2.8.76.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.76.5 Associated Requirements

ID

ID
30.050.015.002.6
30.090.007.003.25

2.8.76.6 Change Orders

ID	Name	Description
1703	EIS - Provider History	The EIS - Provider History report contains eight tabs. The first four tabs represent the detailed information of the ICN, diagnosis, procedures and place of services that have been done by a specific provider. The last four tabs shows all the information claims types (inpatient, dental, pharmacy, and physician).

2.8.77 EIS - Quarterly Growth -- EIS - Quarterly Growth

The EIS - Quarterly report identifies quarterly growth of a provider type.

2.8.77.1 Technical Name

EIS - Quarterly Growth

2.8.77.2 EIS - Quarterly Growth Layout

Run Date: 10/10/2006
Run Time: 12:30:55 PM

Cabinet for Health and Family Services

User ID: rztdly

Department for Medicaid Services

Quarterly Growth Report

Quarterly Growth

For Year: 2002

Quarter: 1

Provider Type Code and Description	Specialty Code and Description	Provider Numbers	Provider Name
64 - Physician Individual	345 - General Pediatrician	NPI: 1000000157 Medicaid Number: 100086089A Base Number:	BEAL, TIM J
60 - Dentist - Individual	271 - General Dentistry Practitioner	NPI: 1000000079 Medicaid Number: 100022589A Base Number:	CHRISTY, SHARON N
60 - Dentist - Individual	272 - Oral Surgeon	NPI: 1000000079 Medicaid Number: 100022589A Base Number:	CHRISTY, SHARON N
60 - Dentist - Individual	276 - Oral Pathologist	NPI: 1000000079 Medicaid Number: 100022589A Base Number:	CHRISTY, SHARON N
01 - General hospital	010 - Acute Care	NPI: 1000002025 Medicaid Number: 200305989A Base Number:	CLEAVER, BEN I

Report Notes

Report Description

ts recently enrolled active provider for a year broken down by quarter.

Search Criteria

Program Eligibility Year Effective Date equal to the year specified by the user.

Program Eligibility Year End Date equal to the year specified by the user.

2.8.77.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
For Year	This is the year of the effective date.	2	Number	T_PR_PHP_ELIG	DTE_EFFECTIVE
Provider Name	The name associated with the organization or person.	50	Character	T_PR_SVC_LOC_DN	NAM_PROVIDER
Provider Numbers	The concatenation of provider ID service location.	15	Char	T_PR_SVC_LOC_DN	ID_PROVIDER_NPI, ID_PROVIDER_MCAID, ID_PROVIDER_BASE
Provider Type Code and Description	This is the provider type code for which a provider is licensed and the provider type description.	52	Char	T_PR_TYPE, T_PR_TYPE_CDE	CDE_PROV_TYPE, DSC_PROV_TYPE
Quarter	This is the quarter of the effective date.	4	Char	T_PR_PHP_ELIG	DTE_EFFECTIVE
Specialty Code and Description	The specialty code and description represents the specialized area of practice for a provider.	53	Char	T_PR_SPEC, T_PR_SPEC_CDE	CDE_PROV_SPEC, DSC_PROV_SPEC

2.8.77.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.77.5 Associated Requirements

ID
30.050.015.002.6

2.8.77.6 Change Orders

ID	Name	Description
1704	EIS - Quarterly Growth	The EIS - Quarterly report identifies quarterly growth of a provider type.

2.8.78 EIS - Selected Provider Address -- EIS - Selected Provider Address

The EIS - Selected Provider Address report lists the top 100 providers ranked by number of claims processed for a specified date range. The providers are sorted in ascending ranking order.

2.8.78.1 Technical Name

EIS - Selected Provider Address

2.8.78.2 EIS - Selected Provider Address Layout

Run Date: 10/10/2006
Run Time: 12:16:28 PM

User ID: rztdly

Cabinet for Health and Family Services

Department for Medicaid Services

Selected Provider Address

Top 100 Providers By Claim Count

From Dates of Service: 01/01/2003 - 01/12/2006

Rank	Billing Provider Numbers	Billing Provider Name	Full Street Address - Billing Addr	City, State and Zip - Billing Addr	Phone Number	Total Claim Count
1	NPI: 1000000969 Medicaid Number: 100673449A Base Number: 10067345	NW GENERAL	3181 MAIN ST MAIL STOP 9067	PORTLAND, KY 97501-	(999) 551-1165	2,984
2	NPI: 1000001933 Medicaid Number: 100814699A Base Number: 10081470	VALLEY FAMILY PLANNING	3084 PARK AVE	PORTLAND, KY 97501-	(999) 551-1078	676
3	NPI: 1000000335 Medicaid Number: 100191749A Base Number: 10019175	COUNTRY MEDICAL CLINIC	3096 PARK AVE	SALEM, KY 97501-8005	(999) 551-1090	660
4	NPI: 1000001639 Medicaid Number: 100755569A Base Number: 10075557	SMITH, JOHN D	5975 NE 1ST ST DROP CODE 10404	SALEM, KY 97501-8404	(999) 551-3695 8888	466
5	NPI: 1000001576 Medicaid Number: 100752749A Base Number: 10075275	WEST HILLS MEMORIAL	5216 PARK AVE	SALEM, KY 97501-	(999) 551-2995	336
6	NPI: 1000000515 Medicaid Number: 100242249A Base Number: 10024225	BAILY MEDICAL SUPPLIES	3148 PARK AVE	PORTLAND, KY 97501-	( ) -	316
7	NPI: 1000000397 Medicaid Number: 100218509E Base Number: 10021851	COUNTRY MEDICAL CLINIC	3079 NE 1ST ST	PORTLAND, KY 97501-8011	(999) 551-1073	315
8	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	5871 NE 1ST ST MAIL STOP 10351	PORTLAND, KY 97501-	(999) 551-1178	309

Report Notes

Report Description

s the top 100 providers by claim count. And, It compares billing providers ra ims processed for a specified dates of service range. The report includes NPI, Medicaid, and Base Ids for each provider. The records are sorted in descending order by rank.

Search Criteria

From Date of Service range specified by the user in a prompt. Format MM/DD/YYYY.

2.8.78.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Name	The name associated with the organization or person.	50	Character	T_CA_PROV_KEY	NAM_PROVIDER
Billing Provider Numbers	The concatenation of provider ID service location.	10	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI, ID_PROVIDER_MCAID, ID_PROVIDER_BASE
City, State, and Zip - Billing Addr	Concatenates the provider's city, state and zip code address information into one object.	26	Char	T_CA_PROV_KEY	ADR_BILL_CITY,ADR_BILL_STATE,ADR_BILLL_ZIP,ADR_BILL_ZIP4
Full Street Address - Billing Addr	Concatenates the provider's street 1 and street 2 address information.	60	Char	T_CA_PROV_KEY	ADR_BILL_STRT1,ADR_BILL_STRT2
Phone Number	This field contains the provider's phone number.	18	Char	T_CA_PROV_KEY	ADR_BILL_PHONE,ADR_BILL_PHO_EXT
Rank	Providers ranked by number of claims processed.	9	Number	T_CA_ICN	CNT_CLAIMS_DENIED,CNT_CLAIMS_PAID
Total Claim Count	The total number of claims per provider.	13	Number	T_CA_ICN	CNT_CLAIMS_DENIED,CNT_CLAIMS_PAID

2.8.78.4 Associated Programs

Program	Description
No associated Programs found.	

2.8.78.5 Associated Requirements

ID
30.050.015.002.6

2.8.78.6 Change Orders

ID	Name	Description
1705	EIS - Selected Provider Address	The EIS - Selected Provider Address report lists the top 100 providers ranked by number of claims processed for a specified date range. The providers are sorted in ascending ranking order.

2.9 Letters

The DSS/DW subsystem does not directly produce, send, or receive any letters.

2.10 Internal and External Interfaces

This folder contains a list of all Data Warehouse Subsystem External (Input and Output) Files, as well as who sends or receives the file and the frequency. It also contains a link to the file layouts for each of the external files in this subsystem.

2.10.1 Input Files

Interface ID	File Description	Entity	Frequency
725	eKASPER Member – Prescription information for controlled substance dispensed to Medicaid members requested.	Cabinet of Health and Family Services	Weekly
677	eKASPER Member – Prescription information for controlled substance prescribed or dispensed by Medicaid providers requested.	Cabinet of Health and Family Services	Weekly
790	KAMES Member Data – Supplemental member information from KAMES.	KAMES	Weekly
781	KAMES SDX Member Data – Supplemental member information from SDX.	KAMES	Weekly
780	KAMES PA62 Member Data – Supplemental member information from PA62.	KAMES	Weekly
803	KAPER – Provider enrollment data from KAPER form.	First Health	Monthly
681	KASES – Child support information	KASES	Monthly
802	maxMC – Supplemental Prior Authorization data.	SHPS	Monthly
679	Vital Statistics Birth – Birth information.	Vital Statistics	Monthly
680	Vital Statistics Death – Death information.	Vital Statistics	Monthly

2.10.2 Output Files

Interface ID	File Description	Entity	Frequency
732	Navigant Inpatient Claim Detail Extract – Inpatient detail claims information for base rate setting.	Navigant Consulting, Inc.	On Demand
731	Navigant Inpatient Claim Header Extract– Inpatient header claims information for base	Navigant	On Demand

Interface ID	File Description	Entity	Frequency
	rate setting.	Consulting, Inc.	
396	Navigant Outpatient Detail Extract – Outpatient detail claims information for base rate setting.	Navigant Consulting, Inc.	On Demand
730	Navigant Outpatient Claim Header Extract – Outpatient header claims information for base rate setting.	Navigant Consulting, Inc.	On Demand
394	PwC Budget Forecasting Claims Extract	Pricewaterhouse Coopers, LLP	On Demand
726	PwC Budget Forecasting Demographics Extract	Pricewaterhouse Coopers, LLP	On Demand
727	PwC Budget Forecasting Eligibility Extract	Pricewaterhouse Coopers, LLP	On Demand
728	PwC Budget Forecasting LTC Extract	Pricewaterhouse Coopers, LLP	On Demand
729	PwC Budget Forecasting Managed Care Extract	Pricewaterhouse Coopers, LLP	On Demand
798	PwC Passport Dental Extract	Pricewaterhouse Coopers, LLP	On Demand
797	PwC Passport Encounter Pharmacy Extract	Pricewaterhouse Coopers, LLP	On Demand
810	PwC Passport Eligibility Extract	Pricewaterhouse Coopers, LLP	On Demand
796	PwC Passport Entitlement Extract	Pricewaterhouse Coopers, LLP	On Demand
395	PwC Passport Facility Extract	Pricewaterhouse Coopers, LLP	On Demand
799	PwC Passport FFS Pharmacy Extract	Pricewaterhouse Coopers, LLP	On Demand
795	PwC Passport Home Health Extract	Pricewaterhouse	On Demand

Interface ID	File Description	Entity	Frequency
		Coopers, LLP	
794	PwC Passport Professional Extract	Pricewaterhouse Coopers, LLP	On Demand
793	PwC Passport Rural Health Extract	Pricewaterhouse Coopers, LLP	On Demand
792	PwC Passport Transportation Extract	Pricewaterhouse Coopers, LLP	On Demand
807	eKASPER Member Request – Medicaid members and applicable identifier information for the eKASPER member request file.	Cabinet of Health and Family Services	Weekly
806	eKASPER Provider Request – Medicaid providers and applicable identifier information for the eKASPER provider request file.	Cabinet of Health and Family Services	Weekly
605	Encounter Activity – Encounter transportation data.	Transportation Cabinet	Weekly
425	First Health J-Codes Extract	First Health	Quarterly
804	First Health Paid Dental Extract	First Health	Monthly
627	First Health Paid Institutional Extract	First Health	Monthly
805	First Health Paid Professional Extract	First Health	Monthly
554	HMS Dental Claims Extract	Health Management Systems, Inc.	Monthly
739	HMS Institutional Claims Extract	Health Management Systems, Inc.	Monthly
737	HMS Pharmacy Claims Extract	Health Management Systems, Inc.	Monthly

Interface ID	File Description	Entity	Frequency
738	HMS Professional Claims Extract	Health Management Systems, Inc.	Monthly
504	ICFMR Claims Extract	OnBase	Monthly
637	Ineligible Part A Crossover Claims Extract – Follow up.	OnBase	Quarterly
636	Ineligible Part A Crossover Claims Extract – Preliminary	OnBase	Quarterly
741	IPRO Dental Extract – Dental claims information.	Island Peer Review Organization, Inc.	Monthly
675	IPRO Drug Code Extract – Information for all effective Drug codes.	Island Peer Review Organization, Inc.	Monthly
673	IPRO Encounters – Monthly paid and denied Encounters processed by Passport.	Island Peer Review Organization, Inc.	Monthly
397	IPRO Member Extract – Member and enrollment information for all eligible Passport members.	Island Peer Review Organization, Inc.	Monthly
674	IPRO Provider Extract – Provider information.	Island Peer Review Organization, Inc.	Monthly
676	IPRO Reference Code Extract – Information for effective reference codes.	Island Peer Review Organization, Inc.	Monthly
503	Nursing Facility Claims Extract	OnBase	Monthly
659	Preventive Services Claims Extract	OnBase	Monthly

2.10.3 File Layouts

- CMS Passport Waiver 1115 Extract Layout
- eKASPER Layout

- First Health J Code Claims Layout
- First Health KAPER Layout
- First Health Paid Claims Layout
- HMS Layout
- ICFMR Claims Interface Layout
- Ineligible Part A Crossover Claims Layout
- IPRO Extract Layout
- KAMES PA62 SDX Layout
- KASES Input Layout
- maxMC Interface Layout
- Navigant Layout
- Nursing Facilities Claims Interface Layout
- Preventive Service Layout
- PwC Budget Forecasting Layout
- PwC Passport Rating Layout
- Transportation Cabinet Encounter Activity Layout
- Vital Statistics Death_Birth File Layout

2.10.4 CMS Passport Waiver 1115 Extract Layout

Field	Data Type	Length	Description
Report QTR	Char	6	The quarter of the report period. For example, it is 2005Q4 for the fourth quarter of calendar year 2005.
Region	Char	5	The region of the member associated with the claim. Valid Values: Space, 1, 2, 3, 4, 5, 6, 7, 8, 9, or OS. For COS 96, if region is other than “3”, value is modified to be “3 – x” (x original value).

Waiver Status	Char	8	The waiver status of the member associated with the claim. +++++ - No member information is found. Y - Enrolled in Managed Care N – Will-never-be enrolled in managed care E – Eligible –but-not-enrolled in managed care X - Others. Y-XXX (Modified value for COS 96) If COS value is 96, and waiver status is not equal to “Y”, value is modified into “Y – XXX” (XXX = original value).
COS	Char	2	The Category of Service.
Waiver Year	Char	4	The waiver year. It is assigned based on the first date of service associated with the claim. WYXX – fist date of service is earlier than11/1/97 WY01 - fist date of service is in between 11/1/97 and 10/31/98 WY02 - fist date of service is in between 11/1/98 and 10/31/99 WY03 - fist date of service is in between 11/1/99 and 10/31/00 WY04 - fist date of service is in between 11/1/00 and 10/31/01 WY05 - fist date of service is in between 11/1/01 and 10/31/02 WY06 - fist date of service is in between 11/1/02 and 10/31/03 WY07 - fist date of service is in between 11/1/03 and 10/31/04 WY08 - fist date of service is in between 11/1/04 and 10/31/05 WY 09 – first date of service is in between 11/1/05 and 10/31/06

Fiscal Year	Char	4	The fiscal Year. It is assigned based on the paid date associated with the claim. For example, it is FY06 for the claims paid during 01-OCT-2005 and 30-SEP-2006. FY98 – Paid date is between 11/1/97 – 9/30/98 FY99 – Paid date is between 10/1/98 – 9/30/99 FY00 – Paid date is between 10/1/99 – 9/30/00 FY01 – Paid date is between 10/1/00 – 9/30/01 FY02 – Paid date is between 10/1/01 – 9/30/02 FY031 – Paid date is between 10/1/02 – 3/31/03 FY032 – Paid date is between 4/1/03 – 9/30/03 FY041 – Paid date is between 10/1/03 – 3/31/04 FY042 – Paid date is between 4/1/04 – 9/30/04 FY05 – Paid date is between 10/1/04 – 9/30/05 FY 06 – Paid date is between 10/01/05 – 9/30/05 FYXX – Prior to 11/1/97 FYWX – Prior to 11/1/97 If tracking backward of adjustment chain reaches an orphan claim then look at the original date-of-service. If the original date-of-service is prior to November 01, 1997 then the Fiscal Year should be FYXX. If the original date-of-service is greater than or equal to November 01, 1997 then the Fiscal Year should be FYWX.
Current Previous QTR	Char	1	The indicator to indicate the claim is paid within the current or previous quarter. It is 'C' if it is paid within the current reporting quarter. It is 'P' if it is paid before the current reporting quarter.
TPL Status – Original	Char	1	The original TPL status. Valid values: N – No TPL Y - TPL Adjustment (KY term - History Only adjustment). X - TPL adjustment (Refund and recoups).

TPL Status	Char	6	The new TPL status which is derived from the original TPL status Valid values: N TPL – Yes Derived from Original TPL Status. TPL – Yes means Original TPL Status is Y or X.
Service Month	Char	6	The first date of service of the claim in YYYY/MM format.
Eligibility Category	Char	6	It is eligibility category code of the member associated with the claim. Valid values: XXX – waiver status is ++++ TANF OTHER SOBRA FOSTER KCHIP SSI_MC SSI Changes are made to: Break the TANF and SOBRA groups into TANF-Adult, TANF-Child, SOBRA-Adult, and SOBRA-Child groups with Child being 17 years of age or younger. Break Program Code PE out from SOBRA and make it a separate COA called Presumptive Eligibility.
Sum Line Item Paid	Number	14	The summarized paid amount for the combination of the above fields.

CMS Line	Char	2	The CMS COS. It is derived from COS. Valid values: 1, 2, 3 , 4 , 5 , 6 , 7, 8 , 9 , 10 11, 12 , 15, 15A , 16, 18A, 18B, 18E, 19 24, 25, 26, 29 999

2.10.4.1 CMS Waiver 1115 Eligible Extract Layout

Field	Data Type	Length	Description
Date	Char	7	Month starting from 97/11 in YYYY/MM format.
Region	Char	5	The region of the member associated with the claim. Valid Values: Space, 1, 2, 3, 4, 5, 6, 7, 8, 9, or OS.
COA - Member Eligibility	Char	8	It is eligibility category code of the member. Valid values: XXX – waiver status is ++++ TANF OTHER SOBRA FOSTER KCHIP SSI_MC SSI Changes are made to: Break the TANF and SOBRA groups into TANF-Adult, TANF-Child, SOBRA-Adult, and SOBRA-Child groups with Child being 17 years of age or younger. Break Program Code PE out from SOBRA and make it a separate COA called Presumptive Eligibility.
MC indicator (Waiver Status)		1	The waiver status of the member.

Field	Data Type	Length	Description
			Y - Enrolled in Managed Care N – Will-never-be enrolled in managed care E – Eligible –but-not-enrolled in managed care X - Others.
Count		14	Number of eligible members grouped by month, region, member eligibility, and waiver status. If member's eligibility changes during the month, calculate the number of month based on days specific to eligibility (for example, 15 day would be counted as 0.5 month).

2.10.5 eKASPER Layout – Provider Request from DSS

Field Name	Data Type	Description	Length	Start Position	End Position
Provider or Dispenser Name	CHAR	This is the name associated with an organization or person.	58	1	58
Provider or Dispenser DEA	CHAR	The Drug Enforcement Agency identification number for a provider.	9	59	67
NDC (if one is not provided eKASPER will return all of the controlled substance prescriptions written by the Provider of interest)	CHAR	National Drug Code is comprised of a 5 byte numeric labeler code, 4 byte numeric product code and a 2 byte numeric package code. Used to uniquely identify a drug, it's labeler & package size of a product for pricing and prior authorization.	11	68	78
From Date	CHAR	From date in YYYYMMDD format.	8	79	86
To Date	CHAR	To date in YYYYMMDD format .	8	87	94

2.10.5.1 Member Extract from eKASPER

Field Name	Data Type	Description	Length	Start Position	End Position

Field Name	Data Type	Description	Length	Start Position	End Position
Medicaid Member ID	CHAR	Member Medicaid ID.	12	1	12
Last Name	CHAR	Member last name.	15	13	27
First Name	CHAR	Member first name.	15	28	42
Middle Name	CHAR	Member middle name.	15	43	57
DOB	Date	Mmeber data of birth.	8	58	65
SSN	CHAR	Member SSN.	9	66	74
Prescription Number	CHAR	Prescription number.	7	75	81
NDC	CHAR	NDC number for the drug.	11	82	92
Drug Name	CHAR	Drug name.	35	93	127
Drug Strength	CHAR	Drug strength.	25	128	152
Date Filled	Date	The date when the prescription is filled.	8	153	160
Quantity Received	Numeric	The quantity of the drug.	5	161	165
Days Supplied	Numeric	The number of days supplied.	3	166	168
Provider Full Name	CHAR	Provider full name.	58	169	226
Provider DEA	CHAR	Provider DEA number.	9	227	235
Provider City	CHAR	Provider's city.	30	236	265
Dispenser Name	CHAR	Dispenser name.	40	266	305
Dispenser DEA	CHAR	Dispenser DEA number.	9	306	314
Dispenser City	CHAR	Dispenser's city.	30	315	344

Field Name	Data Type	Description	Length	Start Position	End Position
Return Code	Numeric	This will used to determine the status of the information 100 - Record found: the return record will contain all of the information 105 - No record found: the return record will contain only the Medicaid ID 106 - Automatch error: the return record will contain only the Medicaid ID 107 - Automatch error: the return record will contain only the Medicaid ID. 108 - Multiple cluster id: the return record will contain all of the information 109 - Multiple DOB: the return record will contain all of the information 110 - Multiple Last Name: the return record will contain all of the information	3	345	347

2.10.5.2 Member Request from DSS

Field Name	Data Type	Description	Length	Start Position	End Position
Member Medicaid ID	CHAR	Unique identifier for the member.	12	1	12
Member SSN	CHAR	The social security number for a member.	9	13	21
Member FName	CHAR	The first name of a member.	15	22	36
Member LName	CHAR	The last name of a member.	20	37	56
Member Middle Initial	CHAR	The middle initial of the member.	1	57	57
Member DOB	CHAR	The date of birth for the member in YYYYMMDD format.	8	58	65

Field Name	Data Type	Description	Length	Start Position	End Position
Member Address Street 1	CHAR	The first line of the member's street address.	30	66	95
Member Address Street 2	CHAR	The second line of a member's street address.	30	96	125
Member Address Street 3	CHAR	The third line of a member's street address.	30	126	155
Member Address City	CHAR	The city where the member resides.	18	156	173
Member Address State	CHAR	The state where the member resides.	2	174	175
Member Zip Code	CHAR	The five character zip code for the member.	5	176	180
Member Zip Code 4	CHAR	The zip plus four of the member.	4	181	184

2.10.5.3 Provider Extract from eKASPER

Field Name	Data Type	Description	Length	Start Position	End Position
Provider/Dispenser DEA	CHAR	The Drug Enforcement Agency identification number for a provider.	9	1	9
Last Name	CHAR	Member last name.	15	10	24
First Name	CHAR	Member first name.	15	25	39
Middle Name	CHAR	Member middle name.	15	40	54
DOB	Date	Mmeber data of birth.	8	55	62
SSN	CHAR	Member SSN.	9	63	71
Prescription Number	CHAR	Prescription number.	7	72	78
NDC	CHAR	NDC number for the drug.	11	79	89

Field Name	Data Type	Description	Length	Start Position	End Position
Drug Name	CHAR	Drug name.	35	90	124
Drug Strength	CHAR	Drug strength.	25	125	149
Date Filled	Date	The date when the prescription is filled.	8	150	157
Quantity Received	Numeric	The quantity of the drug.	5	158	162
Days Supplied	Numeric	The number of days supplied.	3	163	165
Provider Full Name	CHAR	Provider full name.	58	166	223
Provider DEA	CHAR	Provider DEA number.	9	224	232
Provider City	CHAR	Provider's city.	30	233	262
Dispenser Name	CHAR	Dispenser name.	40	263	302
Dispenser DEA	CHAR	Dispenser DEA number.	9	303	311
Dispenser City	CHAR	Dispenser's city.	30	312	341
Return Code	Numeric	This will used to determine the status of the information 100 - Record found: the return record will contain all of the information 105 - No record found: the return record will contain only the Provider or Dispenser DEA	3	342	344

2.10.6 First Health J Code Claims Layout

Name	Type	Length	Position Start	Position End	Description
sak_claim	Char	10	1	10	The claim number
run_date_time	Char	17	11	27	File extract date and time
num_icn	Char	13	28	40	Internal control number

Name	Type	Length	Position Start	Position End	Description
claim_status_dtl	Char	1	41	41	Claim Status: (Detail) • D – DENIED • P - PAID
claim_region	Char	2	42	43	Claim Region; we use region code, first 2 digits of ICN, to indicate original claim, adjustment or void claim
claim_type	Char	1	44	44	Claim Type: • B-Professional Crossover • M-Professional
patient_account	Char	20	45	64	Patient account number;
patient_liab	Num	9	65	73	Amount member is responsible to pay for services rendered. (######.##) Header level
co_pay	Num	8	74	81	Amount paid by member for services rendered. (#####.##) Header level
dte_billed	Char	8	82	89	Date billed;
amt_billed_hdr	Num	10	90	99	Amount Billed; (#######.##) Header level
from_dos	Char	8	100	107	From date of service
to_dos	Char	8	108	115	To date of service
cde_eob	Char	9	116	124	First 2 claim EOB codes
prov_id_billing	Char	15	125	139	Provider ID: billing
id_type_billing	Char	3	140	142	Provider ID Type: billing - (NPI, MCD, or BSE)
cde_txn_billing	Char	10	143	152	Provider ID Taxonomy: billing
rid	Char	12	153	164	Member ID;

Name	Type	Length	Position Start	Position End	Description
num_dtl	Num	4	165	168	Detail Number;
units	Num	9	169	177	Number of units of service provided; (######.##)
amt_billed_dtl	Num	10	178	187	Amount Billed; (#######.##)
prc_cde	Char	6	188	193	Procedure code
cde_diag	Char	7	194	200	Diagnosis code;
amt_alwd_dtl	Num	10	201	210	Amount allowed for services rendered; (#######.##)
amt_paid_dtl	Num	10	211	220	Amount paid for services rendered; (#######.##)
num_ssn	Char	9	221	229	SSN number
cde_sex	Char	1	230	230	Sex
recip_dob	Char	8	231	238	Member Date of Birth
recip_name	Char	38	239	276	Member Name: nam_first + nam_mid_init + nam_last
dte_paid	Char	8	277	284	Date the claim was paid.
amt_tpl	Char	10	285	294	TPL total paid amount (#######.##) Header level
proc_code_mod1	Char	2	295	296	Procedure code modifier
proc_code_mod2	Char	2	297	298	Procedure code modifier
proc_code_mod3	Char	2	299	300	Procedure code modifier
proc_code_mod4	Char	2	301	302	Procedure code modifier
cde_prov_spec	Char	3	303	305	Provider specialty
cde_prov_type	Char	2	306	307	Provider type

Name	Type	Length	Position Start	Position End	Description
pos	Char	2	308	309	Place of service
amt_alwd_mcare_hdr	Char	9	310	318	Amount allowed by Medicare Crossover Part B Claim - Header level
amt_deduct_hdr	Char	9	319	327	Amount of the member's deductible payment -Medicare Crossover Part B Claim - Header level
amt_coinsurace_hdr	Char	9	328	336	Amount of the member's coinsurance payment - Medicare Crossover Part B Claim - Header level
amt_psych_hdr	Char	9	337	345	Amount of the member's psychiatric service payment - Medicare Crossover Part B Claim - Header level
amt_paid_mcare_hdr	Char	9	346	354	Amount paid by Medicare Crossover Part B Claim - Header level
dte_mcare_paid_hdr	Char	8	355	362	Date that Medicare paid the claim - Medicare Crossover Part B Claim - Header level
amt_alwd_mcare_dtl	Char	9	363	371	Amount allowed by Medicare Crossover Part B Claim
amt_deduct_dtl	Char	9	372	380	Amount of the member's deductible payment -Medicare Crossover Part B Claim
amt_coinsurace_dtl	Char	9	381	389	Amount of the member's coinsurance payment - Medicare Crossover Part B Claim
amt_psych_dtl	Char	9	390	398	Amount of the member's psychiatric service payment - Medicare Crossover Part B Claim
amt_paid_mcare_dtl	Char	9	399	407	Amount paid by Medicare Crossover Part B Claim
dte_mcare_paid_dtl	Char	8	408	415	Date that Medicare paid the claim - Medicare Crossover Part B Claim

Name	Type	Length	Position Start	Position End	Description
original_icn	Char	13	416	428	Original ICN for which the adjustment was created
prov_id_perf	Char	15	429	443	Provider ID: performing
id_type_perf	Char	3	444	446	Provider ID Type: performing - (NPI, MCD, or BSE)
cde_txn_perf	Char	10	447	456	Provider ID Taxonomy: performing
prov_id_ref	Char	15	457	471	Provider ID: referring
id_type_ref	Char	3	472	474	Provider ID Type: referring - (NPI, MCD, or BSE)
cde_txn_ref	Char	10	475	484	Provider ID Taxonomy: referring
amt_tot_reimb	Num	11	485	495	Header level amount paid (########.##)

2.10.6.1 Trailer Record

Name	Type	Length	Position Start	Position End	Description
record count desc	Char	15	1	15	"Record Count : "
record count	Char	9	16	24	Number of records in the file. (#########)
pipe delimiter	Char	3	25	27	" | "
total amount paid desc	Char	17	28	44	"Total Amt Paid : "
total amount paid	Char	13	45	57	Total of the amount paid in the file. (##########.##)
pipe delimiter	Char	3	58	60	" | "
file_id desc	Char	10	61	70	"file_id : "
file_id	Char	56	71	126	filename_date_date-processed_time-processed

2.10.7 First Health KAPER Layout

2.10.7.1 Provider Demographics

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 010)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
ProviderType	varchar(25)	Provider Types
StreetAddress1	varchar(100)	Provider Home Address
StreetAddress2	varchar(100)	
City	varchar(40)	
StateCode	varchar(2)	State Code
ZipCode	varchar(12)	
CountyCode	varchar(10)	County Code
CountryCode	varchar(3)	Country Codes
PhoneNumber	varchar(20)	
AlternatePhoneNumber	varchar(20)	
FaxNumber	varchar(20)	
Email	varchar(50)	
GenderCode	char(1)	
Race	varchar(25)	Race codes
BirthDate	char(10)	
BirthCity	varchar(40)	

Column	Datatype	Description
BirthStateCode	varchar(2)	State Code
BirthCountryCode	varchar(3)	Country Codes
DriversLicense	varchar(20)	
OrganizationType	varchar(25)	Organization Type code
NonProfitIndicator	char(1)	

2.10.7.2 Provider Specialty

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 020)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
SpecialtyType	varchar(25)	Specialty Type
PrimaryIndicator	char(1)	Indicatesif the Specialty is the provider's primary specialty
CertificationDate	char(10)	
ExpirationDate	char(10)	
RecertificationDate	char(10)	
BoardCode	varchar(10)	Certifying Board code
BeginDate	char(10)	Begin date of information
EndDate	char(10)	End date of information
HMODirectoryInd	char(1)	Indicates provider's desire to be listed in the HMO directory (Y/N)

Column	Datatype	Description
PPODirectoryInd	char(1)	Indicates provider's desire to be listed in the PPO directory (Y/N)
POSDirectoryInd	char(1)	Indicates provider's desire to be listed in the POS directory (Y/N)
CertificationExamPendingInd	char(1)	Indicates if the provider has taken the exam and is waiting for results (Y/N)
CertificationExamDate	char(10)	Certification Exam Date
BoardCertifiedInd	char(1)	Indicates the provider is Board Certified in this specialty (Y/N)
CertificationExamBoardCode	varchar(10)	The code of the Certification Board giving the exam
NotTakenExamInd	char(1)	Indicates the provider does not intend to take the exam (Y/N)
NotTakenExamRsn	varchar(255)	The reason the provider does not intend to take the exam.
TakenExamInd	char(1)	Indicates the exam has been taken (Y/N)

2.10.7.3 Provider Number

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 030)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
ProviderNumber	varchar(20)	
ProviderNumberType	varchar(25)	Number type code
EffectiveStartDate	char(10)	Start Date of the number

Column	Datatype	Description
EffectiveEndDate	char(10)	End Date of the Number
TaxIDIndicator	char(1)	Y/N indicates if the ID is used for tax purposes
PrimaryIndicator	char(1)	
FNINCountry		Country issuing the provider's FNIN number (See State Codes)

2.10.7.4 Provider Name

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 040)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
ProviderLocationID	int	Contains RecordID of ProviderLocation record if name pertains to a specific location
NameType	varchar(25)	Name Type code
LastName	varchar(255)	
FirstName	varchar(30)	
MiddleInitial	char(1)	
Prefix	varchar(10)	
Suffix	varchar(10)	
FullProviderName	varchar(255)	
BeginDate	char(10)	Begin date of name information.
EndDate	char(10)	End date for name information.

2.10.7.5 Provider License

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 050)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
LicenseNumber	varchar(20)	
LicenseType	varchar(25)	License type code
LicenseStatus	varchar(25)	License Status code
LicenseSpecialtyType	varchar(25)	License Specialty type code
EffectiveDate	char(10)	
ExpirationDate	char(10)	
TerminationDate	char(10)	
IssuingStateCode	varchar(2)	State Code

2.10.7.6 Provider Location

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 060)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
PrimaryIndicator	char(1)	Indicates if this is the provider's primary location

Column	Datatype	Description
AddressPhoneID	int	
StreetAddress1	varchar(100)	Provider Location Address
StreetAddress2	varchar(100)	
City	varchar(40)	
StateCode	varchar(2)	
ZipCode	varchar(12)	
CountyCode	varchar(10)	
CountryCode	varchar(3)	
PhoneNumber	varchar(20)	
AlternatePhoneNumber	varchar(20)	
FaxNumber	varchar(20)	
Email	varchar(50)	
CorrespondenceInd	char(1)	Indicates if the provider requests correspondence be sent to this location address (Y/N)
CurrentlyPracticingInd	char(1)	Indicates if the provider is currently practicing at this address (Y/N)
24HrPhoneCoverageInd	char(1)	Indicates if there is 24 hour phone coverage (Y/N)
AfterHoursPhone	char(10)	The after hours phone number
VMWithInstructions	char(1)	Indicates if voice mail has instructions to call the answering service (Y/N)
VMWithOtherInstructions	char(1)	Indicates if voice mail has other instructions (Y/N)
AnsweringServiceInd	char(1)	Indicates if there is an answering service (Y/N)

2.10.7.7 Location Participants

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 061)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
ProviderLocationID	int	System assigned number to uniquely identify each Location. Same as the RecordID in the ProviderLocation record.
ParticipantType	varchar(25)	Participant type code
LastName	varchar(30)	
FirstName	varchar(30)	
MiddleInitial	char(1)	
SpecialtyType	varchar(25)	Specialty Type of the participant (See Specialty codes)
ProviderType	varchar(25)	Provider type of the participant (See Provider Type codes)
LicenseNumber	varchar(20)	License number of participant
IssuingStateCode	varchar(2)	License issuing state of the participant's license (See state codes)
CertificateNumber	varchar(20)	
SSN	char(9)	
PractitionerType	varchar(25)	Practitioner type code
BeginDate	char(10)	
EndDate	char(10)	

Column	Datatype	Description
StreetAddress1	varchar(100)	Location Participant's Address
StreetAddress2	varchar(100)	
City	varchar(40)	
StateCode	varchar(2)	
ZipCode	varchar(12)	
CountyCode	varchar(10)	
CountryCode	varchar(3)	
PhoneNumber	varchar(20)	
AlternatePhoneNumber	varchar(20)	
FaxNumber	varchar(20)	
Email	varchar(50)	

2.10.7.8 Location Languages

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 062)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
ProviderLocationID	int	System assigned number to uniquely identify each Location. Same as the RecordID in the ProviderLocation record.
LanguageType	varchar(25)	Language type code
InterpreterIndicator	char(1)	Indicates if an interpreter is available at the location for this language. (Y/N)

2.10.7.9 Location Hours

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 063)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
ProviderLocationID	int	System assigned number to uniquely identify each Location. Same as the RecordID in the ProviderLocation record.
DayofWeek	varchar(25)	
StartTime	varchar(5)	
StartAMPM	varchar(2)	Indicates AM or PM (values are AM/PM)
EndTime	varchar(5)	
EndAMPM	varchar(2)	Indicates AM or PM (values are AM/PM)
ClosedIndicator	char(1)	Indicates if office is closed for this day

2.10.7.10 Location Attributes

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 064)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.

Column	Datatype	Description
ProviderLocationID	int	System assigned number to uniquely identify each Location. Same as the RecordID in the ProviderLocation record.
LocationAttributeType	varchar(25)	Values are Accessibility, Services, Practice
AttributeName	varchar(25)	Location Attribute Name
PropertyValue	varchar(255)	

2.10.7.11 Provider Certification

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 070)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
CertificationType	varchar(25)	Certification type code
ExpirationDate	char(10)	

2.10.7.12 Provider Hospital Affiliation

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 080)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
PrimaryIndicator	char(1)	Indicats the primary affiliation for the provider

Column	Datatype	Description
HospitalName	varchar(50)	
StreetAddress1	varchar(100)	Hospital Address
StreetAddress2	varchar(100)	
City	varchar(40)	
StateCode	varchar(2)	
ZipCode	varchar(12)	
CountyCode	varchar(10)	
CountryCode	varchar(3)	
PhoneNumber	varchar(20)	
AlternatePhoneNumber	varchar(20)	
FaxNumber	varchar(20)	
Email	varchar(50)	
DepartmentName	varchar(50)	
DirectorLastName	varchar(50)	
DirectorFirstName	varchar(30)	
DirectorMiddleInitial	char(1)	
AffiliationStartDate	char(10)	
AffiliationEndDate	char(10)	
AdmissionsPercent	numeric(3)	Percent of total admissions
AdmittingPrivilegeStatus	varchar(25)	Admitting Privilege Status code

2.10.7.13 Provider Education

Column	Datatype	Description

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 090)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
EducationTrainingType		Education training type code
InstitutionName1	varchar(30)	
InstitutionName2	varchar(30)	
StreetAddress1	varchar(100)	Education Institution Address
StreetAddress2	varchar(100)	
City	varchar(40)	
StateCode	varchar(2)	
ZipCode	varchar(12)	
CountyCode	varchar(10)	
CountryCode	varchar(3)	
PhoneNumber	varchar(20)	
AlternatePhoneNumber	varchar(20)	
FaxNumber	varchar(20)	
Email	varchar(50)	
EducationStartDate	char(10)	
EducationEndDate	char(10)	
CompletionIndicator	char(1)	

Column	Datatype	Description
DegreeType	varchar(25)	Degree type Code
CollegeCode	varchar(10)	College Code
IncompletionExplanation		

2.10.7.14 Provider Residency

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 091)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
ProviderEducationID	int	System assigned number to uniquely identify each Location. Same as the RecordID in the ProviderEducation record.
ResidencyType	varchar(25)	Residency type code
ResidencyStartDate	char(10)	
ResidencyEndDate	char(10)	
DepartmentName	varchar(30)	
DirectorName	varchar(30)	

2.10.7.15 Provider Insurance

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 100)
RecordID	int	System assigned number used to uniquely identify each row

Column	Datatype	Description
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
PrimaryIndicator	char(1)	
InsurerName	varchar(50)	
StreetAddress1	varchar(100)	Insurance Carrier Address
StreetAddress2	varchar(100)	
City	varchar(40)	
StateCode	varchar(2)	
ZipCode	varchar(12)	
CountyCode	varchar(10)	
CountryCode	varchar(3)	
PhoneNumber	varchar(20)	
AlternatePhoneNumber	varchar(20)	
FaxNumber	varchar(20)	
Email	varchar(50)	
OriginalCoverageEffectiveDate	char(10)	
CurrentCoverageEffectiveDate	char(10)	
ExpirationDate	char(10)	
CoverageType	varchar(25)	Coverage Type
UnlimitedCoverageIndicator	char(1)	
TailCoverageIndicator	char(1)	
PolicyNumber	varchar(20)	

Column	Datatype	Description
OccurrenceCoverageAmount	varchar(255)	
TotalCoverageAmount	varchar(255)	

2.10.7.16 Provider Work History

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 110)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
EmployerName	varchar(50)	
StreetAddress1	varchar(100)	Employer Address
StreetAddress2	varchar(100)	
City	varchar(40)	
StateCode	varchar(2)	
ZipCode	varchar(12)	
CountyCode	varchar(10)	
CountryCode	varchar(3)	
PhoneNumber	varchar(20)	
AlternatePhoneNumber	varchar(20)	
FaxNumber	varchar(20)	
Email	varchar(50)	
EmploymentStartDate	char(10)	

Column	Datatype	Description
EmploymentEndDate	char(10)	
DepartureReason	varchar(255)	

2.10.7.17 Provider Work Gap

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 120)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
GapStartDate	char(10)	
GapEndDate	char(10)	
GapExplanation	varchar(255)	

2.10.7.18 Provider Language

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 130)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
LanguageType	varchar(25)	Language type code
InterpreterIndicator	char(1)	
BeginDate	char(10)	

Column	Datatype	Description
EndDate	char(10)	

2.10.7.19 Provider Reference

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 140)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
FirstName	varchar(30)	
LastName	varchar(30)	
ProviderType	varchar(25)	
StreetAddress1	varchar(100)	Provider Reference Address
StreetAddress2	varchar(100)	
City	varchar(40)	
StateCode	varchar(2)	
ZipCode	varchar(12)	
CountyCode	varchar(10)	
CountryCode	varchar(3)	
PhoneNumber	varchar(20)	
AlternatePhoneNumber	varchar(20)	
FaxNumber	varchar(20)	
Email	varchar(50)	

2.10.7.20 Provider Contact

Column	Datatype	Description
ProviderID		Provider Medicaid ID
RecordType	char(03)	Record Type Code (value = 150)
RecordID	int	System assigned number used to uniquely identify each row
InternalProviderID	int	System assigned number to uniquely identify each provider. ID will not change over time.
ContactType	varchar(25)	Contact Type Code
FirstName	varchar(30)	
LastName	varchar(30)	
StreetAddress1	varchar(100)	Provider Contact Address
StreetAddress2	varchar(100)	
City	varchar(40)	
StateCode	varchar(2)	
ZipCode	varchar(12)	
CountyCode	varchar(10)	
CountryCode	varchar(3)	
PhoneNumber	varchar(20)	
AlternatePhoneNumber	varchar(20)	
FaxNumber	varchar(20)	
Email	varchar(50)	

2.10.8 First Health Paid Claims Layout

2.10.8.1 Prof FFS

Name	Type	Length	Position Start	Position End	Description
sak_claim	Num	10	1	10	The claim number (" ######")
run_date_time	Char	17	11	27	File extract date and time
num_icn	Char	13	28	40	Internal control number
claim_status_dtl	Char	1	41	41	Claim Status: (Detail) V - VOID P - PAID
claim_region	Char	2	42	43	Claim Region; we use region code, first 2 digits of ICN, to indicate original claim, adjustment or void claim
claim_type	Char	1	44	44	Claim Type: B-Professional Crossover M-Professional
patient_account	Char	20	45	64	Patient account number;
patient_liab	Num	9	65	73	Amount member is responsible to pay for services rendered. (" #####.##") Header level
co_pay	Num	8	74	81	Amount paid by member for services rendered. (" ####.##") Header level
dte_billed	Char	8	82	89	Date billed;
amt_billed_hdr	Num	10	90	99	Amount Billed; (" ######.##") Header level
from_dos	Char	8	100	107	From date of service
to_dos	Char	8	108	115	To date of service
cde_eob	Char	9	116	124	First 2 claim EOB codes
prov_id_billing	Char	15	125	139	Provider ID: billing
id_type_billing	Char	3	140	142	Provider ID Type: billing - (NPI, MCD,

Name	Type	Length	Position Start	Position End	Description
					or BSE)
cde_txn_billing	Char	10	143	152	Provider ID Taxonomy: billing
rid	Char	12	153	164	Member ID;
num_dtl	Num	4	165	168	Detail Number; (" ###")
units	Num	7	169	175	Number of units of service provided; (" ###.##")
amt_billed_dtl	Num	10	176	185	Amount Billed; (" ######.##")
prc_cde	Char	6	186	191	Procedure code
cde_diag	Char	7	192	198	Diagnosis code;
amt_alwd_dtl	Num	10	199	208	Amount allowed for services rendered; (" ######.##")
amt_paid_dtl	Num	10	209	218	Amount paid for services rendered; (" ######.##")
num_ssn	Char	9	219	227	SSN number
cde_sex	Char	1	228	228	Sex
recip_dob	Char	8	229	236	Member Date of Birth
recip_name	Char	38	237	274	Member Name: nam_first + nam_mid_init + nam_last
dte_paid	Char	8	275	282	Date the claim was paid.
amt_tpl	Num	10	283	292	TPL total paid amount (" ######.##") Header level
proc_code_mod1	Char	2	293	294	Procedure code modifier
proc_code_mod2	Char	2	295	296	Procedure code modifier
proc_code_mod3	Char	2	297	298	Procedure code modifier

Name	Type	Length	Position Start	Position End	Description
proc_code_mod4	Char	2	299	300	Procedure code modifier
cde_prov_spec	Char	3	301	303	Provider specialty
cde_prov_type	Char	2	304	305	Provider type
pos	Char	2	306	307	Place of service
amt_alwd_mcare_hdr	Num	9	308	316	Amount allowed by Medicare Crossover Part B Claim - Header level
amt_deduct_hdr	Num	9	317	325	Amount of the member's deductible payment -Medicare Crossover Part B Claim - Header level
amt_coinsurace_hdr	Num	9	326	334	Amount of the member's coinsurance payment - Medicare Crossover Part B Claim - Header level
amt_psych_hdr	Num	9	335	343	Amount of the member's psychiatric service payment - Medicare Crossover Part B Claim - Header level
amt_paid_mcare_hdr	Num	9	344	352	Amount paid by Medicare Crossover Part B Claim - Header level
dte_mcare_paid_hdr	Char	8	353	360	Date that Medicare paid the claim - Medicare Crossover Part B Claim - Header level
amt_alwd_mcare_dtl	Char	9	361	369	Amount allowed by Medicare Crossover Part B Claim
amt_deduct_dtl	Num	9	370	378	Amount of the member's deductible payment -Medicare Crossover Part B Claim
amt_coinsurace_dtl	Num	9	379	387	Amount of the member's coinsurance payment - Medicare Crossover Part B Claim
amt_psych_dtl	Num	9	388	396	Amount of the member's psychiatric service payment - Medicare Crossover Part B Claim

Name	Type	Length	Position Start	Position End	Description
amt_paid_mcare_dtl	Num	9	397	405	Amount paid by Medicare Crossover Part B Claim
dte_mcare_paid_dtl	Char	8	406	413	Date that Medicare paid the claim - Medicare Crossover Part B Claim
original_icn	Char	13	414	426	Original ICN for which the adjustment was created
prov_id_perf	Char	15	427	441	Provider ID: performing
id_type_perf	Char	3	442	444	Provider ID Type: performing - (NPI, MCD, or BSE)
cde_txn_perf	Char	10	445	454	Provider ID Taxonomy: performing
prov_id_ref	Char	15	455	469	Provider ID: referring
id_type_ref	Char	3	470	472	Provider ID Type: referring - (NPI, MCD, or BSE)
cde_txn_ref	Char	10	473	482	Provider ID Taxonomy: referring
amt_tot_reimb	Num	11	483	493	Header level amount paid (" #######.##")
ltc_ind	Char	1	494	494	Indicates whether or not the member is in a Long Term Care Facility.
receive_date	Char	5	495	499	The date the claim was received to be processed.
prior_auth	Char	10	500	509	This is the number assigned that authorizes the procedure being performed.
dte_rloc_eff	Char	8	510	517	The date the member entered a Long Term Care Facility.

2.10.8.2 Inst FFS

Name	Type	Length	Position Start	Position End	Description

Name	Type	Length	Position Start	Position End	Description
sak_claim	Num	10	1	10	The claim number (" ######")
run_date_time	Char	17	11	27	File extract date and time
num_icn	Char	13	28	40	Internal control number
claim_status_dtl	Char	1	41	41	Claim Status: (Detail) V - VOID P - PAID
claim_region	Char	2	42	43	Claim Region; we use region code, first 2 digits of ICN, to indicate original claim, adjusment or void claim
claim_type	Char	1	44	44	Claim Types: A-Inpatient Crossover C-Outpatient Crossover H-Home Health I - Inpatient O - Outpatient L-Long Term Care
patient_account	Char	20	45	64	Patient account number;
calc_amt_pd_pat_ub92	Num	10	65	74	This is the amount of patient liability that was used on the claim. (" ######.##") Header level
co_pay	Num	8	75	82	Amount paid by recipient for services rendered. (" ####.##")
dte_billed	Char	8	83	90	Date billed;
amt_billed_hdr	Num	10	91	100	Amount Billed; (" ######.##") Header level
from_dos	Char	8	101	108	From date of service
to_dos	Char	8	109	116	To date of service
admit_date	Char	8	117	124	Date that the recipient was admitted by the provider for inpatient care, outpatient services or start of care.

