2.12.10 Add Lay Description to Procedure - 657

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
657	Change Order		Reference Data Maintenance			1

2.12.10.1 Desired Solution
Add lay description field to the base procedure panel and modify description search.

2.12.10.2 Business Impact
Meet RFP requirement.

2.12.10.3 Technical Specifications
Add lay description field to the HCPCS Procedure Information and HCPCS Procedure Base Information panels. Add column to T_PROC :

- DSC_LAY
- VARCHAR2(100)
- Optional
- Default to space

Add field to panels below Long Description. Label as **Lay Description**. Size same as long description field.

Modify the HCPCS procedure search panel to perform a like search on all three descriptions (short, long and lay), and when you get a hit, pull back the code and short description for each code meeting the search criteria.

For example: If a user enters the word "heart" into the Description and/or Lay Description field(s) and the word "heart" exists **anywhere** in either the short, long or lay description for a procedure code, display all the codes meeting this criteria and their **short** description, even if the word being searched does not exist anywhere in the short description, as long as it exists somewhere in the lay or long description.

2.12.10.4 Clarifications
Core CO 8846 (Modify T_PROC for HCPCS Update) added to modify table T_PROC in Core interChange data model. After table has been modified in Core interChange, it is copied to KY MMIS data model.

Core CO 100399(KY 657 - Add Lay Desc to Procedure) added to track promotion of panel changes in Core. Please update documentation in both workbooks.

[Troy Schexnayder]

Search was handled in another Core CO - 10691

[Troy Schexnayder]

2.12.10.5 Associated Requirements

Requirement ID	Type
30.090.006.002.3	RFP Requirement

2.12.10.6 Associated System Objects

Technical Name	Object Type	Title
Ref.ProcedureBaseEditPanel.ascx	Panel	Base Information-HCPCS Procedure
Ref.ProcedureSearchPanel.ascx	Panel	Reference Procedure Search-Procedure
Ref.ProcedureInformation.ascx	Panel	Procedure Information-HCPCS Procedure

2.12.10.7 Change Order Status

Status	Date
Issue Identified	08/30/2005
SE Assigned	01/15/2006
Construction in Progress	02/09/2006
Ready for Model Office	03/09/2006
Model Office Implemented	03/10/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.11 Add Lay Desc to Diagnosis - 658

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
658	Change Order		Reference Data Maintenance	123.00		1

2.12.11.1 Desired Solution
Add lay description field to the Diagnosis panels and make the description search look at long, short and lay descriptions when performing the like search.

2.12.11.2 Business Impact
Meet RFP requirement

2.12.11.3 Technical Specifications
Add lay description field to the Diagnosis Information and Diagnosis Base Information panels. Add column to T_DIAGNOSIS:

- DSC_LAY
- VARCHAR2(100)
- Optional
- Default to space

Add field to panels below Long Description. Label as **Lay Description**. Size same as long description field.

Modify the Diagnosis search panel to perform a like search on all three descriptions (short, long and lay) and when you get a hit, pull back the code and short description for each code meeting the search criteria.

For example: If a user enters the word "heart" into the Description and/or Lay Description field(s) and the word "heart" exists **anywhere** in either the short, long or lay description for a diagnosis code, display all the codes meeting this criteria and their **short** description, even if the word being searched does not exist anywhere in the short description, as long as it exists somewhere in the lay or long description.

2.12.11.4 Clarifications
Core CO 8967 (KY658 - T_DIAGNOSIS/DSC_LAY) added to modify table T_DIAGNOSIS in Core interChange data model. After table has been modified in Core interChange, it is copied to KY MMIS data model.

Core CO 10401(KY 658 - Add Lay Desc to Diagnosis) added to track promotion of panel changes in Core. Please update documentation in both workbooks.

[Troy Schexnayder]

This change order has been modified to only address the addition of the Lay Description field. The additional Search criteria options are handled in a separate Change Order for Core (10691) which enhances the search functionality for all Reference search panels.

[Pat Bonner]

2.12.11.5 Associated Requirements

Requirement ID	Type
30.090.006.002.4	RFP Requirement
30.090.006.002.5	RFP Requirement

2.12.11.6 Associated System Objects

Technical Name	Object Type	Title
Ref.DiagnosisSearchPanel.ascx	Panel	Reference Diagnosis Search-Diagnosis
Ref.DiagnosisInformation.ascx	Panel	Diagnosis Information-Diagnosis
Ref.DiagnosisBaseEditPanel.ascx	Panel	Base Information-Diagnosis

2.12.11.7 Change Order Status

Status	Date
Issue Identified	08/30/2005
Change Order Written	01/15/2006
SE Assigned	02/14/2006
Technical Design In Progress (obsolete)	02/14/2006
Construction in Progress	02/16/2006
Ready for Model Office	03/03/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.12 Add Lay Desc to ICD Procedure - 660

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
660	Change Order		Reference Data Maintenance			1

2.12.12.1 Desired Solution
Add lay description field to the ICD9 procedure panels and make the description search look at long, short and lay descriptions when performing the like search.

2.12.12.2 Business Impact
Meet RFP requirement.

2.12.12.3 Technical Specifications
Add lay description field to the ICD-9-CM-Procedure Information and ICD-9-CM Base Information panels.

Add column to T_PROC_ICD9:

- DSC_LAY
- VARCHAR2(100)
- Optional
- Default to space

Add field to panels below Long Description. Label as **Lay Description**. Size same as long description field.

Modify the ICD-9 procedure search panel to perform a like search on all three descriptions (short, long and lay), and when you get a hit, pull back the code and short description for each code meeting the search criteria.

For example:
If a user enters the word "heart" into the Description and/or Lay Description field(s), and the word "heart" exists **anywhere** in either the short, long or lay description for a procedure code, display all the codes meeting this criteria and their **short** description, even if the word being searched does not exist anywhere in the short description, as long as it exists somewhere in the lay or long description.

2.12.12.4 Clarifications
Core CO 8968 (KY658 - T_ICD9_PROC/DSC_LAY) added to modify table T_ICD9_PROC in Core interChange data model. After table has been modified in Core interChange, it is copied to KY MMIS data model.

Core CO 10398 (KY 660 - Add Lay Desc to ICD Proc) added to track promotion of panel changes in Core. Please update documentation in both workbooks.

[Troy Schexnayder]

Search is handled in another CORE CO 10691

[Troy Schexnayder]

2.12.12.5 Associated Requirements

Requirement ID	Type
30.090.006.002.3	RFP Requirement

2.12.12.6 Associated System Objects

Technical Name	Object Type	Title
Ref.Icd9Information.ascx	Panel	ICD-9-CM Procedure Information-ICD-9-CM Procedure
Ref.ProcedureIcd9BasePanel.ascx	Panel	Base Information-ICD9 Procedure
Ref.ProcedureSearchPanel.ascx	Panel	Reference Procedure Search-Procedure

2.12.12.7 Change Order Status

Status	Date
Issue Identified	08/30/2005
SE Assigned	01/15/2006
Design Complete	02/09/2006
Construction in Progress	02/09/2006
Ready for Model Office	03/09/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.13 ICD-10 Procedure Implementation - 1063

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1063	Change Order		Reference Data Maintenance			1

2.12.13.1 Desired Solution

CMS is implementing in the future new ICD-10 Procedure code set to replace the current ICD-9 code set.

Make any necessary modifications to handle the new code set.

Please see clarifications for implementation data of ICD-10 code sets.

2.12.13.2 Business Impact

CMS is implementing in the future new ICD-10 code set to replace the current ICD-9 code set.

2.12.13.3 Technical Specifications

Update User Interface and batch processes to handle the expanded ICD-10 code set.

1. Data Model changes
   a. Change the CDE_PROC_ICD9 column on T_PROC_ICD9 from CHAR(4) to CHAR(7)
   b. Add DTE_EFFECTIVE Number (8) and DTE_END Number (8)
   c. ID_ICD CHAR(2) to identify if the code is an ICD-9 or ICD-10 code
2. Modify modules that use CDE_PROC_ICD9 to have the correct length.
3. Modify pages/panels to have the new length and title for the CDE_PROC_ICD9 column.
4. Convert/Configure system to use ICD-10 code set. Update appropriate Edits/Audits, Benefit Plan coverage, and other affected data areas.

2.12.13.4 Clarifications

The final rules for the ICD-10-PCS coding system implementation is still being drafted. See the CMS website for additional information.

[http://www.cms.hhs.gov/paymentsystems/icd9/icd10.asp?]

[Troy Schexnayder]

Changed status from Issue Identified to Deferred. This is a post-implementation change.

[Troy Schexnayder]

2.12.13.5 Associated Requirements

Requirement ID	Type
30.090.006.002.3	RFP Requirement

2.12.13.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.13.7 Change Order Status

Status	Date
Issue Identified	09/14/2005
Deferred	12/14/2005

2.12.14 Update job script for REFJA105 - 1266

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1266	Change Order	1	Reference Data Maintenance			2

2.12.14.1 Desired Solution
Add job steps 25 and 26 to batch job REFJA105 to write reports REF-0007-A (Procedure Code Description Change) and REF-009-A (Modifier Description Change) to COLD. PWB documentation was updated but need to add job steps to the job script in core or copy over the job script and source code (refp0105.sc) from TennCare.

2.12.14.2 Business Impact
Meet existing reporting requirements which reports on changes to procedure code data.

2.12.14.3 Technical Specifications
Add job steps 25 and 26 to batch job REFJA105 to write reports REF-0007-A (Procedure Code Description Change) and REF-009-A (Modifier Description Change) to COLD. PWB documentation was updated but need to add job steps to the job script in core or copy over the job script and source code (refp0105.sc) from TennCare.

2.12.14.4 Clarifications
Reference Core Change Order 8844 - Enhance HCPCS Update - refp0105.

[Troy Schexnayder]

Add job steps to move all the reports to COLD. There are now nine reports generated by refp0105 - Scott Crittenden

2.12.14.5 Associated Requirements

Requirement ID	Type
30.030.006.002.5	RFP Requirement
30.050.006.002.5	RFP Requirement

2.12.14.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.14.7 Change Order Status

Status	Date
Issue Identified	10/12/2005
Change Order Written	01/15/2006
SE Assigned	03/24/2006
Ready for Construction Walkthrough	03/24/2006

Status	Date
Unit Test in Progress (obsolete)	04/03/2006
Ready for Model Office	05/12/2006
Model Office Implemented	06/30/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.15 Modify Report REF-0010-W - 1267

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1267	Change Order		Reference Data Maintenance			2

2.12.15.1 Desired Solution
Modify existing report REF-0010-W (Reference Changes By Clerk ID Weekly Summary) to include Benefit Plan tables, DRG tables and RBRVS tables.

2.12.15.2 Business Impact
Meet customer existing reporting requirements.

2.12.15.3 Technical Specifications
Verify tables listed on report. Use report mock-up and add/remove counts as needed.

2.12.15.4 Clarifications
Reference Core CO 8441. These modifications are used statewide and are not specific to KY.

[Troy Schexnayder]

2.12.15.5 Associated Requirements

Requirement ID	Type
30.020.001.002	RFP Requirement
30.030.006.002.5	RFP Requirement
30.050.006.002.5	RFP Requirement
30.090.006.003.1	RFP Requirement

2.12.15.6 Associated System Objects

Technical Name	Object Type	Title
refp0010	Program	Reference Changes By Clerk ID Weekly Summary
REF-0010-W	Report	Reference Changes By Clerk ID Weekly Summary

2.12.15.7 Change Order Status

Status	Date
Issue Identified	10/12/2005
Construction in Progress	10/14/2005
Construction in Progress	05/03/2007
Ready for Model Office	05/03/2007
Model Office Implemented	05/03/2007
UAT Implemented	05/03/2007

Status	Date
Prod Implemented	05/03/2007

2.12.16 CMS Procedure/Modifier Updates - 1354

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1354	Change Order		Reference Data Maintenance	195.00		1

2.12.16.1 Desired Solution

Modifications needed for the CMS HCPCS update process.

- Remove the word "Annual" in report titles to reflect that the update file is received more frequently.
- Add data source information to documentation.
- Update report documentation to further define discontinued/re-activated codes.
- Assign/define a "clerk id" for the update process to allow easier identification of changes made during the update batch job(s).

2.12.16.2 Business Impact

Meet RFP requirements and business processing needs.

2.12.16.3 Technical Specifications

Define a clerk id to use for batch update process. This allows identification of updates made during the batch job(s) to be easily identified.

Report Modifications:

4. REF-0001-A
   - Change title to CMS HCPCS UPDATE - DISCONTINUED PROCEDURE CODES FOR CCYY.
   - Change columns headers from HCPC to HCPCS.
   - Add HCPCS Code Added Date to report.
   - Add HCPCS Code Termination Date to report.
   - Verify report matches mockup.
5. REF-0003-A
   - Change title to CMS HCPCS UPDATE - ADDED MODIFIER CODES FOR CCYY.
   - Change columns headers from HCPC to HCPCS.
   - Add HCPCS Code Added Date to report.
   - Verify report matches mockup.
6. REF-0003-A
   - Change title to CMS HCPCS UPDATE - ADDED PROCEDURE CODES FOR CCYY.
   - Add HCPCS Code Added Date to report.

- Verify report matches mockup.

7. REF-0004-A
   - Change title to CMS HCPCS UPDATE - SUMMARY REPORT FOR CCYY.
   - Add line for Modifiers with Short Description change.
   - Verify report matches mockup.
8. REF-0005-A
   - Change title to CMS HCPCS UPDATE - ERROR REPORT FOR CCYY.
   - Verify report matches mockup.
9. REF-0006-A
   - Add to CMS HCPCS UPDATE - DISCONTINUED MODIFIER CODES FOR CCYY to list discontinued modifiers.
10. REF-0007-A
    - Add to CMS HCPCS UPDATE - CHANGED PROCEDURE CODES FOR CCYY to list updated procedure codes.
11. REF-0009-A
    - Add to CMS HCPCS UPDATE - CHANGED MODIFIER CODES FOR CCYY to list updated modifier codes.

2.12.16.4 Clarifications

This Change Order is related to CO 1266. COs 1354 and 1266 are worked together.

Reference Core CO 8844 - Enhance HCPCS Update - refp0105 .

[Troy Schexnayder]

2.12.16.5 Associated Requirements

Requirement ID	Type
30.090.006.001.3	RFP Requirement
30.090.006.004.4	RFP Requirement
30.090.006.004.6	RFP Requirement

2.12.16.6 Associated System Objects

Technical Name	Object Type	Title
PRFA105	Batch Cycle	CMS HCPCS Update
REF-0004-A	Report	CMS HCPCS Update - Summary Report for CCYY
REF-0001-A	Report	CMS HCPCS Update - Discontinued Procedure Codes for CCYY

Technical Name	Object Type	Title
REF-0009-A	Report	CMS HCPCS Update - Changed Modifier Codes for CCYY
REF-0007-A	Report	CMS HCPCS Update - Changed Procedure Codes for CCYY
REF-0006-A	Report	CMS HCPCS Update - Reactivated Codes for CCYY
REF-0002-A	Report	CMS HCPCS Update - Added Procedure Codes for CCYY
REF-0003-A	Report	CMS HCPCS Update - Added Modifier Codes for CCYY
REF-0005-A	Report	CMS HCPCS Update - Error Report for CCYY

2.12.16.7 Change Order Status

Status	Date
Issue Identified	10/12/2005
Change Order Written	01/15/2006
SE Assigned	03/02/2006
Ready for Unit Test (obsolete)	03/02/2006
Ready for Unit Test (obsolete)	04/11/2006
Unit Test in Progress (obsolete)	04/11/2006
Ready for Model Office	05/12/2006
Model Office Implemented	06/30/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.17 Add ASC Group to REF-5556-M - 1392

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1392	Change Order	1	Reference Data Maintenance	18.00		1

2.12.17.1 Desired Solution
Add the Ambulatory Surgical Center Group number to the Ambulatory Surgery Center (ASC) Maximum Allowable Payment (REF-5556-M) report.

Sort order of report is by ASC group ascending and then procedure code ascending.

2.12.17.2 Business Impact
Meet business needs.

2.12.17.3 Technical Specifications
Add the ASC Group number to the Ambulatory Surgery Center (ASC) Maximum Allowable Payment (REF-5556-M) report. See report layout.

Sort order of report is by ASC group ascending and then procedure code ascending.

2.12.17.4 Clarifications
Work Core CO 8951 - ASC Pricing Tables prior to beginning this CO.

[Troy Schexnayder]

2.12.17.5 Associated Requirements

Requirement ID	Type
30.020.001.002	RFP Requirement
30.090.006.002.8	RFP Requirement

2.12.17.6 Associated System Objects

Technical Name	Object Type	Title
refp5556	Program	Ambulatory Surgery Maximum Allowable Payment Report
REF-5556-M	Report	Ambulatory Surgery Center (ASC) Maximum Allowable Payment

2.12.17.7 Change Order Status

Status	Date
Issue Identified	10/24/2005
Change Order Written	01/15/2006
Ready for Model Office	03/15/2006
Model Office Implemented	05/11/2006
UAT Implemented	11/01/2006

Status	Date
Prod Implemented	06/14/2007

2.12.18 Add HCPCS Procedure Notes Panel - 1397

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1397	Change Order	1	Reference Data Maintenance	75.00		1

2.12.18.1 Desired Solution
Add a panel to add/view user entered notes for HCPCS Procedure codes.

2.12.18.2 Business Impact
Meet business processing needs.

2.12.18.3 Technical Specifications
Add a new table T_PROC_NOTES to hold HCPCS Procedure related notes.

Add new panel HCPCS Procedure - Notes to allow online users to add notes for a HCPCS procedure code.

Add link for Notes to the HCPCS Procedure Maintenance panel.

Verify that all related data model, page and panel documentation is updated for listed changes.

HCPCS Procedure - Notes panel:

The following fields are system generated:

- Clerk ID
- Sequence Number
- Date
- Time

The Note field is a free-form text field of up to 1000 characters. The Note field is a required field and should not be blank.

The Notes list is sorted in Sequence descending order so that the most recent note is displayed first.

Use the Error Disposition - Notes panel as a template.

2.12.18.4 Clarifications
Core CO 8960 (KY1397 - Add T_PROC_NOTES) added to create table in Core interChange data model. After table has been defined in Core interChange, it is copied to KY MMIS data model.

Core CO 10010 (KY 1397 - Add HCPCS Proc Notes) added to create track promotion of this panel in Core. Please update documentation in both workbooks.

[Troy Schexnayder]

2.12.18.5 Associated Requirements

Requirement ID	Type
30.090.006.002.3	RFP Requirement

2.12.18.6 Associated System Objects

Technical Name	Object Type	Title
Ref.ProcedureNote	Panel	Note-HCPCS Procedure
Ref.ProcedureInformation.ascx-Maintenance	Panel	Procedure Maintenance-HCPCS Procedure

2.12.18.7 Change Order Status

Status	Date
Issue Identified	10/25/2005
Change Order Written	11/16/2005
SE Assigned	12/02/2005
Technical Design In Progress (obsolete)	12/02/2005
Construction in Progress	12/06/2005
Ready for Construction Walkthrough	01/02/2006
Ready for Model Office	01/24/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.19 Add Diagnosis Notes Panel - 1398

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1398	Change Order	1	Reference Data Maintenance	75.00		1

2.12.19.1 Desired Solution
Add a panel to add/view user entered notes for Diagnosis codes

2.12.19.2 Business Impact
Meet business processing requirements.

2.12.19.3 Technical Specifications
Add a new table T_DIAG_NOTES to hold Diagnosis related notes.

Add new panel Diagnosis - Notes to allow online users to add notes for a Diagnosis code.

Add link for Notes to the Diagnosis Maintenance panel.

Diagnosis - Notes panel:

The following fields are system generated:

- Clerk ID
- Sequence Number
- Date
- Time

The Note field is a free-form text field of up to 1000 characters. The Note field is a required field and should not be blank.

The Notes list is sorted in Sequence descending order so that the most recent note is displayed first.

Use the Error Disposition - Notes panel as a template.

2.12.19.4 Clarifications
Core CO 8961 (KY1398 - Add T_DIAG_NOTES) added to create table in Core interChange data model. After table has been defined in Core interChange, it is copied to KY MMIS data model.

Core CO 10012 (KY 1398 - Add Diag Notes Panel) added to create track promotion of this panel in Core. Please update documentation in both workbooks.

[Troy Schexnayder]

2.12.19.5 Associated Requirements

Requirement ID	Type
30.090.006.002.4	RFP Requirement

2.12.19.6 Associated System Objects

Technical Name	Object Type	Title
Ref.DiagnosisNotePanel.ascx	Panel	Note-Diagnosis
Ref.DiagnosisInformation.ascx-Maintenance	Panel	Diagnosis Maintenance-Diagnosis

2.12.19.7 Change Order Status

Status	Date
Issue Identified	10/25/2005
Change Order Written	11/16/2005
SE Assigned	01/19/2006
Define/Analyze In Progress	01/20/2006
Construction in Progress	01/28/2006
Ready for Tech Walkthrough	02/06/2006
Ready for Construction Walkthrough	02/06/2006
Ready for Model Office	02/10/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.20 Add Drug Notes Panel - 1399

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1399	Change Order	1	Reference Data Maintenance	75.00		1

2.12.20.1 Desired Solution
Add a panel to add/view user entered notes for Drug (NDC) codes.

2.12.20.2 Business Impact
Meet business processing requirements.

2.12.20.3 Technical Specifications
Add a new table T_DRUG_NOTES to hold Drug (NDC) related notes.

Add new panel Drug - Notes to allow online users to add notes for a Drug code.

Add link for Notes to the Drug Maintenance panel.

Drug - Notes panel:

The following fields are system generated:

- Clerk ID
- Sequence Number
- Date
- Time

The Note field is a free-form text field of up to 1000 characters. The Note field is a required field and should not be blank.

The Notes list is sorted in Sequence descending order so that the most recent note is displayed first.

Use the Error Disposition - Notes panel as a template.

2.12.20.4 Clarifications
Core CO 8962 (KY1399 - Add T_DRUG_NOTES) added to create table in Core interChange data model. After table has been defined in Core interChange, it is copied to KY MMIS data model.

Core CO 10013 (KY 1399 - Add Drug Notes Panel) added to create track promotion of this panel in Core. Please update documentation in both workbooks.

[Troy Schexnayder]

2.12.20.5 Associated Requirements

Requirement ID	Type
30.090.006.002.6	RFP Requirement

2.12.20.6 Associated System Objects

Technical Name	Object Type	Title
Ref.DrugInformation.ascx-Maintenance	Panel	Drug Maintenance-Drug
Ref.DrugNote	Panel	Note-Drug

2.12.20.7 Change Order Status

Status	Date
Issue Identified	10/25/2005
Change Order Written	11/16/2005
SE Assigned	02/06/2006
Technical Design In Progress (obsolete)	02/06/2006
Construction in Progress	02/06/2006
Ready for Construction Walkthrough	02/10/2006
Ready for Model Office	02/16/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.21 Add Revenue Code Notes Panel - 1400

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1400	Change Order	1	Reference Data Maintenance	75.00		1

2.12.21.1 Desired Solution
Add a panel to add/view user entered notes for Revenue codes.

2.12.21.2 Business Impact
Meet business processing requirements.

2.12.21.3 Technical Specifications
Add a new table T_REVENUE_NOTES to hold Revenue code related notes.

Add new panel Revenue - Notes to allow online users to add notes for a Revenue code.

Add link for Notes to the Revenue Code Maintenance panel.

Revenue - Notes panel:

The following fields are system generated:

- Clerk ID
- Sequence Number
- Date
- Time

The Note field is a free-form text field of up to 1000 characters. The Note field is a required field and should not be blank.

The Notes list is sorted in Sequence descending order so that the most recent note is displayed first.

Use the Error Disposition - Notes panel as a template.

2.12.21.4 Clarifications
Core CO 8963 (KY1400 - Add T_REVENUE_NOTES) added to create table in Core interChange data model. After table has been defined in Core interChange, it is copied to KY MMIS data model.

Core CO 10015 (KY 1400 - Add Rev Notes Panel) added to create track promotion of this panel in Core. Please update documentation in both workbooks.

[Troy Schexnayder]

2.12.21.5 Associated Requirements

Requirement ID	Type
30.090.006.002.7	RFP Requirement

2.12.21.6 Associated System Objects

Technical Name	Object Type	Title
Ref.Region	Panel	Codes-Region
Ref.Revenue - Note	Panel	Note-Revenue

2.12.21.7 Change Order Status

Status	Date
Issue Identified	10/25/2005
Change Order Written	11/16/2005
SE Assigned	02/10/2006
Construction in Progress	02/10/2006
Ready for Construction Walkthrough	02/10/2006
Ready for Model Office	02/16/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.22 Add ICD-9 Procedure Notes Panel - 1401

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1401	Change Order	1	Reference Data Maintenance	34.00		1

2.12.22.1 Desired Solution
Add a panel to add/view user entered notes for ICD-9-CM Procedure codes.

2.12.22.2 Business Impact
Meet business processing requirements.

2.12.22.3 Technical Specifications
Add a new table T_PROC_ICD9_NOTES to hold ICD-9-CM Procedure code related notes.

Add new panel "ICD-9-CM Procedure Notes" to allow online users to add notes for a ICD-9-CM Procedure code.

Add link for Notes to the ICD-9-CM Procedure Maintenance panel.

ICD-9-CM Procedure - Notes panel:

The following fields are system generated:

- Clerk ID
- Sequence Number
- Date
- Time

The Note field is a free-form text field of up to 1000 characters. The Note field is a required field and should not be blank.

The Notes list is sorted in Sequence descending order so that the most recent note is displayed first.

Use the Error Disposition - Notes panel as a template.

2.12.22.4 Clarifications
Core CO 8964 (KY1401 - Add T_ICD9_PROC_NOTES) added to create table in Core interChange data model. After table has been defined in Core interChange, it is copied to KY MMIS data model.

Core CO 10016 (KY 1401 - Add ICD9 Proc Notes) added to create track promotion of this panel in Core. Please update documentation in both workbooks.

[Troy Schexnayder]

Documentation attached for DMS review. Notes has been added to ICD9 panel. Bonnie

2.12.22.5 Associated Requirements

Requirement ID	Type
30.090.006.002.3	RFP Requirement

2.12.22.6 Associated System Objects

Technical Name	Object Type	Title
Ref.Icd9Information.ascx-Maintenance	Panel	Procedure Maintenance-ICD9 Procedure
Ref.ICDProcNote	Panel	Note-ICD-9-CM Procedure

2.12.22.7 Change Order Status

Status	Date
Issue Identified	10/25/2005
Change Order Written	11/16/2005
SE Assigned	12/02/2005
Technical Design In Progress (obsolete)	12/02/2005
Construction in Progress	12/06/2005
Ready for Construction Walkthrough	01/02/2006
Ready for Model Office	01/24/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.23 Add Modifier Notes Panel - 1402

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1402	Change Order	1	Reference Data Maintenance	75.00		1

2.12.23.1 Desired Solution
Add a panel to add/view user entered notes for Modifier codes.

2.12.23.2 Business Impact
Meet business processing requirements.

2.12.23.3 Technical Specifications
Add a new table T_MODIFIER_NOTES to hold Modifier code related notes.

Add new panel Modifier - Notes to allow online users to add notes for a Modifier code.

Add link for Notes to the Modifier Maintenance panel.

Modifier - Notes panel:

The following fields are system generated:

- Clerk ID
- Sequence Number
- Date
- Time

The Note field is a free-form text field of up to 1000 characters. The Note field is a required field and should not be blank.

The Notes list is sorted in Sequence descending order so that the most recent note is displayed first.

Use the Error Disposition - Notes panel as a template.

2.12.23.4 Clarifications
Core CO 8965 (KY1402 - Add T_MODIFIER_NOTES) added to create table in Core interChange data model. After table has been defined in Core interChange, it is copied to KY MMIS data model.

Core CO 10017 (KY 1402 - Add Mod Notes Panel) added to create track promotion of this panel in Core. Please update documentation in both workbooks.

[Troy Schexnayder]

2.12.23.5 Associated Requirements

Requirement ID	Type
30.090.006.002.3	RFP Requirement

2.12.23.6 Associated System Objects

Technical Name	Object Type	Title
Ref.ModifierNote	Panel	Note-Modifier
Ref.ModifierInformation.ascx-Maintenance	Panel	Modifier Maintenance-Modifier

2.12.23.7 Change Order Status

Status	Date
Issue Identified	10/25/2005
Change Order Written	11/16/2005
SE Assigned	12/01/2005
Technical Design In Progress (obsolete)	12/01/2005
Construction in Progress	12/06/2005
Ready for Construction Walkthrough	02/02/2006
Ready for Model Office	02/07/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.24 Add DRG Notes Panel - 1403

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1403	Change Order	1	Reference Data Maintenance	75.00		1

2.12.24.1 Desired Solution
Add a panel to add/view user entered notes for DRG codes.

2.12.24.2 Business Impact
Meet business processing requirements

2.12.24.3 Technical Specifications
Add a new table T_DRG_NOTES to hold DRG code related notes.

Add new panel DRG - Notes to allow online users to add notes for a DRG code.

Add link for Notes to the DRG Maintenance panel.

DRG - Notes panel:

The following fields are system generated:

- Clerk ID
- Sequence Number
- Date
- Time

The Note field is a free-form text field of up to 1000 characters. The Note field is a required field and should not be blank.

The Notes list is sorted in Sequence descending order so that the most recent note is displayed first.

Use the Error Disposition - Notes panel as a template.

2.12.24.4 Clarifications
Core CO 8966 (KY1403 - Add T_DRG_NOTES) added to create table in Core interChange data model. After table has been defined in Core interChange, it is copied to KY MMIS data model.

Core CO 10018 (KY 1403 - Add DRG Notes panel) added to create track promotion of this panel in Core. Please update documentation in both workbooks.

[Troy Schexnayder]

2.12.24.5 Associated Requirements

Requirement ID	Type
30.090.006.002.8	RFP Requirement

2.12.24.6 Associated System Objects

Technical Name	Object Type	Title
Ref.DRGInformation.ascx-maintenance	Panel	DRG Maintenance-DRG
Ref.NoteDRG	Panel	Note-DRG

2.12.24.7 Change Order Status

Status	Date
Issue Identified	10/25/2005
Change Order Written	11/16/2005
Ready for Model Office	02/09/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.25 Add CMS Drug Labeler Update - 1405

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1405	Change Order	1	Reference Data Maintenance	77.00		1

2.12.25.1 Desired Solution

Add batch process necessary to update/maintain the Drug Labeler data using the information on the Quarterly CMS Drug Contact file.

This data is used in pharmacy encounter processing and also made available for online and reporting requirements.

2.12.25.2 Business Impact

Meet pharmacy encounter processing and MMIS reporting requirements.

2.12.25.3 Technical Specifications

Process the CMS Drug Company Contact Information file to update the T_DRUG_LBLR and T_DR_STATUS tables.

Add to the Reference subsystem area the following Drug Rebate system objects for Core interChange:

- job RBTJQ320 - verify that job also updates table T_DR_STATUS
- Add new Autosys box to run RBTJQ320
- Add Drug Rebate Labeler Address Update Exception Report (RBT-2014-Q)
- Add program drex0320.sc

Information on the CMS Drug Labeler file can be found on the CMS Medicaid Drug Rebate Program files.

2.12.25.4 Clarifications

Made some minor modifications for the record length, system parameters and report headers and moved back to MO.

[Troy Schexnayder]

2.12.25.5 Associated Requirements

Requirement ID	Type
30.090.006.002.6	RFP Requirement

2.12.25.6 Associated System Objects

Technical Name	Object Type	Title
RBTJQ320	Batch Job	Drug Rebate Address Update
RBT-2014-Q	Report	Drug Rebate Address Update

2.12.25.7 Change Order Status

Status	Date
Issue Identified	10/26/2005
SE Assigned	01/13/2006
Technical Design In Progress (obsolete)	01/13/2006
Construction in Progress	01/26/2006
Ready for Model Office	03/03/2006
Model Office Implemented	06/02/2006
UAT Implemented	11/01/2006
Ready for Model Office	02/20/2007
Model Office Implemented	02/22/2007
UAT Implemented	02/22/2007
Prod Implemented	02/22/2007

2.12.26 Enable Drug Labeler panels - 1406

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1406	Change Order		Reference Data Maintenance			1

2.12.26.1 Desired Solution

Add User Interface objects necessary to update/maintain the Drug Labeler data using the information.

This data is used in pharmacy encounter processing and also made available for online and reporting requirements.

2.12.26.2 Business Impact

Meet pharmacy encounter processing and MMIS reporting requirements.

2.12.26.3 Technical Specifications

Add to the Reference subsystem area the following Drug Rebate system objects for Core interChange:

- Page - Drug Rebate Labeler Information
- Page - Drug Rebate Labeler Search
- Panel - Drug Rebate Labeler Search
- Panel - Drug Labeler Rebate Status
- Panel - Labeler Address Base Information
- Panel - Labeler Address Information
- Panel - Labeler Maintenance
- Panel - Labeler Mini Search Panel
- Panel - Labeler Search Results
- Panel - Labeler Status List

The Drug Rebate link on the User Interface is enabled. The Security Function is used to enable/disable the appropriate pages and panels needed for the Drug Labeler data. All other Drug Rebate pages and panels are disabled.

2.12.26.4 Clarifications

This change order is implemented by modifying the Kentucky portal to include additional Reference menu items referred to as tabs or pages in the portal. There are two new Reference tabs: Drug Labeler, which displays the Drug labeler search page and iC_DR_DrugLblrInformation, which is a hidden tab associated with the Drug Labeler information module. These new tabs are associated with modules in the DR subsystem. As part of this implementation, several pages and panels were overridden in the Kentucky DR subsystem to include the Reference submenu and to point the internal navigation URLs to the Reference menu tabs. Thus the Kentucky reference team has assumed the responsibility for the Kentucky DR subsystem code.

2.12.26.5 Associated Requirements

Requirement ID	Type
30.090.006.002.6	RFP Requirement

2.12.26.6 Associated System Objects

Technical Name	Object Type	Title
DR.LabelerSearch	Panel	Drug Rebate Labeler Search
LabelerMiniSearchPanel	Panel	Labeler Mini Search Panel
DR.DrugLabelerContactInfo	Panel	Labeler Contact Information
LabelerStatusList	Panel	Labeler Status List
DR.LabelerSearchPg	Internal Page	Drug Rebate Labeler Search Page
LabelerMaintenance	Panel	Labeler Maintenance
LabelerSearchResults	Panel	Labeler Search Results
DR.LabelerBaseInformation	Panel	Labeler Base Information
DR.LabelerInfoPage	Internal Page	Drug Rebate Labeler Information Page

2.12.26.7 Change Order Status

Status	Date
Issue Identified	10/26/2005
Change Order Written	01/15/2006
SE Assigned	02/28/2006
Construction in Progress	02/28/2006
Ready for Construction Walkthrough	03/31/2006
Ready for Model Office	04/04/2006
Model Office Implemented	05/31/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.27 Core 8810 Benefit Adj Factor 1 - 1470

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1470	Change Order		Reference Data Maintenance			1

2.12.27.1 Desired Solution

See Core CO 8810 all documentation is updated on this CO

Provide the infrastructure to allow modifications to all pricing methodologies that have a variance or incentive from the regular pricing methodology.

2.12.27.2 Business Impact

See Core CO 8810 all documentation is updated on this CO

This change order provides the flexibility to enhance existing pricing methodologies and apply different adjustment facts in the form of additional amounts or percentages to be applied to the pricing methodology allowed amount.

2.12.27.3 Technical Specifications

See Core CO 8810 all documentation is updated on this CO

Create new Table: Table Name T_BNFT_ADJ_FACTOR

Action	Column Name	Description	Type	Length	Precision	Primary Key
Add	SAK_BENEFIT_ ADJ_FACTOR	System assigned key to uniquely identify a valid benefit adjustment type.	NUMBER	9	0	Yes
Add	SAK_BENEFIT_ ADJ_FACTOR_ TYPE/TD>	The code identifying the class of services/products to which the adjustment factor applies.	NUMBER	9	0	Yes
Add	DTE_EFFECTIV E	The date of service on which the benefit adjustment factor becomes valid.	DATETIME	8	0	No
Add	DTE_END	The date of service on which the benefit adjustment factor stops being valid.	DATETIME	8	0	No
Add	DTE_INACTIVE	This is the date when this segment becomes inactive and	DATETIME	8	0	No

Action	Column Name	Description	Type	Length	Precision	Primary Key
		is not used for claims received on and after it.				
Add	PCT_RATE_ADJ	The percentage that is used to adjust an allowed amount already calculated using the pricing methodologies that applies to the claim/detail.	NUMBER	5	3	No
Add	AMT_RATE_ADJ	The amount that is used to adjust an allowed amount already calculated using the pricing methodology that applies to the claim/detail.	NUMBER	6	2	No
Add	CDE_ALWD_CALCULATION	This indicator is necessary to identify if the benefit adjustment factor is applied before or after the allowed amount was finalized. Some benefit adjustment factors can be applied before a comparison between the billed amount and the allowed amount is done. Values 'B' - Before the calculated allowed amount is compared to the billed amount. Value 'A' - After the calculated amount is finalized.	CHAR	1	0	No

2.12.27.4 Clarifications

No associated clarifications found.

2.12.27.5 Associated Requirements

Requirement ID	Type
30.090.007.002.41	Claims Pricing

2.12.27.6 Associated System Objects

Technical Name	Object Type	Title
T_BNFT_ADJ_FACTOR_XREF	Database Table	
T_BNFT_ADJ_FACTOR	Database Table	

2.12.27.7 Change Order Status

Status	Date
Issue Identified	11/02/2005
Change Order Written	11/02/2005
SE Assigned	01/11/2006
Technical Design In Progress (obsolete)	01/11/2006
Ready for Tech Walkthrough	01/12/2006
FOLLOW-UP	05/31/2006
UAT Implemented	12/17/2006
Prod Implemented	06/14/2007

2.12.28 Core 8811 Benefit Adj Factor 2 - 1471

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1471	Change Order		Reference Data Maintenance			1

2.12.28.1 Desired Solution

See Core CO 8811 all documentation is updated on this CO

Provide the infrastructure to allow modifications to all pricing methodologies that have a variance or incentive from the regular pricing methodology.

2.12.28.2 Business Impact

See Core CO 8811 all documentation is updated on this CO

This change order provides the flexibility to enhance existing pricing methodologies and apply different adjustment facts in the form of additional amounts or percentages to be applied to the pricing methodology allowed amount.

2.12.28.3 Technical Specifications

See Core CO 8811 all documentation is updated on this CO

Create a new reference panel to provide support for the benefit adjustments factor table: Table:T_BNFT_ADJ_FACTOR.

This table is accessible through Reference - Related Data - Other.

2.12.28.4 Clarifications

We are waiting on Core design to be completed.

2.12.28.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.28.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.28.7 Change Order Status

Status	Date
Issue Identified	11/02/2005
Change Order Written	11/02/2005
FOLLOW-UP	04/26/2006
Model Office Implemented	09/15/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.29 Core 8812 Benefit Adj Factor 3 - 1472

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1472	Change Order		Reference Data Maintenance			1

2.12.29.1 Desired Solution

See Core CO 8812 all documentation is updated on this CO

Provide the infrastructure to allow modifications to all pricing methodologies that have a variance or incentive from the regular pricing methodology.

2.12.29.2 Business Impact

See Core CO 8812 all documentation is updated on this CO

This change order provides the flexibility to enhance existing pricing methodologies and apply different adjustment facts in the form of additional amounts or percentages to be applied to the pricing methodology allowed amount.

2.12.29.3 Technical Specifications

See Core CO 8812 all documentation is updated on this CO

Multiple Benefit Adjustment Factors may be required for the same pricing methodology. This change order is required to build a cross-reference table that allows the user to select the benefit adjustment factors that need to be applied during the pricing process. The user also is required to select the sequence of the benefit adjustment factor application to the pricing methodology.

Create new Table: Table Name T_BNFT_ADJ_FACTOR_XREF

Table Name: T_BNFT_ADJ_FACTOR_XREF

Action	Column Name	Description	Type	Length	Precision	Primary Key
Add	SAK_REIMB_AGRMNT	Unique identifier for rows on this table. This is also the unique index for the audit trail table and does not change.	NUMBER	9	0	Yes
Add	SAK_BENEFIT_ADJ_FACTOR_TYPE	System assigned key to uniquely identify a valid benefit adjustment type.	NUMBER	9	0	Yes
Add	NUM_SEQUENCE	Identifies the sequence the benefit adjustment factors should be applied.	NUMBER	9	0	Yes

2.12.29.4 Clarifications

No associated clarifications found.

2.12.29.5 Associated Requirements

Requirement ID	Type
30.090.007.002.41	Claims Pricing

2.12.29.6 Associated System Objects

Technical Name	Object Type	Title
T_BNFT_ADJ_FACTOR_XREF	Database Table	

2.12.29.7 Change Order Status

Status	Date
Issue Identified	11/02/2005
Change Order Written	11/02/2005
SE Assigned	01/11/2006
Technical Design In Progress (obsolete)	01/11/2006
Ready for Tech Walkthrough	01/12/2006
FOLLOW-UP	05/31/2006
UAT Implemented	12/17/2006
Prod Implemented	06/14/2007

2.12.30 Core 8813 Benefit Adj Factor 4 - 1473

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1473	Change Order		Reference Data Maintenance			1

2.12.30.1 Desired Solution

See Core CO 8813 all documentation is updated on this CO

Provide the infrastructure to allow modifications to all pricing methodologies that have a variance or incentive from the regular pricing methodology.

2.12.30.2 Business Impact

See Core CO 8813 all documentation is updated on this CO

This change order provides the flexibility to enhance existing pricing methodologies and apply different adjustment facts in the form of additional amounts or percentages to be applied to the pricing methodology allowed amount.

2.12.30.3 Technical Specifications

See Core CO 8813 all documentation is updated on this CO

Add the benefit adjustment factor ID to panel from table T_REIMB_AGREEMENT. This information is utilized during claims processing to identify the benefit adjustment factor to apply a percentage or a fixed amount to the allowed amount to get to the final allowed amount. Depending on the pricing methodology, cutbacks may apply to pay the lesser of billed and allowed or to allow greater than billed.

Make the following modifications to the reimbursement agreement panel:

- Add the Benefit Adjustment Factor (BAF) as an optional parameter.
- Edit to ensure that the BAF selected has valid dates that are within the from and through dates of the reimbursement agreement.
- If multiple BAFs are selected:
  - Edit to ensure that the user selects the sequence to which the BAFs should be applied.
  - Ensure that every BAF dates are within the from and through dates of the reimbursement agreement.
- If a single BAF is selected default the sequence to 1.

2.12.30.4 Clarifications

We are waiting on Core design to be completed.

2.12.30.5 Associated Requirements

Requirement ID	Type
30.090.006.002.8	RFP Requirement
30.090.007.002.41	Claims Pricing

2.12.30.6 Associated System Objects

Technical Name	Object Type	Title
Ref.Reimbursement Agreement	Panel	Reimbursement Rules-All Services

2.12.30.7 Change Order Status

Status	Date
Issue Identified	11/02/2005
Change Order Written	11/02/2005
FOLLOW-UP	04/26/2006
Model Office Implemented	12/15/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.31 Core 8817 Benefit Adj Factor 8 - 1477

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1477	Change Order		Reference Data Maintenance			1

2.12.31.1 Desired Solution

See Core CO 8817 all documentation is updated on this CO

Provide the infrastructure to allow modifications to all pricing methodologies that have a variance or incentive from the regular pricing methodology.

2.12.31.2 Business Impact

See Core CO 8817 all documentation is updated on this CO

This change order provides the flexibility to enhance existing pricing methodologies and apply different adjustment facts in the form of additional amounts or percentages to be applied to the pricing methodology allowed amount.

2.12.31.3 Technical Specifications

See Core CO 8817 all documentation is updated on this CO

Create new Table:

Table Name T_BNFT_ADJ_FACTOR_TYPE

Action	Column Name	Description	Type	Length	Precision	Primary Key
Add	SAK_BENEFIT_ADJ_FACTOR_TYPE	System assigned key to uniquely identify a valid benefit adjustment type.	NUMBER	9	0	Yes
Add	CDE_BNFT_ADJ_TYPE	The code identifying the class of services/products to which the adjustment factor applies.	CHAR	11	0	No
Add	DESCRIPTION	The description of the Benefit Adjustment Factor.	VARCHAR	250	0	No

2.12.31.4 Clarifications

No associated clarifications found.

2.12.31.5 Associated Requirements

Requirement ID	Type
30.090.007.002.41	Claims Pricing

2.12.31.6 Associated System Objects

Technical Name	Object Type	Title
T_BNFT_ADJ_FACTOR_TYPE	Database Table	

2.12.31.7 Change Order Status

Status	Date
Issue Identified	11/02/2005
Change Order Written	11/02/2005
SE Assigned	01/11/2006
Technical Design In Progress (obsolete)	01/11/2006
Ready for Tech Walkthrough	01/12/2006
FOLLOW-UP	05/31/2006
UAT Implemented	12/17/2006
Prod Implemented	06/14/2007

2.12.32 Core 8992 Pricing Ind Expansion - 1647

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1647	Change Order		Reference Data Maintenance			1

2.12.32.1 Desired Solution

See Core CO 8992 - all documentation is updated on this CO

To be able to provide an easier identification of pricing methodology that was utilized to price a claim or detail, it is necessary to make an expansion of the pricing indicator field. The current process utilizes a one digit alphanumeric field. The modifications requested impact panels, tables and programs that currently utilize the pricing indicator. The new field size was expanded from one digit to six alphanumeric characters.

2.12.32.2 Business Impact

See Core CO 8992 - all documentation is updated on this CO

Create a more descriptive pricing indicator to identify the pricing methodology utilized to price a claim.

2.12.32.3 Technical Specifications

See Core CO 8992 - all documentation is updated on this CO

Make modifications to reference panels that display the pricing indicator as follows:

- Code-Pricing panel
  - Assign a sak to every pricing code that exists.
  - Expand the Pricing Code field to allow up to the new length.
- All other reference panels
  - Expand the pricing code field to allow up to the new length.
  - Read t_pricing table to get the actual code using the sak_pricing assign to the pricing indicator.