Name	Type	Length	Position Start	Position End	Description
pat_status	Char	2	125	126	Code which indicates the status of the recipient as of the ending service date of the period covered on a UB92 claim.
covered_days	Char	4	127	130	Indicates the total number of days for the statement period of the claim.
cde_eob	Char	9	131	139	First 2 claim EOB codes
prov_id_billing	Char	15	140	154	Provider ID: billing
id_type_billing	Char	3	155	157	Provider ID Type: billing - (NPI, MCD, or BSE)
cde_txn_billing	Char	10	158	167	Provider ID Taxonomy: billing
rid	Char	12	168	179	Recipient ID;
dtl	Num	4	180	183	Detail Number; (" ###")
rev	Char	4	184	187	Revenue code
units	Num	10	188	197	Number units billed; (" ######.##")
amt_billed_dtl	Num	10	198	207	Amount Billed; (" #######.##")
prc_cd	Char	6	208	213	Procedure code
cde_diag1	Char	7	214	220	Diagnosis code 1
cde_diag2	Char	7	221	227	Diagnosis code 2
cde_diag3	Char	7	228	234	Diagnosis code 3
cde_diag4	Char	7	235	241	Diagnosis code 4
cde_diag5	Char	7	242	248	Diagnosis code 5
cde_diag6	Char	7	249	255	Diagnosis code 6
amt_alwd_dtl	Num	10	256	265	Amount allowed for services rendered; (" ######.##")

Name	Type	Length	Position Start	Position End	Description
amt_paid_dtl	Num	10	266	275	Amount paid for services rendered; ("######.##")
num_ssn	Char	9	276	284	SSN number
cde_proc_icd9_1	Char	4	285	288	Code which represents the surgical procedure code.
dte_proc_icd9_1	Char	8	289	296	Date on which the surgical procedure was performed.
cde_proc_icd9_2	Char	4	297	300	Code which represents the surgical procedure code.
dte_proc_icd9_2	Char	8	301	308	Date on which the surgical procedure was performed.
cde_proc_icd9_3	Char	4	309	312	Code which represents the surgical procedure code.
dte_proc_icd9_3	Char	8	313	320	Date on which the surgical procedure was performed.
cde_proc_icd9_4	Char	4	321	324	Code which represents the surgical procedure code.
dte_proc_icd9_4	Char	8	325	332	Date on which the surgical procedure was performed.
cde_proc_icd9_5	Char	4	333	336	Code which represents the surgical procedure code.
dte_proc_icd9_5	Char	8	337	344	Date on which the surgical procedure was performed.
cde_proc_icd9_6	Char	4	345	348	Code which represents the surgical procedure code.
dte_proc_icd9_6	Char	8	349	356	Date on which the surgical procedure was performed.
cde_sex	Char	1	357	357	Sex

Name	Type	Length	Position Start	Position End	Description
recip_dob	Char	8	358	365	Recipient Date of Birth
recip_name	Char	38	366	403	Recipient Name: nam_first + nam_mid_init + nam_last
dte_paid	Char	8	404	411	Date the claim was paid.
bill_type	Char	3	412	414	The location at which a service was rendered, such as office, home, emergency room, etc. This applies only to electronic claims. Paper claims do not carry place of service at header.
attend_phys	Char	15	415	429	The number of the licensed physician who would be expected to certify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.
admit_phys	Char	15	430	444	License number of the physician who performed the principal procedure.
admit_diag	Char	7	445	451	The diagnosis code that was keyed on the claim. (cde_diag/t_ub92_hdr_diag_x)
amt_tpl	Char	10	452	461	This is the TPL amount for header only services. (" ######.##")
proc_code_mod1	Char	2	462	463	Procedure code modifier
proc_code_mod2	Char	2	464	465	Procedure code modifier
proc_code_mod3	Char	2	466	467	Procedure code modifier
proc_code_mod4	Char	2	468	469	Procedure code modifier
amt_alwd_mcare	Num	9	470	478	Amount allowed by Medicare Crossover Part A or C Claim - Header level (" #####.##")
amt_paid_mcare	Num	9	479	487	Amount paid by Medicare Crossover Part A or C Claim - Header level

Name	Type	Length	Position Start	Position End	Description
amt_deduct	Num	9	488	496	Amount of the recipient's deductable payment - Medicare Crossover Part A or C Claim - Header level
amt_coinsurace	Num	9	497	505	Amount of the recipient's coinsurance payment - Medicare Crossover Part A or C Claim - Header level
amt_deduct_blood	Num	9	506	514	Amount of the recipient's blood procedure payment - Medicare Crossover Part A or C Claim - Header level
dte_mcare_paid	Char	8	515	522	Date that Medicare paid the claim - Medicare Crossover Part A or C Claim
original_icn	Char	13	523	535	Original ICN for which the adjustment was created
prov_id_facility	Char	15	536	550	Provider ID: facility
id_type_facility	Char	3	551	553	Provider ID Type: facility - (NPI, MCD, or BSE)
cde_txn_facility	Char	10	554	563	Provider ID Taxonomy: facility
amt_tot_reimb	Num	11	564	574	Header level amount paid (" #######.##")
cde_occ1	Char	2	575	576	Code defining significant event relating to claim
dte_occ1	Char	8	577	584	Date of significant event
dte_occ_to1	Char	8	585	592	To date for span occurrence code
cde_occ2	Char	2	593	594	Code defining significant event relating to claim
dte_occ2	Char	8	595	602	Date of significant event
dte_occ_to2	Char	8	603	610	To date for span occurrence code

Name	Type	Length	Position Start	Position End	Description
cde_occ3	Char	2	611	612	Code defining significant event relating to claim
dte_occ3	Char	8	613	620	Date of significant event
dte_occ_to3	Char	8	621	628	To date for span occurrence code
cde_value1	Char	2	629	630	Code to relate values to a claim
amt_value1	Num	9	631	639	Dollar amount of associated value code
cde_value2	Char	2	640	641	Code to relate values to a claim
amt_value2	Num	9	642	650	Dollar amount of associated value code
cde_value3	Char	2	651	652	Code to relate values to a claim
amt_value3	Num	9	653	661	Dollar amount of associated value code
cde_cond1	Char	2	662	663	Code relating conditions to a UB92 claim
cde_cond2	Char	2	664	665	Code relating conditions to a UB92 claim
cde_cond3	Char	2	666	667	Code relating conditions to a UB92 claim
ltc_ind	Char	1	668	668	Indicates whether or not the member is in a Long Term Care Facility.
receive_date	Char	5	669	673	The date the claim was received to be processed.
prior_auth	Char	10	674	683	This is the number assigned that authorizes the procedure being performed.
cde_drg	Char	4	684	687	e diagnosis related group number assigned to the claim.

Name	Type	Length	Position Start	Position End	Description
amt_base_drg	Char	10	688	697	The normal amount due the provider for the DRG number. It excludes any compensation for outlier days or outlier amount(s).
admit_hour	Char	5	698	702	The hour the recipient was admitted to the hospital. Hour 01 is 1:00 am; hour 24 is midnight.
admit_source	Char	1	703	703	The admission source code is used to indicate if the recipient is coming from a LTC facility. A code of 5 indicates admission from a LTC facility.
admit_type	Char	1	704	704	Code which indicates the priority of the admission for inpatient or outpatient care.
discharge_time	Char	5	705	709	The hour the recipient was discharged from the hospital. Hour 01 is 1:00 am; hour 24 is midnight.
days_not_covered	Char	10	710	719	The number of days between the service begin-date and service end date which were not covered in any part by medical assistance or medicare.
dte_rloc_eff	Char	8	720	727	The date the member entered a Long Term Care Facility.

2.10.8.3 Dental FFS

Name	Type	Length	Position Start	Position End	Description
sak_claim	Num	10	1	10	The claim number (" ######")
run_date_time	Char	17	11	27	File extract date and time
num_icn	Char	13	28	40	Internal control number
claim_status_dtl	Char	1	41	41	Claim Status: (Detail) V - VOID P - PAID

Name	Type	Length	Position Start	Position End	Description
claim_region	Char	2	42	43	Claim Region; we use region code, first 2 digits of ICN, to indicate original claim, adjusment or void claim.
claim_type	Char	1	44	44	Claim Type. "D" for Dental
patient_account	Char	20	45	64	Patient account number
patient_liab	Num	9	65	73	Amount of money that recipient is responsible for paying for services rendered. (" #####.##") Header level
co_pay	Num	8	74	81	Amount paid by recipient for services rendered. (" ####.##")
dte_billed	Char	8	82	89	Date billed
amt_billed_hdr	Num	10	90	99	Header Amount Billed (" ######.##")
from_dos	Char	8	100	107	From date of service
to_dos	Char	8	108	115	To date of service
cde_eob	Char	9	116	124	First 2 claim EOB codes
prov_id_billing	Char	15	125	139	Provider ID: billing
id_type_billing	Char	3	140	142	Provider ID Type: billing - (NPI, MCD, or BSE)
cde_txn_billing	Char	10	143	152	Provider ID Taxonomy: billing
rid	Char	12	153	164	Recipient ID
num_dtl	Num	4	165	168	Detail Number
units	Num	7	169	175	Quantity billed (" ###.##")
amt_billed_dtl	Num	10	176	185	Detail Billed (" ######.##")
prc_cde	Char	6	186	191	Procedure code
cde_diag	Char	7	192	198	Diagnosis code

Name	Type	Length	Position Start	Position End	Description
amt_alwd_dtl	Num	10	199	208	Amount allowed for services rendered; (" ######.##")
amt_paid_dtl	Num	10	209	218	Amount paid for services rendered; (" ######.##")
num_ssn	Char	9	219	227	SSN number
cde_tooth_surface	Char	4	228	231	Code that indicates the tooth surface of a particular tooth. Up to 4 surface codes allowed.
cde_sex	Char	1	232	232	Sex
recip_dob	Char	8	233	240	Recipient Date of Birth
recip_name	Char	38	241	278	Recipient Name: nam_first + nam_mid_init + nam_last
dte_paid	Char	8	279	286	Date the claim was paid.
quadrant	Char	3	287	289	The quadrant of the mouth that the procedure on the claim is related to.
tooth_number	Char	2	290	291	Code which indicates the tooth on which a particular service was performed.
amt_tpl	Num	10	292	301	TPL total paid amount (" ######.##") Header level
proc_code_mod1	Char	2	302	303	Procedure code modifier
proc_code_mod2	Char	2	304	305	Procedure code modifier
proc_code_mod3	Char	2	306	307	Procedure code modifier
proc_code_mod4	Char	2	308	309	Procedure code modifier
original_icn	Char	13	310	322	Original ICN for which the adjustment was created
prov_id_perf	Char	15	323	337	Provider ID: performing

Name	Type	Length	Position Start	Position End	Description
id_type_perf	Char	3	338	340	Provider ID Type: performing - (NPI, MCD, or BSE)
cde_txn_perf	Char	10	341	350	Provider ID Taxonomy: performing
prov_id_ref	Char	15	351	365	Provider ID: referring
id_type_ref	Char	3	366	368	Provider ID Type: referring - (NPI, MCD, or BSE)
cde_txn_ref	Char	10	369	378	Provider ID Taxonomy: referring
amt_tot_reimb	Num	11	379	389	Header level amount paid (" #######.##")
ltc_ind	Char	1	390	390	Indicates whether or not the member is in a Long Term Care Facility.
receive_date	Char	5	391	395	The date the claim was received to be processed.
prior_auth	Char	10	396	405	This is the number assigned that authorizes the procedure being performed.
dte_rloc_eff	Char	8	406	413	The date the member entered a Long Term Care Facility.

2.10.8.4 Amend History

Date	Name	Worksheet	Change Description
9/25/2006	Sachi Wisner	UB92, Physician, Dental	UB92 sheet - claim status and dte_final - These two fields are deleted.
9/25/2006	Sachi Wisner	UB92, Physician, Dental	claim_status_dtl - Valid values are changed to V - Void and P - Paid.
9/25/2006	Sachi Wisner	UB92, Physician, Dental	All field with data type "Num" (Number) will have one byte dedicated to store sign at the beginning (space for positive number, - for negative number). Format is changed to store sign at the beginning of the amount. Length is not changed. For example, the format of

Date	Name	Worksheet	Change Description
			calc_amt_pd_pat_ub92 on UB92 layout is changed from ("########.##") into (" ######.##")
9/25/2006	Sachi Wisner	UB92, Physician, Dental	the data type of sak_claim is changed from Char into Num.
9/25/2006	Sachi Wisner	UB92	The above change applies to co_pay, sak_claim, amt_billed_hdr, dtl, units, amt_billed_dtl and other number fields.
9/25/2006	Sachi Wisner	Physician	The above change applies to sak_claim, patient_liab, co_pay, amt_billed_hdr, num_dtl, units, amt_billed_dtl and other number fields.
9/25/2006	Sachi Wisner	Dental	The above change applies to sak_claim, patient_lieb, co_pay, amt_billed_hdr,num_dtl , units, amt_billed_dtl, amt_alwd_dtl, amt_paid_dtl, amt_tpl.
9/25/2006	Sachi Wisner	UB92	prov_id_billing, attend_phys, admit_phys, prov_od_facility field length are changed from 16 into 15.
9/25/2006	Sachi Wisner	Physician	prov_id_billing, prov_id_perf, prov_id_ref field length are changed from 16 into 15.
9/25/2006	Sachi Wisner	Dental	prov_id_billing, prov_id_perf, prov_id_ref field length are changed from 16 to 15.
9/25/2006	Sachi Wisner	Dental	RID is documented as Number. It is changed to Char.
9/25/2006	Sachi Wisner	UB92	amt_alwd_mcare, amt_paid_mcare, amt_deduct, amt_coinsurace, amt_deduct_blood data types were documented as Char. These fields are changed into Number.
9/25/2006	Sachi Wisner	Physician	amt_tpl, amt_alwd_mcare_hdr, amt_deduct_hdr, amt_coinsurace_hdr, amt_psych_hdr, dte_mcare_paid_hdr, amt_deduct_dtl, amt_coinsurace_dtl, amt_psych_dtl, amt_paid_mcare_dtl were documented as Char. These fields are changed into Number.

Date	Name	Worksheet	Change Description
9/26/2006	Sachi Wisner	Dental	amt_tpl were documented as Char. These fields are changed into Number.
9/25/2006	Sachi Wisner	UB92	Data type of the following fields are changed from Num into Char. dte_occ1, dte_occ_to1, dte_occ2, dte_occ_to2, dte_occ3, dte_occ_to3
9/26/2006	Sachi Wisner	Dental	Quadrant length is changed from 2 into 3.
9/25/2006	Sachi Wisner	UB92, Physician, Dental	Trailer record - length of record count is changed into 10. Data type is changed into Number.
9/25/2006	Sachi Wisner	UB92, Physician, Dental	Trailer record - length of total amount paid is changed into 14. Data type is changed into Number.
9/25/2006	Sachi Wisner	UB92, Physician, Dental	Trailer record - length of file_id is changed into 60. Data type is changed into Num. Format is changed with "filename" + space + data + time, instead of underscore (_) characters in between filename, data and time.
9/25/2006	Sachi Wisner	UB92, Physician, Dental	NOTE is added to clarify sign at the beginning of number data type, and linefeed at the end of each record.
9/28/2006	Sachi Wisner	UB92, Physician, Dental	Modified description of Trailer record. " total amount paid" is total of amt_paid_dtl.
11/27/2006	Paula Keiser	Physician, Dental	Added IND_LTC, Julian Date from the ICN, NUM_PRIOR_AUTH, and DTE_RLOC_EFF to the Physician and Dental Extracts.
11/27/2006	Paula Keiser	UB92	Added IND_LTC, Julian Date from the ICN, NUM_PRIOR_AUTH, CDE_DRG, AMT_BASE_DRG, CDE_ADMIT_HOUR, CDE_ADMIT_SOURCE, CDE_ADMIT_TYPE, TIME_DISCHARGE, NUM_DAYS_NCOVD, and DTE_RLOC_EFFto the UB92 Extracts.

2.10.8.5 Trailer Record

Name	Type	Length	Position Start	Position End	Description

Name	Type	Length	Position Start	Position End	Description
record count desc	Char	15	1	15	"Record Count : "
record count	Num	10	16	25	Number of records in the file. (" #########")
pipe delimiter	Char	3	26	28	" | "
total amount paid desc	Char	17	29	45	"Total Amt Paid : "
total amount paid	Num	14	46	59	Total of the amount paid (amt_paid_dtl) in the file. (" ##########.##")
pipe delimiter	Char	3	60	62	" | "
file_id desc	Char	10	63	72	"file_id : "
file_id	Char	55	73	127	filename_date date-processed time-processed

NOTE:

Each record has linefeed character at the end of each record.

"Number" field is for ASCII character. Only numeric characters will be stored on these fields.

All fields specified as Number will have one byte dedicated to sign (space for positive value, - for negative value)

Number fields are right justified and space filled if data length is shorter than field length.

Character fields are left justified space filled if data length is shorter than field length.

The file is sent without zipping.

2.10.9 HMS Layout

Name	Type	Length	Position Start	Position End	Description
sak_claim	Char	10	1	10	The claim number; System assigned key which uniquely identifies a claim in the system.
run_date_time	Char	17	11	27	File extract date and time

Name	Type	Length	Position Start	Position End	Description
num_icn	Char	13	28	40	Internal control number; Number assigned to a claim processed in the system used for internal control purposes.
claim_status_dtl	Char	1	41	41	Claim Status: (Detail) D - DENIED P - PAID
claim_region	Char	2	42	43	Claim Region; we use region code, first 2 digits of ICN, to indicate original claim, adjustment or void claim
claim_type	Char	1	44	44	Claim Type: 'P' - Pharmacy 'Q' - Compound Pharmacy
patient_liab	Num	9	45	53	Amount that the member is responsible to pay for drugs dispensed. (######.##) Header level
co_pay	Num	8	54	61	Amount paid by the member for drugs dispensed. (#####.##) Header level
dte_billed	Char	8	62	69	Date billed
charge	Num	9	70	78	Amount Billed (######.##) - Header level
dte_dispense	Num	8	79	86	From date of service
cde_eob	Char	9	87	95	Explanation of benefit code that provides the reason for which the adjustment was created. (could be zero or blank for unknown code eob)
prov_id_billing	Char	15	96	110	Provider ID: billing
id_type_billing	Char	3	111	113	Provider ID Type: billing - (NPI, MCD)
cde_txn_billing	Char	10	114	123	Provider ID Taxonomy: billing
rid	Num	12	124	135	Member ID

Name	Type	Length	Position Start	Position End	Description
num_dtl	Num	4	136	139	Detail Number
met_qtt	Num	10	140	149	Quantity dispensed (#####.###) Number of units of a drug dispensed to a member. The type of unit is expressed in CDE DRUG FORM.
amt_alwd	Num	10	150	159	Amount Allowed (#######.##)
ndc_cde	Char	11	160	170	NDC code; National Drug Code prescribed/dispensed to a member.
cde_diag	Char	7	171	177	Diagnosis code; The diagnosis code that was keyed on the claim.
qty_refill	Num	4	178	181	Number of times a drug can be refilled;
num_day_supply	Num	9	182	190	Number of days a prescribed drug should last a member.
id_prov_prescrib	Char	10	191	200	The Drug Enforcement Agency identification number for a provider.
amt_paid	Num	11	201	211	Amount paid for services rendered. (########.##)
num_ssn	Num	9	212	220	The social security number for a member.
nam_drug	Char	30	221	250	Drug Brand Name
gcn	Char	7	251	257	The Generic Code Number (GCN) is a unique number representing the generic formulation for a drug product.
nhi	Char	4	258	261	Indicates whether the drug was dispensed for a member who resides in a nursing home facility. Blank if no data on input xml file. 3 indicates member in nursing home.
disp_fee	Num	11	262	272	Dispensing fee (#######.##); Total dollar reimbursed to providers for a specific claim. (Denied claims always

Name	Type	Length	Position Start	Position End	Description
					zero)
rx_num	Char	7	273	279	RX Number; The prescription number for the drug dispensed
gen_drug	Char	63	280	342	Generic Brand Name; The Generic Name (GNN) field contains the drug ingredient names adopted by United States Adopted Names (USAN). The chemical name is used when the USAN name is not available.
cde_sex	Char	1	343	343	Sex
dob	Char	8	344	351	Date of Birth
recip_name	Char	36	352	387	Member Name: nam_first + nam_mid_init + nam_last
prescrib_ prov_name	Char	50	388	437	Prescribing provider name (This is the name associated with an organization or person.)
Pharmacy Name	Char	50	438	487	Pharmacy Name (This is the name associated with an organization or person.)
mcc_dte_paid	Char	8	488	495	Date the claim was paid.
amt_awp	Num	11	496	506	This is the drug's Blue Book average wholesale unit price and represents the most common wholesaler price to the retailer or hospital. (#####.#####)
original_icn	Char	13	507	519	Original ICN for which the adjustment was created
prov_id_rend	Char	15	520	534	Provider ID: rendering
id_type_rend	Char	3	535	537	Provider ID Type: rendering - (NPI, MCD)

Name	Type	Length	Position Start	Position End	Description
cde_txn_rend	Char	10	538	547	Provider ID Taxonomy: rendering
prov_id_prescrb	Char	15	548	562	Provider ID: prescribing
id_type_prescrb	Char	3	563	565	Provider ID Type: prescribing - (NPI, MCD)
cde_txn_prescrb	Char	10	566	575	Provider ID Taxonomy: prescribing
gpi_ind	Num	1	576	576	GPI_IND - The Generic Product Indicator (GPI) will distinguish a product as either a generic drug product or as the more expensive branded drug products.
amt_tpl	Num	9	577	585	The amount received by the provider from private insurers.
ind_brand_med_nec	Char	1	586	586	Field indicates the reason, if any, that a brand name drug was dispensed.

2.10.9.1 Trailer Record

Name	Type	Length	Position Start	Position End	Description
record count desc	Char	15	1	15	"Record Count : "
record count	Char	10	16	25	Number of records in the file. (##########)
pipe delimiter	Char	3	26	28	" | "
total amount paid desc	Char	17	29	45	"Total Amt Paid : "
total amount paid	Char	14	46	59	Total of the amount paid in the file. (##########.##)
pipe delimiter	Char	3	60	62	" | "
file_id desc	Char	10	63	72	"file_id : "
file_id	Char	40	73	112	filename_date_date-processed_time-

Name	Type	Length	Position Start	Position End	Description
					processed

2.10.9.2 Prof FFS

Name	Type	Length	Position Start	Position End	Description
sak_claim	Char	10	1	10	The claim number
run_date_time	Char	17	11	27	File extract date and time
num_icn	Char	13	28	40	Internal control number
claim_status_dtl	Char	1	41	41	Claim Status: (Detail) D - DENIED P - PAID
claim_region	Char	2	42	43	Claim Region; we use region code, first 2 digits of ICN, to indicate original claim, adjusment or void claim
claim_type	Char	1	44	44	Claim Type: B-Professional Crossover M-Professional
patient_account	Char	20	45	64	Patient account number;
patient_liab	Num	9	65	73	Amount recipient is responsible to pay for services rendered. (######.##) Header level
co_pay	Num	8	74	81	Amount paid by recipient for services rendered. (#####.##) Header level
dte_billed	Char	8	82	89	Date billed;
amt_billed_hdr	Num	10	90	99	Amount Billed; (#######.##) Header level
from_dos	Char	8	100	107	From date of service
to_dos	Char	8	108	115	To date of service
cde_eob	Char	9	116	124	First 2 claim EOB codes

Name	Type	Length	Position Start	Position End	Description
prov_id_billing	Char	15	125	139	Provider ID: billing
id_type_billing	Char	3	140	142	Provider ID Type: billing - (NPI, MCD)
cde_txn_billing	Char	10	143	152	Provider ID Taxonomy: billing
rid	Char	12	153	164	Recipient ID;
num_dtl	Num	4	165	168	Detail Number;
units	Num	7	169	175	Number of units of service provided; (####.##)
amt_billed_dtl	Num	10	176	185	Amount Billed; (#######.##)
prc_cde	Char	6	186	191	Procedure code
date_final	Char	8	192	199	Date final
cde_diag	Char	7	200	206	Diagnosis code;
amt_alwd_dtl	Num	10	207	216	Amount allowed for services rendered; (#######.##)
amt_paid_dtl	Num	10	217	226	Amount paid for services rendered; (#######.##)
num_ssn	Char	9	227	235	SSN number
cde_sex	Char	1	236	236	Sex
recip_dob	Char	8	237	244	Recipient Date of Birth
recip_name	Char	38	245	282	Recipient Name: nam_first + nam_mid_init + nam_last
amt_tpl	Char	10	283	292	TPL total paid amount (#######.##) Header level
proc_code_mod1	Char	2	293	294	Procedure code modifier
proc_code_mod2	Char	2	295	296	Procedure code modifier

Name	Type	Length	Position Start	Position End	Description
proc_code_mod3	Char	2	297	298	Procedure code modifier
proc_code_mod4	Char	2	299	300	Procedure code modifier
cde_prov_spec	Char	3	301	303	Provider specialty
cde_prov_type	Char	2	304	305	Provider type
pos	Char	2	306	307	Place of service
amt_alwd_mcare_hdr	Char	9	308	316	Amount allowed by Medicare Crossover Part B Claim - Header level
amt_deduct_hdr	Char	9	317	325	Amount of the recipient's deductable payment -Medicare Crossover Part B Claim - Header level
amt_coinsurace_hdr	Char	9	326	334	Amount of the recipient's coinsurance payment - Medicare Crossover Part B Claim - Header level
amt_psych_hdr	Char	9	335	343	Amount of the recipient's psychiatric service payment - Medicare Crossover Part B Claim - Header level
amt_paid_mcare_hdr	Char	9	344	352	Amount paid by Medicare Crossover Part B Claim - Header level
dte_mcare_paid_hdr	Char	8	353	360	Date that Medicare paid the claim - Medicare Crossover Part B Claim - Header level
amt_alwd_mcare_dtl	Char	9	361	369	Amount allowed by Medicare Crossover Part B Claim
amt_deduct_dtl	Char	9	370	378	Amount of the recipient's deductable payment -Medicare Crossover Part B Claim
amt_coinsurace_dtl	Char	9	379	387	Amount of the recipient's coinsurance payment - Medicare Crossover Part B Claim

Name	Type	Length	Position Start	Position End	Description
amt_psych_dtl	Char	9	388	396	Amount of the recipient's psychiatric service payment - Medicare Crossover Part B Claim
amt_paid_mcare_dtl	Char	9	397	405	Amount paid by Medicare Crossover Part B Claim
dte_mcare_paid_dtl	Char	8	406	413	Date that Medicare paid the claim - Medicare Crossover Part B Claim
original_icn	Char	13	414	426	Original ICN for which the adjustment was created
prov_id_perf	Char	15	427	441	Provider ID: performing
id_type_perf	Char	3	442	444	Provider ID Type: performing - (NPI, MCD)
cde_txn_perf	Char	10	445	454	Provider ID Taxonomy: performing
prov_id_ref	Char	15	455	469	Provider ID: referring
id_type_ref	Char	3	470	472	Provider ID Type: referring - (NPI, MCD)
cde_txn_ref	Char	10	473	482	Provider ID Taxonomy: referring
amt_tot_reimb	Num	11	483	493	Header level amount paid (########.##)

2.10.9.3 Inst FFS

Name	Type	Length	Position Start	Position End	Description
sak_claim	Char	10	1	10	The claim number
run_date_time	Char	17	11	27	File extract date and time
num_icn	Char	13	28	40	Internal control number
claim_status_dtl	Char	1	41	41	Claim Status: (Detail) D - DENIED P - PAID

Name	Type	Length	Position Start	Position End	Description
claim_region	Char	2	42	43	Claim Region; we use region code, first 2 digits of ICN, to indicate original claim, adjusment or void claim
claim_type	Char	1	44	44	Claim Types: A-Inpatient Crossover C-Outpatient Crossover H-Home Health I - Inpatient O - Outpatient L-Long Term Care
patient_account	Char	20	45	64	Patient account number;
calc_amt_pd_pat_ub92	Num	10	65	74	This is the amount of patient liability that was used on the claim. (#######.##) Header level
co_pay	Num	8	75	82	Amount paid by recipient for services rendered. (#####.##)
dte_billed	Char	8	83	90	Date billed;
amt_billed_hdr	Num	10	91	100	Amount Billed; (#######.##) Header level
from_dos	Char	8	101	108	From date of service
to_dos	Char	8	109	116	To date of service
admit_date	Char	8	117	124	Date that the recipient was admitted by the provider for inpatient care, outpatient services or start of care.
pat_status	Char	2	125	126	Code which indicates the status of the recipient as of the ending service date of the period covered on a UB92 claim.
covered_days	Char	4	127	130	Indicates the total number of days for the statement period of the claim.
cde_eob	Char	9	131	139	First 2 claim EOB codes
prov_id_billing	Char	15	140	154	Provider ID: billing

Name	Type	Length	Position Start	Position End	Description
id_type_billing	Char	3	155	157	Provider ID Type: billing - (NPI, MCD)
cde_txn_billing	Char	10	158	167	Provider ID Taxonomy: billing
rid	Char	12	168	179	Recipient ID;
dtl	Num	4	180	183	Detail Number;
rev	Char	4	184	187	Revenue code
units	Num	10	188	197	Number units billed; (#######.##)
amt_billed_dtl	Num	10	198	207	Amount Billed; (#######.##)
prc_cd	Char	6	208	213	Procedure code
date_final	Char	8	214	221	date final
cde_diag1	Char	7	222	228	Diagnosis code 1
cde_diag2	Char	7	229	235	Diagnosis code 2
cde_diag3	Char	7	236	242	Diagnosis code 3
cde_diag4	Char	7	243	249	Diagnosis code 4
cde_diag5	Char	7	250	256	Diagnosis code 5
cde_diag6	Char	7	257	263	Diagnosis code 6
amt_alwd_dtl	Num	10	264	273	Amount allowed for services rendered; (#######.##)
amt_paid_dtl	Num	10	274	283	Amount paid for services rendered; (#######.##)
num_ssn	Char	9	284	292	SSN number
cde_proc_icd9_1	Char	4	293	296	Code which represents the surgical procedure code.
dte_proc_icd9_1	Char	8	297	304	Date on which the surgical procedure

Name	Type	Length	Position Start	Position End	Description
					was performed.
cde_proc_icd9_2	Char	4	305	308	Code which represents the surgical procedure code.
dte_proc_icd9_2	Char	8	309	316	Date on which the surgical procedure was performed.
cde_proc_icd9_3	Char	4	317	320	Code which represents the surgical procedure code.
dte_proc_icd9_3	Char	8	321	328	Date on which the surgical procedure was performed.
cde_proc_icd9_4	Char	4	329	332	Code which represents the surgical procedure code.
dte_proc_icd9_4	Char	8	333	340	Date on which the surgical procedure was performed.
cde_proc_icd9_5	Char	4	341	344	Code which represents the surgical procedure code.
dte_proc_icd9_5	Char	8	345	352	Date on which the surgical procedure was performed.
cde_proc_icd9_6	Char	4	353	356	Code which represents the surgical procedure code.
dte_proc_icd9_6	Char	8	357	364	Date on which the surgical procedure was performed.
cde_sex	Char	1	365	365	Sex
recip_dob	Char	8	366	373	Recipient Date of Birth
recip_name	Char	38	374	411	Recipient Name: nam_first + nam_mid_init + nam_last
bill_type	Char	3	412	414	The location at which a service was rendered, such as office, home, emergency room, etc. This applies only to electronic claims. Paper claims do

Name	Type	Length	Position Start	Position End	Description
					not carry place of service at header.
attend_phys	Char	15	415	429	The number of the licensed physician who would be expected to certify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.
admit_phys	Char	15	430	444	License number of the physician who performed the principal procedure.
admit_diag	Char	7	445	451	The diagnosis code that was keyed on the claim. (cde_diag/t_ub92_hdr_diag_x)
amt_tpl	Char	10	452	461	This is the TPL amount for header only services. (#######.##)
proc_code_mod1	Char	2	462	463	Procedure code modifier
proc_code_mod2	Char	2	464	465	Procedure code modifier
proc_code_mod3	Char	2	466	467	Procedure code modifier
proc_code_mod4	Char	2	468	469	Procedure code modifier
amt_alwd_mcare	Char	9	470	478	Amount allowed by Medicare Crossover Part A or C Claim - Header level
amt_paid_mcare	Char	9	479	487	Amount paid by Medicare Crossover Part A or C Claim - Header level
amt_deduct	Char	9	488	496	Amount of the recipient's deductable payment - Medicare Crossover Part A or C Claim - Header level
amt_coinsurace	Char	9	497	505	Amount of the recipient's coinsurance payment - Medicare Crossover Part A or C Claim - Header level

Name	Type	Length	Position Start	Position End	Description
amt_deduct_blood	Char	9	506	514	Amount of the recipient's blood procedure payment - Medicare Crossover Part A or C Claim - Header level
dte_mcare_paid	Char	8	515	522	Date that Medicare paid the claim - Medicare Crossover Part A or C Claim
original_icn	Char	13	523	535	Original ICN for which the adjustment was created
prov_id_facility	Char	15	536	550	Provider ID: facility
id_type_facility	Char	3	551	553	Provider ID Type: facility - (NPI, MCD)
cde_txn_facility	Char	10	554	563	Provider ID Taxonomy: facility
amt_tot_reimb	Num	11	564	574	Header level amount paid (########.##)
cde_occ1	Char	2	575	576	Code defining significant event relating to claim
dte_occ1	Num	8	577	584	Date of significant event
dte_occ_to1	Num	8	585	592	To date for span occurrence code
cde_occ2	Char	2	593	594	Code defining significant event relating to claim
dte_occ2	Num	8	595	602	Date of significant event
dte_occ_to2	Num	8	603	610	To date for span occurrence code
cde_occ3	Char	2	611	612	Code defining significant event relating to claim
dte_occ3	Num	8	613	620	Date of significant event
dte_occ_to3	Num	8	621	628	To date for span occurrence code
cde_value1	Char	2	629	630	Code to relate values to a claim

Name	Type	Length	Position Start	Position End	Description
amt_value1	Num	9	631	639	Dollar amount of associated value code
cde_value2	Char	2	640	641	Code to relate values to a claim
amt_value2	Num	9	642	650	Dollar amount of associated value code
cde_value3	Char	2	651	652	Code to relate values to a claim
amt_value3	Num	9	653	661	Dollar amount of associated value code
cde_cond1	Char	2	662	663	Code relating conditions to a UB92 claim
cde_cond2	Char	2	664	665	Code relating conditions to a UB92 claim
cde_cond3	Char	2	666	667	Code relating conditions to a UB92 claim
cde_admit_type	Char	1	668	668	Code which indicates the priority of the admission of a member for inpatient services.
cde_admit_source	Char	1	669	669	The admission source code is used to indicate if the member is coming from a LTC facility. A code of 5 indicates admission from a LTC facility.

2.10.9.4 Dental FFS

Name	Type	Length	Position Start	Position End	Description
sak_claim	Char	10	1	10	The claim number
run_date_time	Char	17	11	27	File extract date and time
num_icn	Char	13	28	40	Internal control number
claim_status_dtl	Char	1	41	41	Claim Status: (Detail) D - DENIED

Name	Type	Length	Position Start	Position End	Description
					P - PAID
claim_region	Char	2	42	43	Claim Region; we use region code, first 2 digits of ICN, to indicate original claim, adjusment or void claim.
claim_type	Char	1	44	44	Claim Type. "D" for Dental
patient_account	Char	20	45	64	Patient account number
patient_liab	Num	9	65	73	Amount of money that recipient is responsible for paying for services rendered. (######.##) Header level
co_pay	Num	8	74	81	Amount paid by recipient for services rendered. (#####.##)
dte_billed	Char	8	82	89	Date billed
amt_billed_hdr	Num	10	90	99	Header Amount Billed (######.##)
from_dos	Char	8	100	107	From date of service
to_dos	Char	8	108	115	To date of service
cde_eob	Char	9	116	124	First 2 claim EOB codes
prov_id_billing	Char	15	125	139	Provider ID: billing
id_type_billing	Char	3	140	142	Provider ID Type: billing - (NPI, MCD)
cde_txn_billing	Char	10	143	152	Provider ID Taxonomy: billing
rid	Num	12	153	164	Recipient ID
num_dtl	Num	4	165	168	Detail Number
units	Num	7	169	175	Quantity billed (####.##)
amt_billed_dtl	Num	10	176	185	Detail Billed (#######.##)

Name	Type	Length	Position Start	Position End	Description
prc_cde	Char	6	186	191	Procedure code
date_final	Char	8	192	199	Date final
cde_diag	Char	7	200	206	Diagnosis code
amt_alwd_dtl	Num	10	207	216	Amount allowed for services rendered; (#######.##)
amt_paid_dtl	Num	10	217	226	Amount paid for services rendered; (#######.##)
num_ssn	Char	9	227	235	SSN number
cde_tooth_surface	Char	4	236	239	Code that indicates the tooth surface of a particular tooth. Up to 4 surface codes allowed.
cde_sex	Char	1	240	240	Sex
recip_dob	Char	8	241	248	Recipient Date of Birth
recip_name	Char	38	249	286	Recipient Name: nam_first + nam_mid_init + nam_last
quadrant	Char	3	287	289	The quadrant of the mouth that the procedure on the claim is related to.
tooth_number	Char	2	290	291	Code which indicates the tooth on which a particular service was performed.
amt_tpl	Char	10	292	301	TPL total paid amount (#######.##) Header level
proc_code_mod1	Char	2	302	303	Procedure code modifier
proc_code_mod2	Char	2	304	305	Procedure code modifier
proc_code_mod3	Char	2	306	307	Procedure code modifier
proc_code_mod4	Char	2	308	309	Procedure code modifier

Name	Type	Length	Position Start	Position End	Description
original_icn	Char	13	310	322	Original ICN for which the adjustment was created
prov_id_perf	Char	15	323	337	Provider ID: performing
id_type_perf	Char	3	338	340	Provider ID Type: performing - (NPI, MCD)
cde_txn_perf	Char	10	341	350	Provider ID Taxonomy: performing
prov_id_ref	Char	15	351	365	Provider ID: referring
id_type_ref	Char	3	366	368	Provider ID Type: referring - (NPI, MCD)
cde_txn_ref	Char	10	369	378	Provider ID Taxonomy: referring
amt_tot_reimb	Num	11	379	389	Header level amount paid (########.##)

2.10.10 ICFMR Claims Interface Layout

Name	Type	Length	Position Start	Position End	Description
Filler	Char	1	1	1	Blank Field
Paid_date	Formatted date (mm/yy)	5	2	6	Date the claim was paid.
Delimiter (";")	Char	1	7	7	*
Provider Number	Char	10	8	17	Provider ID Number
Delimiter (";")	Char	1	18	18	*
Provider Name	Char	45	19	63	Provider Name
Delimiter (";")	Char	1	64	64	*

Name	Type	Length	Position Start	Position End	Description
Covered Days	Number	14	65	78	Indicates the total number of days for the statement period of the claim. (###############)
Delimiter (";")	Char	1	79	79	*
Accom Total Paid	Number	15	80	94	Total Paid of accommodation services. (#############.##)
Delimiter (";")	Char	1	95	95	*
Ancil Total Paid	Number	15	96	110	Total Paid of ancillary services. (#############.##)
Delimiter (";")	Char	1	111	111	*
Member Paid Amount	Number	15	112	126	This is the result of (1) Amount paid by member for services rendered (Copay) plus (2) Amount of patient liability. (#############.##)
Delimiter (";")	Char	1	127	127	*
TPL Amount	Number	15	128	142	This is the TPL amount for header only services.(#############.##)
Delimiter (";")	Char	1	143	143	*
Paid Amount	Number	15	144	158	Amount paid for services rendered.(#############.##)
Delimiter (";")	Char	1	159	159	*
Medicare Paid Amount	Number	15	160	174	Amount paid by Medicare Crossover Part A or C Claim - Header level.(#############.##)
Delimiter (";")	Char	1	175	175	*

Name	Type	Length	Position Start	Position End	Description
Paid Amount + Medicare Paid Amount	Number	15	176	190	Amount paid for services rendered + Medicare Paid Amount.(############.##)

2.10.10.1 Trailer Record

Name	Type	Length	Position Start	Position End	Description
Filler	Char	18	1	18	Blank Field
"TOTAL"	Char	5	19	23	" T O T A L "
Filler	Char	40	24	63	Blank Field
Delimiter (";")	Char	1	64	64	*
Covered Days	Number	14	65	78	Total Number of days Covered in the file.(###############)
Delimiter (";")	Char	1	79	79	*
Accom Total Paid	Number	15	80	94	Grand Total of Accom Total Paid in the file.(############.##)
Delimiter (";")	Char	1	95	95	*
Ancil Total Paid	Number	15	96	110	Grand Total of Ancil Total Paid in the file.(############.##)
Delimiter (";")	Char	1	111	111	*
Member Paid Amount	Number	15	112	126	Total Member Paid Amount in the file.(############.##)
Delimiter (";")	Char	1	127	127	*
TPL Amount	Number	15	128	142	Total TPL Amount in the file.(############.##)
Delimiter (";")	Char	1	143	143	*
Paid Amount	Number	15	144	158	Total Paid Amount in the

Name	Type	Length	Position Start	Position End	Description
					file.(#############.##)
Delimiter (";")	Char	1	159	159	*
Medicare Paid Amount	Number	15	160	174	Total Medicare Paid Amount in the file.(#############.##)
Delimiter (";")	Char	1	175	175	*
Paid Amount + Medicare Paid Amount	Number	15	176	190	Grand Total of (Paid Amount + Medicare Paid Amount) in the file.(#############.##)

2.10.11 Ineligible Part A Crossover Claims Layout

2.10.11.1 Header Record (titles in the first line in both files

Name	Type	Length	Position Start	Position End
"BILL PROV "	char	10	1	10
Delimiter (;)		1	11	11
"BILL PROVIDER LAST NAME"	char	28	12	39
Delimiter (;)		1	40	40
"BILL PROVIDER FIRST NAME"	char	29	41	69
Delimiter (;)		1	70	70
"PROVIDER ADDRESS LINE1"	char	29	71	99
Delimiter (;)		1	100	100
"PROVIDER ADDRESS LINE2"	char	29	101	129
Delimiter (;)		1	130	130
"PROVIDER CITY"	char	18	131	148
Delimiter (;)		1	149	149

Name	Type	Length	Position Start	Position End
"PROV"	char	5	150	154
Delimiter (;)		1	155	155
"PROV ZIP"	char	9	156	164
Delimiter (;)		1	165	165
"PROV TEL"	char	13	166	178
Delimiter (;)		1	179	179
"FIRST DATE"	char	10	180	189
Delimiter (;)		1	190	190
"TRANS CONTROL"	char	19	191	209
Delimiter (;)		1	210	210
"ORIG RECIP"	char	10	211	220
Delimiter (;)		1	221	221
"CASE NAME"	char	25	222	246
Delimiter (;)		1	247	247
"UNITS OF"	number	13	248	260
Delimiter (;)		1	261	261
"PAID DATE"	char	10	262	271
Delimiter (;)		1	272	272
"PAID AMOUNT"	number	12	273	284
Delimiter (;)		1	285	285
"DRUG CODE"	char	11	286	296
Delimiter (;)		1	297	297

Name	Type	Length	Position Start	Position End
"DRUG NAME"	char	30	298	327
Delimiter (;)		1	328	328
"GENERIC"	char	7	329	335
Delimiter (;)		1	336	336
"PRESCRIPTION"	char	12	337	348
Delimiter (;)		1	349	349
"REFERRING PROVIDER LAST NAME"	char	28	350	377
Delimiter (;)		1	378	378
"REFERRING PROVIDER FIRST NAME"	char	29	379	407
Delimiter (;)		1	408	408
"LTC ICN"	char	19	409	427

2.10.11.2 Header Record (titles in the second line in both files

Name	Type	Length	Position Start	Position End
"NUMBER "	char	10	1	10
Delimiter (;)		1	11	11
Filler	char	28	12	39
Delimiter (;)		1	40	40
Filler	char	29	41	69
Delimiter (;)		1	70	70
Filler	char	29	71	99
Delimiter (;)		1	100	100

Name	Type	Length	Position Start	Position End
Filler	char	29	101	129
Delimiter (;)		1	130	130
Filler	char	18	131	148
Delimiter (;)		1	149	149
"STATE"	char	5	150	154
Delimiter (;)		1	155	155
"CODE"	char	9	156	164
Delimiter (;)		1	165	165
"NUMBER"	char	13	166	178
Delimiter (;)		1	179	179
"OF SERVICE"	char	10	180	189
Delimiter (;)		1	190	190
"NUMBER"	char	19	191	209
Delimiter (;)		1	210	210
"ID"	char	10	211	220
Delimiter (;)		1	221	221
Filler	char	25	222	246
Delimiter (;)		1	247	247
"SERVICE"	number	13	248	260
Delimiter (;)		1	261	261
Filler	char	10	262	271
Delimiter (;)		1	272	272

Name	Type	Length	Position Start	Position End
Filler	number	12	273	284
Delimiter (;)		1	285	285
Filler	char	11	286	296
Delimiter (;)		1	297	297
Filler	char	30	298	327
Delimiter (;)		1	328	328
"CODE"	char	7	329	335
Delimiter (;)		1	336	336
"NUMBER"	char	12	337	348
Delimiter (;)		1	349	349
Filler	char	28	350	377
Delimiter (;)		1	378	378
Filler	char	29	379	407
Delimiter (;)		1	408	408
Filler	char	19	409	427

2.10.11.3 Detail Record (both files)

Bill Prov	char	10	1	10	Provider ID: billing
Delimiter (;)		1	11	11	
Bill Provider Last Name	char	28	12	39	This is the name associated with an organization or person.
Delimiter (;)		1	40	40	

Bill Prov	char	10	1	10	Provider ID: billing
Bill Provider First Name	char	29	41	69	This is the name associated with an organization or person.
Delimiter (;)		1	70	70	
Provider Address Line 1	char	29	71	99	Mailing address street 1. This is the street address for a provider.
Delimiter (;)		1	100	100	
Provider Address Line 2	char	29	101	129	Mailing address street 2. This is the street address for a provider.
Delimiter (;)		1	130	130	
Provider City	char	18	131	148	Mailing address city. This is the city where a provider would receive business mail.
Delimiter (;)		1	149	149	
State	char	5	150	154	Mailing address state. This is the state where a provider would receive business mail.
Delimiter (;)		1	155	155	
Prov Zip	char	9	156	164	Mailing address zip code. This is the first 5 digits of the zip code for a business mailing zip code.
Delimiter (;)		1	165	165	

Bill Prov	char	10	1	10	Provider ID: billing
Prov Tel	char	13	166	178	This is a phone number in the format area code + prefix + suffix
Delimiter (;)		1	179	179	
First DOS	char	10	180	189	Date Pharmacy dispense drug to member.
Delimiter (;)		1	190	190	
Trans Control Num (ICN)	char	19	191	209	Number assigned to a claim processed in the system; used for control purposes.
Delimiter (;)		1	210	210	
Orig Recip	char	10	211	220	Unique identifier for the member.
Delimiter (;)		1	221	221	
Case Name	char	25	222	246	Member Name:nam_last + nam_first + nam_mid_init
Delimiter (;)		1	247	247	
Units Of Svc	number	13	248	260	The number of units of a drug dispense to a member. z,zzz,zzz.999
Delimiter (;)		1	261	261	
Paid Date	char	10	262	271	Date the claim was paid.
Delimiter (;)		1	272	272	

Bill Prov	char	10	1	10	Provider ID: billing
Paid Amount	number	12	273	284	Amount paid for services rendered to a member. z,zzz,zzz.99
Delimiter (;)		1	285	285	
Drug Code	char	11	286	296	National Drug Code is comprised of a 5 byte numeric labeler code, 4 byte numeric product code and a 2 byte numeric package code. Used to uniquely identify a drug, it's labeler & package size of a product for pricing and service/prior authorization.
Delimiter (;)		1	297	297	
Drug Name	char	30	298	327	Drug Brand Name
Delimiter (;)		1	328	328	
Generic Code	char	7	329	335	The Generic Code Number (GCN) is a unique number representing the generic formulation for a drug product.
Delimiter (;)		1	336	336	
RX Number	char	12	337	348	Prescription number assigned by a pharmacy to a drug dispensed to a member.

Bill Prov	char	10	1	10	Provider ID: billing
Delimiter (;)		1	349	349	
Referring Provider Last Name	char	28	350	377	Provider Last name : referring.
Delimiter (;)		1	378	378	
Referring Provider First Name	char	29	379	407	Provider First name : referring.
Delimiter (;)		1	408	408	
L T C ICN	char	19	409	427	Long Term Care TCN:Number assigned to a claim processed in the system; used for control purposes.

2.10.12 IPRO Extract Layout

2.10.12.1 IPRO Pharmacy Extract Layout

Field Name	Type	Length	Precision	Description
IND_MEDICARE_A	CHAR	1	0	This is the Part A Medicare indicator. Values include 'P' for Pending, 'Y' for Yes, 'N' for No.
,	CHAR	1	0	Comma Delimiter
IND_MEDICARE_B	CHAR	1	0	This is the Part B Medicare indicator. Values include 'P' for Pending, 'Y' for Yes, 'N' for No.
,	CHAR	1	0	Comma Delimiter
ADR_ZIP_CODE	CHAR	5	0	Member's ZIP code
,	CHAR	1	0	Comma Delimiter
CDE_PROV_SPEC_BILL	CHAR	3	0	The primary area of specialization for the provider for billing provider..
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
CDE_PROV_TYPE_BILL	CHAR	2	0	The primary provider type for which a provider is licensed for billing provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_BASE	CHAR	15	0	This is the high level ID assigned by interChange to the unique instance of a provider without regard to service location for billing provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_MCAID	CHAR	15	0	The Medicaid ID of the provider at the service location for billing provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_NPI	CHAR	15	0	The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs for billing provider.
,	CHAR	1	0	Comma Delimiter
SAK_PROV	NUMBER	10	0	System Assigned Key for the Provider Identifier for billing provider.
,	CHAR	1	0	Comma Delimiter
SAK_PROV_LOC	NUMBER	10	0	System assigned key assigned to the provider service location for billing provider.
,	CHAR	1	0	Comma Delimiter
CDE_COS_ST (for billing)	CHAR	2	0	The state COS code that defines the grouping of services desired on State MAR reports (that is, Inpatient, Outpatient, Psychiatric, and so on.).

Field Name	Type	Length	Precision	Description
,	CHAR	1	0	Comma Delimiter
CDE_POS	CHAR	2	0	A code to indicate where the service was provided.
,	CHAR	1	0	Comma Delimiter
AMT_AWP	NUMBER	11	5	Average wholesale price for drug.
,	CHAR	1	0	Comma Delimiter
AMT_EAC	NUMBER	11	5	Estimated acquisition cost for drug.
,	CHAR	1	0	Comma Delimiter
AMT_MAC	NUMBER	11	5	The unit price for a drug under Federal MAC regulation.
,	CHAR	1	0	Comma Delimiter
AMT_NDC_PROFEE	NUMBER	11	2	Amount that the provider receives for dispensing a prescription drug. This amount varies by provider type.
,	CHAR	1	0	Comma Delimiter
CDE_DEA	CHAR	1	0	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.
,	CHAR	1	0	Comma Delimiter
CDE_NDC	CHAR	11	0	The national drug code for the drug dispensed.
,	CHAR	1	0	Comma Delimiter
CDE_ORGANIZ	CHAR	1	0	A code to indicate the type of

Field Name	Type	Length	Precision	Description
				pharmacy.
,	CHAR	1	0	Comma Delimiter
CDE_THERA_CLS_AHFS	CHAR	10	0	
,	CHAR	1	0	Comma Delimiter
CDE_THERA_CLS_SPEC	CHAR	3	0	Therapeutic Class Code, Specific (GC3, Alias, HIC3). The most specific therapeutic class code offered by First Data Bank, intended for users who need a very definitive therapeutic classification system.
,	CHAR	1	0	Comma Delimiter
DTE_DISPENSE	DATE	8	0	The date the service was incurred.
,	CHAR	1	0	Comma Delimiter
DTE_PRESCRIBE	DATE	8	0	Date the prescription was written by the physician.
,	CHAR	1	0	Comma Delimiter
IND_BRAND_MED_NEC	CHAR	1	0	Field indicates the reason, if any, that a brand name drug was dispensed.
,	CHAR	1	0	Comma Delimiter
IND_DRUG_GENERIC	CHAR	1	0	Generic Product Indicator (GPI) distinguishes a product either as a generic drug product or a more expensive branded drug product.
,	CHAR	1	0	Comma Delimiter
IND_PRICING	CHAR	6	0	Indicates the method used to price the service or product.

Field Name	Type	Length	Precision	Description
,	CHAR	1	0	Comma Delimiter
LEVEL_OF_SERVICE	NUMBER	3	0	Coding indicating the type of service the provider rendered. Valid values are: 0=Not Specified, 1=Patient consultation, 2=Home delivery, 3=Emergency, 4=24 hour service, 5=Patient consultation regarding generic product selection and 6=In-Home Service.
,	CHAR	1	0	Comma Delimiter
NUM_DAY_SUPPLY	NUMBER	10	0	The number of days the prescription should last.
,	CHAR	1	0	Comma Delimiter
NUM_GCN	NUMBER	6	0	The generic drug code is a 5 digit code (left justified in the 12 characters available in the field) assigned by First Data Bank (Medical Assistance contractor for drug pricing data) to group together all identical drugs. For example Acetaminophen tablets/50mg drug codes will have a common Acetaminophen tablets/50mg drug codes will have a common generic drug code.
,	CHAR	1	0	Comma Delimiter
NUM_PRSCRIP	CHAR	7	0	The number assigned to the prescription by the provider.
,	CHAR	1	0	Comma Delimiter
PATIENT_LOCATION	NUMBER	3	0	Code identifying the location of the patient when receiving pharmacy services. Valid values are: 0=Not Specified, 1=Home, 2=Inter-Care3=Nursing Home, 4=Long Term/Extended Care, 5=Rest

Field Name	Type	Length	Precision	Description
				Home6=Boarding Home, 7=Skilled Care Facility, 8=Sub-Acute Care Facility, 9=Acute Care Facility, 10=Outpatient and 11=Hospice.
,	CHAR	1	0	Comma Delimiter
QTY_DISPENSE	NUMBER	12	3	The quantity dispensed for the drug claim.
,	CHAR	1	0	Comma Delimiter
QTY_REFILL	CHAR	2	0	The refill number of the drug that was dispensed on the claim.
,	CHAR	1	0	Comma Delimiter
CDE_EOB_1	CHAR	4	0	A code which represents a policy for Medicaid claim adjudication.
,	CHAR	1	0	Comma Delimiter
CDE_EOB_2	CHAR	4	0	A code which represents a policy for Medicaid claim adjudication.
,	CHAR	1	0	Comma Delimiter
AMT_ALWD	NUMBER	12	2	Amount approved to pay for services provided to a member.
,	CHAR	1	0	Comma Delimiter
AMT_BILLED	NUMBER	12	2	Amount of money requested for payment by a provider for services rendered to a member.
,	CHAR	1	0	Comma Delimiter
AMT_ENCOUNTER	NUMBER	12	2	Amount for encounter services on the claim detail indicated by the detail number on the table.