2.12.32.4 Clarifications

No associated clarifications found.

2.12.32.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.32.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.32.7 Change Order Status

Status	Date
Change Order Written	11/15/2005
Construction in Progress	03/28/2006
Ready for Construction Walkthrough	04/10/2006
Ready for Model Office	04/17/2006
Model Office Implemented	04/28/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.33 Core 8183 Add POS T_REIMB_AGREEM - 1650

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1650	Change Order		Reference Data Maintenance			1

2.12.33.1 Desired Solution
Add the Type of Bill (TOB) parameter to the reimbursement rules table. This allows support for pricing by the place of service.

2.12.33.2 Business Impact
Add the Type of Bill (TOB) parameter to the reimbursement rules panel. This allows support for pricing by the place of service.

2.12.33.3 Technical Specifications
Add the Type of Bill (TOB) to the reimbursement panel to support reimbursement by the place of service.

This CO is being worked in a batch along with 3000,3018,2536,2997,1940,1650,2991.

Technical specifications for all COs - KY Reimbursement Rule CO Matrix

2.12.33.4 Clarifications
Cancelled CO - With the new rules engine design for benefit plan solution, this table change is no longer needed.

[Troy Schexnayder]

This modification did not get made in Core, so needs to be completed in the KY application. Reopened CO. [Troy Schexnayder]

2.12.33.5 Associated Requirements

Requirement ID	Type
30.090.006.002.8	RFP Requirement

2.12.33.6 Associated System Objects

Technical Name	Object Type	Title
Ref.Reimbursement Agreement	Panel	Reimbursement Rules-All Services

2.12.33.7 Change Order Status

Status	Date
Change Order Written	11/15/2005
Cancelled	05/31/2006
Change Order Written	07/25/2006
Ready for Model Office	08/24/2006
Model Office Implemented	09/15/2006

Status	Date
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.34 Core 10359 WI 1124 - DRG RATES - 1687

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1687	Change Order		Reference Data Maintenance			1

2.12.34.1 Desired Solution

See Core CO 10359 all documentation is updated on this CO

See WI CO 1124

The Reference Subsystem area needs to be able to support DRG pricing. The DRG process includes:

- DRG Codes and Descriptions
- DRG Weights and Rates
- DRG Peer Group Weights and Rates

2.12.34.2 Business Impact

See Core CO 10359 all documentation is updated on this CO

See WI CO 1124

Meets RFP requirements to provide the functionality to update, store and view the DRG information required to support the DRG pricing methodology.

2.12.34.3 Technical Specifications

See Core CO 10359 all documentation is updated on this CO

See WI CO 1124

Add the following attributes to table T_DRG_RATE:
NUM_DAY_OUTLIER_LOW
NUM_DAY_OUTLIER_HIGH
PCT_SUPPLEMENTAL
DTE_INACTIVE

The following attributes are removed from the table:
NUM_COST_OUTLIER
PCT_COST_OUTLIER
CDE_STATUS
DTE_STATUS_CHANGE

Please see the data model change form under supplemental documentation for detailed information concerning the new table attributes.

2.12.34.4 Clarifications

Changes related to Wisconsin CO 1124 were made in Core and copied to KY to support KY pricing functionality.

The changes for change order 1684 were merged with this change order so that CO 1684 could be cancelled.

2.12.34.5 Associated Requirements

Requirement ID	Type
30.090.006.001.7	RFP Requirement
30.090.007.002.41	Claims Pricing

2.12.34.6 Associated System Objects

Technical Name	Object Type	Title
T_DRG_RATE	Database Table	

2.12.34.7 Change Order Status

Status	Date
Issue Identified	11/28/2005
Change Order Written	01/15/2006
Ready for Model Office	05/30/2006
Model Office Implemented	06/01/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.35 Core 10362 WI 1450 - DRG Xwlk - 1689

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1689	Change Order		Reference Data Maintenance			1

2.12.35.1 Desired Solution

See Core CO 10362 all documentation is updated on this CO

See WI CO 1450

The ICD-9 procedure codes crosswalk table requires a panel in the reference subsystem area to support the backwards compatibility. The table that stores the ICD-9 procedure codes crosswalk information is identified in change order 1448.

2.12.35.2 Business Impact

See Core CO 10362 all documentation is updated on this CO

See WI CO 1450

This change order is required to support the current DRG grouper policies.

2.12.35.3 Technical Specifications

See Core CO 10362 all documentation is updated on this CO

See WI CO 1450

Create a new panel to support the maintenance of the ICD-9 procedure codes backwards compatibility.

2.12.35.4 Clarifications

Changes related to Wisconsin CO 1450 were made in Core and copied to KY to support KY pricing functionality.

2.12.35.5 Associated Requirements

Requirement ID	Type
30.090.006.001.7	RFP Requirement

2.12.35.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.35.7 Change Order Status

Status	Date
Issue Identified	11/28/2005
Change Order Written	01/15/2006
Construction in Progress	04/04/2006
Ready for Model Office	06/14/2006

Status	Date
Model Office Implemented	01/08/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.36 Core 10361 WI 1449 - DRG Dx Xwlk - 1690

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1690	Change Order		Reference Data Maintenance			1

2.12.36.1 Desired Solution

See Core CO 10361 all documentation is updated on this CO

See WI CO 1449

The diagnosis crosswalk table requires a panel in the reference subsystem area to support the backwards compatibility. The table that stores the diagnosis codes crosswalk information is identified in change order 1447.

2.12.36.2 Business Impact

See Core CO 10361 all documentation is updated on this CO

See WI CO 1449

This change order is required to support the DRG grouper policies.

2.12.36.3 Technical Specifications

See Core CO 10361 all documentation is updated on this CO

See WI CO 1449

Create a new panel to support the maintenance of the diagnosis backwards compatibility.

2.12.36.4 Clarifications

Changes related to Wisconsin CO 1449 were made in Core and copied to KY to support KY pricing functionality.

2.12.36.5 Associated Requirements

Requirement ID	Type
30.090.006.001.7	RFP Requirement

2.12.36.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.36.7 Change Order Status

Status	Date
Issue Identified	11/28/2005
Change Order Written	01/15/2006
Construction in Progress	04/04/2006
Ready for Model Office	06/14/2006

Status	Date
Model Office Implemented	01/08/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.37 Core 10360 WI 1125 - DRG 18 - 1691

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1691	Change Order		Reference Data Maintenance			1

2.12.37.1 Desired Solution

See Core CO 10360 all documentation is updated on this CO

See WI CO 1125

The Reference Subsystem area needs to be able to support DRG pricing. The DRG process includes:

- DRG Codes and Descriptions
- DRG Weights and Rates
- DRG Peer Group Weights and Rates
- DRG Supplemental Percentage

2.12.37.2 Business Impact

See Core CO 10360 all documentation is updated on this CO

See WI CO 1125

Provide the functionality to update, store and view the DRG information required to support this pricing methodology.

2.12.37.3 Technical Specifications

See Core CO 10360 all documentation is updated on this CO

See WI CO 1125

The following changes need to be made to the DRG Rates panel:

- Change Day Outlier column to "Low Day Outlier Threshold"
- Add New Column "High Day Outlier Threshold"
- Change Cost Outlier to "Cost Outlier Threshold"
- Remove Cost Outlier
- Remove Cost Outlier %
- Add New Column Supplemental Percentage. This field is not required and defaults to zero.

2.12.37.4 Clarifications

Changes related to Wisconsin CO 1125 were made in Core and copied to KY to support KY pricing functionality.

Added requirements for supplemental percentage from CO 1688 since all changes were to the same table. CO 1688 is being cancelled.

2.12.37.5 Associated Requirements

Requirement ID	Type
30.090.006.001.7	RFP Requirement
30.090.006.002.8	RFP Requirement

2.12.37.6 Associated System Objects

Technical Name	Object Type	Title
Ref.DRGRatesPanel.ascx	Panel	Rates-DRG

2.12.37.7 Change Order Status

Status	Date
Issue Identified	11/28/2005
Change Order Written	01/15/2006
SE Assigned	03/28/2006
Ready for Model Office	05/25/2006
Model Office Implemented	06/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.38 Add Dose/Package information - 1804

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1804	Change Order		Reference Data Maintenance	41.00		1

2.12.38.1 Desired Solution
It is helpful to display in the Search Results table, the Package/Dose information to the right of the Brand Name column to coincide with the Drug NDC column

2.12.38.2 Business Impact
Meet business needs.

2.12.38.3 Technical Specifications
Change Drug Search Results panel to drug Label Name instead of Brand Name.

The Label Name is a 60-character alphanumeric column that contains a combination of the drug name appearing on the package label, the strength description and the dosage form description for a specified product.

[Troy Schexnayder]

2.12.38.4 Clarifications
Identified by Amie Redmon as part of the GSD review.

Change Drug Search Results panel to drug Label Name instead of Brand Name.

The Label Name is a 60-character alphanumeric column that contains a combination of the drug name appearing on the package label, the strength description and the dosage form description for a specified product.

[Troy Schexnayder]

Supplemental documentation can be found under the corresponding core change order - 10849.

2.12.38.5 Associated Requirements

Requirement ID	Type
30.090.006.002.6	RFP Requirement

2.12.38.6 Associated System Objects

Technical Name	Object Type	Title
Reference Drug Search	Internal Page	Reference Drug Search Page
Ref.DrugSearchPanel.ascx-Search Results	Panel	Search Results-Drug

2.12.38.7 Change Order Status

Status	Date
Issue Identified	12/28/2005
Change Order Written	01/15/2006

Status	Date
SE Assigned	02/28/2006
Construction in Progress	02/28/2006
Ready for Construction Walkthrough	03/17/2006
Ready for Model Office	03/23/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.39 Audit - add conflict parm table - 1816

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1816	Change Order		Reference Data Maintenance			1

2.12.39.1 Desired Solution
Create a parameters table to be used in conflict audit processing in those cases where the standard overlapping date relationship between the current and history claim does not meet the audit requirements. This table is used to support a new audit parameters panel for conflict audits and a corresponding new date function in the claims audit program.

2.12.39.2 Business Impact
Support KY business policy.

2.12.39.3 Technical Specifications
Create a new table (t_conflict_parm). The table structure can be the same as t_conflict_parm. See the attached database change request for details.

2.12.39.4 Clarifications
No associated clarifications found.

2.12.39.5 Associated Requirements

Requirement ID	Type
30.090.007.002.24	Claims Edit/Audit

2.12.39.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.39.7 Change Order Status

Status	Date
Issue Identified	01/09/2006
Change Order Written	01/15/2006
Model Office Implemented	05/31/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.40 Core 9739 Reimb Rule Parms 1 - 1940

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
1940	Change Order		Reference Data Maintenance			1

2.12.40.1 Desired Solution

See Core CO 9739 all documentation is updated on this CO

Modify the Reimbursement Agreement panel to support the new parameters:

- patient status
- admission date
- discharge date

2.12.40.2 Business Impact

See Core CO 9739 all documentation is updated on this CO

This allows the support of DRG pricing for KY DDI implementation.

2.12.40.3 Technical Specifications

See Core CO 9739 all documentation is updated on this CO

Update the reimbursement panels with the new parameters:

- patient status
- admission date
- discharge date

This CO is being worked in a batch along with 3000, 3018, 2536, 2997, 1940, 1650, 2991.

Technical specifications for all COs - KY Reimbursement Rule CO Matrix

2.12.40.4 Clarifications

Change is made in core related to core CO 9739 and then copied to KY.

Cancelled CO - With the new rules engine design for benefit plan solution, this table changes is no longer needed.

[Troy Schexnayder]

This change was not made in Core and needs to be implemented in KY. CO has been reopened. [Troy Schexnayder]

2.12.40.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.40.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.40.7 Change Order Status

Status	Date
Change Order Written	01/12/2006
Cancelled	05/31/2006
Change Order Written	07/25/2006
Ready for Model Office	08/24/2006
Model Office Implemented	09/15/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.41 Add Lay Desc - REFJA100 - 2004

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2004	Change Order		Reference Data Maintenance			1

2.12.41.1 Desired Solution
Add new attribute Layman Description to ICD-9-CM Diagnosis and Procedure update process.

2.12.41.2 Business Impact
Meet KY requirement 30.090.006.002.3 - lay language and KY requirement 30.090.006.002.4 - lay language.

2.12.41.3 Technical Specifications
Tables T_DIAGNOSIS and T_PROC_ICD9 were modified to add a new column DSC_LAY. This column is used to maintain layman descriptions for the two code sets.

Modify the Annual ICD-9-CM Job (REFJA0100) to default the DSC_LAY column to spaces on and Add transaction.

The following SYSIN cards needs to be modified:

- rfa0100.diagnosis.tree.xml
- rfa0100.procIcd9.tree.xml

2.12.41.4 Clarifications
Reference Core Change Order 9030 for detail about predecessor data model change orders 8967 and 8968.

Second release to MO for additional updates required in the data model schemas and control cards needed for the KY DDI.

Corrected issue where the Location field on the report was not populated.

Moved ref0100_rm_decimals PERL script to job directory to allow it to execute. Members in the sysin directory can not be executed.

See Implementation Plan v2.

[Troy Schexnayder]

2.12.41.5 Associated Requirements

Requirement ID	Type
30.090.006.002.3	RFP Requirement
30.090.006.002.4	RFP Requirement

2.12.41.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.41.7 Change Order Status

Status	Date
Issue Identified	01/29/2006
Change Order Written	01/30/2006
SE Assigned	01/30/2006
Ready for Model Office	04/27/2006
Model Office Implemented	05/04/2006
Model Office Implemented	05/05/2006
UAT Implemented	11/01/2006
Ready for Model Office	03/28/2007
Model Office Implemented	03/29/2007
UAT Implemented	03/29/2007
Prod Implemented	03/29/2007

2.12.42 Conflict audit parms-Core 9797 - 2005

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2005	Change Order		Reference Data Maintenance			1

2.12.42.1 Desired Solution
Add a new table T_CONFLICT_PARM. This table allows for an optional definition of a date relationship. If present, the date relationship overrides the normal conflict audit processing that checks for overlapping dates.

2.12.42.2 Business Impact
This change is needed to support current KY audit processing.

2.12.42.3 Technical Specifications
See the database change request and relationship forms in the supplemental documentation.

See Core CO 9797 for supplemental documentation, all documentation is updated on this CO

2.12.42.4 Clarifications
Associated core change order is 9797

2.12.42.5 Associated Requirements

Requirement ID	Type
30.090.007.002.24	Claims Edit/Audit
30.090.007.002.24A	RFP Split Requirement

2.12.42.6 Associated System Objects

Technical Name	Object Type	Title
T_AUDIT_PROC	Database Table	
T_AUDT_PROC_XRF	Database Table	

2.12.42.7 Change Order Status

Status	Date
Change Order Written	01/30/2006
Model Office Implemented	05/18/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.43 New panel-cnflct parms-Core 9801 - 2007

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2007	Change Order		Reference Data Maintenance			1

2.12.43.1 Desired Solution
Create a new panel "Audit Parameters(Conflict)-Error Disposition" to support maintenance of the T_CONFLICT_PARM table.

2.12.43.2 Business Impact
Allowing table driven date processing provides greater flexibility in defining conflict audits.

2.12.43.3 Technical Specifications
The new panel duplicates the processing of the contra-indicated audit parameters (except that an additional indicator IND_FDOS_ADMIT was added for conflict processing). The new indicator accepts either an 'F' (from date of service) or an 'A' (admit). If no value is entered, the default should be 'F'.

See Core CO 9801 - all supplemental documentation is updated on this CO

2.12.43.4 Clarifications
[Susy Bunk]

Please add the following description for the Date Indicator under panel field descriptions:

Date Indicator - Indicates audit processing logic based on different dates.

- 'F' - From Date Of Service - Date relationship between current and history claim is based on from date of service of the institutional claim.
- 'A' - Admit Date - Date relationship between current and history claim is based on the admit date of the institutional claim.
- 'B' - Bypass Same FDOS and Admit - The conflict audit is bypassed if the current claim FDOS is equal to the history Admit date.
- 'D' - Bypass Same FDOS and Discharge- The conflict audit is bypassed if the current claim FDOS is equal to the history Discharge date.
- 'C' - Bypass Same FDOS and Admit or Discharge - The conflict audit is bypassed if the current claim FDOS is equal to the history Admit or Discharge Dates.

2.12.43.5 Associated Requirements

Requirement ID	Type
30.090.006.002.10	RFP Requirement
30.090.007.002.24	Claims Edit/Audit

2.12.43.6 Associated System Objects

Technical Name	Object Type	Title
Ref.ConflictParametersPanel.ascx	Panel	Audit Parameters(Conflict)-Error Disposition

2.12.43.7 Change Order Status

Status	Date
Change Order Written	01/30/2006
SE Assigned	02/06/2006
Technical Design In Progress (obsolete)	02/06/2006
Ready for Tech Walkthrough	02/06/2006
Construction in Progress	03/06/2006
Ready for Construction Walkthrough	03/06/2006
Ready for Model Office	03/08/2006
Ready for Model Office	03/08/2006
Model Office Implemented	03/30/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.44 DM s/d diag audit crit-Core 9798 - 2021

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2021	Change Order		Reference Data Maintenance			1

2.12.44.1 Desired Solution
Add an additional column (CDE_S_D_DIAG) to the audit criteria table (T_AUDIT_CRIT). The new code is used primarily in conflict audit situations where the conflict requires the same primary diagnosis on the current claim and the claim in history. In addition to the same/different indicator, add a new column (CDE_DIAG_TYPE) to the audit criteria table as well. This code is used to determine what type of diagnosis checking is performed (admit, emergency, primary, secondary, discharge, any).

2.12.44.2 Business Impact
This change is needed to support current Kentucky audit policy.

2.12.44.3 Technical Specifications
See the database change request and impact analysis documents in the supplemental documentation.

2.12.44.4 Clarifications
Associated core change order is 9798

2.12.44.5 Associated Requirements

Requirement ID	Type
30.090.007.002.24A	RFP Split Requirement

2.12.44.6 Associated System Objects

Technical Name	Object Type	Title
T_AUDIT_CRIT	Database Table	

2.12.44.7 Change Order Status

Status	Date
Issue Identified	02/02/2006
Change Order Written	02/02/2006
Ready for Model Office	05/01/2006
Model Office Implemented	05/31/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.45 DM s/d quadrant - Core 9891 - 2022

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2022	Change Order		Reference Data Maintenance			1

2.12.45.1 Desired Solution
Certain Kentucky dental procedures are limited to one per quadrant per period. Adding a same/different type indicator allows these audits to be configured as normal limitation audits. Because there can be up to five "quadrants" (oral cavity codes) per detail, the indicator allows for the specification of a complete match, an inclusive match, a partial match or an exclusive match (no match) between the current and history claims.

2.12.45.2 Business Impact
This change supports current Kentucky audit policy.

2.12.45.3 Technical Specifications
See supplemental documentation for detail of the change request and impact.

2.12.45.4 Clarifications
Associated core change order is 9891

2.12.45.5 Associated Requirements

Requirement ID	Type
30.090.007.002.24A	RFP Split Requirement

2.12.45.6 Associated System Objects

Technical Name	Object Type	Title
T_AUDIT_CRIT	Database Table	

2.12.45.7 Change Order Status

Status	Date
Issue Identified	02/02/2006
Change Order Written	02/02/2006
Ready for Model Office	05/01/2006
Model Office Implemented	05/31/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.46 DM Equal audit units -Core 9824 - 2023

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2023	Change Order		Reference Data Maintenance			1

2.12.46.1 Desired Solution
Modify tables that contain procedure information used in limitation auditing to incorporate the ability to audit codes billed in different time units on an equal basis. This ability currently exists in the Kansas implementation of interChange and the requirement to convert billed units into equal auditing units is a requirement for Kentucky. This change is being added to core as it may have benefit for future implementations and does not impact current processing.

2.12.46.2 Business Impact
This change is required to support current Kentucky audit policy.

2.12.46.3 Technical Specifications
See the database change request and relationship forms in the supplemental documentation.

2.12.46.4 Clarifications
Associated core change order is 9797

2.12.46.5 Associated Requirements

Requirement ID	Type
30.090.007.002.24A	RFP Split Requirement

2.12.46.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.46.7 Change Order Status

Status	Date
Issue Identified	02/02/2006
Change Order Written	02/02/2006
Model Office Implemented	05/31/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.47 Audt proc dbChg impact-Core 9829 - 2024

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2024	Change Order		Reference Data Maintenance			1

2.12.47.1 Desired Solution
Remediate system objects affected by the addition of a new column to tables T_AUDIT_PROC and T_AUDT_PROC_XRF and addition of new same/different indicators for diagnosis and tooth quadrant on T_AUDIT_CRIT. The primary impact is to reports that display information related to audit criteria. The following reports are affected: REF-0200-M REF-0201-M.

2.12.47.2 Business Impact
Current reports are updated to reflect the new data elements used in audits. These changes are necessary to provide users with a complete understanding of the audit criteria being applied.

2.12.47.3 Technical Specifications
Modify the Limitation Audit Criteria Report (REF-0201-M) report created in program refp0201.sc to include the 'conversion factor' (NUM_UNIT_FRCT) being added under core change order 9824.

Modify the Audit Criteria Report (REF-0200-M) report created in program refp0200.sc to include the new same/different indicators (CDE_S_D_QUAD, CDE_S_D_DIAG) and the associated new indicators (IND_QUAD_TYPE and IND_DIAG_TYPE) added under core change orders 9798 and 9891.

Also include the new CDE_REFERRAL being added under core change order 10285.

A separate design is needed for each report to determine how to best 'fit' the new data items onto the reports. The current reports use all of the available space within the current report lines.

2.12.47.4 Clarifications
Associated core change order is 9829

Specifications changed and these are the fields that are being added:

- CDE_S_D_DIAG
- IND_DIAG_TYPE
- CDE_QUAD
- CDE_REFERRAL

2.12.47.5 Associated Requirements

Requirement ID	Type
30.090.007.002.24A	RFP Split Requirement

2.12.47.6 Associated System Objects

Technical Name	Object Type	Title
REF-0200-M	Report	Audit Criteria Report

Technical Name	Object Type	Title
refp0201	Program	Limitation Audit Criteria Report
REF-0201-M	Report	Limitation Audit Criteria Report
refp0200	Program	Audit Criteria Report

2.12.47.7 Change Order Status

Status	Date
Issue Identified	02/02/2006
Change Order Written	02/02/2006
SE Assigned	05/02/2006
Construction in Progress	06/16/2006
MO Testing in Progress	06/20/2006
Ready for Model Office	06/22/2006
Model Office Implemented	06/30/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.48 Maintain audit crit - Core 9800 - 2025

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2025	Change Order		Reference Data Maintenance			1

2.12.48.1 Desired Solution

Modify the Audit Criteria Base - Error Disposition panel to incorporate processing of a new same/different indicator for diagnosis and a new diagnosis type indicator.

Modify the Audit Criteria Base - Error Disposition panel to incorporate processing of a new same/different indicator for tooth quadrant and a new quadrant matching indicator to determine whether all oral cavity designations code must match, all codes present on the current detail must be present on the history detail or if at least one quadrant must match between the current and history claim.

Also modify the Audit Criteria Base - Error Disposition panel to incorporate processing of a new "Referral Bypass Code".

2.12.48.2 Business Impact

The primary purpose for this change is to add additional flexibility in configuring audits. The changes support audits which have the condition that both the current and history service have the same principal diagnosis, to support audits which have the condition that limits dental services only where the same quadrant is involved and to allow an audit to be bypassed based on the presence of a referral on the current claim.

2.12.48.3 Technical Specifications

The new field (Tooth Quadrant) appears at the bottom of the current grouping of same/different indicators (under Tooth Surface) and the new field (Diagnosis) appears under Procedure. Both new S/D indicators allow the same values as other S/D indicators. The new referral code appears at the bottom of the "Other Indicators" grouping on the panel and allows two values: "A" - any referring provider ID found on the claim bypasses the audit and "P" - the referring provider ID found on the claim must be the member's PCCM provider.

2.12.48.4 Clarifications

Associated core change order is 9800

2.12.48.5 Associated Requirements

Requirement ID	Type
30.090.007.002.24A	RFP Split Requirement

2.12.48.6 Associated System Objects

Technical Name	Object Type	Title
Ref.AuditCritBasePanel.ascx	Panel	Audit Criteria Base-Error Disposition

2.12.48.7 Change Order Status

Status	Date
Issue Identified	02/02/2006
Change Order Written	02/02/2006

Status	Date
Construction in Progress	03/22/2006
Ready for Construction Walkthrough	03/22/2006
Ready for Model Office	03/23/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.49 Add conversion factor -Core 9840 - 2026

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2026	Change Order		Reference Data Maintenance			1

2.12.49.1 Desired Solution
Update the Audit Restriction-Procedure-Error Disposition panel to process the new data element (NUM_UNIT_FRCT) added to T_AUDIT_PROC and T_AUDT_PROC_XRF.

2.12.49.2 Business Impact
Allows limitations that apply to codes billed with inconsistent unit measurements to be converted to an equal basis. For example, if an audit needs to be set up to allow five hours of group therapy per month and the limitation applies to two procedure codes, one billed in 15 minute units and one billed in hourly units. The new 'conversion factor' (NUM_UNIT_FRCT) field divides the units billed in 15 minute units by four to convert the units to the same basis as the units on the other audited code.

2.12.49.3 Technical Specifications
The NUM_UNIT_FRCT defaults to 1 if not entered. Only the T_AUDT_PROC_XRF table is accessible from the UI. The entity and XML associated with this table needs to be modified so that the NUM_UNIT_FRCT value can be entered and modified from the UI. The T_AUDIT_PROC table entries are created internally by expanding the T_AUDT_PROC_XRF rows such that there is a row for every Procedure code.

2.12.49.4 Clarifications
Associated core change order is 9840

2.12.49.5 Associated Requirements

Requirement ID	Type
30.090.007.002.24A	RFP Split Requirement

2.12.49.6 Associated System Objects

Technical Name	Object Type	Title
Ref.AuditProcedurePanel.ascx	Panel	Audit Restriction-Procedure-Error Disposition

2.12.49.7 Change Order Status

Status	Date
Issue Identified	02/02/2006
Change Order Written	02/02/2006
SE Assigned	02/23/2006
Construction in Progress	02/28/2006
SE Assigned	05/05/2006
Construction in Progress	05/05/2006

Status	Date
Ready for Construction Walkthrough	05/10/2006
Ready for Model Office	05/10/2006
Model Office Implemented	06/01/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.50 Referral on audt crit-Core 10285 - 2027

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2027	Change Order		Reference Data Maintenance			1

2.12.50.1 Desired Solution

Add an additional column (CDE_REFERRAL) to the audit criteria table (T_AUDIT_CRIT). The new code is used like the current PA Override indicator. The referral code accepts two values. A value of 'P' indicates that the audit is bypassed if a valid PCCM referral is found on the claim. A value of 'A' indicates that any referring provider ID (the referral need not be from the PCCM provider) present on the claim causes the audit to be bypassed.

2.12.50.2 Business Impact

This change is being made primarily to support Kentucky audit policy (existing KY audit 820).

2.12.50.3 Technical Specifications

See database change request and relationship documents in supplemental documentation.

2.12.50.4 Clarifications

Corresponding core CO is 10285

Need clarification on the following:
[Responses from Bob Carter]
1) How should this field be labeled on the Audit Criteria panel ? Referral Override
2) The referral codes are defined as A and P, what should the panel display in the drop down as descriptions for these codes?
E.g.
A - Any
P - PCCM
Your examples are correct.
3) Does the drop down need to contain a blank value ?
I'm not sure what criteria are used to make this determination. This is an optional indicator (only on rare occasion would a value of A or P be appropriate). Most of the time no entry would be made. If a blank value in the drop down is needed to support 'no entry' then we would need a blank value.
4) What is the default for this field on an Add ? Blank/spaces.

This CO was completed as part of Core CO 9800.
[Troy Schexnayder]

2.12.50.5 Associated Requirements

Requirement ID	Type
30.090.007.002.24A	RFP Split Requirement

2.12.50.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.50.7 Change Order Status

Status	Date
Change Order Written	02/02/2006
Model Office Implemented	05/31/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.51 Add Codes-ASC Payment Group - 2087

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2087	Change Order		Reference Data Maintenance			3

2.12.51.1 Desired Solution
Add a panel to add/view ASC Payment Group records.

2.12.51.2 Business Impact
Add a panel to add/view ASC Payment Group records.

2.12.51.3 Technical Specifications
Add new panel **Codes-ASC Payment Group** to allow online users to maintain the list of ASC Payment Groups stored on T_ASC_GROUP.

Add link for ASC Payment Group to the Related Data - Codes panel.

See attached business design

Verify that all related data model, page and panel documentation is updated for listed changes

2.12.51.4 Clarifications
This CO is a duplicate of Core CO 10677. Please update documentation in both workbooks.

2.12.51.5 Associated Requirements

Requirement ID	Type
30.090.006.002.8	RFP Requirement

2.12.51.6 Associated System Objects

Technical Name	Object Type	Title
Ref.ASCGroupPanel.ascx	Panel	Codes-ASC Payment Group

2.12.51.7 Change Order Status

Status	Date
Change Order Written	02/17/2006
SE Assigned	02/20/2006
Ready for Construction Walkthrough	03/01/2006
Ready for Model Office	03/08/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.52 Add Other-ASC Pricing - 2088

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2088	Change Order		Reference Data Maintenance			3

2.12.52.1 Desired Solution
Add a panel to add/view ASC Payment Pricing records.

2.12.52.2 Business Impact
Add a panel to add/view ASC Payment Pricing records.

2.12.52.3 Technical Specifications
Add new panel **Other-ASC Pricing** to allow online users to maintain the ASC Pricing Rates stored on T_ASC_PRICING.

Add link for ASC Pricing to the Related Data - Others panel.

See attached business design

Verify that all related data model, page and panel documentation is updated for listed changes.

2.12.52.4 Clarifications
This CO is a duplicate of Core CO 10678. Please update documentation in both workbooks.

2.12.52.5 Associated Requirements

Requirement ID	Type
30.090.006.002.8	RFP Requirement

2.12.52.6 Associated System Objects

Technical Name	Object Type	Title
Ref.ASCPricingPanel.ascx	Panel	Other-ASC Pricing

2.12.52.7 Change Order Status

Status	Date
Change Order Written	02/17/2006
SE Assigned	02/20/2006
Ready for Construction Walkthrough	03/01/2006
Ready for Model Office	03/08/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.53 Add ASC Payment Group-HCPCS Proc - 2089

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2089	Change Order		Reference Data Maintenance			3

2.12.53.1 Desired Solution
Add a panel to add/view ASC Payment Groups for HCPCS procedures.

2.12.53.2 Business Impact
Add a panel to add/view ASC Payment Groups for HCPCS procedures.

2.12.53.3 Technical Specifications
Add new panel **ASC Payment Group-HCPCS Procedure** to allow online users to map ASC Pricing Rates to HCPCS Procedures. Data is stored on stored on T_PROC_ASC.

Add link for ASC Pricing to the HCPCS Procedure panel.

See attached business design

Verify that all related data model, page and panel documentation is updated for listed changes.

2.12.53.4 Clarifications
This CO is a duplicate of Core CO 10680. Please update documentation in both workbooks.

2.12.53.5 Associated Requirements

Requirement ID	Type
30.090.006.002.8	RFP Requirement

2.12.53.6 Associated System Objects

Technical Name	Object Type	Title
Ref.ProcedureASCGroupPanel.ascx	Panel	ASC Payment Group-HCPCS Procedure

2.12.53.7 Change Order Status

Status	Date
Change Order Written	02/17/2006
SE Assigned	02/20/2006
Ready for Construction Walkthrough	03/01/2006
Ready for Model Office	03/08/2006
Model Office Implemented	04/06/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.54 Enhance Search Functionality - 2146

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2146	Change Order		Reference Data Maintenance			1

2.12.54.1 Desired Solution
Enhance the reference panel search criteria.

2.12.54.2 Business Impact
Currently search function only uses the Short description and does a search where the criteria is "contained" in the short description.

Search was modified to allow user to modify how search is perform.

2.12.54.3 Technical Specifications
Modify the description search functionality to do the following:

- Add a Radio Button Collection to indicate how description search function performs with the following choices:
  - Begins with (default to selected)
    Look for codes whose description "begins with" the search criteria entered.
  - Contains
    Look for codes whose description contains the search criteria entered.
- Where applicable add a Radio Button Collection - referred to as the Type radio button collection in this discussion - to indicate which code description is used:
  - Short Description (default to selected)
  - Long Description
  - Lay Description

One and only one radio button can be selected from each radio button collection displayed on the panel.

The Type radio button collection is only applicable to Diagnosis and Procedure searches with all three choices and for Modifier search with only the Short and Long choices.

Where the Type radio button collection is applicable the Search results include a column for the select type (for example, a long, short or lay description column).

The Diagnosis Panel in the Associated System Objects below has been updated to show the new layout.

2.12.54.4 Clarifications
Documentation for this CO is found under the corresponding core CO - 10691.

2.12.54.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.54.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.54.7 Change Order Status

Status	Date
Construction in Progress	03/10/2006
Ready for Construction Walkthrough	03/17/2006
Ready for Model Office	03/23/2006
Model Office Implemented	05/31/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.55 DRG Peer Group Panels - 2212

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2212	Change Order		Reference Data Maintenance			1

2.12.55.1 Desired Solution

This change order is required to support DRG (Diagnosis Related Cost) pricing methodology. Peer group rates are required to be able to price the claims under this pricing methodology.

The following changes need to be made to the DRG Rates panel:

- Change Day Outlier column to "Low Day Outlier Threshold"
- Add New Column "High Day Outlier Threshold"
- Change Cost Outlier to "Cost Outlier Threshold"
- Remove Cost Outlier
- Remove Cost Outlier %
- Add New Column Supplemental Percentage.

2.12.55.2 Business Impact

Meet Kentucky DRG pricing policy requirements.

2.12.55.3 Technical Specifications

The following changes need to be made to the DRG Rates panel:

- Change Day Outlier column to "Low Day Outlier Threshold"
- Add New Column "High Day Outlier Threshold"
- Change Cost Outlier to "Cost Outlier Threshold"
- Remove Cost Outlier
- Remove Cost Outlier %
- Add New Column Supplemental Percentage. This field is not required and defaults to zero.

Please reference/coordinate this CO with Core CO 10360. The changes to the DRG Rate Panel and the Peer Group DRG Rate Panel need to be consistent.

2.12.55.4 Clarifications

This CO is worked under Core CO 10932.

Core DM CO 10311.

2.12.55.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.55.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.55.7 Change Order Status

Status	Date
Issue Identified	03/28/2006
SE Assigned	03/29/2006
Ready for Model Office	05/25/2006
Model Office Implemented	06/01/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.56 Output New Captiva Stub files - 2216

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2216	Change Order	1	Reference Data Maintenance			

2.12.56.1 Desired Solution

Requesting two new weekly files for Captiva data entry system. These files need to be transferred along with the other stub files that are required for Data Capture. The first stub file needs to have the sorted Procedure codes that are in T_PROC_TOOTH_QUAD. The layout of the file is: Proc Code 1 - 6 length of 6 The second stub file has the sorted Modifiers from T_MODIFIER. Modifier Code 1 - 2 length of 2

2.12.56.2 Business Impact

The stub file aids in translating tooth codes to quadrant codes when the tooth code is not allowed under certain procedure code. The modifiers stub file aids in validating the data entered into the modifier field.

2.12.56.3 Technical Specifications

Modify jobstream PRRIXTRT to produce additional stub files needed for the Captiva data capture function.

- Procedure/Tooth Number file
  - Table: T_PROC_TOOTH_QUAD
  - File layout: Proc Code 1-6 CHAR(6)
  - File name: quadstub.dat
  - Sort Order: Proc Code
  - Program: refp0921
  - Job: REFJW921
  - Autosys Box: REFPW921

Note: A procedure code only exists once in the file.

- Modifier file
  - Table: T_MODIFIER
  - File layout: Modifier Code 1-2 CHAR(2)
  - File name: modstub.dat
  - Sort Order: Modifier Code
  - Program: refp0950
  - Job: REFJW950
  - Autosys Box: REFPW950

Note: A modifier code only exists once in the file.

Additional System Modifications:

- Modify REFJW980
  - Add new stub files.
  - Replace FTP process with zip function to compress all the files together and copy the files to DATADIR$/reference/outbound. The System Administrator may need to this directory in all environments.
  - Update Autosys JIL for new jobs. Update the JILs for all environments (TEST, MO, ACC, PROD) if JILs exist for each.

Documentation requirements:

- Update all related PWB documentation including the Job Stream, Job Script, program, and file layout documentation. Please review the current documentation for job stream PRRIXTRT, etc.
- Update the Reference Input/Output layout section of the PWB. Add the file descriptions to the Output Files table and add the file layout documents. The related file documentation is found on the PWB server in /Reference Data Maintenance/External File Layouts/.

2.12.56.4 Clarifications

No associated clarifications found.

2.12.56.5 Associated Requirements

Requirement ID	Type
30.090.007.002.9	RFP Requirement

2.12.56.6 Associated System Objects

Technical Name	Object Type	Title
PRRIXTRT	Batch Cycle	Captiva Stub File Extracts

2.12.56.7 Change Order Status

Status	Date
Change Order Written	03/30/2006
SE Assigned	04/19/2006
Technical Design In Progress (obsolete)	04/19/2006
Construction in Progress	05/19/2006
Ready for Construction Walkthrough	06/05/2006

Status	Date
Ready for Model Office	06/05/2006
Model Office Implemented	06/30/2006
UAT Implemented	11/01/2006
Ready for Model Office	01/25/2007
UAT Implemented	02/01/2007
Prod Implemented	02/01/2007

2.12.57 Fix ConfigValue missing entities - 2236

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2236	Change Order		Reference Data Maintenance			

2.12.57.1 Desired Solution

The information panels in the KY Reference subsystem cannot be loaded because there are items in the Navigator control with a ConfigValue attribute set to a nonexistent entity. These navigator items do not use this ConfigValue to retrieve data for the panel. Note that the Core Interchange application works with unused, nonexistent ConfigValue entities but State Specific applications do not because state specific applications have an addition type translation step to allow for state specific entity replacements. This fails for nonexistent entities.

2.12.57.2 Business Impact

Much of the Reference subsystem is not usable. Diagnosis, DRG, Drug, Procedure and Revenue information cannot be viewed or modified.

2.12.57.3 Technical Specifications

An example of the most common usage for a navigator item is shown below:

```
<iCNav:NavigatorItem runat="server" AscxFilename="DiagnosisNotePanel.ascx"
Description="Note" Group="Diagnosis" ConfigValue= "iC.MMIS.Ref.Entity.DiagnosisNotes,
iC.MMIS.Ref" DataSource= "PanelObject.DiagnosisNotesList" ID="n104" />
```

Here most of the work is done by the framework and the data displayed in the panel is set to the child list indicated in the DataSource attribute , in this case DiagnosisNotesList. However some Navigator panels override code to generate the data displayed in the panel. In the case of the benefit related panels in the Reference information pages the ConfigValue is not used to generate the panel data. A example of one of these is shown below:

```
<iCNav:NavigatorItem runat="server" AscxFilename="CoveredBenefitPanel.ascx"
Description="Benefit Plan Coverage Rules" Group="Diagnosis"
ConfigValue="iC.MMIS.Ref.Entity.CoveredBenefit, iC.MMIS.Ref" DataSource="PanelObject"
ID="BenefitPlan" />
```

The code for these panels override the Datalist_SetDataSource and DataSourceSet methods to create the data displayed on the panel. Currently the Reference Information benefit related panels are referencing a non-existent entity in the ConfigValue. This works in Core but not in StateSpecific Interchange applications, because state specific applications have an addition type translation step to allow for state specific entity replacements. This fails for nonexistent entities.

The logical solution to this problem is to not include a ConfigValue for these Navigator items. However, currently the interchange framework does not allow this. Change Order 10136 addresses a change to framework to not require a ConfigValue parameter. However, this change order was cancelled to avoid introducing the problem with the usual usage. Thus the current solution to this problem is to replace the nonexistent entities with a existing, albeit unused entities.

2.12.57.4 Clarifications

No associated clarifications found.

2.12.57.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.57.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.57.7 Change Order Status

Status	Date
Issue Identified	04/07/2006
Ready for Construction Walkthrough	04/10/2006
Ready for Model Office	04/12/2006
Model Office Implemented	06/07/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.58 Edit Decision - Form - 2248

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2248	Change Order		Reference Data Maintenance			1

2.12.58.1 Desired Solution
Add new decision to configure edits that closely match current policy implementation as defined in the existing edits.

2.12.58.2 Business Impact
Refer to Supplemental Documentation on this CO.

2.12.58.3 Technical Specifications
Refer to Supplemental Documentation on this CO.

2.12.58.4 Clarifications
The code of this CO has been promoted to MO and I have verified it is there. However, it cannot be tested until the MetaData changes have been applied to the MO database.

MetaData for form edits has been defined and is included in the supplementation documentation. When testing with the new MetaData, several fixes were added. Code changes include: correction of some typos in the javascript code, changes to RUFieldEditor so that variables like AGE and QTY appear on the left side like the other variables rather than in a 2nd column, changes in the way the dropdown list of variables is implemented because in some cases variables were not added and removed correctly and also now this list is in sorted order, added the delete rule context menu item for new rules, added sorting to the edit nodes when they are returned from the server and finally removed code from FormEdits\UI.js for loading and caching benefit trees (this was originally included for the now obsolete tree control variable). These changes are identified as version 3. The code checkin comment is KY2248 v3. A test case document and an implementation plan with Version 3 at the end of these document names are included in the supplemental documentation. Also the vault diff file Diff_KY2248_v3.bat is included.[Pat Bonner]

Checked in a few changes with a code checkin comment of KY2248 v4. The changes are: improved exception handling to show the rule number for errors caused by obsolete MetaData and a change to the way variables are added to the Dropdown list. Documentation for Version 4 includes: ImplementationPlan v4 and 2248.v4, which is the vault diff file for 2KY2248 v4. [Pat Bonner]

2.12.58.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.58.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.58.7 Change Order Status

Status	Date
Change Order Written	04/11/2006
SE Assigned	05/18/2006
Construction in Progress	05/22/2006
Ready for Model Office	08/22/2006
Model Office Implemented	08/25/2006
Ready for Model Office	09/07/2006
Model Office Implemented	09/15/2006
Ready for Model Office	10/30/2006
UAT Implemented	11/01/2006
Ready for Model Office	11/20/2006
Model Office Implemented	11/30/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.59 KY Transportation Pricing - 2293

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2293	Change Order		Reference Data Maintenance			

2.12.59.1 Desired Solution
There are some transportation services that receive different rates based on the number of units billed on a detail. The reimbursement rules need to be able to allow a user to create rules based on units on a claim.

2.12.59.2 Business Impact
None.

2.12.59.3 Technical Specifications
The min and max units that are currently grayed out on the reimbursement rules panel need to be made available for user input.

This CO is being worked in a batch along with 3000, 3018, 2536, 2997, 1940, 1650, 2991.

Technical specifications for all COs - KY Reimbursement Rule CO Matrix

2.12.59.4 Clarifications
I listed this as a UI change but it may just be a meta data configuration change.

Laura Battles

2.12.59.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.59.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.59.7 Change Order Status

Status	Date
Issue Identified	04/24/2006
Change Order Written	06/29/2006
Ready for Model Office	08/24/2006
Model Office Implemented	09/15/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.60 Update reference report with new - 2362

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2362	Change Order		Reference Data Maintenance			1

2.12.60.1 Desired Solution
Add fields to report REF-0201-M; t_limit_parm has new fields: cde_benefit_category and cde_benefit_limit_key

2.12.60.2 Business Impact
Add fields to report REF-0201-M; t_limit_parm has new fields: cde_benefit_category and cde_benefit_limit_key

2.12.60.3 Technical Specifications
Add fields to report REF-0201-M; t_limit_parm has new fields: cde_benefit_category and cde_benefit_limit_key

Related Core data model CO 9804.

Reference Core CO 11807.

2.12.60.4 Clarifications
Moved CO to Follow-Up status awaiting data model change approval.

[Troy Schexnayder]

A new field CDE_BENEFIT_CATEGORY_SUSP has been added to t_limit_parm. This should be added to the report. It is a two character field that should be added to test on the 6/27 release.

2.12.60.5 Associated Requirements

Requirement ID	Type
30.050.006.002.5	RFP Requirement

2.12.60.6 Associated System Objects

Technical Name	Object Type	Title
REF-0201-M	Report	Limitation Audit Criteria Report

2.12.60.7 Change Order Status

Status	Date
Change Order Written	05/01/2006
SE Assigned	05/25/2006
FOLLOW-UP	05/31/2006
Ready for Construction Walkthrough	06/05/2006
Ready for Model Office	06/08/2006

Status	Date
Model Office Implemented	06/16/2006
Ready for Model Office	07/05/2006
Model Office Implemented	07/14/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.61 Audit parameters - new time span - 2529

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2529	Change Order		Reference Data Maintenance			1

2.12.61.1 Desired Solution
The Limitation Audit Parameters panel needs to accept a new value for time unit (calendar week). The calendar week period for Kentucky runs from Sunday through Saturday.

2.12.61.2 Business Impact
This change is required to implement current Kentucky audits (439, 440, 581, 584, 586 and 588).

2.12.61.3 Technical Specifications
Modify the Audit Parameters(Limitation)-Error Disposition panel to accept a new time span (CDE_TIME_UNIT)) value '7' (Calendar week). If the calendar week option is selected, the time span (QTY_LIMIT_UNITS) value must be one.