Field Name	Type	Length	Precision	Description
,	CHAR	1	0	Comma Delimiter
AMT_PAID	NUMBER	12	2	Amount that will be applied toward the check amount.
,	CHAR	1	0	Comma Delimiter
AMT_TPL	NUMBER	12	2	The amount received by the provider from private insurers.
,	CHAR	1	0	Comma Delimiter
AMT_CO_PAY	NUMBER	12	2	The amount members age 18 and older are responsible to pay the provider for the service.
,	CHAR	1	0	Comma Delimiter
AMT_PAT_LIAB	NUMBER	12	2	The amount received by the provider from the member. This excludes co-pay. This is the amount that has been determined to be available from the member as partial payment of the cost of care.
,	CHAR	1	0	Comma Delimiter
AMT_MCARE_PAID	NUMBER	12	2	The amount received by the provider for the claim from Medicare.
,	CHAR	1	0	Comma Delimiter
AMT_PD_MCO	NUMBER	12	2	Amount paid by the managed care organization.
,	CHAR	1	0	Comma Delimiter
CDE_ADJ_VOID	CHAR	1	0	A code to indicate whether the record is a new day claim (N), adjustment (A=daughter claim) or a void (V).

Field Name	Type	Length	Precision	Description
,	CHAR	1	0	Comma Delimiter
CDE_CLM_TYPE	CHAR	1	0	A code to indicate the type of medical assistance invoice used by the provider to bill map for the rendered service.
,	CHAR	1	0	Comma Delimiter
CDE_DTL_STATUS	CHAR	1	0	Code that indicates if the claim is approved or rejected.
,	CHAR	1	0	Comma Delimiter
CDE_EMERGENCY	CHAR	1	0	A code to indicate whether the claim was for a service provided in an emergency situation.
,	CHAR	1	0	Comma Delimiter
DTE_BILLED	DATE	8	0	The date the provider completed the invoice.
,	CHAR	1	0	Comma Delimiter
DTE_BIRTH	DATE	8	0	The birth date of the member.
,	CHAR	1	0	Comma Delimiter
DTE_FIRST_SVC	DATE	8	0	Date on which services were first performed for a member.
,	CHAR	1	0	Comma Delimiter
DTE_LAST_SVC	DATE	8	0	Date on which services were last performed for a member.
,	CHAR	1	0	Comma Delimiter
DTE_PAID	DATE	8	0	The date the claim was adjudicated. Except for special processing cycles. This is not the actual date of

Field Name	Type	Length	Precision	Description
				payment; since the payment is issued by the state treasurer after a post-audit and when funds are available.
,	CHAR	1	0	Comma Delimiter
ID_MEDICAID	CHAR	12	0	The unique number assigned to the member by OIM.
,	CHAR	1	0	Comma Delimiter
IND_CLAIM	CHAR	1	0	E=Encounter or F=Fee for service claim.
,	CHAR	1	0	Comma Delimiter
IND_LATEST_CLM	CHAR	1	0	Code to indicate the latest claim in an adjustment chain.
,	CHAR	1	0	Comma Delimiter
IND_MNGD_HLTH	CHAR	1	0	Indicates if the member was enrolled in an HMO/IHO when the claim was adjudicated.
,	CHAR	1	0	Comma Delimiter
IND_REF_EPSDT	CHAR	1	0	Indicates whether the procedure/drug is compensable for children with medically needy only categories of assistance if dispensed through the EPSDT program.
,	CHAR	1	0	Comma Delimiter
NUM_ADJ_ICN	CHAR	13	0	Internal control number of the mother claim.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
NUM_DTL	NUMBER	5	0	Number of the detail on the claim.
,	CHAR	1	0	Comma Delimiter
NUM_ICN	CHAR	13	0	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.
,	CHAR	1	0	Comma Delimiter
NUM_PRIOR_AUTH	CHAR	10	0	This is the number assigned that authorizes the procedure being performed.
,	CHAR	1	0	Comma Delimiter
NUM_RECIP_AGE	NUMBER	5	0	The age of the member on the From Date of Service rounded down to a full year.
,	CHAR	1	0	Comma Delimiter
CDE_REVENUE	CHAR	4	0	Revenue Code
,	CHAR	1	0	Comma Delimiter
QTY_UNITS_ALWD	NUMBER	12	2	The units of service approved for payment.
,	CHAR	1	0	Comma Delimiter
QTY_UNITS_BILLED	NUMBER	12	2	The units of service billed by the provider.

Field Name	Type	Length	Precision	Description
,	CHAR	1	0	Comma Delimiter
CDE_PROV_SPEC_PERF	CHAR	3	0	The primary area of specialization for the provider for Performing Provider.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_TYPE_PERF	CHAR	2	0	The primary provider type for which a provider is licensed for Performing Provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_BASE	CHAR	15	0	This is the high level ID assigned by interChange to the unique instance of a provider without regard to service location for Performing Provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_MCAID	CHAR	15	0	The Medicaid ID of the provider at the service location for Performing Provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_NPI	CHAR	15	0	The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs for Performing Provider.
,	CHAR	1	0	Comma Delimiter
SAK_PROV	NUMBER	10	0	System Assigned Key for the Provider Identifier for Performing Provider.
,	CHAR	1	0	Comma Delimiter
SAK_PROV_LOC	NUMBER	10	0	System assigned key assigned to the provider service location for

Field Name	Type	Length	Precision	Description
				Performing Provider.
,	CHAR	1	0	Comma Delimiter
CDE_AID_CATEGORY	CHAR	2	0	Identifies the type of aid for which a member is eligible.
,	CHAR	1	0	Comma Delimiter
CDE_RACE	CHAR	2	0	Code describing the race of an individual. Each position of this field can contain a different race code.
,	CHAR	1	0	Comma Delimiter
CDE_RECIP_COUNTY	VARCHAR2	10	0	The county number used to identify a geographical/political area in the state.
,	CHAR	1	0	Comma Delimiter
CDE_SEX	CHAR	1	0	Code describing the gender of an individual.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_SPEC_PRIM	CHAR	3	0	The primary area of specialization for the provider for Referring Provider.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_TYPE_PRIM	CHAR	2	0	The primary provider type for which a provider is licensed for Referring Provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_BASE	CHAR	15	0	This is the high level ID assigned by interChange to the unique instance of a provider without regard to service location for Referring

Field Name	Type	Length	Precision	Description
				Provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_MCAID	CHAR	15	0	The Medicaid ID of the provider at the service location for Referring Provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_NPI	CHAR	15	0	The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs for Referring Provider.
,	CHAR	1	0	Comma Delimiter
SAK_PROV	NUMBER	10	0	System Assigned Key for the Provider Identifier for Referring Provider.
,	CHAR	1	0	Comma Delimiter
SAK_PROV_LOC	NUMBER	10	0	System assigned key assigned to the provider service location for Referring Provider.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_SPEC_PRIM	CHAR	3	0	The primary area of specialization for the provider for Submitter.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_TYPE_PRIM	CHAR	2	0	The primary provider type for which a provider is licensed for Submitter.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_BASE	CHAR	15	0	This is the high level ID assigned by interChange to the unique instance of a provider without regard to

Field Name	Type	Length	Precision	Description
				service location for Submitter.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_MCAID	CHAR	15	0	The Medicaid ID of the provider at the service location for Submitter.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_NPI	CHAR	15	0	The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs for Submitter.
,	CHAR	1	0	Comma Delimiter
SAK_PROV	NUMBER	10	0	System Assigned Key for the Provider Identifier for Submitter.
,	CHAR	1	0	Comma Delimiter
SAK_PROV_LOC	NUMBER	10	0	System assigned key assigned to the provider service location for Submitter.
,	CHAR	1	0	Comma Delimiter
AMT_ALWD_MCARE	NUMBER	10	2	The dollar amount allowed by Medicare for the services provided.
,	CHAR	1	0	Comma Delimiter
AMT_COINSURANCE	NUMBER	10	2	The amount of Medicare Co-Insurance paid by the member for this claim.
,	CHAR	1	0	Comma Delimiter
AMT_DEDUCT	NUMBER	10	2	Amount of Medicare deductible the member must meet before Medicare will pay.

Field Name	Type	Length	Precision	Description
,	CHAR	1	0	Comma Delimiter
AMT_PAID_MCARE	NUMBER	10	2	The amount approved by Medicare for the service. The amount approved by Medicare is the basis for deductible paid and/or coinsurance paid for which the member (Medical Assistance) is responsible.

2.10.12.2 IPRO Dental Extract Layout

Field Name	Type	Length	Precision	Description
IND_MEDICARE_A	CHAR	1	0	This is the Part A Medicare indicator. Values include 'P' for Pending, 'Y' for Yes, 'N' for No.
,	CHAR	1	0	Comma Delimiter
IND_MEDICARE_B	CHAR	1	0	This is the Part B Medicare indicator. Values include 'P' for Pending, 'Y' for Yes, 'N' for No.
,	CHAR	1	0	Comma Delimiter
ADR_ZIP_CODE	CHAR	5	0	Member's ZIP code
,	CHAR	1	0	Comma Delimiter
CDE_PROV_SPEC_BILL	CHAR	3	0	The primary area of specialization for the provider.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_TYPE_BILL	CHAR	2	0	The primary provider type for which a provider is licensed.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_BASE	CHAR	15	0	This is the high level ID assigned by interChange to the unique instance

Field Name	Type	Length	Precision	Description
				of a provider without regard to service location
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_MCAID	CHAR	15	0	The Medicaid ID of the provider at the service location for billing provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_NPI	CHAR	15	0	The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs
,	CHAR	1	0	Comma Delimiter
SAK_PROV	NUMBER	10	0	System Assigned Key for the Provider Identifier.
,	CHAR	1	0	Comma Delimiter
SAK_PROV_LOC	NUMBER	10	0	System assigned key assigned to the provider service location.
,	CHAR	1	0	Comma Delimiter
CDE_COS_ST (for billing)	CHAR	2	0	The state COS code that defines the grouping of services desired on State MAR reports (that is, Inpatient, Outpatient, Psychiatric, and so on.).
,	CHAR	1	0	Comma Delimiter
CDE_POS	CHAR	2	0	A code to indicate where the service was provided.
,	CHAR	1	0	Comma Delimiter
CDE_TOOTH_NBR	CHAR	2	0	A code to indicate the tooth on which the service was performed.

Field Name	Type	Length	Precision	Description
,	CHAR	1	0	Comma Delimiter
CDE_TOOTH_SURFACE_1	CHAR	1	0	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.
,	CHAR	1	0	Comma Delimiter
CDE_TOOTH_SURFACE_2	CHAR	1	0	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.
,	CHAR	1	0	Comma Delimiter
CDE_TOOTH_SURFACE_3	CHAR	1	0	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.
,	CHAR	1	0	Comma Delimiter
CDE_TOOTH_SURFACE_4	CHAR	1	0	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.
,	CHAR	1	0	Comma Delimiter
CDE_TOOTH_SURFACE_5	CHAR	1	0	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.
,	CHAR	1	0	Comma Delimiter
CDE_TOOTH_SURFACE_6	CHAR	1	0	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.

Field Name	Type	Length	Precision	Description
,	CHAR	1	0	Comma Delimiter
CDE_EOB_1	CHAR	4	0	A code which represents a policy for Medicaid claim adjudication.
,	CHAR	1	0	Comma Delimiter
CDE_EOB_2	CHAR	4	0	A code which represents a policy for Medicaid claim adjudication.
,	CHAR	1	0	Comma Delimiter
AMT_ALWD	NUMBER	12	2	Amount approved to pay for services provided to a member.
,	CHAR	1	0	Comma Delimiter
AMT_BILLED	NUMBER	12	2	Amount of money requested for payment by a provider for services rendered to a member.
,	CHAR	1	0	Comma Delimiter
AMT_ENCOUNTER	NUMBER	12	2	Amount for encounter services on the claim detail indicated by the detail number on the table.
,	CHAR	1	0	Comma Delimiter
AMT_PAID	NUMBER	12	2	Amount that will be applied toward the check amount.
,	CHAR	1	0	Comma Delimiter
AMT_TPL	NUMBER	12	2	The amount received by the provider from private insurers.
,	CHAR	1	0	Comma Delimiter
AMT_CO_PAY	NUMBER	12	2	The amount members age 18 and older are responsible to pay the

Field Name	Type	Length	Precision	Description
				provider for the service.
,	CHAR	1	0	Comma Delimiter
AMT_PAT_LIAB	NUMBER	12	2	The amount received by the provider from the member. This excludes co-pay. This is the amount that has been determined to be available from the member as partial payment of the cost of care.
,	CHAR	1	0	Comma Delimiter
AMT_MCARE_PAID	NUMBER	12	2	The amount received by the provider for the claim from Medicare.
,	CHAR	1	0	Comma Delimiter
AMT_PD_MCO	NUMBER	12	2	Amount paid by the managed care organization.
,	CHAR	1	0	Comma Delimiter
CDE_ADJ_VOID	CHAR	1	0	A code to indicate whether the record is a new day claim (N), adjustment (A=daughter claim) or a void (V).
,	CHAR	1	0	Comma Delimiter
CDE_CLM_TYPE	CHAR	1	0	A code to indicate the type of medical assistance invoice used by the provider to bill map for the rendered service.
,	CHAR	1	0	Comma Delimiter
CDE_DTL_STATUS	CHAR	1	0	Code that indicates if the claim is approved or rejected.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
CDE_EMERGENCY	CHAR	1	0	A code to indicate whether the claim was for a service provided in an emergency situation.
,	CHAR	1	0	Comma Delimiter
CDE_MODIFIER_1	CHAR	2	0	The first of up to 4 codes that may be used to supplement the procedure code.
,	CHAR	1	0	Comma Delimiter
CDE_MODIFIER_2	CHAR	2	0	The second of up to 4 codes that may be used to supplement the procedure code.
,	CHAR	1	0	Comma Delimiter
CDE_MODIFIER_3	CHAR	2	0	The third of up to 4 codes that may be used to supplement the procedure code.
,	CHAR	1	0	Comma Delimiter
CDE_PROC_PRIM	CHAR	6	0	A code from the MA fee schedule to indicate the service performed.
,	CHAR	1	0	Comma Delimiter
CDE_REVENUE	CHAR	4	0	Revenue Code
,	CHAR	1	0	Comma Delimiter
DTE_BILLED	DATE	8	0	The date the provider completed the invoice.
,	CHAR	1	0	Comma Delimiter
DTE_BIRTH	DATE	8	0	The birth date of the member.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
DTE_FIRST_SVC	DATE	8	0	Date on which services were first performed for a member.
,	CHAR	1	0	Comma Delimiter
DTE_LAST_SVC	DATE	8	0	Date on which services were last performed for a member.
,	CHAR	1	0	Comma Delimiter
DTE_PAID	DATE	8	0	The date the claim was adjudicated. Except for special processing cycles. This is not the actual date of payment; since the payment is issued by the state treasurer after a post-audit and when funds are available.
,	CHAR	1	0	Comma Delimiter
ID_MEDICAID	CHAR	12	0	The unique number assigned to the member by OIM.
,	CHAR	1	0	Comma Delimiter
IND_CLAIM	CHAR	1	0	E=Encounter or F=Fee for service claim.
,	CHAR	1	0	Comma Delimiter
IND_LATEST_CLM	CHAR	1	0	Code to indicate the latest claim in an adjustment chain.
,	CHAR	1	0	Comma Delimiter
IND_MNGD_HLTH	CHAR	1	0	Indicates if the member was enrolled in an HMO/HIO when the claim was adjudicated.
,	CHAR	1	0	Comma Delimiter
IND_REF_EPSDT	CHAR	1	0	Indicates whether the procedure/drug is compensable for

Field Name	Type	Length	Precision	Description
				children with medically needy only categories of assistance if dispensed through the EPSDT program.
,	CHAR	1	0	Comma Delimiter
NUM_ADJ_ICN	CHAR	13	0	Internal control number of the mother claim.
,	CHAR	1	0	Comma Delimiter
NUM_DTL	NUMBER	5	0	Number of the detail on the claim.
,	CHAR	1	0	Comma Delimiter
NUM_ICN	CHAR	13	0	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.
,	CHAR	1	0	Comma Delimiter
NUM_PRIOR_AUTH	CHAR	10	0	This is the number assigned that authorizes the procedure being performed.
,	CHAR	1	0	Comma Delimiter
NUM_RECIP_AGE	NUMBER	5	0	The age of the member on the From Date of Service rounded down to a full year.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
QTY_UNITS_ALWD	NUMBER	11	2	The units of service approved for payment.
,	CHAR	1	0	Comma Delimiter
QTY_UNITS_BILLED	NUMBER	11	2	The units of service billed by the provider.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_SPEC_PERF	CHAR	3	0	The primary area of specialization for the provider.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_TYPE_PERF	CHAR	2	0	The primary provider type for which a provider is licensed.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_BASE	CHAR	15	0	This is the high level ID assigned by interChange to the unique instance of a provider without regard to service location
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_MCAID	CHAR	15	0	The Medicaid ID of the provider at the service location for performing provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_NPI	CHAR	15	0	The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs
,	CHAR	1	0	Comma Delimiter
SAK_PROV	NUMBER	10	0	System Assigned Key for the Provider Identifier.

Field Name	Type	Length	Precision	Description
,	CHAR	1	0	Comma Delimiter
SAK_PROV_LOC	NUMBER	10	0	System assigned key assigned to the provider service location.
,	CHAR	1	0	Comma Delimiter
CDE_AID_CATEGORY	CHAR	2	0	Identifies the type of aid for which a member is eligible.
,	CHAR	1	0	Comma Delimiter
CDE_RACE	CHAR	2	0	Code describing the race of an individual. Each position of this field can contain a different race code.
,	CHAR	1	0	Comma Delimiter
CDE_RECIP_COUNTY	VARCHAR2	10	0	The county number used to identify a geographical/political area in the state.
,	CHAR	1	0	Comma Delimiter
CDE_SEX	CHAR	1	0	Code describing the gender of an individual.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_SPEC_PRIM,	CHAR	3	0	The primary area of specialization for the provider for Referring Provider.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_TYPE_PRIM,	CHAR	2	0	The primary provider type for which a provider is licensed for Referring Provider.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
ID_PROVIDER_BASE	CHAR	15	0	This is the high level ID assigned by interChange to the unique instance of a provider without regard to service location for Referring Provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_MCAID	CHAR	15	0	The Medicaid ID of the provider at the service location for Referring Provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_NPI	CHAR	15	0	The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs for Referring Provider.
,	CHAR	1	0	Comma Delimiter
SAK_PROV	NUMBER	10	0	System Assigned Key for the Provider Identifier for Referring Provider.
,	CHAR	1	0	Comma Delimiter
SAK_PROV_LOC	NUMBER	10	0	System assigned key assigned to the provider service location for Referring Provider.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_SPEC_PRIM	CHAR	3	0	The primary area of specialization for the provider for Submitter.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_TYPE_PRIM	CHAR	2	0	The primary provider type for which a provider is licensed for Submitter.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
ID_PROVIDER_BASE	CHAR	15	0	This is the high level ID assigned by interChange to the unique instance of a provider without regard to service location for Submitter.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_MCAID	CHAR	15	0	The Medicaid ID of the provider at the service location for Submitter.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_NPI	CHAR	15	0	The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs for Submitter.
,	CHAR	1	0	Comma Delimiter
SAK_PROV	NUMBER	10	0	System Assigned Key for the Provider Identifier for Submitter.
,	CHAR	1	0	Comma Delimiter
SAK_PROV_LOC	NUMBER	10	0	System assigned key assigned to the provider service location for Submitter.
,	CHAR	1	0	Comma Delimiter
AMT_ALWD_MCARE	NUMBER	10	2	The dollar amount allowed by Medicare for the services provided.
,	CHAR	1	0	Comma Delimiter
AMT_COINSURANCE	NUMBER	10	2	The amount of Medicare Co-Insurance paid by the member for this claim.
,	CHAR	1	0	Comma Delimiter
AMT_DEDUCT	NUMBER	10	2	Amount of Medicare deductible the member must meet before Medicare

Field Name	Type	Length	Precision	Description
				will pay.
,	CHAR	1	0	Comma Delimiter
AMT_PAID_MCARE	NUMBER	10	2	The amount approved by Medicare for the service. The amount approved by Medicare is the basis for deductible paid and/or coinsurance paid for which the member (Medical Assistance) is responsible.

2.10.12.3 IPRO Other Encounter Extract Layout

Field Name	Type	Length	Precision	Description
IND_MEDICARE_A	CHAR	1	0	This is the Part A Medicare indicator. Values include 'P' for Pending, 'Y' for Yes, 'N' for No.
,	CHAR	1	0	Comma Delimiter
IND_MEDICARE_B	CHAR	1	0	This is the Part A Medicare indicator. Values include 'P' for Pending, 'Y' for Yes, 'N' for No.
,	CHAR	1	0	Comma Delimiter
ADR_ZIP_CODE	CHAR	5	0	Member's ZIP code
,	CHAR	1	0	Comma Delimiter
CDE_PROV_SPEC_BILL	CHAR	3	0	The primary area of specialization for the billing provider.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_TYPE_BILL	CHAR	2	0	The primary provider type for which a billing provider is licensed.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
ID_PROVIDER_BASE	CHAR	15	0	This is the high level ID assigned by interChange to the unique instance of a provider without regard to service location for billing provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_MCAID	CHAR	15	0	The Medicaid ID of the provider at the service location for billing provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_NPI	CHAR	15	0	The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs for billing provider.
,	CHAR	1	0	Comma Delimiter
SAK_PROV	NUMBER	10	0	System Assigned Key for the Provider Identifier for billing provider.
,	CHAR	1	0	Comma Delimiter
SAK_PROV_LOC	NUMBER	10	0	System assigned key assigned to the provider service location for billing provider.
,	CHAR	1	0	Comma Delimiter
CDE_COS_ST (for billing)	CHAR	2	0	The state COS code that defines the grouping of services desired on State MAR reports (that is, Inpatient, Outpatient, Psychiatric, and so on.).
,	CHAR	1	0	Comma Delimiter
CDE_POS	CHAR	2	0	A code to indicate where the service was provided.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
CDE_EOB_1	CHAR	4	0	A code which represents a policy for Medicaid claim adjudication.
,	CHAR	1	0	Comma Delimiter
CDE_EOB_2	CHAR	4	0	A code which represents a policy for Medicaid claim adjudication.
,	CHAR	1	0	Comma Delimiter
CDE_MODIFIER_1	CHAR	2	0	The first of up to 4 codes that may be used to supplement the procedure code for detail record.
,	CHAR	1	0	Comma Delimiter
CDE_MODIFIER_2	CHAR	2	0	The second of up to 4 codes that may be used to supplement the procedure code for the header record.
,	CHAR	1	0	Comma Delimiter
CDE_PROC_ICD9_1	VARCHAR2	4	0	First (primary) surgical procedure code.
,	CHAR	1	0	Comma Delimiter
CDE_PROC_ICD9_2	VARCHAR2	4	0	Second surgery code.
,	CHAR	1	0	Comma Delimiter
AMT_ALWD	NUMBER	12	2	Amount approved to pay for services provided to a member for the header record.
,	CHAR	1	0	Comma Delimiter
AMT_BILLED	NUMBER	12	2	Amount of money requested for payment by a provider for services rendered to a member for the header record.

Field Name	Type	Length	Precision	Description
,	CHAR	1	0	Comma Delimiter
AMT_ENCOUNTER	NUMBER	12	2	Amount for encounter services on the claim detail indicated by the detail number on the table. For zero detail, the first detail record has amt_encounter for the whole claim, the rest of detail records have zero on amt_encounter.
,	CHAR	1	0	Comma Delimiter
AMT_PAID	NUMBER	12	2	Amount that will be applied toward the check amount.
,	CHAR	1	0	Comma Delimiter
AMT_TPL	NUMBER	12	2	The amount received by the provider from private insurers for each detail record.
,	CHAR	1	0	Comma Delimiter
AMT_CO_PAY	NUMBER	12	2	The amount members age 18 and older are responsible to pay the provider for the service.
,	CHAR	1	0	Comma Delimiter
AMT_PAT_LIAB	NUMBER	12	2	The amount received by the provider from the member. This excludes co-pay. This is the amount that has been determined to be available from the member as partial payment of the cost of care.
,	CHAR	1	0	Comma Delimiter
AMT_MCARE_PAID	NUMBER	12	2	The amount received by the provider for the claim from Medicare.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
AMT_PD_MCO	NUMBER	12	2	Amount paid by the managed care organization.
,	CHAR	1	0	Comma Delimiter
CDE_ADJ_VOID	CHAR	1	0	A code to indicate whether the record is a new day claim (N), adjustment (A=daughter claim) or a void (V).
,	CHAR	1	0	Comma Delimiter
CDE_CLM_TYPE	CHAR	1	0	A code to indicate the type of medical assistance invoice used by the provider to bill map for the rendered service.
,	CHAR	1	0	Comma Delimiter
CDE_DIAG_2	CHAR	7	0	The secondary ICD-9-CM diagnosis code.
,	CHAR	1	0	Comma Delimiter
CDE_DIAG_3	CHAR	7	0	The third ICD-9-CM diagnosis code.
,	CHAR	1	0	Comma Delimiter
CDE_DIAG_4	CHAR	7	0	The fourth ICD-9-CM diagnosis code.
,	CHAR	1	0	Comma Delimiter
CDE_DIAG_PRIM	CHAR	7	0	The primary ICD-9-CM diagnosis code.
,	CHAR	1	0	Comma Delimiter
CDE_DTL_STATUS	CHAR	1	0	Code that indicates if the claim is approved or rejected.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
CDE_DTL_STATUS	CHAR	1	0	Code that indicates if the claim detail record is approved or rejected.
,	CHAR	1	0	Comma Delimiter
CDE_EMERGENCY	CHAR	1	0	A code to indicate whether the claim was for a service provided in an emergency situation.
,	CHAR	1	0	Comma Delimiter
CDE_MODIFIER_3	CHAR	2	0	The third of up to 4 codes that may be used to supplement the procedure code.
,	CHAR	1	0	Comma Delimiter
CDE_PROC_PRIM/CDE_PROC	CHAR	6	0	A code from the MA fee schedule to indicate the service performed.
,	CHAR	1	0	Comma Delimiter
CDE_REVENUE	CHAR	4	0	Revenue Code
,	CHAR	1	0	Comma Delimiter
DTE_ADMISSION	DATE	8	0	The date the member was admitted to the hospital.
,	CHAR	1	0	Comma Delimiter
DTE_BILLED	DATE	8	0	The date the provider completed the invoice.
,	CHAR	1	0	Comma Delimiter
DTE_BIRTH	DATE	8	0	The birth date of the member.
,	CHAR	1	0	Comma Delimiter
DTE_DISCHARGE	DATE	8	0	The date the member was discharged from the hospital.

Field Name	Type	Length	Precision	Description
,	CHAR	1	0	Comma Delimiter
DTE_FIRST_SVC	DATE	8	0	Date on which services were first performed for a member.
,	CHAR	1	0	Comma Delimiter
DTE_LAST_SVC	DATE	8	0	Date on which services were last performed for a member.
,	CHAR	1	0	Comma Delimiter
DTE_PAID	DATE	8	0	The date the claim was adjudicated. Except for special processing cycles. This is not the actual date of payment; since the payment is issued by the state treasurer after a post-audit and when funds are available.
,	CHAR	1	0	Comma Delimiter
ID_MEDICAID	CHAR	12	0	The unique number assigned to the member by OIM.
,	CHAR	1	0	Comma Delimiter
IND_CLAIM	CHAR	1	0	E=Encounter or F=Fee for service claim.
,	CHAR	1	0	Comma Delimiter
IND_LATEST_CLM	CHAR	1	0	Code to indicate the latest claim in an adjustment chain.
,	CHAR	1	0	Comma Delimiter
IND_MNGD_HLTH	CHAR	1	0	Indicates if the member was enrolled in an HMO/HIO when the claim was adjudicated.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
IND_REF_EPSDT	CHAR	1	0	Indicates whether the procedure/drug is compensable for children with medically needy only categories of assistance if dispensed through the EPSDT program.
,	CHAR	1	0	Comma Delimiter
NUM_ADJ_ICN	CHAR	13	0	Internal control number of the mother claim.
,	CHAR	1	0	Comma Delimiter
NUM_DTL	NUMBER	5	0	Number of the detail on the claim.
,	CHAR	1	0	Comma Delimiter
NUM_ICN	CHAR	13	0	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.
,	CHAR	1	0	Comma Delimiter
NUM_PRIOR_AUTH	CHAR	10	0	This is the number assigned that authorizes the procedure being performed.
,	CHAR	1	0	Comma Delimiter
NUM_RECIP_AGE	NUMBER	5	0	The age of the member on the From Date of Service rounded down to a full year.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
QTY_UNITS_ALWD	NUMBER	12	2	The units of service approved for payment.
,	CHAR	1	0	Comma Delimiter
QTY_UNITS_BILLED	NUMBER	12	2	The units of service billed by the provider.
,	CHAR	1	0	Comma Delimiter
CDE_OCCUR_1	CHAR	2	0	Code which defines a significant event relating to an institutional claim that may affect payer processing (1 of 8).
,	CHAR	1	0	Comma Delimiter
CDE_OCCUR_2	CHAR	2	0	Code which defines a significant event relating to an institutional claim that may affect payer processing (2 of 8).
,	CHAR	1	0	Comma Delimiter
CDE_OCCUR_3	CHAR	2	0	Code which defines a significant event relating to an institutional claim that may affect payer processing (3 of 8).
,	CHAR	1	0	Comma Delimiter
DTE_OCCUR_1	DATE	8	0	The occurrence date of a significant event relating to an institutional claim that may affect payer processing (1 of 8).
,	CHAR	1	0	Comma Delimiter
DTE_OCCUR_2	DATE	8	0	The occurrence date of a significant event relating to an institutional claim that may affect payer processing (2 of 8).

Field Name	Type	Length	Precision	Description
,	CHAR	1	0	Comma Delimiter
DTE_OCCUR_3	DATE	8	0	The occurrence date of a significant event relating to an institutional claim that may affect payer processing (3 of 8).
,	CHAR	1	0	Comma Delimiter
CDE_PROV_SPEC_PERF	CHAR	3	0	The primary area of specialization for the perform provider.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_TYPE_PERF	CHAR	2	0	The primary provider type for which a performing provider is licensed.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_BASE	CHAR	15	0	This is the high level ID assigned by interChange to the unique instance of a provider without regard to service location for performing provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_MCAID	CHAR	15	0	The Medicaid ID of the provider at the service location for performing provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_NPI	CHAR	15	0	The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs for performing provider.
,	CHAR	1	0	Comma Delimiter
SAK_PROV	NUMBER	10	0	System Assigned Key for the Provider Identifier for performing provider.

Field Name	Type	Length	Precision	Description
,	CHAR	1	0	Comma Delimiter
SAK_PROV_LOC	NUMBER	10	0	System assigned key assigned to the provider service location for performing provider.
,	CHAR	1	0	Comma Delimiter
CDE_AID_CATEGORY	CHAR	2	0	Identifies the type of aid for which a member is eligible.
,	CHAR	1	0	Comma Delimiter
CDE_RACE	CHAR	2	0	Code describing the race of an individual. Each position of this field can contain a different race code.
,	CHAR	1	0	Comma Delimiter
CDE_RECIP_COUNTY	VARCHAR2	10	0	The county number used to identify a geographical/political area in the state.
,	CHAR	1	0	Comma Delimiter
CDE_SEX	CHAR	1	0	Code describing the gender of an individual.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_SPEC_PRIM	CHAR	3	0	The primary area of specialization for the provider for Referring Provider.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_TYPE_PRIM	CHAR	2	0	The primary provider type for which a provider is licensed for Referring Provider.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
ID_PROVIDER_BASE	CHAR	15	0	This is the high level ID assigned by interChange to the unique instance of a provider without regard to service location for Referring Provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_MCAID	CHAR	15	0	The Medicaid ID of the provider at the service location for Referring Provider.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_NPI	CHAR	15	0	The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs for Referring Provider.
,	CHAR	1	0	Comma Delimiter
SAK_PROV	NUMBER	10	0	System Assigned Key for the Provider Identifier for Referring Provider.
,	CHAR	1	0	Comma Delimiter
SAK_PROV_LOC	NUMBER	10	0	System assigned key assigned to the provider service location for Referring Provider.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_SPEC_PRIM	CHAR	3	0	The primary area of specialization for the provider for Submitter.
,	CHAR	1	0	Comma Delimiter
CDE_PROV_TYPE_PRIM	CHAR	2	0	The primary provider type for which a provider is licensed for Submitter.
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
ID_PROVIDER_BASE	CHAR	15	0	This is the high level ID assigned by interChange to the unique instance of a provider without regard to service location for Submitter.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_MCAID	CHAR	15	0	The Medicaid ID of the provider at the service location for Submitter.
,	CHAR	1	0	Comma Delimiter
ID_PROVIDER_NPI	CHAR	15	0	The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs for Submitter.
,	CHAR	1	0	Comma Delimiter
SAK_PROV	NUMBER	10	0	System Assigned Key for the Provider Identifier for Submitter.
,	CHAR	1	0	Comma Delimiter
SAK_PROV_LOC	NUMBER	10	0	System assigned key assigned to the provider service location for Submitter.
,	CHAR	1	0	Comma Delimiter
CDE_PATIENT_STATUS	CHAR	2	0	The patient status code indicates the reason for discharge or that there was no discharge from a hospital or long term care facility at the end of the billing period.
,	CHAR	1	0	Comma Delimiter
AMT_VALUE_1	NUMBER	11	2	Dollar amount of the corresponding value code (1 of 12).
,	CHAR	1	0	Comma Delimiter

Field Name	Type	Length	Precision	Description
AMT_VALUE_2	NUMBER	11	2	Dollar amount of the corresponding value code (2 of 12).
,	CHAR	1	0	Comma Delimiter
AMT_VALUE_3	NUMBER	11	2	Dollar amount of the corresponding value code (3 of 12).
,	CHAR	1	0	Comma Delimiter
CDE_VALUE_1	CHAR	2	0	Code used to relate values to identified data elements necessary to process an institutional claim (1 of 12).
,	CHAR	1	0	Comma Delimiter
CDE_VALUE_2	CHAR	2	0	Code used to relate values to identified data elements necessary to process an institutional claim (2 of 12).
,	CHAR	1	0	Comma Delimiter
CDE_VALUE_3	CHAR	2	0	Code used to relate values to identified data elements necessary to process an institutional claim (3 of 12).
,	CHAR	1	0	Comma Delimiter
AMT_ALWD_MCARE	NUMBER	10	2	The dollar amount allowed by Medicare for the services provided.
,	CHAR	1	0	Comma Delimiter
AMT_COINSURANCE	NUMBER	10	2	The amount of Medicare Co-Insurance paid by the member for this claim.
,	CHAR	1	0	Comma Delimiter
AMT_DEDUCT	NUMBER	10	2	Amount of Medicare deductible the member must meet before Medicare

Field Name	Type	Length	Precision	Description
				will pay.
,	CHAR	1	0	Comma Delimiter
AMT_PAID_MCARE	NUMBER	10	2	The amount approved by Medicare for the service. The amount approved by Medicare is the basis for deductible paid and/or coinsurance paid for which the member (Medical Assistance) is responsible.

2.10.12.4 IPRO Member Extract Layout

Field Name	Type	Length	Description
ID_MEDICAID	CHAR	12	Unique identifier for the beneficiary.
,	CHAR	1	Comment Delimiter
NAM_LAST	CHAR	20	The last name of a beneficiary.
,	CHAR	1	Comment Delimiter
NAM_FIRST	CHAR	15	The first name of a beneficiary
,	CHAR	1	Comment Delimiter
NAM_MID_INIT	CHAR	1	The middle initial of the beneficiary.
,	CHAR	1	Comment Delimiter
NUM_SSN	CHAR	9	The social security number for a beneficiary.
,	CHAR	1	Comment Delimiter
CDE_SEX	CHAR	1	Indicates the sex of the beneficiary
,	CHAR	1	Comment Delimiter
DTE_BIRTH	CHAR	8	The date of birth for the beneficiary.

Field Name	Type	Length	Description
,	CHAR	1	Comment Delimiter
CDE_RACE	CHAR	2	The beneficiary's first race code.
,	CHAR	1	Comment Delimiter
ADR_ZIP_CODE	CHAR	5	The five character zip code for the beneficiary
,	CHAR	1	Comment Delimiter
ADR_ZIP_CODE_4	CHAR	4	The zip plus four of the beneficiary.
,	CHAR	1	Comment Delimiter
CDE_COUNTY	CHAR	10	The 2 digit county code used to identify a county in the state.
,	CHAR	1	Comment Delimiter
DTE_ELIG_EFF	CHAR	8	The date that the beneficiary becomes eligible for the corresponding Medical Assistance program.
,	CHAR	1	Comment Delimiter
DTE_ELIG_END	CHAR	8	The date that the beneficiary is no longer eligible for the corresponding Medical Assistance program.
,	CHAR	1	Comment Delimiter
CDE_AID_CATEGORY	CHAR	2	This is the Population code.
,	CHAR	1	Comment Delimiter
IND_ACTIVE	CHAR	1	Indicates if the beneficiary Medicaid ID is active or purged because of a link. When two Medicaid IDs are linked one of them is no longer valid and will have an IND ACTIVE of 'N'. All others are active and will have a 'Y' or a 'P' (BID has changed).

2.10.12.5 IPRO Provider Extract Layout

Field Name	Type	Length	Description
SAK_PROV	NUMBER	10	System assigned key (SAK) that identifies the provider.
,	CHAR	1	Comma Delimiter
SAK_PROV_LOC	NUMBER	10	System Assigned Key for Provider Location.
,	CHAR	1	Comma Delimiter
ID_PROVIDER_BASE	CHAR	15	This is the high level ID assigned by interChange to the unique instance of a provider without regard to service location
,	CHAR	1	Comma Delimiter
ID_PROVIDER_NPI	CHAR	15	The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs
,	CHAR	1	Comma Delimiter
ID_PROVIDER_MCAID	CHAR	15	The Medicaid ID of the provider at the service location.
,	CHAR	1	Comma Delimiter
NUM_PROV_SSN	CHAR	9	This is the SSN or FEIN for a provider where the license is valid.
,	CHAR	1	Comma Delimiter
NAME	CHAR	50	This is the name associated with an organization or person.
,	CHAR	1	Comma Delimiter
NAM_TITLE	CHAR	15	This field indicates the professional title of an individual.
,	CHAR	1	Comma Delimiter

Field Name	Type	Length	Description
ADR_MAIL_STRT1	CHAR	30	Provider's address line 1.
,	CHAR	1	Comma Delimiter
ADR_MAIL_STRT2	CHAR	30	Provider's address line 2.
,	CHAR	1	Comma Delimiter
ADR_MAIL_CITY	CHAR	30	Provider's address city
,	CHAR	1	Comma Delimiter
ADR_MAIL_STATE	CHAR	2	Provider's address state.
,	CHAR	1	Comma Delimiter
ADR_MAIL_ZIP	CHAR	5	Provider's address zip cde.
,	CHAR	1	Comma Delimiter
ADR_MAIL_ZIP_4	CHAR	4	Provider's address zip code+4 extension
,	CHAR	1	Comma Delimiter
NUM_PHONE	CHAR	10	Provider's phone number.
,	CHAR	1	Comma Delimiter
NUM_PHONE_EXT	CHAR	4	Phone number extension
,	CHAR	1	Comma Delimiter
CDE_GENDER	CHAR	1	Identifies the gender of the provider. Valid values are: "M" = male, "F" = female, "O" = organization, "N" = N/A.
,	CHAR	1	Comma Delimiter
DTE_BIRTH	DATE	8	The provider's DOB.

Field Name	Type	Length	Description
,	CHAR	1	Comma Delimiter
CDE_COUNTY	VARCHAR2	10	Code representing the county in the state.
,	CHAR	1	Comma Delimiter
CDE_PROV_TYPE	CHAR	2	Type that a provider is licensed for.
,	CHAR	1	Comma Delimiter
CDE_PROV_SPEC	CHAR	3	This field contains the provider specialty which is the main focus of the provider's practice. Each provider type must have a primary specialty and the primary specialty must be one of the provider's existing specialties.
,	CHAR	1	Comma Delimiter
NUM_TAX_ID	CHAR	9	Tax identification number assigned to a provider by the Internal Revenue Service.
,	CHAR	1	Comma Delimiter
NUM_PROV_LIC	CHAR	10	A provider license number.
,	CHAR	1	Comma Delimiter
NUM_MEDICARE	CHAR	10	Medicare number assigned by the government to the provider.
,	CHAR	1	Comma Delimiter
NUM_DEA	CHAR	9	The Drug Enforcement Agency identification number for a provider.
,	CHAR	1	Comma Delimiter
NUM_PHONE_FAX		10	Fax number of the provider's office.
,	CHAR	1	Comma Delimiter

Field Name	Type	Length	Description
ID_PROV_PREV	CHAR	15	Medicaid provider number previously used by a provider to bill Medicaid services. This will be either the current MAMIS character field or the MPI ID
,	CHAR	1	Comma Delimiter
CDE_ORGANIZ	CHAR	1	Proprietary nature of a provider's practice. Values: "1" = individual, "2" = partnership, "3" = corporation, and so on
,	CHAR	1	Comma Delimiter
CDE_ENROLL_STATUS	CHAR	1	This is the letter assigned to the enrollment status description to uniquely identify it. Examples of valid values are: R=Retired, D=Deceased, M=Return Mail, I=Term by IFSSA, H=Term by HCFA, B=Term by HPB, and A=Active.
,	CHAR	1	Comma Delimiter
DTE_END	CHAR	8	The date that a provider's eligibility within the specific program has expired.
,	CHAR	1	Comma Delimiter
DTE_EFFECTIVE	CHAR	8	Effective date for a provider's program eligibility. Used to signify the start of a span or period of program eligibility.
,	CHAR	1	Comma Delimiter
NUM_UPIN	CHAR	6	This is the universal provider identification number.
,	CHAR	1	Comma Delimiter
CDE_TAXONOMY	CHAR	10	Provider Taxonomy Code.

2.10.12.6 IPRO Reference Extract Layout (only need a SQL dump of the following tables)

DDI Table Name in DSS	Fields pulled from the table

DDI Table Name in DSS	Fields pulled from the table
T_CDE_AID	CDE_AID_CATEGORY, DSC_AID_CATEGORY
T_CDE_RACE	CDE_RACE, DSC_RACE
T_CDE_CMS_TOS	CDE_CMS_TOS, DSC_CMS_TOS
T_CDE_SEX	CDE_SEX, DSC_SEX
T_CLAIM_TYPE	CDE_CLM_TYPE , DSC_CLM_TYP
T_CLM_STATUS	CDE_CLM_STATUS, DSC_CLM_STATUS
T_COUNTY	CDE_COUNTY, DSC_COUNTY
T_DEA_CODE	CDE_DEA, DSC
T_DIAGNOSIS	CDE_DIAG, DSC_25
T_DRUG_DN	CDE_NDC, DSC_NDC
T_DRUG_CLASS	CDE, DSC_25
T_EOB	CDE_EOB, DSC_EOB, DSC_EOB2
T_MODIFIER	CDE_PROC_MOD, DSC_MODIFIER
T_PATIENT_STAT	CDE_PATIENT_STATUS, DSC_PATIENT_STATUS
T_PLACE_OF_SERVICE	CDE_POS, DSC_POS
T_PR_LOC_CODE	CDE_LEVEL_OF_CARE, DSC_LOC
T_PR_SPEC_CDE	CDE_PROV_SPEC, DSC_PROV_SPEC
T_PR_TAXONOMY_CDE	CDE_TAXONOMY, DSC_TAXONOMY
T_PR_TYPE_CDE	CDE_PROV_TYPE, DSC_PROV_TYPE
T_PROC_ICD9	CDE_PROC_ICD9, DSC_PROCEDURE
T_PROC	CDE_PROC, CDE_CMS_TOS, DSC_PROCEDURE
T_REGION	NUM_REGION, DSC_REGION

DDI Table Name in DSS	Fields pulled from the table
T_REVENUE_CODE	CDE_REVENUE, DSC_REV_CODE, DTE_EFFECTIVE, DTE_END
T_STATE	CDE_STATE, DSC_STATE
T_THERA_FDA	CDE_THERA_CLS_FDA , DSC
T_TOOTH	CDE_TOOTH_NBR, DSC_TOOTH_NBR
T_TOOTH_SURFACE	CDE_TOOTH_SURFACE, DSC_TOOTH_SURFACE
T_TYPE_OF_BILL	CDE_TYPE_OF_BILL, DSC_TYPE_OF_BILL

2.10.13 KAMES PA62 SDX Layout

Field Name	Data Type	Length	Start Position	End Position
KIMF3C-MMIS-ELIGIBILITY-TAPE		800	1	800
KIMF3C-PERSON-SSN-NUM	CHAR	9	1	9
KIMF3C-PERSON-SSN-CHK-DGT	CHAR	1	10	10
KIMF3C-SPL-CIR-IND	CHAR	1	11	11
KIMF3C-CASE-NUM	CHAR	10	12	21
KIMF3C-PROGRAM-CDE	CHAR	2	22	23
KIMF3C-COUNTY-CDE	CHAR	3	24	26
KIMF3C-RECIP-STATUS-CDE	CHAR	2	27	28
KIMF3C-RECIP-LAST-NME	CHAR	15	29	43
KIMF3C-RECIP-FIRST-NME	CHAR	9	44	52
KIMF3C-RECIP-MI-NME	CHAR	1	53	53
KIMF3C-CASE-LAST-NME	CHAR	15	54	68
KIMF3C-CASE-FIRST-NME	CHAR	9	69	77

Field Name	Data Type	Length	Start Position	End Position
KIMF3C-CASE-MI-NME	CHAR	1	78	78
KIMF3C-AGENT-LAST-NME	CHAR	15	79	93
KIMF3C-AGENT-FIRST-NME	CHAR	9	94	102
KIMF3C-AGENT-MI-NME	CHAR	1	103	103
KIMF3C-CASE-ADDR1-TXT	CHAR	25	104	128
KIMF3C-CASE-ADDR2-TXT	CHAR	25	129	153
KIMF3C-CASE-ADDR3-TXT	CHAR	25	154	178
KIMF3C-CASE-CITY-TXT	CHAR	22	179	200
KIMF3C-CASE-STATE-CDE	CHAR	2	201	202
KIMF3C-CASE-ZIP-CDE	CHAR	9	203	211
KIMF3C-PERSON-BIRTH-DTE	NUMBER	8	212	219
KIMF3C-PERSON-SEX-CDE	CHAR	1	220	220
KIMF3C-PERSON-RACE-CDE	CHAR	2	221	222
KIMF3C-ELIG-START-DTE	NUMBER	8	223	230
KIMF3C-ELIG-END-DTE	NUMBER	8	231	238
KIMF3C-MONEY-PAYMENT-CDE	CHAR	1	239	239
KIMF3C-IM-ID-CDE	CHAR	2	240	241
KIMF3C-CRTD-ELIG-START-DTE	NUMBER	8	242	249
KIMF3C-CRTD-ELIG-END-DTE	NUMBER	8	250	257
KIMF3C-PREV-SSN-NUM	NUMBER	9	258	266
KIMF3C-MA-CO-PAY	CHAR	1	267	267
KIMF3C-HLTH-INS-TYPE-CDE	CHAR	1	268	268

Field Name	Data Type	Length	Start Position	End Position
KIMF3C-SOC-SEC-CLAIM-NUM	CHAR	12	269	280
KIMF3C-GROSS-INCOME-AMT	NUMBER-PACKED	5	281	285
FILLER	CHAR	8	286	293
KIMF3C-MC-BEHAV-REGION-NUM	NUMBER	2	294	295
KIMF3C-MC-BEHAV-START-DTE	NUMBER	8	296	303
KIMF3C-MC-BEHAV-END-DTE	NUMBER	8	304	311
KIMF3C-SPD-LIAB-AMT	NUMBER-PACKED	5	312	316
FILLER	CHAR	4	317	320
KIMF3C-MMIS-INSTIT-STATUS	CHAR	2	321	322
FILLER	CHAR	76	323	398
KIMF3C-QMB-IND	CHAR	1	399	399
KIMF3C-QMB-START-DTE	NUMBER	8	400	407
KIMF3C-QMB-END-DTE	NUMBER	8	408	415
KIMF3C-SEQ-NUM	CHAR	2	416	417
KIMF3C-MC-PHYS-REGION-NUM	NUMBER	2	418	419
KIMF3C-MC-PHYS-START-DTE	NUMBER	8	420	427
KIMF3C-MC-PHYS-END-DTE	NUMBER	8	428	435
KIMF3C-MC-EXPT-DELIVERY-MM	CHAR	2	436	437
KIMF3C-MC-EXPT-DELIVERY-YY	CHAR	2	438	439
KIMF3C-PERSON-AREA-CDE-NUM	NUMBER	3	440	442
KIMF3C-PERSON-EXCHANGE-	NUMBER	3	443	445

Field Name	Data Type	Length	Start Position	End Position
NUM				
KIMF3C-PERSON-PHONE-NUM	NUMBER	4	446	449
KIMF3C-MC-DOD-DTE	CHAR	8	450	457
KIMF3C-DSS-STATUS-CDE	CHAR	1	458	458
KIMF3C-DJJ-CHILD	CHAR	1	459	459
KIMF3C-PROCESS-DTE	NUMBER	5	460	464
KIMF3C-LANGUAGE-CDE	CHAR	2	465	466
KIMF3C-MAIL-ADDR1-TXT	CHAR	25	467	491
KIMF3C-MAIL-ADDR2-TXT	CHAR	25	492	516
KIMF3C-MAIL-ADDR3-TXT	CHAR	25	517	541
KIMF3C-MAIL-CITY-TXT	CHAR	22	542	563
KIMF3C-MAIL-STATE-CDE	CHAR	2	564	565
KIMF3C-MAIL-ZIP-CDE	CHAR	9	566	574
KIMF3C-MAID-CARD-ID-NUM	NUMBER	10	575	584
FILLER	CHAR	120	585	704
KIMF3C-HOUSEHOLD-SIZE	NUMBER	2	705	706
KIMF3C-GROSS-EARNED-INC	NUMBER	10	707	716
KIMF3C-GROSS-UNEARNED-INC	NUMBER	10	717	726
KIMF3C-COUNTABLE-INC	NUMBER	10	727	736
KIMF3C-MBR-GROSS-UNEARNED-INC	NUMBER	10	737	746
KIMF3C-MBR-GROSS-EARNED-INC	NUMBER	10	747	756

Field Name	Data Type	Length	Start Position	End Position
KIMF3C-MBR-VETERAN-AMOUNT	NUMBER	10	757	766
KIMF3C-PREMIUM-START-DATE	NUMBER	8	767	774
KIMF3C-MBR-HIGHEST-GRADE-COMP	NUMBER	2	775	776
KIMF3C-PAY-PREMIUM	CHAR	1	777	777
FILLER	CHAR	23	778	800

2.10.14 KASES Input Layout

Required Data Elements:	Field Length	Comments
IVD#	Char 10	KASES System assigned unique identifier case #
Case Type	Char 04	AFDC = KTAP ARRN = KTAP/NKTAP/FC/NFC arrears only ARRP = KTAP/FC arrears only FC = Foster Care LOCO = Locate only MA = Medical assistance only NFC = Non-IV-E Foster Care NIVD = Non-IV-D NPA = Non-KTAP TCC = Transitional Child Care
Case Location Code	Char 10	Values: First two are always '21'. Next three are county code. Last five are blank.
Child SSN	Char 09	Child's Social Security Number
Child Last Name	Char 05	Child's Last Name
Child First Name	Char 02	Child's First Name

Required Data Elements:	Field Length	Comments
Child DOB	Char 08	Child's Date of Birth
Child Family Violence Ind	Char 01	Values: P = Perpetrator, V = Victim, N = No, or Y = Yes
NCP SSN	Char 09	Non-Custodial Parent's Social Security Number
NCP Last name	Char 15	Non-Custodial Parent's Last Name
NCP First name	Char 09	Non-Custodial Parent's First Name
NCP DOB	Char 08	Non-Custodial Parent's Date of Birth
NCP address1	Char 25	Non-Custodial Parent's MAIL address line 1
NCP address2	Char 25	Non-Custodial Parent's MAIL address line 2
NCP City	Char 22	Non-Custodial Parent's City
NCP State	Char 02	Non-Custodial Parent's State
NCP Zip	Char 09	Non-Custodial Parent's Zip Code
NCP Family Violence Ind	Char 01	Values: P = Perpetrator, V = Victim, N = No, or Y = Yes
CP SSN	Char 09	Custodial Parent's Social Security Number
CP Last name	Char 15	Custodial Parent's Last Name
CP First Name	Char 09	Custodial Parent's First Name
CP DOB	Char 08	Custodial Parent's Date of Birth
CP Address1	Char 25	Custodial Parent's MAIL address line 1
CP Address2	Char 25	Custodial Parent's MAIL address line 2
CP City	Char 22	Custodial Parent's City
CP State	Char 02	Custodial Parent's State

Required Data Elements:	Field Length	Comments
CP Zip	Char 09	Custodial Parent's Zip
CP Family Violence Ind	Char 01	Values: P = Perpetrator, V = Victim, N = No, or Y = Yes
Wage Indicator	Char 01	Values: 'N' = New Hire or 'U' = Update The wage indicator is the source of the employment data. We don't have a source field on KASES. For records coming from new hire the program name, KASES377 is placed in the worker # field to identify it as New Hire data. All others would be considered worker update. This can be a one byte field. Assign a value to New Hire and a value to worker update and populate the field on the file.
Employer EIN	Char 10	Provide employer data for the active NCP participant type of the case.
Employer Name	Char 33	Employer's Full name.
Employer Address1	Char 31	Employer's address 1.
Employer Address2	Char 31	Employer's address 2.
Employer City	Char 16	Employer's city.
Employer State	Char 02	Employer's state.
Employer Zip	Char 09	Employer's zip code.
Employee Start Date	Char 08	The date when employee start.
Employee End Date	Char 08	The date when employee end.
Employee Last Update Date	Char 08	The last date when employee's record is updated.
Employee Salary	Num (10,2)	The employee's salary.
Employee Salary Frequency	Char 04	Values: 'BIWK', 'DAY', 'HOUR', 'MNTH', 'S-MO', 'WKLY', 'YEAR'

Required Data Elements:	Field Length	Comments
Child support order indicator	Char 01	Values: 'Y', 'N'. Child Support Order Indicator is a yes or no entry.
Last child support payment amount	Num (10,2)	
Last child support payment type	Char 04	II = Wage IO = Regular Pay IT = Regular Pay RO = Regular Pay RT = Regular Pay ADJ = Manual Adjustment ADJO = Manual Adjustment Order AFTX = AFDC Federal Tax Intercept (No longer used) ALOT = Wage Allot APFE = NCP Fee Payment BOND = Bonds CASH = Cash CCKF = Cold Check Fee (Future Use) CHEK = Check CLSD = Reduces Arrearage Sub accounts to 0 When Case is Placed in CLSD Case Status FIDM = Financial Institution Data Match (Payment will allocate and distribute as REGP Payment). FPLS = Federal Parent Locator Service FTAX = KTAP and NPA Federal Tax Intercept IRSF = IRS Full Collection Service Fee

Required Data Elements:	Field Length	Comments
		LUMP = Lump Sum Pay MARR = Arrears Adjustment MORD = Money Order NAAP = NPA Application Fee NAIF = Client Fee NFTX = NPA Federal Tax Intercept (No Longer Used) ORD = Support Order OSFE = State Administrative Offset REGP = Regular Pay RMNT = Recoupment SADM = State Administrative Offset SADO = State Administrative Offset SNTX = NPA State Tax Intercept STTX = AFDC State Tax Intercept UIAG = Unemployment Ins. Agreement UINO = Unemployment Insurance Notice of Claim URES = URESA Payment from Out of State WAGE = Wage Withholding Assignment WTHD = Withhold and Deliver
Last child support payment date	Char 08	The last date when the child get the support payment.
Medical support order Indicator	Char 04	Medical Support Order Indicator is a 4 character entry. If the following court order types exist, write the Medical Support Order Indicator as the court order type: MABO means Ordered to Pay Medical Bills Only, MAIO means Medical Insurance Only and MMED means Modification for Medical Insurance. Or, if the order term is MEDO enter MEDO, Medical Insurance Ordered, as the Medical Support Order Indicator.

Required Data Elements:	Field Length	Comments
Insurance Carrier Name	Char 31	Private Insurance Carrier information for the NCP participant only.
Policy ID	Char 15	Private Insurance Policy # for the NCP participant only.
Group #	Char 15	Private Insurance Group # for the NCP participant only, if applicable.
Coverage Type	Char 01	Type of insurance coverage provided under policy. 1 = Hospital 2 = Medical 3 = Dental 4 = Vision 5 = Drugs 6 = Cancer Only 7 = VA Health Benefits 8 = Other (Accident/Casualty) 9 = Self Pay
Effective Date	Char 08	Start Date of insurance coverage
Cancellation Date	Char 08	End Date of insurance coverage.
Covered Child Indicator	Char 01	Values: ‘Y’ = Yes, ‘N’ = No
Court order file number	Char 15	Civil Action # from Most Recent Order
Start date of court order	Char 08	Order Start Date from Most Recent Order
End date of court order	Char 08	Order End date from Most recent Order
Court Fips code	Char 10	Use the most recent order.
Court Order Covered	Char 01	Values: ‘Y’ , ‘N’ or Spaces

Required Data Elements:	Field Length	Comments
Children Ind		
Total: 618		

2.10.15 maxMC Interface Layout

2.10.15.1 Subscriber

Field Name	Position	Length	Type	maxMC Schema Field Name
Record Type	1	3	Alpha	N/A
Case-Level Reference Number	4	25	Alpha	TAU_REFERENCE_NUMBER
Subscriber Number	29	30	ID	MEM_ID
Subscriber Last Name	59	35	Alpha	MEM_LAST _NAME
Subscriber First Name	94	25	Alpha	MEM_FIRST_NAME
Subscriber Middle Name	119	25	Alpha	MEM_MIDDLE_NAME
Subscriber SSN	144	11	Alpha	MEM_SSN
Subscriber Address Line 1	155	55	Alpha	MEM_ADDRESS_LINE_1
Subscriber Address Line 2	210	55	Alpha	MEM_ADDRESS_LINE_2
Subscriber Address Line 3	265	55	Alpha	MEM_ADDRESS_LINE_3
Subscriber Address Line 4	320	55	Alpha	MEM_ADDRESS_LINE_4
Subscriber City	375	30	Alpha	MEM_CITY
Subscriber State Code	405	6	Code	MEM_STA_CODE
Subscriber Zip	411	15	Alpha	MEM_POC_CODE
Subscriber Postal Extension	426	4	Alpha	MEM_POSTAL_EXTENSION
Subscriber Home Phone Number	430	20	Alpha	MEM_HOME_PHONE_PRIMAR Y

Field Name	Position	Length	Type	maxMC Schema Field Name
Subscriber Work Phone Number	450	20	Alpha	MEM_WORK_PHONE_PRIMARY
Filler	430	3420	Spaces	N/A

2.10.15.2 Patient

Field Name	Position	Length	Type	maxMC Schema Field Name
Record Type	1	3	Alpha	N/A
Case-Level Reference Number	4	25	Alpha	TAU_REFERENCE_NUMBER
Patient Number	29	30	ID	MEM_ID
Patient First Name	59	25	Alpha	MEM_FIRST_NAME
Patient Middle Name	84	25	Alpha	MEM_MIDDLE_NAME
Patient Last Name	109	35	Alpha	MEM_LAST_NAME
Patient Social Security Number	144	11	Alpha	MEM_SSN
Patient Sex	155	1	Code	MEM_GENDER
Patient Date of Birth	156	8	Date	MEM_DATE_OF_BIRTH
Patient Birth Sequence	164	2	Numeric	MEM_BIRTH_SEQUENCE
Patient Relationsip Code	166	6	Code	MRO_CODE
Plan Id	172	20	ID	MPG_OPP_ID
Network	192	6	Code	MPG_PVN_CODE
Group Number	198	15	ID	ORG_CODE
Group Type	213	6	Code	ORG_ORT_CODE
Group ID	219	20	Alpha	ORG_GROUP_ID
Client ID	239	15	ID	TPA_ID

Field Name	Position	Length	Type	maxMC Schema Field Name
Division	254	15	Alpha	MPG_TPD_ID
Client State Code	269	6	Code	TPA_STA_CODE
Line of Business Code	275	6	Code	OPP_LOB_CODE
Plan Type	281	6	Code	OPP_PLT_CODE
Service Area	287	6	Code	MPG_SAR_CODE
Policy Number	293	30	Alpha	MPG_POLICY_NUMBER
Principal Diagnosis	323	7	Code	TAU_DXC_UID_PRIMARY
Admitting Diagnosis	330	7	Code	TAU_DXC_UID_ADMIT
Discharge Diagnosis	337	7	Code	TAU_DXC_UID_DISCH
Additional Diagnosis 1	344	7	Code	TDA_DXC_UID
Additional Diagnosis Date 1	351	8	Date	TDA_DATE_DIAGNOSED
Additional Diagnosis Type 1	359	6	Code	TDA_TYPE
Additional Diagnosis 2	365	7	Code	TDA_DXC_UID
Additional Diagnosis Date 2	372	8	Date	TDA_DATE_DIAGNOSED
Additional Diagnosis Type 2	380	6	Code	TDA_TYPE
Additional Diagnosis 3	386	7	Code	TDA_DXC_UID
Additional Diagnosis Date 3	393	8	Date	TDA_DATE_DIAGNOSED
Additional Diagnosis Type 3	401	6	Code	TDA_TYPE
Additional Diagnosis 4	407	7	Code	TDA_DXC_UID
Additional Diagnosis Date 4	414	8	Date	TDA_DATE_DIAGNOSED
Additional Diagnosis Type 4	422	6	Code	TDA_TYPE
Additional Diagnosis 5	428	7	Code	TDA_DXC_UID

Field Name	Position	Length	Type	maxMC Schema Field Name
Additional Diagnosis Date 5	435	8	Date	TDA_DATE_DIAGNOSED
Additional Diagnosis Type 5	443	6	Code	TDA_TYPE
Additional Diagnosis 6	449	7	Code	TDA_DXC_UID
Additional Diagnosis Date 6	456	8	Date	TDA_DATE_DIAGNOSED
Additional Diagnosis Type 6	464	6	Code	TDA_TYPE
Additional Diagnosis 7	470	7	Code	TDA_DXC_UID
Additional Diagnosis Date 7	477	8	Date	TDA_DATE_DIAGNOSED
Additional Diagnosis Type 7	485	6	Code	TDA_TYPE
Additional Diagnosis 8	491	7	Code	TDA_DXC_UID
Additional Diagnosis Date 8	498	8	Date	TDA_DATE_DIAGNOSED
Additional Diagnosis Type 8	506	6	Code	TDA_TYPE
Additional Diagnosis 9	512	7	Code	TDA_DXC_UID
Additional Diagnosis Date 9	519	8	Date	TDA_DATE_DIAGNOSED
Additional Diagnosis Type 9	527	6	Code	TDA_TYPE
Additional Diagnosis 10	533	7	Code	TDA_DXC_UID
Additional Diagnosis Date 10	540	8	Date	TDA_DATE_DIAGNOSED
Additional Diagnosis Type 10	548	6	Code	TDA_TYPE
PCP Physician ID	554	30	ID	PVD_ID
PCP Physician Tax ID	584	15	Alpha	PVD_TAX_ID
PCP Physician Alternate ID	599	30	ID	PID_ID

Field Name	Position	Length	Type	maxMC Schema Field Name
PCP Physician Last Name	629	35	Alpha	PVD_LAST_NAME
PCP Physician First Name	664	25	Alpha	PVD_FIRST_NAME
PCP Physician Name	689	50	Alpha	PVD_NAME
PCP Group ID	739	30	ID	PVD_ID
PCP Group Tax ID	769	15	Alpha	PVD_TAX_ID
PCP Group Alternate ID	784	30	ID	PID_ID
PCP Group Name	814	50	Alpha	PVD_NAME
PCP Location ID	864	30	ID	AFA_ADR_ID_SERVICE
Filler	894	2956	Spaces	N/A

2.10.15.3 Case Level

Field Name	Position	Length	Type	maxMC Schema Field Name
Record Type	1	3	Alpha	N/A
Case-Level Reference Number	4	25	Alpha	TAU_REFERENCE_NUMBER
Second Reference Number	29	25	Alpha	TAU_AUTHORIZATION_NUMBER_1
Third Reference Number	54	25	Alpha	TAU_AUTHORIZATION_NUMBER_2
Authorization Type	79	3	Alpha	TAU_SYSTEM_MEANING
Pregnancy Related?	82	1	Y/N	TAU_PREGNANCY_YN
Estimated Date of Birth	83	8	Date	OBI_DATE_EDC
Benefits Flexed?	91	1	Y/N	TAU_BENEFITS_FLEXED_YN
Place of Service Summary	92	50	Alpha	TAU_POS_SUMMARY

Field Name	Position	Length	Type	maxMC Schema Field Name
Event Classification	142	6	Code	TAU_ECL_CODE
Case Type	148	6	Code	TAU_CTE_CODE
Health Management Program	154	6	Code	TAU_HMP_CODE
Case-Level Status Summary	160	3	Code	TAU_STATUS_SUMMARY
Admission Date	163	8	Date	TAU_DATE_ADMITTED
Discharge Date	171	8	Date	TAU_DATE_DISCHARGED
Discharge Disposition	179	6	Code	TAU_DDS_CODE
Initial Approved Days	185	3	Numeric	TAU_DAYS_INITIAL
Total Approved Extended Days	188	3	Numeric	TAU_DAYS_EXTENDED
Total Days Authorized	191	3	Numeric	TAU_DAYS_AUTHORIZED
Total Days Denied	194	3	Numeric	TAU_DAYS_DENIED
Total Length of Stay	197	3	Numeric	TAU_DAYS_LOS
Reimbursement Type	200	6	Code	TAU_RTY_CODE
DRG Code	206	3	Code	TAU_DRG_CODE (via TAU_DRG_UID)
Date Eligibility was Verified	209	8	Date	TAU_DATE_ELIG_VERIFIED
User ID who Verified Eligibility	217	12	ID	STF_ID via TAU_STF_UID_VERIFY_ELIG
User Last Name who Verified Eligibility	229	35	Alpha	STF_LAST_NAME via TAU_STF_UID_VERIFY_ELIG
User First Name who Verified Eligibility	264	25	Alpha	STF_FIRST_NAME via TAU_STF_UID_VERIFY_ELIG
Date Benefits were Verified	289	8	Date	TAU_DATE_BENEFITS_VERIFI

Field Name	Position	Length	Type	maxMC Schema Field Name
				ED
User ID who Verified Benefits	297	12	ID	STF_ID via TAU_STF_UID_VERIFY_BENEFITS
User Last Name who Verified Benefits	309	35	Alpha	STF_LAST_NAME via TAU_STF_UID_VERIFY_BENEFITS
User First Name who Verified Benefits	344	25	Alpha	STF_FIRST_NAME via TAU_STF_UID_VERIFY_BENEFITS
Requesting Provider ID	369	30	ID	PVD_ID
Requesting Provider Tax ID	399	15	Alpha	PVD_TAX_ID
Requesting Provider Alternate ID	414	30	ID	PID_ID
Requesting Provider Last Name	444	35	Alpha	PVD_LAST_NAME
Requesting Provider First Name	479	25	Alpha	PVD_FIRST_NAME
Requesting Provider Name	504	50	Alpha	PVD_NAME
Requesting Group ID	554	30	ID	PVD_ID
Requesting Group Tax ID	584	15	Alpha	PVD_TAX_ID
Requesting Group Alternate ID	599	30	ID	PID_ID
Requesting Group Name	629	50	Alpha	PVD_NAME
Requesting Provider Location ID	679	30	ID	AFA_ADR_ID_SERVICE
Date Authorization Initiated	709	8	Date	TAU_DATE_INITIATED

Field Name	Position	Length	Type	maxMC Schema Field Name
User ID of Authorization Case Manager	717	12	ID	STF_ID
Last Name of Authorization Case Manager	729	35	Alpha	STF_LAST_NAME
First Name of Authorization Case Manager	764	25	Alpha	STF_FIRST_NAME
Date Authorization Valid From	789	8	Date	TAU_DATE_VALID_BEGIN
Date Authorization Valid To	797	8	Date	TAU_DATE_VALID_END
Days Valid	805	3	Numeric	TAU_DAYS_VALID
Record Create Date	808	8	Date	TAU_CREATE_DATE
User ID Who Created Record	816	12	ID	STF_ID
User Last Name of Who Created Record	828	35	Alpha	STF_LAST_NAME
User First Name of Who Created Record	863	25	Alpha	STF_FIRST_NAME
Last Update Date	888	8	Date	TAU_LAST_UPDATE_DATE
User ID Who Last Updated Record	896	12	ID	STF_ID
User Last Name of Who Last Updated Record	908	35	Alpha	STF_LAST_NAME
User First Name of Who Last Updated Record	943	25	Alpha	STF_FIRST_NAME
Authorization Closed?	968	1	Y/N	TAU_AUTH_CLOSED_YN
Date Authorization Closed	969	8	Date	TAU_DATE_AUTH_CLOSED
Case-Level Claims Notes	977	2000	Alpha	TAU_AUTH_CLAIMS_NOTES
Contact Name (the person who called in the auth)	2977	64	Alpha	TAU_PRIMARY_CONTACT_NAME

Field Name	Position	Length	Type	maxMC Schema Field Name
Contact Phone Number	3041	20	Alpha	TAU_PRIMARY_CONTACT_PHONE
Filler	2977	873	Spaces	N/A

2.10.15.4 Service Level

Field Name	Position	Length	Type	maxMC Schema Field Name
Record Type	1	3	Alpha	N/A
Case-Level Reference Number	4	25	Alpha	TAU_REFERENCE_NUMBER
Service Sequence Number	29	3	Numeric	TCM_SEQUENCE
Service Level Reference Number	32	25	Alpha	TCM_REFERENCE_NUMBER
Service Level Authorization Number	57	25	Alpha	TCM_AUTHORIZATION_NUMBER_1
Service Level Secondary Authorization Number	82	25	Alpha	TCM_AUTHORIZATION_NUMBER_2
Status Code	107	6	Code	TCM_AST_CODE
Status Determination Reason Code	113	6	Code	TCM_DTR_CODE
Staff ID Who Recorded the Status	119	12	ID	STF_ID
Staff Last Name Who Recorded the Status	131	35	Alpha	STF_LAST_NAME
Staff First Name Who Recorded the Status	166	25	Alpha	STF_FIRST_NAME
Staff ID Who Determined the Status	191	12	Code	STF_ID
Staff Last Name Who Determined the Status	203	35	Alpha	STF_LAST_NAME

Field Name	Position	Length	Type	maxMC Schema Field Name
Staff First Name Who Determined the Status	238	25	Alpha	STF_FIRST_NAME
Service Code	263	6	Code	TCM_SEV_CODE
Service Type Code	269	6	Code	SEV_SVT_CODE
Requested Place of Service Code	275	6	Code	TCM_POS_CODE_REQD
Requested Physician ID	281	30	ID	PVD_ID
Requested Physician Type	311	6	Alpha	PVD_PVT_CODE
Requested Physician Tax ID	317	15	Alpha	PVD_TAX_ID
Requested Physician Alternate ID	332	30	ID	PID_ID
Requested Physician Last Name	362	35	Alpha	PVD_LAST_NAME
Requested Physician First Name	397	25	Alpha	PVD_FIRST_NAME
Requested Group ID	422	30	ID	PVD_ID
Requested Group Type	452	6	Alpha	PVD_PVT_CODE
Requested Group Tax ID	458	15	Alpha	PVD_TAX_ID
Requested Group Alternate ID	473	30	ID	PID_ID
Requested Group Name	503	50	Alpha	PVD_NAME
Requested Physician/Group Location ID	553	30	ID	AFA_ADR_ID_SERVICE
Requested Physician/Group City	583	30	Alpha	ADR_CITY
Requested Physician/Group State	613	6	Code	ADR_STA_CODE

Field Name	Position	Length	Type	maxMC Schema Field Name
Requested Physician/Group In Network Flag	619	1	Y/N	N/A
Requested Facility/Vendor ID	620	30	ID	PVD_ID
Requested Facility/Vendor Type	650	6	Alpha	PVD_PVT_CODE
Requested Facility/Vendor Tax ID	656	15	Alpha	PVD_TAX_ID
Requiested Facility/Vendor Alternate Id	671	30	ID	PID_ID
Requested Facility/Vendor Name	701	50	Alpha	PVD_NAME
Requested Facility/Vendor Location ID	751	30	ID	AFA_ADR_ID_SERVICE
Requested Facility City	781	30	Alpha	ADR_CITY
Requested Facility State	811	6	Code	ADR_STA_CODE
Requested Facility In Network Flag	817	1	Y/N	N/A
Requested Procedure Code Low Value	818	11	ID	PXC_CODE_DISPLAY
Requested Procedure Code High Value	829	11	ID	PXC_CODE_DISPLAY
Requested Procedure Code Type	840	6	Code	PXC_TYPE
Requested Procedure Code Modifier 1	846	2	Code	TCM_CMD_CODE_1_REQD

Field Name	Position	Length	Type	maxMC Schema Field Name
Requested Procedure Code Modifier 2	848	2	Code	TCM_CMD_CODE_2_REQD
Requested Procedure Code Modifier 3	850	2	Code	TCM_CMD_CODE_3_REQD
Requested Procedure Code Modifier 4	852	2	Code	TCM_CMD_CODE_4_REQD
Requested Procedure Code Modifier 5	854	2	Code	TCM_CMD_CODE_5_REQD
Requested Rate	856	12	Numeric	TCM_RATE_REQD
Requested Total Cost	868	12	Numeric	TCM_TOTAL_COST_REQD
Requested Total Quantity	880	12	Numeric	TCM_TOTAL_QUANTITY_REQD
Requested Service Date Begin	892	8	Date	TCM_DATE_BEGIN_REQD
Requested Service Date End	900	8	Date	TCM_DATE_END_REQD
Requested Days	908	3	Numeric	TCM_DAYS_REQD
Requested Quantity Qualifier	911	2	Code	TCM_QUANTITY_QUALIFIER_REQD
Requested Quantity	913	12	Numeric	TCM_QUANTITY_REQD
Requested Frequency Qualifier	925	2	Code	TCM_FREQUENCY_QUALIFIER_REQD
Requested Frequency	927	12	Numeric	TCM_FREQUENCY_REQD
Requested Duration Qualilfier	939	2	Code	TCM_DURATION_QUALIFIER_REQD
Requested Duration	941	3	Numeric	TCM_DURATION_REQD
Requested Setting of Inpatient Y/N	944	1	Y/N	TCM_INPATIENT_REQD_YN
Authorized Place of Service	945	6	Code	TCM_POS_CODE_AUTHD

Field Name	Position	Length	Type	maxMC Schema Field Name
Authorized Physician ID	951	30	ID	PVD_ID
Authorized Physician Type	981	6	Alpha	PVD_PVT_CODE
Authorized Physician Tax ID	987	15	Alpha	PVD_TAX_ID
Authorized Physician Alternate ID	1002	30	ID	PID_ID
Authorized Physician Last Name	1032	35	Alpha	PVD_LAST_NAME
Authorized Physician First Name	1067	25	Alpha	PVD_FIRST_NAME
Authorized Group ID	1092	30	ID	PVD_ID
Authorized Group Type	1122	6	Alpha	PVD_PVT_CODE
Authorized Group Tax ID	1128	15	Alpha	PVD_TAX_ID
Authorized Group Alternate ID	1143	30	ID	PID_ID
Authorized Group Name	1173	50	Alpha	PVD_NAME
Authorized Physician/Group Location ID	1223	30	ID	AFA_ADR_ID_SERVICE
Authorized Physician/Group City	1253	30	Alpha	ADR_CITY
Authorized Physician/Group State	1283	6	Code	ADR_STA_CODE
Authorized Physician/Group In Network Flag	1289	1	Y/N	N/A
Authorized Facility/Vendor ID	1290	30	ID	PVD_ID
Authorized Facility/Vendor	1320	6	Alpha	PVD_PVT_CODE

Field Name	Position	Length	Type	maxMC Schema Field Name
Type				
Authorized Facility/Vendor Tax ID	1326	15	Alpha	PVD_TAX_ID
Authorized Facility/Vendor Alternate ID	1341	30	ID	PID_ID
Authorized Facility/Vendor Name	1371	50	Alpha	PVD_NAME
Authorized Facility/Vendor Location ID	1421	30	ID	AFA_ADR_ID_SERVICE
Authorized Facility City	1451	30	Alpha	ADR_CITY
Authorized Facility State	1481	6	Code	ADR_STA_CODE
Authorized Facility In Network Flag	1487	1	Y/N	N/A
Authorized Procedure Code Low Value	1488	11	ID	PXC_CODE_DISPLAY
Authorized Procedure Code High Value	1499	11	ID	PXC_CODE_DISPLAY
Authorized Procedure Code Type	1510	6	Code	PXC_TYPE
Authorized Procedure Code Modifier 1	1516	2	Code	TCM_CMD_CODE_1_AUTHD
Authorized Procedure Code Modifier 2	1518	2	Code	TCM_CMD_CODE_2_AUTHD
Authorized Procedure Code Modifier 3	1520	2	Code	TCM_CMD_CODE_3_AUTHD
Authorized Procedure Code Modifier 4	1522	2	Code	TCM_CMD_CODE_4_AUTHD

Field Name	Position	Length	Type	maxMC Schema Field Name
Authorized Procedure Code Modifier 5	1524	2	Code	TCM_CMD_CODE_5_AUTHD
Authorized Rate	1526	12	Numeric	TCM_RATE_AUTHD
Authorized Total Cost	1538	12	Numeric	TCM_TOTAL_COST_AUTHD
Authorized Total Quantity	1550	12	Numeric	TCM_TOTAL_QUANTITY_AUTHD
Authorized Service Date Begin	1562	8	Date	TCM_DATE_BEGIN_AUTHD
Authorized Service Date End	1570	8	Date	TCM_DATE_END_AUTHD
Authorized Days	1578	3	Numeric	TCM_DAYS_AUTHD
Authorized Quantity Qualifier	1581	2	Code	TCM_QUANTITY_QUALIFIER_AUTHD
Authorized Quantity	1583	12	Numeric	TCM_QUANTITY_AUTHD
Authorized Frequency Qualifier	1595	2	Code	TCM_FREQUENCY_QUALIFIER_AUTHD
Authorized Frequency	1597	12	Numeric	TCM_FREQUENCY_AUTHD
Authorized Duration Qualilfier	1609	2	Code	TCM_DURATION_QUALIFIER_AUTHD
Authorized Duration	1611	3	Numeric	TCM_DURATION_AUTHD
Authorized Setting of Inpatient Y/N	1614	1	Y/N	TCM_INPATIENT_AUTHD_YN
Percentage Authorized	1615	4	Numeric	TCM_PERCENT_AUTHD
Reason for Place of Service Change	1619	6	Code	TCM_CVR_CODE_PLACE_OF_SERVICE
Reason for Procedure Code Change	1625	6	Code	TCM_CVR_CODE_PROCEDURE
Reason for Quantity Change	1631	6	Code	TCM_CVR_CODE_QUANTITY

Field Name	Position	Length	Type	maxMC Schema Field Name
Reason for Rate Change	1637	6	Code	TCM_CVR_CODE_RATE
Total Cost Variance	1643	12	Numeric	TCM_TOTAL_COST_VARIANCE
Total Quantity Variance	1655	8	Numeric	TCM_TOTAL_QUANTITY_VARIANCE
Was Service Appealed Y/N	1663	1	Y/N	TCM_APPEALED_YN
Was In-Network Overridden for the Physician Y/N	1664	1	Y/N	TCM_OVERRIDE_NTWRK_PHYS_YN
Was In-Network Overridden for the Facility Y/N	1665	1	Y/N	TCM_OVERRIDE_NTWRK_FAC_YN
Date all Required Information was Received	1666	8	Date	TCM_DATE_INFO_RECEIVED
Date Verbal Notice of Decision of Given	1674	8	Date	TCM_DATE_VERBAL_NOTICE
Date Written Notice of Decision was Given	1682	8	Date	TCM_DATE_WRITTEN_NOTICE
Record Create Date	1690	8	Date	TCM_CREATE_DATE
User ID Who Created Record	1698	12	ID	STF_ID
User Last Name of Who Created Record	1710	35	Alpha	STF_LAST_NAME
User First Name of Who Created Record	1745	25	Alpha	STF_FIRST_NAME
Last Update Date	1770	8	Date	TCM_LAST_UPDATE_DATE
User ID Who Last Updated Record	1778	12	ID	STF_ID
User Last Name of Who Last Updated Record	1790	35	Alpha	STF_LAST_NAME
User First Name of Who Last Updated Record	1825	25	Alpha	STF_FIRST_NAME

Field Name	Position	Length	Type	maxMC Schema Field Name
Service Notes	1850	2000	Alpha	TCM_CLAIMS_NOTES

2.10.15.5 Days Detail

Field Name	Position	Length	Type	maxMC Schema Field Name
Record Type	1	3	Alpha	N/A
Case-Level Reference Number	4	25	Alpha	TAU_REFERENCE_NUMBER
Review Date	29	8	Date	TID_DATE_REVIEW
Action	37	2	Code	TID_ACTION
Begin Date	39	8	Date	TID_DATE_BEGIN
End Date	47	8	Date	TID_DATE_END
Number of Days	55	3	Numeric	TID_DAYS
Level of Care Requested	58	6	Code	TID_LOC_CODE_REQD
Level of Care Authorized	64	6	Code	TID_LOC_CODE_AUTHD
Level of Care Reason	70	6	Code	TID_LCR_CODE
Inpatient Review Decision Reason	76	6	Code	TID_IRR_CODE
Per Diem Requested	82	10	Numeric	TID_PERDIEM_REQD
Per Diem Authorized	92	10	Numeric	TID_PERDIEM_AUTHD
Per Diem Variance	102	10	Numeric	TID_PERDIEM_VARIANCE
Staff ID Who Made the Decision	112	12	ID	STF_ID
Staff Last Name Who Made the Decision	124	35	Alpha	STF_LAST_NAME
Staff First Name Who Made	159	25	Alpha	STF_FIRST_NAME

Field Name	Position	Length	Type	maxMC Schema Field Name
the Decision				
Date all Required Information was Received	184	8	Date	TID_DATE_INFO_RECEIVED
Date Verbal Notice of Decision of Given	192	8	Date	TID_DATE_VERBAL_NOTICE
Date Written Notice of Decision was Given	200	8	Date	TID_DATE_WRITTEN_NOTICE
Record Create Date	208	8	Date	TID_CREATE_DATE
User ID Who Created Record	216	12	ID	STF_ID
User Last Name of Who Created Record	228	35	Alpha	STF_LAST_NAME
User First Name of Who Created Record	263	25	Alpha	STF_FIRST_NAME
Last Update Date	288	8	Date	TID_LAST_UPDATE_DATE
User ID Who Last Updated Record	296	12	ID	STF_ID
User Last Name of Who Last Updated Record	308	35	Alpha	STF_LAST_NAME
User First Name of Who Last Updated Record	343	25	Alpha	STF_FIRST_NAME
Filler	368	3482	Spaces	N/A

2.10.15.6 Provider Address

Field Name	Position	Length	Type	maxMC Schema Field Name
Record Type	1	3	Alpha	N/A
Case-Level Reference Number	4	25	Alpha	TAU_REFERENCE_NUMBER
Service Sequence Number	29	3	Numeric	TCM_SEQUENCE

Field Name	Position	Length	Type	maxMC Schema Field Name
Requested Physician Name	32	64	Alpha	TAD_ADDRESSEE
Requested Physician Address ID	96	30	Alpha	ADR_ID
Requested Servicing Physician Address Line 1	126	55	Alpha	TAD_ADDRESS_LINE_1 or ADR_ADDRESS_LINE_1
Requested Servicing Physician Address Line 2	181	55	Alpha	TAD_ADDRESS_LINE_2 or ADR_ADDRESS_LINE_2
Requested Servicing Physician Address Line 3	236	55	Alpha	TAD_ADDRESS_LINE_3 or ADR_ADDRESS_LINE_3
Requested Servicing Physician Address Line 4	291	55	Alpha	TAD_ADDRESS_LINE_4 or ADR_ADDRESS_LINE_4
Requested Servicing Physician City	346	30	Alpha	TAD_CITY or ADR_CITY
Requested Servicing Physician State Code	376	6	Code	TAD_STA_CODE or ADR_STA_CODE
Requested Servicing Physician Zip	382	15	Alpha	TAD_POC_CODE or ADR_POC_CODE
Requested Servicing Physician Postal Extension	397	4	Alpha	TAD_POSTAL_EXTENSION or ADR_POSTAL_EXTENSION

Field Name	Position	Length	Type	maxMC Schema Field Name
Requested Servicing Physician Phone Number	401	20	Alpha	TAD_PVD_PHONE_VOICE, if populated, else ADR_PHONE_VOICE, if populated, else PVD_PHONE_VOICE
Requested Facility Name	421	64	Alpha	TAD_ADDRESSEE
Requested Facility Address ID	485	30	Alpha	ADR_ID
Requested Servicing Facility Address Line 1	515	55	Alpha	TAD_ADDRESS_LINE_1 or ADR_ADDRESS_LINE_1
Requested Servicing Facility Address Line 2	570	55	Alpha	TAD_ADDRESS_LINE_2 or ADR_ADDRESS_LINE_2
Requested Servicing Facility Address Line 3	625	55	Alpha	TAD_ADDRESS_LINE_3 or ADR_ADDRESS_LINE_3
Requested Servicing Facility Address Line 4	680	55	Alpha	TAD_ADDRESS_LINE_4 or ADR_ADDRESS_LINE_4
Requested Servicing Facility City	735	30	Alpha	TAD_CITY or ADR_CITY
Requested Servicing Facility State Code	765	6	Code	TAD_STA_CODE or ADR_STA_CODE
Requested Servicing Facility Zip	771	15	Alpha	TAD_POC_CODE or ADR_POC_CODE

Field Name	Position	Length	Type	maxMC Schema Field Name
Requested Servicing Facility Postal Extension	786	4	Alpha	TAD_POSTAL_EXTENSION or ADR_POSTAL_EXTENSION
Requested Servicing Facility Phone Number	790	20	Alpha	TAD_PVD_PHONE_VOICE, if populated, else ADR_PHONE_VOICE, if populated, else PVD_PHONE_VOICE
Authorized Physician Name	810	64	Alpha	TAD_ADDRESSEE
Authorized Physician Address ID	874	30	Alpha	ADR_ID
Authorized Servicing Physician Address Line 1	904	55	Alpha	TAD_ADDRESS_LINE_1 or ADR_ADDRESS_LINE_1
Authorized Servicing Physician Address Line 2	959	55	Alpha	TAD_ADDRESS_LINE_2 or ADR_ADDRESS_LINE_2
Authorized Servicing Physician Address Line 3	1014	55	Alpha	TAD_ADDRESS_LINE_3 or ADR_ADDRESS_LINE_3
Authorized Servicing Physician Address Line 4	1069	55	Alpha	TAD_ADDRESS_LINE_4 or ADR_ADDRESS_LINE_4
Authorized Servicing Physician City	1124	30	Alpha	TAD_CITY or ADR_CITY

Field Name	Position	Length	Type	maxMC Schema Field Name
Authorized Servicing Physician State Code	1154	6	Code	TAD_STA_CODE or ADR_STA_CODE
Authorized Servicing Physician Zip	1160	15	Alpha	TAD_POC_CODE or ADR_POC_CODE
Authorized Servicing Physician Postal Extension	1175	4	Alpha	TAD_POSTAL_EXTENSION or ADR_POSTAL_EXTENSION
Authorized Servicing Physician Phone Number	1179	20	Alpha	TAD_PVD_PHONE_VOICE, if populated, else ADR_PHONE_VOICE, if populated, else PVD_PHONE_VOICE
Authorized Facility Name	1199	64	Alpha	TAD_ADDRESSEE
Authorized Facility Address ID	1263	30	Alpha	ADR_ID
Authorized Servicing Facility Address Line 1	1293	55	Alpha	TAD_ADDRESS_LINE_1 or ADR_ADDRESS_LINE_1
Authorized Servicing Facility Address Line 2	1348	55	Alpha	TAD_ADDRESS_LINE_2 or ADR_ADDRESS_LINE_2
Authorized Servicing Facility Address Line 3	1403	55	Alpha	TAD_ADDRESS_LINE_3 or ADR_ADDRESS_LINE_3

Field Name	Position	Length	Type	maxMC Schema Field Name
Authorized Servicing Facility Address Line 4	1458	55	Alpha	TAD_ADDRESS_LINE_4 or ADR_ADDRESS_LINE_4
Authorized Servicing Facility City	1513	30	Alpha	TAD_CITY or ADR_CITY
Authorized Servicing Facility State Code	1543	6	Code	TAD_STA_CODE or ADR_STA_CODE
Authorized Servicing Facility Zip	1549	15	Alpha	TAD_POC_CODE or ADR_POC_CODE
Authorized Servicing Facility Postal Extension	1564	4	Alpha	TAD_POSTAL_EXTENSION or ADR_POSTAL_EXTENSION
Authorized Servicing Facility Phone Number	1568	20	Alpha	TAD_PVD_PHONE_VOICE, if populated, else ADR_PHONE_VOICE, if populated, else PVD_PHONE_VOICE
Filler	1588	2262	Spaces	N/A

2.10.16 Navigant Layout

2.10.16.1 Navigant Inpatient Hdr

Field Name	Length	Position Start	Position End
ICN	13	1	13
;	1	14	14
CLAIM TYPE	1	15	15
;	1	16	16
CLAIM STATUS	1	17	17
;	1	18	18

Field Name	Length	Position Start	Position End
ADMISSION DATE	10	19	28
;	1	29	29
ADMISSION HOUR	5	30	34
;	1	35	35
ADMIT SOURCE	1	36	36
;	1	37	37
ADMIT TYPE	1	38	38
;	1	39	39
MEDICARE PAID AMT	14	40	53
;	1	54	54
BILL PROV CAT OF SVC	2	55	56
;	1	57	57
BILL PROV COUNTY CODE	10	58	67
;	1	68	68
FFS/MC IND	1	69	69
;	1	70	70
BILL PROV MCAID	15	71	85
;	1	86	86
BILL PROV NPI	15	87	101
;	1	102	102
BILL PROV SPEC CODE	3	103	105
;	1	106	106

Field Name	Length	Position Start	Position End
BILL PROV TYPE	2	107	108
;	1	109	109
PERF PROV NPI	15	110	124
;	1	125	125
PERF PROV MCAID	15	126	140
;	1	141	141
REFER PROV NPI	15	142	156
;	1	157	157
REFER PROV MCAID	15	158	172
;	1	173	173
PATIENT LIAB AMT	14	174	187
;	1	188	188
CONDITION CODE 1	2	189	190
;	1	191	191
CONDITION CODE 2	2	192	193
;	1	194	194
NUM COVERED DAYS	10	195	204
;	1	205	205
DATE BILLED	10	206	215
;	1	216	216
DATE OF PAID	10	217	226
;	1	227	227

Field Name	Length	Position Start	Position End
DRG_CODE	4	228	231
;	1	232	232
WEIGHT	8	233	240
;	1	241	241
DIAG CODE 1	7	242	248
;	1	249	249
DIAG CODE 2	7	250	256
;	1	257	257
DIAG CODE 3	7	258	264
;	1	265	265
DIAG CODE 4	7	266	272
;	1	273	273
DIAG CODE 5	7	274	280
;	1	281	281
DIAG CODE 6	7	282	288
;	1	289	289
DIAG CODE 7	7	290	296
;	1	297	297
DIAG CODE 8	7	298	304
;	1	305	305
DIAG CODE 9	7	306	312
;	1	313	313

Field Name	Length	Position Start	Position End
SVC ADDR ZIP	5	314	318
;	1	319	319
TPL IND	1	320	320
;	1	321	321
EOB CODE 1	4	322	325
;	1	326	326
EOB CODE 2	4	327	330
;	1	331	331
FIRST DATE OF SVC	10	332	341
;	1	342	342
KENPAC IND	1	343	343
;	1	344	344
LAST DATE OF SVC	10	345	354
;	1	355	355
MCARE COINS AMT	15	356	370
;	1	371	371
MCARE DEDUCT AMT	15	372	386
;	1	387	387
MEDICAL RCD NUM	30	388	417
;	1	418	418
NONCOV DAYS	4	419	422
;	1	423	423

Field Name	Length	Position Start	Position End
OCCUR CODE 1	2	424	425
;	1	426	426
OCCUR CODE 2	2	427	428
;	1	429	429
OCCUR CODE 3	2	430	431
;	1	432	432
OCCUR DATE 1	10	433	442
;	1	443	443
OCCUR DATE 2	10	444	453
;	1	454	454
OCCUR DATE 3	10	455	464
;	1	465	465
PRIOR AUTH NUM	10	466	475
;	1	476	476
HCPCS PROC CODE	6	477	482
;	1	483	483
ICD9 PROC CODE 1	4	484	487
;	1	488	488
ICD9 PROC CODE 2	4	489	492
;	1	493	493
ICD9 PROC CODE 3	4	494	497
;	1	498	498

Field Name	Length	Position Start	Position End
ICD9 PROC CODE 4	4	499	502
;	1	503	503
ICD9 PROC CODE 5	4	504	507
;	1	508	508
ICD9 PROC CODE 6	4	509	512
;	1	513	513
MEMBER ID	12	514	525
;	1	526	526
MEMBER AGE	5	527	531
;	1	532	532
MEMBER COUNTY	10	533	542
;	1	543	543
MEMBER DATE OF BIRTH	10	544	553
;	1	554	554
MEMBER MCARE IND A	1	555	555
;	1	556	556
MEMBER MCARE IND B	1	557	557
;	1	558	558
MEMBER AID CATEGORY	2	559	560
;	1	561	561
MEMBER RACE CODE	2	562	563
;	1	564	564

Field Name	Length	Position Start	Position End
MEMBER SEX CODE	1	565	565
;	1	566	566
MEMBER ZIP CODE	5	567	571
;	1	572	572
AMT PAID	14	573	586
;	1	587	587
TPL PMT AMT	15	588	602
;	1	603	603
AMT BILLED	15	604	618
;	1	619	619
AMT ENCOUNTER	14	620	633
;	1	634	634
VALUE CODE 1	2	635	636
;	1	637	637
VALUE CODE 2	2	638	639
;	1	640	640
VALUE CODE 3	2	641	642
;	1	643	643
VALUE DOLLAR AMOUNT 1	13	644	656
;	1	657	657
VALUE DOLLAR AMOUNT 2	13	658	670
;	1	671	671

Field Name	Length	Position Start	Position End
VALUE DOLLAR AMOUNT 3	13	672	684
'Record Count :	15	1	15
;	1	16	16
sak_claim	10	17	26
;	1	27	27
'Total Amt Paid :	17	28	44
;	1	45	45
AMT_PAID	15	46	60
;	1	61	61
'Total Amt Bill :	17	62	78
;	1	79	79
AMT_BILLED	15	80	94

2.10.16.2 Navigant Inpatient Line Item

Name	Length	Position Start	Position End
ICN	13	1	13
;	1	14	14
DETAIL NUMBER	5	15	19
;	1	20	20
TOT DETAIL NUMBER	11	21	31
;	1	32	32
ATTENDING PROVIDER	15	33	47

Name	Length	Position Start	Position End
;	1	48	48
HDR ALLOWED AMT	14	49	62
;	1	63	63
HDR DISCHARGE DATE	10	64	73
;	1	74	74
DISCHARGE HOUR	5	75	79
;	1	80	80
EPSDT IND	1	81	81
;	1	82	82
EMERGENCY IND	1	83	83
;	1	84	84
DETAIL PROC CODE	6	85	90
;	1	91	91
DETAIL ALLOWED AMT	13	92	104
;	1	105	105
DETAIL FIRST DATE OF SVC	10	106	115
;	1	116	116
DETAIL LAST DATE OF SVC	10	117	126
;	1	127	127
DETAIL TPL PAY	13	128	140
;	1	141	141
DETAIL BILLED AMT	13	142	154

Name	Length	Position Start	Position End
;	1	155	155
DETAIL STATUS CODE	1	156	156
;	1	157	157
MEDICARE PAID AMT	14	158	171
;	1	172	172
PAID AMOUNT	13	173	185
;	1	186	186
PATIENT STATUS	2	187	188
;	1	189	189
DETAIL REVENUE CODE	5	190	194
;	1	195	195
CLM TYPE	1	196	196
;	1	197	197
HDR TYPE BILL	3	198	200
;	1	201	201
DETAIL UNITS	13	202	214
'Record Count :	15	1	15
;	1	16	16
sak_claim	10	17	26
;	1	27	27
'Total Amt Paid :	17	28	44

Name	Length	Position Start	Position End
;	1	45	45
AMT_PAID	15	46	60
;	1	61	61
'Total Amt Bill :	17	62	78
;	1	79	79
AMT_BILLED	15	80	94

2.10.16.3 Navigant Outpatient Hdr

Name	Length	Position Start	Position End
ADMISSION DATE	10	1	10
;	1	11	11
ADMISSION HOUR	5	12	16
;	1	17	17
ADMIT SOURCE	1	18	18
;	1	19	19
ADMIT TYPE	1	20	20
;	1	21	21
AMT PAID BY MEDICARE	14	22	35
;	1	36	36
ATTENDING PROVIDER	15	37	51
;	1	52	52
CAT OF SVC	2	53	54
;	1	55	55

Name	Length	Position Start	Position End
BILL PROV COUNTY CODE	10	56	65
;	1	66	66
FFS/MC IND	1	67	67
;	1	68	68
BILL PROV NPI	15	69	83
;	1	84	84
BILL PROV MCAID	15	85	99
;	1	100	100
BILL PROV SPEC CODE	3	101	103
;	1	104	104
BILL PROV TYPE	2	105	106
;	1	107	107
PERF PROV NPI	15	108	122
;	1	123	123
PERF PROV MCAID	15	124	138
;	1	139	139
REFER PROV NPI	15	140	154
;	1	155	155
REFER PROV MCAID	15	156	170
;	1	171	171
CLAIM STATUS	1	172	172
;	1	173	173

Name	Length	Position Start	Position End
CLAIM TYPE	1	174	174
;	1	175	175
PATIENT LIAB AMT	15	176	190
;	1	191	191
CONDITION CODE 1	2	192	193
;	1	194	194
CONDITION CODE 2	2	195	196
;	1	197	197
COVERED DAYS	10	198	207
;	1	208	208
DATE BILLED	10	209	218
;	1	219	219
DATE PAID	10	220	229
;	1	230	230
DIAG CODE 1	7	231	237
;	1	238	238
DIAG CODE 2	7	239	245
;	1	246	246
DIAG CODE 3	7	247	253
;	1	254	254
EOB CODE 1	4	255	258
;	1	259	259

Name	Length	Position Start	Position End
EOB CODE 2	4	260	263
;	1	264	264
FIRST DATE OF SVC	10	265	274
;	1	275	275
KENPAC IND	1	276	276
;	1	277	277
LAST DATE OF SVC	10	278	287
;	1	288	288
MCARE COINS AMT	14	289	302
;	1	303	303
MCARE DEDUCTIBLE AMT	14	304	317
;	1	318	318
MEDICAL REC NUM	30	319	348
;	1	349	349
NONCOV DAYS	4	350	353
;	1	354	354
OCCUR CODE 1	2	355	356
;	1	357	357
OCCUR CODE 2	2	358	359
;	1	360	360
OCCUR CODE 3	2	361	362
;	1	363	363

Name	Length	Position Start	Position End
OCCUR DATE 1	10	364	373
;	1	374	374
OCCUR DATE 2	10	375	384
;	1	385	385
OCCUR DATE 3	10	386	395
;	1	396	396
PRIOR AUTH NUM	10	397	406
;	1	407	407
PROC CODE 1	4	408	411
;	1	412	412
PROC CODE 2	4	413	416
;	1	417	417
MEMBER AGE	5	418	422
;	1	423	423
MEMBER COUNTY	10	424	433
;	1	434	434
MEMBER DATE OF BIRTH	10	435	444
;	1	445	445
MEMBER IDENT NUMBER	12	446	457
;	1	458	458
MEMBER MCARE IND A	1	459	459
;	1	460	460

Name	Length	Position Start	Position End
MEMBER MCARE IND B	1	461	461
;	1	462	462
MEMBER AID CATEGORY	2	463	464
;	1	465	465
MEMBER RACE CODE	2	466	467
;	1	468	468
MEMBER SEX CODE	1	469	469
;	1	470	470
MEMBER ZIP CODE	5	471	475
;	1	476	476
TOT PAID AMOUNT	11	477	487
;	1	488	488
TPL PMT AMT	15	489	503
;	1	504	504
TOT CLAIM CHARGE	10	505	514
;	1	515	515
TOT AMT ENCOUNTER	15	516	530
;	1	531	531
VALUE CODE 1	2	532	533
;	1	534	534
VALUE CODE 2	2	535	536
;	1	537	537

Name	Length	Position Start	Position End
VALUE CODE 3	2	538	539
;	1	540	540
VALUE DOLLAR AMOUNT 1	15	541	555
;	1	556	556
VALUE DOLLAR AMOUNT 2	15	557	571
;	1	572	572
VALUE DOLLAR AMOUNT 3	15	573	587
;	1	588	588
ICN NUM	13	589	601
Record Count :	15	1	15
;	1	16	16
sak_claim	10	17	26
;	1	27	27
Total Amt Paid :	17	28	44
;	1	45	45
amt_paid	40	46	85
;	1	86	86
Total Amt Billed :	19	87	105
;	1	106	106
amt_billed	11	107	117