2.12.61.4 Clarifications
This change was implemented by KY558.

2.12.61.5 Associated Requirements

Requirement ID	Type
30.090.007.002.24A	RFP Split Requirement

2.12.61.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.61.7 Change Order Status

Status	Date
Issue Identified	05/15/2006
Model Office Implemented	06/30/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.62 KY Supports Comm Living - UI - 2536

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2536	Change Order		Reference Data Maintenance			2

2.12.62.1 Desired Solution
Create new pricing method to support current pricing method used for Supports for Community Living.

2.12.62.2 Business Impact
KY programs identified that use this pricing methodology. Provider Type 33 - Supports for Community Living

2.12.62.3 Technical Specifications
Update the reimbursement agreement panel by adding the high intensity indicator to this panel. The values for this indicator are 'Y' or 'N'. The default value is 'N' and the user(s) can change the value as needed.

This CO is being worked in a batch along with 3000, 3018, 2536, 2997, 1940, 1650, 2991.

Technical specifications for all COs - KY Reimbursement Rule CO Matrix

2.12.62.4 Clarifications
No associated clarifications found.

2.12.62.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.62.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.62.7 Change Order Status

Status	Date
Issue Identified	05/15/2006
SE Assigned	06/07/2006
Ready for Model Office	08/24/2006
Model Office Implemented	09/15/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.63 DM - County Rate Table - 2555

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2555	Change Order		Reference Data Maintenance			

2.12.63.1 Desired Solution
Some claims in Kentucky are priced using rates based on the county in which the member receiving the service resides. Currently, hospice claims determine rates in this manner.

2.12.63.2 Business Impact
None.

2.12.63.3 Technical Specifications
A new table needs to be created (T_COUNTY_RATE) to contain the member county pricing parameters. The table contains the following attributes: sak_county_rate, cde_county, sak_revenue, dte_effective, dte_end, dte_active, dte_inactive, cde_rate_type, and amt_rate.

2.12.63.4 Clarifications
No associated clarifications found.

2.12.63.5 Associated Requirements

Requirement ID	Type
30.090.007.002.43	Claims Pricing

2.12.63.6 Associated System Objects

Technical Name	Object Type	Title
T_COUNTY_RATE	Database Table	

2.12.63.7 Change Order Status

Status	Date
Issue Identified	05/16/2006
Change Order Written	05/22/2006
Ready for Model Office	07/12/2006
Model Office Implemented	07/13/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.64 UI - County Rate Panel - 2556

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2556	Change Order		Reference Data Maintenance			

2.12.64.1 Desired Solution
Some claims in Kentucky are priced using rates based on the county in which the member receiving the service resides. Currently, hospice claims determine rates in this manner.

2.12.64.2 Business Impact
None.

2.12.64.3 Technical Specifications
Create a new panel to view and maintain the T_COUNTY_RATE table under Reference > Related Data > Other

See attached document for field layout.

2.12.64.4 Clarifications
No associated clarifications found.

2.12.64.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.64.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.64.7 Change Order Status

Status	Date
Issue Identified	05/16/2006
SE Assigned	12/17/2006
Construction in Progress	02/18/2007
Ready for Construction Walkthrough	03/27/2007
Ready for Model Office	03/27/2007
Model Office Implemented	04/05/2007
UAT Implemented	04/05/2007
Ready for Model Office	04/10/2007
Model Office Implemented	04/13/2007

Status	Date
UAT Implemented	04/13/2007
Prod Implemented	06/14/2007

2.12.65 KY DM Rev Code Xwalk - 2578

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2578	Change Order		Reference Data Maintenance			

2.12.65.1 Desired Solution

Hospice claims submitted with services for inpatient respite care and general inpatient care are priced using the provider procedure rate on file up to a certain number of units.

In the case of inpatient respite care, the last unit billed on a detail is priced using the routine home care rate. If more than four units are billed, all units after the fourth unit are priced using the routine home care rate. The only exception to this additional unit pricing is if the patient status is 41 and the claim header TDOS is equal to the detail TDOS. In this case, all units price using the inpatient respite care rate.

In the case of general inpatient care, the last unit billed on a detail is priced using the routine home care rate. The exceptions to this additional unit pricing are:

- If the patient status is 41 and the claim date of discharge is equal to the detail TDOS. In this case, all units price using the inpatient respite care rate.
- If the patient status is 30 and the last digit of the type of bill is a 2 or 3. In this case, all units price using the inpatient respite care rate.

2.12.65.2 Business Impact

None.

2.12.65.3 Technical Specifications

A new table, T_REV_HOSPICE_XWALK, needs to be created. It contains the following attributes:

- SAK_HOSPICE_XWALK: num 9: This is a unique key into the table.
- SAK_REV_CLAIM:num 9: This is the unique key that identifies a revenue code that was submitted on a claim detail.
- DTE_EFFECTIVE: num 8: This is the service date that the row becomes effective.
- DTE_END: num 8: This is the service date that the row is no longer effective.
- DTE_ACTIVE: date: This is the date that the row becomes active based on the date that the claim is processed.
- DTE_INACTIVE: date: This is the date that the row is no longer active based on the date that the claim is processed.
- QTY_UNITS_MIN: num 9: This is the low end of the range of the number of units billed on a claim detail. If the number of units billed on a claim detail is less than this number, it is not valid for this row.
- QTY_UNITS_MAX: num 9: This is the high end of the range of the number of units billed on a claim detail. If the number of units billed on a claim detail is greater than this number, then it is not valid for this row.

- CDE_UNIT_TYPE: char 1: This indicates whether only the last unit on the detail should be priced using a different revenue code or if all units within the range of units on the record are priced using a different revenue code. Valid values are "L" for last unit only and "A" for all units in range.
- SAK_REV_PRICE:num 9: This is the unique key that identifies a revenue code that is used to price the number of units based on the ind_unit_type and the number of units billed on the detail.

2.12.65.4 Clarifications

No associated clarifications found.

2.12.65.5 Associated Requirements

Requirement ID	Type
30.090.007.002.43	Claims Pricing

2.12.65.6 Associated System Objects

Technical Name	Object Type	Title
T_REV_HOSPICE_XWALK	Database Table	

2.12.65.7 Change Order Status

Status	Date
Issue Identified	05/19/2006
Change Order Written	06/13/2006
Ready for Model Office	07/05/2006
Model Office Implemented	07/11/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.66 Add new fields to t_limit_parms - 2698

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2698	Change Order		Reference Data Maintenance			1

2.12.66.1 Desired Solution
Add CDE_BENEFIT_CATEGORY and CDE_BENEFIT_LIMIT_KEY to panel for T_LIMIT_PARMS; add BL - Benefit Limits to drop down for cde_error_type for t_audit_crit

2.12.66.2 Business Impact
Add benefit limit parameters to define benefit limit audits

2.12.66.3 Technical Specifications
Add CDE_BENEFIT_CATEGORY and CDE_BENEFIT_LIMIT_KEY to panel for T_LIMIT_PARMS; add BL - Benefit Limits to drop down for cde_error_type for t_audit_crit

- Add Benefit Limits selection to Audit Type drop down list on the Audit Criteria Base panel.
  - Insert into T_CDE_ERR_TYPE values ('BL', 'Benefit Limits');
- Add new fields Benefit Limit Category and Benefit Limit Key to Audit Parameters (Limitation) panel.
  - Benefit Limit Category- drop down using code table T_BENEFIT_LIMIT_CATEGORY.
    The Benefit Limit Category is required if the Audit Type is Benefit Limit (BL), otherwise default to Spaces. (Note: We probably need to add a row in the table for spaces with a description of `N/A?).
  - Benefit Limit Key- drop down values:
    - R - Member
    - B - Provider and Member
    - P - Pharmacy
    - Space - N/A

    The Benefit Limit Key is required if the Audit Type is Benefit Limit (BL), otherwise default to Spaces.
- Field definitions:
  - Benefit Limit Category - The Benefit Limit Category field is used for Benefit Limit audits used to count visits/contacts/encounters. The Benefit Limit Category identifies they classification of service being tracked/counted.
  - Benefit Limit Key - The Benefit Limit Key field is used for Benefit Limit audits used to count visits/contacts/encounters. The Benefit Limit Key identifies if the contact count is by member, both member and provider or by pharmacy.

2.12.66.4 Clarifications

This CO was worked in Core under Core CO 11985.

[Troy Schexnayder]

The attribute CDE_BENEFIT_CATEGORY_SUSP has been added to T_LIMIT_PARM. It was available in test on the 6/27 release. It is a two character field. This attribute was added to the panel.

Please add a value for benefit_limit_key: "U" for units

2.12.66.5 Associated Requirements

Requirement ID	Type
30.090.006.002.10	RFP Requirement

2.12.66.6 Associated System Objects

Technical Name	Object Type	Title
Ref.LimitParmPanel.ascx	Panel	Audit Parameters(Limitation)-Error Disposition

2.12.66.7 Change Order Status

Status	Date
Task Assigned	06/05/2006
Ready for Model Office	06/27/2006
Model Office Implemented	11/22/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.67 KY UI Add Relationships - 2991

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2991	Change Order		Reference Data Maintenance			

2.12.67.1 Desired Solution
In order to price KY claims correctly, users need to be able to establish reimbursement rules using combinations of the following attributes: revenue code, DRG codes, ICD9 procedure code and HCPCS procedure codes.

2.12.67.2 Business Impact
None.

2.12.67.3 Technical Specifications
The following relationships need to be added to reimbursement rules panels:

- Revenue Code to ICD9 Procedure Code
- DRG Code to ICD9 Procedure Code
- Revenue Code to HCPCS/CPT Procedure Code
- ICD9 Procedure Code to ICD9 Procedure Code

The ability to compare lists of ICD9 Procedures against the ones submitted on a claim must also be available. For example, a user needs to be able to set up a reimbursement rule based on the existence of at least one ICD9 Procedure from each of two different lists.

This CO is being worked in a batch along with 3000, 3018, 2536, 2997, 1940, 1650, 2991.

Technical specifications for all COs - KY Reimbursement Rule CO Matrix

2.12.67.4 Clarifications
Updates to member plan and provider contract panels were missed. Have put back in construction and made relevant changes. [Mark Veness]

In the implementation of this CO, new meta data variables and decision variables were created PRCX and ICDX for the benefit to benefit relationships. Note: Because PROC decision variables were in the previous version of the Meta data, this previous meta data file needs to be unloaded or all the metadata needs to be deleted and loaded from scratch. [Pat Bonner].

Additionally, for these range set variables to work, a change was required in the RuleFactory.cs because the current code was correctly interpreting the new variables as range sets on save but when loading them mistakenly decided they were range values.

Additionally in the CO, code was added to display the rule number when an exception occurs on loading a rule.

2.12.67.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.67.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.67.7 Change Order Status

Status	Date
Issue Identified	06/28/2006
Change Order Written	06/29/2006
Ready for Model Office	08/24/2006
Model Office Implemented	09/15/2006
Construction in Progress	09/28/2006
Ready for Model Office	10/16/2006
Model Office Implemented	10/21/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.68 KY CFG Add Relationships - 2992

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2992	Change Order		Reference Data Maintenance			

2.12.68.1 Desired Solution
In order to price KY claims correctly, users need to be able to establish reimbursement rules using combinations of the following attributes: revenue code, DRG codes, ICD9 procedure code, and HCPCS procedure codes.

2.12.68.2 Business Impact
None.

2.12.68.3 Technical Specifications
The following relationships need to be added to reimbursement rules:

- Revenue Code to ICD9 Procedure Code
- DRG Code to ICD9 Procedure Code
- Revenue Code to HCPCS/CPT Procedure Code
- ICD9 Procedure Code to ICD9 Procedure Code

ICD9 Procedure Codes need a getter that returns an array since there can be multiple ICD9 Procedures on a claim. This is currently being done for modifiers.

The ability to compare lists of ICD9 Procedures against the ones submitted on a claim must also be available. For example, a user needs to be able to set up a reimbursement rule based on the existence of at least one ICD9 Procedure from each of two different lists.

2.12.68.4 Clarifications
No associated clarifications found.

2.12.68.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.68.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.68.7 Change Order Status

Status	Date
Issue Identified	06/28/2006
Change Order Written	06/29/2006
Ready for Model Office	08/24/2006

Status	Date
Model Office Implemented	09/15/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.69 KY UI Bundled Pricing Variable - 2997

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2997	Change Order		Reference Data Maintenance			

2.12.69.1 Desired Solution
Some institutional and professional claims are priced using a provider bundled rate for specific revenue and/or procedure codes. When a bundled rate revenue/procedure code is billed on a claim, all non-bundled rate codes are zero paid.

2.12.69.2 Business Impact
None.

2.12.69.3 Technical Specifications
Create a new output variable that can be set in the reimbursement rules. This is called "Bundled Pricing" and only appears on the reimbursement rules panel.

The valid values are:

- F - First Bundled Service Only
- Y - Pay All Bundled Services
- N - Bundled Pricing Does Not Apply

This CO is being worked in a batch along with 3000, 3018, 2536, 2997, 1940, 1650, 2991.

Technical specifications for all COs - KY Reimbursement Rule CO Matrix

2.12.69.4 Clarifications
No associated clarifications found.

2.12.69.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.69.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.69.7 Change Order Status

Status	Date
Issue Identified	06/28/2006
Change Order Written	06/29/2006
Ready for Model Office	08/24/2006
Model Office Implemented	09/15/2006

Status	Date
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.70 KY CFG Bundled Pricing Variable - 2998

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
2998	Change Order		Reference Data Maintenance			

2.12.70.1 Desired Solution
Some institutional and professional claims are priced using a provider bundled rate for specific revenue and/or procedure codes. When a bundled rate revenue/procedure code is billed on a claim, all non-bundled rate codes are zero paid.

2.12.70.2 Business Impact
None.

2.12.70.3 Technical Specifications
Create a new output variable that can be set in the reimbursement rules. This is called "Bundled Pricing".

The valid values are:

- F - First Bundled Service Only
- Y - Pay All Bundled Services
- N - Bundled Pricing Does Not Apply

2.12.70.4 Clarifications
No associated clarifications found.

2.12.70.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.70.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.70.7 Change Order Status

Status	Date
Issue Identified	06/28/2006
Change Order Written	06/29/2006
Ready for Model Office	08/24/2006
Model Office Implemented	09/15/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.71 KY UI Add OOS Ind Variable - 3000

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3000	Change Order		Reference Data Maintenance			

2.12.71.1 Desired Solution
Some institutional claims are priced based on the type of out-of-state indicator assigned to the billing provider on the claim. The billing provider's bed size and disproportionate share status are also used to determine the pricing method. These attributes need to be available to assign the appropriate pricing methods in the reimbursement rules.

2.12.71.2 Business Impact
None.

2.12.71.3 Technical Specifications
Add a new input variable, "OOS Provider", to the reimbursement rules panel. Valid values can be found on t_pr_oos_cde, which is a new table being created under CO 3010. The getter in libclmcomm.so is called get_pb_cdeOOS.

Add a new input variable range "Bed Size" to the reimbursement rules panel. Valid values range from 0000 through 9999. The ranges cannot overlap with other rules. The getter in libclmcomm.so is called get_pb_numBedSize.

Add a new input variable "DSH Provider" to the reimbursement rules panel. Valid values are "Y" and "N". The getter in libclmcomm.so is called get_pb_indDSH.

This CO is being worked in a batch along with 3000, 3018, 2536, 2997, 1940, 1650, 2991.

Technical specifications for all COs - KY Reimbursement Rule CO Matrix

2.12.71.4 Clarifications
No associated clarifications found.

2.12.71.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.71.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.71.7 Change Order Status

Status	Date
Issue Identified	06/28/2006
Change Order Written	06/29/2006
SE Assigned	08/02/2006
Construction in Progress	08/02/2006

Status	Date
Ready for Model Office	08/24/2006
Model Office Implemented	09/15/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.72 KY CFG Add OOS Ind Variable - 3001

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3001	Change Order		Reference Data Maintenance			

2.12.72.1 Desired Solution
Some institutional claims are priced based on the type of out-of-state indicator assigned to the billing provider on the claim. The billing provider's bed size is also used to determine the pricing method. These attributes need to be available to assign the appropriate pricing methods in the reimbursement rules.

2.12.72.2 Business Impact
None.

2.12.72.3 Technical Specifications
Create a new input variable, "OOS Provider" that comes from the ind_oos on t_pr_svc_loc_state. It only applies to reimbursement rules.

Create a new input variable range "Bed Size" that is compared to the num_both_beds on t_pr_beds. Valid values are 0000 through 9999. It applies to reimbursement rules.

2.12.72.4 Clarifications
No associated clarifications found.

2.12.72.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.72.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.72.7 Change Order Status

Status	Date
Issue Identified	06/28/2006
Change Order Written	06/29/2006
Ready for Model Office	08/24/2006
Model Office Implemented	09/15/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.73 KY UI Add Member County - 3018

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3018	Change Order		Reference Data Maintenance			

2.12.73.1 Desired Solution
Non Emergency transportation claims from 1/1/2000 through 4/30/2003 are billed on paper and use the member's county code, detail procedure code and the billing provider's specialty to determine the method to be used to price each detail.

2.12.73.2 Business Impact
None.

2.12.73.3 Technical Specifications
Add a new input variable "Member County" to the reimbursement rules panel. Valid values can be found on in attribute cde_county on table t_county.

This CO is being worked in a batch along with 3000, 3018, 2536, 2997, 1940, 1650, 2991.

Technical specifications for all COs - KY Reimbursement Rule CO Matrix

2.12.73.4 Clarifications
No associated clarifications found.

2.12.73.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.73.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.73.7 Change Order Status

Status	Date
Change Order Written	06/29/2006
Ready for Model Office	08/24/2006
Model Office Implemented	09/15/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.74 KY CFG Add Member County - 3019

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3019	Change Order		Reference Data Maintenance			

2.12.74.1 Desired Solution
Non Emergency transportation claims from 1/1/2000 through 4/30/2003 are billed on paper and use the member's county code, detail procedure code and the billing provider's specialty to determine the method to be used to price each detail.

2.12.74.2 Business Impact
None.

2.12.74.3 Technical Specifications
Create a new input variable "Member County" that comes from the icde_county on t_re_base. It only applies to reimbursement rules.

2.12.74.4 Clarifications
No associated clarifications found.

2.12.74.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.74.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.74.7 Change Order Status

Status	Date
Change Order Written	06/29/2006
Ready for Model Office	08/24/2006
Model Office Implemented	09/15/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.75 KY DRG Reference Panel Updates - 3099

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3099	Change Order		Reference Data Maintenance			

2.12.75.1 Desired Solution
There are some fields and panels related to DRGs that are not needed by the KY customer. In order to prevent confusion and potential payment errors, these fields and panels need to be removed from the KY UI.

2.12.75.2 Business Impact
None.

2.12.75.3 Technical Specifications
Under Reference-> Related Data -> Other, remove the Peer Group link.

On the DRG Maintenance panel, remove the Peer Group link.

On the DRG Rates panel, remove Low Outlier days (default to 999 on adds), High Outlier Days (default to 999 on adds), Supplemental Percentage (default to 0 on adds), Percent Outlier Adjustment (default to 1 on adds) and Daily Rate (default to 0 on adds).

2.12.75.4 Clarifications
No associated clarifications found.

2.12.75.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.75.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.75.7 Change Order Status

Status	Date
Change Order Written	07/07/2006
SE Assigned	07/18/2006
Ready for Tech Walkthrough	11/09/2006
Ready for Model Office	11/09/2006
Model Office Implemented	12/14/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.76 Reimb Panel - Service Sort - 3255

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3255	Change Order		Reference Data Maintenance			3

2.12.76.1 Desired Solution

Currently, on the Reimbursement Agreement panel when you expand any high level group (Procedures, Revenue Code, DRG) and drill down to a specific benefit groups and then look at the individual services within that group. Notice that the services are not always sequenced properly.

An additional need is to add a Search function to the Benefit Classification panel.

2.12.76.2 Business Impact

Currently, on the Reimbursement Agreement panel when you expand any high level group (Procedures, Revenue Code, DRG) and drill down to a specific benefit group and then look at the individual services within that group. Notice that the services are not always sequenced properly.

From a business perspective, it presents a challenge to a user to easily find/identify the service that they may need to add, modify or exclude a rule from.

2.12.76.3 Technical Specifications

In researching this issue, the sort is being done on the service SAK instead of the code value. Please see the attached doco in the supplemental doco section. This provides some example screen shots along with SQL examples.

There are other rule panels that use the tree display in the UI. These panels are also reviewed to ensure a consistent look and feel.

Add a search function to the Benefit Classification panel similar to the search functionality found on the Provider Contracts and Reimbursement rules.

2.12.76.4 Clarifications

Added requirement for a search function on the benefit classification panel.

[Troy Schexnayder]

Troy asked that we replace the 'add benefit' functionality with the 'add benefit range' logic and default the to code to the from code if omitted.

2.12.76.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.76.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.76.7 Change Order Status

Status	Date
Issue Identified	08/03/2006
Change Order Written	08/03/2006
SE Assigned	09/05/2006
Construction in Progress	09/05/2006
Ready for Construction Walkthrough	09/07/2006
Ready for Model Office	09/08/2006
Model Office Implemented	09/15/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.77 Historical view for EBP - 3261

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3261	Change Order		Reference Data Maintenance			3

2.12.77.1 Desired Solution

The user wants to see what the rules for Member Plans, Provider Contracts and Reimbursement Agreements were at some previous point in time (inactive rules). Using the same screens that maintain the rules, we can display a historical view if the page can easily be made read-only. The user specifies a date/time in the past, and the benefit-tree of rules is displayed as it existed in that moment.

2.12.77.2 Business Impact

This is a feature for users to see how the claim-engine processed at a previous point in time. It aids them in researching why a claim processed the way it did.

2.12.77.3 Technical Specifications

None.

2.12.77.4 Clarifications

The other objects to be added to this CO are:

- BenefitCoverageEditPanel.ascx
- Ref.ProviderContractPanel.ascx
- Ref.ReimbursementAgreement [Schmidt]

This CO has been deferred.

This is desired future functionality but is not required for correct claims processing.

2.12.77.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.77.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.77.7 Change Order Status

Status	Date
Change Order Written	08/03/2006
Deferred	12/15/2006

2.12.78 EPSDT/Primary Care Referral Code - 3306

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3306	Change Order		Reference Data Maintenance			2

2.12.78.1 Desired Solution
Add a EPSDT/Primary Care Referral Code table to support KY specific edit in interChange to match KY policy for existing edit 073.

iC edit number 3312: EPSDT/Primary Care Referral Code Invalid

2.12.78.2 Business Impact
Support current KY claims policy.

2.12.78.3 Technical Specifications
Create code table to support iC edit number 3312: EPSDT/Primary Care Referral Code Invalid.

Table Name: T_CDE_REFERRAL

Attributes: CDE_REFERRAL CHAR(2), DSC_REFERRAL VARCHA2(100)

Index: I_CDE_REFERRAL CDE_REFERRAL ASC

Conversion Impact: This table is manually loaded using the data in the supplemental documentation.

See supplemental documentation for DB Change documents and valid code set.

2.12.78.4 Clarifications
Table needed to support claims edit CO 2454.

[Troy Schexnayder]

2.12.78.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.78.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.78.7 Change Order Status

Status	Date
Change Order Written	08/07/2006
Ready for DM Review	08/09/2006
DM Review Board Approved	08/10/2006
Ready for Construction	08/11/2006

Status	Date
Walkthrough	

2.12.79 EBP - Reimb Modifier Pricing Typ - 3373

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3373	Change Order		Reference Data Maintenance			2

2.12.79.1 Desired Solution

Reimbursement Agreement rules are used in the claim-engine to decide how a service is priced. Currently, these rules can be restricted to specific modifier codes. And modifier codes have a default pricing type.

States have a need to create reimbursement rules that vary the pricing type a modifier uses.

The UI screen for creating Reimbursement rules needs an extra field to specify pricing types for individual modifiers.

2.12.79.2 Business Impact

Today, exceptions to modifier pricing are hard-coded in the claim-engine. This change allows pricing rules to be configured by a business analyst.

2.12.79.3 Technical Specifications

None.

2.12.79.4 Clarifications

A new modifier override editing control was added to the Reimbursement Agreement Edit Panel. A new variable MTOR was added to the metadata. This variable is a multi-valued output array variable where each value is array consisting of a modifier code and a type override code. See the "Design Document 3373" in the supplemental documentation section for additional information.

There is a problem with a + sign appearing in front of rules containing Adjustment Factor or MTOR variables. This problem was introduced by the array output variable rewrite for this CO. When the fix is available, it will be included in the CO and this CO will be re- promoted. See the supplemental documentation file "3373 Plus Sign On Adj rule" to see the plus sign.

The plus sign problem was fixed by adding the xtv_visible attribute with a value of true to the MTOR and ADJF nested XML nodes.

An additional fix was needed to remove the plus sign after saving a rule. The xtv_notVisible attribute had to be added on the server side. This change is in RuTransactionRuleEditor.cs method CreateXml_Action. The line varNode.SetAttribute(TreeView.XTV_NOTVISIBLE, "true"); was added to this method.

2.12.79.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.79.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.79.7 Change Order Status

Status	Date
Change Order Written	08/14/2006
Construction in Progress	09/19/2006
Ready for Model Office	11/13/2006
Model Office Implemented	11/20/2006
Construction in Progress	11/20/2006
Ready for Model Office	12/11/2006
Ready for Model Office	12/17/2006
Model Office Implemented	12/22/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.80 Add Modifier to Rev Reimb Rules - 3392

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3392	Change Order		Reference Data Maintenance			

2.12.80.1 Desired Solution
The Commonwealth needs to be able to configure reimbursement rules for revenue codes based on modifiers.

2.12.80.2 Business Impact
None.

2.12.80.3 Technical Specifications
The reimbursement rules panel needs to be updated to allow users to enter Modifier criteria for Revenue Codes. This option is currently grayed out on the panel.

This CO is being worked in a batch along with 3000, 3018, 2536, 2997, 1940, 1650, 2991.

Technical specifications for all COs - KY Reimbursement Rule CO Matrix

2.12.80.4 Clarifications
No associated clarifications found.

2.12.80.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.80.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.80.7 Change Order Status

Status	Date
Change Order Written	08/16/2006
Ready for Model Office	08/24/2006
Model Office Implemented	09/15/2006
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.81 Add Xover Pricing Ind Table - 3409

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3409	Change Order		Reference Data Maintenance			1

2.12.81.1 Desired Solution
In order to facilitate setting a crossover special pricing indicator in reimbursement rules configuration, a code table needs to be created that contains the valid code values and their descriptions.

2.12.81.2 Business Impact
None.

2.12.81.3 Technical Specifications
Create a new table, T_PRICING_XOVER, that contains the following attributes: CDE_PRICING_XOVER, and DSC_PRICING_XOVER.

Column Name	*Description*	*Type*	*Length*	*Precision*	*Primary Key*
CDE_PRICING_XOVER	*This is the special pricing method to be used to price crossover claims.*	*CHAR*	*6*	*0*	*Y*
DSC_PRICING_XOVER	*Description of the crossover claim pricing method.*	*VARCHAR*	*50*	*0*	*N*

2.12.81.4 Clarifications
Since this table is being created for the reimbursement rules panel and new values require claims engine changes, a panel is not going to be developed at this time to view or update this table.

Laura Battles

2.12.81.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.81.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.81.7 Change Order Status

Status	Date
Change Order Written	08/17/2006
Design Complete	08/24/2006
Ready for DM Review	08/24/2006
DM Review Board Approved	08/25/2006
Ready for Construction Walkthrough	08/26/2006
Ready for Model Office	08/31/2006
Model Office Implemented	12/14/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.82 Add Xover Pricing to Reimb Rules - 3410

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3410	Change Order		Reference Data Maintenance			1

2.12.82.1 Desired Solution

Many crossover claims are priced using methods that compare the regular Medicaid allowable with the Medicare paid amount. As a result, crossover claims need to first be priced as if they were "straight" Medicaid claims. Once this has been done, a special crossover pricing method needs to be applied to determine the final claim payment amount. In order for the claims engine to know which special crossover pricing method to use, a new field needs to be added to the reimbursement rules panel to allow users to enter the crossover pricing method that applies to the rule for crossover claims.

2.12.82.2 Business Impact

None.

2.12.82.3 Technical Specifications

Create a new output variable that can be set in the reimbursement rules. This is called "Crossover Pricing" and only appears on the reimbursement rules panel.

Lookup table: T_PRICING_XOVER
Setter name: set_ru_cdePricingXover
Library name: libclmcomm.so
Decisions: Reimbursement - Diagnosis (RD), DRG (RG), Icd-9 Procedure (RI), Drug (RN), Procedure (RP), and Revenue Code (RR)
Multiple Choices Allowed? No

2.12.82.4 Clarifications

None.

2.12.82.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.82.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.82.7 Change Order Status

Status	Date
Change Order Written	08/17/2006
Construction in Progress	09/11/2006
Ready for Construction Walkthrough	09/11/2006
Ready for Model Office	09/13/2006

Status	Date
Model Office Implemented	12/14/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.83 Error Disp UI Disply Line Item - 3476

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3476	Change Order		Reference Data Maintenance			2

2.12.83.1 Desired Solution

Another thing we are adding to Kansas that really needs to be in CORE/Kentucky. 1) Update the error disposition line item window to display the error disposition line item number. 2) Update the claim error window to display the line item number used to disposition the claim. MANY MANY MANY times the user thinks we used one disposition line item when we used another. They say it dispositioned incorrectly or we cutback when we should not have . Having this on the window helps the ACCOUNT review what really happened vs. having an SE use sql to look at the tables.

2.12.83.2 Business Impact

None.

2.12.83.3 Technical Specifications

Add the SAK_ERROR_DISP column to the data panel on Disposition Criteria-Error Disposition. Field is display only.

2.12.83.4 Clarifications

No associated clarifications found.

2.12.83.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.83.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.83.7 Change Order Status

Status	Date
Change Order Written	08/25/2006
SE Assigned	08/25/2006
Construction in Progress	08/25/2006
Ready for Construction Walkthrough	08/25/2006
Ready for Model Office	08/28/2006
Ready for Model Office	08/29/2006
Model Office Implemented	09/08/2006

Status	Date
UAT Implemented	11/01/2006
Prod Implemented	06/14/2007

2.12.84 DM - t_accident_type - 3562

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3562	Change Order		Reference Data Maintenance			2

2.12.84.1 Desired Solution
Update the T_ACCIDENT_TYPE table to allow for the proper HIPPA codes and descriptions.

2.12.84.2 Business Impact
Update the T_ACCIDENT_TYPE table to allow for the proper HIPPA codes and descriptions.

2.12.84.3 Technical Specifications
(currently in TEST / MO / ACC) for:
T_ACCIDENT_TYPE;
Name Null? Type
--- --- --- ---
CDE_ACC_TYP NOT NULL CHAR(1)
DSC_LENGTH_15 NOT NULL CHAR(15)

CDE_ACC_TYP <-- Needs to be at least CHAR(3) - HIPAA length for CLM11-1 - CLM11-3
DSC_LENGTH_15 <-- Needs to be at least CHAR(25) - longest length of the related cause description

Desired table columns and lengths for:
T_ACCIDENT_TYPE
Name Null? Type
--- --- ---
CDE_ACC_TYP NOT NULL CHAR(3)
DSC_ACC_TYP NOT NULL VARCHAR2(25)

2.12.84.4 Clarifications
This CO is co-released with the following COs: [Schmidt]

- 5527
- 5529
- 5762

This is being moved because there is no state sponsor - it can be recalled if a state deems necessary

2.12.84.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.84.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.84.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Define/Analyze In Progress	09/25/2006
SE Assigned	01/11/2007
Ready for DM Review	01/11/2007
SE Assigned	01/15/2007
Ready for Model Office	01/19/2007
Model Office Implemented	01/25/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.85 WI - Rmv PT/PS on err disp line - 3567

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3567	Change Order		Reference Data Maintenance			

2.12.85.1 Desired Solution

The error disposition line item panel has parameters where ONE specific PT/PS value can be used to determine the disposition of an error and does not allow the user to indicate the provider role (billing/performing). There is also another option to use an I/E indicator for PT/PS, which allows multiple PT/PS values and the provider role (billing/performing). This is confusing to the user. There should only be one method to indicate the PT/PS and that option is the I/E functionality.

Also, PT/PS UI is similar across reference. Coverage, Billing and Reimbursement rules allow the user to input ranges of PT/PS. Dispositioning and Audits work the same way.

2.12.85.2 Business Impact

Meet RFP requirement.

2.12.85.3 Technical Specifications

Update the dispositioning UI for PT and PS and update the audit PT/PS UI to allow ranges of PT's and PS's. See the coverage rule UI PT/PS logic.

Currently in the "Provider Type Specialty Data" panel, the overlap checking logic is like: "if (mb1.PrRoleCode == mb2.PrRoleCode) { if (mb1.InExIndicator != mb2.InExIndicator) return true;} return false;

To enhance the overlap logic for this panel, please refer to the following PowerBuilder logic and code in the supplementary document section.

Window: Error Disposition Line Item Provider Type - Spec Maintenance
Table: t_err_disp_pt_ps_x

Validations:
- can not have duplicate Provider Role, Provider Type, Provider Specialty and Provider Type / Provider Specialty for the same error disposition line item.

- can not have the same Provider Role, Provider Type, Provider Specialty and Provider Type / Provider Specialty as any other error disposition line item for the same Error Code with the same values for: Claim Type, Benefit Plan, Disposition Status, Outcome Code, Oth Ins Gtr 0, Effective DOR, Effective DOS, Level of Care, Mdcr Allwd > 0, Bill PT/PS, Ref PT/PS, Perf PT/PS, Mdcr Pd > 0 and KBH (Under 21).

2.12.85.4 Clarifications

CORE has both options and should have removed the option on the error disp line item table. (Doerter)

Currently in the "Provider Type Specialty Data" panel, the overlap checking logic is like: "if (mb1.PrRoleCode == mb2.PrRoleCode) { if (mb1.InExIndicator != mb2.InExIndicator) return true;} return false;

To enhance the overlap logic for this panel. Please refer to the following PowerBuilder logic and code in the supplementary document section.

Window: Error Disposition Line Item Provider Type - Spec Maintenance
Table: t_err_disp_pt_ps_x

Validations:
- can not have duplicate Provider Role, Provider Type, Provider Specialty and Provider Type / Provider Specialty for the same error disposition line item.

- can not have the same Provider Role, Provider Type, Provider Specialty and Provider Type / Provider Specialty as any other error disposition line item for the same Error Code with the same values for: Claim Type, Benefit Plan, Disposition Status, Outcome Code, Oth Ins Gtr 0, Effective DOR, Effective DOS, Level of Care, Mdcr Allwd > 0, Bill PT/PS, Ref PT/PS, Perf PT/PS, Mdcr Pd > 0 and KBH (Under 21).

2.12.85.5 Associated Requirements

Requirement ID	Type
30.020.002	RFP Requirement
30.090.007.002.39	RFP Requirement

2.12.85.6 Associated System Objects

Technical Name	Object Type	Title
Ref.DispositionCriteriaPanel.ascx	Panel	Disposition Criteria-Error Disposition
Ref.DispositionCriteriaTpSpcXPanel.ascx	Panel	Disposition Criteria-Provider Type Specialty Data-Error Disposition

2.12.85.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
SE Assigned	11/21/2006
Construction in Progress	11/21/2006
Ready for Construction Walkthrough	11/21/2006
Ready for Model Office	12/05/2006
Model Office Implemented	12/08/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.86 WI - Update PT/PS logic: DM - 3568

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3568	Change Order		Reference Data Maintenance			

2.12.86.1 Desired Solution

The error disposition line item panel has parameters where ONE specific PT/PS value can be used to determine the disposition of an error and does not allow the user to indicate the provider role (billing/performing). There is also another option to use an I/E indicator for PT/PS which allows multiple PT/PS values and the provider role (billing/performing). This is confusing to the user. There should only be one method to indicate the PT/PS and that option is the I/E functionality.

2.12.86.2 Business Impact

Provide uniform PT/PS configuration across reference.

2.12.86.3 Technical Specifications

Remove CDE_PROV_TYPE and CDE_PROV_SPEC from T_ERR_DISP_LINE.

2.12.86.4 Clarifications

This CO originated in Wisconsin. There is no matching Kentucky CO. (F. Maggard)

Old world: User was allowed to enter one PT/PS combo per line item. And they were not able to distinguish billing and/or performing provider. The CE was coded to assume the performing provider for certain claim types and the billing provider for other claim types.

New world: User can enter multiple PT/PS combos for one line item. The relationship is still on the line item (not from t_region_disp). It reduces the number of line items. And it allows them to indicate both billing and performing for whatever claim type.

The claims engine already looks at the new table and dispositions based on the new table. (Carol Doerter)

2.12.86.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.86.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.86.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	12/17/2006

2.12.87 PT/PS CT Editing: UI - 3569

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3569	Change Order		Reference Data Maintenance			

2.12.87.1 Desired Solution

Claim type and PT/PS relationship editing is now set up by using coverage and billing rules. A user can go to a benefit plan/contract and set up a claim type to PT/PS restriction to be applicable to all services within the benefit plan/contract. Therefore a claim type to PT/PS restriction table is no longer needed.

Edits 1032 and 1036 could be replaced by:

4876
4873
4871
4874
4313
4886
4376
4373
4371
4374
4001
4016
4017
4018
4136
4137
4138
4139
4140
4141
4142
4143
4776
4144
4145
4146
4177
4147
4775
4148
4149
4150
4151
4152

2.12.87.2 Business Impact

Support enhanced benefit administration.

2.12.87.3 Technical Specifications
Remove panel for T_PROV_CLM_XREF.

2.12.87.4 Clarifications
This panel has already been removed from the menu.

I moved this back into "issue identified" status after getting hits on the table name as part of my impact analysis for CO 8146 (the data model change order to remove the table). Although the panel for this table is not active, supporting elements still exist in the UI should be removed to avoid confusion. Scan for T_PROV_CLM_XREF and ProviderClaimXref in all subsystems.

2.12.87.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.87.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.87.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	12/17/2006

2.12.88 Remove Consecutive Days Rqd Ind - 3573

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3573	Change Order		Reference Data Maintenance			

2.12.88.1 Desired Solution

REMOVE the CONSECUTIVE DAYS REQUIRED indicator from the Limit Audit Parameter window. The claims engine has NO CODE FOR IT.

REMOVE the CONSECUTIVE DAYS REQUIRED indicator from the BE layer.

REMOVE the CONSECUTIVE DAYS REQUIRED indicator from the mock up.

2.12.88.2 Business Impact

Removing an unused indicator alleviates confusion.

2.12.88.3 Technical Specifications

Remove the 'Consecutive days required' field from the 'Limit Audit Parameter' panel.

Update doco for the 'Limit Audit Parameter' panel.

2.12.88.4 Clarifications

Co-release with CO 5846 [Schmidt]

Does not show on the Audit Parameters panel in Core. The column cde_days_consec exists on the t_limit_parm table.

Checked UI w/ Ed - code exists in UI, defaults to 'N', but never used or displayed - UI code clean-up. [Schmidt]

Nalini Mysore : Field was removed from panel back in March 05. However, it exists in BE layer. It needs to be removed from BE layer for clean up - to be scheduled along with CO5846 (remove the field from DB).

Nalini Mysore - Added mock up change (from 5236) to this defect so 5236 may be cancelled.

This change is being moved to the parking lot because there is not state sponsor - the CO can be recalled if a state deems necessary

2.12.88.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.88.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.88.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Construction in Progress	10/10/2006
Ready for Model Office	10/19/2006
Model Office Implemented	01/19/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.89 Remove Consecutive Days Rqd Ind - 3574

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3574	Change Order		Reference Data Maintenance			

2.12.89.1 Desired Solution
REMOVE the CONSECUTIVE DAYS REQUIRED indicator from the Limit Audit Parameter window. The claims engine has NO CODE FOR IT.

2.12.89.2 Business Impact
None.

2.12.89.3 Technical Specifications
None.

2.12.89.4 Clarifications
Co-release with CO 5077 [Schmidt]

2.12.89.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.89.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.89.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Model Office Implemented	09/15/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.90 Error Disp UI Disply Line Item - 3575

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3575	Change Order		Reference Data Maintenance			

2.12.90.1 Desired Solution

Another thing we are adding to Kansas that really needs to be in CORE/Kentucky. 1) Update the error disposition line item window to display the error disposition line item number. 2) Update the claim error window to display the line item number used to disposition the claim. MANY MANY MANY times the user thinks we used one disposition line item when we used another. They say it dispositioned incorrectly or we cutback when we should not have . Having this on the window helps the ACCOUNT review what really happened vs. having an SE use sql to look at the tables.

2.12.90.2 Business Impact

None.

2.12.90.3 Technical Specifications

Add the SAK_ERROR_DISP column to the data panel on Disposition Criteria-Error Disposition. Field is display only. Set the displayLength on the level of care field to 30 characters.

2.12.90.4 Clarifications

This was moved to the parking lot because no state sponsor - the change order can be recalled if a state deems necessary

2.12.90.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.90.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.90.7 Change Order Status

Status	Date
Model Office Implemented	08/15/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.91 UF - E900 -UI - Prov Type Spec G - 3578

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3578	Change Order		Reference Data Maintenance			

2.12.91.1 Desired Solution
From Core edit review:

Do immediately for those groups that currently exists in Core. For those groups that do not exist in Core yet we want to add the group and this edit to check the type table for that group.

Claim processing is not performing correctly when a group (procedure/modifier/diag/) and the group has not been CREATED (as opposed to the group being EMPTY). If a group has not been created (does not exist on the grouping window), the edit is performed as if the data in the group was NOT FOUND. This could cause incorrect processing of a claim. An example is audit 5000/5012 (Suspect Dupe Medical/Outpatient). The audits use proc group 3056 (radiology procedures) to bypass for TC/26 modifiers. The logic acts like the procedure was not radiology and not perform the bypass logic. Create new edits to identify when groups used by claims DO NOT EXIST (HAVE NEVER BEEN CREATED vs. existing with no data). Since the edit can not tell you what group is missing, the claim needs to suspend and the Method for correction is to contact an SE to identify the missing group.

2.12.91.2 Business Impact
Do immediately for those groups that currently exist in Core. For those groups that do not exist in Core yet, we want to add the group and this edit to check the type table for that group.

2.12.91.3 Technical Specifications
Build a panel to support the provider type & specialty group.

2.12.91.4 Clarifications
This CO was not originated in any State. It was written to clean up issues in core. (F. Maggard)

This is being moved because there is no state sponsor - it can be recalled if a state deems necessary

2.12.91.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.91.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.91.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	09/28/2006

2.12.92 PT/PS CT Editing DM - 3579

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3579	Change Order		Reference Data Maintenance			

2.12.92.1 Desired Solution

Claim type and PT/PS relationship editing is now set up by using coverage and billing rules. A user can go to a benefit plan/contract and set up a claim type to PT/PS restriction to be applicable to all services within the benefit plan/contract. Therefore a claim type to PT/PS restriction table is no longer needed.

Edits 1032 and 1036 could be replaced by:

4876
4873
4871
4874
4313
4886
4376
4373
4371
4374
4001
4016
4017
4018
4136
4137
4138
4139
4140
4141
4142
4143
4776
4144
4145
4146
4177
4147
4775
4148
4149
4150
4151
4152

2.12.92.2 Business Impact

Support enhanced benefit administration.

2.12.92.3 Technical Specifications
Remove T_PROV_CLM_XREF

2.12.92.4 Clarifications
This was moved to the parking lot because no state sponsor - the change order can be recalled if a state deems necessary

2.12.92.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.92.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.92.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	09/28/2006

2.12.93 EBP - Remove t_type_spec_excl - 3581

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3581	Change Order		Reference Data Maintenance			

2.12.93.1 Desired Solution
The table T_TYPE_SPEC_EXCL is not needed since Edit 1050 is not using it.

2.12.93.2 Business Impact
Support enhanced benefit administration.

2.12.93.3 Technical Specifications
Remove references to the table T_TYPE_SPEC_EXCL from application.

2.12.93.4 Clarifications
This CO is part of the EBP project. (F. Maggard)

Moved to Parking lot because of no state sponsor - can be moved back to Multi-state support if a state deems necessary (Cathy Sims)

2.12.93.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.93.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.93.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	09/28/2006

2.12.94 Remove T_LOCATION columns - 3582

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3582	Change Order		Reference Data Maintenance			

2.12.94.1 Desired Solution
The columns CDE_SEVER_LOC, IND_EXTERNAL and IND_INTEREST on T_LOCATION are no longer used.

2.12.94.2 Business Impact
Remove unused columns to alleviate confusion.

2.12.94.3 Technical Specifications
Remove CDE_SEVER_LOC, IND_EXTERNAL and IND_INTEREST from T_LOCATION.

2.12.94.4 Clarifications
The information from this CO was received from Carol Doerter and approved by several of the Reference TFALs. (F. Maggard)

Need to scan for DSS impact and fill out the new DSS impact form and create a stub CO for DSS impact.

Added the MAR/SUR/DSS impact analysis and opened 11256 and 11257 in MAR and DSS to validate any potential impact. (F. Maggard)

Need to take this CO to the Steering committee to find a sponsor for it. This CO needs to be completed because the columns being removed from the table are not used in the system and should be removed. We have already hidden the columns on the panel. (F. Maggard)

This was moved to the parking lot because of no state sponsor - this change order can be recalled if a state deems necessary

2.12.94.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.94.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.94.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	09/28/2006

2.12.95 Remove values from Clm loc panel - 3583

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3583	Change Order		Reference Data Maintenance			

2.12.95.1 Desired Solution
Remove 'Server Location', 'External Indicator' and 'Interest Indicator' on the 'Codes-Claim Location' panel.

2.12.95.2 Business Impact
Remove unused columns.

2.12.95.3 Technical Specifications
Remove columns 'Server Location', 'External Indicator' and 'Interest indicator' on the 'Codes-Claim Location' panel. Note, these columns were hidden in defect 9393.