2.10.16.4 Navigant Outpatient Line Item

Name	Length	Position Start	Position End
HDR ALLOWED CHARGE	14	1	14
;	1	15	15
HDR DISCHARGE DATE	10	16	25
;	1	26	26
DISCHARGE HOUR	5	27	31
;	1	32	32
EPSDT IND	1	33	33
;	1	34	34
ER IND	1	35	35
;	1	36	36
IND REF FAM PLAN	1	37	37
;	1	38	38
DETAIL ALLOWED AMT	13	39	51
;	1	52	52
DETAIL EOB 1	4	53	56
;	1	57	57
DETAIL EOB 2	4	58	61
;	1	62	62
DETAIL FIRST DATE OF SVC	10	63	72
;	1	73	73
DETAIL LAST DATE OF SVC	10	74	83

Name	Length	Position Start	Position End
;	1	84	84
DETAIL TPL PAY	13	85	97
;	1	98	98
DETAIL BILLED	13	99	111
;	1	112	112
DETAIL NUMBER	5	113	117
;	1	118	118
TOT DETAIL NUMBER	11	119	129
;	1	130	130
DETAIL STATUS CODE	1	131	131
;	1	132	132
AMT DEDUCT BLOOD	14	133	146
;	1	147	147
AMT PAID MCARE	14	148	161
;	1	162	162
AMT PAID	13	163	175
;	1	176	176
PATIENT STATUS	2	177	178
;	1	179	179
PERF PROVIDER NPI	15	180	194
;	1	195	195
PERF PROVIDER MCAID	15	196	210

Name	Length	Position Start	Position End
;	1	211	211
DETAIL PROC CODE	6	212	217
;	1	218	218
DETAIL REVENUE CODE	5	219	223
;	1	224	224
CDE CLM TPYE	1	225	225
;	1	226	226
HDR TYPE BILL	3	227	229
;	1	230	230
DETAIL UNITS OF SERVICE	13	231	243
;	1	244	244
ICN	13	245	257
Record Count :	15	1	15
;	1	16	16
sak_claim	10	17	26
;	1	27	27
Total Amt Paid :	17	28	44
;	1	45	45
amt_paid	14	46	59
;	1	60	60
Total Amt Bill :	17	61	77

Name	Length	Position Start	Position End
;	1	78	78
amt_billed	14	79	92

2.10.17 Nursing Facilities Claims Interface Layout

Name	Type	Length	Position Start	Position End	Description
Filler	Char	1	1	1	Blank Field
Paid_date	Formatted date (mm/yy)	5	2	6	Date the claim was paid.
Delimiter (";")	Char	1	7	7	*
Provider Number	Char	10	8	17	Provider ID Number
Delimiter (";")	Char	1	18	18	*
Provider Name	Char	45	19	63	Provider Name
Delimiter (";")	Char	1	64	64	*
Covered Days	Number	14	65	78	Indicates the total number of days for the statement period of the claim. (###############)
Delimiter (";")	Char	1	79	79	*
Accom Total Paid	Number	15	80	94	Total Paid of accommodation services. (############.##)
Delimiter (";")	Char	1	95	95	*
Ancil Total Paid	Number	15	96	110	Total Paid of ancillary services. (############.##)
Delimiter (";")	Char	1	111	111	*

Name	Type	Length	Position Start	Position End	Description
Member Paid Amount	Number	15	112	126	This is the result of (1) Amount paid by member for services rendered (Copay) plus (2) Amount of patient liability. (############.##)
Delimiter (";")	Char	1	127	127	*
TPL Amount	Number	15	128	142	This is the TPL amount for header only services.(############.##)
Delimiter (";")	Char	1	143	143	*
Paid Amount	Number	15	144	158	Amount paid for services rendered.(############.##)
Delimiter (";")	Char	1	159	159	*
Medicare Paid Amount	Number	15	160	174	Amount paid by Medicare Crossover Part A or C Claim - Header level.(############.##)
Delimiter (";")	Char	1	175	175	*
Paid Amount + Medicare Paid Amount	Number	15	176	190	Amount paid for services rendered + Medicare Paid Amount.(############.##)

2.10.17.1 Trailer Record

Name	Type	Length	Position Start	Position End	Description
Filler	Char	18	1	18	Blank Field
"TOTAL"	Char	5	19	23	" T O T A L "
Filler	Char	40	24	63	Blank Field

Name	Type	Length	Position Start	Position End	Description
Delimiter (";")	Char	1	64	64	*
Covered Days	Number	14	65	78	Total Number of days Covered in the file.(###############)
Delimiter (";")	Char	1	79	79	*
Accom Total Paid	Number	15	80	94	Grand Total of Accom Total Paid in the file.(############.##)
Delimiter (";")	Char	1	95	95	*
Ancil Total Paid	Number	15	96	110	Grand Total of Ancil Total Paid in the file.(############.##)
Delimiter (";")	Char	1	111	111	*
Member Paid Amount	Number	15	112	126	Total Member Paid Amount in the file.(############.##)
Delimiter (";")	Char	1	127	127	*
TPL Amount	Number	15	128	142	Total TPL Amount in the file.(############.##)
Delimiter (";")	Char	1	143	143	*
Paid Amount	Number	15	144	158	Total Paid Amount in the file.(############.##)
Delimiter (";")	Char	1	159	159	*
Medicare Paid Amount	Number	15	160	174	Total Medicare Paid Amount in the file.(############.##)
Delimiter (";")	Char	1	175	175	*
Paid Amount + Medicare Paid Amount	Number	15	176	190	Grand Total of (Paid Amount + Medicare Paid Amount) in the file.(############.##)

2.10.18 Preventive Service Layout

2.10.18.1 Header Record (TITLES)

Name	Type	Length	Position Start	Position End	Description
Header Record (TITLES)					
"PROVIDER NUMBER"	char	15	1	15	
Delimiter (;)	char	1	16	16	
"MODIFIER"	char	8	17	24	
Delimiter (;)	char	1	25	25	
"PROC CODE"	char	10	26	35	
Delimiter (;)	char	1	36	36	
"UNITS PAID TILL BEGIN"	char	24	37	60	
Delimiter (;)	char	1	61	61	
"AMOUNTS PAID TILL BEGIN"	char	24	62	85	
Delimiter (;)	char	1	86	86	
"UNITS PAID TILL BEGIN"	char	24	87	110	
Delimiter (;)	char	1	111	111	
"AMOUNTS PAID TILL BEGIN"	char	24	112	135	
Delimiter (;)	char	1	136	136	
"UNITS PAID DURING"	char	24	137	160	
Delimiter (;)	char	1	161	161	
"AMOUNTS PAID DURING"	char	24	162	185	

2.10.18.2 Header Record 2

Name	Type	Length	Position Start	Position End	Description
Filler	*	15	1	15	
Delimiter (;)	char	1	16	16	
Filler	*	8	17	24	
Delimiter (;)	char	1	25	25	
Filler	*	10	26	35	
Delimiter (;)	char	1	36	36	
"OF FISCAL YEAR"	char	15	37	51	
Last Year	date (CCYY)	4	52	55	Fiscal Year
Filler	*	5	56	60	
Delimiter (;)	char	1	61	61	
"OF FISCAL YEAR"	char	15	62	76	
Last Year	date(CCYY)	4	77	80	Fiscal Year
Filler	*	5	81	85	
Delimiter (;)	char	1	86	86	
"OF THE MONTH"	char	13	87	99	
Last Month	date(MMM,CCYY)	9	100	108	MMM =Current Month CCYY= Current Year
Filler	*	2	109	110	
Delimiter (;)	char	1	111	111	
"OF THE MONTH"	char	13	112	124	

Name	Type	Length	Position Start	Position End	Description
Last Month	date(MMM,CCYY)	9	125	133	MMM =Current Month CCYY= Current Year
Filler	*	2	134	135	
Delimiter (;)	char	1	136	136	
"THE MONTH OF"	char	13	137	149	
Current Month	date(MMM,CCYY)	9	150	158	MMM =Current Month CCYY= Current Year
Filler	*	2	159	160	
Delimiter (;)	char	1	161	161	
"THE MONTH OF"	char	13	162	174	
Current Month	date(MMM,CCYY)	9	175	183	MMM =Current Month CCYY= Current Year
Filler	*	2	184	185	

2.10.18.3 Detail Record

Name	Type	Length	Position Start	Position End	Description
Provider Number	char	15	1	15	Provider ID Number
Delimiter (;)	char	1	16	16	
Procedure Modifier	char	8	17	24	Code used to further define a procedure define.
Delimiter (;)	char	1	25	25	
Procedure Code	char	10	26	35	Code used to identify a medical, dental , or a DME procedure.

Name	Type	Length	Position Start	Position End	Description
Delimiter (;)	char	1	36	36	
Filler	*	6	37	42	
Units Paid Last Fiscal Year	number	10	43	52	Number of units of service that were provided. zz,zzz,zz9
Filler	*	8	53	60	
Delimiter (;)	char	1	61	61	
Filler	char	4	62	65	
Amount Paid Last Fiscal Year	number	16	66	81	Amount sent to a provider for payment for services rendered to a member. z,zzz,zzz,zzz.99
Filler	*	4	82	85	
Delimiter (;)	char	1	86	86	
Filler	*	6	87	92	
Units Paid Current Fiscal Year Previous Month	number	10	93	102	Number of units of service that were provided. zz,zzz,zz9
Filler	*	8	103	110	
Delimiter (;)	char	1	111	111	
Filler	*	5	112	116	
Amounts Paid Current Fiscal Year Previous Month	number	16	117	132	Amount sent to a provider for payment for services rendered to a member. z,zzz,zzz,zzz.99

Name	Type	Length	Position Start	Position End	Description
Filler	*	3	133	135	
Delimiter (;)	char	1	136	136	
Filler	*	4	137	142	
Units Paid This Month	number	10	143	152	Number of units of service that were provided. zz,zzz,zz9
Filler	*	10	153	162	
Delimiter (;)	char	1	163	163	
Filler	*	4	164	167	
Amount Paid This Month	number	16	168	183	Amount sent to a provider for payment for services rendered to a member. z,zzz,zzz,zzz.99
Filler	*	4	184	187	

2.10.18.4 Trailer Record 1

Name	Type	Length	Position Start	Position End	Description
Filler	*	15	1	15	
Delimiter (;)	char	1	16	16	
Procedure Modifier || ' ' || "TOTAL"	char	8	17	24	
Delimiter (;)	char	1	25	25	
Filler	*	10	26	35	
Delimiter (;)	char	1	36	36	
Filler	*	6	37	42	

Name	Type	Length	Position Start	Position End	Description
Units Paid Last Fiscal Year	number	10	43	52	Total of Units Paid Last Fiscal Year by Procedure Modifier zz,zzz,zz9
Filler	*	8	53	60	
Delimiter (;)	char	1	61	61	
Filler	char	4	62	65	
Amount Paid Last Fiscal Year	number	16	66	81	Total Amount Paid Last Fiscal Year by Procedure Modifier z,zzz,zzz,zzz.99
Filler	*	4	82	85	
Delimiter (;)	char	1	86	86	
Filler	*	6	87	92	
Units Paid Current Fiscal Year Previous Month	number	10	93	102	Total Units Paid Previous Month in Current Fiscal Year by Procedure Modifier zz,zzz,zz9
Filler	*	8	103	110	
Delimiter (;)	char	1	111	111	
Filler	*	5	112	116	
Amounts Paid Current Fiscal Year Previous Month	number	16	117	132	Total Amounts Paid Previous Month in Current Fiscal Year by Procedure Modifier z,zzz,zzz,zzz.99
Filler	*	3	133	135	

Name	Type	Length	Position Start	Position End	Description
Delimiter (;)	char	1	136	136	
Filler	*	4	137	142	
Units Paid This Month	number	10	143	152	Total Units Paid This Month by Procedure Modifier zz,zzz,zz9
Filler	*	10	153	162	
Delimiter (;)	char	1	163	163	
Filler	*	4	164	167	
Amount Paid This Month	number	16	168	183	Total Amount Paid This Month by Procedure Modifier z,zzz,zzz,zzz.99
Filler	*	4	184	187	

2.10.18.5 Trailer Record 2

Name	Type	Length	Position Start	Position End	Description
"PROV TOTALS"	char	15	1	15	
Delimiter (;)	char	1	16	16	
Filler	*	8	17	24	
Delimiter (;)	char	1	25	25	
Filler	*	10	26	35	
Delimiter (;)	char	1	36	36	
Filler	*	6	37	42	

Name	Type	Length	Position Start	Position End	Description
Units Paid Last Fiscal Year	number	10	43	52	Grand Total of Units Paid Last Fiscal Year by Provider zz,zzz,zz9
Filler	*	8	53	60	
Delimiter (;)	char	1	61	61	
Filler	char	4	62	65	
Amount Paid Last Fiscal Year	number	16	66	81	Grand Total Amount Paid Last Fiscal Year by Provider z,zzz,zzz,zzz.99
Filler	*	4	82	85	
Delimiter (;)	char	1	86	86	
Filler	*	6	87	92	
Units Paid Current Fiscal Year Previous Month	number	10	93	102	Grand Total Units Paid Previous Month in Current Fiscal Year by Provider zz,zzz,zz9
Filler	*	8	103	110	
Delimiter (;)	char	1	111	111	
Filler	*	5	112	116	
Amounts Paid Current Fiscal Year Previous Month	number	16	117	132	Grand Total Amounts Paid Previous Month in Current Fiscal Year by Provider z,zzz,zzz,zzz.99
Filler	*	3	133	135	
Delimiter (;)	char	1	136	136	

Name	Type	Length	Position Start	Position End	Description
Filler	*	4	137	142	
Units Paid This Month	number	10	143	152	Grand Total Units Paid This Month by Provider zz,zzz,zz9
Filler	*	10	153	162	
Delimiter (;)	char	1	163	163	
Filler	*	4	164	167	
Amount Paid This Month	number	16	168	183	Grand Total Amount Paid This Month by Provider z,zzz,zzz,zzz.99
Filler	*	4	184	187	

2.10.18.6 Trailer Record 3

Name	Type	Length	Position Start	Position End	Description
"GRAND TOTALS"	char	15	1	15	
Delimiter (;)	char	1	16	16	
Filler	*	8	17	24	
Delimiter (;)	char	1	25	25	
Filler	*	10	26	35	
Delimiter (;)	char	1	36	36	
Filler	*	6	37	42	
Units Paid Last Fiscal Year	number	10	43	52	Grand Total of all Units Paid Last Fiscal Year zz,zzz,zz9

Name	Type	Length	Position Start	Position End	Description
Filler	*	8	53	60	
Delimiter (;)	char	1	61	61	
Filler	char	4	62	65	
Amount Paid Last Fiscal Year	number	16	66	81	Grand Total of all Amount Paid Last Fiscal Year z,zzz,zzz,zzz.99
Filler	*	4	82	85	
Delimiter (;)	char	1	86	86	
Filler	*	6	87	92	
Units Paid Current Fiscal Year Previous Month	number	10	93	102	Grand Total of all Units Paid Previous Month in Current Fiscal Year by zz,zzz,zz9
Filler	*	8	103	110	
Delimiter (;)	char	1	111	111	
Filler	*	5	112	116	
Amounts Paid Current Fiscal Year Previous Month	number	16	117	132	Grand Total of all Amounts Paid Previous Month in Current Fiscal Year z,zzz,zzz,zzz.99
Filler	*	3	133	135	
Delimiter (;)	char	1	136	136	
Filler	*	4	137	142	
Units Paid This Month	number	10	143	152	Grand Total of all Units Paid This Month zz,zzz,zz9

Name	Type	Length	Position Start	Position End	Description
Filler	*	10	153	162	
Delimiter (;)	char	1	163	163	
Filler	*	4	164	167	
Amount Paid This Month	number	16	168	183	Grand Total of all Amount Paid This Month z,zzz,zzz,zzz.99
Filler	*	4	184	187	

2.10.19 PwC Budget Forecasting Layout

2.10.19.1 PwC Budget Forecasting Claims

	Length	Position Start	Position End
PAID DATE	7	1	7
;	1	8	8
MEMBER COUNTY	10	9	18
;	1	19	19
BILL PROV TYPE	2	20	21
;	1	22	22
MEMBER PROGRAM CODE	2	23	24
;	1	25	25
BILL PROV CAT OF SVC	2	26	27
;	1	28	28
FIRST DATE OF SERVICE	10	29	38
;	1	39	39
MEMBER STATUS CODE	2	40	41

	Length	Position Start	Position End
;	1	42	42
MCARE A IND	1	43	43
;	1	44	44
MCARE B IND	1	45	45
;	1	46	46
AGE GROUP	12	47	58
;	1	59	59
KENPAC IND	1	60	60
;	1	61	61
SUM PAID AMOUNT	15	62	76

2.10.19.2 PwC Budget Forecasting Demographics

	Length	Position Start	Position End
MEDICAID ID	12	1	12
;	1	13	13
CASE NUMBER	12	14	25
;	1	26	26
MEMBER LAST NAME	20	27	46
;	1	47	47
MEMBER FIRST NAME	15	48	62
;	1	63	63
MEMBER COUNTY	10	64	73
;	1	74	74

	Length	Position Start	Position End
MEMBER DATE OF BIRTH	10	75	84
;	1	85	85
MEMBER GENDER	1	86	86
;	1	87	87
MEMBER ELG BEGIN DATE	10	88	97
;	1	98	98
MEMBER ELG END DATE	10	99	108

2.10.19.3 PwC Budget Forecasting Eligibility

	Length	Position Start	Position End
MEDICAID ID	12	1	12
;	1	13	13
MEMBER ELIG BEG DATE	10	14	23
;	1	24	24
MEMBER ELIG END DATE	10	25	34
;	1	35	35
MEMBER PROGRAM CODE	2	36	37
;	1	38	38
MEMBER COUNTY CODE	10	39	48
;	1	49	49
MEMBER DATE OF BIRTH	10	50	59
;	1	60	60
MEMBER STATUS	2	61	62

	Length	Position Start	Position End
;	1	63	63
MEMBER PROGRAM HEALTH	5	64	68
;	1	69	69
MEMBER GENDER	1	70	70
;	1	71	71
MEMBER DATE OF DEATH	10	72	81

2.10.19.4 PwC Budget Forecasting Long Term Care

	Length	Position Start	Position End
MEDICAID ID	12	1	12
	1	13	13
LEVEL OF CARE CODE	5	14	18
	1	19	19
RLOC EFF DATE	8	20	27
	1	28	28
RLOC BEGIN DATE	8	29	36
	1	37	37
MEMBER STATUS	2	38	39
	1	40	40
DUAL STATUS	2	41	42

2.10.19.5 PwC Budget Forecasting Medicare

	Length	Position Start	Position End
MEDICAID ID	12	1	12

	Length	Position Start	Position End
;	1	13	13
BUYIN A DATE EFF	10	14	23
;	1	24	24
BUYIN A DATE END	10	25	34
;	1	35	35
BUYIN B DATE EFF	10	36	45
;	1	46	46
BUYIN B DATE END	10	47	56

2.10.20 PwC Passport Rating Layout

2.10.20.1 PP Facility

	Length	Position Start	Position End
FFS/ENCOUNTER IND	1	1	1
;	1	2	2
CDE COS	2	3	4
;	1	5	5
ID PROVIDER NPI	15	6	20
;	1	21	21
ID PROVIDER MCAID	15	22	36
;	1	37	37
CDE PROV TYPE BILL	2	38	39
;	1	40	40
CDE DTL STATUS	1	41	41

	Length	Position Start	Position End
;	1	42	42
CDE CLM TYPE	1	43	43
;	1	44	44
CDE DIAG PRIM	7	45	51
;	1	52	52
CDE DIAG 2	7	53	59
;	1	60	60
AMT ENCOUNTER	13	61	73
;	1	74	74
DTE PAID	10	75	84
;	1	85	85
TPL IND	1	86	86
;	1	87	87
CDE EOB 1	4	88	91
;	1	92	92
CDE EOB 2	4	93	96
;	1	97	97
LEVEL OF CARE	5	98	102
;	1	103	103
IND REF EPSDT	1	104	104
;	1	105	105
DETAIL FDOS	10	106	115

	Length	Position Start	Position End
;	1	116	116
DETAIL LDOS	10	117	126
;	1	127	127
DTL NUM DTL	21	128	148
;	1	149	149
NUM OF DETAILS	11	150	160
;	1	161	161
DETAIL CLM STATUS	1	162	162
;	1	163	163
ID MEDICAID	12	164	175
;	1	176	176
CDE PROC PRIM	6	177	182
;	1	183	183
CDE COUNTY	10	184	193
;	1	194	194
DTE BIRTH	10	195	204
;	1	205	205
IND MEDICARE A	1	206	206
;	1	207	207
IND MEDICARE B	1	208	208
;	1	209	209
CDE AID CATEGORY	2	210	211

	Length	Position Start	Position End
;	1	212	212
CDE SEX	1	213	213
;	1	214	214
AMOUNT BILLED	12	215	226
;	1	227	227
NUM ICN	13	228	240
;	1	241	241
UNITS	16	242	257
;	1	258	258
CDE DRG	4	259	262
;	1	263	263
MEMBER STATUS	2	264	265
;	1	266	266
CDE REVENUE	4	267	270
;	1	271	271
CDE POS	2	272	273
;	1	274	274
AMT BILLED	21	275	295
;	1	296	296
DTE ADMISSION	10	297	306
;	1	307	307
NUM DAYS COVD	13	308	320

	Length	Position Start	Position End
;	1	321	321
CDE EMERGENCY	1	322	322
;	1	323	323
TYPE OF BILL	3	324	326
;	1	327	327
TOTAL PAID AMT	12	328	339

2.10.20.2 PP FFS RX

	Length	Position Start	Position End
FFS/ENCOUNTER IND	1	1	1
;	1	2	2
COS	2	3	4
;	1	5	5
ID PROV NPI	15	6	20
;	1	21	21
ID PROV MCAID	15	22	36
;	1	37	37
PROV TYPE BILL	2	38	39
;	1	40	40
HDR CLM STATUS	1	41	41
;	1	42	42
CLM TYPE	1	43	43
;	1	44	44

	Length	Position Start	Position End
AMT PAID	10	45	54
;	1	55	55
EOB 1	4	56	59
;	1	60	60
EOB 2	4	61	64
;	1	65	65
ID MEDICAID	12	66	77
;	1	78	78
DTE PAID	10	79	88
;	1	89	89
RECIP COUNTY	10	90	99
;	1	100	100
DTE BIRTH	10	101	110
;	1	111	111
IND MEDICARE A	1	112	112
;	1	113	113
IND MEDICARE B	1	114	114
;	1	115	115
AID CATEGORY	2	116	117
;	1	118	118
SEX	1	119	119
;	1	120	120

	Length	Position Start	Position End
AMT BILLED	10	121	130
;	1	131	131
ICN	13	132	144
;	1	145	145
NDC	11	146	156
;	1	157	157
THERA CLS AHFS	10	158	167
;	1	168	168
AMT NDC PROFEE	25	169	193
;	1	194	194
IND BRAND MED NEC	1	195	195
;	1	196	196
QTY DISPENSE	23	197	219
;	1	220	220
UNIT DOSE IND	1	221	221
;	1	222	222
AMT MAC	18	223	240
;	1	241	241
DSC NDC	35	242	276
;	1	277	277
DTE FIRST SVC	10	278	287
;	1	288	288

	Length	Position Start	Position End
DTE LAST SVC	10	289	298
;	1	299	299
AMT CO PAY	10	300	309
;	1	310	310
DTE DISPENSE	10	311	320
;	1	321	321
DTE PRESCRIBE	10	322	331
;	1	332	332
QTY UNITS BILLED	16	333	348
;	1	349	349
MEMBER STATUS	2	350	351

2.10.20.3 PP ENC RX

	Length	Position Start	Position End
IND CLAIM	1	1	1
;	1	2	2
CDE COS ST	2	3	4
;	1	5	5
ID PROV NPI	15	6	20
;	1	21	21
ID PROV MCAID	15	22	36
;	1	37	37
PROVIDER TYPE	2	38	39

	Length	Position Start	Position End
;	1	40	40
HDR CLM STATUS	1	41	41
;	1	42	42
CLM TYPE	1	43	43
;	1	44	44
AMT ENCOUNTER	13	45	57
;	1	58	58
DTE PAID	10	59	68
;	1	69	69
EOB 1	4	70	73
;	1	74	74
EOB 2	4	75	78
;	1	79	79
LEVEL OF CARE	5	80	84
;	1	85	85
ID MEDICAID	12	86	97
;	1	98	98
MEMBER COUNTY	10	99	108
;	1	109	109
DTE BIRTH	10	110	119
;	1	120	120
IND MEDICARE A	1	121	121

	Length	Position Start	Position End
;	1	122	122
IND MEDICARE B	1	123	123
;	1	124	124
AID CATEGORY	2	125	126
;	1	127	127
SEX	1	128	128
;	1	129	129
TOT AMT BILLED	10	130	139
;	1	140	140
ICN	13	141	153
;	1	154	154
AMT PAT LIAB	12	155	166
;	1	167	167
DTE FIRST SVC	10	168	177
;	1	178	178
DTE LAST SVC	10	179	188
;	1	189	189
DIAG PRIM	7	190	196
;	1	197	197
NDC	11	198	208
;	1	209	209
THERA CLS AHFS	10	210	219

	Length	Position Start	Position End
;	1	220	220
AMT NDC PROFEE	25	221	245
;	1	246	246
IND BRAND MED NEC	1	247	247
;	1	248	248
QTY DISPENSE	23	249	271
;	1	272	272
AMT MAC	18	273	290
;	1	291	291
DSC NDC	35	292	326
;	1	327	327
AMT CO PAY	10	328	337
;	1	338	338
MEMBER STATUS	2	339	340
;	1	341	341
TOT AMT PAID	10	342	351

2.10.20.4 PP Dental

	Length	Position Start	Position End
IND CLAIM	1	1	1
;	1	2	2
PROV COS	2	3	4
;	1	5	5

	Length	Position Start	Position End
PROVIDER NPI	15	6	20
;	1	21	21
PROVIDER MCAID	15	22	36
;	1	37	37
PROV TYPE BILL	2	38	39
;	1	40	40
DTL STATUS	1	41	41
;	1	42	42
CLM TYPE	1	43	43
;	1	44	44
AMT ENCOUNTER	13	45	57
;	1	58	58
DTE PAID	10	59	68
;	1	69	69
EOB 1	4	70	73
;	1	74	74
EOB 2	4	75	78
;	1	79	79
LEVEL OF CARE	5	80	84
;	1	85	85
IND REF EPSDT	1	86	86
;	1	87	87

	Length	Position Start	Position End
DTE FIRST SVC	10	88	97
;	1	98	98
DTE LAST SVC	10	99	108
;	1	109	109
AMT PAID	10	110	119
;	1	120	120
NUM ICN	13	121	133
;	1	134	134
NUM DTL	10	135	144
;	1	145	145
TOT NUM DTL	11	146	156
;	1	157	157
ID MEDICAID	12	158	169
;	1	170	170
POS	2	171	172
;	1	173	173
PROC PRIM	6	174	179
;	1	180	180
MODIFIER 1	2	181	182
;	1	183	183
MODIFIER 2	2	184	185
;	1	186	186

	Length	Position Start	Position End
MODIFIER 3	2	187	188
;	1	189	189
MODIFIER 4	2	190	191
;	1	192	192
MEMBER COUNTY	10	193	202
;	1	203	203
DTE BIRTH	10	204	213
;	1	214	214
MEDICARE A	1	215	215
;	1	216	216
MEDICARE B	1	217	217
;	1	218	218
AID CATEGORY	2	219	220
;	1	221	221
SEX	1	222	222
;	1	223	223
AMT BILLED	10	224	233
;	1	234	234
TOT AMT BILLED	12	235	246
;	1	247	247
QTY UNITS BILLED	16	248	263
;	1	264	264

	Length	Position Start	Position End
AMT COPAY	10	265	274
;	1	275	275
TOT AMT PAID	12	276	287
;	1	288	288
MEMBER STATUS	2	289	290

2.10.20.5 PP Member Eligibility

	Length	Position Start	Position End
MEDICAID ID	12	1	12
;	1	13	13
MEMBER ELIG BEG DATE	10	14	23
;	1	24	24
MEMBER ELIG END DATE	10	25	34
;	1	35	35
MEMBER PROGRAM CODE	2	36	37
;	1	38	38
MEMBER COUNTY CODE	10	39	48
;	1	49	49
MEMBER DATE OF BIRTH	10	50	59
;	1	60	60
MEMBER STATUS	2	61	62
;	1	63	63
MEMBER GENDER	1	64	64

	Length	Position Start	Position End
;	1	65	65
MEMBER DATE OF DEATH	10	66	75

2.10.20.6 PP Entitlement

	Length	Position Start	Position End
MEDICAID ID	12	1	12
;	1	13	13
MCARE A IND	1	14	14
;	1	15	15
MCARE B IND	1	16	16
;	1	17	17
BUYIN A DATE EFF	10	18	27
;	1	28	28
BUYIN A DATE END	10	29	38
;	1	39	39
BUYIN B DATE EFF	10	40	49
;	1	50	50
BUYIN B DATE END	10	51	60

2.10.20.7 PP Prof

	Length	Position Start	Position End
IND CLAIM	1	1	1
;	1	2	2
CDE COS ST	2	3	4

	Length	Position Start	Position End
;	1	5	5
PROVIDER NPI	15	6	20
;	1	21	21
PROVIDER MCAID	15	22	36
;	1	37	37
PROV TYPE	2	38	39
;	1	40	40
CLAIM STATUS	1	41	41
;	1	42	42
CLM TYPE	1	43	43
;	1	44	44
DTE PAID	10	45	54
;	1	55	55
DIAG ICD9 CM 1	7	56	62
;	1	63	63
DIAG ICD9 CM 2	7	64	70
;	1	71	71
AMT ENCOUNTER	13	72	84
;	1	85	85
EOB_1	4	86	89
;	1	90	90
EOB_2	4	91	94

	Length	Position Start	Position End
;	1	95	95
LEVEL OF CARE	5	96	100
;	1	101	101
IND EPSDT	1	102	102
;	1	103	103
DTE FIRST SVC	10	104	113
;	1	114	114
DTE LAST SVC	10	115	124
;	1	125	125
AMT PAID	10	126	135
;	1	136	136
NUM ICN	13	137	149
;	1	150	150
NUM DTL	10	151	160
;	1	161	161
DTL CLM STATUS	1	162	162
;	1	163	163
TOT NUM DTL	11	164	174
;	1	175	175
ID MEDICAID	12	176	187
;	1	188	188
CDE POS	2	189	190

	Length	Position Start	Position End
;	1	191	191
CDE PROC PRIM	6	192	197
;	1	198	198
CDE MODIFIER 1	2	199	200
;	1	201	201
CDE MODIFIER 2	2	202	203
;	1	204	204
CDE MODIFIER 3	2	205	206
;	1	207	207
CDE MODIFIER 4	2	208	209
;	1	210	210
AMT BILLED	10	211	220
;	1	221	221
MEMBER COUNTY	10	222	231
;	1	232	232
DTE BIRTH	10	233	242
;	1	243	243
IND MEDICARE A	1	244	244
;	1	245	245
IND MEDICARE B	1	246	246
;	1	247	247
AID CATEGORY	2	248	249

	Length	Position Start	Position End
;	1	250	250
SEX	1	251	251
;	1	252	252
UNITS	16	253	268
;	1	269	269
NDC	11	270	280
;	1	281	281
TOT AMT BILLED	12	282	293
;	1	294	294
TOT AMT PAID	12	295	306
;	1	307	307
MEMBER STATUS	2	308	309

2.10.20.8 PP Rural Health

	Length	Position Start	Position End
IND CLAIM	1	1	1
;	1	2	2
PROV COS	2	3	4
;	1	5	5
PROVIDER_NPI	15	6	20
;	1	21	21
PROVIDER_MCAID	15	22	36
;	1	37	37

	Length	Position Start	Position End
PROV TYPE_BILL	2	38	39
;	1	40	40
DTL STATUS	1	41	41
;	1	42	42
CLM TYPE	1	43	43
;	1	44	44
DIAG PRIM	7	45	51
;	1	52	52
DIAG 2	7	53	59
;	1	60	60
AMT ENCOUNTER	13	61	73
;	1	74	74
DTE PAID	10	75	84
;	1	85	85
AMT PAT LIAB	12	86	97
;	1	98	98
EOB 1	4	99	102
;	1	103	103
EOB 2	4	104	107
;	1	108	108
NUM ICN	13	109	121
;	1	122	122

	Length	Position Start	Position End
NUM DTL	10	123	132
;	1	133	133
TOT NUM DTL	11	134	144
;	1	145	145
LEVEL_OF_CARE	5	146	150
;	1	151	151
IND EPSDT	1	152	152
;	1	153	153
DTE FIRST SVC	10	154	163
;	1	164	164
DTE LAST SVC	10	165	174
;	1	175	175
AMT PAID	10	176	185
;	1	186	186
ID MEDICAID	12	187	198
;	1	199	199
POS	2	200	201
;	1	202	202
PROC PRIM	6	203	208
;	1	209	209
MODIFIER 1	2	210	211
;	1	212	212

	Length	Position Start	Position End
MODIFIER 2	2	213	214
;	1	215	215
MODIFIER 3	2	216	217
;	1	218	218
MODIFIER 4	2	219	220
;	1	221	221
MEMBER COUNTY	10	222	231
;	1	232	232
DTE BIRTH	10	233	242
;	1	243	243
MEDICARE A	1	244	244
;	1	245	245
MEDICARE B	1	246	246
;	1	247	247
AID CATEGORY	2	248	249
;	1	250	250
SEX	1	251	251
;	1	252	252
AMT BILLED	10	253	262
;	1	263	263
TOT AMT BILLED	12	264	275
;	1	276	276

	Length	Position Start	Position End
QTY UNITS BILLED	16	277	292
;	1	293	293
NDC	11	294	304
;	1	305	305
AMT CO PAY	10	306	315
;	1	316	316
TOT AMT PAID	12	317	328
;	1	329	329
MEMBER STATUS	2	330	331

2.10.20.9 PP Trans

	Length	Position Start	Position End
IND CLAIM	1	1	1
;	1	2	2
PROVIDER NPI	15	3	17
;	1	18	18
PROVIDER MCAID	15	19	33
;	1	34	34
PROV TYPE BILL	2	35	36
;	1	37	37
PROV COS	2	38	39
;	1	40	40
DTL STATUS	1	41	41

	Length	Position Start	Position End
;	1	42	42
CLM TYPE	1	43	43
;	1	44	44
DTE PAID	10	45	54
;	1	55	55
AMT ENCOUNTER	13	56	68
;	1	69	69
EOB 1	4	70	73
;	1	74	74
EOB 2	4	75	78
;	1	79	79
DTE FIRST SVC	10	80	89
;	1	90	90
DTE LAST SVC	10	91	100
;	1	101	101
AMT PAID	10	102	111
;	1	112	112
NUM ICN	13	113	125
;	1	126	126
NUM DTL	10	127	136
;	1	137	137
TOT NUM DTL	11	138	148

	Length	Position Start	Position End
;	1	149	149
LEVEL OF CARE	5	150	154
;	1	155	155
ID MEDICAID	12	156	167
;	1	168	168
POS	2	169	170
;	1	171	171
PROC PRIM	6	172	177
;	1	178	178
AMT BILLED	10	179	188
;	1	189	189
MEMBER COUNTY	10	190	199
;	1	200	200
DTE BIRTH	10	201	210
;	1	211	211
MEDICARE A	1	212	212
;	1	213	213
MEDICARE B	1	214	214
;	1	215	215
AID CATEGORY	2	216	217
;	1	218	218
SEX	1	219	219

	Length	Position Start	Position End
;	1	220	220
TOT AMT BILLED	12	221	232
;	1	233	233
QTY UNITS BILLED	16	234	249
;	1	250	250
AMT CO PAY	10	251	260
;	1	261	261
TOT AMT PAID	12	262	273
;	1	274	274
MEMBER STATUS	2	275	276

2.10.20.10 PP Home Health

	Length	Position Start	Position End
MCARE PAID AMT	14	1	14
;	1	15	15
IND CLAIM	1	16	16
;	1	17	17
CDE COS ST	2	18	19
;	1	20	20
BILL PROVIDER NPI	15	21	35
;	1	36	36
BILL PROVIDER MCAID	15	37	51
;	1	52	52

	Length	Position Start	Position End
PROV TYPE	2	53	54
;	1	55	55
HDR DTE PAID	10	56	65
;	1	66	66
HDR CLM STATUS	1	67	67
;	1	68	68
CLM TYPE	1	69	69
;	1	70	70
MCARE PAID DATE	10	71	80
;	1	81	81
EOB 1	4	82	85
;	1	86	86
EOB 2	4	87	90
;	1	91	91
LEVEL OF CARE	5	92	96
;	1	97	97
DTL DTE FIRST SVC	10	98	107
;	1	108	108
DTL DTE LAST SVC	10	109	118
;	1	119	119
ICN	13	120	132
;	1	133	133

	Length	Position Start	Position End
DTL NUM	10	134	143
;	1	144	144
TOT DTL NUM	11	145	155
;	1	156	156
ID_MEDICAID	12	157	168
;	1	169	169
POS	2	170	171
;	1	172	172
MEMBER COUNTY	10	173	182
;	1	183	183
BIRTH	10	184	193
;	1	194	194
MEDICARE_A	1	195	195
;	1	196	196
MEDICARE_B	1	197	197
;	1	198	198
AID_CATEGORY	2	199	200
;	1	201	201
SEX	1	202	202
;	1	203	203
TOT AMT BILLED	12	204	215
;	1	216	216

	Length	Position Start	Position End
QTY UNITS BILLED	16	217	232
;	1	233	233
DIAG PRIM	7	234	240
;	1	241	241
DIAG 2	7	242	248
;	1	249	249
TYPE OF BILL	3	250	252
;	1	253	253
AMT ENCOUNTER	13	254	266
;	1	267	267
PROC PRIM	6	268	273
;	1	274	274
REVENUE	4	275	278
;	1	279	279
AMT_BILL	10	280	289
;	1	290	290
NDC	11	291	301
;	1	302	302
TOT AMT COPAY	14	303	316
;	1	317	317
DRG	4	318	321
;	1	322	322

	Length	Position Start	Position End
TOT AMT PAID	12	323	334
;	1	335	335
MEMBER STATUS	2	336	337

2.10.21 Transportation Cabinet Encounter Activity Layout

2.10.21.1 Activity Records

Name	Type	Length	Position Start	Position End	Description
record_code	Char	2	1	2	Record type code: "E1" for detail record
partnership_number	Num	10	3	12	Partnership Number - set to "5890001000"
member_id	Num	10	13	22	Member ID - truncated to first 10 characters
prov_id_billing	Num	10	23	32	Provider ID: billing (Formerly provider_id) - truncated to first 10 characters
icn	Num	17	33	49	Internal control number. (Formerly trans_cntl_num, TCN) Padded on right with zeroes. Claim Region is in the first 2 digits of ICN - See link to KY iC Claim Regions under CO Clarifications.
pat_acct_no	Char	20	50	69	Patient account number - truncated to first 20 characters
line_num	Num	2	70	71	Detail line number - limited to first 99 detail records
from_date	Num	8	72	79	From date of service - mmddyyyy
thru_date	Num	8	80	87	To date of service - mmddyyyy
rev_code	Char	4	88	91	Revenue code

Name	Type	Length	Position Start	Position End	Description
proc	Char	11	92	102	Procedure code
acc_denied_ind	Char	1	103	103	"A" - Accepted "D" - Denied
deny_reasons	Num	75	104	178	EOB codes (up to 25 occurrences of a 3 digit code)
type_of_claim	Char	1	179	179	"1" - Submission transaction "2" - Void transaction "3" - Crossover transaction "4" - Re-submission transaction "5" - Crossover re-submission transaction
filler	Char	44	180	223	spaces
end_rec	Char	1	224	224	"A"

2.10.21.2 Summary Records

Name	Type	Length	Position Start	Position End	Description
record_code	Char	2	1	2	Record type code: "E2" for summary record
partnership_number	Num	10	3	12	Partnership Number - set to "5890001000"
count	Num	10	13	22	Count of activity records output for this partnership including this summary record.
filler	Num	10	23	32	0000000000
filler	Num	17	33	49	00000000000000000
filler	Char	20	50	69	spaces
filler	Num	2	70	71	0
cycle_date	Num	8	72	79	Processing cycle date - mmddyyyy

Name	Type	Length	Position Start	Position End	Description
filler	Num	8	80	87	00000000
filler	Char	92	88	179	spaces
filler	Char	44	180	223	spaces
end_rec	Char	1	224	224	"A"

2.10.22 Vital Statistics Death_Birth File Layout

2.10.22.1 Death Record

Input Column	Description	Type	Length	Begin Position	End Position
VOLUME	Volume number.	CHAR	3	1	3
CERTIFICATE	Certification number.	CHAR	5	4	8
FIRST NAME	The deceased first name.	CHAR	10	9	18
MIDDLE INITIAL	The deceased middle initial name.	CHAR	1	19	19
LAST NAME	The deceased last name.	CHAR	13	20	32
SEX	The deceased sex.	CHAR	1	33	33
DATE OF DEATH (MMDDCCYY)	The date of death.	CHAR	8	34	41
SOCIAL SECURITY NUMBER	SSN.	CHAR	9	42	50
AGE UNIT	The age unit.	CHAR	1	51	51
AGE	The age.	CHAR	2	52	53
DATE OF BIRTH (MMDDCCYY)	The date of birth.	CHAR	8	54	61

Input Column	Description	Type	Length	Begin Position	End Position
STATE OF BIRTH	The state of birth.	CHAR	3	62	64
PLACE OF DEATH	The place of birth.	CHAR	1	65	65
HOSPITAL NUMBER	The hospital number.	CHAR	2	66	67
COUNTY OF DEATH	The county of death.	CHAR	3	68	70
COUNTY OF DEATH-ALPHA	The county of death alpha.	CHAR	5	71	75
MARITAL STATUS	The marital status.	CHAR	1	76	76
OCCUPATION	The occupation.	CHAR	3	77	79
BUSINESS OR INDUSTRY	The business industry.	CHAR	3	80	82
STATE OF RESIDENCE	The state of residence.	CHAR	3	83	85
CITY/COUNTY OF RES. CODE	The city county of residence.	CHAR	3	86	88
CITY OF RESIDENCE	The city of residence.	CHAR	12	89	100
STREET AND NUMBER OF RESIDENCE	The street's name of address.	CHAR	20	101	120
RESIDENCE IN CITY LIMITS	The residence in the city limits.	CHAR	1	121	121
ZIP-CODE OF RESIDENCE	The residence's zip code.	CHAR	5	122	126
HISPANIC	The original Hispanic.	CHAR	1	127	127

Input Column	Description	Type	Length	Begin Position	End Position
ORIGIN					
RACE	Race.	CHAR	1	128	128
EDUCATION	Education.	CHAR	2	129	130
FATHER'S SURNAME	Father's surname.	CHAR	13	131	143
BURIAL	The flag for burial.	CHAR	1	144	144
CERTIFICATION	Certification number.	CHAR	1	145	145
HOUR OF DEATH	The number of hours since death.	CHAR	3	146	148
CASES REFERRED TO MED EX OR CONRNER	Cases referred to coroner.	CHAR	1	149	149
UNDERLYING CAUSE OF DEATH	Underlying cause of death.	CHAR	4	150	153
SUPPLEMENTAL CAUSE #1	Supplemental cause 1.	CHAR	4	154	157
SUPPLEMENTAL CAUSE #2	Supplemental cause 2.	CHAR	4	158	161
SUPPLEMENTAL CAUSE #3	Supplemental cause 3.	CHAR	4	162	165
TB-CANCER-VD	The flag for TB cancer VD.	CHAR	1	166	166
AUTOPSY	The flag for autopsy.	CHAR	1	167	167

Input Column	Description	Type	Length	Begin Position	End Position
MANNER OF DEATH	The manner of death.	CHAR	1	168	168
DATE OF INJURY (MMDDCCYY)	The date of injury.	CHAR	8	169	176
HOUR OF INJURY	The number of hours of injury,	CHAR	3	177	179
INJURY AT WORK	The flag for if injury at work.	CHAR	1	180	180
PLACE OF INJURY	The place of injury,	CHAR	1	181	181
LOCATION OF INJURY	The location of injury.	CHAR	3	182	184
YEAR OF VOLUME	The year of volume.	CHAR	4	185	188
RECORD TYPE	The record type.	CHAR	1	189	189
PROCESS PERIOD (MMCCYY)	The process period.	CHAR	6	190	195
BIRTH CERTIFICATE YEAR OF VOLUME	The birth certificate year of volume.	CHAR	4	196	199
CERTIFICATE NUMBER	The birth certificate number.	CHAR	6	200	205
CORRECTION CODE	Correction code.	CHAR	1	206	206
SUPPLEMENT BIRTH STATUS	Supplement birth status.	CHAR	2	207	208
PREGNANCY	The flag for pregnancy.	CHAR	1	209	209

Input Column	Description	Type	Length	Begin Position	End Position
DIABETES	The flag for diabetes.	CHAR	1	210	210
DIABETES CAUSE	Diabetes cause.	CHAR	1	211	211
BIRTH CERTIFICATE VOLUME	Birth Certificate Volume.	CHAR	3	212	214
CHANGE DATE (CCYYMMDD)	Date record was changed.	CHAR	8	215	222
PROCESS DATE (CCYYMMDD)	Date record was processed.	CHAR	8	223	230

2.10.22.2 Birth Record

Input Column	Description	Type	Length	Begin Position	End Position
CERT-KEY	Birth certification key which include year of volume, volume and certification.	CHAR	13	1	13
CH-FIRST	Child first name.	CHAR	12	14	25
CH-MID	Child middle name,	CHAR	12	26	37
CH-LAST	Child last name,	CHAR	14	38	51
CH-JR	Child JR name.	CHAR	3	52	54
CH-DOB	Child date of birth.	CHAR	8	55	62
CH-SEX	Child's sex.	CHAR	1	63	63
CNTY-OCCUR	The 3 digit code of the county the birth occurred in.	CHAR	3	64	66
CNTY-ALPHA	The 5 digit abbreviation of the county the birth occurred in.	CHAR	5	67	71
CH-PLACE-BIRTH	The place where the child is born.	CHAR	1	72	72

Input Column	Description	Type	Length	Begin Position	End Position
FAC-ID	Facility ID.	CHAR	4	73	76
MO-FRST	Mother first name.	CHAR	12	77	88
MO-MID	Mother middle name.	CHAR	12	89	100
MO-LAST	Mother last name.	CHAR	14	101	114
MO-JR	Mother JR name.	CHAR	3	115	117
MO-SSN	Mother ssn.	CHAR	9	118	126
MOTHER-DOB	Mother date of birth.	CHAR	8	127	134
MO-AGE	Mother's age.	CHAR	2	135	136
MO-STATE-RES	Mother's resident state.	CHAR	3	137	139
BRCEDS-MO-CNTY-RES	Mother's resident county	CHAR	3	140	142
BRCEDS-MO-MAIL-CITY	Mother's resident city.	CHAR	17	143	159
BRCEDS-MO-MAIL-STATE	Mother's resident state.	CHAR	2	160	161
BRCEDS-MO-MAIL-ZIP	Mother's resident zip	CHAR	9	162	170
BRCEDS-MO-MAIL-STREET	Mother's mail street address.	CHAR	21	171	191
MO-MARRIED	Is mother married.	CHAR	1	192	192
SRCPAY-CD	The principle source of payment for the birth.	CHAR	1	193	193
BREAST-FED	The flag for if mother breast feed.	CHAR	1	194	194
FA-FIRST	Father's first name.	CHAR	12	195	206
FA-MID	Father's middle name.	CHAR	12	207	218

Input Column	Description	Type	Length	Begin Position	End Position
FA-LAST	Father's last name.	CHAR	14	219	232
FA-JR	Father's JR name.	CHAR	3	233	235
FA-SSN	Father's ssn.	CHAR	9	236	244
FATHER-DOB	Father date of birth.	CHAR	8	245	252
FA-AGE	Father's age.	CHAR	2	253	254
MO-HISPANIC	The flag for mother's Hispanic.	CHAR	1	255	255
MO-RACE	Mother's race.	CHAR	1	256	256
MO-EDUC	Mother's education level.	CHAR	2	257	258
FA-HISPANIC	The flag for father's Hispanic.	CHAR	1	259	259
FA-RACE	Father's race.	CHAR	1	260	260
FA-EDUC	Father's education level.	CHAR	2	261	262
PREV-CH-LIVING	Number of previous children still living.	CHAR	2	263	264
PREV-CH-NOW-DEAD	Number of previous children now dead.	CHAR	2	265	266
DATE-LST-LVE-BRTH	Date last live birth occurred.	CHAR	6	267	272
NBR-OTHR-TERMS	Number of other pregnancy terminations.	CHAR	2	273	274
NBR-PREN-VISITS	Number of prenatal visits.	CHAR	2	275	276
WEIGHT-UNITS	The weight units the child's weight is recorded in.	CHAR	1	277	277
GRAMS	Child's weight in grams.	CHAR	4	278	281
PHY-EST-GEST	Physicians estimate of gestation weeks.	CHAR	2	282	283

Input Column	Description	Type	Length	Begin Position	End Position
PLURALITY	Records number of babies in the event of a plural birth.	CHAR	1	284	284
APGAR-SCORE1	Apgar score 1 of baby.	CHAR	2	285	286
APGAR-SCORE2	Apgar score 2 of baby.	CHAR	2	287	288
MO-SMOKER	The flag for mother is smoker or not.	CHAR	1	289	289
MO-ALCOHOL	The flag for mother drink alcohol or not.	CHAR	1	290	290
MR-DIABETES	Indicates if mother has chronic diabetes.	CHAR	1	291	291
MR-DIAB-GEST	Indicates if mother has gestational diabetes.	CHAR	1	292	292
MR-HYPER-PRE-PREG	Indicates if mother has chronic hypertension.	CHAR	1	293	293
MR-HYPER-GEST	Indicates if mother has gestational hypertension.	CHAR	1	294	294
INF-SYPHILIS	Indicates if mother had syphilis.	CHAR	1	295	295
INF-HEPATITIS-B	Indicates if mother had Hep B.	CHAR	1	296	296
INF-HEPATITIS-C	Indicates if mother had Hep C .	CHAR	1	297	297
AC-SEIZURE	Indicates if child had seizures at birth.	CHAR	1	298	298
AC-BIRTH-INJURY	Indicates if child had a significant birth injury.	CHAR	1	299	299
AC-NONE	Indicates if child had no abnormal conditions at birth.	CHAR	1	300	300
ANOM-HEART-CONG	Indicates if child had a congenital heart anomaly.	CHAR	1	301	301

Input Column	Description	Type	Length	Begin Position	End Position
ANOM-HEART-NCONG	Indicates if child had a non-congenital heart anomaly.	CHAR	1	302	302
SSN-REQUESTED	The flag for if the child's SSN has been requested or not.	CHAR	1	303	303
SSA-RECORD-SENT-DATE	Date certificates sent for automatic enumeration.	CHAR	8	304	311
HOSP-NAME	The name of hospital where the child is born.	CHAR	50	312	361
COUNTY-OF-BIRTH	County of birth.	CHAR	20	362	381
MO-BIRTH-COUNTRY	Mother's country of birth.	CHAR	20	382	401
CNTY-OF-RES	Mother's county of residence.	CHAR	20	402	421
CREATE-DATE	The date when the record is created.	CHAR	8	422	429
MODIFY-DATE	The date when the record is modified.	CHAR	8	430	437
MO-MAIL-APT	Mother's mail address apartment number.	CHAR	10	438	447
REC-TYPE	Record type.	CHAR	1	448	448

2.11 Requirement Matrix and Cross Reference

This section provides a crosswalk of each functional requirement included in the KY MMIS Requirements Checklist shown in the RFP Appendix to MMIS design components. This is accomplished by listing each requirement with its current status, associated change orders and mapped system objects.