2.12.95.4 Clarifications
In defect 9393, we hid the three columns being removed in this CO because they were causing confusion with customers. This CO is to remove them completely. (F. Maggard)

This was moved to the parking lot because of no state sponsor - this change order can be recalled if a state deems necessary

2.12.95.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.95.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.95.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	09/28/2006

2.12.96 KY DRG Table Clean Up - 3584

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3584	Change Order		Reference Data Maintenance			

2.12.96.1 Desired Solution
There are several tables that were used in other states for DRG pricing that are no longer utilized in CORE interChange. These tables should be removed from the data model.

2.12.96.2 Business Impact
Unused tables can cause confusion when researching change orders.

2.12.96.3 Technical Specifications
Remove the following tables:

- T_DRG_MAPPER
- T_DRG_NEONATAL
- T_MARG_COST
- T_PR_MARG_CST
- T_PR_CAPT_CST
- T_PEER_GRP_CAPT
- T_CAPITAL_COST
- T_PR_MDED_CST
- T_PEER_GRP_EDUC

2.12.96.4 Clarifications
This CO was approved by the steering committee along with the rest of the DRG project. (F. Maggard)

This was moved from the parking lot to multi-state support on 5/3 because it should be part of all the DRG pricing changes (Cathy Sims).

Laura Battles and Frank Maggard indicated this change was not needed for DRG pricing. Moved back to the parking lot (Cathy Sims)

2.12.96.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.96.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.96.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	09/28/2006

2.12.97 DM - Error Disp by Prov Contract - 3592

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3592	Change Order		Reference Data Maintenance			

2.12.97.1 Desired Solution
Support error dispositioning by provider contract. Add provider contract information to the dispositioning tables.

2.12.97.2 Business Impact
Support error dispositioning by provider contract.

2.12.97.3 Technical Specifications
Add SAK_PROV_PGM from the T_PR_ENROLL_PGM table to both T_ERR_DISP_LINE and T_REGION_DISP. SAK_PROV_PGM are included in the primary key for both tables.

2.12.97.4 Clarifications
This CO co-releases with the following COs: [Schmidt] 1835 - CE 5816 - UI

2.12.97.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.97.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.97.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	09/28/2006

2.12.98 UI - Error Disp by Prov Contract - 3593

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3593	Change Order		Reference Data Maintenance			

2.12.98.1 Desired Solution
Support error dispositioning by provider contract. The panels 'Disposition Criteria-Region Data-Error Disposition', 'Disposition Criteria-Error Disposition' and 'Error Disposition Information-Error Disposition' need to have the provider contract information added.

2.12.98.2 Business Impact
Support error dispositioning by provider contract.

2.12.98.3 Technical Specifications
Upon completion of the data model changes in 5815, Modify panels 'Disposition Criteria-Region Data-Error Disposition', 'Disposition Criteria-Error Disposition' and 'Error Disposition Information-Error Disposition' as follows:

- Add a field to each panel called 'Contract'. This column is updateable.
- The new column displays the CDE_PROV_PGM from T_PR_ENROLL_PGM.
- The panel stores the SAK_PROV_PGM from T_PR_ENROLL_PGM on the tables T_ERR_DISP_LINE and T_REGION_DISP depending on which panel is being updated.
- Update the system doco related to this change.

2.12.98.4 Clarifications
This CO co-releases with the following COs: [Schmidt]

- 1835 - CE
- 5815 - DM

2.12.98.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.98.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.98.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	09/28/2006

2.12.99 WI - 2579: Attach Ind - 3600

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3600	Change Order		Reference Data Maintenance			

2.12.99.1 Desired Solution
The attachment requirement indicator needs to be moved from the service code level (procedure and diagnosis codes) to the billing rule.

2.12.99.2 Business Impact
None.

2.12.99.3 Technical Specifications
Update configurator to have an attachment indicator for the billing rule. See CO 8394 for more specifics.

2.12.99.4 Clarifications
Made CO a configuration change. Indicated as EBP. Changed estimate to 10 hours. Put on hold to wait for configurator. Notified FAAs and Tech Leads. (Doerter)

The files are not missing, the claims are missing. They appear to be not written to the DB after processing. David is checking with Randy Sedgwick & Phil Stokes. Per Mike Wadja.

2.12.99.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.99.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.99.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	09/28/2006

2.12.100 WI 2579: Attachment Indicator - - 3601

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3601	Change Order		Reference Data Maintenance			

2.12.100.1 Desired Solution
The attachment requirement indicator needs to be moved from the service code level (procedure and diagnosis codes) to the billing rule.

2.12.100.2 Business Impact
None.

2.12.100.3 Technical Specifications
IND_ATTACHMENT is going to be removed from the table T_PROC_LIMITS. Remove the field from the update to T_PROC_LIMITS in refp0105.sc.

2.12.100.4 Clarifications
Talk to Brenda/Lisa regarding this.

This CO was previously for the updates to the CE for the removal of the attachment indicators from the limit tables. Because that is so intertwined with adding the attachment indicator to the billing rules, I added that task to CO 8394 (attachment logic from billing rules). I made this CO for Reference which updates refp0105. Notified FAAs and TFALs. (Doerter)

2.12.100.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.100.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.100.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	09/28/2006

2.12.101 EBP - Copy BP/Cntrct - 3605

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3605	Change Order		Reference Data Maintenance			

2.12.101.1 Desired Solution
We have documented in the BP and Contract Administrative documents that we are able to copy Benefit Plan to a new Benefit Plan as an option when creating a new Benefit Plan or contract. This enables quick configuration. See administrative documents for more detail.

2.12.101.2 Business Impact
Enables quick configuration.

2.12.101.3 Technical Specifications
None.

2.12.101.4 Clarifications
Per Gabe Halsmer: 'This is a new screen. A design-document/mock-up for it has not been created yet. And this CO has not been scheduled yet by Alan.' (F. Maggard)

This is moved to the parking lot because of no state sponsor - The change order can be recalled if a state deems necessary

2.12.101.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.101.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.101.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	09/28/2006

2.12.102 WI 2579: Attachment Indicator - 3606

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3606	Change Order		Reference Data Maintenance			

2.12.102.1 Desired Solution
The attachment requirement indicator needs to be moved from the service code level (procedure and diagnosis codes) to the billing rule.

2.12.102.2 Business Impact
EBP

2.12.102.3 Technical Specifications
Remove from T_PROC_LIMITS:
IND_ATTACHMENT Indicates whether attachments are required for the procedure.

Remove from T_DIAG_LIMIT:
IND_ATTACHMENT Indicates whether documentation is required for the diagnosis.

Remove from T_PROC_ICD9_LIM:
IND_ATTACHMENT Indicates whether documentation is required for the diagnosis.

2.12.102.4 Clarifications
No associated clarifications found.

2.12.102.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.102.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.102.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	09/28/2006

2.12.103 WI7936 - Create Cost Hierarchy t - 3608

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3608	Change Order		Reference Data Maintenance			

2.12.103.1 Desired Solution
Create the Cost Share Hierarchy table.

2.12.103.2 Business Impact
This table allows the user to configure the order that the different cost shares apply to a claim.

2.12.103.3 Technical Specifications
Create the new Cost Share Hierarchy table: T_COST_SHARE_HIERARCHY

- CDE_CLM_TYPE CHAR[1] NOT NULL
- SAK_PUH_HLTH NUMBER 8 NOT NULL
- HIER_ID_1 CHAR[10] NOT NULL
- HIER_ID_2 CHAR[10] NOT NULL
- HIER_ID_3 CHAR[10] NOT NULL
- HIER_ID_4 CHAR[10] NOT NULL
- HIER_ID_5 CHAR[10] NOT NULL
- HIER_ID_6 CHAR[10] NOT NULL
- HIER_ID_7 CHAR[10] NOT NULL
- DTE_EFFECTIVE NUMBER[8] NOT NULL
- DTE_END NUMBER[8] NOT NULL
- DTE_INACTIVE DATE NOT NULL

2.12.103.4 Clarifications
This was moved to the parking lot because of no state sponsor - the change order can be recalled if a state deems necessary

2.12.103.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.103.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.103.7 Change Order Status

Status	Date
Issue Identified	09/05/2006
Deferred	09/28/2006

2.12.104 Create COS BE and Config files - 3610

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3610	Change Order		Reference Data Maintenance			

2.12.104.1 Desired Solution
Create a Business Entity and Configuration file for two tables: t_cos_assign_crit and t_cde_cos_values. Include an interface so that the Financial Subsystem can access the data.

2.12.104.2 Business Impact
None.

2.12.104.3 Technical Specifications
Create a Business Entity and Configuration file for two tables: t_cos_assign_crit and t_cde_cos_values. Include an interface so that the Financial Subsystem can access the data. The tables already exist in Test and Model Office. This can be moved to MO as soon as the coding and unit testing is complete. Work with Narsimha Reddy to unit test the interface from Financial.

2.12.104.4 Clarifications
No associated clarifications found.

2.12.104.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.104.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.104.7 Change Order Status

Status	Date
Change Order Written	09/04/2006
SE Assigned	09/05/2006
Construction in Progress	09/07/2006
Ready for Model Office	10/03/2006
Model Office Implemented	10/19/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.105 Create Prov Type/Spec View - 3632

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3632	Change Order		Reference Data Maintenance			

2.12.105.1 Desired Solution
Create a view that combines the valid combinations of Provider Types/Specialties and also provides the option to specify either All provider types (provider type = 00) or All provider specialties (provider specialty = 000).

2.12.105.2 Business Impact
Allows Benefit Administration related rules to use the All provider type or All provider specialty concept.

2.12.105.3 Technical Specifications
Add view V_PR_TYPE_SPEC

Select cde_prov_type,cde_prov_spec from aim.t_pr_type_spec union select '00', cde_prov_spec from aim.t_pr_spec_cde where cde_prov_spec <> '000' union select cde_prov_type, '000' from aim.t_pr_type_cde where cde_prov_type <> '00' order by 1,2;

This view is only used in the Reference EBP User Interface (UI) and is not needed in the MAR/DSS/SUR subsystems.

2.12.105.4 Clarifications
No associated clarifications found.

2.12.105.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.105.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.105.7 Change Order Status

Status	Date
Issue Identified	09/06/2006
Change Order Written	09/07/2006
Ready for DM Review	09/08/2006
DM Review Board Approved	09/11/2006
Ready for Model Office	09/15/2006
Model Office Implemented	10/15/2006
UAT Implemented	06/14/2007

Status	Date
Prod Implemented	06/14/2007

2.12.106 Copay Method Code Table - 3835

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3835	Change Order		Reference Data Maintenance			

2.12.106.1 Desired Solution
In order to process copay for the KyHealth Choices and the previous programs, a code table needs to be implemented. This table contains the copay methods.

2.12.106.2 Business Impact
Support copay.

2.12.106.3 Technical Specifications
Create a new table called T_CDE_COPAY_METHOD for the copay methods used (that is, once per day, once per admission). The new table structure is a document in the Supplemental Documentation section.

Potential Copay Methods (sample data for T_CDE_COPAY_METHOD):

cde_copay_method	*dsc_copay_method*
PADMT	*Once per admission (Inpatient Services).*
PDOPD	*Once per date of service*
PDOPC	*Once per claim*
BYPAS	*Bypass co-pay processing*

2.12.106.4 Clarifications
Table moved into KY TEST on 10/17 TEST release [Schmidt].

2.12.106.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.106.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.106.7 Change Order Status

Status	Date
Issue Identified	09/22/2006
Change Order Written	09/25/2006
Ready for DM Review	10/03/2006
Ready for Construction Walkthrough	10/13/2006

Status	Date
SE Assigned	10/18/2006
Model Office Implemented	11/15/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.107 Copay Time Period Table - 3836

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3836	Change Order		Reference Data Maintenance			

2.12.107.1 Desired Solution
In order to process copay for the KyHealth Choices and the previous programs, a code table needs to be implemented. This table contains the copay time periods.

2.12.107.2 Business Impact
Support copay.

2.12.107.3 Technical Specifications
Create a new table called T_CDE_COPAY_TIME_PERIOD for the copay periods used (that is, calendar year). The new table structure is a document in the Supplemental Documentation section.

Potential Copay Time Periods (sample data for T_CDE_COPAY_TIME_PERIOD):

cde_copay_time_period	*dsc_copay_time_period*
CY	*Calendar Year*
CM	*Calendar Month*

2.12.107.4 Clarifications
Table moved into KY TEST on 10/17 TEST release [Schmidt].

2.12.107.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.107.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.107.7 Change Order Status

Status	Date
Issue Identified	09/22/2006
Change Order Written	09/25/2006
Ready for DM Review	10/03/2006
Ready for Construction Walkthrough	10/13/2006
SE Assigned	10/18/2006
Model Office Implemented	11/15/2006

Status	Date
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.108 Copay Deduct Accum Table - 3837

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3837	Change Order		Reference Data Maintenance			

2.12.108.1 Desired Solution
In order to process copay for the KyHealth Choices and the previous programs, a code table needs to be implemented. This table contains the copay deduction or accumulation from the claim.

2.12.108.2 Business Impact
Support copay.

2.12.108.3 Technical Specifications
Create a new table called T_CDE_COPAY_DEDUCT_ACCUM for the copay deduction or accumulation for the claim. The new table structure is a document in the Supplemental Documentation section.

Potential Copay Deduct Accumulate Codes (sample data for T_CDE_COPAY_DEDUCT_ACCUM):

cde_copay_deduct_accum	*dsc_copay_deduct_accum*
DA	*Deduct and accumulate copay*
OA	*Only accumulate copay*

2.12.108.4 Clarifications
Table moved into KY TEST on 10/17 TEST release [Schmidt].

2.12.108.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.108.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.108.7 Change Order Status

Status	Date
Change Order Written	09/22/2006
Ready for DM Review	10/03/2006
Ready for Construction Walkthrough	10/13/2006
SE Assigned	10/18/2006

Status	Date
Model Office Implemented	11/15/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.109 Remove Copay Tables - 3840

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3840	Change Order		Reference Data Maintenance			

2.12.109.1 Desired Solution
Remove the previous copay tables (T_COPAY_TYPE & T_COPAY) after the new copay solution is installed.

2.12.109.2 Business Impact
Support copay.

2.12.109.3 Technical Specifications
Remove the T_COPAY_TYPE & T_COPAY tables.

2.12.109.4 Clarifications
Deferred - waiting on claims engine changes to remove the table from the code.

[Troy Schexnayder]

2.12.109.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.109.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.109.7 Change Order Status

Status	Date
Issue Identified	09/22/2006
Define/Analyze In Progress	09/25/2006
Change Order Written	09/25/2006
Ready for DM Review	10/03/2006
Ready for Construction Walkthrough	10/13/2006
Deferred	01/17/2007

2.12.110 Remove Copay Panels - 3841

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3841	Change Order		Reference Data Maintenance			3

2.12.110.1 Desired Solution
Remove the previous copay panels (Copay & Copay/Claim Type) after the new copay solution is installed.

2.12.110.2 Business Impact
Support copay.

2.12.110.3 Technical Specifications
Remove the Copay/Claim Type & Copay panels.

2.12.110.4 Clarifications
No associated clarifications found.

2.12.110.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.110.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.110.7 Change Order Status

Status	Date
Issue Identified	09/22/2006
Change Order Written	09/25/2006
Ready for Tech Walkthrough	12/19/2006
Ready for Model Office	12/19/2006
Model Office Implemented	01/19/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.111 Copay Rules Panel - 3842

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3842	Change Order		Reference Data Maintenance			

2.12.111.1 Desired Solution
Add a new panel for the copay rules.

2.12.111.2 Business Impact
Support copay.

2.12.111.3 Technical Specifications
Add a new panel for the copay rules. This panel allows the user to set up the parameters to use for applying copay to the claim.

Panel to be in the Reference subsystem. Reference --> Benefit Administration --> Reimbursement Agreement --> Copay Rules.

Parameters to have on the panel:

- Member / Benefit Plan
- Effective & End date
- Active & Inactive date
- Member Age
- Pregnancy indicator (pharmacy claims - prior to 7/1/2006)
- Services (Procedure Code, Revenue Code, Drug)
- Member Copay Ind (new table T_RE_OLD_COPAY - not for KyHealth Choices)
- Copay Method
- Copay Time Period
- Copay Deduction / Accumulation
- Copay Amount
- Claim Type
- Place of Service
- Modifier Editing
- Provider Type / Specialty Editing (Billing, Performing provider)
- Provider Contract
- Procedure to Diagnosis

Program Code (cde_aid_category - T_CDE_AID - user education - not for KyHealth Choices)
Member Status (cde_pgm_status - T_RE_AID_ELIG - not for KyHealth Choices)

2.12.111.4 Clarifications
No associated clarifications found.

2.12.111.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.111.6 Associated System Objects

Technical Name	Object Type	Title
Ref.CopayEditPanel.ascx	Panel	Benefit Administration-Copay

2.12.111.7 Change Order Status

Status	Date
Issue Identified	09/22/2006
SE Assigned	10/03/2006
Construction in Progress	10/13/2006
Ready for Construction Walkthrough	10/24/2006
Ready for Model Office	10/25/2006
Model Office Implemented	11/11/2006
Construction in Progress	11/27/2006
Ready for Model Office	11/27/2006
Model Office Implemented	12/08/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.112 Panel for copay method code - 3898

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3898	Change Order		Reference Data Maintenance			

2.12.112.1 Desired Solution
Add a new panel for the copay method.

2.12.112.2 Business Impact
Support copay.

2.12.112.3 Technical Specifications
Add a new panel for the copay method. This panel displays the data from the T_CDE_COPAY_METHOD table. Panel to be in codes - Reference --> Related Data --> Codes.

2.12.112.4 Clarifications
No associated clarifications found.

2.12.112.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.112.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.112.7 Change Order Status

Status	Date
Change Order Written	09/28/2006
Ready for Model Office	11/08/2006
Model Office Implemented	11/10/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.113 Panel for copay time period - 3899

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3899	Change Order		Reference Data Maintenance			

2.12.113.1 Desired Solution
Add a new panel for the copay time period.

2.12.113.2 Business Impact
Support copay.

2.12.113.3 Technical Specifications
Add a new panel for the copay time period. This panel displays the data from the T_CDE_COPAY_TIME_PERIOD table. Panel to be in codes - Reference --> Related Data --> Codes.

2.12.113.4 Clarifications
No associated clarifications found.

2.12.113.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.113.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.113.7 Change Order Status

Status	Date
Change Order Written	09/28/2006
Ready for Model Office	11/08/2006
Model Office Implemented	11/10/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.114 Panel for copay deduct accum - 3900

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3900	Change Order		Reference Data Maintenance			

2.12.114.1 Desired Solution
Add a new panel for the copay deduction/accumulation or copay accumulation only.

2.12.114.2 Business Impact
Support copay.

2.12.114.3 Technical Specifications
Add a new panel for the copay deduction / accumulation. This panel displays the data from the T_CDE_COPAY_DEDUCT_ACCUM table. Panel to be in codes - Reference --> Related Data --> Codes.

2.12.114.4 Clarifications
No associated clarifications found.

2.12.114.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.114.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.114.7 Change Order Status

Status	Date
Change Order Written	09/28/2006
Ready for Model Office	11/08/2006
Model Office Implemented	11/10/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.115 Correct T_DRG_RATE Indexes - 3910

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3910	Change Order		Reference Data Maintenance			

2.12.115.1 Desired Solution
The indexes for the table T_DRG_RATE are not set up correctly. As a result, there could be unique constraint issues that could cause claims to be unable to process.

2.12.115.2 Business Impact
None.

2.12.115.3 Technical Specifications
Index I_DRG_RATE_2 needs to be modified to also contain DTE_INACTIVE.

Reorder the columns so that the primary key SAK_DRG_RATE is the first column on the table.

2.12.115.4 Clarifications
This change was implemented into CORE in July, 2006 and was approved by the full CORE DM Review Process.

-- Laura Battles

2.12.115.5 Associated Requirements

Requirement ID	Type
30.090.007.002.41	Claims Pricing

2.12.115.6 Associated System Objects

Technical Name	Object Type	Title
T_DRG_RATE	Database Table	

2.12.115.7 Change Order Status

Status	Date
Change Order Written	09/27/2006
DM Review Board Approved	01/30/2007
Model Office Implemented	02/17/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.116 Remove T__COPAY - REFP0010 - 3933

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
3933	Change Order		Reference Data Maintenance			2

2.12.116.1 Desired Solution
Remove the call to the Copay Table (T_COPAY) from the REF-0010-W report.

2.12.116.2 Business Impact
Table is being replaced by a new copay solution.

2.12.116.3 Technical Specifications
Remove Select on table T_COPAY from program refp0010.sc

Remove Copay Count from report REF-0010-W under Miscellaneous Data.

2.12.116.4 Clarifications
No associated clarifications found.

2.12.116.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.116.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.116.7 Change Order Status

Status	Date
Issue Identified	09/27/2006
Change Order Written	09/28/2006

2.12.117 Add alt ind T_RU_COMPARISON - 4258

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
4258	Change Order		Reference Data Maintenance			2

2.12.117.1 Desired Solution
Add alternate indexes to table T_RU_COMPARISON.

2.12.117.2 Business Impact
Alternate indexes are needed to support reporting requirements.

2.12.117.3 Technical Specifications
Add the following secondary indexes to T_RU_COMPARISON:

- X_RU_COMPARISON_VAR - CDE_VARIABLE - Non-Unique
- X_RU_COMPARISON_VALUE - CDE_VALUE_COMP - Non-Unique

See supplemental documentation for additional detail.

2.12.117.4 Clarifications
No associated clarifications found.

2.12.117.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.117.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.117.7 Change Order Status

Status	Date
Change Order Written	10/13/2006
Ready for DM Review	10/16/2006
Model Office Implemented	12/17/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.118 Remove links Proc Nav Panel - 4347

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
4347	Change Order		Reference Data Maintenance			4

2.12.118.1 Desired Solution
Remove the link on the procedure navigation panel for Lab Fee.

2.12.118.2 Business Impact
Remove the link on the procedure navigation panel for Lab Fee. This is not used for KY.

2.12.118.3 Technical Specifications
Remove the link on the procedure navigation panel for Lab Fee.

Reference --> Procedure (that is, 8100) --> Lab Fee on the Procedure Maintenance navigation panel.

2.12.118.4 Clarifications
CO status put to deferred status. [Schmidt]

2.12.118.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.118.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.118.7 Change Order Status

Status	Date
Change Order Written	10/18/2006
Deferred	11/01/2006
SE Assigned	03/23/2007
Ready for Construction Walkthrough	03/23/2007
Ready for Model Office	03/27/2007
Model Office Implemented	04/05/2007
UAT Implemented	04/05/2007
Prod Implemented	06/14/2007

2.12.119 Remove T_LAB_FEE table - 4348

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
4348	Change Order		Reference Data Maintenance			4

2.12.119.1 Desired Solution
Remove the T_LAB_FEE table - no longer used.

2.12.119.2 Business Impact
Remove the T_LAB_FEE table - no longer used.

2.12.119.3 Technical Specifications
Remove the T_LAB_FEE table - no longer used.

One reference found for this table's audit table (a_t_lab_fee) in refp0010.sc.

2.12.119.4 Clarifications
CO status put to deferred status. [Schmidt]

2.12.119.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.119.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.119.7 Change Order Status

Status	Date
Change Order Written	10/18/2006
Deferred	11/01/2006

2.12.120 Change Decision Act for UB Price - 4380

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
4380	Change Order		Reference Data Maintenance			1

2.12.120.1 Desired Solution

UB04 claims contain multiple types of services that may be used for pricing. Outpatient, Home Health and LTC claims contain both procedure codes and revenue codes. In KY, the procedure code is never used for setting up reimbursement rules on these claim types. Inpatient claims use ICD9 procedure codes, DRG codes and revenue codes. This is the order in which reimbursement rules are evaluated and once one has been set, there is not need to continue looking for pricing methods on reimbursement rules.

2.12.120.2 Business Impact

None.

2.12.120.3 Technical Specifications

Create a new variable:

- CDE_VARIABLE -- UBPD
- CDE_TRANSACTION -- C
- DSC_VARIABLE -- UB92 Pricing Decision
- CDE_INPUT_OUTPUT -- O
- NAM_FUNCTION -- set_ru_ub92PricingDecision
- NAM_LIBRARY -- libclmcomm.so

Update decisions RR, RG, and RI to use UBPD where EDIT is currently being used. ach time this is updated, the action needs to be changed from an edit number to a N.

2.12.120.4 Clarifications

No associated clarifications found.

2.12.120.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.120.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.120.7 Change Order Status

Status	Date
Change Order Written	10/20/2006
Model Office Implemented	11/03/2006

Status	Date
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.121 Add TOB & Exceptions to OI Plan - 4417

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
4417	Change Order	2	Reference Data Maintenance			2

2.12.121.1 Desired Solution
Add Type of Bill (TOB) editing to the Other Insurance (OI) Plan rules panels.

2.12.121.2 Business Impact
Needed to meet TPL Matrix business policy.

2.12.121.3 Technical Specifications
Make the following modifications to the OI Plan rule panels:

- Add OI Plan exception as an output (action) on OI Plan panel.
  - OI Plan exceptions are maintained on T_PUB_HLTH_PGM
  - Use BP Groupings (T_BENEFIT_PLAN_TYPE/GROUP) to identify OI Plan exceptions.
  - Do not allow exceptions on exceptions.
  - Services (procedures/diagnoses/revenue codes. Etc.) for exceptions are keyed into separate classifications/hierarchies.
  - Exception rules are keys based on exception hierarchies.
- Add TOB to OI Plan rules panel.

2.12.121.4 Clarifications
Create Benefit Plan Type/Group - 3009 OIEXCLUSIONS to identify the list of OI Plans that are treated as exception rules.

[Troy Schexnayder]

2.12.121.5 Associated Requirements

Requirement ID	Type
30.090.006.002.3	RFP Requirement

2.12.121.6 Associated System Objects

Technical Name	Object Type	Title
Ref.OIProgramPanel.ascx	Panel	Benefit Administration-OI Plan

2.12.121.7 Change Order Status

Status	Date
Issue Identified	10/20/2006
Change Order Written	10/23/2006

Status	Date
SE Assigned	10/30/2006
Construction in Progress	10/30/2006
Ready for Construction Walkthrough	10/30/2006
Ready for Model Office	10/31/2006
Model Office Implemented	11/03/2006
Construction in Progress	11/06/2006
Ready for Model Office	11/06/2006
Model Office Implemented	11/11/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.122 Rules - prov contrac member plan - 4557

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
4557	Change Order		Reference Data Maintenance			2

2.12.122.1 Desired Solution
Currently on the rules panels (reimbursement, provider contract, member plan) when the user selects to add either the provider contract or the member plan to the rule, the sak of the provider contract along with a short description is displayed. We should also display the code for the provider contract or member plan and the short description.

2.12.122.2 Business Impact
To the user, the sak values displayed in the panel are not useful. Using the code for the provider contact with the short description is helpful for the user(s). The same applies to the member/benefit plan.

2.12.122.3 Technical Specifications
Update the rule panel to concatenate the provider contract code and description for the provider contract and also do the same for the member plan code and description along with keeping the sak on the panel.

From the T_PR_ENROLL_PGM table use the:

- CDE_PROV_PGM NOT NULL CHAR(5)
- DSC_PROV_PGM NOT NULL CHAR(20)

From the T_PUB_HLTH_PGM table use the:

- CDE_PGM_HEALTH NOT NULL CHAR(5)
- DSC_PGM_HEALTH NOT NULL VARCHAR2(50)

See attachment in supplemental doco for an example of each.

Minor clean-up item :
For KY UI, update the Member Plans Editing to Member Plans Editing on the rules panel (reimbursement agreement, provider contract, member plan).

Another issue exists where the available plans control is displaying all plans. It needs to limit list to assignment and benefit plans only.

2.12.122.4 Clarifications
No associated clarifications found.

2.12.122.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.122.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.122.7 Change Order Status

Status	Date
Change Order Written	10/31/2006
SE Assigned	11/21/2006
Construction in Progress	11/21/2006
Ready for Construction Walkthrough	11/22/2006
Ready for Model Office	11/24/2006
Model Office Implemented	11/28/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.123 Add new High Int Ind to Rules - 4724

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
4724	Change Order		Reference Data Maintenance			1

2.12.123.1 Desired Solution
Changes were made to the legacy system (Transition CO 1006) to add an additional high intensity indicator that allows SCL claims to be priced differently for individuals being deinstitutionalized from an ICF MR DD.

2.12.123.2 Business Impact
None.

2.12.123.3 Technical Specifications
The reimbursement rules panel currently allows values of "Both", "Yes" and "No" to be entered. A value of "Deinstitutionalized", which resolves to a code value of "D", needs to be added to the list of valid selections. The value of "Both" probably needs to be removed.

2.12.123.4 Clarifications
Several reimbursement rules for SCL are not able to be entered until this change has been made.

Laura Battles

2.12.123.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.123.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.123.7 Change Order Status

Status	Date
Change Order Written	11/07/2006
SE Assigned	11/20/2006
Construction in Progress	11/20/2006
Ready for Construction Walkthrough	11/20/2006
Ready for Model Office	11/21/2006
Model Office Implemented	11/28/2006
Construction in Progress	12/18/2006
Ready for Construction	12/19/2006

Status	Date
Walkthrough	
Ready for Model Office	12/19/2006
Model Office Implemented	12/28/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.124 Add Proc edits to Diag EBP rule - 4764

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
4764	Change Order		Reference Data Maintenance			1

2.12.124.1 Desired Solution
Enable Procedure Editing on Diagnosis Related rules.

This functionality was added to Provider Contracts, Member Plans and Reimbursement rules.

2.12.124.2 Business Impact
Meet KY claims processing policy.

2.12.124.3 Technical Specifications
Enable Procedure Code editing on Provider Contracts, Reimbursement Rules and Member Plans.

See clarification from Pat Bonner.

2.12.124.4 Clarifications
Eduardo and I discussed this. What we need to do is put a PRCX variable on the Provider Contract page and include PRCX as a variable for the PD decision. This is similar to CO2991 (only then there was a issue with the code not working correctly for benefit to benefit variables other than the ones in the diagnosis group, which have been fixed).

Note: On the Member Plan panel, you must have a benefit plan selected. If you have an assignment plan selected, Procedure Editing is not enabled.

[Pat Bonner]

This CO just requires a metadata change. The control for procedure editing is already on the Provider Contract, Reimbursement Agreement and Benefit Coverage Edit panels. To enable procedure editing, metadata has to be added to include the PRCX variable as a decision variable for the RD (Reimbursement - Diagnosis), BD (Benefit Coverage - Diagnosis) and PD (Provider Contract - Diagnosis) decisions [Pat Bonner]

2.12.124.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.124.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.124.7 Change Order Status

Status	Date
Issue Identified	11/10/2006
Change Order Written	11/10/2006

Status	Date
Ready for Model Office	11/14/2006
Model Office Implemented	11/20/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.125 Add Search to Provider Contract - 4982

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
4982	Change Order		Reference Data Maintenance			3

2.12.125.1 Desired Solution
Add the ability to search by Provider Contract code on the Provider Contract panel.

2.12.125.2 Business Impact
Allow a user to quickly access Provider Contract information.

2.12.125.3 Technical Specifications
Add a search panel to the Provider Contract panel to allow the user to search the list by Enrollment Program code. This is similar to the change made in CO 3455 for the Member Plans.

2.12.125.4 Clarifications
Added mini-search. I requested that it not be released on 12/7 due to confusion over comments. Currently marked for 12/14 release

2.12.125.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.125.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.125.7 Change Order Status

Status	Date
Issue Identified	11/28/2006
Change Order Written	11/28/2006
SE Assigned	11/29/2006
Ready for Tech Walkthrough	11/29/2006
Ready for Model Office	11/29/2006
Ready for Model Office	12/12/2006
Model Office Implemented	12/18/2006
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.126 Expand TOB code to 4 bytes - 5095

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
5095	Change Order		Reference Data Maintenance			2

2.12.126.1 Desired Solution
The UB04 beta billing manual that reflects four character TOBs. Expand the Type of Bill code table to carry four character TOB codes.

2.12.126.2 Business Impact
Met UB04 billing requirements.

2.12.126.3 Technical Specifications
Expanded TOB codes to four characters.

Current Table definitions:

```
Name Null? Type
---------------------------------------------------- -------- ------------------------------------
CDE_TYPE_OF_BILL NOT NULL CHAR(3)
DSC_TYPE_OF_BILL NOT NULL CHAR(20)
IND_PROC_IN_EXCLUD NOT NULL CHAR(1)
```

Expanded TOB codes:

```
Name Null? Type
---------------------------------------------------- -------- ------------------------------------
CDE_TYPE_OF_BILL NOT NULL CHAR(4)
DSC_TYPE_OF_BILL NOT NULL CHAR(20)
DSC_TOB_LONG NOT NULL VARCHAR2(200)
```

2.12.126.4 Clarifications
No associated clarifications found.

2.12.126.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.126.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.126.7 Change Order Status

Status	Date
No associated Change Orders found.	

2.12.127 New table - Annual out of pocket - 5140

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
5140	Change Order		Reference Data Maintenance			3

2.12.127.1 Desired Solution
Create a new table to hold the annual (calendar year) out-of-pocket.

2.12.127.2 Business Impact
Create a new table to hold the annual (calendar year) out-of-pocket.

2.12.127.3 Technical Specifications
Create a new table to hold the annual (calendar year) out-of-pocket.

The new table has the following columns:

- one for the member plan
- one for the calendar year (or if needed in the future, time periods; also added effective, end, active and inactive dates)
- one for the amount for the out-of-pocket maximum.
- suggested table name - T_MAX_OUT_OF_POCKET
- sak_pub_htlh number(9)
- calendar_year char(4)
- amt_max_out_of_pocket number (8,2)

2.12.127.4 Clarifications
Change order put in a deferred status per Judy Bullock from review meeting on 12/11/2006. [Schmidt]

2.12.127.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.127.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.127.7 Change Order Status

Status	Date
Change Order Written	12/12/2006
Deferred	12/12/2006

2.12.128 New panel - Max out-of-pocket - 5141

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
5141	Change Order		Reference Data Maintenance			3

2.12.128.1 Desired Solution
Add a new panel to support the maximum out-of-pocket (copay & coinsurance) table.

2.12.128.2 Business Impact
Add a new panel to support the maximum out-of-pocket (copay & coinsurance) table.

2.12.128.3 Technical Specifications
Add the new panel in Reference --> Related Data --> Codes --> [new panel name]

2.12.128.4 Clarifications
Change order put in a deferred status per Judy Bullock from review meeting on 12/11/2006. [Schmidt]

2.12.128.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.128.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.128.7 Change Order Status

Status	Date
Change Order Written	12/12/2006
Deferred	12/12/2006

2.12.129 Decision Rules - Search - 5473

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
5473	Change Order		Reference Data Maintenance			2

2.12.129.1 Desired Solution

The decision rules panel under claims/reference show the decision rules used by the claims engine. The panel displays the rule #, but there is no way to search by rule number under the reference panels.

Desired Solution:
There should be a search feature on all benefit/reference screens to search by rule number (coverage/reimbursement/copay/)

2.12.129.2 Business Impact

None.

2.12.129.3 Technical Specifications

The decision rules panel under claims shows the decision rules used by the claims engine. It shows the rule #, but there is no way to search by rule number under the reference panels. There is a search feature on all benefit/reference screens to search by rule number (coverage/reimbursement/copay/)

2.12.129.4 Clarifications

Per email from Mike Wajda on 01/05/07, this was originally entered as Defect 5421. He wants Defect 5421 cancelled and same information added as a Change Order.

This CO needs to go to a Scope Control Board review before being implemented.

[Troy Schexnayder]

2.12.129.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.129.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.129.7 Change Order Status

Status	Date
Change Order Written	01/05/2007

2.12.130 Provide Contracts - Config - 5474

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
5474	Change Order		Reference Data Maintenance			2

2.12.130.1 Desired Solution

Under Procedures for Reference, the coverage rules show the individual packages. Based on a meeting this morning, seems like the coverage rule is actually an intersection of the "ALL Global contract and the individual provider type contract. This is very confusing and will be a nightmare to manage.

The rules for individual provider type need to be moved from the ALL to the individual provider contracts. Leslie is aware of this issue.

2.12.130.2 Business Impact

None.

2.12.130.3 Technical Specifications

None.

2.12.130.4 Clarifications

Email received 01/05/07 from Mike Wajda that Defect 5433 should be cancelled and this information entered into a new change order.

2.12.130.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.130.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.130.7 Change Order Status

Status	Date
Change Order Written	01/05/2007

2.12.131 New Form Edits Vars for CO5097 - 5554

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
5554	Change Order		Reference Data Maintenance			1

2.12.131.1 Desired Solution
This CO is related to CO 5097. CO 5097 was implemented via Form Edits. To do. this variables for Amount Billed and for the Provider Contract were added to the Form Edits Detail decisions.

2.12.131.2 Business Impact
None.

2.12.131.3 Technical Specifications
The change requires additional form edits metadata. The provider contract variable is an existing variable that just needs to be added to the form edits detail decisions. For amount billed, a new variable is needed - AMTB and a new currency range domain - CURG. Code changes are required to support this new domain.

2.12.131.4 Clarifications
No associated clarifications found.

2.12.131.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.131.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.131.7 Change Order Status

Status	Date
SE Assigned	01/09/2007
Construction in Progress	01/09/2007
Ready for Model Office	01/10/2007
Model Office Implemented	01/22/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.132 Update Accident Type panel - 5622

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
5622	Change Order		Reference Data Maintenance			2

2.12.132.1 Desired Solution
Update the Accident Type panel to use the updated T_ACCIDENT_TYPE table.

2.12.132.2 Business Impact
Update this table to support the HIPAA values for accident types (related causes - CLM11-1, CLM11-2, CLM11-3).

2.12.132.3 Technical Specifications
The T_ACCIDENT_TYPE table changes both column lengths.

Is now:

- CDE_ACC_TYP NOT NULL CHAR(3)
- DSC_ACC_TYP NOT NULL VARCHAR2(25)

Previously was:

- CDE_ACC_TYP NOT NULL CHAR(1)
- DSC_LENGTH_15 NOT NULL CHAR(15)

2.12.132.4 Clarifications
No associated clarifications found.

2.12.132.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.132.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.132.7 Change Order Status

Status	Date
Change Order Written	01/11/2007
SE Assigned	01/11/2007
Construction in Progress	01/12/2007
Ready for Construction Walkthrough	01/12/2007
Ready for Model Office	01/15/2007

Status	Date
Model Office Implemented	01/19/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.133 New indexes for RU tables - 5911

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
5911	Change Order		Reference Data Maintenance			3

2.12.133.1 Desired Solution

The following indexes are needed for KY:

- Table T_RU_CONDITION - NON-UNIQUE index on column SAK_RULE.
- Table T_RU_DECISION_VAR - NON-UNIQUE index on column CDE_VARIABLE.
- Table T_RU_TUPLE_SET - NON-UNIQUE index on column SAK_VALUE_DISCRETE.
- Table T_RU_RULE_ACTION - NON-UNIQUE index on column SAK_ACTION
- Table T_RU_RULE - NON-UNIQUE index on column CDE_DECISION

2.12.133.2 Business Impact

Improve runtime.

2.12.133.3 Technical Specifications

- Table T_RU_CONDITION - NON-UNIQUE index on column SAK_RULE.
- Table T_RU_DECISION_VAR - NON-UNIQUE index on column CDE_VARIABLE.
- Table T_RU_TUPLE_SET - NON-UNIQUE index on column SAK_VALUE_DISCRETE.
- Table T_RU_RULE_ACTION - NON-UNIQUE index on column SAK_ACTION
- Table T_RU_RULE - NON-UNIQUE index on column CDE_DECISION

2.12.133.4 Clarifications

See attached email from Eduardo Bastida.

[Troy Schexnayder]

2.12.133.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.133.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.133.7 Change Order Status

Status	Date
Change Order Written	01/20/2007
Ready for DM Review	01/20/2007

Status	Date
DM Review Board Approved	01/20/2007
Ready for Model Office	01/27/2007
Model Office Implemented	02/01/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.134 Error Disp Search - 6058

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
6058	Change Order		Reference Data Maintenance			3

2.12.134.1 Desired Solution
Allow Error Disposition Search to search by a range of Error Status Codes.

2.12.134.2 Business Impact
Allow user to list a range of Error Status Codes.

2.12.134.3 Technical Specifications
Search by a range of Error codes on the Error Disposition Search page. If the user only enters in the from code, default the to code to equal the from code. If only one row is returned on the search, go to the Base information page as it does today.

2.12.134.4 Clarifications
No associated clarifications found.

2.12.134.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.134.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.134.7 Change Order Status

Status	Date
Change Order Written	01/26/2007
SE Assigned	01/26/2007
Ready for Construction Walkthrough	01/26/2007
Ready for Model Office	01/29/2007
Model Office Implemented	02/02/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.135 Config for Coinsurance - 6172

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
6172	Change Order		Reference Data Maintenance			4

2.12.135.1 Desired Solution
Change order to support future UI changes for coinsurance.

2.12.135.2 Business Impact
Change order to support future UI changes for coinsurance.

2.12.135.3 Technical Specifications
None.

2.12.135.4 Clarifications
No associated clarifications found.

2.12.135.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.135.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.135.7 Change Order Status

Status	Date
Deferred	02/01/2007

2.12.136 Drop index I_DRG_CROSSWALK_CE - 6251

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
6251	Change Order		Reference Data Maintenance			2

2.12.136.1 Desired Solution
Remove alternate index I_DRG_CROSSWALK_CE from table T_DRG_CROSSWALK.

It is not needed and it is causing duplicate row issues when trying to load KY pricing data.

2.12.136.2 Business Impact
Preventing KY data load.

2.12.136.3 Technical Specifications
Remove alternate index I_DRG_CROSSWALK_CE from table T_DRG_CROSSWALK.

It is not needed and it is causing duplicate row issues when trying to load KY pricing data.

2.12.136.4 Clarifications
No associated clarifications found.

2.12.136.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.136.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.136.7 Change Order Status

Status	Date
Issue Identified	02/05/2007
Change Order Written	02/06/2007
Ready for DM Review	02/06/2007
DM Review Board Approved	03/17/2007
Model Office Implemented	03/30/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.137 pring type l on error disp panel - 6318

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
6318	Change Order	2	Reference Data Maintenance			2

2.12.137.1 Desired Solution
Enc report CLM0123D and claim report CLM 023D use error disposition criteria of print type L. The only print types available for selection currently are: W (worksheet), N (do not report) and S (summary). Type L needs to be added

2.12.137.2 Business Impact
None.

2.12.137.3 Technical Specifications
None.

2.12.137.4 Clarifications
Changed the dropdown list to remove Summary (S) and add CLM-0023-D/CLM-0123-D Report(L). See attached email communication for details.

2.12.137.5 Associated Requirements

Requirement ID	Type
30.020.002	RFP Requirement

2.12.137.6 Associated System Objects

Technical Name	Object Type	Title
Ref.DispositionCriteriaPanel.ascx	Panel	Disposition Criteria-Error Disposition

2.12.137.7 Change Order Status

Status	Date
Issue Identified	02/10/2007
SE Assigned	02/12/2007
Ready for Construction Walkthrough	02/12/2007
Ready for Model Office	02/12/2007
Model Office Implemented	02/16/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.138 BA Missing Rule to Error Assoc - 6525

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
6525	Change Order		Reference Data Maintenance			3

2.12.138.1 Desired Solution

User accesses Benefit Admin, Member Plan, KCHIP, Proc Code 92507, Rule 15352. This rule restricts coverage for BPTS 45/000. User needs to be able to see the error codes that are posted as a result of this rule.

Resolution of this defect may be deferred until after go live.

2.12.138.2 Business Impact

None.

2.12.138.3 Technical Specifications

None.

2.12.138.4 Clarifications

No associated clarifications found.

2.12.138.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.138.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.138.7 Change Order Status

Status	Date
Defect Identified	03/01/2007
Deferred	03/05/2007

2.12.139 Add Member Program code to Rules - 6539

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
6539	Change Order		Reference Data Maintenance			2

2.12.139.1 Desired Solution
In order to configure rules to include/exclude QMB-only member, program code needs to be added to the benefit plan, provider contract and reimbursement rule decisions and panels.

2.12.139.2 Business Impact
Allow processing of QMB only members according to KY policy.

2.12.139.3 Technical Specifications
Create a new input variable that applies to benefit plans, provider contract and reimbursement decisions.

- label on panel - Member Program Code Editing
- cde_variable - AIDC
- table - T_CDE_AID Column - CDE_AID_CATEGORY
- getter function - get_ru_memberAidCode
- library - libclmcomm.so

Member Program Code Editing uses a dropdown list of No/Include/Exclude and then allows the user to select one to many program codes to edit against if include/exclude is selected.

2.12.139.4 Clarifications
New variable is added to all benefit types for Contracts, Member Plans and Reimbursement Rules. The aid category code is stored on the rule tables.

2.12.139.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.139.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.139.7 Change Order Status

Status	Date
Issue Identified	03/02/2007
SE Assigned	03/05/2007
Construction in Progress	03/05/2007
Ready for Construction Walkthrough	03/06/2007
Ready for Model Office	03/14/2007

Status	Date
Model Office Implemented	03/16/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.140 UI - Add Pa on Claim Variable - 6591

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
6591	Change Order		Reference Data Maintenance			

2.12.140.1 Desired Solution
There are several edits in KY that perform differently if there is a PA number present on the submitted claim. A new variable needs to be added so that form edits and other decisions can check for the existence of a PA number on a claim.

2.12.140.2 Business Impact
None.

2.12.140.3 Technical Specifications
Create a new input variable that applies to form edits (all decisions), benefit plans and provider contracts.

- label on panel - PA Number on Claim
- cde_variable - CLPA
- table - Yes/No value
- getter function - get_ru_PAonClaim
- library - libclmcomm.so

2.12.140.4 Clarifications
No associated clarifications found.

2.12.140.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.140.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.140.7 Change Order Status

Status	Date
Change Order Written	03/08/2007
SE Assigned	03/08/2007
Construction in Progress	03/08/2007
Ready for Construction Walkthrough	03/09/2007
Ready for Model Office	03/09/2007
Model Office Implemented	03/16/2007

Status	Date
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.141 Add OOS Ind to Prov Contracts - 6992

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
6992	Change Order		Reference Data Maintenance			

2.12.141.1 Desired Solution
Legacy edit 274 (iC edit 3001) is bypassed if a provider is out of state and not a contiguous state.

2.12.141.2 Business Impact
None.

2.12.141.3 Technical Specifications
Add variable OOSP to the provider contract decisions (PP, PR, PD, PG, PI, PN). This variable already exists on the reimbursement decisions and form edits.

Once this has been added to the provider contracts panels, the HOSP and NACIP contracts need to be updated to not require PA for a OOS indicator of 2, 3 or 4. Pat Nolte just needs to be notified so she can make these updates.

2.12.141.4 Clarifications
No associated clarifications found.

2.12.141.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.141.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.141.7 Change Order Status

Status	Date
Change Order Written	03/30/2007
SE Assigned	03/30/2007
Construction in Progress	03/30/2007
Ready for Model Office	04/02/2007
Model Office Implemented	04/06/2007
UAT Implemented	04/19/2007
Prod Implemented	06/14/2007

2.12.142 Reference JIL updates - 7098

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
7098	Change Order		Reference Data Maintenance			3

2.12.142.1 Desired Solution
Update Reference JILs to KY MMIS standards.

2.12.142.2 Business Impact
Meet batch cycle requirements.

2.12.142.3 Technical Specifications
Review:

Review for standards and singe-source functionality:

- PRBQJOBS
- PRFA100
- PRFA105
- PRFA150
- PRFM200
- PRFO120
- PRFW010

Rename:

- PREFWFDB to PRFWFDB
- PREFQ046 to PRFQ046

Remove from Autosys:

Keep JIL for future functionality, but add Delete Box at end:

- PREFW300
- PRFA110
- PRFA111
- PRFM100
- PRFM5556
- PRFO130
- PRFO150
- PRFO170

- PRFQ031

Validate/verify PWB documentation.

2.12.142.4 Clarifications

No associated clarifications found.

2.12.142.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.142.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.142.7 Change Order Status

Status	Date
Issue Identified	04/01/2007
Change Order Written	04/01/2007
Construction in Progress	04/04/2007

2.12.143 T_RU_COMPARISON add attr 2 index - 7105

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
7105	Change Order		Reference Data Maintenance			2

2.12.143.1 Desired Solution

Add the cde_variable attribute/column to the x_ru_comparison_value index on the T_RU_COMPARISON table.

The x_ru_comparison_value index only has the cde_value_comp in this index.

Currently, in the UAT environment, x_ru_comparison_3 is being used (cde_value_comp & cde_variable). This can be dropped after updating x_ru_comparison_value for all environments.

2.12.143.2 Business Impact

None.

2.12.143.3 Technical Specifications

Add the cde_variable attribute/column to the x_ru_comparison_value index on the T_RU_COMPARISON table.

2.12.143.4 Clarifications

Verified change is in MO & UAT via Oracle OEM [Schmidt].

2.12.143.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.143.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.143.7 Change Order Status

Status	Date
Change Order Written	04/04/2007
Ready for DM Review	04/05/2007
DM Review Board Approved	04/05/2007
Ready for Model Office	04/11/2007
Model Office Implemented	04/20/2007
UAT Implemented	04/20/2007
Prod Implemented	04/20/2007

2.12.144 UI Add Amt Billed to Rules - 7339

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
7339	Change Order		Reference Data Maintenance			

2.12.144.1 Desired Solution
Some DME services only require prior authorization under KY policy if the amount billed for a service exceeds a specific dollar amount. Users need to be able to configure provider contract and reimbursement rules using the detail amount billed as criteria.

2.12.144.2 Business Impact
None.

2.12.144.3 Technical Specifications
Create a new input variable that applies to provider contracts and reimbursement decisions:

- - cde_variable – DBIL
- - getter function - get_ru_AmountBilledDtlTotal
- - library - libclmcomm.so
- - domain - currency - CURG

This variable is entered as a range. For example: $0.00 through $300.00. The claims engine getter needs to call get_cd_amtBilled().

2.12.144.4 Clarifications
No associated clarifications found.

2.12.144.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.144.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.144.7 Change Order Status

Status	Date
Change Order Written	04/11/2007
SE Assigned	04/12/2007
Ready for Construction Walkthrough	04/12/2007
Ready for Model Office	04/12/2007
Model Office Implemented	04/20/2007

Status	Date
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.145 Tuple Set compare - 7383

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
7383	Change Order		Reference Data Maintenance			4

2.12.145.1 Desired Solution

Tuple set compare functionality needs to be added to benefit functionality. Currently, it is always assumed that tuple sets are disjoint. Tuple set compare functionality has been implemented in CORE - see Core 15081 and also 15851. The code is merged from Core. Because of the complexity, it is considered its own KY CO.

2.12.145.2 Business Impact

None.

2.12.145.3 Technical Specifications

None.

2.12.145.4 Clarifications

No associated clarifications found.

2.12.145.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.145.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.145.7 Change Order Status

Status	Date
Deferred	04/13/2007

2.12.146 Error Disp - Potent Hist Adj Rpt - 7414

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
7414	Change Order		Reference Data Maintenance			3

2.12.146.1 Desired Solution

The panel that displays error disposition information - Error Disposition Information - Error Disposition panel in reference has a field called Potential History to Adjust Report (panel attached in email below). This field is used to indicate if the error is reported on the Potential History To Adjust Report. If the box is checked, the error is included in the report. This field is informational only - the customer is not allowed to update this field.

2.12.146.2 Business Impact

x

2.12.146.3 Technical Specifications

Modify the Potential History To Adjust Report field to be Inquiry Only.

The indicator is set by the Claims Reports Team using SQL and is not updateable through the UI.

See email RE: KY DDI - High - Act - CLM0015D - ClaimCheck Potential History to Adjust Report Layout in Supplemental Documentation.

2.12.146.4 Clarifications

See email **RE: KY DDI - High - Act - CLM0015D - ClaimCheck Potential History to Adjust Report Layout** in Supplemental Documentation.

[Troy Schexnayder]

2.12.146.5 Associated Requirements

Requirement ID	Type
30.090.006.002.11	RFP Requirement

2.12.146.6 Associated System Objects

Technical Name	Object Type	Title
Ref.ErrorDispBaseEditPanel.ascx	Panel	Base Information-Error Disposition

2.12.146.7 Change Order Status

Status	Date
Issue Identified	04/14/2007
Change Order Written	04/16/2007
Construction in Progress	04/16/2007
Ready for Construction Walkthrough	04/16/2007
Ready for Model Office	04/16/2007

Status	Date
Model Office Implemented	05/02/2007
UAT Implemented	06/14/2007
Prod Implemented	06/14/2007

2.12.147 I3378 - 7705

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
7705	Change Order		Reference Data Maintenance			1

2.12.147.1 Desired Solution
All PRTF's Provider contracts need to be changed to require Prior Authorization. Provider Type (A4). This is for DDI.

2.12.147.2 Business Impact
None.

2.12.147.3 Technical Specifications
None.

2.12.147.4 Clarifications
Should have been put in new system to start with.

Request to cancel CO 7705 sent to DMS. Rules for all room and board revenue codes on inpatient hospital provider contracts in interChange were added to include the requirement for Prior Authorization.

Waiting on response from DMS regarding cancellation of Memo.

Waiting on response from DMS regarding cancellation of CO.

Waiting on response from DMS regarding cancellation of CO.

DMS Business Analyst Jimmie Estill was not cc'd on the cancellation memo; email and copy of memo sent on 7/27/2007. No response to date.

Waiting on response from DMS regarding cancellation of memo.

Waiting on response from DMS regarding cancellation of memo.

Sign-off memo received today

2.12.147.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.147.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.147.7 Change Order Status

Status	Date
Change Order Written	04/27/2007
Assigned BA	04/27/2007

Status	Date
Sign-Off Requested	06/26/2007
Completed	08/22/2007

2.12.148 Config - LTC Treat Auth Pricing - 7903

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
7903	Change Order		Reference Data Maintenance			

2.12.148.1 Desired Solution
x

2.12.148.2 Business Impact
None.

2.12.148.3 Technical Specifications
Create a new output variable that only applies to reimbursement rules:

- - cde_variable – TAUT
- - setter function - set_ru_indPaTOS
- - library - libclmcomm.so

Valid values are B, C, H, V and Y. Only one value is selected for a rule. The descriptions are:

- B - Brain Injury Behavioral Unit
- C - Infectious Disease
- H - Brain Injury
- V – Ventilator
- Y - Nursing Facility

2.12.148.4 Clarifications
No associated clarifications found.

2.12.148.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.148.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.148.7 Change Order Status

Status	Date
Change Order Written	05/08/2007
SE Assigned	05/09/2007
Construction in Progress	05/09/2007

Status	Date
Ready for Construction Walkthrough	05/09/2007
Ready for Model Office	05/10/2007
Model Office Implemented	05/18/2007
UAT Implemented	05/18/2007
Prod Implemented	06/14/2007

2.12.149 Add Diag HDR Any (Inst) to EBP - 8060

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
8060	Change Order		Reference Data Maintenance			3

2.12.149.1 Desired Solution
Add new variable - Diagnosis Header Any (Inst) to the Member Plan configuration rules panels. This functionality is needed for KenPac assignment plan configuration.

2.12.149.2 Business Impact
Required for KenPac member plan configuration

2.12.149.3 Technical Specifications
We need to add a new Diagnosis Header - Any variable for Institutional claims on Member plans for Procedures and Revenue codes. This is different from the current Diagnosis Header Any in that it is only used for Institutional claims and it is a multi-value variable instead of a tuple set.

Let's call it Diagnosis Header Any (Inst.) Editing (cde_variable = DHAI). Eduardo says that we can use the same getter as the DHA variable. This variable is similar to the Primary and Secondary diagnosis functionality. We may want to think about changing the existing variable to be Diagnosis Header Any (Phys.) Editing to avoid confusion.

Add the new variable to the same panels as the Diagnosis Header Any (DHA) currently exist. Use the existing edit numbers from the DHA variable.

2.12.149.4 Clarifications
New variable was added to the following decisions BP, BR, PR, RR. Existing edits for DHA were used.

Eduardo confirmed that this variable *is* multi-valued even though it has no sub-relations.

2.12.149.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.149.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.149.7 Change Order Status

Status	Date
Issue Identified	05/19/2007
Change Order Written	05/22/2007
Assigned SE	05/22/2007
Construction in Progress	05/22/2007
Ready for Construction	05/22/2007

Status	Date
Walkthrough	
Ready for Model Office	05/22/2007
Model Office Implemented	05/28/2007
UAT Implemented	05/28/2007
Prod Implemented	06/14/2007

2.12.150 Add panel - default percentage - 8129

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
8129	Change Order		Reference Data Maintenance			4

2.12.150.1 Desired Solution
Create a panel to display the data from the T_DEFAULT_PRICING table.

2.12.150.2 Business Impact
Create a panel to display the data from the T_DEFAULT_PRICING table.

This table is use to price a claim using a default percentage time the billed amount on the claim.

2.12.150.3 Technical Specifications
Create a panel to display the data from the T_DEFAULT_PRICING table.

Add panel to Reference --> related data --> Other

2.12.150.4 Clarifications
No associated clarifications found.

2.12.150.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.150.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.150.7 Change Order Status

Status	Date
Change Order Written	05/29/2007
Deferred	05/29/2007

2.12.151 Add panel - Hospice Crosswalk - 8130

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
8130	Change Order		Reference Data Maintenance			4

2.12.151.1 Desired Solution
Create a panel to display the data from the T_REV_HOSPICE_XWALK table.

2.12.151.2 Business Impact
Create a panel to display the data from the T_REV_HOSPICE_XWALK table.

This table is used to vary the rate based on certain conditions on the claim for Hospice claims.

2.12.151.3 Technical Specifications
Create a panel to display the data from the T_REV_HOSPICE_XWALK table.

Add panel to Reference --> related data --> Other

For the sak_rev_claim and the sak_rev_price column, please display the revenue code value (cde_revenue) from the T_REVENUE_CODE table instead of the SAK values.

2.12.151.4 Clarifications
No associated clarifications found.

2.12.151.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.151.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.151.7 Change Order Status

Status	Date
Change Order Written	05/29/2007
Deferred	05/29/2007

2.12.152 Add panel - Mult Surg Percentage - 8131

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
8131	Change Order		Reference Data Maintenance			4

2.12.152.1 Desired Solution
Create a panel to display the data from the T_CLM_MULT_SURG table.

2.12.152.2 Business Impact
Create a panel to display the data from the T_CLM_MULT_SURG table.

2.12.152.3 Technical Specifications
Create a panel to display the data from the T_CLM_MULT_SURG table.

Add panel to Reference --> related data --> Other

2.12.152.4 Clarifications
No associated clarifications found.

2.12.152.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.152.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.152.7 Change Order Status

Status	Date
Change Order Written	05/29/2007
Deferred	05/29/2007

2.12.153 New associated audits panels - 8223

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
8223	Change Order		Reference Data Maintenance			2

2.12.153.1 Desired Solution
Create two new panels to display the associated audits for procedure and revenue code.

- Reference > Procedure > Associated Audits
- Reference > Revenue > Associated Audits

2.12.153.2 Business Impact
Add functionality to the UI that exposes the associated audit information directly to the user, eliminating the need for a developer to run ad hoc queries.

2.12.153.3 Technical Specifications
The panels pull their information from:

- T_AUDT_PROC_XRF
- T_AUDIT_REV_XREF

They are read only, showing only a datalist with the columns Audit Number, Audit Type and Audit Description.

The panels can be modeled on the Associated Audits NDC Panel under Drug.
https://ddipwb.kymmis.com/KYXIXDDI/Subsystem/Utils/Panel.asp?Window_Name=Associated+Audits%2DNDC%2DDrug&SUBSYSTEM=Reference+Data+Maintenance&Technical_Name=Ref%2EAssocAuditsNDC&sak_object_panel=13336240

2.12.153.4 Clarifications
No associated clarifications found.

2.12.153.5 Associated Requirements

Requirement ID	Type
30.090.006.002.3	RFP Requirement
30.090.006.002.7	RFP Requirement

2.12.153.6 Associated System Objects

Technical Name	Object Type	Title
Reference.AssocAuditsRevenuePanel	Panel	Associated Audits-Revenue
Ref.AssocAuditsProcedurePanel.ascx	Panel	Associated Audits-Procedure

2.12.153.7 Change Order Status

Status	Date
Change Order Written	06/06/2007

Status	Date
Construction in Progress	06/07/2007
Ready for Construction Walkthrough	06/29/2007
Ready for Model Office	07/02/2007
Model Office Implemented	07/02/2007
UAT Implemented	07/02/2007
Prod Implemented	07/05/2007

2.12.154 I3409 - 8319

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
8319	Change Order		Reference Data Maintenance			2

2.12.154.1 Desired Solution
Payment increase for 153 Physician codes

2.12.154.2 Business Impact
None.

2.12.154.3 Technical Specifications
None.

2.12.154.4 Clarifications
As of a 7/1/07 implementation date, please update the rates for the attached list of codes.

Addendum requested to add a new Reimbursement Rule for proc code 99050 (After Hours) for PT 64 & 65 -

Waiting on addendum for procedure code 99050, email to Kalan.

Addendum to CO 8319 received 07/13/07: "We need to allow only PROVIDER TYPES 64 and 65 to bill this code 99050 at the $72.00 price. The other provider TYPES can continue to bill it at the current rate on the fee schedule.

Addendum testing approved by Charles Douglass 8/13/07.

All rates verified in production.

Waiting on updated pricing manual to send sign-off request.

2.12.154.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.154.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.154.7 Change Order Status

Status	Date
Change Order Written	06/12/2007
Assigned BA	06/12/2007
MO Testing in Progress	06/29/2007
Prod Implemented	07/05/2007

Status	Date
Testing Approved - DMS	08/18/2007

2.12.155 I3410 - 8320

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
8320	Change Order		Reference Data Maintenance			2

2.12.155.1 Desired Solution
To end date the following codes

2.12.155.2 Business Impact
None.

2.12.155.3 Technical Specifications
None.

2.12.155.4 Clarifications
For RR modifier - please end-date the following coes: E0168, E0170, E0171, E0172, E0197. These codes are now purchase only as of 7/2/07.

The following codes need to be end-dated in the system as of 4/2/07: K0010, K0011, K0012 and K0014. They are to be end-dated for both rental and purchase.

Regulatory requirement to update the fee DME fee schedule quarterly. The next update is due on 7/1/07.

Testing was shown and approved by Karen Sayles and Patricia Biggs on Friday, June 29, 2007.

Sign-off memo submitted to the Commonwealth 07/26/07.

Memo dated 07/31/07 from the Commonwealth was received 08/03/07 by EDS. Commonwealth is requesting corrections be made to the PWB, the production environment and new testing results be scheduled for review. Any claims processed after the effective dates within the CO should be identified and re-processed for correction.

The Commonwealth responded with questions. Jan Thornton was contacted in Karen Sayles absence. Patricia Biggs approved leaving the end date of 7/1/07 for E0168 and E0197. A new sign off memo was sent to the Commonwealth.

Issues corrected, new sign off memo sent - 8/16/07 - JP

Sign-off approval received from Commonwealth 8/30/07

2.12.155.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.155.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.155.7 Change Order Status

Status	Date
Change Order Written	06/12/2007
Assigned BA	06/12/2007
MO Testing Complete	07/02/2007
Sign-Off Requested	07/26/2007
Sign-Off Requested	08/16/2007
Completed	08/30/2007

2.12.156 Move EBT Sync to Production - 8329

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
8329	Change Order		Reference Data Maintenance			3

2.12.156.1 Desired Solution
The "Master" copy of the Enhanced Benefit Plan (EBP) data is maintained in Parallel (KYMISM2).

Implement jobs to copy EBP Rules data from Parallel (KYMISM2) to MO, UAT and PROD.

2.12.156.2 Business Impact
This process allows the users to maintain EBP data without impacting the claims engine process.

2.12.156.3 Technical Specifications
Create jobs to copy the following tables from Parallel (KYMISM2) to MO, UAT and PROD:

- t_bnft_group_std
- t_classification_bnft
- t_group_std_bnft
- t_ru_action
- t_ru_array
- t_ru_comparison
- t_ru_condition
- t_ru_discrete_set
- t_ru_rule
- t_ru_rule_action
- t_ru_tuple_set
- t_ru_decision
- t_ru_decision_var
- t_ru_domain
- t_ru_relation
- t_ru_relation_xref
- t_ru_transaction
- t_ru_variable

This job is able to be requested by the user to execute.

Remove temporary job MEBTSYNC from Autosys.

See attached PRFOEBP - On Request - EBP Sync documentation.

2.12.156.4 Clarifications
No associated clarifications found.

2.12.156.5 Associated Requirements

Requirement ID	Type
30.020.001.002	RFP Requirement

2.12.156.6 Associated System Objects

Technical Name	Object Type	Title
REFJOEBP	Batch Job	Request EBP Sync
REFJDA01	Batch Job	Copy Enhanced Benefit Plan (EBP) data

2.12.156.7 Change Order Status

Status	Date
Issue Identified	06/13/2007
Change Order Written	06/13/2007
Assigned SE	06/13/2007
Construction in Progress	06/14/2007
Ready for Model Office	06/22/2007
Model Office Implemented	06/25/2007
UAT Implemented	06/26/2007

2.12.157 I3417 - 8394

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
8394	Change Order		Reference Data Maintenance			1

2.12.157.1 Desired Solution
End date V2744 June 4, 07

2.12.157.2 Business Impact
None.

2.12.157.3 Technical Specifications
None.

2.12.157.4 Clarifications
This code was made active to accommodate an override.

Approval memo received from the Commonwealth on 6/29/07. JP

2.12.157.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.157.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.157.7 Change Order Status

Status	Date
Change Order Written	06/18/2007
Assigned BA	06/18/2007
Sign-Off Requested	06/25/2007
Completed	06/29/2007

2.12.158 I3454 - 8813

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
8813	Change Order		Reference Data Maintenance			1

2.12.158.1 Desired Solution
To correct the outpatient claim payment to Critical Access Hospitals

2.12.158.2 Business Impact
None.

2.12.158.3 Technical Specifications
None.

2.12.158.4 Clarifications
Currently the provider contract for Critical Access Outpatient Hospitals (NACOP) has rules that deny details with revenue codes 360, 450, 452, 456 and 481, if billed with a procedure code other than the ones specified on Legacy edits 199 and 673. When Legacy edit 673 was updated with the change noted in CO0318, the intent was to ensure that Critical Access Hospitals (CAH) bill a procedure code with a revenue code, when appropriate. Also, the majority of procedure codes listed on Legacy edit 673, as valid for revenue codes 450, 452, 456 and 481, are reimbursed a "flat rate", whereas CAHs are paid a percentage. Please inactivate current rules on provider contract NACOP for revenue codes 360, 450, 452, 456 and 481 and add a new rule with effective date 01/01/1990 to allow revenue codes 360, 450, 452, 456 and 481 to be billed with any valid CPT/HCPCS procedure code.

MO testing in progress.

Walkthrough of testing with Kalan Slattery and David Dennis this morning at 10AM. Testing approved. Rules updated in ebp and moved into production tonight.

Rules moved into production. Edit pages need to be updated; waiting DMS approval on edit Manual.

Edit pages need to be updated; waiting DMS approval on edit Manual. Sign-off Memo needs to be sent with updated edit page.

Edit pages need to be updated. Waiting DMS approval on edit Manual. Sign-off Memo needs to be sent with updated edit page.

No change in status. Edit pages need to be updated. Waiting DMS approval on edit Manual. Sign-off Memo needs to be sent with updated edit page.

Need to update a draft of edit page, per John Hoffmann's approval and send with sign off.

2.12.158.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.158.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.158.7 Change Order Status

Status	Date
Change Order Written	07/24/2007
Assigned BA	07/24/2007
Assigned SE	07/24/2007
MO Testing in Progress	07/26/2007
Testing Approved - DMS	07/30/2007
Prod Implemented	08/01/2007

2.12.159 I3456 - 8816

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
8816	Change Order		Reference Data Maintenance			2

2.12.159.1 Desired Solution
Add diagnosis codes V28.0 - V28.9 to copay exempt list for pregnant women

2.12.159.2 Business Impact
None.

2.12.159.3 Technical Specifications
None.

2.12.159.4 Clarifications
Need to add diagnosis codes V28.0 through V28.9 (per Donna Chapman's email) to the copay exempt list for pregnant women. If the codes are in any of the diagnosis fields, then a copay is not taken. Claims adjustment need to be done to correct any copays that may have been assessed.

Email from Donna Simpson dated 07/24/07 stated V28 should also be included in the exclusion list.

Requested due date extension to July 27. Due date extension approved in email from Kalan Slattery dated 07/26/07.

Testing approved by Kalan Slattery and Beth Jennings on 07/26/2007

Copay reimbursement rule moved to production on 07/27/2007. No other changes were necessary.

Cannot send sign-off - waiting on new Pricing Manual to be approved. Also waiting on Laura Battles to generate mass adjustments of the claims with these diagnosis codes where copay was deducted.

Phil Stokes is working on generating the requested mass adjustments. Still waiting on approval of the Pricing Manual before completing documentation and sign-off.

2.12.159.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.159.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.159.7 Change Order Status

Status	Date
Change Order Written	07/24/2007

Status	Date
Assigned BA	07/24/2007
Prod Implemented	07/27/2007
Production Verified	07/27/2007

2.12.160 I3478 - 8953

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
8953	Change Order		Reference Data Maintenance			1

2.12.160.1 Desired Solution
To raise the fee on CPT 01960 from $200.00 to $215.00, CPT 01961 from $320.00 to $335.00 and CPT 01967 from $335.00 to $350.00.

2.12.160.2 Business Impact
None.

2.12.160.3 Technical Specifications
None.

2.12.160.4 Clarifications
In addition to price the attached, Anesthesia CPT codes to reimburse based on the base payment of $15.20 times the ASA RVU + the actual time units (one unit equals up to 15 minutes of time).

Sent questions to Kalan Slattery. Also, indicated in the email that we could not complete this project in the timeframe requested and that we would forward a proposed alternate due date once the questions were answered and we assessed what changes are needed.

Received answers to our questions. The answer to the question regarding where we would find ASA RVU values indicated we get these from the Legacy PDD File. However, when we questioned this further, Barry Ingram suggested we download these from the ASA website for a small fee and suggested we are probably using these in other states. We are in the process of following up on this.

Received reply from inquiry and they indicated they are using the ASA RVU to price anesthesia claims. They indicated they download these each year from the CMS website and provided the link. EDS sent an inquiry to Barry Ingram asking him to review this site and determine if these are the values we need for the pricing changes requested in this CO.

2.12.160.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.160.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.160.7 Change Order Status

Status	Date
Change Order Written	08/14/2007
Assigned BA	08/14/2007

Status	Date
Awaiting Further Definition	08/20/2007

2.12.161 I3479 - 8954

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
8954	Change Order		Reference Data Maintenance			1

2.12.161.1 Desired Solution
Add attached list of CPT procedure codes as covered for PT 20 and discontinue

2.12.161.2 Business Impact
None.

2.12.161.3 Technical Specifications
None.

2.12.161.4 Clarifications
Add the attached CPT procedure codes as valid for PT 20 under the standard Medicaid benefit classification

Code 90649 restricted to ages 9-18 years only.

Code 90471 restricted to ages 19-26 years only.

See attachment for effective dates.

Sent testing to Commonwealth to view.

Commonwealth Approved testing.

Sign-off memo submitted to the Commonwealth 08/17/07.

Sign-off memo submitted to the Commonwealth 08/17/07.

Completion memo from the Commonwealth dated 08/21/070 was received by EDS 08/30/07.

2.12.161.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.161.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.161.7 Change Order Status

Status	Date
Change Order Written	08/14/2007
Assigned BA	08/14/2007
MO Testing Complete	08/15/2007
Testing Approved - DMS	08/17/2007

Status	Date
Sign-Off Requested	08/17/2007
Completed	08/21/2007

2.12.162 I3492 - 9082

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
9082	Change Order		Reference Data Maintenance			1

2.12.162.1 Desired Solution
To add additional codes to be reimbursed

2.12.162.2 Business Impact
None.

2.12.162.3 Technical Specifications
None.

2.12.162.4 Clarifications
Please add the following five codes and prices to the system and allow reimbursement by the following provider types: 64, 65, 78 and 01 (outpatient only). The start date for these codes to become effective is 01-01-2007 (Jan. 1, 2007).

- G0202: Global - $91.56, 26 - $25.26, TC - $66.30
- G0204: Global - $99l.65, 26 - #41.30, TC - $68.35
- G0206: Global - $80.30, 26 - $25.26, TC - $55.04
- 77051: Global - $11.74, 26 - $2.27, TC - $9.47
- 77052: Global - $11.47, 26 - $2.27, TC - $9.47

Received clarification Proc code 77052 pays $11.74 instead of $11.47.

Testing sent to the Commonwealth for review- Tanya

2.12.162.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.162.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.162.7 Change Order Status

Status	Date
Change Order Written	08/28/2007
Assigned BA	08/28/2007
MO Testing Complete	08/30/2007

2.12.163 I3497 - 9143

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
9143	Change Order		Reference Data Maintenance			1

2.12.163.1 Desired Solution
Add codes A6530 and A6531.

2.12.163.2 Business Impact
None.

2.12.163.3 Technical Specifications
None.

2.12.163.4 Clarifications
Add code A6530 for 90 provider type effective 7/27/07. Pricing is manual with an upper limit of $100.00. PA required.

Add code A6531 for 90 provider type effective 9/3/07. Pricing is #38.94. PA is required.

Members have been approved for these items and are waiting for addition to system to receive.

2.12.163.5 Associated Requirements

Requirement ID	Type
No associated Requirements found.	

2.12.163.6 Associated System Objects

Technical Name	Object Type	Title
No associated Change Orders found.		

2.12.163.7 Change Order Status

Status	Date
Change Order Written	09/04/2007
Assigned BA	09/04/2007

2.13 Data Element Dictionary

Because of the length of some column names and the use of underscore characters, some names in the tables below may wrap to the next line.

2.13.1 T_ACCIDENT_TYPE

List of valid reasons for types of accidents and a brief description.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_ACC_TYP	A code that indicates a type of accident that qualifies a member for services.	CHAR	3	0	Y
DSC_ACC_TYP	Description of the valid accident reason type codes.	VARCHAR2	25	0	N

2.13.2 T_ADMIT_SOURCE

Code table used to edit the source of admission found in block 20 of the claim form.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_ADMIT_SOURCE	Code identifying the source of admission in block 20 on the UB04 claim record for inpatient and LTC claims.	CHAR	1	0	Y
DSC_ADMIT_SOURCE	Description of the source of admission code found in block 20 on the UB04 claim record for inpatient and LTC claims.	VARCHAR2	50	0	N

2.13.3 T_ADMIT_TYPE

Contains the valid codes and corresponding descriptions which indicate the priority of the admission of a member for inpatient services.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_ADMIT_TYPE	Code which indicates the priority of the admission of a member for inpatient services.	CHAR	1	0	Y
DSC_ADMIT_TYPE	Description for the priority of the admission of a member for inpatient services.	CHAR	10	0	N

2.13.4 T_ASC_GROUP

Ambulatory Surgical Center (ASC) payment groups classify procedures into different payment groups that are based on surgical procedure complexity. ASC payment groups and rates for the payment groups are established by CMS. An Ambulatory Surgical Center (ASC) is a distinct entity that operates exclusively for the purpose to providing surgical services to patients not requiring hospitalization and has an agreement with the Centers for Medicare & Medicaid Services (CMS) to participate in Medicare as an ASC. ASCs must be state licensed and Medicare certified. An ASC may be either independent (that is, not a part of any other facility) or hospital affiliated.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_ASC	Ambulatory Surgical Center (ASC) payment group codes classify procedures into different payment groups that are based on surgical procedure complexity. Rates by ASC payment group are established by CMS.	CHAR	1	0	Y
DSC_50	Text describing the Ambulatory Surgical Center pricing group.	VARCHAR2	50	0	N

2.13.5 T_ASC_PRICING

Reimbursement rates paid to providers for a Ambulatory Surgical Center (ASC) procedure. An Ambulatory Surgical Center (ASC) is a distinct entity that operates exclusively for the purpose to providing surgical services to patients not requiring hospitalization and has an agreement with the Centers for Medicare & Medicaid Services (CMS) to participate in Medicare as an ASC. ASCs must be state licensed and Medicare certified. An ASC may be either independent (that is, not a part of any other facility) or hospital affiliated. Ambulatory Surgical Center (ASC) facility services are reimbursed based on prospectively determined rates. The rates are based upon the classifications of procedures into different payment groups that are based on surgical procedure complexity. Rates by payment group are established by CMS.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_ASC	Ambulatory Surgical Center (ASC) payment group codes classify procedures into different payment groups that are based on surgical procedure complexity. Rates by ASC payment group are established by CMS.	CHAR	1	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_SEQUENCE	Sequence number used to uniquely identify a row for an ASC pricing group/ rate type combination.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date an Ambulatory Surgical Center rate becomes effective for claims processing.	NUMBER	8	0	N
DTE_END	The date an Ambulatory Surgical Center rate is no longer in effect for claims processing.	NUMBER	8	0	N
AMT_PRICE_ASC	Rate to be paid for an Ambulatory Surgical Center procedure. The rate is based on the ASC pricing group.	NUMBER	11	2	N

2.13.6 T_ASNG_HIERARCHY

An assignment hierarchy is an ordered set of assignment plans for which a member may be assigned concurrently. For example, a beneficiary may be assigned to a PCP and to a Health Community Based Services agency at overlapping periods of time. A hierarchy tread is used to determine which assignment to select at the time of processing

Column Name	Description	Type	Length	Precision	Primary Key
SAK_THREAD_ASSIGNMENT	System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment Plans for beneficiaries who are enrolled in multiple entities of any of these types..	NUMBER	9	0	Y
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	N
DTE_EFFECTIVE	Date the hierarchy thread becomes valid for use in claims processing.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_END	The last date the thread is valid for use in claims processing. The thread may still be used when the date of service on the claim is within the effective dates of the thread. To stop the use of a particular thread altogether the DTE_INACTIVE date must be used.	NUMBER	8	0	N
NUM_PGM_1_32	Bit flags for T_PUB_HLTH_PGM.NUM_HIER_ID_ASGN 1 to 32. Used as part of the primary key and editing to determine assignment plans order of processing within a Financial Payer. If NUM_HIER_ID_ASGN column of T_PUB_HLTH_PGM IS BETWEEN 1 AND 32 for a benefit plan on the thread, then corresponding bit in this column will be set to 1 otherwise the bit will be set to 0.	NUMBER	10	0	N
NUM_PGM_33_64	Bit flags for T_PUB_HLTH_PGM.NUM_HIER_ID_ASGN 33 to 64. Used as part of the primary key and editing to determine assignment plans order of processing within a Financial Payer. If NUM_HIER_ID_ASGN column of T_PUB_HLTH_PGM IS BETWEEN 33 AND 64 for a benefit plan on the thread, then corresponding bit in this column will be set to 1 otherwise the bit will be set to 0.	NUMBER	10	0	N

Column Name	Description	Type	Length	Precision	Primary Key
NUM_PGM_65_96	Bit flags for T_PUB_HLTH_PGM.NUM_HIER_ID_ASGN 65 to 96. Used as part of the primary key and editing to determine assignment plans order of processing within a Financial Payer. If NUM_HIER_ID_ASGN column of T_PUB_HLTH_PGM IS BETWEEN 65 AND 96 for a benefit plan on the thread, then corresponding bit in this column will be set to 1 otherwise the bit will be set to 0.	NUMBER	10	0	N
DTE_INACTIVE	This is the date when the usage of this thread was stopped. From this date onwards the thread will not be used regardless of the date of service billed on a claim.	NUMBER	8	0	N

2.13.7 T_ASNG_NODE

A given thread may have as many participants as required by business policy. This table is used to identify the participating entities as well as the processing sequence within the thread. The entity types in a thread are assignment plans.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_THREAD_ASSIGNMENT	System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment Plans for beneficiaries who are enrolled in multiple entities of any of these types..	NUMBER	9	0	Y
SAK_ASGN_PLAN	System assigned internal key for a medical assistance program.	NUMBER	9	0	N

Column Name	Description	Type	Length	Precision	Primary Key
NUM_SEQUENCE_THREAD	This column determines the processing order for the entities participating in the thread. For example, if the thread is of type 'PAYR', then this sequence number determines which Financial Payer will be processed first, second, and so on.	NUMBER	4	0	N

2.13.8 T_AUDIT_AGEREST

Range of ages that will be included or excluded from audit criteria.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
QTY_AGE_MAX	Last age in a range that should be included or excluded from audit criteria.	NUMBER	4	0	Y
QTY_AGE_MIN	First age in a range that should be included or excluded from audit criteria.	NUMBER	4	0	Y

2.13.9 T_AUDIT_CLAIM_FORM

Audit table to retrieve claim form by claim type

Column Name	Description	Type	Length	Precision	Primary Key
CDE_CLM_TYPE	Value for the type of claim that can be processed in the MMIS system.	CHAR	1	0	Y
CDE_CLM_FORM	Claim form	CHAR	4	0	N

2.13.10 T_AUDIT_CL_FORM_X

Audit table to list valid claim type to claim type relationships

Column Name	Description	Type	Length	Precision	Primary Key
CDE_CLM_TYPE_2	Value for the type of claim that can be processed in the MMIS system.	CHAR	1	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_CLM_TYPE	Value for the type of claim that can be processed in the MMIS system.	CHAR	1	0	Y

2.13.11 T_AUDIT_CL_TYPE_X

Audit/Claim Type cross reference.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
CDE_CLM_TYPE_CURR	Value for the type of claim that can be processed in the MMIS system.	CHAR	1	0	Y
CDE_CLM_TYPE_HIST	Value for the type of claim that can be processed in the MMIS system.	CHAR	1	0	Y
CDE_CLM_FORM_CURR	Claim form for current claim	CHAR	4	0	N
CDE_CLM_FORM_HIST	Claim form for history claim.	CHAR	4	0	N
IND_CONFLICT	Value of "Y" causes execution of conflict date overlap logic	CHAR	1	0	N

2.13.12 T_AUDIT_CRIT

The Audit Criteria table contains general information concerning a specific audit. This information includes whether diagnosis codes, provider specialties, member levels of care, member ages, and member programs are part of the audit criteria. For each of the above criteria that is used, this table indicates whether the attached list is included in or excluded from the audit. This table also includes information about whether the provider number, tooth number, tooth surface, and procedure code of the current detail must be the same as, different from, or either same as or different from the detail in history to meet the audit criteria.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
CDE_ERROR_TYPE	Identifies the audit as limitation, bundling, unbundling, contraindicated, or umbrella.	CHAR	2	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	Date on which audit criteria should begin processing in the MMIS system.	NUMBER	8	0	N
DTE_END	Date audit criteria ceases to process in the system.	NUMBER	8	0	N
CDE_SPEC_IN_EX	Indication of whether provider specialty is included, excluded, or not in the audit criteria.	CHAR	1	0	N
CDE_DIAG_IN_EX	Indication of whether diagnosis code(s) is included, excluded, or not in the audit criteria.	CHAR	1	0	N
CDE_S_D_TO_NUM	Indication of whether the same or different tooth identification number is to be used in the audit criteria.	CHAR	1	0	N
CDE_S_D_TO_SURF	Indication of whether the same or different tooth surface number is to be used in the audit criteria.	CHAR	1	0	N
CDE_SAM_DIF_PR	Indication of whether the same or different provider number is to be used in the audit criteria.	CHAR	1	0	N
CDE_SAM_DIF_PRC	Indication of whether the same or different procedure code is to be used in the audit criteria.	CHAR	1	0	N
CDE_AGE_IN_EX	Indication of whether a member's age is included, excluded, or not in the audit criteria.	CHAR	1	0	N
CDE_PROG_IN_EX	Indicates if a program from a member is included, excluded, or not applicable for a specified audit.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PAYER_IN_EX	Indicates if a FINANCIAL PAYER from a member is included, excluded, or not applicable for a specified audit.	CHAR	1	0	N
CDE_SEX_RSTRCTN	Indicates which sex (male, female, both) should be included in the audit criteria.	CHAR	1	0	N
IND_SVC_LMT_AUD	This field indicates whether the audit is reported by EVS when the service limit enforced by the audit has been reached.	CHAR	1	0	N
CDE_SAM_DIF_CLM	Indication of whether the specified audit should audit against details of the current claim only, details on claims in history only, or either current or history details.	CHAR	1	0	N
IND_PA	Indicates whether prior authorization is required.	CHAR	1	0	N
CDE_TH_CL_IN_EX	Include/Exclude indicator for therapeutic class	CHAR	1	0	N
CDE_GPI_IN_EX	Include/Exclude indicator for generic pricing indicator	CHAR	1	0	N
CDE_GEN_CDE_IN_EX	Include/Exclude indicator for generic code	CHAR	1	0	N
CDE_GEN_CD_SQ_IN_EX	Include/Exclude indicator for generic code sequence	CHAR	1	0	N
CDE_HICL_IN_EX	Include/Exclude indicator for HICL	CHAR	1	0	N
CDE_NDC_IN_EX	Include/Exclude indicator for NDC	CHAR	1	0	N
CDE_CLM_TYP_IN_EX	Include/Exclude indicator for claim type	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_POS_IN_EX	Include/Exclude indicator for place of service	CHAR	1	0	N
CDE_PROC_MOD_IN_EX	Include/Exclude indicator for procedure modifier	CHAR	1	0	N
CDE_TOB_IN_EX	Include/Exclude indicator for type of bill	CHAR	1	0	N
CDE_REV_IN_EX	Include/Exclude indicator for revenue code	CHAR	1	0	N
IND_RX_FOR_J_CODE	Y/N flag to check ndc/generic code match to J codes	CHAR	1	0	N
CDE_PR_TYPE_IN_EX	Include/Exclude indicator for provider type	CHAR	1	0	N
CDE_SAM_DIF_DOS	Indication of whether the same or different DOS (date of service) is to be used in the audit criteria.	CHAR	1	0	N
CDE_SAM_DIF_PAYER	This code defines the Payer "scope" of the audit. A value of "S" indicates only services with the same payer as the current service are considered in the audit. A value of "D" indicates only services from different payers from the current service are considered in the audit. A value of "A" means all services are considered in the audit regardless of payer.	CHAR	1	0	N
CDE_S_D_DIAG	Indication of whether the same or different primary diagnosis is to be used in the audit criteria.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
IND_DIAG_TYPE	Indicates whether the diagnosis code(s) to be checked is (A)dmit, (D)ischarge, (E)mergency, (P)rimary, (S)econdary, (space)any	CHAR	1	0	N
CDE_QUAD	Indication of whether matching should be done on quadrant between the current and history claim. Values are (C)omplete, (I)nclusive, (P)artial and (E)xclusive	CHAR	1	0	N
CDE_REFERRAL	Specifies criterion for bypassing an audit based on the presence of a referring provider on the claim being audited. Values are 'A' (any), 'P' (PCCM) and space (not considered).	CHAR	1	0	N

2.13.13 T_AUDIT_GEN_SEQ_X

List or range of drug generic sequence numbers (GCN Seq No) that should be included or excluded in audit criteria for limitation and umbrella audits.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
NUM_GCN_FROM	The beginning GCN Sequence Number of the GCN Sequence Number range for an audit. The Generic Code Number Sequence Number (GCN_SEQNO) is a unique number representing a generic formulation.	NUMBER	9	0	N
NUM_GCN_TO	The ending GCN Sequence Number of the GCN Sequence Number range for an audit. The Generic Code Number Sequence Number (GCN_SEQNO) is a unique number representing a generic formulation.	NUMBER	9	0	N

2.13.14 T_AUDIT_GPI_XREF

List or range of Generic Product Indicators that should be included or excluded in audit criteria for limitation and umbrella audits.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
IND_DRUG_GENERIC	The Generic Price Indicator (GPI) distinguishes a product as either priced as a generic or priced as a brand.	CHAR	2	0	Y

2.13.15 T_AUDIT_HICL_XREF

Audit cross reference for HICL

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
NUM_HICL_FROM	The start value for a range of HICL sequence numbers. The HICL Sequence Number is a six-byte numeric field which provides a link from either an NDC or a GCN Sequence Number record to the Hierarchical Ingredient Code List.	NUMBER	9	0	N
NUM_HICL_TO	The end value for a range of HICL sequence numbers. The HICL Sequence Number is a six-byte numeric field which provides a link from either an NDC or a GCN Sequence Number record to the Hierarchical Ingredient Code List.	NUMBER	9	0	N

2.13.16 T_AUDIT_NDC

List or range of NDCs (drugs) that should be included or excluded in audit criteria for limitation and umbrella audits.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
SAK_DRUG	Drug key	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
IND_IN_EX	Determines inclusive query of drugs for this audit or Exclusive. (I,E)	CHAR	1	0	N

2.13.17 T_AUDIT_NDC_XREF

Audit cross reference for NDC

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
CDE_NDC_FROM	The first NDC in a range of codes	CHAR	11	0	N
CDE_NDC_TO	The last NDC in a range of codes.	CHAR	11	0	N

2.13.18 T_AUDIT_PAYER_XREF

Listing of FINANCIAL PAYERS that should be included or excluded from audit criteria.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	Y

2.13.19 T_AUDIT_PROC

A table created from the audit proc xref table. It extracts the proc ranges into single procedure rows and associates the audit number.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
SAK_PROC	Procedure code	NUMBER	9	0	Y
CDE_MOD	Procedure modifier	CHAR	2	0	Y
NUM_UNIT_FRCT	Conversion factor to be applied when codes being audited are measured in different increments to allow units to be counted toward limitations on an equal basis.	NUMBER	5	2	N

2.13.20 T_AUDIT_PR_TYPE_X

List or range of provider specialties that should be included or excluded in audit criteria for limitation and umbrella audits.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
CDE_PROV_TYPE	Provider type	CHAR	2	0	Y

2.13.21 T_AUDIT_PURGE

List of all audit tables, each owner, and retention period.

Column Name	Description	Type	Length	Precision	Primary Key
OWNER	This is the owner of the audit table. Valid values are AIM and AIM00.	CHAR	8	0	N
TABLE_NAME	Name of the audit table.	CHAR	30	0	N
RET_PERIOD	Retention period for rows on the audit tables. See entity description for details.	NUMBER	9	0	N

2.13.22 T_AUDIT_REV

List of revenue codes that should be included or excluded in audit criteria for limitation and umbrella audits.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
SAK_REV	System assigned key to uniquely identify a revenue code.	NUMBER	9	0	Y

2.13.23 T_AUDIT_REV_XREF

List or range of revenue codes that should be included or excluded in audit criteria for limitation audits.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_REVC_FROM	This identifies the first accommodation or ancillary service in the range that is included in the audit.	NUMBER	4	0	N
CDE_REVC_TO	This identifies the last accommodation or ancillary service in the range that is included in the audit.	NUMBER	4	0	N

2.13.24 T_AUDIT_ST

List of Step Therapy Groups associated to an Audit.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_GROUP	Unique Identifier of step groups	NUMBER	9	0	Y
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y

2.13.25 T_AUDIT_ST_GROUP

The group of drugs, both preferred and non-preferred, having a particular therapeutic effect is called a "step therapy group" (STG).

Column Name	Description	Type	Length	Precision	Primary Key
SAK_GROUP	Unique Identifier of step groups	NUMBER	9	0	Y
DSC_GROUP_NAME	Description of the step therapy group.	CHAR	30	0	N
DTE_EFFECTIVE	The begin date the step therapy group will be used for auditing.	NUMBER	8	0	N
DTE_END	The date the step therapy group will no longer be used for auditing.	NUMBER	8	0	N

2.13.26 T_AUDIT_ST_LEVEL

The drugs in a Step Therapy Group (STG) are classified into at least two preference levels, which are called "step therapy levels" (STLs).