Requirement	Status	Mapped Objects	Change Orders
2866	Open	PDSWDMCM DSSJWDCM DSSJWMXC DSSJWPAT PA.unv PASSR.unv T_PA_CASE_LVL_MAXMC T_PA_DAYS_DTL_MAXMC T_PA_LINE_ITEM T_PA_LINE_ITEM T_PA_MEMBER_MAXMC T_PA_PAUTH_DN T_PA_SVC_LVL_MAXMC t_ps_applicant t_ps_body_system t_ps_drug t_ps_drug_hist t_ps_findings t_ps_interpret t_ps_level1 t_ps_medical_hist t_ps_mental_assmt t_ps_mr_findings t_ps_mr_part_a t_ps_mr_part_b t_ps_mr_part_c t_ps_mr_part_d t_ps_physical t_ps_psych_soc t_ps_referral t_ps_tracking t_ps_treat_plan t_ps_treatment_rev BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	2417 - KYAmend - Training for Profiler 3138 - KY Amend - New Prior Auth Fields 2410 - KYAmend - Create maxMC Tables 4938 - KYAmend - Create PASRR Universe 2415 - KYAmend -ETL (DI) - DM/CM Data 4937 - KYAmend - ETL/DM - Add PASRR 2414 - KYAmend - Add maxMC in PA Univ 2412 - KYAmend - First Health - KAPER 4479 - KYAmend - T_PA_LINE_ITEM 2411 - KYAmend - maxMC Interface
30.030.015	No mapping required		
30.030.015.001	No mapping required		

Requirement	Status	Mapped Objects	Change Orders
30.030.015.001.1	No mapping required		
30.030.015.001.2	No mapping required		
30.030.015.001.3	No mapping required		
30.030.015.001.4	No mapping required		
30.030.015.001.5	No mapping required		
30.030.015.001.6	No mapping required		
30.030.015.001.7	No mapping required		
30.030.015.001.8	No mapping required		
30.030.015.001.9	No mapping required		
30.030.015.002	No mapping required		
30.030.015.002.1	No mapping required		
30.030.015.002.10	No mapping required		
30.030.015.002.11	No mapping required		
30.030.015.002.2	No mapping required		
30.030.015.002.3	No mapping required		
30.030.015.002.4	No mapping required		
30.030.015.002.5	No mapping required		
30.030.015.002.6	No mapping		

Requirement	Status	Mapped Objects	Change Orders
	required		
30.030.015.002.7	No mapping required		
30.030.015.002.8	No mapping required		
30.030.015.002.9	No mapping required		
30.050.001G	RV Sign-Off CO		520 - Change Recip to Member - DW
30.050.001I	RV Sign-Off CO		520 - Change Recip to Member - DW
30.050.010	Informational		
30.050.010.001	Informational		
30.050.010.001.1	Commonwealth		
30.050.010.001.2	Commonwealth		
30.050.010.001.3	Commonwealth		
30.050.010.001.4	Commonwealth		
30.050.010.001.5	Commonwealth		
30.050.010.001.6	Commonwealth		
30.050.010.001.7	Commonwealth		
30.050.010.001.8	Commonwealth		
30.050.010.002	Informational		
30.050.010.002.3	RV Sign-Off CO	Random Sample - 1 - Request Information Tab Random Sample - 2 - Request Filters Tab Random Sample - 3 - Request Result Tab Random Sample - 4 - Request Log Tab Random Sample - 5 - Claim Detail Window Random Sample - 6 - ID Listing Window	490 - Install Random Sample Process 1368 - Develop Random Sample Universe 8540 - Random Sample Report 492 - Random Sample Targeted Queries

Requirement	Status	Mapped Objects	Change Orders
30.050.010.002.7	RV Sign-Off Task		1628 - Corrective Actions
30.050.012.002.14 A	RV Sign-Off CO	PDSQPSWV DSSJQWCL DSSJQWEL DSSJQWEL2 DSSJQWEL3 DSSJQWEL4 DSSJQWEL5 DSSJQWLD DSSJQWVR BusinessObjects: ETL- Data Integrator Enterprise (v.XI) cat clmphash cp dsspcap.c dsspcty.c dsspwel.c dsspwvr.c oraload.sh rm sed	1641 - CMS Passport Waiver 1115 Extract
30.050.014.002.3	RV Sign Off	CA.unv BusinessObjects: Reporter (v.XI)	1629 - Access to Pharmacy Data for MC
30.050.014.002.5	RV Sign Off	CA.unv Code.unv Prov.unv BusinessObjects: Reporter (v.XI)	1630 - Managed Care Ad-Hoc response
30.050.014.002.6	RV Sign Off		1631 - Generate Managed Care Reports
30.050.015	Informational		
30.050.015.001	Informational		
30.050.015.001.1	Commonwealth		
30.050.015.001.2	Commonwealth		
30.050.015.001.3	Commonwealth		
30.050.015.001.4	Commonwealth		
30.050.015.001.5	Commonwealth	PDSMIPRO	

Requirement	Status	Mapped Objects	Change Orders
30.050.015.001.6	Commonwealth		
30.050.015.001.7	Commonwealth		
30.050.015.001.8	Commonwealth		
30.050.015.001.9	Commonwealth		
30.050.015.002	Informational		
30.050.015.002.1	RV Sign-Off Task	CA.unv Code.unv DR.unv DssMeas.unv EPSDT.unv Financial.unv MC.unv Member.unv PA.unv PE.unv Prov.unv Reference.unv TPL.unv VitalStat.unv eKASPER.unv BusinessObjects: Infoview (v.XI) BusinessObjects: Reporter (v.XI) BusinessObjects: Supervisor (v.XI) BusinessObjects: Webintelligence (v.XI) DSSNavigator - Corporate Documents DSSNavigator - Corporate Documents Expanded DSSNavigator - Login Window DSSNavigator - Welcome Window	24 - Develop Claims Analysis Universe 544 - Develop Claims Analysis Universe 2995 - Update PA Universe - DM 3093 - Update Financial Universe - DM 3222 - DSSMeasureBase DM Changes 3687 - Develop eKASPER Universe 1495 - Develop Prior Auth Universe 2223 - Implement User Security 2994 - Update Provider Universe - DM 4114 - Managed Care Universe Issues 4044 - KAMES Data to Member Universe 4108 - TPL Universe 4111 - Member Universe Issues 543 - Cust. InfoView Report Library 1496 - Develop TPL Universe 4264 - Financial Universe Issues 547 - Develop Reference Universe 1493 - Develop Financial Universe 1494 - Develop Managed Care Universe 1983 - Develop PE Universe 4075 - KASES Data to Member Universe 4115 - Prior Auth Universe

Requirement	Status	Mapped Objects	Change Orders
			Issues 546 - Develop Provider Universe 1529 - Operate/Maintain DSS/Data Wrhse 4110 - Reference Universe Issues 4223 - Universe Update/Adds eKasper 4112 - Provider Universe Issues 4113 - Claims Analysis Universe Issues 545 - Develop Member Universe 1981 - Develop MeasureBase Universe 4120 - PE Universe Issues
30.050.015.002.10	RV Sign-Off Task		1539 - Provide DSS/Data Wrhse training
30.050.015.002.11	RV Sign-Off Task		1540 - Develop/Maintain help screens
30.050.015.002.12	RV Sign-Off Task		1542 - DMS approval for DSS changes
30.050.015.002.13	RV Sign-Off Task	BusinessObjects: Reporter (v.XI) SPSS (v.10)	1616 - BO - Install BO CMC 1615 - BO - Install BO Environment 1545 - Ensure system capability 1614 - SPSS - Install version 10
30.050.015.002.14	RV Sign-Off Task		1546 - Coordinate data changes with DBA
30.050.015.002.15	RV Sign-Off Task		1632 - Incorrect Report Notification
30.050.015.002.16	RV Sign-Off Task		1550 - Tool/Software Upgrades
30.050.015.002.17	RV Sign-Off Task		1560 - Recommend system improvements
30.050.015.002.18	RV Sign-Off Task	BusinessObjects: Application Foundataion - Statistical Process Control	1561 - Utilize COTS tools/software

Requirement	Status	Mapped Objects	Change Orders
		(v.XI) BusinessObjects: Application Foundation - Predictive Analysis (v.XI) BusinessObjects: Reporter (v.XI) ESRI: Geo Mapping SPSS (v.10)	
30.050.015.002.19	RV Sign-Off Task		1566 - CHFS access to tools
30.050.015.002.2	RV Sign-Off Task	BusinessObjects: ETL - Meta Data Bridge (v.XI) BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	1633 - Data Transfers to Data Warehouse
30.050.015.002.20	RV Sign Off		1634 - DW Infrastucture Share
30.050.015.002.3	RV Sign-Off Task	BusinessObjects: ETL - Meta Data Bridge (v.XI) BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	1635 - Data Warehouse ETL
30.050.015.002.4	RV Sign-Off Task	PDSMDMSX PDSMFHEX PDSMPCGX PDSONAVG PDSOPWC1 PDSOPWC2 PDSQDMSX PDSQJCDE PDSWEKOU PDSWTCAE DSSJMART DSSJMDM1 DSSJMDM3 DSSJMDM4 DSSJMDM5 DSSJMDQ3 DSSJMFH1 DSSJMFH2 DSSJMFH3 DSSJMKAS DSSJMLP1 DSSJMPCG DSSJMVSB DSSJMVSD DSSJOIP1 DSSJOIP2	2070 - eKASPER Interface 2074 - LPSM Extract 2142 - Ineligible Part A X-Over Claims 3022 - Update LPSM Extract 1352 - BO - Install and Confiqure DI 1567 - Data extraction specifications 1581 - Myers & Stauffer Extract 2141 - Nursing Facilities Claim Extract 3021 - Update Navigant Extract 6003 - Install ZIP in In/Outbound Jobs 1582 - PwC Extract 1642 - IPRO Extract 3218 - Update PCG Claim History Extract 1583 - Navigant Extract 2143 - Preventive Services Extract 3020 - Update PWC Extract 4923 - PBA-Monthly Claim

Requirement	Status	Mapped Objects	Change Orders
		DSSJOIP3 DSSJOIP4 DSSJOIP5 DSSJOIP6 DSSJONAV DSSJOPW1 DSSJOPW2 DSSJQ160 DSSJWIKM DSSJWIKP DSSJWKAM DSSJWMXC DSSJWOKP DSSJWTCA First Health PBA Paid Claim extract job BOLoadVsDeath.sh BusinessObjects: ETL- Data Integrator Enterprise (v.XI) EK_Load_PROVIDER_Job.sh KS_Load_KASES_Job_$env.sh VS_Load_Deaths_Job_$env.sh cat clmphash copy2routedir cp dss16010.10.shl dss16010.20.shl dss16040.ctl dssjdq220.01.shl dssjdq220.02.shl dssjmfh3.10.11.shl dssjmfh3.10.12.shl dssjmfh3.10.13.shl dssjmfh3.10.21.shl dssjmfh3.10.22.shl dssjmfh3.10.31.shl dssjmfh3.10.32.shl dssjmfh3.10.33.shl dssjmpcg.03a.shl dssjmpcg.03b.shl dssjmpcg.05a.shl dsspmdm5 dsspmdq3 dssqp160.c dswtca010.01.sql	Data 8838 - HMS External Extracts 9177 - HMS Phys Date Format Change

Requirement	Status	Mapped Objects	Change Orders
		dswtca020.01.shl dswtca020.02.shl mailx mv oraload.sh otsortd rm rptrangeex.src sed sqlplus unzip zip	
30.050.015.002.5	RV Sign-Off Task		1568 - DSS/Data Warehouse Balancing
30.050.015.002.6	RV Sign-Off Task	DSS - ADHC Monitoring DSS - AR Over Payments by SFY DSS - Accounts Payable Closing Package DSS - Alternate Budget Model DSS - Ancillary Verifications with Names DSS - Ancillary per Revenue Code DSS - Bed Days for Nursing Homes DSS - Breast and Cervical Cancer Member DSS - BusinessObjects Report Template DSS - Central Baptist Neonatal Claims DSS - Certification Failures DSS - Dental Access DSS - Drug Utilization DSS - Encounter Transportation DSS - Hospice Total Days DSS - Hospice Total Dual Eligibles DSS - Hospice Total Inpatient Days DSS - Hospital Inpatient Paid Days DSS - IMPACT DCBS DSS - KenPAC Member	1422 - ADHC Monitoring 1440 - Encounter Transportation 1447 - QIO Monitoring 1455 - Medicaid Member History Request 1461 - Support for Comm Living Member 4265 - ADHC Monitoring report 1432 - Ancillary per Revenue Code 1434 - Certification Failures 1443 - Central Baptist Neonatal Claims 1444 - Drug Utilization Report 1458 - KenPAC Member History 1699 - EIS - Drug Company File Listing 1702 - EIS - Nursing Facility Stats 1704 - EIS - Quarterly Growth 4275 - Provider History Report 4544 - Drug Utilization Report 1431 - Ancillary Verifications-Names 1433 - Bed Days for Nursing Homes 1436 - NF Initiative Ancillary Units 1437 - Unduplicated Members/Month 1438 - AR Over Payments by

Requirement	Status	Mapped Objects	Change Orders
		History DSS - Medicaid Eligible Children DSS - Medicaid Member History Request DSS - Member Eligibility Segment Dates DSS - Member History Request DSS - NF Initiative Ancillary Paid DSS - NF Initiative Ancillary Units DSS - Non Actual Budget Model DSS - Paid Claims History DSS - Performance Report Card DSS - Preventive Health Payments - DOS DSS - Provider History DSS - QIO Monitoring DSS - Ray Prior Auth DSS - SCL 2005 DSS - Support for Community Living Member DSS - Unduplicated Members EIS - Drug Company File Listing EIS - Member History EIS - Monthly Home Health Visits EIS - Nursing Facility Statistics EIS - Provider History EIS - Quarterly Growth EIS - Selected Provider Address	SFY 1439 - Preventive Health Payments-DOS 1446 - Hospice Total Days 4547 - Hospice Total Days Report 1442 - Breast and Cervical Cancer Memb 1453 - SCL 2005 1454 - Accounts Payable Closing Package 4266 - Ancillary Verification Report 4269 - Member History Request Report 4270 - Non Actual Budget Model 4273 - Paid Claims History Report 4502 - EIS Monthly Home Health Visits 4546 - PRO Monitoring Rpt 1448 - IMPACT DCBS 1456 - Dental Access Report 1457 - Hospital Inpatient Paid Days 1459 - Paid Claims History 1700 - EIS - Member History 2197 - Measures of Success - Nursing 1435 - NF Initiative Ancillary Paid 1460 - Provider History 1468 - Hospice Total Dual Eligibles 1701 - EIS - Monthly Home Health Visits 2229 - Preventive Hlth Pymnts - Dt Paid 2233 - Member Claim Detail - eKasper 1441 - Alternate Budget Model 1450 - Medicaid Eligible Children 1463 - Member History Request 1619 - DSS - Performance Report Card 1705 - EIS - Selected Provider

Requirement	Status	Mapped Objects	Change Orders
			Address 1445 - Hospice Total Inpatient Days 1451 - Non Actual Budget Model 1452 - Ray Prior Auth 1569 - Ensure availability of reporting 1703 - EIS - Provider History 4267 - Bed Days For Nursing Homes 4278 - Unduplicated Members Report 4545 - Encounter Transportation Rpt
30.050.015.002.7	RV Sign-Off Task		1568 - DSS/Data Warehouse Balancing
30.050.015.002.8	RV Sign-Off Task		1636 - DSS - History Retention
30.050.015.002.9	RV Sign-Off Task		1637 - Data Warehouse - Archived Hist
30.090.003.003.18	RV Sign Off		
30.090.007.003.20	RV Sign Off		
30.090.007.003.22	RV Sign Off	CA.unv BusinessObjects: Reporter (v.XI)	
30.090.007.003.25	RV Sign-Off CO	Held Paid Claims.unv BusinessObjects: ETL- Data Integrator Enterprise (v.XI) EIS - Member History EIS - Provider History	2175 - ETL (DI) - Held Claims 1700 - EIS - Member History 1703 - EIS - Provider History
30.090.007.003.26	RV Sign Off		
30.090.010	Informational		
30.090.010.001	Informational		
30.090.010.001.1	RV Sign Off	CA.unv	
30.090.010.001.2	RV Sign Off	Member.unv MemberBaseInformation MemberBenefitPlan	

Requirement	Status	Mapped Objects	Change Orders
30.090.010.001.3	RV Sign Off	Prov.unv	
30.090.010.001.4	RV Sign Off	Reference.unv	
30.090.010.001.5	RV Sign Off	PA.unv	
30.090.010.001.6	RV Sign-Off CO	TPL.unv	1496 - Develop TPL Universe
30.090.010.001.7	RV Sign-Off CO	Random Sample - 1 - Request Information Tab Random Sample - 2 - Request Filters Tab Random Sample - 3 - Request Result Tab Random Sample - 4 - Request Log Tab Random Sample - 5 - Claim Detail Window Random Sample - 6 - ID Listing Window	490 - Install Random Sample Process 1368 - Develop Random Sample Universe 8540 - Random Sample Report 492 - Random Sample Targeted Queries
30.090.010.002	Informational		
30.090.010.002.3	RV Sign-Off Task		
30.090.010.002.5	RV Sign-Off Task		1638 - Corrective Activity Audit trail
30.090.010.002.6	RV Sign-Off Task		
30.090.010.003	Informational		
30.090.010.003.1	RV Sign-Off Duplicate		
30.090.010.003.2	RV Sign-Off Duplicate		
30.090.010.003.3	RV Sign-Off Duplicate		
30.090.010.004	Informational		
30.090.010.004.1	RV Sign-Off Duplicate		
30.090.012.002.15 A	RV Sign Off	CA.unv BusinessObjects: Reporter (v.XI)	

Requirement	Status	Mapped Objects	Change Orders
30.090.012.002.16A	RV Sign Off	BusinessObjects: Reporter (v.XI)	
30.090.012.003.3A	RV Sign-Off CO	PDSMKNP DSSJM465 Clm.ClaimDeliveryPanel.ascx DSS - KenPAC Utilization Data DSS - KenPAC Utilization Data All Providers DSS - KenPAC Utilization Review Detail DSS - KenPAC Utilization Review Exception DSS - KenPAC Utilizers By Provider Type of Service	1609 - DSS - KenPAC Utilization Data 1613 - DSS - KenPAC Utilizers-Prov Spc 522 - KenPAC Reports - 1610 - DSS - KenPAC Utilizatn Data All 1611 - DSS - KenPAC Utilization Detail 1612 - DSS - KenPAC Utilization Exceptn
30.090.014.002.2	RV Sign Off		
30.090.014.002.3	RV Sign Off	DSS - Provider Reimbursement KCHIP DSS - Provider Reimbursement KCHIP Lockin Cycle DSS - Provider Reimbursement KCHIP Phase III DSS - Provider Reimbursement KCHIP Phase III Lockin Cycle	
30.090.014.003.1	RV Sign Off		
30.090.014.003.2	RV Sign Off	DSS - CMHC Monthly Summary DSS - CMHC Quarterly Summary DSS - DRG Retro Review - Claims Rebilled Detail DSS - DRG Retro Review - Claims Rebilled Summary By Provider DSS - Medicare Crossover Part B Repricing DSS - Paid Claims DME Providers For Procedure E1399 DSS - Paid Claims Hi - Low DSS - Primary Care Rural	1596 - University of Louisville Provs 4277 - Q6 Modifier Claims Billed Report 1598 - Provider Type 55-56 Ex by County 1599 - Ranking of Providers 1606 - DRG Retro Review-Clms Rebill Dtl 1607 - DRG Retro Review-Clms Summary 1594 - Provider Denial Rates 4279 - U of L Provs Report 1601 - CMHC Monthly Summary Report 1602 - CMHC Quarterly

Requirement	Status	Mapped Objects	Change Orders
		Health Crossover Cost Savings DSS - Provider Denial Rates Above 50 Percent DSS - Provider Reimbursement KCHIP KenPAC Cycle DSS - Provider Reimbursement KCHIP Phase III KenPAC Cycle DSS - Provider Reimbursement KenPAC Cycle DSS - Provider Reimbursement Lockin Cycle DSS - Provider Type 55-56 (16) Ex by Proc DSS - Provider Type 55-56 (16) Transportation Expenditures by County DSS - Q6 Modifier Claims Billed for 60 Consecutive Days DSS - Ranking of Provider Type 55 and 56 (16) DSS - SCL Hi Intensity Summary DSS - School Based Procedure Code Summary DSS - University of Louisville Providers	Summary Report 1604 - Paid Claims DME Prov Proc E1399 4542 - DRG Retro Review - Claims Rebill 1603 - SCL Hi Intensity Summary 1593 - Paid Claim Hi/Low Report 1600 - School Based Procedure Code Summ 4272 - Paid Claims Hi - Low Report 4274 - Provider Denial Rate Report 4543 - DRG Retro Rev-Claims Rebill Summ 1595 - Q6-Modifier Claims Billed 1597 - Provider Type 55-56 Ex by Proc
30.090.015	Informational		
30.090.015.001	Informational		
30.090.015.001.1	RV Sign-Off CO	DR_Drug_Rebate_Job BusinessObjects: ETL - Meta Data Bridge (v.XI) BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	536 - ETL (DI) Clms Adjustment Process 1483 - ETL (DI) - Code Tables 529 - ETL (DI) - Institutional Claims 539 - ETL (DI) - Prov Financial Trans 1482 - ETL (DI) - Dental Claims 1487 - ETL (DI) - Reference-Procedure 528 - ETL (DI) - Professional Claims

Requirement	Status	Mapped Objects	Change Orders
			533 - ETL (DI) - Member Dimension 540 - ETL (DI) - MMIS Provider File 541 - ETL (DI) - Reference-Diag/Other 531 - ETL (DI) - Diagnosis Dimension 534 - ETL (DI) - Provider Dimension 535 - ETL (DI) - TPL 538 - ETL (DI) - MMIS Prior Auth 532 - ETL (DI) - Claims Dimension 1481 - ETL (DI) - Pharmacy Claims 1485 - ETL (DI) - EPSDT 1486 - ETL (DI) - Managed Care 1488 - ETL (DI) - Reference-Drug 530 - ETL (DI) - Procedure Dimension 537 - ETL (DI) - MMIS Eligibility
30.090.015.001.2	RV Sign Off	BusinessObjects: ETL - Meta Data Bridge (v.XI) BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	
30.090.015.002	Informational		
30.090.015.002.1	RV Sign-Off Task	BusinessObjects: ETL- Data Integrator Enterprise (v.XI) BusinessObjects: Reporter (v.XI) BusinessObjects: Scheduler (v.XI)	1570 - Integrate external data
30.090.015.002.10	RV Sign Off	ESRI: Geo Mapping	523 - ESRI - Install - For GeoMapping
30.090.015.002.11	RV Sign Off	DSSJW600 DSSJWCDE DSSJWEPS DSSJWFIN DSSJWMBR DSSJWPAT	544 - Develop Claims Analysis Universe 3687 - Develop eKASPER Universe 1495 - Develop Prior Auth Universe

Requirement	Status	Mapped Objects	Change Orders
		DSSJWPRV DSSJWREF DSSJWSTG DSSJWTPL CA.unv DR.unv EPSDT.unv Financial.unv MC.unv Member.unv PA.unv PE.unv Prov.unv Reference.unv TPL.unv eKASPER.unv	4114 - Managed Care Universe Issues 4044 - KAMES Data to Member Universe 4108 - TPL Universe 4111 - Member Universe Issues 1496 - Develop TPL Universe 4264 - Financial Universe Issues 547 - Develop Reference Universe 1493 - Develop Financial Universe 1494 - Develop Managed Care Universe 1983 - Develop PE Universe 4075 - KASES Data to Member Universe 4115 - Prior Auth Universe Issues 546 - Develop Provider Universe 4110 - Reference Universe Issues 4112 - Provider Universe Issues 4113 - Claims Analysis Universe Issues 545 - Develop Member Universe
30.090.015.002.12	RV Sign Off	BusinessObjects: Reporter (v.XI) SPSS (v.10)	
30.090.015.002.13	RV Sign Off	BusinessObjects: Reporter (v.XI)	
30.090.015.002.14	RV Sign Off	BusinessObjects: Reporter (v.XI)	
30.090.015.002.15	RV Sign Off	BusinessObjects: Reporter (v.XI) ESRI: Geo Mapping	523 - ESRI - Install - For GeoMapping
30.090.015.002.16	RV Sign Off	BusinessObjects: Application Foundataion - Performance Manager (v.XI)	1639 - DSSDM - Medicaid EIS Dashboard 549 - BO - Install Performance Manager

Requirement	Status	Mapped Objects	Change Orders
		BusinessObjects: Application Foundataion - Set Analysis (v.XI) BusinessObjects: Application Foundation - Dashboard Manager (v.XI) DSSDM - EIS - Dashboard Measures	548 - BO - Install Dashboard Manager
30.090.015.002.17	RV Sign Off	SPSS (v.10)	
30.090.015.002.18	RV Sign Off	BusinessObjects: Application Foundation - Dashboard Manager (v.XI) BusinessObjects: Application Foundation - Predictive Analysis (v.XI)	
30.090.015.002.2	RV Sign-Off Task	BusinessObjects: Supervisor (v.XI)	1571 - Control data access
30.090.015.002.20	RV Sign-Off CO	PDSMMM01 PDSQMB01 DSSJM699 DSSJQ710 DSSJQ715 DSSJQ720 DSSJQ721 DSSJQ722 DSSJQ723 DSSJQ724 DSSJQ725 DSSJQ726 DSSJQ727 DSSJQ730 DSSJQ731 DSSJQ732 DSSJQ733 DSSJQ734 DSSJQ735 DSSJQ736 DSSJQ737 DSSJQ738 DSSJQ739 DSSJQ740 DSSJQ741 DSSJQ742 DSSJQ743 DSSJQ744 DSSJQ745	1621 - DSSMeasureBase - Measure Detail 4550 - MBase Multi Measure 1620 - DSSMeasureBase - All Measure 1624 - DSSMeasureBase - Numerator Dtl 4553 - MBase All Measures Summary 5048 - Updates to T_ELIGCNT Process 8851 - RTI - Measurebase 1625 - DSSMeasureBase - Numerator Memb 4552 - MBase Measure Detail 1622 - DSSMeasureBase - Members not Mtg 4548 - MBase Numerator Members 1623 - DSSMeasureBase - Multi Measure 4551 - MBase Members not meeting 553 - DSSMeasureBase - Extract/Build 1504 - DSSMeasureBase - Maint Windows 4549 - MBase Numerator

Requirement	Status	Mapped Objects	Change Orders
		DSSJQ746 DSSJQ760 DSSJQ770 T_ELIGCNT dsq00115.sql dsq701010.03.shl dsq701010.04.shl dsq701010.07.shl dsq730150.ctl dsq730160.ctl dsq770010.20.shl dsq770010.30.shl dsq770010.40.shl dsq770010.50.shl dsq770010.60.shl dsq770010.70.shl dssjoip1.sql dssjoip3.sql dssjoip4.sql dssjoip5.sql dssjoip_cnt1.sql dssjoip_cnt3.sql dssjoip_cnt4.sql dssjoip_cnt5.sql dssloadonline.sh dsspmband.c dsspmbcalc.c dsspmbfinal.c dsspmbif.c dsspmbkeys.c dsspmbnhome.c dsspmboutp.c eligmnths.c mv oraload.sh t_recip_eligcnt.sql DSSMeasureBase - All Measure Summary DSSMeasureBase - Denominator Details DSSMeasureBase - Measure Detail DSSMeasureBase - Members Not Meeting DSSMeasureBase - Multiple Measure Details DSSMeasureBase - Numerator Details DSSMeasureBase -	Details

Requirement	Status	Mapped Objects	Change Orders
		Numerator Members DSSMB - MeasureBase Maintenance DSSMB - MeasureBase Selection DSSMB - Qualifier Maintenance	
30.090.015.002.21	RV Sign Off	Reference.unv	
30.090.015.002.22	RV Sign Off		
30.090.015.002.3	RV Sign Off	BusinessObjects: Designer (v.XI) BusinessObjects: ETL- Data Integrator Enterprise (v.XI) BusinessObjects: Reporter (v.XI) BusinessObjects: Supervisor (v.XI) Model Manager	
30.090.015.002.4	RV Sign Off	BusinessObjects: Infoview (v.XI) BusinessObjects: Webintelligence (v.XI) Oracle Software Utility Suite	543 - Cust. InfoView Report Library
30.090.015.002.5	RV Sign Off	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	
30.090.015.002.6	RV Sign Off		1640 - ETL Process Responsibility
30.090.015.002.7	RV Sign Off	Oracle Software Utility Suite	
30.090.015.002.8	RV Sign Off	CA.unv BusinessObjects: Reporter (v.XI)	
30.090.015.002.9	RV Sign Off	BusinessObjects: Reporter (v.XI) BusinessObjects: Scheduler (v.XI) BusinessObjects: Software Development Kit (v.XI) Oracle Software Utility Suite	
30.090.015.003	Informational		
30.090.015.003.1	RV Sign-Off CO	BusinessObjects: Reporter	1615 - BO - Install BO

Requirement	Status	Mapped Objects	Change Orders
		(v.XI)	Environment
30.090.015.003.2	RV Sign-Off CO	BusinessObjects: Application Foundataion - Performance Manager (v.XI) BusinessObjects: Supervisor (v.XI)	551 - BO - Install Predictive Analysis 550 - BO - Install Set Analysis 552 - BO - Install Statistical Process
30.090.015.003.3	RV Sign-Off CO	BusinessObjects: ETL- Data Integrator Enterprise (v.XI) dsspbal dsspbal.c	525 - ETL Balancing
30.090.015.003.4	RV Sign Off	BusinessObjects: Reporter (v.XI)	
30.090.015.003.5	RV Sign-Off CO	BusinessObjects: Application Foundataion - Performance Manager (v.XI) Oracle Software Utility Suite	549 - BO - Install Performance Manager
30.090.015.004	Informational		
30.090.015.004.1	RV Sign-Off CO	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	1643 - Vital Statistics Interface
30.090.015.004.2	RV Sign-Off CO	DSSJMKAS DSSJWIKM DSSJWIKP DSSJWKAM DSSJWOKM DSSJWOKP BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	2070 - eKASPER Interface 1644 - ETL (DI) - Presumptive Elig 2072 - KCHIP Premium Interface 2119 - KAMES Interface 2120 - KASES Interface
30.090.017.003.1	RV Sign Off		
30.090.017.004	Informational		
30.090.017.004.1	RV Sign Off		
30.100.015	No mapping required		
30.100.015.001	No mapping required		
30.100.015.002	No mapping required		

Requirement	Status	Mapped Objects	Change Orders
30.100.015.003	No mapping required		
30.100.015.004	No mapping required		
30.100.015.005	No mapping required		
30.100.015.006	No mapping required		
30.100.015.007	No mapping required		
30.110.007.020B	RV Sign-Off Task		
30.110.008.010B	RV Sign-Off Duplicate		
30.110.010	Informational		
30.110.010.002	RV Sign-Off Task		
30.110.015	Informational		
30.110.015.001	RV Sign-Off Task		1572 - Type A,B,C,D,E report delivery
30.110.015.002	RV Sign-Off Task		1572 - Type A,B,C,D,E report delivery
30.110.015.003	RV Sign-Off Task		1572 - Type A,B,C,D,E report delivery
30.110.015.004	RV Sign-Off Task		1572 - Type A,B,C,D,E report delivery
30.110.015.005	RV Sign-Off Task		1572 - Type A,B,C,D,E report delivery
30.110.015.006	RV Sign-Off Task		1573 - Notify of DSS/Data Wrhse outage

2.12 Change Orders

Note: Change Orders with a status of “Cancelled” at the time this document was prepared are not included in this document.

2.12.1 PBA-Pharmacy J-Codes Extract - 160

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
160	Change Order		Data Warehouse			1

2.12.1.1 Desired Solution

Create a process to send physician claims with "J" procedure codes to First Health/PBA for drug rebate processing. Frequency of the interface is quarterly. Format of this extract needs to be defined.

2.12.1.2 Business Impact

Meet the Commonwealth's business needs.

2.12.1.3 Technical Specifications

See current transition information (job, program, and so on) for these extracts in the supplemental documentation. Exclude encounters. Refer to clarification section.

2.12.1.4 Clarifications

Action item - Debbie Salleng: Please verify if the encounters with J codes should be forwarded to the PBM for drug rebate.

DS email 11/2/2005 - We have never included encounters for rebate processing.

SB email 11/2/2005 - I have a follow-up question. Does DMS wants to continue this practice with the new system (interChange)?

DS email 11/04/200 - According to John Hoffmann, we do want to continue this practice.

Region codes and descriptions will change over time. The current list can be found at KY iC Claim Regions
[Dwight Spitzer]

The newly added, calculated `status? field is not needed in DSS because of the way their data is structured. The existing header status field will be used to denote whether the claim is P(paid) or V(Voided). This calculated `status? field will not be added to the other Claim interface COs.
[Dwight Spitzer]

Claims resolved final two outstanding questions with this change order. See previous clarification concerning resolution for new status field. See email titled KY DDI - High - Info - CO 160 - Eliminate the Requirement for PHS Provider Exclusion in supplemental documentation below concerning resolution on how to exclude PHS providers from interface. CO transferred to DSS. --- Jennifer Brown

The order in which the Provider Id is chosen has change. If there is a Medicaid Provider Id, it will be put on the extract. If there is no Medicaid Provider Id, then the NPI Provider Id will be on the extract. If there are no Medicaid or NPI Provider Ids, then the Base Provider Id will be on the extract. The code change was requested by First Health.

2.12.1.5 Associated Requirements

Requirement ID	Type
30.050.015.002.4	RFP Requirement
30.090.007.004.3	RFP Requirement
30.090.008.004.3	Claims Encounters
30.090.014.003.3	RFP Split Requirement

2.12.1.6 Associated System Objects

Technical Name	Object Type	Title
DSSJQ160	Batch Job	Creates J code claims extract
cp	Program	Unix Copy
oraload.sh	Program	Oracle Table Load-Unload Utility
PDSQJCDE	Batch Cycle	JCode Quarterly Extract
dss16040.ctl	Program	Sort/Remove
zip	Program	ZIP
otsortd	Program	Sort - UNIX
cat	Program	Concatenate
sed	Program	Unix command stream editor
dssqp160.c	Program	Creates trailer record for J code extract file

2.12.1.7 Change Order Status

Status	Date
Issue Identified	06/26/2005
SE Assigned	01/13/2006
Define/Analyze In Progress	03/07/2006
Ready for Tech Walkthrough	05/05/2006
Ready for Construction Walkthrough	11/08/2006
Ready for Model Office	11/13/2006
UAT Implemented	12/06/2006
Ready for Model Office	12/13/2006
UAT Implemented	01/05/2007

Status	Date
Ready for Model Office	01/11/2007
UAT Implemented	02/26/2007
Ready for Model Office	05/01/2007
Model Office Implemented	05/03/2007
UAT Implemented	05/03/2007
Prod Implemented	05/03/2007
Ready for Model Office	06/12/2007
Model Office Implemented	06/14/2007
UAT Implemented	06/14/2007

2.12.2 PCG Claim History - 215

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
215	Change Order		Data Warehouse			

2.12.2.1 Desired Solution
The Commonwealth currently creates an extract of end of month claim data for PCG. The frequency of the extract is monthly. This CO should re-create this extract in interChange.

2.12.2.2 Business Impact
Meet the Commonwealth's business needs.

2.12.2.3 Technical Specifications
Need to determine the format for the file. See current transition information(job, program, and so on) for the extract in the supplemental documentation.

2.12.2.4 Clarifications
Region codes and descriptions will change over time. The current list can be found at KY iC Claim Regions
[Dwight Spitzer]

Received approval of new interface layout from Chris Sallee (PCG) via email on 05/16. See email attached in Supplemental Documentation - RE: KY DDI - High - Act - Proposed Extract of End of Month Claim Data for PCG - 05/16. --- Jennifer Brown

Received approval from Sydney Lam via email to transfer CO to DSS subsystem. --- Jennifer Brown

2.12.2.5 Associated Requirements

Requirement ID	Type
30.050.015.002.4	RFP Requirement
30.090.007.004.2	RFP Requirement
30.090.007.004.3	RFP Requirement
30.090.014.003.3	RFP Split Requirement

2.12.2.6 Associated System Objects

Technical Name	Object Type	Title
sqlplus	Program	SQLPLUS - SQLDBA
sed	Program	Unix command stream editor
mv	Program	Unix Move File Command
zip	Program	ZIP
DSSJMPCG	Batch Job	PCG Claim History Extract
oraload.sh	Program	Oracle Table Load-Unload Utility

Technical Name	Object Type	Title
rptrangeex.src	Program	External Extract Date conversion script

2.12.2.7 Change Order Status

Status	Date
Issue Identified	07/07/2005
SE Assigned	12/15/2005
Define/Analyze In Progress	12/27/2005
Ready for Tech Walkthrough	05/05/2006
SE Assigned	06/27/2006
Unit Test in Progress (obsolete)	07/19/2006
Ready for Construction Walkthrough	07/24/2006
Ready for Model Office	07/31/2006
Model Office Implemented	08/21/2006
UAT Implemented	11/01/2006
Ready for Model Office	05/16/2007
Model Office Implemented	05/25/2007
UAT Implemented	05/25/2007
Prod Implemented	05/25/2007

2.12.3 ETL Balancing - 525

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
525	Change Order		Data Warehouse			

2.12.3.1 Desired Solution
Extract. Transform, and Load (ETL) balancing necessary to confirm successful update of the Data Warehouse..

2.12.3.2 Business Impact
Balancing processes and procedures are important to ensure that all data is correctly loaded to the Data Warehouse.

2.12.3.3 Technical Specifications
The Balancing process will provide a process summary to;

- Balance between the number of records for paid claims for each Claim Type for FFS and Encounter claims from the MMIS to the DSS. .
- Balance between total dollars for paid claims for each Claim Type for FFS and Encounter claims from the MMIS to the DSS.
- Balance between the number of records for denied claims for each Claim Type for FFS claims from the MMIS to the DSS.
- Balance process will verify the balance between the MMIS history and the DSS for the initial DSS claim history load.
- Balance process will verify the balance between the MMIS Financial and DSS for the ongoing weekly DSS claim load. The balance result will be shown in BO report.

2.12.3.4 Clarifications
No associated clarifications found.

2.12.3.5 Associated Requirements

Requirement ID	Type
30.090.015.003.3	RFP Requirement

2.12.3.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)

2.12.3.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	05/02/2006

Status	Date
Construction in Progress	06/13/2006
Ready for Model Office	07/26/2006
Model Office Implemented	08/01/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.4 ETL (DI) - Professional Claims - 528

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
528	Change Order		Data Warehouse			

2.12.4.1 Desired Solution
ETL Professional Claims - Using BusinessObjects Data Integrator

2.12.4.2 Business Impact
This change order extracts, transforms, and loads professional claims data to support access of this data using the Business Objects reporting tool.

2.12.4.3 Technical Specifications
Set up the Autosys job script DSSJW400 to call the Business Objects Data Integrator Claims Analysis job flow. This job flow will pull the Weekly Fee for Service and Encounter paid and denied claims. The ETL process will then validate the dates, code, and text fields. This will be done for Professional, Dental, Institutional, and Pharmacy claim Data. This Change order deals with the Professional portion of the process. See the mapping document (iCe_ClaimsAnalysisMapping.xls) in the Supplemental documentation for more information

2.12.4.4 Clarifications
No associated clarifications found.

2.12.4.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.4.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)
DSSJWSTG	Batch Job	Claims Analysis Stage MMIS Claim History Tables

2.12.4.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
Define/Analyze In Progress	01/03/2006
SE Assigned	01/04/2006
Design Complete	04/14/2006

Status	Date
Construction in Progress	04/14/2006
Ready for Model Office	08/02/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.5 ETL (DI) - Institutional Claims - 529

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
529	Change Order		Data Warehouse			

2.12.5.1 Desired Solution
ETL Institutional Claims Using BusinessObjects Data Integrator

2.12.5.2 Business Impact
This change order extracts, transforms, and loads institutional claims data to support access of this data using the Business Objects reporting tool

2.12.5.3 Technical Specifications
Set up the Autosys job script DSSJW400 to call the Business Objects Data Integrator Claims Analysis job flow. This job flow will pull the Weekly Fee for Service and Encounter paid and denied claims. The ETL process will then validate the dates, code, and text fields. This will be done for Professional, Dental, Institutional, and Pharmacy claim Data. This Change order deals with the Institutional portion of the process. See the mapping document (iCe_ClaimsAnalysisMapping.xls) in the Supplemental documentation for more information

2.12.5.4 Clarifications
No associated clarifications found.

2.12.5.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.5.6 Associated System Objects

Technical Name	Object Type	Title
DSSJWSTG	Batch Job	Claims Analysis Stage MMIS Claim History Tables
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)

2.12.5.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	01/04/2006
Construction in Progress	04/20/2006
Unit Test in Progress (obsolete)	05/08/2006

Status	Date
Ready for Model Office	07/26/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.6 ETL (DI) - Procedure Dimension - 530

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
530	Change Order		Data Warehouse			

2.12.6.1 Desired Solution
ETL Procedure Dimension Using BusinessObjects Data Integrator

2.12.6.2 Business Impact
The Procedure dimension in the claims analysis portion of the data warehouse provides quick access to claim and encounter data using conditions based on procedure code

2.12.6.3 Technical Specifications
Set up the Autosys job script DSSJW400 to call the Business Objects Data Integrator Claims Analysis job flow. This job flow will pull the Weekly Fee for Service and Encounter paid and denied claims. The ETL process will then validate the dates, code, and text fields. This will be done for Professional, Dental, Institutional, and Pharmacy claim Data. This Change order deals with the creation of the Procedure Dimension of the Claims Analysis Star. See the mapping document (iCe_ClaimsAnalysisMapping.xls) in the Supplemental documentation for more information

2.12.6.4 Clarifications
No associated clarifications found.

2.12.6.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.6.6 Associated System Objects

Technical Name	Object Type	Title
DSSJWSTG	Batch Job	Claims Analysis Stage MMIS Claim History Tables
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)

2.12.6.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	01/04/2006
Unit Test in Progress (obsolete)	04/20/2006

Status	Date
Ready for Model Office	07/25/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.7 ETL (DI) - Diagnosis Dimension - 531

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
531	Change Order		Data Warehouse			

2.12.7.1 Desired Solution
ETL Diagnosis Dimension Using BusinessObjects Data Integrator

2.12.7.2 Business Impact
The diagnosis dimension in the claims analysis portion of the data warehouse provides quick access to claim and encounter data using conditions based on diagnosis code

2.12.7.3 Technical Specifications
Set up the Autosys job script DSSJW400 to call the Business Objects Data Integrator Claims Analysis job flow. This job flow will pull the Weekly Fee for Service and Encounter paid and denied claims. The ETL process will then validate the dates, code, and text fields. This will be done for Professional, Dental, Institutional, and Pharmacy claim Data. This Change order deals with the creation of the Diagnosis Dimension of the Claims Analysis Star. See the mapping document (iCe_ClaimsAnalysisMapping.xls) in the Supplemental documentation for more information

2.12.7.4 Clarifications
No associated clarifications found.

2.12.7.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.7.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)
DSSJWSTG	Batch Job	Claims Analysis Stage MMIS Claim History Tables

2.12.7.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	01/04/2006
Construction in Progress	04/20/2006
Ready for Model Office	07/25/2006

Status	Date
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.8 ETL (DI) - Claims Dimension - 532

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
532	Change Order		Data Warehouse			

2.12.8.1 Desired Solution
ETL Claims Dimension Using BusinessObjects Data Integrator

2.12.8.2 Business Impact
The claim dimension in the claims analysis portion of the data warehouse provide quick access to claim and encounter data using conditions based on claim type, claim and/or detail status, MAR COS, CMS 64 COS, place of service, type of service, crossover type, fee for service/encounter indicator, CMS money code, and CMS eligibility code or any combination of these.

2.12.8.3 Technical Specifications
Set up the Autosys job script DSSJW400 to call the Business Objects Data Integrator Claims Analysis job flow. This job flow will pull the Weekly Fee for Service and Encounter paid and denied claims. The ETL process will then validate the dates, code, and text fields. This will be done for Professional, Dental, Institutional, and Pharmacy claim Data. This Change order deals with the creation of the Claims Dimension of the Claims Analysis Star. See the mapping document (iCe_ClaimsAnalysisMapping.xls) in the Supplemental documentation for more information

2.12.8.4 Clarifications
No associated clarifications found.

2.12.8.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.8.6 Associated System Objects

Technical Name	Object Type	Title
DSSJWSTG	Batch Job	Claims Analysis Stage MMIS Claim History Tables
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)

2.12.8.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	01/04/2006

Status	Date
Construction in Progress	04/20/2006
Unit Test in Progress (obsolete)	06/02/2006
Ready for Model Office	08/07/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.9 ETL (DI) - Member Dimension - 533

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
533	Change Order		Data Warehouse			

2.12.9.1 Desired Solution
ETL Member Dimension Using BusinessObjects Data Integrator

2.12.9.2 Business Impact
The member dimension in the claims analysis portion of the data warehouse provide quick access to claim and encounter data using conditions based on member gender, race, waiver type, ME code, town and district in any combination

2.12.9.3 Technical Specifications
Set up the Autosys job script DSSJW400 to call the Business Objects Data Integrator Claims Analysis job flow. This job flow will pull the Weekly Fee for Service and Encounter paid and denied claims. The ETL process will then validate the dates, code, and text fields. This will be done for Professional, Dental, Institutional, and Pharmacy claim Data. This Change order deals with the creation of the Member Dimension of the Claims Analysis Star. See the mapping document (iCe_ClaimsAnalysisMapping.xls) in the Supplemental documentation for more information

2.12.9.4 Clarifications
No associated clarifications found.

2.12.9.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.9.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)
DSSJWSTG	Batch Job	Claims Analysis Stage MMIS Claim History Tables

2.12.9.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
Define/Analyze In Progress	01/03/2006
SE Assigned	01/04/2006

Status	Date
Design Complete	03/20/2006
Construction in Progress	03/21/2006
Ready for Model Office	08/02/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.10 ETL (DI) - Provider Dimension - 534

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
534	Change Order		Data Warehouse			

2.12.10.1 Desired Solution
ETL Provider Dimension Using BusinessObjects Data Integrator

2.12.10.2 Business Impact
The provider dimension in the claims analysis portion of the data warehouse provides quick access to claim and encounter data using conditions based on provider type, specialty, and location.

2.12.10.3 Technical Specifications
Set up the Autosys job script DSSJW400 to call the Business Objects Data Integrator Claims Analysis job flow. This job flow will pull the Weekly Fee for Service and Encounter paid and denied claims. The ETL process will then validate the dates, code, and text fields. This will be done for Professional, Dental, Institutional, and Pharmacy claim Data. This Change order deals with the creation of the Provider Dimension of the Claims Analysis Star. See the mapping document (iCe_ClaimsAnalysisMapping.xls) in the Supplemental documentation for more information

2.12.10.4 Clarifications
No associated clarifications found.

2.12.10.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.10.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)
DSSJWSTG	Batch Job	Claims Analysis Stage MMIS Claim History Tables

2.12.10.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	01/04/2006
Unit Test in Progress (obsolete)	04/20/2006

Status	Date
Ready for Model Office	07/25/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.11 ETL (DI) - TPL - 535

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
535	Change Order		Data Warehouse			

2.12.11.1 Desired Solution
ETL for TPL Using BusinessObjects Data Integrator

2.12.11.2 Business Impact
TPL updates to MMIS history can occur as a result of financial processing. These need to be added to the data warehouse to capture all of the TPL activity for the claims

2.12.11.3 Technical Specifications
The TPL job truncates and reloads the TPL tables in the DSS database. The ETL validates the dates, codes and text fields and inserts the default values when there is NULL data in the target. See the mapping document in the Supplemental documentation for more information.

2.12.11.4 Clarifications
No associated clarifications found.

2.12.11.5 Associated Requirements

Requirement ID	Type
30.050.015.002.3	RFP Requirement
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.11.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)
DSSJWTPL	Batch Job	Extract and Load TPL DSS Tables

2.12.11.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	01/04/2006
Design Complete	02/16/2006
Unit Test in Progress (obsolete)	04/20/2006
Ready for Construction	07/14/2006

Status	Date
Walkthrough	
Ready for Model Office	07/26/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.12 ETL (DI) Clms Adjustment Process - 536

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
536	Change Order		Data Warehouse			

2.12.12.1 Desired Solution
ETL Claims Adjustment Process Using BusinessObjects Data Integrator

2.12.12.2 Business Impact
The claims adjustment process is critical to the accurate reporting of claims that have been adjusted and the corresponding voided claims that result from the adjustment process.

2.12.12.3 Technical Specifications
Set up the Autosys job script DSSJW400 to call the Business Objects Data Integrator Claims Analysis job flow. This job flow will pull the Weekly Fee for Service and Encounter paid and denied claims. The ETL process will then validate the dates, code, and text fields. This will be done for Professional, Dental, Institutional, and Pharmacy claim Data. This Change order deals with the addition of adjustment to the Main fact table and the creation of a void process to negate the original claim on the Claims Analysis Star main fact table. See the mapping document (iCe_ClaimsAnalysisMapping.xls) in the Supplemental documentation for more information

2.12.12.4 Clarifications
No associated clarifications found.

2.12.12.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.12.6 Associated System Objects

Technical Name	Object Type	Title
DSSJWSTG	Batch Job	Claims Analysis Stage MMIS Claim History Tables
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)

2.12.12.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
Design Complete	01/03/2006
SE Assigned	01/04/2006

Status	Date
Construction in Progress	06/02/2006
Unit Test in Progress (obsolete)	07/13/2006
Ready for Model Office	08/02/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.13 ETL (DI) - MMIS Eligibility - 537

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
537	Change Order		Data Warehouse			

2.12.13.1 Desired Solution
ETL MMIS Eligibility Using BusinessObjects Data Integrator

2.12.13.2 Business Impact
This change order is to extract, transform and load (ETL) the MMIS Eligibility file data to the data warehouse to give access to the MMIS Eligibility file for query and reporting. The metadata will be exchanged from the member data model into the Business Objects Data Integrator repository

2.12.13.3 Technical Specifications
The job truncates and reloads the subject area tables in the DSS database. The ETL validates the dates, codes and text fields and inserts the default values when there is NULL data in the target. See the mapping document in the Supplemental documentation for more information.

2.12.13.4 Clarifications
No associated clarifications found.

2.12.13.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.13.6 Associated System Objects

Technical Name	Object Type	Title
DSSJWMBR	Batch Job	Extract and Load Member DSS Tables
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)

2.12.13.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	02/08/2006
Define/Analyze In Progress	02/08/2006
Construction in Progress	02/15/2006
Ready for Construction Walkthrough	07/14/2006

Status	Date
Ready for Model Office	07/26/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.14 ETL (DI) - MMIS Prior Auth - 538

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
538	Change Order		Data Warehouse			

2.12.14.1 Desired Solution
ETL MMIS Prior Authorization Using BusinessObjects Data Integrator

2.12.14.2 Business Impact
This change order is to extract, transform and load (ETL) the MMIS Prior Authorization file data to the data warehouse to give access to the MMIS Prior Authorization file for query and reporting. The metadata will be exchanged from the member data model into the Business Objects Data Integrator repository.

2.12.14.3 Technical Specifications
The Prior Authorization job truncates and reloads the PA tables in the DSS database. The ETL validates the dates, codes and text fields and inserts the default values when there is NULL data in the target. See the mapping document in the Supplemental documentation for more information.