Column Name	Description	Type	Length	Precision	Primary Key
SAK_GROUP	Unique Identifier of a step therapy group. A step therapy group is a group of drugs, both referred and non preferred, having a particular therapeutic effect.	NUMBER	9	0	Y
CDE_LEVEL	Step therapy level assigned by the user. The drugs in a STG are classified into levels. The most preferred level in an STG is called "step therapy level A (Stl-A), the next most preferred level is "step level B (STL-B). STLs other than STL-A are called "non-preferred" STLs	CHAR	1	0	Y
DSC_LEVEL	Description of the level	CHAR	30	0	N
NUM_STEP_DAYS	Minimum number of days a patient must have been under continuous therapy to meet the requirements for the drugs in a particular step therapy level.	NUMBER	4	0	N
NUM_DRUG_COUNT	Minimum number of distinct drugs needed to meet the requirements for the drugs in a particular step therapy level. Drugs are counted as distinct drugs if they have different HICL sequence numbers.	NUMBER	4	0	N
NUM_GAP_DAYS	Maximum number of days break allowed.	NUMBER	4	0	N

2.13.27 T_AUDIT_ST_MEM

The individual drugs in a Step Therapy Level (STL) are called "step therapy members" (STM).

Column Name	Description	Type	Length	Precision	Primary Key
SAK_GROUP	Unique Identifier of a step therapy group. A step therapy group is a group of drugs, both referred and non preferred, having a particular therapeutic effect.	NUMBER	9	0	Y
CDE_LEVEL	Step therapy level assigned by the user. The drugs in a STG are classified into levels. The most preferred level in an STG is called "step therapy level A (Stl-A), the next most preferred level is "step level B (STL-B). STLs other than STL-A are called "non-preferred" STLs	CHAR	1	0	Y
SAK_DRUG_GEN	The system assigned key for a unique generic drug.	NUMBER	9	0	Y
DTE_EFFECTIVE	Begin date of an individual drug in a STL.	NUMBER	8	0	Y
DTE_END	End date of an individual drug in a STL.	NUMBER	8	0	N
NUM_INGRED_LIST	ID representing a drug's active ingredient list. For FDB implementations, this holds the HICL Sequence Number. For Micromedex, this holds the Generic Cross-Reference (GCR) code.	NUMBER	6	0	N

2.13.28 T_AUDIT_THER_CL_X

List or range of drug therapeutic classes that should be included or excluded in audit criteria for limitation and umbrella audits.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
CDE_THERA_CLS_ST_FROM		CHAR	2	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_THERA_CLS_ST_TO		CHAR	2	0	N

2.13.29 T_AUDIT_TIME_UNIT_XREF

This table is used to cross reference error types with their valid time units.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_ERROR_TYPE	Identifies the audit as limitation, bundling, unbundling, contraindicated, or umbrella.	CHAR	2	0	Y
CDE_TIME_UNIT	Indicates the unit of time measurement to be used in auditing.	CHAR	1	0	Y

2.13.30 T_AUDIT_TOB_XREF

List or range of Type of Bills (TOB) that should be included or excluded in audit criteria for limitation and umbrella audits.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
CDE_TYPE_OF_BILL	Code which indicates a specific type of facility.	CHAR	3	0	N

2.13.31 T_AUDT_DIAG_XRF

The Audit Diagnosis Cross-reference table is used to represent the relationship between the Audit Criteria table and the Diagnosis Table. The Audit Criteria table contains a code which indicates whether diagnosis codes are part of the audit criteria, and if they are, whether the diagnosis codes associated to the audit are included in or excluded from the audit. This table contains the system assigned keys of the audit, the system assigned keys of the first and last diagnosis codes, and the first and last diagnosis codes in the range that is associated to the audit.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
SAK_DIAG_FROM	System assigned key that uniquely identifies a specific diagnosis or the first in range of diagnoses that should be included or excluded from audit criteria.	NUMBER	9	0	N

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DIAG_TO	System assigned key that identifies that last diagnosis in a range.	NUMBER	9	0	N
CDE_DIAG_FROM	Code used to indicate the first diagnosis in a range used for audit criteria.	CHAR	5	0	N
CDE_DIAG_TO	Code used to indicate the last diagnosis in a range used for audit criteria.	CHAR	5	0	N

2.13.32 T_AUDT_PGM_XREF

Listing of programs that should be included or excluded from audit criteria.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
SAK_PUB_HLTH	System assigned internal key for a medical assistance program.	NUMBER	9	0	Y

2.13.33 T_AUDT_PROC_XRF

List or range of procedure codes that should be included or excluded in audit criteria for limitation and umbrella audits.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
SAK_PROC_FROM	System assigned key that identifies the first procedure code in a range of codes.	NUMBER	9	0	N
SAK_PROC_TO	System assigned key that identifies the last procedure code in a range of codes.	NUMBER	9	0	N
CDE_PROC_MOD	Further specifies what type of procedure codes should be included in an audit. This code applies to both the beginning and ending procedures in the range.	CHAR	2	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROC_TO	Code for the last procedure in a range of procedures used to define audit criteria.	CHAR	5	0	N
CDE_PROC_FROM	Code for the first procedure in a range of procedures used to define audit criteria.	CHAR	5	0	N
NUM_UNIT_FRCT	Conversion factor to be applied when codes being audited are measured in different increments to allow units to be counted toward limitations on an equal basis.	NUMBER	5	2	N

2.13.34 T_AUDT_SPC_XREF

List of specific provider specialties that will be included or excluded from audit criteria.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
CDE_PROV_SPEC	Provider specialty code that should be included or excluded for audit criteria.	CHAR	3	0	N

2.13.35 T_BASE_ENDO_PROC

The national multiple surgery payment policy established by HCFA requires special reductions for multiple endoscopic services performed through the same orifice. The purpose is to only pay once for the insertion of the endoscopic instrument which is included in the profile for all endoscopic procedures. Endoscopic surgeries are grouped into families and within each family, the highest valued service is determined. The highest valued service retains the cost of insertion of the endoscopic instrument and all other details in the family are reduced by the value of the base diagnostic endoscopic procedure for the family.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_BASE_PROC	System assigned key used to uniquely identify the base diagnostic endoscopic procedure for a family of endoscopy procedures.	NUMBER	9	0	N
CDE_FAMILY	Endoscopic services performed through the same orifice are grouped into families of endoscopic surgeries.	CHAR	2	0	N

2.13.36 T_BATCH_ERR_SUM

Table contains summary information (error counts) of batch encounter errors.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_BATCH	System assigned key for the batch. This sak is the same as the SAK_UPLOAD in T_UPLOAD	NUMBER	9	0	Y
SAK_ESC	System assigned key that uniquely identifies an error number	NUMBER	9	0	Y
SAK_SUM_ERR	System assigned key for the batch/error/claim relationship	NUMBER	9	0	N
CNT_ERROR	Number of claims setting an error.	NUMBER	9	0	N
CDE_DISP_STATUS	Code indicating disposition status.	CHAR	1	0	N

2.13.37 T_BENEFIT_PLAN_GROUP

Groups benefit plans by benefit plan type. This will be used by various parts of the system for different processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_BENEFIT_PLAN_TYPE	System assigned key for a unique Benefit Plan group that represents a single or collection of Benefit Plan codes.	NUMBER	9	0	Y
SAK_PUB_HLTH	System assigned internal key for a member plan.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date of service on which the Benefit Plan becomes valid for the Benefit Plan group.	NUMBER	8	0	Y
DTE_END	The date of service on which the Benefit Plan code is no longer valid for the Benefit Plan group.	NUMBER	8	0	N

2.13.38 T_BENEFIT_PLAN_TYPE

A benefit plan type is associated with a group of benefit plan codes. Used to identify benefit plans for use in certain processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_BENEFIT_PLAN_TYPE	System assigned key for a unique Benefit Plan group that represents a single or collection of Benefit Plan codes.	NUMBER	9	0	Y
DSC_50	Describes the benefit plan type.	CHAR	50	0	N
DSC_DEFINITION	Definition of where and/ or how this benefit plan group is used.	VARCHAR2	4000	0	N

2.13.39 T_BENEFIT_TYPE

The service type is used is used to identify the coding scheme for a service. Valid schemes include procedure (HCPCS & CPT-4), ICD-9-CM procedures, ICD-9-CM diagnosis, Revenue Code and Drug codes (NDCs).

Column Name	Description	Type	Length	Precision	Primary Key
CDE_BENEFIT_TYPE	The benefit type code is used to identify the coding scheme for a service. Valid schemes include procedure (HCPCS & CPT-4), ICD-9-CM procedures, ICD-9-CM diagnosis, Revenue Code and Drug codes (NDCs).	CHAR	3	0	Y
DSC_BENEFIT_TYPE	Describes the type of benefit.	VARCHAR2	18	0	N

2.13.40 T_BIRTH_WEIGHT

Birth weight for members who are neonatal patients. Neonatal patients represent distinct demands on hospital resources, therefore the birth weight classifications are used in determining DRG. Birth weights are assigned to diagnosis codes 764XX - 765XX.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DIAG	System assigned key for the diagnosis.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
NUM_WEIGHT_MIN	The minimum birth weight specified for a diagnosis code. Unit of measurement is in grams. Used when DRG grouping is performed for members under 1 year of age.	NUMBER	4	0	N
NUM_WEIGHT_MAX	The maximum birth weight specified for a diagnosis code. Unit of measurement is in grams. Used when DRG grouping is performed for members under 1 year of age.	NUMBER	4	0	N

2.13.41 T_BNFT_ADJ_FACTOR

This table is used to store most of the information required for benefit adjustments to current pricing methodology in some states. Information on this table may or may not be used for claim auditing. This table will or will not be populated with miscellaneous information based on states needs.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_BENEFIT_ADJ_FACTOR	System assigned key to uniquely identify a valid benefit adjustment type.	NUMBER	9	0	Y
SAK_BENEFIT_ADJ_FACTOR_TYPE	System assigned key to uniquely identify a valid benefit adjustment type.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date of service on which the benefit adjustment factor stops being valid.	NUMBER	8	0	N
DTE_END	The date of service on which the benefit adjustment factor stops being valid.	NUMBER	8	0	N
DTE_INACTIVE	This is the date when this segment becomes inactive and will not be used in for claims received on and after it.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
PCT_RATE_ADJ	The percentage that will be used to adjust an allowed amount already calculated using the pricing methodologies that applies to the claim/detail.	NUMBER	5	3	N
AMT_RATE_ADJ	The amount that will be used to adjust an allowed amount already calculated using the pricing methodology that applies to the claim/detail.	NUMBER	9	2	N
CDE_ALWD_CALCULATION	This indicator is necessary to identify if the benefit adjustment factor will be applied before or after the allowed amount was finalized. Some Benefit adjustment factors can be applied before a comparison between the billed amount and the allowed amount is done. Values "B" Before the calculated allowed amount is compared to the billed amount. Value "A" after the calculated amount is finalized	CHAR	1	0	N

2.13.42 T_BNFT_ADJ_FACTOR_TYPE

This table is used to store information about the type and the description of the class of products or services to which the adjustment factor applies. Information on this table may or may not be used for claim auditing. This table will or will not be populated with miscellaneous information based on states needs.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_BENEFIT_ADJ_FACTOR_TYPE	System assigned key to uniquely identify a valid benefit adjustment type.	NUMBER	9	0	Y
CDE_BNFT_ADJ_TYPE	The code identifying the class of services/products to which the adjustment factor applies.	CHAR	11	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DSC_BNFT_ADJ_TYPE	The description of the Benefit Adjustment Factor	VARCHAR2	250	0	N

2.13.43 T_BNFT_ADJ_FACTOR_XREF

Multiple Benefit Adjustment Factors may be required for the same pricing methodology. This data model change request is required to build a cross-reference table that allows the user to select the benefit adjustment factors that need to be applied during the pricing process. The user will also be required to select the sequence of the benefit adjustment factor application to the pricing methodology.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_REIMB_AGRMNT	Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.	NUMBER	9	0	Y
SAK_BENEFIT_ADJ_FACTOR	System assigned key to uniquely identify a valid benefit adjustment type. Migrated from relationship to table T_BNFT_ADJ_FACTOR	NUMBER	9	0	Y
NUM_SEQUENCE	Identifies the sequence the benefit adjustment factors should be applied.	NUMBER	9	0	N

2.13.44 T_BNFT_GROUP_STD

This table represents hierarchies of groups of benefits for the purpose of defining conditions at levels higher than the individual benefits. This structure will allow end users to set up benefit and assignment plans easier and faster than defining conditions at the individual benefit level. Each type of benefit such as procedure code, NDC, and the rest can be grouped into sets of benefits. These groups may then be grouped into a larger set of benefits. An example of this grouping technique is the procedure codes CPT4 manual. This manual defines a hierarchy of groups of procedures. The end user may then define conditions at any point of the hierarchy. The conditions are then inherited by the lower levels.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_BNFT_GROUP	System assigned key for a unique benefit group.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_BENEFIT_TYPE	The benefit type code is used to identify the coding scheme for a service. Valid schemes include procedure (HCPCS & CPT-4), ICD-9-CM procedures, ICD-9-CM diagnosis, Revenue Code and Drug codes (NDCs). Other allowed values may identify GROUPS of benefits such as Procedure groups and so on.	CHAR	3	0	Y
SAK_CLASS_HIERARCHY	Unique row identifier for this table.	NUMBER	9	0	Y
SAK_PARENT_GROUP	System assigned key for a unique parent group.	NUMBER	9	0	N
DSC_GROUP	This is the description of the group originating from the standard code sets. For example, the source for procedure code group descriptions will be the CPT4 and HCPCS standard manuals.	VARCHAR2	4000	0	N
NAM_GROUP	This is the description of the group that the codes are in within the CPT or HCPC group.	VARCHAR2	100	0	N

2.13.45 T_BNFT_PLAN_COB

This table is used to identify pairs of benefit plans that coordinate benefits. Each pairing is associated with a particular thread. This allows for a pair of benefit plans to coordinate benefits in one thread but not in another one. Order is significant. BP1 and BP2 may coordinate for one thread but BP2, BP1 may never coordinate. If order is not significant then both pairs must appear on the table.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_BNFT_COB_GRP	This is a unique identifier for a row on this table.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PUB_HLTH	System assigned internal key for a member plan.	NUMBER	9	0	N
SAK_PUB_HLTH_CHILD	System assigned internal key for a member plan.	NUMBER	9	0	N
DTE_EFFECTIVE	The date the Benefit Plan COB took effect	NUMBER	8	0	N
DTE_END	The date the Benefit Plan COB is no longer in effect	NUMBER	8	0	N
SAK_THREAD	System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment Plans for beneficiaries who are enrolled in multiple entities of any of these types..	NUMBER	9	0	N
DTE_INACTIVE	This is the date this row becomes inactive. For new claims the ICN is compared to this date. If the ICN date is greater than or equal to this date, the row will not be used to process the claim.	NUMBER	8	0	N

2.13.46 T_BNFT_PLAN_REIMB

This will restrict the reimbursement method to specific benefit plan.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_REIMB_AGRMNT	Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.	NUMBER	9	0	Y
SAK_PUB_HLTH	System assigned internal key for a member plan.	NUMBER	9	0	Y

2.13.47 T_CAPITAL_COST

Capital cost is the adjustment component of the DRG rate calculation to account for a providers expense for new construction or equipment.

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The date the Capital Cost component took effect.	NUMBER	8	0	N
DTE_END	The date the Capital Cost component is no longer in effect.	NUMBER	8	0	N
AMT	This is the adjustment component of the DRG rate for new construction or equipment. Used for the statewide calculation.	NUMBER	9	2	N

2.13.48 T_CC_INDICATORS

This table contains indicators that are used in various claim check reports.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	The system assigned key for the error code.	NUMBER	9	0	Y
IND_CC_SAVINGS	Indicates if an edit should appear on the claim check savings report.	CHAR	1	0	N
IND_CC_PHTAR	Indicates if an edit should appears on the potential history to adjust report.	CHAR	1	0	N
NUM_CC_RANK	Rank for claim check savings report.	NUMBER	3	0	N
NUM_CC_PCT	Percentage for claim check savings report.	NUMBER	3	0	N

2.13.49 T_CDE_ATTACHMENT

Code table used to identify and describe claims attachments.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_ATTACHMENT	Code used to identify the type of claims attachment.	CHAR	1	0	Y
DSC_ATTACHMENT	Text description of claims attachment.	VARCHAR2	50	0	N

2.13.50 T_CDE_CMS_TOS

Column Name	Description	Type	Length	Precision	Primary Key
CDE_CMS_TOS	The carrier assigned CMS type of service which describes the particular kind(s) of service represented by the procedure code	CHAR	1	0	Y
DSC_CMS_TOS	Description which describes the TOS code value.	VARCHAR2	100	0	N

2.13.51 T_CDE_COPAY_DEDUCT_ACCUM

List of valid copay deduction or accumulation codes.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_COPAY_DEDUCT_ACCUM	Determines if the row has actual copay deducted from the claim or if the copay was just additive and not deducted from the claim	CHAR	2	0	Y
DSC_COPAY_DEDUCT_ACCUM	Description of the copay deduct / accumulate code	CHAR	200	0	N

2.13.52 T_CDE_COPAY_METHOD

List of valid copay methods to be used in processing a claim.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_COPAY_METHOD	Code used to identify the copay method	CHAR	5	0	Y
DSC_COPAY_METHOD	The description of the copay method	CHAR	200	0	N

2.13.53 T_CDE_COPAY_TIME_PERIOD

List of valid copay time periods.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_COPAY_TIME_PERIOD	Copay time frames	CHAR	2	0	Y
DSC_COPAY_TIME_PERIOD	Copay time frame descriptions	CHAR	200	0	N

2.13.54 T_CDE_CSHCS_STATUS

Maintains the list of valid status codes for CSHCS member eligibility segments

Column Name	Description	Type	Length	Precision	Primary Key
CDE_CSHC_STATUS	Identifies a valid status code for CSHCS member eligibility	CHAR	1	0	N
DSC_CDE	Describes the status code for CSHCS member eligibility	CHAR	15	0	N

2.13.55 T_CDE_DIAG_COMPAT

The Diagnosis Compatibility Group represents a group of related diagnosis codes. It is compared to the Procedure/Diagnosis Compatibility Group(s) on the Procedure Record to ensure that the two codes are compatible.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DIAG_COMPAT	System assigned key for the diagnosis compatibility code.	NUMBER	9	0	Y
CDE_DIAG_COMPAT	Code for Diagnosis Compatibility code.	CHAR	3	0	N
DSC_DIAG_COMPAT	Description of the diagnosis compatibility group.	VARCHAR2	100	0	N

2.13.56 T_CDE_DISP_STATUS

This table contains all the valid disposition status codes and their descriptions.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DISP_STATUS	Code that represents the action (pay, deny, suspend, super suspend, Pay and List) that should be taken on a claim at dispositioning time.	CHAR	1	0	Y
DSC_DISP_STATUS	Description that represents the action (pay, deny, suspend, super suspend, Pay and List) that should be taken on a claim at dispositioning time.	VARCHAR2	25	0	N

2.13.57 T_CDE_DOSAGE_FORM

The Dosage Form describes the dosage form by which a drug is formulated.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DOSAGE_FORM	An abbreviated two-byte code (GCDF on NDDF update) is available for applications. Users may request the code in addition to or instead of the description.	CHAR	2	0	Y
DSC_DOSAGE_FORM	The Dosage Form Description (D) field describes the dosage form by which a drug is formulated. Descriptive terms include tablet, capsule, and cream. Abbreviations may be used to conform to space requirements.	VARCHAR2	10	0	N
DSC_DOSAGE_LONG	Dosage Form Code Interpretation (GCDF_DESC on NDDF)	VARCHAR2	40	0	N
NUM_SKEY_DOSE	Smart Key Dosage Form Code	NUMBER	3	0	N

2.13.58 T_CDE_DRUG_ACT

The drug activation describes the status and program coverage for a specific drug.

Column Name	Description	Type	Length	Precision	Primary Key
IND_ACTIVATE	The activation indicator is used to indicate what status and program coverage the drug will have. It is also used in claims editing. This attribute is determined by FDB and is part of the FDB Drug update process.	CHAR	1	0	Y
DSC_INDICATOR	Text description of activation indicator.	VARCHAR2	40	0	N

2.13.59 T_CDE_DRUG_ROUTE

The Route indicates the normal site or method by which a drug is administered. This table is loaded from the NDDF update file ROUTETBL-RROUTED2.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_ROUTE_ADMIN	The Route indicates the normal site or method by which a drug is administered. On the NDDF alternate forms of the route description are available in two codes: A one-byte route code (GCRT) is available for applications where the description is transparent to the user. A two-byte route code (GCRT2) is available as an abbreviation. This is the one-byte code (GCRT).	CHAR	1	0	Y
DSC_ROUTE	The Route Description (RT) indicates the normal site or method by which a drug is administered. The current range of descriptors includes oral, topical, injection, and so on.	VARCHAR2	10	0	N
CDE_ROUTE_2	On the NDDF alternate forms of the route description are available in two codes: A one-byte route code (GCRT) is available for applications where the description is transparent to the user. A two-byte route code (GCRT2) is available as an abbreviation. This is the two-byte code (GCRT2).	CHAR	2	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DSC_ROUTE_LONG	The Route Description indicates the normal site or method by which a drug is administered. The current range of descriptors includes oral, topical, injection, and so on. This is the Route Code Interpretation data element (GCRT_DESC) on the NDDF update file.	VARCHAR2	40	0	N
CDE_SYSTEMIC	Route of Admin. Systemic Indicator.	CHAR	1	0	N
CDE_SKEY_RT	The sixth component of the Smart Key is the Smart Key - Route Code (SKEY-RT), a two-digit number. An SKEY-RT code value is interpreted the same across all like NDCs.	NUMBER	2	0	N

2.13.60 T_CDE_EDIT_PARM_TYPE

Contains the description of the parameter type.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PARM_TYPE	The parameter type	CHAR	10	0	Y
DSC_PARM_SHORT	The short parameter type description	VARCHAR2	50	0	N
DSC_PARM	The parameter type description	VARCHAR2	4000	0	N

2.13.61 T_CDE_ERR_TYPE

This table is used to identify valid audit types such as limitation, contra and so on.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_ERROR_TYPE	Identifies the audit as limitation, bundling, unbundling, contraindicated, or umbrella.	CHAR	2	0	Y
DSC_ERROR_TYPE	Description of the error type.	CHAR	30	0	N

2.13.62 T_CDE_HIPAA_ADJRSN

HIPAA mandates the use of standard X12N defined Claim Adjustment Reason Codes to appear on the 835 Transaction Set. The HIPAA Claim Adjustment Reason Codes provide similar

functionality to the current MMIS EOB codes but lack detail. Their main purpose is to itemize the differences between the claim submitted amount and the claim paid amount.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ADJ_RSN	System assigned key used internally by the system to uniquely identify an HIPAA Adjustment Reason code.	NUMBER	9	0	Y
CDE_ADJ_RSN	HIPAA requires that every "adjustment" to the allowed price of a claim that causes it to differ from the amount originally billed on the claim should be accounted for. As a result, all cutbacks/denials of units and dollars need to be captured and mapped to HIPAA specific adjustment reason codes and remarks codes.	CHAR	4	0	N
DTE_EFFECTIVE	The date the HIPAA Adjustment Reason code becomes valid for use in the system.	NUMBER	8	0	N
DTE_END	The last date the HIPAA Adjustment Reason code is valid for use in the system.	NUMBER	8	0	N
DSC_ADJ_RSN	Text description of HIPAA adjustment reason code.	VARCHAR2	300	0	N
CDE_GROUP	Code identifying the general category of the payment adjustment.	CHAR	2	0	N

2.13.63 T_CDE_HIPAA_REMRKS

Standard X12 remark codes that must be sent on the 835 transaction (Remittance Advice set).

Column Name	Description	Type	Length	Precision	Primary Key
SAK_REMARK	System assigned key used internally in the system to uniquely identify the HIPAA remark code.	NUMBER	9	0	Y
CDE_REMARK	HIPAA remarks code	CHAR	5	0	N
DTE_EFFECTIVE	The date the remark code becomes valid for use in the system.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_END	The last date the remark code is valid for use in the system.	NUMBER	8	0	N
DSC_REMARK	Text Description of HIPAA remarks code.	VARCHAR2	300	0	N

2.13.64 T_CDE_MARITAL

Valid marital status.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_MARITAL	The marital status code.	CHAR	1	0	Y
DSC_MARITAL	The marital status description.	CHAR	10	0	N

2.13.65 T_CDE_MCARE_COVRG

Column Name	Description	Type	Length	Precision	Primary Key
CDE_MCAR_COVRG	A code denoting Medicare coverage status	CHAR	1	0	Y
DSC_MCARE_COVRG	Description which describes the Medicare coverage code value	VARCHAR2	100	0	N

2.13.66 T_CDE_OBC

Relates the Orange Book Code (OBC) to its text description.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_OBC	Identifies the equivalency ratings assigned to an approved prescription product according to the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book).	CHAR	2	0	Y
DSC_OBC	Provides the text description for the Orange Book Code.	VARCHAR2	500	0	N

2.13.67 T_CDE_SEX

Contains valid sex codes.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_SEX	Code describing the gender of an individual.	CHAR	1	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
DSC_SEX	Text describing the gender of an individual.	VARCHAR2	18	0	N

2.13.68 T_CDE_STD_POLICY

This code table lists the system assigned keys which uniquely designate each distinct Standard Policy Statement that appears on the NCCI database.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_STD_POLICY	This system assigned key distinguishes the different Standard Policy Statements, as they appear on the NCCI database.	NUMBER	9	0	Y
DSC_STD_POLICY	This field corresponds to Field 6 on the NCCI database, containing the Standard Policy Statement.	CHAR	256	0	N

2.13.69 T_CDE_STRENGTH

The Drug Strength is a description of drug potency in units of grams, milligrams, percentage, and other terms. Strength is expressed in metric units. This field includes needle sizes, length of devices, and release rates of transdermal patches.

Column Name	Description	Type	Length	Precision	Primary Key
DSC_STRENGTH	The Drug Strength Description (STR) is a description of drug potency in units of grams, milligrams, percentage, and other terms. Strength is expressed in metric units. This field includes needle sizes, length of devices, and release rates of transdermal patches.	CHAR	10	0	Y
QTY_DRUG_STRGTH	The Drug Strength Number (STRNUM) must be used in conjunction with the Drug Strength Unit (STRUN), the Drug Strength Volume Number (VOLNUM), and the Drug Strength Volume Units (VOLUN) to obtain a conventional strength expression for the drug product. The strength of a drug product is usually expressed in the metric system.	NUMBER	11	3	N

Column Name	Description	Type	Length	Precision	Primary Key
DSC_DRUG_STRGTH_U	The Drug Strength Units (STRUN) must be used in conjunction with the Drug Strength Number (STRNUM), the Drug Strength Volume Number (VOLNUM), and the Drug Strength Volume Units (VOLUN) to obtain a conventional strength expression of the drug product. The strength of a drug product is usually expressed in the metric system.	CHAR	10	0	N
QTY_DRUG_STRGTH_V	The Drug Strength Volume Number (VOLNUM) indicates the volume or weight of the drug product which contains the indicated amounts of active ingredients. This field must be used in conjunction with the Drug Strength Number (STRNUM), the Drug Strength Units (STRUN), and the Drug Strength Volume Units (VOLUN) to obtain a conventional strength expression of the drug product. The strength of a drug product is usually expressed in the metric system.	NUMBER	7	3	N

Column Name	Description	Type	Length	Precision	Primary Key
DSC_DRUG_STR_VOL_U	The Drug Strength Volume Units (VOLUN) must be used in conjunction with the Drug Strength Number (STRNUM), the Drug Strength Units (STRUN), and the Drug Volume Number (VOLUN) to obtain a conventional strength expression of the drug product. The strength of a drug product is usually expressed in the metric system.	CHAR	5	0	N

2.13.70 T_CDE_THERA_AHFS

Relates the AHFS Therapeutic Class code to its text description.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_THERA_CLS_AHFS	Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	CHAR	10	0	Y
DSC_THERA_CLS_AHFS	Provides the text description for the AHFS Therapeutic Class code.	VARCHAR2	55	0	N

2.13.71 T_CDE_THERA_GEN

The is the Generic Therapeutic Class Description table, which relates the Generic Therapeutic Class code to its description.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_THERA_CLS_GEN	The Generic Therapeutic Class code classifies drugs according to the most general therapeutic groupings.	CHAR	3	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
DSC_THERA_CLS_GEN	Provides the text description for a Generic Therapeutic Class code.	VARCHAR2	100	0	N

2.13.72 T_CDE_THERA_STD

The is the Standard Therapeutic Class Description table, which relates the Standard Therapeutic Class code to its description.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_THERA_CLS_STD	The Standard Therapeutic Class code classifies drugs according to the most common intended use. This therapeutic classification is intended to service those users who need a definitive but not comprehensive therapeutic classification system.	CHAR	3	0	Y
DSC_THERA_CLS_STD	Provides the text description for a Standard Therapeutic Class code.	VARCHAR2	100	0	N

2.13.73 T_CDE_TIME_UNIT

This table is used to allow different States to set up their own time unit values used for auditing claims.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_TIME_UNIT	Indicates the unit of time measurement to be used in auditing.	CHAR	1	0	Y
DSC_TIME_UNIT	Description of the time unit.	CHAR	30	0	N

2.13.74 T_CLAIM_BDL_LABPANEL

This table contains the individual component lab codes that constitute a laboratory panel code, which drives the Kentucky defined Lab Panel bundling activity.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE_GT	This system assigned key corresponds to Field 1 on the NCCI database, containing a Comprehensive or Mutually Exclusive column 1 procedure code.	NUMBER	9	0	Y
SAK_PROCEDURE_LT	This system assigned key corresponds to Field 2 on the NCCI database, containing a Comprehensive or Mutually Exclusive column 2 procedure code.	NUMBER	9	0	Y
DTE_EFFECTIVE	This is the code's effective date.	DATE	0	0	N
DTE_END	This is the code's deletion date if applicable.	DATE	0	0	N
QTY_BILLED	Number of units of service required for the procedure code combination.	NUMBER	6	2	N
DTE_LAST_UPDATE	This date shows when this row was created or last modified.	DATE	0	0	N

2.13.75 T_CLAIM_BDL_NCCD

This table contains the NCCI (National Correct Coding Information) database, obtained from NTIS (National Technical Information Service), which consists of several procedure code edit pairs (comprehensive/greater codes and component/lesser codes). When coupled with the override information in T_CLAIM_BDL_OVERRIDE, these edit pairs drive the claims subsystem bundling activity. Note that this table contains edits that exist within both the active and inactive file sets. As a result, a small group of edit pairs may appear as no longer active when in fact they are active. This group of codes were terminated at some point in the past and then subsequently reinstated as active as a later date.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_CLAIM_BDL	This system assigned key uniquely distinguishes each row on this table and is in the same domain as T_CLAIM_BDL_OVERRIDE (so that they do not overlap).	NUMBER	9	0	Y
SAK_PROCEDURE_GT	This system assigned key corresponds to Field 1 on the NCCI database, containing a Comprehensive or Mutually Exclusive column 1 procedure code.	NUMBER	9	0	N
SAK_PROCEDURE_LT	This system assigned key corresponds to Field 2 on the NCCI database, containing a Comprehensive or Mutually Exclusive column 2 procedure code.	NUMBER	9	0	N
DTE_EFFECTIVE	This field corresponds to Field 3 on the NCCI database, containing the code's effective date.	DATE	0	0	N
DTE_END	This field corresponds to Field 4 on the NCCI database, containing the code's deletion date if applicable.	DATE	0	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PRIOR96	This field corresponds to Field 5 on the NCCI database, containing the Prior Rebundled Code Indicator. An '*' designates rebundled prior to 1996 edits. A blank space shows the code was rebundled 1/1/1996 or later.	CHAR	1	0	N
SAK_STD_POLICY	This system assigned key distinguishes the different Standard Policy Statements, as they appear on the NCCI database.	NUMBER	9	0	N
CDE_GB_MOD	This field corresponds to Field 7 on the NCCI database, containing the GB Modified Indicator. The valid values are: 0, 1, 9. Please refer to the NCCD documentation for a more detailed description of this field.	CHAR	1	0	N
DTE_LAST_UPDATE	This date shows when this row was created or last modified, due to an alteration in the NCCI database.	DATE	0	0	N

2.13.76 T_CLAIM_BDL_OVERRIDE

This table contains the override information for the NCCI (National Correct Coding Information) database. When coupled with the information in T_CLAIM_BDL_NCCD, these edit pairs drive the claims subsystem bundling activity. Note that this table contains edits that exist within both the active and inactive file sets. As a result, a small group of edit pairs may appear as no longer active when in fact they are active. This group of codes were terminated at some point in the past and then subsequently reinstated as active as a later date.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_CLAIM_BDL	This system assigned key uniquely distinguishes each row on this table and is in the same domain as T_CLAIM_BDL_NCCD (so that they do not overlap).	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE_GT	This system assigned key corresponds to Field 1 on the NCCI database, containing a Comprehensive or Mutually Exclusive column 1 procedure code.	NUMBER	9	0	N
SAK_PROCEDURE_LT	This system assigned key corresponds to Field 2 on the NCCI database, containing a Comprehensive or Mutually Exclusive column 2 procedure code.	NUMBER	9	0	N
DTE_EFFECTIVE	This field is the code's effective date.	DATE	0	0	N
DTE_END	This is the code's deletion date if applicable.	DATE	0	0	N
SAK_BDL_NCCD	This system assigned key uniquely distinguishes each row on this table and is in the same domain as T_CLAIM_BDL_OVERRIDE (so that they do not overlap).	NUMBER	9	0	N
DTE_LAST_UPDATE	This date shows when this row was created or last modified.	DATE	0	0	N

2.13.77 T_PR_CLAIM_ROLE

This table lists some of the possible roles a Provider may represent on a claim. For example, Billing, Performing, and so on.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PR_ROLE	This code represents the provider role on the claim. For example, a value of BILL REPRESENTS THE BILLING PROVIDER ON THE CLAIM.	CHAR	4	0	Y
DSC_PROVIDER_ROLE		VARCHAR2	50	0	N

2.13.78 T_CLAIM_PR_ROLE

This table lists some of the possible roles a Provider may represent on a claim. For example, Billing, Performing, and so on.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PR_ROLE	This code represents the provider role on the claim. For example, a value of BILL REPRESENTS THE BILLING PROVIDER ON THE CLAIM.	CHAR	4	0	Y
DSC_PROVIDER_ROLE		VARCHAR2	50	0	N

2.13.79 T_CLAIM_TYPE

List of the valid types of claims that can be submitted and processed in the MMIS.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_CLM_TYPE	Value for the type of claim that can be processed in the MMIS system.	CHAR	1	0	Y
DSC_CLM_TYP	Description of the value assigned to a specific claim type.	CHAR	50	0	N

2.13.80 T_CLASSIFICATION_BNFT

These are the group classifications for the benefits. Each classification structures the grouping into hierarchies. For example, drugs (NDC) are likely to have more than one classification each represented by a hierarchy of groups; one hierarchy could be used to specify general coverage conditions such as age and gender; a different hierarchy of groups may be more appropriate for Preferred drug conditions.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_CLASS_HIERARCHY	Unique row identifier for this table.	NUMBER	9	0	Y
CDE_CLASS_BNFT_HIER	A short hand code to identify the hierarchy.	CHAR	4	0	N
DSC_CLASS_HIERARCHY	A description of what the hierarchy is and to use it.	VARCHAR2	20	0	N

2.13.81 T_CONDITION

Contains the valid codes used to identify conditions relating to a UB04 claim that may affect payer processing.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_COND	Code used to identify conditions relating to a UB04 claim that may affect payer processing.	CHAR	2	0	Y
DSC_COND	Description of a conditions relating to a UB04 claim that may affect payer processing.	CHAR	40	0	N

2.13.82 T_COND_INP_LOC

A condition code may be assigned to an inpatient level of care. This assignment will allow a provider to be paid a per diem rate for inpatient claims submitted.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_COND	Used to identify conditions relating to a UB04 claim that may affect payer processing.	CHAR	2	0	Y
DTE_EFFECTIVE	Date Level of Care assignment to a condition code becomes valid for used in processing and determination of level of care for a claim.	NUMBER	8	0	Y
DTE_END	Date level of care assignment to a condition code is no longer valid for processing.	NUMBER	8	0	N
CDE_LEVEL_OF_CARE	A two digit code indicating the type and amount of care provided for a member in an institution.	CHAR	2	0	N

2.13.83 T_CONTRA_PARM

Auditing performed for services that contradict services that have already been paid for a member. Also known as relationship auditing criteria.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_TIME_UNIT	Indicates whether days, months, or years should be used as the unit of measure for the audit.	CHAR	1	0	N
CDE_BEF_AFT	Indicates whether the time limit specified should be checked for services before, after, or before and after the current claim.	CHAR	1	0	N
NUM_UNIT_BEFORE	Specifies the number of units (days, months, years) in history that should be checked before a claim's dates of service.	NUMBER	4	0	N
NUM_UNIT_AFTER	Specifies the number of units (days, months, years) in history that should be checked after a claim's dates of service.	NUMBER	4	0	N
CDE_AUDIT_DIR	This indicates whether the audit is a one-way or two-way audit.	CHAR	1	0	N

2.13.84 T_CONTRA_PROC

List or range of procedure codes that should be included in audit criteria for contra, bundling and unbundling audits.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
CDE_CURR_FROM	Code for the first procedure in a range of procedures used to define audit criteria.	CHAR	6	0	Y
CDE_CURR_TO	Code for the last procedure in a range of procedures used to define audit criteria.	CHAR	6	0	Y
CDE_CURR_MOD	Further specifies what type of procedure codes should be included in an audit.	CHAR	2	0	Y
CDE_CURR_TYPE	Indicates the type of code (revenue or procedure) used in the audit.	CHAR	1	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_HIST_FROM	Code for the first procedure in a range of procedures used to define audit criteria.	CHAR	6	0	N
CDE_HIST_TO	Code for the last procedure in a range of procedures used to define audit criteria.	CHAR	6	0	N
CDE_HIST_MOD	Further specifies what type of procedure codes audited against.	CHAR	2	0	N
CDE_HIST_TYPE	Indicates the type of code (revenue or procedure) used in the audit.	CHAR	1	0	N

2.13.85 T_CONV_FACTOR

Total Base RVU for a procedure is multiplied by conversion factor to obtain the base fee schedule payment amount during RBRVS pricing calculation.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	Y
DTE_EFFECTIVE	The date a conversion factor becomes valid (effective) for claims processing.	NUMBER	8	0	Y
DTE_END	The date a conversion factor is no longer valid for claims processing.	NUMBER	8	0	N
AMT_CONV_FACTOR	Multiplier which transforms relative values into payment amounts during RBRVS pricing calculations.	NUMBER	9	4	N

2.13.86 T_COUNTY

This table represents the geographical/political counties in a given state. Only one address per county code is used.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_COUNTY	The county code used to identify a geographical/political area in the state.	VARCHAR2	10	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_LOCALITY	This attribute indicates the locality code for a county. Valid values include 01 - Metropolitan, 02 - Urban, 03 - Rural.	CHAR	2	0	N
DSC_COUNTY	Twelve character field containing the name of a specific county.	CHAR	12	0	N
ADR_STREET_1	The first line of the address to use in correspondence with county.	CHAR	30	0	N
ADR_STREET_2	The second line of the address to use in correspondence with county.	CHAR	30	0	N
ADR_CITY	The name of the city to use in correspondence with county.	CHAR	15	0	N
ADR_STATE	This is the state code for the county office address.	CHAR	2	0	N
ADR_ZIP_CODE	The five byte zip code to use in correspondence with county.	CHAR	5	0	N
ADR_ZIP_CODE_4	The 4 digit zip code that follows the 5 digit zip code.	CHAR	4	0	N
CDE_URBAN_RURAL	Indicates whether or not a county is Rural (R) or Urban (U). This is used for payment of capitation under the Managed Care RBMC program.	CHAR	1	0	N
CDE_IDCARD_CNTL	This control number is assigned by West Lake, Ohio for each county office to determine which return address to print on the envelope for the member id card. Not used by OK MMIS.	CHAR	5	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_REGION_GEO	A user defined code that identifies a geographical region.	CHAR	4	0	N

2.13.87 T_CST_CHG_RATIO

"State-wide" cost to charge ratio used in DRG cost outlier calculations. This is a percentage based on charges providers have made over a base period of time.

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The date the Cost to Charge Ratio component took effect.	NUMBER	8	0	N
DTE_END	The date the Cost to Charge Ratio component is no longer in effect.	NUMBER	8	0	N
NUM_RATIO	The percentage of charges over a base period of time. Used for the state-wide calculation.	NUMBER	6	4	N

2.13.88 T_DEA_CODE

The Drug Enforcement Administration Code denotes the degree of potential abuse and Federal control of a drug.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DEA	The Drug Enforcement Administration (DEA) code denotes the degree of potential abuse and Federal control of a drug. This code is subject to change by Federal regulation.	CHAR	1	0	Y
DSC	Text describing the Drug Enforcement Administration (DEA) code.	CHAR	100	0	N

2.13.89 T_DESI

The table holds data for the three "types" of DESI values carried on the NDDF, DESI, DESI2 and HCFA DESI. The DESI Drug Indicator (DESI) marks a particular drug as declared less than effective by the Food and Drug Administration. In 1990, HCFA appended the DESI listing of drugs to include a "similar and related" category. Drugs included in this category have a DESI2 of "1" and were not previously flagged as DESI. The HCFA DESI Code (HCFA_DESI) indicates the DESI code as supplied on the Health Care Financing Administration's quarterly tape.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG	System assigned key for a unique drug	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DESI_TYPE	Code used to indicate the DESI type. 1 = DESI Drug Indicator DESI on the NDDF. 2 = DESI 2 Drug Indicator on the NDDF. H = HCFA DESI code on the NDDF.	CHAR	1	0	Y
DTE_EFFECTIVE	The date the HCFA DESI status took effect.	NUMBER	8	0	Y
IND_STATUS	Indicates whether the DESI segment is in an active (0) or inactive (1) status. Only active segments will be used for claims processing. Inactive segments will be maintained for historical purposes.	CHAR	1	0	Y
DTE_END	The date the HCFA DESI status is no longer in effect.	NUMBER	8	0	N
CDE_DESI	Values 0 - 1 are used with the DESI and DESI2 indicators and indicate this drugs is DESI (1) or DESI at one point in time, but no longer (0). Values 0, 2-6 are used with the HCFA DESI and indicate this drug's status as less than effective.	CHAR	1	0	N
CDE_SOURCE	Indicates the source used to update the DESI. CQ = CMS, FW = FDB, MX = MDX.	CHAR	2	0	N

2.13.90 T_DESI_CODE

The code identifies the DESI status of the NDC drug with current valid values of 0-6. The DESI Drug Indicator (DESI) marks a particular drug as declared less than effective by the Food and Drug Administration. The HCFA DESI Code (HCFA_DESI) indicates the DESI code as supplied on the Health Care Financing Administration's quarterly tape.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DESI	Values 0 - 1 are used with the DESI and DESI2 indicators and indicate this drugs is DESI (1) or DESI at one point in time, but no longer (0). Values 0, 2-6 are used with the HCFA DESI and indicate this drug's status as less than effective.	CHAR	1	0	Y
DSC	The description of the DESI code value, 2-6.	CHAR	100	0	N

2.13.91 T_DIAGNOSIS

A condition that requires medical attention.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DIAG	System assigned key for the diagnosis.	NUMBER	9	0	Y
CDE_DIAG	A code for the condition requiring medical attention.	CHAR	7	0	N
DSC_25	The short nomenclature for a medical condition.	CHAR	40	0	N
DSC_LONG	The long nomenclature for a medical condition.	CHAR	250	0	N
DSC_LAY	Description of the code in layman terms.	VARCHAR2	100	0	N

2.13.92 T_DIAG_COMPAT_GRP

This table represents a group of related diagnosis compatibility code.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DIAG_COMPAT	System assigned key for the diagnosis compatibility code.	NUMBER	9	0	Y
SAK_DIAG	System assigned key for the diagnosis.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date that the diagnosis code is to become effective for the diagnosis compatibility in claims processing.	NUMBER	8	0	Y
DTE_END	The last date that the diagnosis code is in effect for the diagnosis compatibility in claims processing.	NUMBER	8	0	N

2.13.93 T_DIAG_GROUP

Groups diagnosis by diagnosis type. This will be used by various parts of the system for different processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DIAG_TYPE	System assigned key for a unique diagnosis type, that represents a collection of diagnosis codes.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DIAG_FROM	System assigned key for the diagnosis.	NUMBER	9	0	Y
SAK_DIAG_TO	System assigned key for the diagnosis.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date that the diagnosis code is to become effective for the diagnosis type in claims processing.	NUMBER	8	0	Y
DTE_END	The last date that the diagnosis code is in effect for the diagnosis type in claims processing.	NUMBER	8	0	N

2.13.94 T_DIAG_LIMIT

This table contains the general restrictions for a certain diagnosis and the dates that the restrictions are in effect.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	Y
SAK_DIAG	System assigned key for the diagnosis.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date that the limitations for the diagnosis code became effective.	NUMBER	8	0	Y
DTE_END	The date that the limitations for the diagnosis code stopped being effective.	NUMBER	8	0	Y
CDE_SEX	Code that identifies the sex for which the diagnosis is limited. If a diagnosis is valid for both sexes, the value in this field will be 'B'.	CHAR	1	0	N
QTY_AGE_MAX	The maximum age that is valid for the diagnosis.	NUMBER	4	0	N
QTY_AGE_MIN	The minimum age that is valid for the diagnosis.	NUMBER	4	0	N
IND_FAM_PLAN	The indicator for determining whether or not this diagnosis is a Family Planning diagnosis.	CHAR	1	0	N
IND_PREGNANCY	Indicates if the diagnosis is for a pregnancy.	CHAR	1	0	N
IND_EMERGENCY	Indicates whether the diagnosis is for an emergency ASC condition. Valid values are 'Y' - yes and 'N' - no.	CHAR	1	0	N
IND_ATTACHMENT	Indicates whether documentation is required for the diagnosis.	CHAR	1	0	N
IND_PRIMARY	Indicates primary diagnosis codes cannot be billed. The valid values are Y/N.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
IND_SUB_CLASS	Indicates whether the diagnosis requires further specification.	CHAR	1	0	N

2.13.95 T_DIAG_NOTES

This table will allow online users to add notes for a diagnosis code.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DIAG	System assigned key for the diagnosis.	NUMBER	9	0	Y
NUM_SEQ	Sequence number of note.	NUMBER	9	0	Y
ID_CLERK	User ID of person who is logged in.	VARCHAR2	8	0	N
DTE_NOTE	The date that the note was entered.	NUMBER	8	0	N
TME_NOTE	The TIME that the note was entered.	NUMBER	6	0	N
DSC_NOTE	The text of the note.	VARCHAR2	1000	0	N

2.13.96 T_DIAG_POS_LIM

This is the Place of Service diagnosis limitation table. For each restriction, the SAK, place of service, and date range for the restriction are entered. To determine if the list of diagnosis codes are valid or invalid for the place of service, the indicator on the place of service table must be checked.

2.13.97 T_DIAG_TYPE

A diagnosis type is associated with a group of diagnosis codes. Used to identify diagnosis codes for use in certain processing methodologies. For example, "Abortion" is a diagnosis type.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DIAG_TYPE	System assigned key for a unique diagnosis type, that represents a collection of diagnosis codes.	NUMBER	9	0	Y
DSC_50	Describes the diagnosis type.	CHAR	50	0	N
DSC_DEFINITION	Definition of where and/or how this diagnosis group is used.	VARCHAR2	4000	0	N

2.13.98 T_DISP_FEE

This is the fee that the provider receives for dispensing a prescription legend drug when the provider has the given specialty and is certified under the given contract.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROV_SPEC	A code representing the specialized area of practice for a provider.	CHAR	3	0	Y
SAK_PROV_PGM	This is the system assigned key to the provider Contract under which Providers may be certified..	NUMBER	9	0	Y
DTE_EFFECTIVE	The date that the dispensing fee for the provider specialty is in effect.	NUMBER	8	0	Y
IND_DRUG_TYPE	Indicates Generic/Branded/Either for a provider.	CHAR	1	0	Y
NUM_INGRED_FROM	Number of ingredients from range(1-9999) to allow for compounds to pay varying based on the number of unique ingredients in the compound.	NUMBER	4	0	Y
DTE_END	The date that the dispensing fee for the provider specialty is no longer in effect.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
AMT_NDC_PROFEE	The amount that the provider receives for dispensing a prescription drug. This amount may vary by provider specialty.	NUMBER	7	2	N
NUM_INGRED_TO	Number of ingredients to range(1-9999) to allow for compounds to pay varying based on the number of unique ingredients in the compound.	NUMBER	4	0	N

2.13.99 T_DISP_SHARE

The disproportionate share entity is used in old inpatient pricing. This table may be used in the future, but is not currently used to calculate inpatient pricing.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_SERVICE_LOC	Suffix added to the provider number to identify the various locations that a provider does business.	CHAR	1	0	Y
DTE_EFFECTIVE	The effective date is used to specify a date range for an entry in the disproportionate share entity.	NUMBER	8	0	Y
SAK_PROV	System assigned key that uniquely identifies the provider enrollment tracking.	NUMBER	9	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	N
DTE_END	The end date is used to specify a date range for an entry in the disproportionate share entity.	NUMBER	8	0	N
PCT_DISP_SHARE	Disproportionate share is used in old inpatient pricing. After the allowed amount is calculated, then a percent may be added to the allowed amount.	NUMBER	5	4	N
IND_NPI_TRIGGER	"Temporary Column: Trigger action indicator 'C': Updated cde_service_loc 'S': Updated sak_prov_loc"	CHAR	1	0	N

2.13.100 T_DISP_SPEC

Provider specialties that are approved to receive dispensing fees.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROV_SPEC	A code representing the specialized area of practice for a provider.	CHAR	3	0	Y

2.13.101 T_DRG

Diagnosis Related Groups are used as the standard classification system for dealing with inpatient hospital data. Developed for evaluating resource use and utilization patterns. DRGs are used nationwide as the basis for the analysis and prospective payment of hospital care.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRG	System assigned key for a unique DRG.	NUMBER	9	0	Y
CDE_DRG	This is a three byte code field used to identify a DRG grouping. The DRG code and description are obtained from HCIA.	CHAR	4	0	N
DSC_DRG	This is a forty byte character field used to describe a DRG grouping. The DRG code and description are obtained from HCIA.	VARCHAR2	132	0	N

2.13.102 T_DRG_CROSSWALK

This table supports the DRG crosswalk from Medicare DRG codes (grouper assigned) to more state-specific DRG codes. Reasons for the further crosswalk include neonatal and transplant services. If a match is found on this table for the DRG the claim is grouped to based on the additional criteria, then the pricing DRG on the table will be used to price the claim.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRG_CROSSWALK	The system assigned key that uniquely identifies a row in this table.	NUMBER	9	0	Y
SAK_DRG	System assigned key for a unique DRG.	NUMBER	9	0	N
DTE_EFFECTIVE	The date that the DRG code crosswalk becomes effective.	NUMBER	8	0	N
DTE_END	The date that the DRG code crosswalk is no longer effective.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_REPLACEMENT_TYPE	The code that identifies the type of DRG code that needs to be replaced. Valid codes are: 1. N - Neonatal DRG codes 2. T - Transplant DRG codes 3. P - Provider specific crosswalks	CHAR	1	0	N
SAK_DIAG	System assigned key for the diagnosis.	NUMBER	9	0	N
CDE_PATIENT_STATUS	Indicates the status of the member as of the ending service date of the period covered on a UB04 claim.	CHAR	2	0	N
NUM_MIN_LOS	Identifies the minimum number of days covered for the member in order for the crosswalk to apply.	NUMBER	4	0	N
NUM_MAX_LOS	Identifies the maximum number of days covered for the member in order for the crosswalk to apply.	NUMBER	4	0	N
CDE_ADMIT_SOURCE	Code identifying the source of admission in block 20 on the UB04 claim record for inpatient and LTC claims.	CHAR	1	0	N
SAK_PROC_ICD9_1	The procedure code that identifies the crosswalk. This code is only required for Neonatal DRG crosswalks.	NUMBER	9	0	N
SAK_PROC_ICD9_2	The ICD9 procedure code that identifies the crosswalk. This is only required for Transplant DRG crosswalks.	NUMBER	9	0	N

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROV_LOC	Service Location SAK. This is only required for provider specific crosswalks.	NUMBER	9	0	N
SAK_DRG_ENHANCED	The system assigned key that identifies the DRG code that will be utilized during the pricing process.	NUMBER	9	0	N

2.13.103 T_DRG_DIAG_XWALK

This table is required to crosswalk diagnosis codes from new diagnosis codes to old diagnosis codes. The crosswalk is required to support DRG pricing methodology since the DRG grouper is not installed at the same time new diagnosis codes are released. The information in this table will be utilized for processing purposes, but the diagnosis codes received with the claim will not be replaced.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRG_DX_XWLK	The system assigned key that uniquely identifies a row in this table.	NUMBER	9	0	Y
SAK_DIAG	System assigned key for the diagnosis.	NUMBER	9	0	N
SAK_DIAG_XWALK	System assigned key assigned to the code that describes the condition that requires medical attention. This represents the old diagnosis code that will be used by the grouper to assign a DRG code to a claim.	NUMBER	9	0	N
DTE_EFFECTIVE	The effective date identifies the date that the cross walk process will be performed for the diagnosis code. This will be based on the first date of service on the claim.	NUMBER	8	0	N
DTE_END	The end date identifies the date that the cross walk process should be terminated. This will be based on the first date of service on the claim.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_INACTIVE	Crosswalk segment inactive date. This is the date/time that the crosswalk can no longer be used, regardless of the dates of service on the claim.	DATE	0	0	N

2.13.104 T_DRG_GROUP

Groups DRG codes by DRG type. This is used in various parts of the system for different processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRG_FROM	System assigned key for a unique DRG.	NUMBER	9	0	Y
SAK_DRG_TO	System assigned key for a unique DRG.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date that the DRG code is to become effective for the DRG group.	NUMBER	8	0	Y
SAK_DRG_TYPE		NUMBER	4	0	Y
DTE_END	The date that the DRG code stops being effective for the DRG group.	NUMBER	8	0	N

2.13.105 T_DRG_GROUPER

DRG Grouper is a collection of programs and files that are used to assign the Diagnosis Related Grouper (DRG) to a claim. New versions of the DRG Grouper software are released annually. This entity contains information about each release of the grouper software that is used in claims processing.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_GRP_VERSION	Version number of the Grouper to be used for DRG assignment. Through version 9, enter the corresponding 1-digit version number. After version 9, use the following coding scheme: A = version 10; B = version 11, and so on.	VARCHAR2	20	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The date the version of DRG Grouper software is valid for claims processing. The claim from date of service is compared to the grouper effective and end dates to determine the correct version to use for the claim.	NUMBER	8	0	Y
DTE_END	The date DRG Grouper is no longer effective for processing.	NUMBER	8	0	N
CDE_GRP_TYPE	A 1-character binary field which contains a value identifying the requested Grouper type. 1 = HCFA, 2 = NY, 4 = CHAMPUS, 8 = NJ, 16 = PA	NUMBER	4	0	N

2.13.106 T_DRG_ICD9_XWALK

This table is required to crosswalk ICD9-CM procedure codes from new codes to old codes. The crosswalk is required to support DRG pricing methodology since the DRG grouper is not installed at the same time new ICD9-CM procedure codes are released. The information in this table will be utilized for processing purposes, but the ICD9-CM procedure codes received with the claim will not be replaced.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRG_PROC_XWLK	The system assigned key that uniquely identifies a row in this table.	NUMBER	9	0	Y
SAK_PROC_ICD9	System assigned key used to uniquely identify an ICD-9-CM procedure.	NUMBER	9	0	N
SAK_PROC_ICD9_XWLK	System assigned key used to uniquely identify an ICD9-CM procedure. This represents the old ICD9 procedure code that will be used by the grouper to assign a DRG code to a claim	NUMBER	9	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The effective date identifies the date that the cross walk process will be performed for the ICD9 procedure code. This will be based on the first date of service on the claim.	NUMBER	8	0	N
DTE_END	The end date identifies the date that the cross walk process should be terminated. This will be based on the first date of service on the claim.	NUMBER	8	0	N
DTE_INACTIVE	Crosswalk segment inactive date. This is the date/time that the crosswalk can no longer be used, regardless of the dates of service on the claim.	DATE	0	0	N

2.13.107 T_DRG_INP_LOC

A Diagnosis Related Group (DRG) may be assigned to an inpatient level of care. This assignment will allow a provider to be paid a per diem rate for inpatient claims submitted.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRG	System assigned key for a unique DRG.	NUMBER	9	0	Y
DTE_EFFECTIVE	Date Level of Care assignment to a Diagnosis Related Group (DRG) becomes valid for used in processing and determination of level of care for a claim.	NUMBER	8	0	Y
DTE_END	Date level of care assignment to a Diagnosis Related Group (DRG) is no longer valid for processing.	NUMBER	8	0	N
CDE_LEVEL_OF_CARE	A two digit code indicating the type and amount of care provided for a member in an institution.	CHAR	2	0	N

2.13.108 T_DRG_MAPPER

The MAPPER will take dx and proc codes and map them to new or old codes. This is done for the following reasons: State may be using an old DRG Grouper version with new dx/proc codes and the mapper accommodates this. A new version of the grouper may not be released, yet new codes would be so this would accommodate these new codes in grouping.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_MAPPER_TYPE	Mapper type code	CHAR	2	0	N
CDE_MAP_VERSION	Map version code	CHAR	3	0	N
NUM_ICD9CM_TYPE	ICD-9 CM type number	NUMBER	4	0	N
CDE_INPUT	Input code	CHAR	5	0	N
DTE_EFFECTIVE	Effective date	NUMBER	8	0	N
DTE_END	End date	NUMBER	8	0	N
CDE_MAPPED	Mapped code	CHAR	5	0	N

2.13.109 T_DRG_MDC

This is the cross reference between DRGs and MDCs.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRG	System assigned key for a unique DRG.	NUMBER	9	0	Y
SAK_MDC	System assigned key for a unique MDC.	NUMBER	9	0	Y

2.13.110 T_DRG_NEONATAL

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DRG	This code represents the original DRG code that will be replaced in a claim through the Neonatal logic.	CHAR	4	0	Y
DTE_EFFECTIVE	This is the effective date the replacing process will take place.	NUMBER	8	0	Y
CDE_DRG_REPLACING	This code represents the 800 series Neonatal DRG codes that replace the original DRG code.	CHAR	4	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
DTE_END	This date represents the end of the replacing code for this DRG code.	NUMBER	8	0	N
CDE_BIRTH_WT_FROM	This is the last digit from the diagnosis code that represents the birth weight.	NUMBER	1	0	N
CDE_BIRTH_WT_TO	This is the last digit from the diagnosis code that represents the birth weight.	NUMBER	1	0	N

2.13.111 T_DRG_NOTES

This table will allow online users to add notes for a DRG code.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRG	System assigned key for a unique DRG.	NUMBER	9	0	Y
NUM_SEQ	Sequence number of note.	NUMBER	9	0	Y
ID_CLERK	User ID of person who is logged in.	VARCHAR2	8	0	N
DTE_NOTE	The date that the note was entered.	NUMBER	8	0	N
TME_NOTE	The TIME that the note was entered.	NUMBER	6	0	N
DSC_NOTE	The text of the note.	VARCHAR2	1000	0	N

2.13.112 T_DRG_RATE

The DRG Rate contains information used to calculate the total DRG reimbursement rate paid to a provider. The date sensitive information includes the DRG base rate, weight, and average length of stay data for the DRG calculation.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRG	System assigned key for a unique DRG.	NUMBER	9	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	Y
DTE_EFFECTIVE	The date the DRG Rate took effect.	NUMBER	8	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRG_RATE	The system assigned key that uniquely identifies a row in this table.	NUMBER	9	0	N
DTE_END	The date the DRG Rate is no longer in effect.	NUMBER	8	0	N
NUM_DAILY_RATE	This is a date sensitive pricing factor expressed in dollars terms, and is one of the primary components for the DRG calculation. This base rate is used for the statewide calculation.	NUMBER	10	2	N
NUM_WEIGHT	This is a date sensitive pricing factor expressed in the 9.9999 form, and is one of the primary components for the DRG calculation. Some DRGs will not be assigned weights, so for these the Level of Care pricing method will be used.	NUMBER	7	4	N
NUM_MEAN_LOS	This is the average length of stay associated to a particular DRG classification group.	NUMBER	5	1	N
PCT_OUTLIER_ADJ	The percentage to adjust outlier days.	NUMBER	5	4	N
NUM_BASE_RATE	This is a date sensitive pricing factor expressed in dollars terms, and is one of the primary components for the DRG calculation. This base rate is used for the statewide calculation.	NUMBER	10	2	N

Column Name	Description	Type	Length	Precision	Primary Key
NUM_DAY_OUTLIER_LOW	Low number of days used in outlier payment determination - This attribute will not be used at this time in the code, but it is necessary to prepare for future usage when the state is ready to develop some policy that uses the day outliers logic.	NUMBER	3	0	N
NUM_DAY_OUTLIER_HIGH	High number of days used in outlier payment determination - This attribute will not be used at this time in the code, but it is necessary to prepare for future usage when the state is ready to develop some policy that uses the day outliers logic.	NUMBER	3	0	N
PCT_SUPPLEMENTAL	This is the outlier supplemental percentage that will be utilized during the DRG pricing calculation.	NUMBER	5	2	N
DTE_INACTIVE	Rate segment inactive date. This is the date/time that the rate can no longer be used, regardless of the dates of service on the claim.	DATE	0	0	N

2.13.113 T_DRG_TYPE

A DRG type is associated with a group of DRG codes. Used to identify DRG codes for use in certain processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRG_TYPE		NUMBER	4	0	Y
DSC_50		VARCHAR2	50	0	N
DSC_DEFINITION		VARCHAR2	4000	0	N

2.13.114 T_DRUG

The necessary data that defines a drug. This includes the drug's NDC code, manufacturer, strength, dosage form, package size, and so on. The majority of this data is supplied by our drug vendor, First Data Bank. Some drugs and their data are supplied by the State for State-unique drugs. Also, some data updates are received from First Data Bank through the National ProDUR system.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG	System assigned key for a unique drug	NUMBER	9	0	Y
CDE_NDC	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.	CHAR	11	0	N
SAK_DRUG_MANUF	This is the system assigned key used to uniquely identify the drug manufacturer.	NUMBER	9	0	N
SAK_DRUG_GEN	The system assigned key for a unique generic drug.	NUMBER	9	0	N
SAK_DRUG_RBT_LBLR	System assigned key that is 4 bytes long	NUMBER	9	0	N
CDE_UPDATE_TYPE	Indicates if drug record should by updated by Drug Update process. 'Y' = Yes (Update), 'N' = No (Bypass).	CHAR	1	0	N
CDE_DRUG_CATGRY	The Drug Category Code indicates that a drug product belongs to a category that is commonly treated as an exception in third party plans.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DEA	The Drug Enforcement Administration (DEA) code denotes the degree of potential abuse and Federal control of a drug. This code is subject to change by Federal regulation.	CHAR	1	0	N
CDE_DRUG_CLASS	Classifies a drug by its availability to the consumer according to federal specifications. Values may change even after the NDC has become obsolete. Valid Values are: O = Over-the-Counter. A prescription is not required per the product labeling. F = Prescription required per the product labeling.	CHAR	1	0	N
CDE_DRUG_FORM	The Drug Form Code indicates the basic drug measurement unit for performing price calculations. The current codes are: EA - (tables, kits and so on) ML - (liquids) GM - (solids).	CHAR	2	0	N
CDE_DRUG_SOURCE	The Drug Source Code differentiates single source from multiple source drugs. The current codes are: 1 - Multiple sources & 2 - Single source. Note that this field does not distinguish between the "innovator" products and its substitutes.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_THERA_CLS_FDA	The HCFA FDA Therapeutic Equivalency Code (HCFA_FDA) indicates that although the drugs may have a different therapeutic classification, the FDA considers them therapeutically equivalent. The HCFA_FDA is provided on the Health Care Financing Administration's quarterly tape.	CHAR	2	0	N
CDE_THERA_CLS_AHFS	Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	CHAR	10	0	N
CDE_NDC_FORMAT	The NDC Format Indicator (NDCFI) is used to identify the original 10-character format of the NDC and the type of code, such as NDC, UPC, and HRI. See the "National Drug Code Configuration Editorial Policies" and "National Drug Code Format Indicator Editorial Policies" in the NDDF documentation for further discussion.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
NUM_TOP_VOL_RANK	Indicates the top volume products' rankings as determined by syndicated market research studies. Volume rankings are updated annually based on the total number of prescriptions dispensed (new and refills) through retail pharmacy outlets. All forms and package sizes of the product are factored into the aggregate rank; therefore, each applicable NDC carries the same rank number. For products ranked below the top 200 (FDB) or top 999 (Micromedex), this field is 0.	NUMBER	4	0	N
DSC_NDC	Contains the name that appears on the package label provided by the manufacturer. This column is populated for all products, brand and generic.	VARCHAR2	35	0	N
DSC_DRUG_PACK	The Package Description Mnemonic is the abbreviated description of the package.	CHAR	10	0	N
DTE_NDDF_ADD	The date on which the drug record was added to the National Drug Data File (NDDF) master file	NUMBER	8	0	N
DTE_NDDF_UPDT	Date of update (DUPDC) of NDC Record (NDCTBL) on the weekly NDDF update file.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_LST_CHG_AWP	The date on which the drug's current blue book average wholesale unit or package price was changed on the NDDF master file	NUMBER	8	0	N
DTE_TERM_HCFA	This date is supplied on the CMS quarterly tape. The date is actually supplied to CMS from the drug manufacture/distributor. The date represents the shelf life expiration date of the last batch produced.	NUMBER	8	0	N
DTE_DRUG_OBSOLETE	The date on which the drug product was no longer available in the market place as per the manufacturer's notification, or the best estimate of that date.	NUMBER	8	0	N
IND_DRUG_GENERIC	The Generic Product Indicator (GPI) will distinguish a product as either a generic drug product or as the more expensive branded drug products.	CHAR	1	0	N
IND_DRUG_INNOV	This field identifies the original innovator product for a particular generic code number. Values are: (0)=Default - non innovator drug; (1)=Innovator - held original patent. It is possible to have more than one product to appear to be the innovator.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
IND_DRUG_STD_PACK	Identifies the package size and associated price vectors to be used when pricing the "standard package size" which is defined as 100's for non-unit dose, non-prepack tablets and capsules and 473 or 480 ml for liquids. Current codes are: 0 -All & 1-Std.	CHAR	1	0	N
IND_SYSTEMIC	This indicates if the drug is systemic, which means that it can "seep" into the body, be absorbed, and affect the entire body. Values are: "S" - Systemic, "N" - Non-systemic, "O" - Other.	CHAR	1	0	N
IND_UNIT_DOSE	Marks a drug as packaged in unit doses. Unit dose is defined by FDB as all products labeled as Unit Dose by the mfr. This indicator does not apply to injectable products, suppositories, or powder packets. Current codes are: 1=Unit Dose & 0=All other.	CHAR	1	0	N
IND_UNIT_OF_USE	The Unit of Use (UU) field denotes those packages which are supplied with appropriate labeling and (usually) child resistant closures and are appropriate to dispense as a unit. Valid values are: 1 = Unit of Use, 0 = All Other Products	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
QTY_DRUG_PACK_SZ	This field contains the metric quantity used to derive a unit price. It is the usual labeled quantity from which the pharmacist dispenses, such as 100 tablets, 1000 capsules, 20 ml vial, and so on.	NUMBER	11	3	N
QTY_SHELF_PACK	The number of saleable units packed together and sold as a unit	NUMBER	9	0	N
QTY_SHIPPER	The number of saleable units (packages) in the case available from the manufacturer	NUMBER	9	0	N
QTY_DRUG_CASE_SZ	This field is used as a divisor. The labeler's catalog case price is divided by the Case Size to calculate the single package price.	NUMBER	9	0	N
CDE_STATUS1	This field is used to identify whether the drug has been replaced or reused. The valid values are 'R' for replace and 'U' for reuse.	CHAR	1	0	N
CDE_DRUG_STATUS	This field is used to identify the status of a drug. A drug will be marked as either Active (A) or Inactive (I). This information is used to allow the user to review additions and updates to a drug before they are activated for use by the MMIS.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DSC_LN	The Label Name contains a combination of the drug name appearing on the package label, the strength description, and the dosage form description for a specified product.	VARCHAR2	40	0	N
IND_HCFA_UNIT	Indicates a product's unit of measure, as supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. These units represent the standard measurements used by CMS for determining rebate quantities.	CHAR	3	0	N
NUM_HCFA_PS	CMS Units Per Package Size indicates the number of units per package as supplied on the Centers for Medicare and Medicaid Services' (CMS) quarterly update. This column must be used in conjunction with the CMS Unit Type Indicator to determine the appropriate number of units. Information in this column is provided by CMS and may vary from the First DataBank Package Size and Drug Form Code.	NUMBER	11	3	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_HCFA_APPC	CMS Approval date contains the date the FDA approves a product for sale in the marketplace, for products introduced after 9/30/90 (the date the Rebate program started). Products introduced prior to this date will contain 19900930 in this column in lieu of the actual market entry date. This data is supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The date is supplied to CMS by the drug labeler.	NUMBER	8	0	N
DTE_HCFA_MRKC	CMS Market Entry Date contains the date a manufacturer releases the drug product to the marketplace, for products introduced after 9/30/90 (the date the Rebate program started). Products introduced prior to this date will contain 19900930 in this column in lieu of the actual market entry date. This data is supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The date is provided to CMS by the drug labeler.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_OBC3	Orange Book Code (3-Byte version) identifies the equivalency ratings assigned to approved prescription products according to the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book).	CHAR	3	0	N
CDE_UPDATE_SOURCE	Indicates source of drug update data. F = FDB or M = Micromedex.	CHAR	1	0	N
IND_GNI	A one-character alphanumeric column that specifies whether a product is a brand named product, a generically named product, or an alternative product, using the product name as the criteria.	CHAR	1	0	N
IND_MAINT	A one-character alphanumeric column that identifies a drug as a maintenance drug. Blank = Not a maintenance drug 1 = Maintenance drug	CHAR	1	0	N

2.13.115 T_DRUG_ACT_COV

This entity is used to set up default coverage information for a drug being added through the drug update process. The update process uses the activation indicator on the NDDF file to determine default coverage information for the drug. If an activation indicator/program combination does not exist on the table, the drug will be "not covered" for that program.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PUB_HLTH	System assigned internal key for a medical assistance program.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
IND_ACTIVATE	The activation indicator is used to indicate what status and program coverage the drug will have. It is also used in claims editing. This attribute is determined by FDB and is part of the FDB Drug update process.	CHAR	1	0	Y
DTE_EFFECTIVE	The date the Drug Activation/Program coverage information becomes active for use.	DATE	0	0	Y
DTE_END	The last date the Drug Activation/Program coverage information is active for use.	DATE	0	0	N
NUM_AGE_FROM	The minimum age of the member on the date of service that the service will be covered within the program.	NUMBER	3	0	N
NUM_AGE_TO	The maximum age of the member on the date of service that the service will be covered within the program.	NUMBER	3	0	N
IND_PA	Indicates if Prior Authorization (PA) is required for the activation indicator/program combination. A 'Y' indicates PA is required. A 'N' indicates PA is not required.	CHAR	1	0	N
NUM_PA_AGE_FROM	Minimum member age for PA requirement. This attribute is used with the PA indicator to determine if a service requires PA. (Example: If the PA indicator is 'Y' and the member age is between 0 and 21, the service requires PA)	NUMBER	3	0	N

Column Name	Description	Type	Length	Precision	Primary Key
NUM_PA_AGE_TO	Maximum member age for PA requirement. This attribute is used with the PA indicator to determine if a service requires PA. (Example: If the PA indicator is 'Y' and the member age is between 0 and 21, the service requires PA)	NUMBER	3	0	N

2.13.116 T_DRUG_AWP

This table contains the drug's Blue Book Average Wholesale unit Price. The AWP represents the most common wholesaler price to the retailer or hospital and is based on actual surveys of drug wholesalers.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG	System assigned key for a unique drug	NUMBER	9	0	Y
SAK_SEQUENCE	Sequence number of rows. Used to make a unique key without using the effective date of the row as part of the primary key.	NUMBER	9	0	Y
DTE_EFFECTIVE	This is the date that the Average Wholesale Price and the Estimated Acquisition Cost took effect.	NUMBER	8	0	N
IND_STATUS	Indicates whether the AWP pricing segment is in an active (0) or inactive (1) status. Only active segments will be used for pricing. Inactive segments will be maintained for historical purposes.	CHAR	1	0	N
DTE_END	This is the date that the Average Wholesale Price and the Estimated Acquisition Cost is no longer in effect.	NUMBER	8	0	N
AMT_AWP	This is the drug's Blue Book average wholesale unit price and represents the most common wholesaler price to the retailer or hospital. This price is based on actual surveys of drug wholesalers.	NUMBER	12	5	N

Column Name	Description	Type	Length	Precision	Primary Key
IND_CONV	This column is used to identify AWP prices that were converted from the mainframe system. Converted AWP rates will always be multiplied by an EAC of 100% to get the EAC price for a drug.	CHAR	1	0	N
DTE_SEG_ADDED	The date the pricing segment was created.	NUMBER	8	0	N

2.13.117 T_DRUG_CAT_CODE

The Drug Category Code indicates that a drug product belongs to a category that is commonly treated as an exception in third party plans.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DRUG_CATGRY	The Drug Category Code indicates that a drug product belongs to a category that is commonly treated as an exception in third party plans.	CHAR	1	0	Y
DSC	Text description of Drug Category Code.	VARCHAR2	100	0	N

2.13.118 T_DRUG_CLASS

Code used to classify a drug, for drug rebate and coverage purposes, along with the classification's description.

Column Name	Description	Type	Length	Precision	Primary Key
CDE	Identifies the classification of the drug. Classifications are Vaccine (V), Insulin (I), Supply (S), Nutritional (N), Class 1A (1), Anorexic (A), Family Planning (F), Smoking Cessation (C), Fertility Enhancements (E) and Minoxidil (M).	CHAR	1	0	Y
DSC_25	Description of the drug's classification code (FOR EXAMPLE Vaccine, Insulin, Supply, Nutritional, Class 1A, Anorexic, Family Planning, Smoking Cessation, Fertility Enhancement and Minoxidil).	CHAR	25	0	N
IND	This indicator is used to determine if the classification is exempt from the drug rebate program. The valid values are 'N'=non-exempt, 'E'=exempt.	CHAR	1	0	N

2.13.119 T_DRUG_GROUP

Groups National Drug Codes (NDC) by NDC type. This will be used by various parts of the system for different processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG_TYPE	System assigned key for a unique NDC type, that represents a collection of NDCs	NUMBER	9	0	Y
SAK_DRUG_FROM	System assigned key for a unique drug	NUMBER	9	0	Y
SAK_DRUG_TO	System assigned key for a unique drug	NUMBER	9	0	Y
DTE_EFFECTIVE	The date that the NDC is to become effective for the NDC type in claims processing	NUMBER	8	0	Y
DTE_END	The last date that the NDC is in effect for the NDC type in claims processing	NUMBER	8	0	N

2.13.120 T_DRUG_HCPCS

This table is used to maintain the NDC - HCPCS Crosswalk.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG	System assigned key for a unique drug	NUMBER	9	0	Y
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date the NDC to HCPCS code association takes effect.	NUMBER	8	0	Y
DTE_END	The date the NDC to HCPCS code association is no longer in effect.	NUMBER	8	0	N

2.13.121 T_DRUG_LBLR

The contacts and addresses of a drug manufacturer that is participating in the drug rebate program. The manufacturer manufacturers drugs under a labeler code(s). The labeler code is assigned by the FDA and the drug rebate program is administered using this labeler code.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG_RBT_LBLR	System assigned key that is 4 bytes long	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_LABELER	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.	CHAR	5	0	N
NAME	The name of the drug labeler	CHAR	39	0	N
CDE_MAILING	Code indicating the address to which the labeler's invoice is being mailed	CHAR	2	0	N
CDE_MEDIA_TYPE	Media used to send Drug Labeler Invoice Information. Valid values are blank for paper and "D" for 3 1/4" diskettes. Note: All invoices are always produced on paper as well as the alternate format if requested.	CHAR	1	0	N
CDE_COLLECT_MEDIA	Media used to collect rebate payments	CHAR	1	0	N
PARENT_LBLR	The labeler code of the parent manufacturer	CHAR	5	0	N

2.13.122 T_DRUG_LIMITS

This table contains the limitations/restrictions for a certain drug and the dates that these are in effect.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG	System assigned key for a unique drug	NUMBER	9	0	Y
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	Y
DTE_EFFECTIVE	This is the date that the drug limitations take effect.	NUMBER	8	0	Y
DTE_END	This is the date that the drug limitations no longer are in effect.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
QTY_AGE_MIN	This is a number used to indicate the lower value in an age range. It is the minimum member age that is valid and is entered in number of years.	NUMBER	4	0	N
QTY_AGE_MAX	This is a number used to indicate the upper value in an age range. It is the maximum member age that is valid and is entered in number of years.	NUMBER	4	0	N
IND_OVERRIDE	Yes/No indicator used to identify drugs that will not be edited for a 34 day supply. An indicator of Y (yes) will bypass editing.	CHAR	1	0	N
QTY_DAYS_SPLY_MIN	The minimum number of days a prescribed drug should last a Medicaid member from the date it is dispensed.	NUMBER	4	0	N
QTY_DAYS_SPLY_MAX	The maximum number of days a prescribed drug should last a Medicaid member from the date it is dispensed.	NUMBER	4	0	N
QTY_SUPPLY_MIN	The minimum quantity of the drug which can be dispensed. The default value is 1.	NUMBER	10	3	N
QTY_SUPPLY_MAX	The maximum quantity of the drug which can be dispensed. The default value is 100.	NUMBER	10	3	N
QTY_REFILL	The number of refills available for a specific prescribed drug.	CHAR	2	0	N
CDE_SEX	Identifies the sex of a person that this drug is limited to.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
IND_DRUG_CNS	This will indicate whether or not a drug affects the central nervous system.	CHAR	1	0	N
IND_DRUG_MAINT	This will indicate that the drug is required for "maintaining" health and as such provisions have been made to provide the drug in quantities greater than the standard 30-day or monthly supply.	CHAR	1	0	N
CDE	Identifies the classification of the drug. Classifications are Vaccine (V), Insulin (I), Supply (S), Nutritional (N), Class 1A (1), Anorexic (A), Family Planning (F), Smoking Cessation (C), Fertility Enhancements (E) and Minoxidil (M).	CHAR	1	0	N
IND_MCARE_COVERED	Yes/No indicator used to identify drugs covered by Medicare. A "N" (no) indicates the drugs is not covered by Medicare. This attribute is manually entered.	CHAR	1	0	N
IND_LTC	Indicates whether the drug is covered if the member lives a long term care facility. I = Reimbursable Only in LTC Facility. N = Reimbursable Only if NOT in LTC facility. O = Reimbursable in Either case (default).	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
IND_DISP_FEE	Yes/No indicator used to identify drugs that should pay a percentage of the normally calculated dispensing fee. This indicator is used with the attribute NUM_DISP_FEE_PCT to determine the dispensing fee to pay. If the indicator is a Y (yes), the dispensing fee will be multiplied by the dispensing fee percentage to get the final dispensing fee to pay to the provider.	CHAR	1	0	N
NUM_DISP_FEE_PCT	If the dispensing fee indicator is a Y (yes), the dispensing fee will be multiplied by the dispensing fee percentage to get the final dispensing fee to pay to the provider.	NUMBER	5	4	N

2.13.123 T_DRUG_MAC

This table contains the BIG MAC and/or MAC unit price for a drug and the dates that they are in effect. The MAC is the unit price under Federal MAC regulation and the BIG MAC unit price is published by HCFA in the State Medicaid Manual. It is valid to have an effective date for the MAC/BIG MAC with a zero price. This would indicate a period when the MAC/BIG MAC did not apply.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG	System assigned key for a unique drug	NUMBER	9	0	Y
SAK_SEQUENCE	Sequence number of rows. Used to make a unique key without using the effective date of the row as part of the primary key	NUMBER	9	0	Y
IND_STATUS	Indicates whether the MAC pricing segment is in an active (0) or inactive (1) status. Only active segments will be used for pricing. Inactive segments will be maintained for historical purposes.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	This is the date that the drug's Maximum Allowable Cost takes effect.	NUMBER	8	0	N
DTE_END	This is the date that the drug's Maximum Allowable Cost is no longer in effect.	NUMBER	8	0	N
AMT_MAC	This is the BIG MAC and/or MAC unit price. The MAC is the unit price for a drug under Federal MAC regulation. The BIG MAC unit price is the Federal Participation Plan Upper Limits for a drug and is published by HCFA in the State Medicaid Manual.	NUMBER	12	5	N
DTE_SEG_ADDED	The date the pricing segment was created.	NUMBER	8	0	N

2.13.124 T_DRUG_MAC_PCT

MAC prices for drugs with a class of "O" (Over the Counter) are multiplied by the MAC Percent to adjust payment amounts for providers. Over the Counter Drug MAC prices are normally adjusted upwards in order to persuade providers to use generic OTC drugs.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DRUG_CLASS	Identifies a classification of drugs; for example, barbiturate or amphetamine.	CHAR	1	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	Y
CDE_DRUG_TYPE	This will indicate if the drug is State-unique (S), First Data Bank (F) supplied (is added and updated by them), MediSpan unique (M) from the old system or was added by the National Pro-DUR system (N).	CHAR	1	0	Y
DTE_EFFECTIVE	The date the MAC percentage becomes valid for drug pricing.	NUMBER	8	0	Y
DTE_END	The date the MAC percentage is no longer valid for drug pricing.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
PCT	Percent used to adjust the MAC price sent to us by First Data Bank for Over the Counter drugs.	NUMBER	3	2	N

2.13.125 T_DRUG_MANUF

The necessary data that defines a drug manufacturer. This includes the FDB code used to uniquely identify the distributor and the name of the distributor as listed on the drug label or as indicated by the NDC code.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG_MANUF	This is the system assigned key used to uniquely identify the drug manufacturer.	NUMBER	9	0	Y
CDE_LABELER_ID	This field is a FDB code used to uniquely identify the distributor. This field is independent of the NDC and facilitates the grouping of the NDCs by unique distributor.	CHAR	6	0	N
NAM_DRUG_MANUF	This is the name of the distributor as listed on the drug label or as indicated by the NDC code. It does not necessarily identify the actual drug fabricator.	CHAR	15	0	N
NUM_CORP_ID	The CORPID represents a parent or holding company that relates to the labeler ID or a division of a company. There can be several labeler IDs to one CORPID.	NUMBER	5	0	N
IND_LBLRIND	The Labeler Indicator (LBLRIND) data element is blank for an active labeler (at least 1 active NDC) or 'I' for an inactive labeler (no NDCs or all obsolete).	CHAR	1	0	N

2.13.126 T_DRUG_NOTES

This table will allow online users to add notes for a drug code.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG	System assigned key for a unique drug	NUMBER	9	0	Y
NUM_SEQ	Sequence number of note.	NUMBER	9	0	Y
ID_CLERK	User ID of person who is logged in.	VARCHAR2	8	0	N
DTE_NOTE	The date that the note was entered.	NUMBER	8	0	N
TME_NOTE	The TIME that the note was entered.	NUMBER	6	0	N
DSC_NOTE	The text of the note.	VARCHAR2	1000	0	N

2.13.127 T_DRUG_OTC_MAC

The First DataBank Smart Key value separated into seven unique fields, are used to determine an OTC MAC drug value.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_SKEY_GEN_CLS	Independent code that is the first two characters of the FDB Smart Key. This code is a high level therapeutic class code (2 bytes).	CHAR	2	0	Y
CDE_SKEY_SPEC_CLS	Independent code that is part of the FDB Smart Key. This code is a specific therapeutic class code (4 bytes).	CHAR	4	0	Y
CDE_SKEY_HICL	Independent code that is part of the FDB Smart Key. This code is the modified hierarchical ingredient code list sequence number (5 bytes).	CHAR	5	0	Y
CDE_SKEY_STRENGTH	Independent code that is part of the FDB Smart Key. This code is the strength number (4 bytes).	CHAR	4	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_SKEY_DOSG_FRM	Independent code that is part of the FDB Smart Key. This code is the dosage form number (3 bytes).	CHAR	3	0	Y
CDE_SKEY_RT	Independent code that is part of the FDB Smart Key. This code is the route of administration code (2 bytes).	CHAR	2	0	Y
CDE_SKEY_PACK_SIZ	Independent code that is part of the FDB Smart Key. This code is the package size number (4 bytes).	CHAR	4	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	N
AMT_MAC	For the OTC MAC table (t_drug_otc_mac):This is a calcd value (that is 150%) using a base rate. For State MAC table (t_drug_s_mac):This value is used for pricing which is determined as 150% of the base MAC rate like that on the t_drug_mac table.	NUMBER	9	5	N

2.13.128 T_DRUG_PREV

The necessary data to link a replaced or reused NDC to its associated NDC.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG	System assigned key for a unique drug	NUMBER	9	0	Y
SAK_DRUG_PREV	This is a system assigned key for a drug that has been replaced or reused.	NUMBER	9	0	N

2.13.129 T_DRUG_REBATE_TEMP

This is a temporary table to be used until the Drug Rebate process can be defined and implemented. This table will be used in claims editing to deny claims for "Non-Participating manufacturer on date of service" edit number 1016. The edit will be set if the manufacturer of the NDC on the claim is not participating in the Drug Rebate program on the date of service on the claim.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_LABELER	This code is used to uniquely identify the labeler of a drug. This code is assigned by HCFA and is used as the first 5 characters of the labeler's NDCs.	CHAR	5	0	N
DTE_EFFECTIVE	The date the drug manufacturer Drug Rebate segment is active.	NUMBER	8	0	N
DTE_END	The date the drug manufacturer's Drug Rebate segment is inactive..	NUMBER	8	0	N
IND	A one byte indicator to identify if the corresponding labeler is participating in Drug Rebate for the date rand (Y) or not participating (N).	CHAR	1	0	N

2.13.130 T_DRUG_STATE

This entity is used to carry State defined attributes used in claims processing and reporting functions.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG	System assigned key for a unique drug	NUMBER	9	0	Y

2.13.131 T_DRUG_S_MAC

This table contains the State determined Maximum Allowable Cost (MAC) for a drug, along with its effective dates and status. Usually drugs that have a State MAC do not have a Federal MAC, but the State MAC can be used to override a Federal MAC if one exists for the drug.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG	System assigned key for a unique drug	NUMBER	9	0	Y
SAK_SEQUENCE	Sequence number of rows. Used to make a unique key without using the effective date of the row as part of the primary key	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	This is the date that the State MAC will take effect.	NUMBER	8	0	N
IND_STATUS	Indicates whether the State MAC pricing segment is in an active (0) or inactive (1) status. Only active segments will be used for pricing. Inactive segments will be maintained for historical purposes.	CHAR	1	0	N
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	N
DTE_END	This is the date that the State MAC will no longer be in effect.	NUMBER	8	0	N
AMT_MAC	This is the Maximum Allowable Cost for a drug as determined by the State.	NUMBER	12	5	N

2.13.132 T_DRUG_TYPE

A drug type is associated with a group of National Drug Codes (NDC). These types are used to identify NDC groups for use in certain processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG_TYPE	System assigned key for a unique NDC type, that represents a collection of drugs	NUMBER	9	0	Y
DSC_50	Describes the NDC type	CHAR	50	0	N
DSC_DEFINITION	Definition of where and/or how this NDC group is used	VARCHAR2	4000	0	N

2.13.133 T_DUPE_AUDIT

Criteria used to determine what type of duplicate auditing is to be performed based on procedure code on the detail of a claim.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
CDE_CLM_TYPE	Type of claim that will be checked for duplication.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROC_FROM	System assigned key that uniquely identifies the first procedure code used in duplicate checking in the MMIS system.	NUMBER	9	0	N
SAK_PROC_TO	System assigned key that uniquely identifies the last procedure code used in duplicate checking in the MMIS system.	NUMBER	9	0	N
CDE_PROC_FROM	Code that identifies the first procedure code used in duplicate checking in the MMIS system.	CHAR	6	0	N
CDE_PROC_TO	Code that identifies the last procedure code used in duplicate checking in the MMIS system.	CHAR	6	0	N
IND	Indicates whether provider number should be used as part of duplicate check (Y/N).	CHAR	1	0	N

2.13.134 T_EAC

Estimated acquisition cost is a pricing factor used to price pharmacy claims. This table contains by drug class, the EAC percentage that should be applied to result in an allowable reimbursement amount.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DRUG_CLASS	Identifies a classification of drugs; for example, barbiturate or amphetamine.	CHAR	1	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	N
DTE_EFFECTIVE	The first date of service that the associated percentage is effective.	NUMBER	8	0	N
DTE_END	The last date of service, or dispense date, that this percentage is applicable.	NUMBER	8	0	N
PCT	The actual percentage value to be applied to the estimated acquisition cost to determine reimbursement amount.	NUMBER	4	3	N

Column Name	Description	Type	Length	Precision	Primary Key
IND_CONV	This column is used to identify EAC percentages to use with AWP rates that were converted from the mainframe system.	CHAR	1	0	N

2.13.135 T_EDIT_PARMS

Contains parameter values for edits. The value format will depend on the edit number and parameter type. For example, edit 513 compares the member first and last name on the claim to the values contained on T_RE_BASE. T_EDIT_PARMS will indicate which characters of the first (parameter type RFN) and last (parameter type RLN) name to compare against, that is, 513 RFN 01/01/2005 12/31/2299 XXX********** 513 RLN 01/01/2005 12/31/2299 XXXXX********* These entries would cause edit 513 to look at first 3 characters of first name and first 5 characters of last name.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_EDIT_PARM	Sak to make primary key unique	NUMBER	9	0	Y
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	N
CDE_PARM_TYPE	The parameter type	CHAR	10	0	N
DTE_EFF	Effective date for this parameter value	NUMBER	8	0	N
DTE_END	End date for this parameter value	NUMBER	8	0	N
DSC_PARM_VALUE	Value of the parameter (format will vary depending on edit number and parameter type)	VARCHAR2	4000	0	N

2.13.136 T_EDIT_RECYCLE

The Edit Recycle entity is used to maintain the parameter necessary to identify suspended claims that are recycled based on user defined criteria. Edits may be set up as a one-time request for claims to be recycled for a particular corrections cycle or edits may be set up permanently to recycle on a reoccurring frequency.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
IND_TYPE_CLMS	Value for the type of claim that can be processed in the MMIS system.	CHAR	1	0	Y
CDE_RECYCLE_TYPE	Indicates whether the recycle is a one-time request or an on-going request.	CHAR	1	0	Y
NUM_RECYCLE_DAY	Contains the day of the week that the recycle should occur.	NUMBER	1	0	N
NUM_DAYS	The number of days to recycle the edit/audit before it is assigned the final edit/audit.	NUMBER	4	0	N
SAK_FINAL_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	N

2.13.137 T_EDUCATION_CST

Medical education costs are costs incurred by a teaching hospital for training physicians, nurses, and other health care professionals. This is an additional add-on payment adjustment used in DRG pricing.