2.12.14.4 Clarifications
No associated clarifications found.

2.12.14.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.14.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)
DSSJWPAT	Batch Job	Extract and Load Prior Auth DSS Tables

2.12.14.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
Design Complete	02/16/2006
Unit Test in Progress (obsolete)	04/20/2006
Ready for Model Office	07/21/2006

Status	Date
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.15 ETL (DI) - Prov Financial Trans - 539

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
539	Change Order		Data Warehouse			

2.12.15.1 Desired Solution
ETL Provider Financial Transaction File Using BusinessObjects Data Integrator

2.12.15.2 Business Impact
This change order is to extract, transform and load (ETL) the MMIS Provider Financial Transaction file data to the data warehouse to give access to the Provider Financial Transaction data for query and reporting. The metadata will be exchanged from the Provider data model into the Business Objects Data Integrator repository

2.12.15.3 Technical Specifications
The job truncates and reloads the provider Financial tables in the DSS database. The ETL validates the dates, codes and text fields and inserts the default values when there is NULL data in the target. See the mapping document in the Supplemental documentation for more information.

2.12.15.4 Clarifications
No associated clarifications found.

2.12.15.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.15.6 Associated System Objects

Technical Name	Object Type	Title
DSSJWFIN	Batch Job	Extract Financial MMIS Tables
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)

2.12.15.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	02/16/2006
Construction in Progress	02/21/2006
Ready for Construction Walkthrough	06/22/2006

Status	Date
Ready for Model Office	06/30/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.16 ETL (DI) - MMIS Provider File - 540

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
540	Change Order		Data Warehouse			

2.12.16.1 Desired Solution
ETL MMIS Provider File Using BusinessObjects Data Integrator

2.12.16.2 Business Impact
This change order is to extract, transform and load (ETL) the MMIS Provider File data to the data warehouse to give access to the MMIS Provider File for query and reporting. The metadata will be exchanged from the Provider data model into the Business Objects Data Integrator repository.

2.12.16.3 Technical Specifications
The job truncates and reloads the MMIS provider tables in the DSS database. The ETL validates the dates, codes and text fields and inserts the default values when there is NULL data in the target. See the mapping document in the Supplemental documentation for more information.

2.12.16.4 Clarifications
No associated clarifications found.

2.12.16.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.16.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL-Data Integrator Enterprise (v.XI)
DSSJWPRV	Batch Job	Extract and Load Provider DSS Tables

2.12.16.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	04/20/2006
Construction in Progress	04/22/2006
Ready for Construction Walkthrough	07/14/2006

Status	Date
Ready for Model Office	07/26/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.17 ETL (DI) - Reference-Diag/Other - 541

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
541	Change Order		Data Warehouse			

2.12.17.1 Desired Solution
ETL Reference - Diagnosis and Other misc. reference data using BusinessObjects Data Integrator

2.12.17.2 Business Impact
This change order is to extract, transform and load (ETL) the MMIS diagnosis reference file data to the data warehouse to give access to the MMIS diagnosis reference file for query and reporting. The metadata will be exchanged from the reference data model into the Business Objects Data Integrator repository.

2.12.17.3 Technical Specifications
The job truncates and reloads the Reference(diagnosis/other) tables in the DSS database. The ETL validates the dates, codes and text fields and inserts the default values when there is NULL data in the target. See the mapping document in the Supplemental documentation for more information.

2.12.17.4 Clarifications
No associated clarifications found.

2.12.17.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.17.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)
DSSJWREF	Batch Job	Extract and Load Reference DSS Tables

2.12.17.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
Construction in Progress	04/20/2006
Ready for Unit Test (obsolete)	06/02/2006
Unit Test in Progress (obsolete)	07/13/2006

Status	Date
Ready for Model Office	07/26/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.18 Cust. InfoView Report Library - 543

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
543	Change Order		Data Warehouse			

2.12.18.1 Desired Solution

The InfoView interface is essentially a portal letting users access various tools within the DSS subsystem. For example, there are areas to access provider, member, and claim data. From the InfoView sight, users will also access the DSSProfiler Maintenance panels. Banner images and background colors for InfoView should be customized to conform to pre-defined standards. This Change Order is only for the modifications of the InfoView Web application

2.12.18.2 Business Impact

Provide the capability to access various tools within the DSS subsystem

2.12.18.3 Technical Specifications

Modify the InfoView report Library to support the applications used by the Data Warehouse.

2.12.18.4 Clarifications

No associated clarifications found.

2.12.18.5 Associated Requirements

Requirement ID	Type
30.050.015.002.1	RFP Requirement
30.090.015.002.4	RFP Requirement

2.12.18.6 Associated System Objects

Technical Name	Object Type	Title
DSSNavigator - Corporate Documents Expanded	Window	DSSNavigator - Corporate Documents Expanded
DSSNavigator - Corporate Documents	Window	DSSNavigator - Corporate Documents
BusinessObjects: Infoview (v.XI)	Program	BusinessObjects: Infoview (v.XI)
DSSNavigator - Login Window	Window	DSSNavigator - Login Window
DSSNavigator - Welcome Window	Window	DSSNavigator - Welcome Window

2.12.18.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	01/04/2006

Status	Date
Ready for Model Office	07/14/2006
Model Office Implemented	07/15/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.19 Develop Claims Analysis Universe - 544

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
544	Change Order		Data Warehouse			

2.12.19.1 Desired Solution
Develop the Claims Analysis Universe for access to the claims history data.

2.12.19.2 Business Impact
Users will have the ability to develop and execute queries against the claims history data carried in the data warehouse

2.12.19.3 Technical Specifications
The Claims Analysis universe is created using BusinessObjects Designer. The classes, subclasses, and objects should be alphabetized.

The following KY specific changes were applied to the Universe:

- Changed references to 'Member' or 'Recip' in objects and descriptions to 'Member'.
- Added objects for Provider Program Code and Provider Review Type Code to all providers classes.
- Added T_PR_CDE_PROV_PGM, T_PR_CDE_REVIEW and T_RE_PGM_STATUS_CODE code tables to use for LOVs.
- Added Provider Member plan Indicator to all providers classes.
- Added object called Provider KenPAC Indicator where a Y or N will be plugged based on the value in the Provider Program Code column. 'KENP' will be a Y, everything else is a N.
- Added object called Provider Passport Indicator where a Y or N will be plugged based on the value in the Provider Program Code column. 'PART' will be a Y, everything else is a N.
- Created a filter under each provider class for KenPAC only providers.
- Created a filter under each provider class for Passport only providers.
- Added Disease Management Indicator, EPSDT Screening Indicator, Provider Group Indicator and TPL Indicator to claim indicators class.
- Added Member Program Status Code and Desc objects. Also added Member IM ID Code to the Member Demographic Information class.
- Added RA Number from T_CA_ICN under Detailed Claim Information..
- Changed data type of Num_check in T_CA_FIN from number to character.
- Modified several of the claim type filters. Added Home Health Claims Only filter. Modified LTC Claims Filter to check for TOB '81' for Claim Type A(LTC crossover).
- Created filter for PBA Encounter Flag of 'H' on the claim indicator.

- Updated the text of the Claim Indicator filter to also include PBA Encounter.

2.12.19.4 Clarifications
None.

2.12.19.5 Associated Requirements

Requirement ID	Type
30.050.015.002.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.19.6 Associated System Objects

Technical Name	Object Type	Title
CA.unv	DSS Universe	Claims Analysis Universe

2.12.19.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	01/04/2006
Construction in Progress	03/21/2006
Ready for Model Office	06/26/2006
Model Office Implemented	08/18/2006
UAT Implemented	12/12/2006
Prod Implemented	06/14/2007

2.12.20 Develop Member Universe - 545

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
545	Change Order		Data Warehouse			

2.12.20.1 Desired Solution
Develop the Member Universe for access to the member data.

2.12.20.2 Business Impact
Users will have the ability to develop and execute queries against the member data carried in the DSS data warehouse

2.12.20.3 Technical Specifications
The Member universe is created using BusinessObjects Designer. The classes, subclasses, and objects should be alphabetized.

2.12.20.4 Clarifications
No associated clarifications found.

2.12.20.5 Associated Requirements

Requirement ID	Type
30.050.015.002.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.20.6 Associated System Objects

Technical Name	Object Type	Title
Member.unv	DSS Universe	Member Universe

2.12.20.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	01/04/2006
Ready for Model Office	06/28/2006
Model Office Implemented	10/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.21 Develop Provider Universe - 546

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
546	Change Order		Data Warehouse			

2.12.21.1 Desired Solution
Develop the Provider Universe for access to the provider data

2.12.21.2 Business Impact
Users will have the ability to develop and execute queries against the provider data carried in the DSS data warehouse.

2.12.21.3 Technical Specifications
The Provider universe is created using BusinessObjects Designer. The classes, subclasses, and objects should be alphabetized.

These changes were as defined in Core CO 11708.

But, additional changes identified on integrity checks on 6/14/2006. The columns CDE_SERVICE_LOC and IND_NPI_TRIGGER have been removed from the following tables:

- T_PR_IDENTIFIER
- T_PR_SVC_CERT
- T_PR_UB_LOC_RATE
- T_PR_GRP_MBR
- T_PR_MCARE_BILL
- T_PR_DISP_FEE
- T_PR_PAY_PULL
- T_PR_SVC_LANG
- T_PR_REVIEW
- T_PR_PHP_ELIG
- T_PR_TYPE
- T_PR_SURS_SPEC
- T_PMP_SVC_LOC
- T_PR_RST_SVC
- T_PR_SPEC
- T_PR_PEER_LEVEL
- T_PR_LOC_RATE

- T_PR_CLIA_STAT
- T_PR_TAX_ID

Remove references to any objects to these in the Universe.

Add conditions and indicators for Program Code types Kenpac & Passport.

The following KY specific changes were applied to the Universe:

- Changed references to 'Member' or 'Recip' in objects and descriptions to 'Member'.
- Added object called Provider KenPAC Indicator where a Y or N will be plugged based on the value in the Provider Program Code column. 'KENP' will be a Y, everything else is a N.
- Added object called Provider Passport Indicator where a Y or N will be plugged based on the value in the Provider Program Code column. 'PART' will be a Y, everything else is a N.
- Created a filter under each provider class for KenPAC only providers.
- Created a filter under each provider class for Passport only providers.
- Fixed Join errors due to columns referencing CDE_SERVICE_LOC columns which were dropped in the above list of tables.

2.12.21.4 Clarifications

No associated clarifications found.

2.12.21.5 Associated Requirements

Requirement ID	Type
30.050.015.002.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.21.6 Associated System Objects

Technical Name	Object Type	Title
Prov.unv	DSS Universe	Provider Universe

2.12.21.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	05/02/2006
Construction in Progress	06/09/2006
Ready for Construction Walkthrough	06/22/2006

Status	Date
Ready for Model Office	06/28/2006
Model Office Implemented	07/25/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.22 Develop Reference Universe - 547

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
547	Change Order		Data Warehouse			

2.12.22.1 Desired Solution
Develop the reference universe for access to the reference data.

2.12.22.2 Business Impact
Users will have the ability to develop and execute queries against the reference data carried in the DSS data warehouse.

2.12.22.3 Technical Specifications
The Reference universe is created using BusinessObjects Designer. The classes, subclasses, and objects should be alphabetized.

2.12.22.4 Clarifications
No associated clarifications found.

2.12.22.5 Associated Requirements

Requirement ID	Type
30.050.015.002.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.22.6 Associated System Objects

Technical Name	Object Type	Title
Reference.unv	DSS Universe	Reference Universe

2.12.22.7 Change Order Status

Status	Date
Change Order Written	08/20/2005
SE Assigned	05/02/2006
SE Assigned	06/12/2006
Ready for Model Office	08/07/2006
Model Office Implemented	10/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.23 DSSMeasureBase - Extract/Build - 553

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
553	Change Order		Data Warehouse			

2.12.23.1 Desired Solution
Install the DSSMeasureBase Claim Data extract and Data Mart build.

2.12.23.2 Business Impact
Provides health care analysis and reporting of detailed health care utilization data. Allows the view and analyzing of user entered health care measures to verify the continued efficient and effective operation of the Medicaid program.

2.12.23.3 Technical Specifications
Install the following Scripts

- DSSJQ710
- DSSJQ715
- DSSJQ720
- DSSJQ721
- DSSJQ722
- DSSJQ723
- DSSJQ724
- DSSJQ725
- DSSJQ726
- DSSJQ727
- DSSJQ730
- DSSJQ731
- DSSJQ732
- DSSJQ733
- DSSJQ734
- DSSJQ735
- DSSJQ736
- DSSJQ737
- DSSJQ738
- DSSJQ739

- DSSJQ740
- DSSJQ741
- DSSJQ742
- DSSJQ743
- DSSJQ744
- DSSJQ745
- DSSJQ746
- DSSJQ760
- DSSJQ770

Install the following Programs:

- dssloadonline.sh
- dsspmband.c
- dsspmbbirth.c
- dsspmbcalc.c
- dsspmbdent.c
- dsspmbdrug.c
- dsspmbelig.c
- dsspmbfinal.c
- dsspmbif.c
- dsspmbkeys.c
- dsspmbmed.c
- dsspmbnhome.c
- dsspmbout.c
- dsspmboutp.c
- dsspmbub.c

2.12.23.4 Clarifications

No associated clarifications found.

2.12.23.5 Associated Requirements

Requirement ID	Type
30.090.015.002.20	RFP Requirement

2.12.23.6 Associated System Objects

Technical Name	Object Type	Title
dssloadonline.sh	Program	DSS Load Script
DSSJQ738	Batch Job	Process Measures for Measurebase - 9
DSSJQ742	Batch Job	Process Measures for Measurebase -13
dsq770010.20.shl	Program	Load table t_mb_num_recip
DSSJQ721	Batch Job	Process Dental Inputs
DSSJQ730	Batch Job	Process Measures for Measurebase - 1
PDSQMB01	Batch Cycle	DSSMeasurebase Box
dsq770010.60.shl	Program	Load table T_MB_DEN_RECIP
dsspmbcalc.c	Program	Measure Calculation Initial Step
dsspmbfinal.c	Program	Measure Final
DSSJQ739	Batch Job	Process Measures for Measurebase -10
dsq770010.30.shl	Program	Load table T_MB_DEN_RECIP
dsspmbif.c	Program	Determines Roup for Input Claim
DSSJQ710	Batch Job	Extracts Information from the Database
DSSJQ715	Batch Job	Measurebase Eligibility lookups
DSSJQ735	Batch Job	Process Measures for Measurebase - 6
DSSJQ736	Batch Job	Process Measures for Measurebase - 7
dsq00115.sql	Program	DSSMeasurebase Parm Update
dsspmband.c	Program	Measure Processor
DSSJQ720	Batch Job	Process Medical Inputs
DSSJQ722	Batch Job	Process Outpatient Inputs
DSSJQ725	Batch Job	Process long term care inputs
DSSJQ726	Batch Job	Process Eligibility
DSSJQ741	Batch Job	Process Measures for Measurebase -12

Technical Name	Object Type	Title
dsq770010.70.shl	Program	Load table T_MB_DEN_RECIP
DSSJQ724	Batch Job	Process Inpatient data
DSSJQ732	Batch Job	Process Measures for Measurebase - 3
DSSJQ733	Batch Job	Process Measures for Measurebase - 4
DSSJQ744	Batch Job	Process Measures for Measurebase -15
dsq770010.40.shl	Program	Load table T_MB_DEN_RECIP
dsq770010.50.shl	Program	Load table T_MB_DEN_RECIP
dsspmbkeys.c	Program	Measure Keys
DSSJQ723	Batch Job	Process Pharmacy Data
DSSJQ734	Batch Job	Process Measures for Measurebase - 5
DSSJQ740	Batch Job	Process Measures for Measurebase -11
DSSJQ743	Batch Job	Process Measures for Measurebase -14
DSSJQ746	Batch Job	Process Measures for Measurebase - 17
DSSJQ770	Batch Job	Process MeasureBase Calc
DSSJQ731	Batch Job	Process Measures for Measurebase - 2
DSSJQ737	Batch Job	Process Measures for Measurebase - 8
DSSJQ745	Batch Job	Process Measures for Measurebase -16
DSSJQ760	Batch Job	Load Tables

2.12.23.7 Change Order Status

Status	Date
Change Order Written	08/21/2005
SE Assigned	04/03/2006
Construction in Progress	06/05/2006
Ready for Model Office	08/28/2006
Model Office Implemented	09/01/2006
Ready for Model Office	09/11/2006
Model Office Implemented	09/28/2006
UAT Implemented	11/01/2006

Status	Date
Ready for Model Office	11/21/2006
Ready for Model Office	11/27/2006
Model Office Implemented	11/28/2006
UAT Implemented	12/04/2006
Ready for Model Office	12/19/2006
UAT Implemented	12/22/2006
Ready for Model Office	01/09/2007
Model Office Implemented	01/15/2007
UAT Implemented	01/15/2007
Prod Implemented	06/14/2007
Ready for Model Office	06/28/2007
Model Office Implemented	07/02/2007
UAT Implemented	07/02/2007
Ready for Model Office	07/03/2007
Prod Implemented	07/05/2007
Model Office Implemented	07/09/2007
UAT Implemented	07/09/2007

2.12.24 ADHC Monitoring - 1422

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1422	Change Order		Data Warehouse			

2.12.24.1 Desired Solution
Develop the ADHC Monitoring Report according to specifications.

2.12.24.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.24.3 Technical Specifications
User Prompts:

- First Date of Service Range
- Bill Provider Number

Table Row Selection Criteria:

- First Date of Service per user input
- FFS Claims only
- Latest Claims only
- Bill Provider Number per user input

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Billing Provider ID
- Original Member ID
- Transaction Control Number
- First Date of Service
- Last Date of Service
- Paid Amount
- Billed Quantity
- Billed Amount
- Member Case Name
- Procedure Code and Description

Report Column Grouping Order:

- None

Report Column Sort Order:

- Original Member ID
- Last Date of Service
- Transaction Control Number

Frequency:

- Weekly

Priority:

- 2

Owner:

- Kristina Hayden

2.12.24.4 Clarifications

Member case name not available at this time. Will use member name until the member case name is available. This is on Hilma's list of items to be added with a future change order.

2.12.24.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.24.6 Associated System Objects

Technical Name	Object Type	Title
DSS - ADHC Monitoring	Report	ADHC Monitoring

2.12.24.7 Change Order Status

Status	Date
Change Order Written	10/28/2005
Construction in Progress	07/06/2006
Ready for Model Office	07/13/2006
Model Office Implemented	08/21/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.25 Ancillary Verifications-Names - 1431

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1431	Change Order		Data Warehouse			

2.12.25.1 Desired Solution
Develop Ancillary Verification - Names Report according to specifications.

2.12.25.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6

2.12.25.3 Technical Specifications
User Prompts:

- First Date of Service Range
- Bill Provider Number
- Revenue Code Range

Table Row Selection Criteria:

- First Date of Service Range per user input
- Latest Claims only
- Paid Claims only
- Fee for Service Claims only
- Bill Provider Number per user input
- Revenue Code per user input
- Type of Bill between 891 and 894

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Transaction Control Number
- Billed Amount
- Original Member ID
- Member Name in Full (FML)
- First Date of Service
- Last Date of Service
- Revenue Code Description

Report Column Grouping Order:

- Transaction Control Number

- Original Member ID
- Member Name in Full (FML)
- First Date of Service
- Last Date of Service
- Revenue Code Description

Report Column Sort Order:

- None

Frequency:

- On Demand

Priority:

- 5

Owner:

- Frances Wise

2.12.25.4 Clarifications

No associated clarifications found.

2.12.25.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.25.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Ancillary Verifications with Names	Report	Ancillary Verifications with Names

2.12.25.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
Construction in Progress	07/06/2006
Ready for Model Office	07/14/2006
Model Office Implemented	08/21/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.26 Ancillary per Revenue Code - 1432

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1432	Change Order		Data Warehouse			

2.12.26.1 Desired Solution
Develop Ancillary per Revenue Code Report according to specifications.

2.12.26.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.26.3 Technical Specifications
User Prompts:

- First Date of Service Range
- Revenue Code

Table Row Selection Criteria:

- Paid Claims only
- Latest Claims only
- Fee for Service Claims only
- Revenue Code per user input
- Bill Provider Type equal to 12
- Type of Bill between 891 and 894
- First Date of Service Range per user input

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Billing Provider Number
- Original Member ID
- Member Full Name
- Revenue Code Description
- Transaction Control Number
- Billed Amount
- Ancillary Total Paid Amount

Report Column Grouping Order:

- Billing Provider Number
- Original Member ID

- Member Full Name
- Revenue Code Description
- Transaction Control Number

Report Column Sort Order:

- Bill Provider Number, ascending
- Member Last Name, ascending
- Member First Name, ascending

Frequency:

- On Demand

Priority:

- 3

Owner:

- Frances Wise

2.12.26.4 Clarifications

Due to lack of test data, this report was tested by temporarily removing the Type of Bill between 891-894 condition.

2.12.26.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.26.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Ancillary per Revenue Code	Report	Ancillary per Revenue Code

2.12.26.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
Construction in Progress	07/10/2006
Ready for Model Office	07/19/2006
Model Office Implemented	08/21/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.27 Bed Days for Nursing Homes - 1433

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1433	Change Order		Data Warehouse			

2.12.27.1 Desired Solution
Develop the Bed Days for Nursing Homes Report according to specifications.

2.12.27.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.27.3 Technical Specifications
User Prompts:

- First Date of Service Range
- Bill Provider Number

Table Row Selection Criteria:

- First Date of Service Range per user input
- Latest Claims only
- Paid Claims only
- Fee for Service only
- Bill Provider ID per user input
- Type of Bill between 891 and 894

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Billing Provider Number
- Covered Days
- Billing Provider Full Name

Report Column Grouping Order:

- Bill Provider Number
- Provider Last Name in Full

Report Column Sort Order:

- Bill Provider Number, ascending

Frequency:

- On Demand

Priority:

- 5

Owner:

- Frances Wise

2.12.27.4 Clarifications

Due to lack of test data, this report was tested by temporarily removing the Type of Bill between 891-894 condition.

2.12.27.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.27.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Bed Days for Nursing Homes	Report	Bed Days for Nursing Homes

2.12.27.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
Construction in Progress	07/10/2006
Ready for Model Office	07/19/2006
Model Office Implemented	08/21/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.28 Certification Failures - 1434

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1434	Change Order		Data Warehouse			

2.12.28.1 Desired Solution
Develop the Certification Failures Report according to specifications.

2.12.28.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.28.3 Technical Specifications
User Prompts:

- First Date of Service Range
- Bill Provider Number
- Original Member ID

Table Row Selection Criteria:

- First Date of Service Range per user input
- Latest Claims only
- Paid Claims only
- Fee for Service Claims only
- Bill Provider Number per user input
- Original Member ID per user input
- Type of Bill between 891 and 894

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Original Member ID
- Member Name in Full(LFM)
- Billing Provider Number
- Provider Name in Full
- Paid Amount
- First Date of Service
- Last Date of Service
- Transaction Control Number

Report Column Grouping Order:

- Original Member ID
- Member Name in Full(LFM)
- Billing Provider Number
- Provider Name in Full
- First Date of Service
- Last Date of Service
- Transaction Control Number

Report Column Sort Order:

- First Date of Service, ascending

Frequency:

- On Demand

Priority:

- 5

Owner:

- Frances Wise

2.12.28.4 Clarifications

Due to lack of test data, this report was tested by temporarily removing the Type of Bill between 891-894 condition.

2.12.28.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.28.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Certification Failures	Report	Certification Failures

2.12.28.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
Construction in Progress	07/10/2006
Ready for Model Office	07/19/2006
Model Office Implemented	08/21/2006

Status	Date
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.29 NF Initiative Ancillary Paid - 1435

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1435	Change Order		Data Warehouse			

2.12.29.1 Desired Solution
Develop the NF Initiative Ancillary Paid Report according to specifications.

2.12.29.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.29.3 Technical Specifications
User Prompts:

- First Date of Service Range

Table Row Selection Criteria:

- First Date of Service Range per user input
- FFS Claims only
- Bill Provider Type equal to 12 (Nursing Home)
- Latest Claims only
- Paid Claims only
- Claim Type equal to T or X.

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- First Date of Service
- Billing Provider ID
- Provider Last Name in Full
- Covered Days Sum
- Total Accommodation Paid
- Total Ancillary Paid
- Patient Liability Amount
- Third Party Payment
- Claim Payment Amount Sum (Institutional Care Claims)
- Claim Payment Amount Sum (Institutional Xover Claims)
- Total Sum of Encounter Claim Payment Amount + Amount Paid by Medicare

Report Column Grouping Order:

- First Date of Service
- Bill Provider Number
- Provider Last Name in Full

Report Column Sort Order:

- Month of Service, Ascending
- Bill Provider Number, Ascending

Frequency:

- Monthly

Priority:

- 2

Owner:

- Frances Wise

2.12.29.4 Clarifications

Per 10/25/2005 meeting minutes: Potential changes needed to include additional data. May be incorporated with NF Initiative Ancillary Units and Unduplicated Members per Month reports. This is an action item for Ashish Virmani and Frances Wise.

2.12.29.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.29.6 Associated System Objects

Technical Name	Object Type	Title
DSS - NF Initiative Ancillary Paid	Report	NF Initiative Ancillary Paid

2.12.29.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
Ready for Model Office	08/03/2006
Model Office Implemented	08/21/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.30 NF Initiative Ancillary Units - 1436

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1436	Change Order		Data Warehouse			

2.12.30.1 Desired Solution
Develop the NF Initiative Ancillary Units Report according to specifications.

2.12.30.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.30.3 Technical Specifications
User Prompts:

- First Date of Service Range

Table Row Selection Criteria:

- First Date of Service per user input
- FFS Claims only
- Bill Provider Type equal to 12 (Nursing Home)
- Type of Bill in (891,894)
- Latest Claims only
- Paid Claims only
- Covered Charges only
- Revenue Code in (320, 410, 412, 419) or Revenue Code between 300 and 314 or Revenue Code between 420 and 424 or Revenue Code between 430 and 433 or Revenue Code between 440 and 444

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- First Date of Service
- Revenue Code
- Submitted Charge (calculate the sum of submitted charge column for each FDOS and Revenue Code)
- Units of Service (calculate the sum of the Units of Service column for each FDOS and Revenue Code)
- Original Member ID (calculate the distinct count of the Original Member ID column for each FDOS and Revenue Code)
- Internal Control Number (calculate the distinct count of the ICN column for each FDOS and Revenue Code)

Report Column Grouping Order:

- First Date of Service
- Revenue Code

Report Column Sort Order:

- First Date of Service , ascending
- Revenue Code , ascending

Frequency:

- Monthly

Priority:

- 2

Owner:

- Frances Wise

2.12.30.4 Clarifications

Per 10/25/2005 meeting minutes: Potential changes needed to include additional data. May be incorporated with NF Initiative Ancillary Paid and Unduplicated Members per Month reports. This is an action item for Ashish Virmani and Frances Wise.

2.12.30.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.30.6 Associated System Objects

Technical Name	Object Type	Title
DSS - NF Initiative Ancillary Units	Report	NF Initiative Ancillary Units

2.12.30.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
Ready for Model Office	08/03/2006
Model Office Implemented	08/21/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.31 Unduplicated Members/Month - 1437

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1437	Change Order		Data Warehouse			

2.12.31.1 Desired Solution
Develop the Unduplicated Members/Month Report according to specifications.

2.12.31.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.31.3 Technical Specifications
User Prompts:

- First Date of Service Range

Table Row Selection Criteria:

- First Date of Service per user input
- Latest Claims only
- Paid Claims only
- Fee for Service only
- Bill Provider Type equal to 12 (Nursing Home)

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Original Member Distinct Count

Report Column Grouping Order:

- None

Report Column Sort Order:

- None

Frequency:

- Once a month

Priority:

- 2

Owner:

- Frances Wise

2.12.31.4 Clarifications

Per 10/25/2005 meeting minutes: Potential changes needed to include additional data. May be incorporated with NF Initiative Ancillary Units and NF Initiative Ancillary Paid reports. This is an action item for Ashish Virmani and Frances Wise.

2.12.31.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.31.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Unduplicated Members	Report	Unduplicated Members

2.12.31.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
Ready for Model Office	08/03/2006
Model Office Implemented	08/21/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.32 AR Over Payments by SFY - 1438

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1438	Change Order		Data Warehouse			

2.12.32.1 Desired Solution
Develop the AR Over Payments by SFY Report according to specifications.

2.12.32.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.32.3 Technical Specifications
User Prompts:

- AR Set Up Date Range

Table Row Selection Criteria:

- AR Set Up Date as input by user

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- AR Number
- Provider Number
- AR Set Up Date
- Original Amount Requested
- Adjustments
- Recoupment/Payments
- Interest Calculated
- Interest Received
- Penalty Calculated
- Penalty Received
- Ending Balance

Report Column Grouping Order:

- None

Report Column Sort Order:

- AR Number

Frequency:

- Annual

Priority:

- 5

Owner:

- Steve Bechtel

2.12.32.4 Clarifications

Report is to list all AR's setup (keyed into the system) from 7/1-6/30 of the FY requested but only list transactions (dispositions) posted to the AR during that time period so that the auditors receive the outstanding balance that showed in the system as of 6/30.

Bob Odenweller sent email to Financial TFAL Darren Swift asking for clarification on AR disposition fields in database. Report may need modification based on his response.

2.12.32.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.32.6 Associated System Objects

Technical Name	Object Type	Title
DSS - AR Over Payments by SFY	Report	AR Over Payments by SFY

2.12.32.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
Construction in Progress	08/17/2006
Ready for Model Office	08/21/2006
Model Office Implemented	10/12/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.33 Preventive Health Payments-DOS - 1439

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1439	Change Order		Data Warehouse			

2.12.33.1 Desired Solution
Develop the Preventive Health Payments - DOS Report according to specifications.

2.12.33.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.33.3 Technical Specifications
User Prompts:

- First Date of Service Range

Table Row Selection Criteria:

- First Date of Service per user input
- Bill Provider Type equal to 20 (Preventive Care)
- Fee for Service Claims only
- Paid Claims only
- Latest Claims only

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- First Date of Service
- Procedure Description
- Paid Amount
- Billed Quantity
- ICN Count

Report Column Grouping Order:

- First Date of Service
- Procedure Description

Report Column Sort Order:

- First Date of Service

Frequency:

- Monthly

Priority:

- 2

Owner:

- Cassie Keffer

2.12.33.4 Clarifications

Action item for Kurt Godshall per 10/25/2005 meeting minutes: Test transition version of this report to see if changes are needed.

2.12.33.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.33.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Preventive Health Payments - DOS	Report	Preventive Health Payments - DOS

2.12.33.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
Ready for Model Office	08/09/2006
Model Office Implemented	10/12/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.34 Encounter Transportation - 1440

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1440	Change Order		Data Warehouse			

2.12.34.1 Desired Solution
Develop the Encounter Transportation Report according to specifications.

2.12.34.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.34.3 Technical Specifications
User Prompts:

- First Date of Service Range

Table Row Selection Criteria:

- First Date of Service per user input
- Latest Claims only
- Encounter Claims only
- Bill Provider Type in (55, 56, 57, 58)
- Claim Type not equal to 2

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Member County Description
- Billing Provider Specialty Code and Description
- Billing Provider Specialty Type and Description
- Encounter Amount

Report Column Grouping Order:

- Member County Description
- Billing Provider Specialty Code and Description
- Billing Provider Specialty Type and Description

Report Column Sort Order:

- None

Frequency:

- Annual

Priority:

- 5

Owner:

- Dan Moccia

2.12.34.4 Clarifications

This report will need to be changed per 10/25/2005 meeting minutes.

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Encounter Transportation report.

User Prompts:

- From Date of Service Range

Table Row Selection Criteria:

- From Date of Service per user input
- Latest Claims only
- Encounter Claims only
- Billing Provider Type Code in (55, 56, 57, 58)

Report Column Order:

- Member County Code & Description
- Billing Provider Specialty Code & Description
- Billing Provider Type Code & Description
- Encounter Amount

Report Column Grouping Order:

- Member County Code & Description
- Billing Provider Specialty Code and Description
- Billing Provider Type Code and Description

2.12.34.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.34.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Encounter Transportation	Report	Encounter Transportation

2.12.34.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Construction in Progress	07/18/2006
Ready for Model Office	08/10/2006
Model Office Implemented	08/14/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.35 Alternate Budget Model - 1441

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1441	Change Order		Data Warehouse			

2.12.35.1 Desired Solution
Develop the Alternate Budget Model Report according to specifications.

2.12.35.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.35.3 Technical Specifications
User Prompts:

- Paid Date Range

Table Row Selection Criteria:

- FFS Claims only
- Paid Claims only
- Paid Date per user input
- Accounting Code NOT in (G,H,I,J,K,L,1,6,7,8,9)

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Paid Month
- Category of Service
- KCHIP Flag
- Paid Amount
- Distinct Utilizers

Report Column Grouping Order:

- Paid Month
- Category of Service

Report Column Sort Order:

- Paid Month
- Category of Service

Frequency:

- Monthly

Priority:

- 1

Owner:

- Tammy Bullock / Justine Detzel / Don Moccia

2.12.35.4 Clarifications

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Alternate Budget Model report.

User Prompts:

- Payment Date Range

Table Row Selection Criteria:

- FFS Claims only
- Paid Claims only
- Payment Date per user input
- Accounting Code not being converted

Report Column Order:

- Payment Date (MM/YYY)
- State COS Code & Description
- KCHIP Flag (Calculated)
- Paid Amount
- Distinct Utilizers (Member Undup Count)

Report Column Grouping Order:

- Payment Date
- State COS Code & Description

Report Column Sort Order:

- Payment Date
- State COS Code & Description

2.12.35.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.35.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Alternate Budget Model	Report	Alternate Budget Model

2.12.35.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Construction in Progress	07/18/2006
Ready for Model Office	08/14/2006
Model Office Implemented	08/18/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.36 Breast and Cervical Cancer Memb - 1442

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1442	Change Order		Data Warehouse			

2.12.36.1 Desired Solution
Develop the Breast and Cervical Cancer Member Report according to specifications.

2.12.36.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.36.3 Technical Specifications
User Prompts:

- Member Eligibility Begin Date less than or equal to user input
- Member Eligibility End Date greater than or equal to user input

Table Row Selection Criteria:

- Member Eligibility Begin Date per user input
- Member Eligibility End Date per user input
- Member Program Code equal to 'V'

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Original Member ID
- Member Last Name in Full
- Member First Name in Full
- Member Middle Initial
- Member County

Report Column Grouping Order:

- None

Report Column Sort Order:

- None

Frequency:

- On Demand

Priority:

- 5

Owner:

- Tammy Bullock

2.12.36.4 Clarifications

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Breast and Cervical Cancer Member report.

User Prompts:

- Aid Eligibility Date Range

Table Row Selection Criteria:

- Beginning Aid Eligibility Date per user input
- Ending Aid Eligibility Date per user input
- Aid Code = 'X' (DSS Adm MA Chld Title IV-E Pay)

Report Column Order:

- Member ID
- Last Name
- First Name
- Middle Initial
- Current Address County Description

2.12.36.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.36.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Breast and Cervical Cancer Member	Report	Breast and Cervical Cancer Member

2.12.36.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Construction in Progress	07/18/2006
Ready for Model Office	08/14/2006
Model Office Implemented	08/18/2006
UAT Implemented	11/01/2006

Status	Date
Prod Implemented	06/14/2007

2.12.37 Central Baptist Neonatal Claims - 1443

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1443	Change Order		Data Warehouse			

2.12.37.1 Desired Solution
Develop the Central Baptist Neonatal Claims Report according to specifications.

2.12.37.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.37.3 Technical Specifications
User Prompts:

- Paid Date Range

Table Row Selection Criteria:

- Paid Date per user input
- Bill Provider Number is equal to '0101256600'
- DRG Number is between '0385' and '0390'

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Transaction Control Number
- Original Member ID
- Admission Date
- Claim Paid Amount
- Paid Date
- DRG Number
- Member Age
- Member Birth Date

Report Column Grouping Order:

- None

Report Column Sort Order:

- None

Frequency:

- Semi Annual

Priority:

- 5

Owner:

- Harriet Devore

2.12.37.4 Clarifications

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Central Baptist Neonatal Claims report.

NOTE TO TESTER: Criteria 'Billing Provider Number = Central Baptist Hosp' needs to be tested that the number remains as '0101256600' and the number is a Base Number.

User Prompts:

- Payment Date Range

Table Row Selection Criteria:

- Payment Date per user input
- Billing Provider Base Number = '0101256600'
- DRG Code - between '385' and '390'
- Latest Claims Only
- Paid Claims Only
- FFS Only

Report Column Order:

- ICN
- Member ID
- Admission Date
- Paid Amount
- Payment Date
- DRG Code & Description
- Member Age
- Member Date of Birth

2.12.37.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.37.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Central Baptist Neonatal Claims	Report	Central Baptist Neonatal Claims

2.12.37.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Construction in Progress	07/18/2006
Ready for Model Office	08/15/2006
Model Office Implemented	08/25/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.38 Drug Utilization Report - 1444

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1444	Change Order		Data Warehouse			

2.12.38.1 Desired Solution
Develop the Drug Utilization Report according to specifications.

2.12.38.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.38.3 Technical Specifications
User Prompts:

- Drug Code
- Paid Date Range
- Bill Provider ID

Table Row Selection Criteria:

- Paid Date Range per user input
- Billing Provider ID per user input
- Accounting Code equal to 0
- NDC Code in the list of drug codes entered by the user.

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Drug Code
- Billing Provider Number
- Original Member ID
- First Date of Service
- Paid Date
- Drug Quantity
- Total Claim Charge
- Claim Pay Amount
- Transaction Control Number
- Prescription Number
- Days Supplied

- Third Party Payment Amount
- Member Name in Full

Report Column Grouping Order:

- None

Report Column Sort Order:

- None

Frequency:

- On Demand

Priority:

- 3

Owner:

- Evette Patton

2.12.38.4 Clarifications

Action item for Ashish Virmani per 10/25/2005 meeting minutes: Follow up with the need of Drug Utilization report with Zack Ramsey for Interim DSS. Report owner is out indefinitely.

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Drug Utilization report.

NOTE: Transition report used 'Net Billed Amount', which is difference between total claim charges and all non-covered charges. Since we are not converting 'Non Coveraged Charges', we are using 'Billed Amount' for this report.

User Prompts:

- NDC Code
- Payment Date Range
- Billing Provider Numbers

Table Row Selection Criteria:

- Payment Date Range per user input
- Billing Provider Base, Medicaid or NPI Number(s) per user input
- NDC Code(s) per user input
- Accounting Code not being converted

Report Column Order:

- NDC Code & Description

- Billing Provider Numbers
- Member ID
- From Date of Service
- Payment Date
- Quantity Dispensed
- Billed Amount
- Paid Amount
- ICN
- Prescription Number
- Days Supply
- Third Party Payment Amount

2.12.38.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.38.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Drug Utilization	Report	Drug Utilization

2.12.38.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Construction in Progress	07/18/2006
Ready for Model Office	08/16/2006
Model Office Implemented	08/25/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.39 Hospice Total Inpatient Days - 1445

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1445	Change Order		Data Warehouse			

2.12.39.1 Desired Solution
Develop the Hospice Total Inpatient Days Report according to specifications.

2.12.39.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.39.3 Technical Specifications
User Prompts:

- First Date of Service Range

Table Row Selection Criteria:

- First Date of Service per user input
- Last Date of Service per user input
- Bill Provider Type equal to 44 (Hospice)
- Latest Claims only
- Revenue Code in (655,656)

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Revenue Code Description
- Billing Provider ID
- Billed Quantity
- Paid Amount
- Transaction Control Number

Report Column Grouping Order:

- None

Report Column Sort Order:

- None

Frequency:

- Semi Annual

Priority:

- 5

Owner:

- Kristina Hayden

2.12.39.4 Clarifications

Action item for Francis Wise per 10/25/2005 meeting minutes: Follow up with Kristina Hayden regarding any changes needed for this report.

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Hospice Total Inpatient Days report.

NOTE TO TESTER: There was not enough data in development to refresh report with the following selection criteria.

User Prompts:

- From Date(s) of Service
- To Date(s) of Service

Table Row Selection Criteria:

- From Date of Service
- To Date of Service
- Billing Provider Type Code = 44 (Hospice)
- Latest Claims only
- Home Health Claims only (Claim type = H)
- Revenue Code in (0655,0656)

Report Column Order:

- Revenue Code & Description
- Billing Provider Numbers
- Billed Quantity
- Paid Amount
- ICN

2.12.39.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.39.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Hospice Total Inpatient Days	Report	Hospice Total Inpatient Days

2.12.39.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Construction in Progress	07/18/2006
Ready for Model Office	08/15/2006
Model Office Implemented	08/25/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.40 Hospice Total Days - 1446

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1446	Change Order		Data Warehouse			

2.12.40.1 Desired Solution
Develop the Hospice Total Days Report according to specifications.

2.12.40.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.40.3 Technical Specifications
User Prompts:

- First Date of Service Range
- Last Date of Service Range

Table Row Selection Criteria:

- Latest Claims only
- First Date of Service per user input
- Revenue Code in (651,652,655,656,155,183,185,182,184)
- Bill Provider Type equal to 44 (Hospice)

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Revenue Code Description
- Billing Provider ID
- Billed Quantity
- Paid Amount
- Transaction Control Number
- First Date of Service
- Last Date of Service
- Original Member ID

Report Column Grouping Order:

- None

Report Column Sort Order:

- None

Frequency:

- Semi Annual

Priority:

- 5

Owner:

- Kristina Hayden

2.12.40.4 Clarifications

Action item for Francis Wise per 10/25/2005 meeting minutes: Follow up with Kristina Hayden regarding any changes needed for this report.

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Hospice Total Days report.

NOTE TO TESTER: There was not enough data in development to refresh this report with the following selection criteria.

User Prompts:

- From Date of Service Range
- To Date of Service Range

Table Row Selection Criteria:

- Latest Claims only
- Home Health Claims only (Claim type = H)
- From Date of Service per user input
- To Date of Service per user input
- Revenue Code in (0651,0652,0655,0656,0155,0183,0185,0182,0184)
- Billing Provider Type Code = 44 (Hospice)

Report Column Order:

- Revenue Code & Description
- Billing Provider Numbers
- Billed Quantity
- Paid Amount
- Encounter Amount
- ICN
- From Date of Service
- To Date of Service

- Member ID

2.12.40.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.40.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Hospice Total Days	Report	Hospice Total Days

2.12.40.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Construction in Progress	07/18/2006
Ready for Model Office	08/15/2006
Model Office Implemented	08/25/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.41 QIO Monitoring - 1447

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1447	Change Order		Data Warehouse			

2.12.41.1 Desired Solution
Develop the QIO Monitoring Report according to specifications.

2.12.41.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.41.3 Technical Specifications
User Prompts:

- First Date of Service Range
- Last Date of Service Range

Table Row Selection Criteria:

- FFS Claims only
- Latest Claims only
- First Date of Service per user input
- Last Date of Service per user input
- Bill Provider ID per user input

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Revenue Code Description
- Billed Amount
- Billed Quantity
- Transaction Control Number
- First Date of Service
- Last Date of Service
- Member Case Name
- Original Member ID
- Billing Provider Number
- Paid Amount

Report Column Grouping Order:

- None

Report Column Sort Order:

- Original Member ID
- Transaction Control Number
- Last Date of Service

Frequency:

- Unknown

Priority:

- 5

Owner:

- Kristina Hayden

2.12.41.4 Clarifications

Action item for Francis Wise per 10/25/2005 meeting minutes: Follow up with Kristina Hayden regarding any changes needed for this report.

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the PRO Monitoring report.

User Prompts:

- From Date of Service Range
- To Date of Service Range

Table Row Selection Criteria:

- FFS Claims only
- Latest Claims only
- From Date of Service Range per user input
- To Date of Service range per user input
- Billing Provider Base, Medicaid or NPI Number per user input

Report Column Order:

- Revenue Code & Description
- Billed Amount
- Billed Quantity
- ICN
- From Date of Service

- To Date of Service
- Member Case Name (L, FM)
- Member ID
- Billing Provider Numbers
- Paid Amount

Report Column Grouping Order:

- None

Report Column Sort Order:

- Member ID
- ICN
- To Date of Service

2.12.41.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.41.6 Associated System Objects

Technical Name	Object Type	Title
DSS - QIO Monitoring	Report	QIO Monitoring

2.12.41.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Construction in Progress	07/18/2006
Ready for Model Office	08/15/2006
Model Office Implemented	08/25/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.42 IMPACT DCBS - 1448

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1448	Change Order		Data Warehouse			

2.12.42.1 Desired Solution
Develop the IMPACT DCBS Report according to specifications.

2.12.42.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.42.3 Technical Specifications
User Prompts:

- Paid Date
- Bill Provider ID

Table Row Selection Criteria:

- Paid Date per user input
- Bill Provider Number per user input

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Billing Provider ID
- Claim Paid Amount
- Paid Date

Report Column Grouping Order:

- Bill Provider ID
- Paid Date

Report Column Sort Order:

- Paid Date

Frequency:

- On Demand

Priority:

- 3

Owner:

- Kim Stinetorf

2.12.42.4 Clarifications

This report will need changes per the 10/25/2005 meeting minutes. Action item for Kurt Godshall per 10/25/2005 meeting minutes: Follow up with Kim Stinetorf regarding any change to this report.

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Impact DCBS report.

User Prompts:

- Payment Date
- Billing Provider Base, Medicaid or NPI Number

Table Row Selection Criteria:

- Payment Date(s) per user input
- Billing Provider Base, Medicaid or NPI Numbers(s) per user input

Report Column Order:

- Billing Provider Numbers
- Paid Amount
- Payment Date

Report Column Grouping Order:

- Billing Provider Numbers
- Payment Date

Report Column Sort Order:

- Payment Date

2.12.42.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.42.6 Associated System Objects

Technical Name	Object Type	Title
DSS - IMPACT DCBS	Report	IMPACT DCBS

2.12.42.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006

Status	Date
Ready for Model Office	07/12/2006
Model Office Implemented	07/14/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.43 Medicaid Eligible Children - 1450

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1450	Change Order		Data Warehouse			

2.12.43.1 Desired Solution
Develop the Medicaid Eligible Children Report according to specifications.

2.12.43.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.43.3 Technical Specifications
User Prompts:

- Member Eligibility Begin Date less than or equal to User Input
- Member Eligibility End Date greater than or equal to User Input
- Member Birth Date
- Program Code

Table Row Selection Criteria:

- Medicaid Flag equal to 'Y'
- Member Eligibility Begin Date per user input
- Member Eligibility End Date per user input
- Member Age (Member Eligibility End Date minus Member Date Of Birth) <= 18

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Member Race Code Description
- Member Age
- KCHIP Flag
- Original Member ID Count

Report Column Grouping Order:

- Member Race Code Description
- Member Age
- Program Code
- Member Status

Report Column Sort Order:

- None

Frequency:

- On Demand

Priority:

- 3

Owner:

- Don Moccia

2.12.43.4 Clarifications

This report will need changes per the 10/25/2005 meeting minutes.

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Medicaid Eligible Children report.

User Prompts:

- Aid Category Effective Date less than or equal to User Input
- Aid Category Begin Effective Date greater than or equal to User Input
- Current Age (doesn't give you a user prompt as in old universe)
- Aid Code

Table Row Selection Criteria:

- Medicaid Flag is not in the new universe.
- Aid Category Effective Date per user input
- Aid Category Effective Date per user input
- Current Age

Report Column Order:

- Race Description
- Current Age
- KCHIP Flag - Same ? this is a calculated field (If (InList ("I" ,"P" ,"KC") And (InList ("M4" ,"M5" ,"M6" ,"M7" ,"P4" ,"P5" ,"P6" ,"P7"))) Then "Y" Else "N"
- Member Count

Report Column Grouping Order:

- Race Description
- Current Age
- Aid Code

- Member Status Code

2.12.43.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.43.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Medicaid Eligible Children	Report	Medicaid Eligible Children

2.12.43.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Ready for Model Office	07/14/2006
Model Office Implemented	07/24/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.44 Non Actual Budget Model - 1451

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1451	Change Order		Data Warehouse			

2.12.44.1 Desired Solution
Develop the Non Actual Budget Estimate Report according to specifications.

2.12.44.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.44.3 Technical Specifications
User Prompts:

- Paid Date Range
- Adjudication Date Range

Table Row Selection Criteria:

- FFS Claims only
- Accounting Code NOT in (G,H,I,J,K,L,1,6,7,8,9)
- Bill Provider Category of Service in (24,26,29)
- Paid Date per user input
- Date of Adjudication per user input

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Bill Provider Category of Service
- Paid Amount
- Original Member ID distinct Count

Report Column Grouping Order:

- Bill Provider Category of Service

Report Column Sort Order:

- None

Frequency:

- Monthly

Priority:

- 1

Owner:

- Tammy Bullock / Justine Detzel / Don Moccia

2.12.44.4 Clarifications

Action item for Kurt Godshall per the 10/25/2005 meeting minutes: Follow up with Justine Detzel regarding any changes needed for this report.

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Non Actual Budget Model report.

User Prompts:

- Payment Date Range
- Adjudication Date not in the new universe

Table Row Selection Criteria:

- FFS Claims only
- Accounting Code not in the new universe
- State COS Code in (24,26,29)
- Payment Date Range per user input
- Date of Adjudication not in the new universe

Report Column Order:

- State COS Code & Description
- Paid Amount
- Member Undup Count

Report Column Grouping Order:

- State COS Code & Description

2.12.44.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.44.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Non Actual Budget Model	Report	Non Actual Budget Model

2.12.44.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006

Status	Date
Ready for Model Office	07/17/2006
Model Office Implemented	07/24/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.45 Ray Prior Auth - 1452

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1452	Change Order		Data Warehouse			

2.12.45.1 Desired Solution
Develop the Ray Prior Authorization Report according to specifications.

2.12.45.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.45.3 Technical Specifications
User Prompts:

- Authorization End Date

Table Row Selection Criteria:

- Authorization End Date per user input
- Waiver Code equal to A

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- End Date
- Provider Number
- Original Member ID

Report Column Grouping Order:

- Provider Number
- Original Member ID
- End Date

Report Column Sort Order:

- Provider Number
- Original Member ID

Frequency:

- On Demand

Priority:

- 3

Owner:

- Kim Stinetorf

2.12.45.4 Clarifications

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Ray Prior Auth report.

User Prompts:

- Authorization Prior Auth End Date

Table Row Selection Criteria:

- No pre-defined filter for Authorization End Date, used dimension `Authorization Prior Auth End Date? to create a User Prompt
- Assignment Code = 50 (SCL Waiver)

Report Column Order:

- Authorization Prior Auth End Date
- Requesting Provider Medicaid Number
- Member ID

Report Column Grouping Order:

- Requesting Provider Medicaid Number
- Member ID
- Authorization Prior Auth End Date

Report Column Sort Order:

- Requesting Provider Medicaid Number
- Member ID

2.12.45.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.45.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Ray Prior Auth	Report	Ray Prior Auth

2.12.45.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Ready for Model Office	07/17/2006

Status	Date
Model Office Implemented	07/24/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.46 SCL 2005 - 1453

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1453	Change Order		Data Warehouse			

2.12.46.1 Desired Solution
Develop the SCL 2005 Report according to specifications.

2.12.46.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.46.3 Technical Specifications
User Prompts:

- First Date of Service Range

Table Row Selection Criteria:

- First Date of Service Range per user input
- Bill Provider Type equal to 33

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Paid Amount
- Member Distinct Count
- Procedure Code and Description
- Revenue Code and Description
- Billed Quantity

Report Column Grouping Order:

- Procedure Code and Description
- Revenue Code and Description

Report Column Sort Order:

- None

Frequency:

- On Demand

Priority:

- 2

Owner:

- Kim Stinetorf

2.12.46.4 Clarifications

Action item for Kurt Godshall per 10/25/2005 meeting minutes: Follow up with Kim Stinetorf regarding any change to this report.

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the SCL 2005 report.

User Prompts:

- From Date of Service Range

Table Row Selection Criteria:

- From Date of Service Range per user input
- Billing Provider Type Code equal to 33(SCL)

Report Column Order:

- Paid Amount
- Member Undup Count
- Primary Procedure Code & Desc
- Revenue Code & Description
- Billed Quantity

2.12.46.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.46.6 Associated System Objects

Technical Name	Object Type	Title
DSS - SCL 2005	Report	SCL 2005

2.12.46.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Ready for Model Office	07/17/2006
Model Office Implemented	07/24/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.47 Accounts Payable Closing Package - 1454

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1454	Change Order		Data Warehouse			

2.12.47.1 Desired Solution
Develop the Accounts Payable Closing Package Report according to specifications.

2.12.47.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.47.3 Technical Specifications
User Prompts:

- First Date of Service less than or equal to User Input
- Paid Date Range

Table Row Selection Criteria:

- FFS Claims
- Original Claims
- Paid Claims
- First Date of Service <= user input
- Paid Date range per user input
- Claim Credit Indicator not equal to Y

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Paid Month
- Paid Amount
- ICN Distinct Count

Report Column Grouping Order:

- Paid Month

Report Column Sort Order:

- Paid Month

Frequency:

- Annual

Priority:

- 5

Owner:

- Steve Bechtel

2.12.47.4 Clarifications

This report may need to be changed. Report owner is out indefinitely.

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Accounts Payable Closing Package report.

User Prompts:

- From Date of Service <= user input
- Payment Date Range

Table Row Selection Criteria:

- FFS Claims
- Paid Claims
- From Date of Service <= user input
- Payment Date range per user input
- Adjust/Void Code not equal to Y

Report Column Order:

- Payment Date
- Paid Amount
- ICN Undup Count

2.12.47.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.47.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Accounts Payable Closing Package	Report	Accounts Payable Closing Package

2.12.47.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Ready for Model Office	07/18/2006

Status	Date
Model Office Implemented	07/24/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.48 Medicaid Member History Request - 1455

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1455	Change Order		Data Warehouse			

2.12.48.1 Desired Solution
Develop the Medicaid Member History Request Report according to specifications.

2.12.48.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.48.3 Technical Specifications
User Prompts:

- First Date of Service Range
- Member ID

Table Row Selection Criteria:

- FFS Claims only
- Latest Claims only
- Paid Claims only
- Member ID per user input
- Dates of Service per user input

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Transaction Control Number
- Provider Phone Number
- Provider Full Name
- Billing Provider Full Address
- First Date of Service
- Revenue Code Description
- Procedure Code Description
- Diagnosis Code1 Description
- Billed Date
- Billed Amount
- Paid Amount

- Paid Date

Report Column Grouping Order:

- None

Report Column Sort Order:

- Date of Service

Frequency:

- Monthly

Priority:

- 1

Owner:

- Della Mazzoni

2.12.48.4 Clarifications

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Medicaid Member History Request report.

User Prompts:

- From Date of Service Range
- Member ID

Table Row Selection Criteria:

- FFS Claims only
- Latest Claims only
- Paid Claims only
- Member ID per user input
- From Date of Service Range per user input

Report Column Order:

- ICN
- Phone Number
- Billing Provider Name
- Billing Provider Full Address (concatenate Full Street Address - Billing Addr+City, State and Zip - Billing Addr)
- From Date of Service

- Revenue Code & Description
- Primary Procedure Code & Desc
- Primary Diagnosis Code & Desc
- Claim Date
- Billed Amount
- Paid Amount
- Payment Date

Removed FFS Claims Only filter as per Della Mazzoni request

2.12.48.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.48.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Medicaid Member History Request	Report	Medicaid Member History Request

2.12.48.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Ready for Model Office	07/18/2006
Model Office Implemented	08/07/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.49 Dental Access Report - 1456

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1456	Change Order		Data Warehouse			

2.12.49.1 Desired Solution
Develop the Dental Access Report according to specifications.

2.12.49.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.49.3 Technical Specifications
User Prompts:

- First Date of Service Range

Table Row Selection Criteria:

- First date of service range per user input
- Fee for service only
- Latest claims only
- Billing provider type is 56, 60, or 61 and specialty is 56
- Member age less than 21
- Paid claims only

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section)

- County Description
- Total Population
- Licensed Dentists
- Enrolled Dentists
- Billing Dentists
- Total Eligible Members
- Client/Provider Ratio
- Eligible Members under 21
- Under 21 receive dental care Spec 56
- Under 21 receive dental care Spec 08
- Under 21 receive dental care Spec 80

- Under 21 receive dental care Spec 88
- Unduplicated Members under 21
- % of members under 21 receive care
- Eligible members 21 and older
- 21 & over Rec'v Dental Care other than Spec.56
- 21 & over Rec'v Dental Care Spec.56
- Undup. Members 21 & over
- % of Members 21 and over rec'v Care

Report Column Grouping Order:

- None

Report Column Sort Order:

- None

Frequency:

- Quarterly/Semi-Annually/Annually

Priority:

- 5

Owner:

- Charles Douglass

2.12.49.4 Clarifications

This report may need to be changed. How will the census data get updated?

Per my walkthrough and analysis, the updated report specs, for the DDI version of the Dental Access report, is located under Supplemental Documentation, CO1456 Change Order Clarifications.doc.

2.12.49.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.49.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Dental Access	Report	Dental Access

2.12.49.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Construction in Progress	07/18/2006
Ready for Model Office	08/01/2006
Model Office Implemented	08/07/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.50 Hospital Inpatient Paid Days - 1457

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1457	Change Order		Data Warehouse			

2.12.50.1 Desired Solution
Develop the Hospital Inpatient Paid Days Report according to specifications.

2.12.50.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.50.3 Technical Specifications
User Prompts:

- First Date of Service Range
- Bill Provider ID

Table Row Selection Criteria:

- FFS Claims only
- Paid Claims only
- Latest Claims only
- Type bill not equal to '110'
- Billing Provider ID per user input
- First Date of Service per user input
- Bill Provider Type equal to (01,02,92, or 93)

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Billing Provider ID
- Covered Days

Report Column Grouping Order:

- Bill Provider ID

Report Column Sort Order:

- None

Frequency:

- Monthly

Priority:

- 1

Owner:

- Harriet Devore

2.12.50.4 Clarifications

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Hospital Inpatient Paid Days report.

User Prompts:

- From Date of Service Range
- Billing Provider Base, Medicaid or NPI Numbers

Table Row Selection Criteria:

- FFS Claims only
- Paid Claims only
- Latest Claims only
- Type of Bill Code not equal to '110'
- Billing Provider Base, Medicaid or NPI Number's per user input
- From Date of Service per user input
- Billing Provider Type Code in list (01,02)
- Claim Type=I (Inpatient Claims)

Report Column Order:

- Billing Provider Numbers
- Covered Days

2.12.50.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.50.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Hospital Inpatient Paid Days	Report	Hospital Inpatient Paid Days

2.12.50.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006

Status	Date
Construction in Progress	07/18/2006
Ready for Model Office	08/01/2006
Model Office Implemented	08/07/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.51 KenPAC Member History - 1458

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1458	Change Order		Data Warehouse			

2.12.51.1 Desired Solution
Develop the KenPAC Member History Report according to specifications.

2.12.51.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.51.3 Technical Specifications
User Prompts:

- Member County Code
- First Date of Service Range
- Billing Provider Type
- Billing Provider ID
- Member County Code
- Original Member ID
- Diagnosis Code

Table Row Selection Criteria:

- County Code per user input
- First Date of Service per user input
- Billing Provider Type
- Billing Provider ID
- Member County Code
- Original Member ID
- Diagnosis Code

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Member County Description
- Transaction Control Number
- Billing Provider Full Name
- Procedure Code Description

- Type of Service
- Prescribing Provider Full Name
- Member SSN
- Member Full Name
- Member Birth Date
- Member Telephone
- Member Full Address
- NDC Code and Description
- Diagnosis Code1 and Description
- Diagnosis Code2 and Description
- Billed Date
- Paid Date
- Billing Provider Phone #
- Billing Provider Full Address
- Paid Amount
- Billed Amount

Report Column Grouping Order:

- None

Report Column Sort Order:

- Member County Description

Frequency:

- On Demand

Priority:

- 5

Owner:

- April Ruble

2.12.51.4 Clarifications

This report will need changes per the 10/25/2005 meeting minutes. Action item for Kurt Godshall per 10/25/2005 meeting minutes: Follow up with April Ruble regarding any change to this report.

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the KenPAC Member History report.

User Prompts:

- Member County Code(s)
- From Date of Service Range
- Billing Provider Type Code(s)
- Billing Provider Base, Medicaid or NPI Number(s)
- Member ID(s)
- Primary Diagnosis Code(s)

Table Row Selection Criteria:

- Member County Code per user input
- From Date of Service per user input
- Billing Provider Type Code
- Billing Provider Base, Medicaid or NPI Number
- Member County Code
- Member ID
- Primary Diagnosis Code
- Latest Claim Only

Report Column Order:

- Member County Code & Description
- ICN
- Claim Type
- Claim Indicator
- Billing Provider Name
- Primary Procedure Code & Desc
- State COS Code & Description
- Referring Provider Name
- Member SSN
- Member Full Name FML

- Member Date of Birth
- Member Phone Number
- Member Full Address
- NDC Code & Description
- Primary Diagnosis Code & Desc
- Secondary Diagnosis Code & Desc
- Claim Date
- Payment Date
- Phone Number
- Billing Provider Full Address
- Paid Amount
- Billed Amount

2.12.51.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.51.6 Associated System Objects

Technical Name	Object Type	Title
DSS - KenPAC Member History	Report	KenPAC Member History

2.12.51.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	07/10/2006
Construction in Progress	07/18/2006
Ready for Model Office	08/08/2006
Model Office Implemented	08/14/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.52 Paid Claims History - 1459

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1459	Change Order		Data Warehouse			

2.12.52.1 Desired Solution
Develop the Paid Claims History Report according to specifications.

2.12.52.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.52.3 Technical Specifications
User Prompts:

- Member ID
- First Date of Service Range

Table Row Selection Criteria:

- FFS Claims only
- Latest Claims only
- Member ID per user input
- First Date of Service per user input

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Billing Provider Full Name
- Billing Provider Full Address
- First Date of Service
- Last Date of Service
- Medicare Submitted
- Diagnosis Code Description
- Procedure Description
- Paid Amount
- Paid Date

Report Column Grouping Order:

- Billing Provider Full Name
- Billing Provider Full Address
- First Date of Service

- Last Date of Service
- Medicare Submitted
- Diagnosis Code Description
- Procedure Description
- Paid Amount
- Paid Date

Report Column Sort Order:

- None

Frequency:

- Monthly

Priority:

- 1

Owner:

- Kurt Godshall

2.12.52.4 Clarifications

Action item for Kurt Godshall per 10/25/2005 meeting minutes: Follow up with Kim Stinetorf regarding any change to this report.

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Paid Claims History report.

User Prompts:

- Member ID
- From Date of Service Range

Table Row Selection Criteria:

- FFS Claims only
- Latest Claims only
- Member ID per user input
- From Date of Service per user input

Report Column Order:

- Billing Provider Name
- Billing Provider Full Address

- From Date of Service
- To Date of Service
- Medicare Submitted
- Primary Diagnosis Code & Desc
- Primary Procedure Code & Desc
- Paid Amount
- Payment Date

Report Column Grouping Order:

- Billing Provider Name
- Billing Provider Full Address
- From Date of Service
- To Date of Service
- Medicare Submitted
- Primary Diagnosis Code & Desc
- Primary Procedure Code & Desc
- Paid Amount
- Payment Date

2.12.52.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.52.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Paid Claims History	Report	Paid Claims History

2.12.52.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	08/21/2006
Construction in Progress	08/22/2006
Ready for Model Office	08/25/2006

Status	Date
Model Office Implemented	09/05/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.53 Provider History - 1460

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1460	Change Order		Data Warehouse			

2.12.53.1 Desired Solution
Develop the Provider History Report according to specifications.

2.12.53.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.53.3 Technical Specifications
Update 8/2/06 - COs 359 and 630 in Transition system result in changes to this report's specifications. These changes are noted in the Clarifications section of this CO.

User Prompts:

- Date of Service Range
- Paid Dates Range
- Billing Provider ID
- Original Member ID

Table Row Selection Criteria:

- FFS Claims only
- Latest Claims only
- Billing Provider ID per user input
- Original Member ID per user input
- Dates of Service Range per user input
- Paid Dates Range per user input

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Procedure Code and Description
- First Date of Service
- Transaction Control Number
- Paid Date
- Diagnosis Code and Description
- Remittance Advice Number
- Warrant Number

- Transportation Voucher Number
- Billed Amount
- Paid Amount

Report Column Grouping Order:

- Procedure Code and Description
- First Date of Service
- Transaction Control Number
- Paid Date
- Diagnosis Code and Description
- Remittance Advice Number
- Warrant Number
- Transportation Voucher Number

Report Column Sort Order:

- Date of Service

Frequency:

- On Demand

Priority:

- 3

Owner:

- Kim Stinetorf

2.12.53.4 Clarifications

Action item for Kurt Godshall per 10/25/2005 meeting minutes: Follow up with Kim Stinetorf regarding any change to this report.

Changes to this report has been documented in COs 359 and 630 in the Transition project workbook. Also, make sure to look at production version of this report in the Interim DSS for reference or clarification. --SLam

Add fields:

- Detail Number
- Last Date of Service
- Billed Quantity

Delete fields:

- Paid Date
- Diagnosis Code 1 Description
- Remittance
- Warrant Number
- Transportation Voucher Number
- Billed Amount

Fields should be displayed in the following order on the report:

- Detail Number
- ICN
- Procedure Description
- First Date of Service
- Last Date of Service
- Paid Amount
- Billed Quantity

Sort by:

- Procedure Code, then First Date of Service for each Member requested.

Per my walkthrough and analysis 8/25/06 (SLeonard), these are the updated report specs for the DDI version of the Provider History report.

User Prompts:

- From Date of Service Range
- Billing Provider Number(s)
- Member ID

Table Row Selection Criteria:

- FFS Claims only
- Latest Claims only
- Billing Provider Numbers per user input
- Member IDs per user input
- From Date of Service Range per user input

Report Column Order:

- ICN
- Detail Number
- Primary Procedure Code & Desc
- From Date of Service
- To Date of Service
- Paid Amount
- Billed Quantity

Report Column Sort Order:

- Primary Procedure Code & Desc
- From Date of Service

Report Row Grouping:

- Billing Provider Number and Billing Provider Name
- Member ID and Member Full Name

2.12.53.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.53.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Provider History	Report	Provider History

2.12.53.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	08/21/2006
Construction in Progress	08/22/2006
Ready for Model Office	08/25/2006
Model Office Implemented	09/05/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.54 Support for Comm Living Member - 1461

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1461	Change Order		Data Warehouse			

2.12.54.1 Desired Solution
Develop the Support for Community Living Member Report according to specifications.

2.12.54.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.54.3 Technical Specifications
User Prompts:

- Dates of Service Range
- Paid Dates Range
- Billing Provider ID

Table Row Selection Criteria:

- Latest Claims only
- Dates of Service Range
- Paid Dates Range
- Billing Provider Number per user input
- Billing Provider Type equal to 33

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Billing Provider ID
- Billing Provider Full Name
- Member ID
- Original Member ID
- Member Full Name

Report Column Grouping Order:

- None

Report Column Sort Order:

- None

Frequency:

- Monthly

Priority:

- 1

Owner:

- Kim Stinetorf

2.12.54.4 Clarifications

Action item for Kurt Godshall per 10/25/2005 meeting minutes: Follow up with Kim Stinetorf regarding any change to this report.

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Support for Community Living Member report.

NOTE TO TESTER: There was insufficient data in development to refresh report with the following selection criteria.

User Prompts:

- From Date of Service Range
- Payment Date Range
- Billing Provider Numbers

Table Row Selection Criteria:

- Latest Claims only
- From Date of Service Range
- Payment Date Range
- Billing Provider Number(s) per user input
- Billing Provider Type Code equal to 33 (SCL)

Report Column Order:

- Billing Provider Numbers
- Billing Provider Name
- Member ID
- Member Full Name (L, FM)

2.12.54.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.54.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Support for Community Living Member	Report	Support for Community Living Member

2.12.54.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	08/21/2006
Construction in Progress	08/23/2006
Ready for Model Office	08/25/2006
Model Office Implemented	09/05/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.55 Member History Request - 1463

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1463	Change Order		Data Warehouse			

2.12.55.1 Desired Solution
Develop the Member History Request Report according to specifications.

2.12.55.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.55.3 Technical Specifications
User Prompts:

- First Date of Service Range
- FFS Member Case Number

Table Row Selection Criteria:

- First Date of Service per user input
- FFS Member Case Number per user input
- Fee for Service only
- Paid Claims only

Report Column Order: (Some of these report columns may be moved out of the main report section and placed above the main report section as section headers)

- Member Case Number
- Member ID
- Original Member ID
- Member Full Name(LFM)
- First Date of Service
- Paid Amount

Report Column Grouping Order:

- Member Case Number
- Member ID
- Original Member ID
- Member Full Name(LFM)
- First Date of Service

Report Column Sort Order:

- None

Frequency:

- Monthly

Priority:

- 1

Owner:

- Della Mazzoni

2.12.55.4 Clarifications

Per my walkthrough and analysis, these are the updated report specs for the DDI version of the Member History Request report.

User Prompts:

- From Date of Service Range
- Member ID

Table Row Selection Criteria:

- From Date of Service per user input
- Member ID per user input
- Fee for Service only
- Paid Claims only

Report Column Order: Break on Member Case Record, Member ID and Member Full Name to get Paid Amount subtotals

- Member County/Case Record Number
- Member ID
- Member Full Name (L,FM)
- From Date of Service
- Paid Amount

Report Column Grouping Order:

- Member County/Case Record Number
- Member ID
- Member Full Name(L,FM)
- From Date of Service

2.12.55.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.55.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Member History Request	Report	Member History Request

2.12.55.7 Change Order Status

Status	Date
Change Order Written	10/31/2005
SE Assigned	08/21/2006
Construction in Progress	08/23/2006
Ready for Model Office	08/25/2006
Ready for Model Office	08/25/2006
Model Office Implemented	09/05/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.56 Hospice Total Dual Eligibles - 1468

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1468	Change Order		Data Warehouse			

2.12.56.1 Desired Solution
Develop the Hospice Total Dual Eligibles Report according to specifications.

2.12.56.2 Business Impact
This change order will meet the Requirement 30.050.015.002.6.

2.12.56.3 Technical Specifications
User Prompts:

- Need to be defined by the Commonwealth

Table Row Selection Criteria:

- Need to be defined by the Commonwealth

Report Column Order:

- Member ID
- Dual Eligible Flag
- Member Program Code
- Member Age
- Medicare ID
- Member Status

Report Column Grouping Order:

- Member ID
- Dual Eligible Flag
- Member Program Code
- Member Age
- Medicare ID
- Member Status

Report Column Sort Order:

- Member ID

Frequency:

- Semi Annual

Priority:

- N/A

Owner:

- Kristina Hayden (Kurt Godshall will work with the report owner to redefine the report specifications)

2.12.56.4 Clarifications

Action item for Kurt Godshall per 10/25/2005 meeting minutes: Follow up with Kristina Hayden to see if new report logic meets her needs.

Calculate dual eligibility indicator using the following formula: If (= ("Z")) Then "01" Else If (= ("ZL")) Then "05" Else If (= ("ZQ")) Then "06" Else If (= ("ZJ")) Then "07" Else If (= ("ZK")) Then "03" Else If (InList ("AA" , "BB" , "CC" ,"EE" , "GG" ,"HH" ,"MC" ,"ME" , "ZZ")) Then "02" Else If (InList ("L3" ,"L5" ,"S1" ,"S2" , "S7")) Then "04" Else If ((>64) And (Not (IsNull()))) Then "08" Else " "

Formula is still being determined, by Kurt. (9/11/06 SLeonard)

Spoke with Kurt Godshall 9/8/06 regarding fields wanted on report since I had this CO and CO68 from KY Transition PWB and a Business Object report as sources. After speaking with users, this was the data requested.

User Prompts:

- From Date of Service per user input

Table Row Selection Criteria:

- From Date of Service prompt
- Billing Provider Type Code = 44(Hospice)
- Latest Claims Only
- Revenue Code in (0655,0656)
- Home Health Care Only (Claim Type=H)
- Dual Eligibility Indicator = Y

Report Column Order:

- Revenue Code & Description
- Billing Provider Numbers
- Billed Quantity
- From Date of Service
- To Date of Service
- Member ID

- ICN

Report Column Grouping Order:

- N/A

Report Column Sort Order:

- Revenue Code & Description

2.12.56.5 Associated Requirements

Requirement ID	Type
30.050.015.002.6	RFP Requirement

2.12.56.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Hospice Total Dual Eligibles	Report	Hospice Total Dual Eligibles

2.12.56.7 Change Order Status

Status	Date
Change Order Written	11/01/2005
SE Assigned	08/21/2006
Construction in Progress	08/23/2006
Ready for Model Office	09/11/2006
Model Office Implemented	09/19/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.57 ETL (DI) - Pharmacy Claims - 1481

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1481	Change Order		Data Warehouse			

2.12.57.1 Desired Solution
ETL Pharmacy Claims - Using BusinessObjects Data Integrator

2.12.57.2 Business Impact
This change order extracts, transforms, and loads pharmacy claims data to support access of this data using the Business Objects reporting tool.

2.12.57.3 Technical Specifications
Set up the Autosys job script DSSJW400 to call the Business Objects Data Integrator Claims Analysis job flow. This job flow will pull the Weekly Fee for Service and Encounter paid and denied claims. The ETL process will then validate the dates, code, and text fields. This will be done for Professional, Dental, Institutional, and Pharmacy claim Data. This Change order deals with the Pharmacy portion of the process. See the mapping document (iCe_ClaimsAnalysisMapping.xls) in the Supplemental documentation for more information

2.12.57.4 Clarifications
No associated clarifications found.

2.12.57.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.57.6 Associated System Objects

Technical Name	Object Type	Title
DSSJWSTG	Batch Job	Claims Analysis Stage MMIS Claim History Tables
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)

2.12.57.7 Change Order Status

Status	Date
Change Order Written	11/03/2005
SE Assigned	01/04/2006
Construction in Progress	04/20/2006
Unit Test in Progress (obsolete)	06/02/2006

Status	Date
Ready for Model Office	08/07/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.58 ETL (DI) - Dental Claims - 1482

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1482	Change Order		Data Warehouse			

2.12.58.1 Desired Solution
ETL Dental Claims - Using BusinessObjects Data Integrator

2.12.58.2 Business Impact
This change order extracts, transforms, and loads dental claims data to support access of this data using the Business Objects reporting tool.

2.12.58.3 Technical Specifications
Set up the Autosys job script DSSJW400 to call the Business Objects Data Integrator Claims Analysis job flow. This job flow will pull the Weekly Fee for Service and Encounter paid and denied claims. The ETL process will then validate the dates, code, and text fields. This will be done for Professional, Dental, Institutional, and Pharmacy claim Data. This Change order deals with the Dental portion of the process. See the mapping document (iCe_ClaimsAnalysisMapping.xls) in the Supplemental documentation for more information

2.12.58.4 Clarifications
No associated clarifications found.

2.12.58.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.58.6 Associated System Objects

Technical Name	Object Type	Title
DSSJWSTG	Batch Job	Claims Analysis Stage MMIS Claim History Tables
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)

2.12.58.7 Change Order Status

Status	Date
Change Order Written	11/03/2005
SE Assigned	01/04/2006
Define/Analyze In Progress	01/05/2006
Design Complete	05/12/2006

Status	Date
Construction in Progress	05/13/2006
Ready for Model Office	08/02/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.59 ETL (DI) - Code Tables - 1483

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1483	Change Order		Data Warehouse			

2.12.59.1 Desired Solution
ETL Code Tables - Using BusinessObjects Data Integrator

2.12.59.2 Business Impact
This change order extracts, transforms, and loads the systems code tables to support access of this data using the Business Objects reporting tool.

2.12.59.3 Technical Specifications
The job truncates and reloads the Code tables in the DSS database. The ETL validates the dates, codes and text fields and inserts the default values when there is NULL data in the target. See the mapping document in the Supplemental documentation for more information.

2.12.59.4 Clarifications
No associated clarifications found.

2.12.59.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.59.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)
DSSJWCDE	Batch Job	Extract Code Tables from MMIS

2.12.59.7 Change Order Status

Status	Date
Change Order Written	11/03/2005
SE Assigned	02/16/2006
Define/Analyze In Progress	02/17/2006
Construction in Progress	03/16/2006
Ready for Model Office	07/26/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006

Status	Date
Prod Implemented	06/14/2007

2.12.60 ETL (DI) - EPSDT - 1485

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1485	Change Order		Data Warehouse			

2.12.60.1 Desired Solution
ETL EPSDT - Using BusinessObjects Data Integrator

2.12.60.2 Business Impact
This change order extracts, transforms, and Loads Early Periodic Screening Diagnosis and Treatment (EPSDT) data to support access of this data using the Business Objects reporting tool.

2.12.60.3 Technical Specifications
The job truncates and reloads the EPSDT tables in the DSS database. The ETL validates the dates, codes and text fields and inserts the default values when there is NULL data in the target. See the mapping document in the Supplemental documentation for more information.

2.12.60.4 Clarifications
No associated clarifications found.

2.12.60.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.60.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)
DSSJWEPS	Batch Job	Extract MMIS EPSDT Tables

2.12.60.7 Change Order Status

Status	Date
Change Order Written	11/03/2005
Construction in Progress	03/20/2006
Ready for Construction Walkthrough	06/22/2006
Ready for Model Office	06/30/2006
Model Office Implemented	09/22/2006

Status	Date
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.61 ETL (DI) - Managed Care - 1486

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1486	Change Order		Data Warehouse			

2.12.61.1 Desired Solution
ETL Managed care - Using BusinessObjects Data Integrator

2.12.61.2 Business Impact
This change order extracts, transforms, and loads Managed care data to support access of this data using the Business Objects reporting tool.

2.12.61.3 Technical Specifications
The job truncates and reloads the Managed Care tables in the DSS database. The ETL validates the dates, codes and text fields and inserts the default values when there is NULL data in the target. See the mapping document in the Supplemental documentation for more information.

2.12.61.4 Clarifications
No associated clarifications found.

2.12.61.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement

2.12.61.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)

2.12.61.7 Change Order Status

Status	Date
Change Order Written	11/03/2005
SE Assigned	03/06/2006
Define/Analyze In Progress	03/09/2006
Construction in Progress	04/05/2006
Ready for Model Office	07/26/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.62 ETL (DI) - Reference-Procedure - 1487

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1487	Change Order		Data Warehouse			

2.12.62.1 Desired Solution
ETL Reference - Procedure Codes - Using BusinessObjects Data Integrator

2.12.62.2 Business Impact
This change order extracts, transforms, and loads professional claims data to support access of this data using the Business Objects reporting tool.

2.12.62.3 Technical Specifications
The job truncates and reloads the Reference(procedure) tables in the DSS database. The ETL validates the dates, codes and text fields and inserts the default values when there is NULL data in the target. See the mapping document in the Supplemental documentation for more information.

2.12.62.4 Clarifications
No associated clarifications found.

2.12.62.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement

2.12.62.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)

2.12.62.7 Change Order Status

Status	Date
Change Order Written	11/03/2005
Construction in Progress	04/20/2006
Ready for Unit Test (obsolete)	06/02/2006
Unit Test in Progress (obsolete)	07/13/2006
Ready for Model Office	07/26/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.63 ETL (DI) - Reference-Drug - 1488

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1488	Change Order		Data Warehouse			

2.12.63.1 Desired Solution
ETL Drug data - Using BusinessObjects Data Integrator

2.12.63.2 Business Impact
This change order extracts, transforms, and loads drug data to support access of this data using the Business Objects reporting tool.

2.12.63.3 Technical Specifications
The job truncates and reloads the Reference(Drug) tables in the DSS database. The ETL validates the dates, codes and text fields and inserts the default values when there is NULL data in the target. See the mapping document in the Supplemental documentation for more information.

2.12.63.4 Clarifications
No associated clarifications found.

2.12.63.5 Associated Requirements

Requirement ID	Type
30.090.015.001.1	RFP Requirement

2.12.63.6 Associated System Objects

Technical Name	Object Type	Title
BusinessObjects: ETL- Data Integrator Enterprise (v.XI)	Program	BusinessObjects: ETL- Data Integrator Enterprise (v.XI)

2.12.63.7 Change Order Status

Status	Date
Change Order Written	11/03/2005
Construction in Progress	04/20/2006
Ready for Unit Test (obsolete)	06/02/2006
Unit Test in Progress (obsolete)	07/13/2006
Ready for Model Office	07/26/2006
Model Office Implemented	09/22/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.64 Develop Financial Universe - 1493

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1493	Change Order		Data Warehouse			

2.12.64.1 Desired Solution
Develop the Financial universe for access to the Financial data.

2.12.64.2 Business Impact
Users will have the ability to develop and execute queries against the Financial data carried in the data warehouse.

2.12.64.3 Technical Specifications
The Financial universe is created using BusinessObjects Designer. The classes, subclasses, and objects should be alphabetized.

These changes were as defined in Core CO 12026.

The following KY specific changes will need to be applied.

- Add Filters and indicators for Program codes: KenPAC & Passport.
- Replace references to 'Member' with 'Member'.

Based on CO 2624

- Add Table: T_CA_PROV_KEY:
- Remove IND_ON_REVIEW column and add CDE_REVIEW_TYPE
- Add CDE_PROV_PGM
- Add DSC_REVIEW_TYPE
- Add DSC_PROV_PGM

Based on Core Stabilization new CO 12442

- Add Table: T_CHECK_STATUS_HIST
- Remove Tables: T_CHECK_CLEARED, T_CHK_STALE_DATE

The following KY specific changes were applied to the Universe:

- Changed references to 'Member' or 'Recip' in objects and descriptions to 'Member'.
- Added objects for Provider Program Code and Provider Review Type Code to Provider Demographics class.
- Added T_PR_CDE_PROV_PGM, T_PR_CDE_REVIEW code tables to use for LOVs.
- Added object called Provider KenPAC Indicator where a Y or N will be plugged based on the value in the Provider Program Code column. 'KENP' will be a Y, everything else is a N.

- Added object called Provider Passport Indicator where a Y or N will be plugged based on the value in the Provider Program Code column. 'PART' will be a Y, everything else is a N.
- Created a filter under each provider class for KenPAC only providers.
- Created a filter under each provider class for Passport only providers.
- Removed Classes that referenced T_CHECK_CLEARED, T_CHK_STALE_DATE
- Added all objects for table T_CHECK_STATUS_HIST under Payment & Non Provider Information
- Added new object 'TPL Action Indicator' for table T_PUB_HLTH_PGM under 2 classes for Medical Assistance Programs.

2.12.64.4 Clarifications

No associated clarifications found.

2.12.64.5 Associated Requirements

Requirement ID	Type
30.050.015.002.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.64.6 Associated System Objects

Technical Name	Object Type	Title
Financial.unv	DSS Universe	Financial Universe

2.12.64.7 Change Order Status

Status	Date
Change Order Written	11/04/2005
Construction in Progress	06/23/2006
Ready for Construction Walkthrough	07/05/2006
Ready for Model Office	07/05/2006
Model Office Implemented	07/25/2006
UAT Implemented	11/06/2006
Prod Implemented	06/14/2007

2.12.65 Develop Managed Care Universe - 1494

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1494	Change Order		Data Warehouse			

2.12.65.1 Desired Solution
Develop the Managed Care universe for access to the Managed Care data.

2.12.65.2 Business Impact
Users will have the ability to develop and execute queries against the Managed Care data.

2.12.65.3 Technical Specifications
The Managed Care universe is created using BusinessObjects Designer. The classes, subclasses, and objects should be alphabetized.

2.12.65.4 Clarifications
No associated clarifications found.

2.12.65.5 Associated Requirements

Requirement ID	Type
30.050.015.002.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.65.6 Associated System Objects

Technical Name	Object Type	Title
MC.unv	DSS Universe	Managed Care Universe

2.12.65.7 Change Order Status

Status	Date
Change Order Written	11/04/2005
SE Assigned	06/12/2006
Ready for Model Office	07/05/2006
Model Office Implemented	08/18/2006
UAT Implemented	12/12/2006
Prod Implemented	06/14/2007

2.12.66 Develop Prior Auth Universe - 1495

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1495	Change Order		Data Warehouse			

2.12.66.1 Desired Solution
Develop the Prior Authorization universe for access to the Prior Authorization data.

2.12.66.2 Business Impact
Users will have the ability to develop and execute queries against the Prior Authorization data carried in the data warehouse.

2.12.66.3 Technical Specifications
The Prior Authorization universe is created using BusinessObjects Designer. The classes, subclasses, and objects should be alphabetized.

These changes were as defined in Core CO 12102.

But, additional changes identified on integrity checks on 6/15/2006. Based on CO 2624, the following objects will need to be added/removed.

Table: T_CA_PROV_KEY:

- Remove IND_ON_REVIEW column and add CDE_REVIEW_TYPE
- Add CDE_PROV_PGM
- Add DSC_REVIEW_TYPE
- Add DSC_PROV_PGM

Table: T_RE_BASE_DN:

- Add IND_FOSTER_CARE.
- Add IND_DJJ
- Add IND_TRUST
- Add IND_INVESTIGATION
- Add IND_DUPE
- Add IND_TWIN
- Add CDE_MULTI_RACE

Table: Add new code table T_RE_CDE_MULTI_RACE

- Add DSC_MULTI_RACE

Replace references to 'Member' with 'Member'.

The following KY specific changes were applied to the Universe:

- Changed references to 'Member' or 'Recip' in objects and descriptions to 'Member'.

- Added objects for Provider Program Code and Provider Review Type Code to Requesting and Servicing provider classes.
- Added T_PR_CDE_PROV_PGM, T_PR_CDE_REVIEW and T_RE_CDE_MULTI_RACE code tables to use for LOVs.
- Added Department of Juvenile Indicator, Duplicate Indicator, Foster Care Indicator, Trust Indicator, Investigation Indicator, Twin Indicator to Prior Authorization indicators class.
- Added Multiple race code and description objects to Prior Authorization codes class - HIDDEN - not needed in this universe.

2.12.66.4 Clarifications

No associated clarifications found.

2.12.66.5 Associated Requirements

Requirement ID	Type
30.050.015.002.1	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.66.6 Associated System Objects

Technical Name	Object Type	Title
PA.unv	DSS Universe	Prior Authorization Universe

2.12.66.7 Change Order Status

Status	Date
Change Order Written	11/04/2005
Construction in Progress	06/13/2006
Ready for Construction Walkthrough	06/22/2006
Ready for Model Office	06/28/2006
Model Office Implemented	07/25/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.67 Develop TPL Universe - 1496

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1496	Change Order		Data Warehouse			

2.12.67.1 Desired Solution
Develop the TPL universe for access to the TPL data.

2.12.67.2 Business Impact
Users will have the ability to develop and execute queries against the TPL data carried in the data warehouse.

2.12.67.3 Technical Specifications
The TPL universe is created using BusinessObjects Designer. The classes, subclasses, and objects should be alphabetized.

2.12.67.4 Clarifications
No associated clarifications found.

2.12.67.5 Associated Requirements

Requirement ID	Type
30.050.015.002.1	RFP Requirement
30.090.010.001.6	RFP Requirement
30.090.015.002.11	RFP Requirement

2.12.67.6 Associated System Objects

Technical Name	Object Type	Title
TPL.unv	DSS Universe	TPL Universe

2.12.67.7 Change Order Status

Status	Date
Change Order Written	11/04/2005
SE Assigned	06/12/2006
Ready for Model Office	07/13/2006
Model Office Implemented	08/18/2006
UAT Implemented	12/12/2006
Prod Implemented	06/14/2007

2.12.68 Develop Vital Statistics Univers - 1497

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1497	Change Order		Data Warehouse			

2.12.68.1 Desired Solution
Develop the Vital Statistics Universe for access to the Vital Statistics data.

2.12.68.2 Business Impact
Users will have the ability to develop and execute queries against the Vital Statistics data carried in the data warehouse.

2.12.68.3 Technical Specifications
The Vital Statistics universe is created using BusinessObjects Designer. The classes, subclasses, and objects should be alphabetized.

2.12.68.4 Clarifications
Change order canceled per Ashish. Commonwealth was not able to get agreement with Vital Statistics to receive monthly updates of birth information. - SChao

Change Order reopened per request from Commonwealth. -SChao

2.12.68.5 Associated Requirements

Requirement ID	Type
30.050.015.002.1	RFP Requirement

2.12.68.6 Associated System Objects

Technical Name	Object Type	Title
VitalStat.unv	DSS Universe	Vital Statistics Universe

2.12.68.7 Change Order Status

Status	Date
Change Order Written	11/04/2005
Cancelled	01/25/2006
Change Order Written	02/27/2006
SE Assigned	06/30/2006
Ready for Model Office	08/29/2006
Model Office Implemented	10/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.69 DSSMeasureBase - Maint Windows - 1504

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1504	Change Order		Data Warehouse			

2.12.69.1 Desired Solution
Install the existing DSSmeasureBase Maintenance window application. Thus, allowing the users the ability to perform maintenance functions on the control parameters of the DSSMeasureBase process. The user can view, add and update various pieces of information on the DSSMeasureBase maintenance applications. This Change Order is for the online part of the DSSMeasureBase process.

2.12.69.2 Business Impact
Provide the user with the capability to maintain DSSMeasureBase Criteria.

2.12.69.3 Technical Specifications
1.) Install Measure Base Windows

2.) Update the Database and Table Names

3.) Remove all occurrences of Remote Scripting and replace it with HTTP Connect

2.12.69.4 Clarifications
No associated clarifications found.

2.12.69.5 Associated Requirements

Requirement ID	Type
30.090.015.002.20	RFP Requirement

2.12.69.6 Associated System Objects

Technical Name	Object Type	Title
DSSMB - MeasureBase Selection	Window	DSSMeasureBase - MeasureBase Selection
DSSMB - MeasureBase Maintenance	Window	DSSMeasureBase - MeasureBase Maintenance
DSSMB - Qualifier Maintenance	Window	DSSMeasureBase - Qualifier Maintenance

2.12.69.7 Change Order Status

Status	Date
Change Order Written	11/06/2005
Construction in Progress	04/24/2006
Ready for Model Office	05/22/2006
Model Office Implemented	09/20/2006

Status	Date
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.70 Myers & Stauffer Extract - 1581

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1581	Change Order		Data Warehouse			

2.12.70.1 Desired Solution
The Myers & Stauffer extracts include full exports of Claims, Member, Provider and Prior Authorization information from the DSS. These exports are sent to Myers & Stauffer LC.

2.12.70.2 Business Impact
The Myers & Stauffer extracts provide Claims, Member, Provider, and Prior Authorization information to Myers & Stauffer LC for fraud and abuse analysis and rate setting.

2.12.70.3 Technical Specifications
The Myers & Stauffer extracts are sent to Myers & Stauffer LC every month. The extracts include full Oracle exports of the Member, Provider, and Prior Authorization tables as well as a month's worth of claims from the Claims Analysis tables. Final tables included in the export to be determined. See the Data List document under Supplemental Documentation for tables used in Interim DSS.

2.12.70.4 Clarifications
Change order placed in deferred status per Dean Taunton and Jason Webster (email dated 5/2/06). -SLam

2.12.70.5 Associated Requirements

Requirement ID	Type
30.050.015.002.4	RFP Requirement

2.12.70.6 Associated System Objects

Technical Name	Object Type	Title
oraload.sh	Program	Oracle Table Load-Unload Utility

2.12.70.7 Change Order Status

Status	Date
Change Order Written	11/11/2005
SE Assigned	03/27/2006
Construction in Progress	04/21/2006
Deferred	05/03/2006

2.12.71 PwC Extract - 1582

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1582	Change Order		Data Warehouse			

2.12.71.1 Desired Solution
The PricewaterhouseCoopers (PwC) extracts include claims and eligibility information from the DSS. These extracts are sent to PricewaterhouseCoopers, LLP.

2.12.71.2 Business Impact
The PwC extracts provide claims and eligibility information to PricewaterhouseCoopers, LLP for budget forecasting, non-emergency transportation, and Passport rate setting.

2.12.71.3 Technical Specifications
The PwC extracts are sent to PricewaterhouseCoopers, LLP on demand via FTP. See the Budget Forecasting, Encounter Transportation, and Passport Rate Setting documents under Supplemental Documentation for the data elements to be sent. These data elements need to be mapped to the new DSS.

2.12.71.4 Clarifications
All the extracts will have a header (Title) record and be semi colon delimited. The extracts will not be converted to ASCII characters.

Budget Forecasting

- The Waiver Extract will not be produced per PWC.
- The HMO Extract will not be produced per PWC.
- Dual Status in the Claims extract will replace the Medicaid Flag. The Dual Status field will determine dual eligibility.
- Member Status in the Claim extract is called cde_pgm_status in DDI DSS.
- The LTC Flag in the LTC extract is considered redundant and will be removed per PWC.
- Package Code and the Package Code effective/end dates need to be added to the Eligibility extract.
- The transition Original ID is the ID Medicaid in DDI DSS. There is only one Member ID in DSS.
- The Case Number will be added to and the County Code will be removed from the Eligibility extract.

Empowerment Transportation

- This extract is not needed per Kurt.

Passport Rate Setting

- The Passport Rate Setting extracts will be per Claim Type.

Comments on the sql scripts.

Passport Rate Setting

- Waiver Elig Code - not carried
- Type of Trip - not carried
- Drug Formul Ind - not carried
- Diag Related Code - is being added and is called cde_diag_treat_ind , will be added to the query.
- Xover Flag - the claim type will indicate whether or not the claim is a crossover.
- Enc Capitation Ind
- Num of Line Items - May be calculated, but the count field will be displayed on each detail row.
- Tot Claim Paid Amt - Claims paid at the header have the total paid amount in the paid amount field. Claims paid at the detail have the paid amount per detail. A calculation can put into the sql script to sum the detail paid amount, but the sum field will be displayed on each detail row.

Budget Forecasting

- EligCat - the extract will include member birthday, member status, and aid category.
- Do not include amt_encounter on the claims query.
- Include only Fee for Service claims.
- Claims will be pulled by the paid date range.

There will be coding changes during Model Office testing to include table elements not yet on the tables. The changes will have to be tested.

2.12.71.5 Associated Requirements

Requirement ID	Type
30.050.015.002.4	RFP Requirement

2.12.71.6 Associated System Objects

Technical Name	Object Type	Title
sed	Program	Unix command stream editor
DSSJOPW1	Batch Job	PWC Budget Forecasting Extracts
sqlplus	Program	SQLPLUS - SQLDBA
DSSJOPW2	Batch Job	PWC Passport Rating

2.12.71.7 Change Order Status

Status	Date
Change Order Written	11/11/2005
SE Assigned	03/27/2006
Construction in Progress	04/21/2006
Unit Test in Progress (obsolete)	06/15/2006
Ready for Construction Walkthrough	06/16/2006
Ready for Model Office	06/25/2006
Model Office Implemented	06/30/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.72 Navigant Extract - 1583

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1583	Change Order		Data Warehouse			

2.12.72.1 Desired Solution
The Navigant extracts include Inpatient and Outpatient claim information from the DSS. These extracts are sent to Navigant Consulting, Inc.

2.12.72.2 Business Impact
The Navigant extracts provide claims information to Navigant Consulting, Inc for DRG and base rate setting.

2.12.72.3 Technical Specifications
The Navigant extracts are sent to Navigant Consulting, Inc. on demand via CD. See the dso7000* documents under Supplemental Documentation for the data elements to be sent. These data elements need to be mapped to the new DSS.

2.12.72.4 Clarifications
The Navigant SQL Script does not currently include the following Table Elements:

- medical record - will be added
- admit type - will be added
- occurrence span - will not be added

The code will have to be updated when these table elements become available.

The aim.t_system_parms table will no longer be accessed by dso70005.sql. The dss.t_dss_parms table will hold the date parameter ranges. Dso70005.sql and DSSJONAV will have to reflect this change and be retested.

2.12.72.5 Associated Requirements

Requirement ID	Type
30.050.015.002.4	RFP Requirement

2.12.72.6 Associated System Objects

Technical Name	Object Type	Title
zip	Program	ZIP
sed	Program	Unix command stream editor
DSSJONAV	Batch Job	Navigant External Extract
sqlplus	Program	SQLPLUS - SQLDBA
cp	Program	Unix Copy
mv	Program	Unix Move File Command

2.12.72.7 Change Order Status

Status	Date
Change Order Written	11/11/2005
SE Assigned	03/27/2006
Construction in Progress	04/21/2006
Unit Test in Progress (obsolete)	06/15/2006
Ready for Model Office	06/16/2006
Model Office Implemented	06/30/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.73 Paid Claim Hi/Low Report - 1593

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1593	Change Order		Data Warehouse			

2.12.73.1 Desired Solution
Lists the 100 highest paid and 100 lowest paid physician claims. Lists the 25 highest and lowest paid non-institutional/other claims. Lists the 50 highest and lowest paid claims for each of the other claim types. The frequency of this report is weekly. (KYMC8700-R001)

2.12.73.2 Business Impact
To transfer production of existing Commonwealth report to the DDI Business Office DSS reporting. To provide continuity of information between the Legacy and DDI systems.

2.12.73.3 Technical Specifications
User Prompts:

- None

Table Row Selection Criteria:

- Select paid claim information for highest and lowest payment amounts for the reporting period, group by claim type.

Report Column Order:

- Various tables on report. See report layout for column order.

Report Column Grouping Order:

- N/A

Report Column Sort Order:

- N/A

Frequency:

- Weekly

Priority:

- N/A

Owner:

- N/A

2.12.73.4 Clarifications
Columns vary depending on claim type. Not clear which columns should appear for each possible claim type.

These are the updated report specs for the DDI version of the Paid Claims Hi/Low report.

User Prompts:

- None

Table Row Selection Criteria:

- Select paid claim information for highest and lowest payment amounts for the reporting period, group by claim type
- Paid Claims Only.
- Latest Claims Only.

Report Column Order:

- Various tables on report. See report layout for column order.

Report Column Grouping Order:

- Claim Type
- Paid Amount

Report Column Sort Order:

- Claim Type
- Paid Amount

2.12.73.5 Associated Requirements

Requirement ID	Type
30.090.014.003.2	Case Management Reporting

2.12.73.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Paid Claims Hi - Low	Report	Paid Claims Hi - Low

2.12.73.7 Change Order Status

Status	Date
Change Order Written	11/11/2005
Ready for Model Office	08/01/2006
Model Office Implemented	09/28/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.74 Provider Denial Rates - 1594

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1594	Change Order		Data Warehouse			

2.12.74.1 Desired Solution
Lists providers who have 50% of the claims submitted denied. The frequency of this report is monthly. (KYMC9300-R001)

2.12.74.2 Business Impact
To transfer production of existing Commonwealth report to the DDI Business Office DSS reporting. To provide continuity of information between the Legacy and DDI systems.

2.12.74.3 Technical Specifications
User Prompts:

- None

Table Row Selection Criteria:

- Select providers where # of denied claims > # paid claims for the reporting period

Report Column Order:

- Provider Number
- Denied Claims
- Denial Percentage

Report Column Grouping Order:

- Provider Number

Report Column Sort Order:

- Provider Number

Frequency:

- Monthly

Priority:

- N/A

Owner:

- N/A

2.12.74.4 Clarifications
No associated clarifications found.

2.12.74.5 Associated Requirements

Requirement ID	Type
30.090.014.003.2	Case Management Reporting

2.12.74.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Provider Denial Rates Above 50 Percent	Report	Provider Denial Rates Above 50 Percent

2.12.74.7 Change Order Status

Status	Date
Change Order Written	11/11/2005
Ready for Model Office	08/01/2006
Model Office Implemented	09/28/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.75 Q6-Modifier Claims Billed - 1595

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1595	Change Order		Data Warehouse			

2.12.75.1 Desired Solution
To report Claims that have billed over 60 consecutive days using the Q6 modifier. The frequency of this report is monthly. (KYMC9515-R001)

2.12.75.2 Business Impact
To transfer production of existing Commonwealth report to the DDI Business Office DSS reporting. To provide continuity of information between the Legacy and DDI systems.

2.12.75.3 Technical Specifications
User Prompts:

- None

Table Row Selection Criteria:

- Select claims that have billed over 60 consecutive days using the Q6 modifier.

Report Column Order:

- Provider Number
- Provider Name
- First Date of Service
- Last Date of Service
- ICN Exceeding 60 Days

Report Column Grouping Order:

- Provider Number
- Provider Name
- First Date of Service
- Last Date of Service
- ICN Exceeding 60 Days

Report Column Sort Order:

- Provider Number
- Provider Name
- First Date of Service

Frequency:

- Monthly

Priority:

- N/A

Owner:

- N/A

2.12.75.4 Clarifications

These are the updated report specs for the DDI version of the Q6-Modifier Claims Billed report.

User Prompts:

- First Date of Service Range

Table Row Selection Criteria:

- Select claims that have billed over 60 consecutive days using the Q6 modifier.

Report Column Order:

- Billing Provider Number
- Billing Provider Name
- From Date of Service
- To Date of Service
- ICN exceeding 60 days

Report Column Grouping Order:

- Billing Provider Number
- Billing Provider Name

Report Column Sort Order:

- Billing Provider Number
- Billing Provider Name
- From Date of Service
- To Date of Service

2.12.75.5 Associated Requirements

Requirement ID	Type
30.090.014.003.2	Case Management Reporting

2.12.75.6 Associated System Objects

Technical Name	Object Type	Title
DSS - Q6 Modifier Claims Billed for 60 Consecutive Days	Report	Q6 Modifier Claims Billed for 60 Consecutive Days

2.12.75.7 Change Order Status

Status	Date
Change Order Written	11/11/2005
Ready for Model Office	08/14/2006
Model Office Implemented	09/28/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.76 University of Louisville Provs - 1596

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1596	Change Order		Data Warehouse			

2.12.76.1 Desired Solution
This report lists all physician clinic billing under FEIN 611014882 giving month to date and year to date totals. The frequency of this report is monthly. (KYMC9901-R001)

2.12.76.2 Business Impact
To transfer production of existing Commonwealth report to the DDI Business Office DSS reporting. To provide continuity of information between the Legacy and DDI systems.

2.12.76.3 Technical Specifications
User Prompts:

- None

Table Row Selection Criteria:

- Select paid claim amounts for providers billing under FEIN 611014882..

Report Column Order:

- Provider Number
- Provider Name
- MTD Paid
- YTD Paid

Report Column Grouping Order:

- Provider Number

Report Column Sort Order:

- Provider Number

Frequency:

- Monthly

Priority:

- N/A

Owner:

- N/A

2.12.76.4 Clarifications
These are the updated report specs for the DDI version of the University of Louisville Providers report.

User Prompts:

- Payment Month Range

Table Row Selection Criteria:

- Select paid claim amounts for providers billing under FEIN 611014882.
- Professional Claims Only.
- Billing Provider Tax id = 611014882.
- Billing Provider Tax id type = F.

Report Column Order:

- Billing Provider Number
- Billing Provider Name
- MTD Paid
- YTD Paid

Report Column Grouping Order:

- Billing Provider Number

Report Column Sort Order:

- Billing Provider Number

2.12.76.5 Associated Requirements

Requirement ID	Type
30.090.014.003.2	Case Management Reporting

2.12.76.6 Associated System Objects

Technical Name	Object Type	Title
DSS - University of Louisville Providers	Report	University of Louisville Providers Billing Under FEIN 611014882

2.12.76.7 Change Order Status

Status	Date
Change Order Written	11/11/2005
Model Office Implemented	08/18/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007