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The date the Education Cost took effect.	NUMBER	8	0	N
DTE_END	The date the Education Cost is no longer in effect.	NUMBER	8	0	N
AMT	Costs incurred by a teaching hospital for training physicians, nurses, and other health care professionals. Used for the statewide calculation.	NUMBER	9	2	N

2.13.138 T_ENC_BATCH_PROCESS

Table contains summary information related to a batch of encounters. Information is first added by the encounter splitter process, summarized by claims engine and updated by other batch processes. Information on this table is displayed in the Encounter page/panels.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_BATCH	System assigned key for the batch. This sak is the same as the SAK_UPLOAD in T_UPLOAD	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
DTE_PAY_CYCLE	The payment cycle date of the batch.	DATE	0	0	N
ORIG_CLM_TOT	The total count of newday claims in the batch.	NUMBER	9	0	N
ORIG_CLM_CNT	The number of newday claims in the batch that have been processed.	NUMBER	9	0	N
BAD_CLM_CNT	The number of claims not processed due to internal errors in the batch.	NUMBER	9	0	N
AMT_BILLED	The total amount billed for the batch.	NUMBER	13	2	N
AMT_PAID	The total amount paid for the batch.	NUMBER	13	2	N
IND_BAD_STATUS	Indicator updated when bad claims have been manually resolved.	CHAR	1	0	N
CDE_BATCH_STATUS	The status of the batch.	CHAR	1	0	N
ID_CREATE	The ID of the creating user or process.	CHAR	8	0	N
DTE_CREATE	The date the record was created.	DATE	0	0	N
ID_UPDATE	The ID of the last update user or process.	CHAR	8	0	N
DTE_UPDATE	The date the record was last updated.	DATE	0	0	N
DTE_PROCESSED_ENC	Date the batch was processed by Medicaid.	DATE	0	0	N
CNT_THRESHOLD	The count of threshold errors on the batch.	NUMBER	9	0	N
CNT_INFORMATIONAL	The count of informational errors on the batch.	NUMBER	9	0	N

2.13.139 T_ENC_ERR_THRESHLD

Table contains the threshold percentage segments as defined by the user. As batches of encounter data are processed, reject errors are tracked. Reject errors may result in rejection of a batch based on the encounter batch error rejection threshold.

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The start date of the encounter batch error threshold. segment.	NUMBER	8	0	Y
DTE_END	The end date of the encounter batch error threshold segment.	NUMBER	8	0	N
PCT_THRESHOLD	The percentage of reject errors that can occur before the batch of encounter data is rejected.	NUMBER	5	2	N

2.13.140 T_EOB

An Explanation of Benefit (EOB) which is assigned in claims processing.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_EOB	The system assigned key for the EOB table. This key will make it possible to renumber the EOB file in the future without affecting the other tables that carry EOB (such as claim or ESC).	NUMBER	9	0	Y
CDE_EOB	A code which represents a policy for Medicaid claim adjudication.	CHAR	4	0	N
DSC_EOB	This field is the first line of the nomenclature for an Explanation of Benefits that will be printed on the remittance advice.	CHAR	79	0	N
DSC_EOB2	This field is the second line of the nomenclature for an Explanation of Benefits that will be printed on the remittance advice.	CHAR	79	0	N
DSC_EOB3	This field is the third line of the nomenclature for an Explanation of Benefits that will be printed on the remittance advice.	CHAR	79	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DSC_EOB4	This field is the fourth line of the nomenclature for an Explanation of Benefits that will be printed on the remittance advice.	CHAR	79	0	N
DSC_EOB5	This field is the fifth line of the nomenclature for an Explanation of Benefits that will be printed on the remittance advice.	CHAR	79	0	N
DTE_EFFECTIVE	This is the date of service that the Explanation of Benefits code became effective.	NUMBER	8	0	N
CDE	Indication of what type of processing should be performed. This is used for processing of adjustments based on the EOB assigned as the adjustment reason.	CHAR	1	0	N
CDE_HC_CLM_STATUS	The HIPAA Health Care Claim Status Codes. Claim status codes communicate information about the status of a claim, that is, whether it's been received, pended, or paid.	CHAR	3	0	N
CDE_HC_ENTITY_ID	The HIPAA Health Care Claim Status Entity Identifier Code.	CHAR	2	0	N

2.13.141 T_EOB_ADJRSN_XREF

Cross reference of EOBs to adjustment reason codes.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_EOB	The system assigned key for the EOB table. This key will make it possible to renumber the EOB file in the future without affecting the other tables that carry EOB (such as claim or ESC).	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ADJ_RSN	System assigned key used internally by the system to uniquely identify an HIPAA Adjustment Reason code.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date the relationship between MMIS EOB codes and HIPAA adjustment reason codes becomes valid for use in processing.	NUMBER	8	0	Y
DTE_END	The last date the relationship between MMIS EOB codes and HIPAA adjustment reason codes is valid for use in processing.	NUMBER	8	0	N

2.13.142 T_EOB_MMIS

An Explanation of Benefit code that was assigned Kentucky MMIS processing. It is informational purposes only. Claims converted from MMIS will not have their EOB codes changed to the EOB codes used in the Kentucky system.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_EOB	System assigned key for EOBs used in the MMIS system.	NUMBER	9	0	Y
CDE_EOB	Code used to explain the processing of a claim (detail and header) in the MMIS. These codes will not be used in the MMIS system. It is used as information about claims that are converted from the MMIS system to AIM system.	NUMBER	4	0	N
DSC_EOB	First line of text description for MMIS EOB code.	CHAR	79	0	N
DSC_EOB2	Second line of text description for MMIS EOB code	CHAR	79	0	N
DSC_EOB3	Third line of text description for MMIS EOB code	CHAR	79	0	N
DSC_EOB4	Fourth line of text description for MMIS EOB code	CHAR	79	0	N
DSC_EOB5	Fifth line of text description for MMIS EOB code	CHAR	79	0	N

2.13.143 T_EOB_REMRKS_XREF

Cross reference of EOB to HIPAA remarks.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_EOB	The system assigned key for the EOB table. This key will make it possible to renumber the EOB file in the future without affecting the other tables that carry EOB (such as claim or ESC).	NUMBER	9	0	Y
SAK_REMARK	System assigned key used internally in the system to uniquely identify the HIPAA remark code.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date the relationship between MMIS EOB codes and HIPAA remark codes becomes valid for use in processing.	NUMBER	8	0	Y
DTE_END	The last date the relationship between MMIS EOB codes and HIPAA remark codes is valid for use in processing.	NUMBER	8	0	N

2.13.144 T_EOB_TYPES

Valid values and descriptions that will indicate what type of adjustment processing should be performed. The type is assigned to the Explanation of Benefit code. For example, 'A', full refund will cause claim status to be set to deny (no editing/auditing) and claim will pay zero dollars.

Column Name	Description	Type	Length	Precision	Primary Key
CDE	One character code used to identify the type of processing that should occur when an EOB is assigned. For example, A-full refund, U-underpayment, E-enter mass adjustment	CHAR	1	0	Y
DSC_50	Description of one character code.	CHAR	50	0	N

2.13.145 T_ERROR_DISP

List of the possible edits or audits that can be applied during processing in the MMIS.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
CDE_ESC	Code used to indicate an error was discovered on a claim during processing in the MMIS system. This can be either an edit or an audit.	NUMBER	4	0	N
DSC_ERROR_STAT	Description of an edit or an audit.	CHAR	50	0	N
IND_ALW_CCF	Indicates (Y/N) whether a claim correction form can be generated for the specific error code. Not used currently.	CHAR	1	0	N
IND_ALW_DENY	Indicates (Y/N) whether the claim should be allowed to deny upon review of the claim.	CHAR	1	0	N
IND_ALW_OVERIDE	Indicates (Y/N) whether a clerk should be allowed to override an edit/audit upon review of the claim.	CHAR	1	0	N
IND_COST_CONT	Indicates whether the error status code is a cost containment error.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_HDR_DTL_LVL	Indicates whether edit or audit should be set on the header - 'H', or detail - 'D' of a claim.	CHAR	1	0	N
IND_SD_PRE_EMPTIVE	Used to determine if the edit prevents short term spenddown from applying	CHARACTER	1	0	N
IND_CC_PRE_EMPTIVE	Used to determine if the edit is bypassed in Claim Check processing.	CHAR	1	0	N
IND_CC_PHTAR	Indicates if the error should be reported on the Potential History To Adjust Report.	CHAR	1	0	N
IND_CC_SAVINGS	Indicates if the error should be reported on the ClaimCheck / ClaimReview Savings Report.	CHAR	1	0	N
IND_CRITICAL	Indicator identifying if the ESC is critical and can not be inactivated or marked as pay (forced).	CHAR	1	0	N
IND_FORCE_MANUAL_PRICE	This is used to override IND_CRITICAL = "Y'. A 'Y' in this column means this ESC may be forced if the service is priced manually.	CHAR	1	0	N

2.13.146 T_ERROR_DISP_MMIS

List of the possible edits and audits used in the MMIS system. This table is used for informational purposes only, not in claims processing.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	Error status code system assigned key that uniquely identifies an ESC within the system.	NUMBER	9	0	Y
CDE_ESC	A code that corresponds to a particular edit/audit.	NUMBER	4	0	N
DSC_ERROR_STAT	Description of an edit/audit that is performed in the MMIS system.	CHAR	50	0	N

2.13.147 T_ERROR_EXTRACT

The PAID/DENIED claims which have an EOB/ Audit number to report on the estimated savings. The table contains claims data from paid, denied, claim error, error disposition and EOB tables.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_EOB	This is the number assigned to an explanation of benefits description to uniquely identify it.	NUMBER	4	0	Y
CDE_ESC	This is a number that corresponds to a particular edit/audit.	NUMBER	4	0	Y
DTE_GENERIC	Generic date	NUMBER	8	0	Y
CDE_CLM_TYPE	This is the value used to describe the type of Medicaid claim being processed.	CHAR	1	0	Y
AMT_PAID_ADJ	Contains the dollar amount paid for adjustment claims contained in this entity	NUMBER	12	2	N
AMT	This is the amount of money requested by a provider for payment. This can appear on the header or detail of a claim.	NUMBER	9	2	N

2.13.148 T_ERR_DISP_LINE

Detail dispositioning information concerning a specific edit/audit. The correct disposition detail to use for a claim will be determined based on the claim type, level of care, outcome (full failure or cutback), provider specialty, date of receipt, and date of service of the claim. If there is not an exact match on claim type or provider specialty, the defaults of 0 and 00 are used.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
SAK_ERROR_DISP	System assigned key used to define an occurrence of an error disposition for a specific edit/audit.	NUMBER	4	0	Y
SAK_PUB_HLTH	System assigned internal key for a medical assistance program.	NUMBER	9	0	Y
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	N
CDE_OUTCOME	Indicates how to handle the possible types of failure of an edit or audit (full failure or cutback).	CHAR	1	0	N
CDE_CLM_TYPE	Type of claim assigned to specified error criteria used for disposition of the claim.	CHAR	1	0	N
CDE_PROV_TYPE	Type that a provider is licensed for.	CHAR	2	0	N
CDE_PROV_SPEC	A code representing the specialized area of practice for a provider.	CHAR	3	0	N
DTE_EFFEC_DOR	Date claim processes in the system (date of receipt) for which the error should be set.	NUMBER	8	0	N
DTE_EFFEC_DOS	Date of service for which the error should be set.	NUMBER	8	0	N
CDE_DISP_STATUS	Indicates if a line item criteria is active or inactive.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_CLM_LOC	Type of location in which a claim can be placed during processing in the MMIS system.	CHAR	2	0	N
IND_RA_PRINT	Indicates if the error should be posted on the RA.	CHAR	1	0	N
CDE_PRINT_TYPE	Indicates if details that fail this edit/audit should produce a paper worksheet or appear on the edit list report.	CHAR	1	0	N

2.13.149 T_ERR_DISP_NOTES

Notes associated to Edit/Audit criteria. The notes are used to describe why changes were made to a specific edit/audit.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
NUM_SEQ	Sequence number of note.	NUMBER	9	0	Y
ID_CLERK	Logon user id.	CHAR	8	0	Y
DTE_NOTE	The date that the note was entered.	NUMBER	8	0	N
TME_NOTE	The time that the note was entered.	NUMBER	6	0	N
DSC_NOTE	The text of the note.	VARCHAR2	1000	0	N

2.13.150 T_ERR_DISP_PT_PS_X

This information will be used to include or exclude combinations of Provider type/specialty in/from participating in the disposition of the edit/audit.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
SAK_ERROR_DISP	System assigned key used to define an occurrence of an error disposition for a specific edit/audit.	NUMBER	4	0	Y
SAK_PUB_HLTH	System assigned internal key for a medical assistance program.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PR_ROLE	This is used to designate the role of the provider in the claim against which this criteria should apply. Valid codes are "B" for billing; "P" for performing; "R" for referring. For example, if the code is "B" then the Provider Type/Specialty of the Billing Provider will be used to match against the restriction in this table.	CHAR	1	0	Y
CDE_PR_TYPE	This is the code used to identify the Provider Type. A value of "00" will designate any type.	CHAR	2	0	Y
CDE_PR_SPEC	This is the code used to identify the Provider Specialty. A value of "000" will be used to designate any specialty.	CHAR	3	0	Y
CDE_PT_SPEC_EI	This code will state whether the type/specialty combination will be excluded (E) or included(I) in the restriction.	CHAR	1	0	N

2.13.151 T_ERR_RESO_CLRFCTNS

This table is basically like clarifications in COs. It allows users to add notes about why the edit resolution might be on hold, or what the issue is, and so on.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
DTE_CLARIFICATION		DATE	0	0	Y
DSC_CLARIFICATION		CLOB	0	0	N

2.13.152 T_ERR_RESO_CRIT

Describes the criteria for an error to set.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
DSC_CRITERIA		CLOB	0	0	N

2.13.153 T_ERR_RESO_GRP_XREF

Cross reference between an ESC and an error resolution group.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
SAK_GROUP_CLASS		NUMBER	9	0	Y
SAK_GROUP_TYPE	System assigned key for a unique Benefit Plan group that represents a single or collection of Benefit Plan codes.	NUMBER	9	0	Y
DTE_ERR_GRP_EFF	The date the group starts applying to this ESC	NUMBER	8	0	N
DTE_ERR_GRP_END	The last date the group applies to this ESC	NUMBER	8	0	N

2.13.154 T_ERR_RESO_MTHD_CORR

Contains the method of correction for specific error status codes.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
DSC_MTHD_CORR		CLOB	0	0	N

2.13.155 T_ERR_RESO_NOTES

Contains resolution clerk notes pertaining to special handling of an ESC.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
DSC_RESO_NOTES		CLOB	0	0	N

2.13.156 T_ERR_RESO_POLICY

Contains policy information related to an ESC.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_POLICY		VARCHAR2	80	0	N

2.13.157 T_ERR_RESO_STATUS

Code table of values of error resolution status codes. Valid values include: NOT REVIEWED ISSUE IDENTIFIED WORK READY FOR REVIEW APPROVED HOLD

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
SAK_RESO_STATUS		NUMBER	9	0	Y
DTE_ERR_RESO_STATUS		DATE	0	0	N

2.13.158 T_ESC_EOB_XREF

Contains the EOB (Explanation of Benefit) code that will be assigned to a claim header/detail for each ESC (Error Status Code) that may be posted as a result of an edit or audit. This EOB represents a meaningful message for the provider.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
SAK_EOB	The system assigned key for the EOB table. This key will make it possible to renumber the EOB file in the future without affecting the other tables that carry EOB (such as claim or ESC).	NUMBER	9	0	Y

2.13.159 T_ESC_NCPDP_XREF

Contains the SAKs of ESCs that map to NCPDP Error Codes. When a pharmacy POS claim fails an AIM edit, the system checks for a corresponding NCPDP error code. If one is found, the NCPDP code is returned on the response to the provider. Otherwise, the EOB which corresponds to the ESC is returned.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number	NUMBER	9	0	Y
CDE_ERROR_NCPDP	Contains one of the valid NCPDP values	CHAR	2	0	N

2.13.160 T_FINANCIAL_PAYER

The Financial payer will generally represent a unique organization responsible for the underwriting of the claims transactions to be paid.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	Y
SAK_FIN_CYCLE	The system assigned key that identifies a unique financial cycle within interChange.	NUMBER	9	0	N
NUM_HIER_ID_PAYER	This is another system assigned identifier that is used to identify a hierarchy thread that contains this Financial Payer.	NUMBER	9	0	N
CDE_FIN_PAYER	An optional business code value used to identify the payer. This code may be used for reporting or identifying payers on feeds to external systems.	CHAR	4	0	N
DSC_FIN_PAYER_SHORT	A short business description of the payer.	VARCHAR2	30	0	N
DSC_FIN_PAYER	A business description of the payer that will be used for reporting and windows.	VARCHAR2	1000	0	N
IND_RECOUP_OTH_PAY	Indicates whether this payer is allowed to recoup funds from other payers claims payments or only recoup funds from the same payers claim payments.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
IND_OTH_PAY_RECOUP	Indicates whether this payer allows other payers to recoup funds from this payers claim payments or if this payer does not allow this.	CHAR	1	0	N
IND_BUDGET	Indicates if this payer limits the amount of claims paid based on a budget.	CHAR	1	0	N
DTE_EFFECTIVE	The date the claim type to program restriction becomes effective for use in claims editing.	NUMBER	8	0	N
DTE_END	The last date the claim type to program restriction is effective for use in claims editing.	NUMBER	8	0	N
DTE_INACTIVE	This is the date this row becomes inactive. For new claims the system date is compared to this date. If the system date is greater than or equal to this date, the row will not be used to process the claim.	DATE	0	0	N

2.13.161 T_FIN_PAYER_COB

This represents pairs of Financial Payers that Coordinate payment of Benefits. These pairs are matched against pairs from threads in the PAYER hierarchy table (T_PAYER_HIERARCHY). The order of the SAK_FIN_PAYER is significant. It does not follow that if Payer 1 coordinates with Payer 2 that Payer 2 coordinates with Payer 1. For example a hierarchy thread may have Payer 1 followed by Payer 2. Another thread may have Payer 3 followed by Payer 2 and then Payer 1. Payer 1 may coordinate with Payer 2 in the first thread, but Payer 2 may not coordinate with Payer 1 in the second thread. If order is not relevant then two rows must be inserted in this table, one for each combination for the specific thread.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_FIN_COB_GRP	This is a unique identifier for a row on this table.	NUMBER	0	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	N
SAK_FIN_PAYER_CHILD	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	N
DTE_EFFECTIVE	The date the financial payer COB took effect	NUMBER	0	0	N
DTE_END	The date the financial payer COB is no longer in effect	NUMBER	0	0	N
DTE_INACTIVE	This is the date this row becomes inactive. For new claims the ICN is compared to this date. If the ICN date is greater than or equal to this date, the row will not be used to process the claim.	NUMBER	8	0	N

2.13.162 T_FIN_PAYER_REIMB

This is used to restrict the reimbursement method of a benefit to a Financial Payer.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_REIMB_AGRMNT	Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.	NUMBER	9	0	Y
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	Y

2.13.163 T_FMAP_PCT

Federal Medical Assistance Percentage (FMAP). The FMAP rate is that used for the Federal share of benefit payments.

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The first date of service to which this FMAP percentage should be applied	NUMBER	8	0	N
DTE_END	The last date of service to which this particular FMAP percentage should be applied	NUMBER	8	0	N
PCT	The actual FMAP percentage amount to be applied to calculate the state share amount.	NUMBER	6	5	N

2.13.164 T_GCN

Contains Generic Code Number Sequence Numbers.

Column Name	Description	Type	Length	Precision	Primary Key
NUM_DRUG_GCN_SEQ	The Generic Code Number Sequence Number (GCN_SEQNO) is a unique number representing a generic formulation. Like the GCN, it is specific to the generic ingredient(s), route of administration, and drug strength. Both are the same across manufacturers and/or package sizes. Unlike the GCN, which in some cases may have the same value for different dosage forms, the GCN_SEQNO is specific to its dosage form.	NUMBER	9	0	Y
NUM_GCN	The Generic Code Number (GCN) is a unique number representing the generic formulation. The GCN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GCN is the same across manufacturers and/or package sizes.	NUMBER	5	0	N

2.13.165 T_GCN_SEQNO_GROUP

This table provides a drug classification/grouping specific to active ingredient(s), route of administration, dosage form and drug strength. The same ID is assigned regardless of manufacturers and/or package sizes.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_GCN_SEQNO_TYPE	System assigned key for a unique GCN seqno type, which represents a single or collection of GCN sequence number.	NUMBER	4	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
NUM_FORMULATION_FROM	This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds either the FDB GCN Sequence Number or the Micromedex Generic Formulation Code.	NUMBER	6	0	Y
NUM_FORMULATION_TO	This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds either the FDB GCN Sequence Number or the Micromedex Generic Formulation Code.	NUMBER	6	0	Y
DTE_EFFECTIVE	The date that the GCN seqno grouping is to become effective for the GCN seqno type in processing.	NUMBER	8	0	Y
DTE_END	The last date that the GCN seqno grouping is in effect for the GCN seqno type in processing.	NUMBER	8	0	N

2.13.166 T_GCN_SEQNO_TYPE

A GCN sequence number type is associated with a group of GCN sequence number. Used to identify GCN for use in certain processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_GCN_SEQNO_TYPE	System assigned key for a unique GCN seqno type, which represents a single or collection of GCN sequence number.	NUMBER	4	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
DSC_GCN_SEQNO_TYPE	Description of GCN Sequence number grouping.	CHAR	25	0	N
DSC_DEFINITION	Definition of where and/or how this GCN Sequence Number group is used.	VARCHAR2	4000	0	N

2.13.167 T_GENERIC_DRUG

The generic drug classification is specific to ingredient combination, route of administration, dosage form and drug strength. It is also the same across manufacturers and/or package sizes.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG_GEN	The system assigned key for a unique generic drug.	NUMBER	9	0	Y
NUM_FORMULATION	This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds either the FDB GCN Sequence Number or the Micromedex Generic Formulation Code.	NUMBER	6	0	N
NUM_DRUG_GCN_SEQ	The Generic Code Number Sequence Number (GCN_SEQNO) is a unique number representing a generic formulation. Like the GCN, it is specific to the generic ingredient(s), route of administration, and drug strength. Both are the same across manufacturers and/or package sizes. Unlike the GCN, which in some cases may have the same value for different dosage forms, the GCN_SEQNO is specific to its dosage form.	NUMBER	9	0	N

Column Name	Description	Type	Length	Precision	Primary Key
NAM_DRUG_GENERIC	The first field (30 characters) is the generic drug name, the next is the route description (10), the next is the dosage form (10) and the last is the drug strength description(10). These fields are each separated by a space, for a total of 3 spaces.	CHAR	63	0	N
CDE_ROUTE_ADMIN	This field contains a meaningful abbreviation of the normal method by which a drug is administered. Some abbreviations include: IV = Intravenous (only), DT = Dental and NS = Nasal. GCRT on NDDF.	CHAR	2	0	N
CDE_STATE_VAR	This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re-add; 4 = delete.	CHAR	1	0	N
SAK_DRUG_THERA_CLS	The system assigned key for a unique drug therapeutic class.	NUMBER	9	0	N
NUM_DRUG_HICL_SEQ	ID representing a drug's active ingredient list. For FDB implementations, this holds the HICL Sequence Number. For Micromedex, this holds the Generic Cross-Reference (GCR) code.	NUMBER	6	0	N
CDE_DOSAGE_FORM	An abbreviated two-byte code (GCDF on NDDF update) is available for applications. Users may request the code in addition to or instead of the description.	CHAR	2	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DSC_STRENGTH	The Drug Strength Description (STR) is a description of drug potency in units of grams, milligrams, percentage, and other terms. Strength is expressed in metric units. This field includes needle sizes, length of devices, and release rates of transdermal patches.	CHAR	10	0	N
NUM_THERA_CLS_GEN	The Therapeutic Class Code, Generic (GTC) is used to classify drugs according to the most common intended use. This classification provides the broadest therapeutic groupings available in NDDF. Users that need more definitive therapeutic classing should consider Therapeutic Class, Standard (TC), Therapeutic Class, Specific (GC3), or the Therapeutic Class, AHFS (AHFS).	NUMBER	2	0	N
NUM_THERA_CLS_STD	The Therapeutic Class Code, Standard (TC) can be used to classify drugs according to the most common intended use. This therapeutic classification is intended to service those users who need a definitive but not comprehensive therapeutic classification system. Comprehensive therapeutic classification is provided by Therapeutic Class, Specific (GC3), Therapeutic Class, AHFS (AHFS), or Therapeutic Class, Generic (GTC).	NUMBER	2	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DRUG_CATGRY	The Drug Category Code (DCC) indicates that a drug product belongs to a category that is commonly treated as an exception in third party plans.	CHAR	1	0	N
IND_GCNSEQ_GI	The Generic Indicator (GI) differentiates single-source from multiple-source drugs. Valid values are: 1 = Multiple source 2 = Single source This is the GCNSEQ_GI on NDDF update.	CHAR	1	0	N
IND_GENDER	The Gender-Specific Drug Indicator (GENDER) identifies drugs that are used for a specific gender. It can be used to help determine appropriateness of therapy based upon the sex of the patient (or to infer the sex of a patient). An indicator value is attached to the Generic Code Number (GCN) or the Generic Code Number Sequence Number (GCN_SEQNO) which identifies whether it is used in males or females or both.	CHAR	1	0	N
NUM_HIC3_SEQN	Hierarchical Specific Therapeutic Class Code Sequence Number (HIC3_SEQN on NDDF update).	NUMBER	6	0	N

Column Name	Description	Type	Length	Precision	Primary Key
NUM_GCN	The Generic Code Number (GCN) is a unique number representing the generic formulation. The GCN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GCN is the same across manufacturers and/or package sizes. The number by itself has no significance, but is useful for online computer applications, such as generic substitution.	NUMBER	5	0	N
CDE_THERA_CLS_AHFS	The Therapeutic Class Code, AHFS identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system. For FDB implementations, it is an 8-character field as supplied by ASHP (American Society of Health-System Pharmacists). For MDX implementations, it is a 10-digit code; the first 6 digits represent the AHFS Drug Information Classification System as supplied by ASHP, and the last four digits are a suffix added by Micromedex to differentiate the product's ingredient formulation.	CHAR	10	0	N

2.13.168 T_GEN_RATES

This Entity contains rates for the QI-2 processing but is also step up to contain any that is non admin related

Column Name	Description	Type	Length	Precision	Primary Key
CDE_CATEGORY		CHAR	1	0	Y
DTE_EFFECTIVE		NUMBER	8	0	Y
DTE_END		NUMBER	8	0	N
AMT_GENERIC_DOLLAR		NUMBER	9	2	N

2.13.169 T_GPCI

Geographic practice cost indexes (GPCIs) are adjustment factors used to adjusts the three RVU components in RBRVS pricing. The GPCIs are divided into practice expenses, malpractice expenses, and relative cost of physician work.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_LOCALITY	This field indicates the locality code for a provider to indicate if the provider practices in an urban, metropolitan, rural, or out-of-state location.	CHAR	2	0	Y
DTE_EFFECTIVE	The date the GPCI for a location becomes valid for use in claims processing.	NUMBER	8	0	Y
DTE_END	The date the GPCI for a locality is no longer valid for claims processing.	NUMBER	8	0	N
NUM_GPCI_M	The malpractice expense geographic adjustment factor used in computing the RBRVS fee schedule amount.	NUMBER	5	3	N
NUM_GPCI_PE	The practice expense geographic adjustment factor used in computing the RBRVS fee schedule amount.	NUMBER	5	3	N
NUM_GPCI_W	The work geographic adjustment factor used in computing the RBRVS fee schedule amount.	NUMBER	5	3	N

2.13.170 T_GROUP_STD_BNFT

This is the "leaf" node of the benefit hierarchies. The bottom group in the T_BNFT_GROUP_STD points to this table and relates that leaf group to a specific benefit.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_BNFT_GROUP	System assigned key for a unique benefit group.	NUMBER	9	0	Y
CDE_BENEFIT_TYPE	The benefit type code is used to identify the coding scheme for a service. Valid schemes include procedure (HCPCS & CPT-4), ICD-9-CM procedures, ICD-9-CM diagnosis, Revenue Code and Drug codes (NDCs). Other allowed values may identify GROUPS of benefits such as Procedure groups and so on..	CHAR	3	0	Y
SAK_BENEFIT	System assigned key for a unique drug	NUMBER	9	0	Y
SAK_CLASS_HIERARCHY	Unique row identifier for this table.	NUMBER	9	0	Y

2.13.171 T_GROUP_TYPE

Describes groups used for error resolution.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_GROUP_CLASS		NUMBER	9	0	Y
DSC_GROUP_CLASS	This is the description for the group class that will be displayed on the resolution window. Examples: Procedure Groups, Diagnosis Groups	VARCHAR2	4000	0	N

Column Name	Description	Type	Length	Precision	Primary Key
NAM_TABLE	This is the name of the table that contains the groups of a Group Class. For example, if the Group Class is Procedure group then the table name is T_PROC_TYPE	VARCHAR2	40	0	N

2.13.172 T_HC_CLM_STATUS

Claim Status codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-2, STC10-2 and STC11-2 composite elements. They indicate the detail about the general status communicated in the Claim Status Category Codes carried in STC01-1, STC10-1 and STC11-1. For users who are new to the Claim Status transaction, please review the guidelines for utilizing claim status codes. Claim status codes communicate information about the status of a claim, that is whether it has been received, pended or paid. The Claim Status transaction is not used as a financial transaction.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_HC_CLM_STATUS	The HIPAA Health Care Claim Status Codes. Claim status codes communicate information about the status of a claim, that is, whether it's been received, pended, or paid.	CHAR	3	0	Y
DSC_HC_CLM_STATUS	Description of the Health Care Claim Status Code.	VARCHAR2	200	0	N

2.13.173 T_HC_CLM_STAT_CAT

Claim Status Category codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-1, STC10-1 and STC11-1 composite elements. They indicate the general category of the status (accepted, rejected, additional information requested and so on) which is then further detailed in the Claim Status Codes carried in STC01-2, STC10-2 and STC11-2. Claim status codes communicate information about the status of a claim.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_CLM_CAT_STATUS	HIPAA Claim Category Status Code.	CHAR	2	0	Y
DSC_CLM_CAT_STATUS	Description of HIPAA Claim Category Status Codes	VARCHAR2	200	0	N

2.13.174 T_HC_ENTITY_ID

The MMIS will be using the 277 Claim Status Request Response as a response to the 276 Claim Status Request. The 277 format includes a segment to return EOBs associated to a claim. However, HIPAA has their own codes for EOBs associated to the claim. The two elements used on the 277 are in the Claim Level Status Information, elements STC01-2 (Health Care Claim Status Code), and STC01-3 (Health Care Claim Status Entity Identifier Code).

Column Name	Description	Type	Length	Precision	Primary Key
CDE_HC_ENTITY_ID	The HIPAA Health Care Claim Status Entity Identifier Code.	CHAR	2	0	Y
DSC_HC_ENTITY_ID	Description of Health Care Claim Status Entity Identifier Code.	VARCHAR2	200	0	N

2.13.175 T_HICL_CLASS_XREF

A cross-reference of what therapeutic classes are treated with what drugs

Column Name	Description	Type	Length	Precision	Primary Key
SAK_HICL_XREF	The system assigned key of the HICL Class XREF Table	NUMBER	9	0	Y
NUM_DRUG_HICL_SEQ	The HICL Sequence Number is a unique and randomly assigned 6 byte numeric field which provides a link from either the NDC or the GCN Sequence Number record to the Hierarchical Ingredient Code List. It can serve as an association which reduces redundancy.	NUMBER	9	0	N
CDE_STATE_VAR	This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re-add; 4 = delete.	CHAR	1	0	N
SAK_DRUG_THERA_CLS	The system assigned key for a unique drug therapeutic class.	NUMBER	9	0	N

2.13.176 T_HICL_SEQ_NO

The HICL Sequence Number (HICL_SEQNO) is a six-byte numeric field which provides a link from either an NDC or a GCN Sequence Number record to the Hierarchical Ingredient Code List. The HICL_SEQNO can serve as an association which reduces data redundancy by consolidating the occurrences of HICLs at the NDC or GCN_SEQNO levels, or it can be used to uniquely identify a product's ingredient combination. A HICL_SEQNO can be used to identify a unique combination of ingredients, irrespective of the manufacturer, package size, dosage form, drug strength, or route of administration. The HICL Sequence Number can be combined with the specific therapeutic class, route code, dosage form code, and/or strength description for specialized Drug Utilization Review reporting applications.

Column Name	Description	Type	Length	Precision	Primary Key
NUM_INGRED_LIST	ID representing a drug's active ingredient list. For FDB implementations, this holds the HICL Sequence Number. For Micromedex, this holds the Generic Cross-Reference (GCR) code.	NUMBER	6	0	Y
NAM_GENERIC	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. For multi-ingredient products, abbreviations may be used (such as HCTZ [Hydrochlorothiazide] and PP [Phenylpropanolamine]). Although this field is free-format, the data has been generated from a table to provide consistent spelling and sequence for sorting and reporting applications.	VARCHAR2	30	0	N
NAM_GENERIC_LONG	USAN Generic Name (Long Description).	VARCHAR2	60	0	N

2.13.177 T_HIERARCHY_NODE

A given thread may have as many participants as required by business policy. This table is used to identify the participating entities as well as the processing sequence within the thread. The entity types in a thread are benefit plans.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_THREAD	System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment Plans for beneficiaries who are enrolled in multiple entities of any of these types..	NUMBER	9	0	Y
SAK_PUB_HLTH	System assigned internal key for a member plan.	NUMBER	9	0	N
NUM_SEQUENCE_THREAD	This column determines the processing order for the entities participating in the thread. For example, if the thread is of type 'PAYR', then this sequence number determines which Financial Payer will be processed first, second, and so on.	NUMBER	4	0	N

2.13.178 T_HIPAA_ADJRSN_XRF

This table contains the HIPAA adjustment reason code mapped to TPL A/R reason code

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ADJ_RSN	System assigned key used internally by the system to uniquely identify an HIPAA Adjustment Reason code.	NUMBER	9	0	Y
CDE_REASON_TWO	The reason that the A/R disposition was added.	CHAR	2	0	Y

2.13.179 T_HOSPICE_RATE

This table will identify the Hospice level of care rate based upon both the revenue code (group) and county code billed. This rate is date specific.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_COUNTY	The 2 digit county number used to identify a geographical and/or political area in the state. CHAR	CHAR	2	0	Y
SAK_REV_TYPE	System assigned key for a unique revenue type, that represents a single or collection of revenue codes.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date the hospice rate took effect.	NUMBER	8	0	Y
DTE_END	The date the hospice rate is no longer in effect.	NUMBER	8	0	N
AMT	The hospice level of care rate.	NUMBER	9	2	N

2.13.180 T_INP_LOC

This entity contains the Inpatient Level of Care Rate.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_LOC	A code that identifies the provider level of care, such as skilled, intermediate, developmentally disabled	CHAR	3	0	Y
DSC_LOC	The text description of the provider level of care associated with the code indicator	CHAR	100	0	N

2.13.181 T_INP_LOC_RATE

This table is used to determine the per diem rate for the provider who is providing a particular level of care for a member

Column Name	Description	Type	Length	Precision	Primary Key
CDE_LOC	A unique code identifying a specific provider level of care	CHAR	3	0	Y
SAK_SHORT	System assigned key for level of care	NUMBER	4	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The first date that this level of care rate is effective; compared to the actual claim processed	NUMBER	8	0	N
DTE_END	The last date to apply this level of care rate to claims, as compared to the actual claim	NUMBER	8	0	N
AMT	The per diem rate to be paid for the related level of care.	NUMBER	9	2	N

2.13.182 T_LAB_FEE

Lab fee schedule used in pricing claims billing lab fee tests.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y
DTE_EFFECTIVE	Date lab fee schedule becomes active (effective) for claims processing.	NUMBER	8	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	N
DTE_END	Date lab fee schedule is no longer active for claims processing.	NUMBER	8	0	N
CDE	Used to determine the pricing methodology for the lab test procedure (this is the procedure exemption code). Values are "B" (blood product), "E" (exempt from fee schedule), "M" (multichannel procedure) and "R" (related lab test).	CHAR	1	0	N
AMT_60_PCT	The lab fee reimbursement rate base on 60% of the lab fee schedule.	NUMBER	9	2	N
AMT_62_PCT	The lab fee reimbursement rate base on 62% of the lab fee schedule.	NUMBER	9	2	N

2.13.183 T_LIMITPARM_POS

List of the place of services that are included or excluded from limitation auditing.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
CDE_POS	Code representing the place of service which should be included or excluded from limitations.	CHAR	2	0	N

2.13.184 T_LIMIT_PARM

This table contains the limitation audit parameters, including the time span audited, the number of allowed units and/or dollars, and whether the audit is restricted to particular places of service.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
CDE_UNIT_TYPE	Indicates whether units, dollars, or both should be used as the unit of measure for audit.	CHAR	1	0	N
IND_POS	Indicates (Y/N) whether place of service will be used as a limit criteria.	CHAR	1	0	N
QTY_LIMIT_UNITS	Maximum number of units allowed for specified services.	NUMBER	9	2	N
QTY_LIMIT_DOLL	Maximum dollar amount allowed for specified services.	NUMBER	9	2	N
CDE_TIME_UNIT	Indicates whether days, months, or years should be used as a unit of measure for an audit.	CHAR	1	0	N
NUM_UNIT_BEFORE	Specifies the number of units (days, months, years) in history that should be checked before a claim's dates of service.	NUMBER	4	0	N
CDE	This code indicates whether the limitation audit limits procedure codes ( ) or revenue codes (R).	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DAYS_CONSEC	Determine if the number of days must be consecutive	CHAR	1	0	N
CDE_50_PCT_APPLY	Determine if the units should be halved if first claim is after July 1	CHAR	1	0	N
CDE_COMP_DAYS	value 'Y' causes last compensable day to be re-calculated	CHAR	1	0	N
CDE_BENEFIT_CATEGORY	The key to define the criteria for a benefit limit audit	CHAR	2	0	N
CDE_BENEFIT_LIMIT_KEY	This defines a contact by member, member and provider, pharmacy or dental	CHAR	1	0	N
CDE_BENEFIT_CATEGORY_SUSP	Corresponding Benefit category to cde_benefit_category So that suspended counts can be separated.	CHAR	2	0	N

2.13.185 T_LOCALITY

Locality and description used to indicate whether a provider is located in an urban, rural, metropolitan, or out-of-state area.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_LOCALITY	Locality code used to indicate geographical area of practice for a provider. Valid values include 01 - Metropolitan, 02 - Urban, 03 - Rural, 07 - Out-of-state, and 99 - Statewide.	CHAR	2	0	Y
DSC_LENGTH_15	Text description of pricing locality. Valid values are metropolitan, rural, urban, out-of-state, statewide.	CHAR	15	0	N

2.13.186 T_LOCATION

High level classification of the processes performed in the system. For example, all edits that pertain to member information is one classification.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_LOCATION	Type of location in which a claim can be placed during processing in the MMIS system.	CHAR	2	0	Y
DSC_LOCAT_TYPE	Description of the type of location in which a claim can be placed during claims processing.	CHAR	50	0	N
CDE_SEVER_LOC	Indicates the priority of the claim location.	CHAR	2	0	N
IND_EXTERNAL	Indicates whether the location is external to the Fiscal Agent (EDS). If it is an "X" then the location is external and should be treated like a CCF location in the MAR performance reports. If it is " " then the location is within the EDS control.	CHAR	1	0	N
IND_INTEREST	A 'Y' indicates that the code location is acceptable in a claim interest calculation. An 'N' indicates that if the claim has ever been in this location to exclude the entire claim from a claim interest calculation.	CHAR	1	0	N

2.13.187 T_LTC_LEAVE_RATE

Contains long term care leave rates.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_LOC	A unique code identifying member level of care	CHAR	3	0	Y
PCT_LEAVE_RATE	The percentage of the regular per diem rate for the level of care in the nursing home that the claim is billed for	NUMBER	5	2	Y
DTE_EFFECTIVE	Begin date to a rate segment.	NUMBER	8	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	N
DTE_END	End date to a rate segment.	NUMBER	8	0	N

2.13.188 T_MARG_COST

"State wide" marginal cost factor used in DRG calculation. It represents the marginal cost of care beyond the outlier threshold.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	N
DTE_EFFECTIVE	The date the Marginal Cost Factor took effect.	NUMBER	8	0	N
DTE_END	The date the Marginal Cost Factor is no longer in effect.	NUMBER	8	0	N
NUM_COST_FACTOR	This is the marginal cost of care beyond the outlier threshold. Used for the state-wide calculation.	NUMBER	4	2	N

2.13.189 T_MAX_FEE

Maximum Fee for a Procedure/Modifier combination (Level III pricing). For any given procedure code there usually is a "base" price. This occurs when the values for all four modifiers is equal to space and the cde_rate_type is equal to "DEF". When inserting a row on this table with modifier values other than spaces, the modifiers MUST be sorted in ascending sequence from cde_proc_mod to cde_proc_mod4.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	Y
CDE_PROC_MOD	The modifier code used to further describe a procedure.	CHAR	2	0	Y
CDE_PROC_MOD2	Pricing modifier used to identify the appropriate max fee for a procedure modifier combination.	CHAR	2	0	Y
CDE_PROC_MOD3	The modifier code used to further describe a procedure.	CHAR	2	0	Y
CDE_PROC_MOD4	The modifier code used to further describe a procedure.	CHAR	2	0	Y
DTE_EFFECTIVE	The date a max fee rate for a procedure/modifier combination becomes effective for claims processing.	NUMBER	8	0	Y
DTE_END	The date a max fee rate for a procedure/modifier combination is no longer in effect for claims processing.	NUMBER	8	0	N
AMT	The maximum fee amount that may be paid for a procedure.	NUMBER	9	2	N
NUM_REL_VALUE	Relative value unit is a grading of the relative difficulty of all medical services and procedures and is used in determining claims payment.	NUMBER	4	1	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_INACTIVE	This is the date this row becomes inactive. For new claims the ICN is compared to this date. I the ICN date is greater than this date, the row will not be used to process the claim.	DATE	0	0	N

2.13.190 T_MC_DIAG_RATE

This entity is used to store the managed care rate cell that is assigned to an ICD9 diagnosis code. The capitation process for the MCPD program will use this entity to calculate the payments to be made to the MCOs. Each MCPD member will be assigned a primary diagnosis code and each primary diagnosis code will be assigned to a rate cell. When the capitation process runs, the system will use the member's current primary diagnosis code to select the rate cell from this entity. The rate cell will then be used to obtain the capitation amount for that MCO.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DIAG	System assigned key for the diagnosis.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date that the assignment of the diagnosis code to the rate cell becomes effective.	NUMBER	8	0	Y
SAK_RATE_CELL	The system assigned key used to uniquely identify a managed care rate cell.	NUMBER	9	0	N
DTE_END	The date that the assignment of the diagnosis code to the rate cell is no longer effective.	NUMBER	8	0	N

2.13.191 T_MC_SVC_CLASS

The Managed Care service class describes the type of services provided.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_MC_SVC_CLASS	The service class indicates the type of services provided.	CHAR	2	0	Y
DSC_MC_SVC_CLASS	Description of the type of services provided.	VARCHAR2	100	0	N

2.13.192 T_MDC

An MDC is determined by dividing all possible principal diagnoses into mutually exclusive principal diagnosis categories. These are used in conjunction with DRGs to further define a grouping.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_MDC	System assigned key for a unique Major Diagnostic Category code.	NUMBER	9	0	Y
CDE_MDC	This is a two byte code field used to identify a MDC. The MDC code and description are supplied by HCIA.	CHAR	2	0	N
DSC_MDC	This is a forty byte character field used to describe a MDC. The MDC code and description are supplied by HCIA.	CHAR	40	0	N

2.13.193 T_MODIFIER

A modifier provides the means by which the reporting physician or provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the member of a report that: 1. A service or procedure has both a professional and technical component. 2. A service or procedure was performed by more than one physician and/or in more than one location. 3. A service or procedure has been increased or reduced. 4. Only part of a service was performed. 5. An adjunctive service was performed. 6. A bilateral procedure was performed. 7. A service or procedure was provided more than once. 8. Unusual events occurred. The attribute CDE indicates the type of modifier as follows: Code Description Affect on Claim. D Denial Will cause a detail to deny. 1 Pricing Used to "look up" the allowed amount for a procedure. 2 Processing Will change the allowed amount by a specified percentage or dollar amount or change allowed units by a specified quantity. 3 Informational Provides additional information about the procedure performed. 4 Review Indicates that the detail should be suspended for manual review. M Max Payment Indicates the maximum payment allowed for a procedure billed with modifier of this type. The effective date is used to specify when the modifier and it's type is effective for claims processing.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROC_MOD	The modifier code used to further describe a procedure.	CHAR	2	0	Y
DTE_EFFECTIVE	The date that the modifier and its type are to become effective for claims processing.	NUMBER	8	0	N
DTE_END	The date that the modifier and its type are no longer in effect for claims processing.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DSC_MODIFIER	Short text that describes the modifier.	VARCHAR2	40	0	N
DSC_LONG	Long text that describes the modifier.	VARCHAR2	4000	0	N
CDE	Describes the usage/type of the modifier. Valid values are Pricing (1), Processing (2), Information (3), and Suspend for Manual Review (4).	CHAR	1	0	N
SAK_MODIFIER	This is a unique identifier for a row on this table.	NUMBER	9	0	N
CDE_CATEGORY	Indicates whether the modifier is a HCPCS or Ambulance Modifier. Valid values are A(Ambulance) and H(HCPCS)	CHAR	1	0	N
DTE_CMS_ADD	Date that CMS added the Modifier	NUMBER	8	0	N
DTE_CMS_TERM	Date that CMS terminated the Modifier.	NUMBER	8	0	N

2.13.194 T_MODIFIER_NOTES

This table will allow online users to add notes for a modifier code.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_MODIFIER	This is a unique identifier for a row on this table.	NUMBER	9	0	Y
NUM_SEQ	Sequence number of note.	NUMBER	9	0	Y
ID_CLERK	User ID of person who is logged in.	VARCHAR2	8	0	N
DTE_NOTE	The date that the note was entered.	NUMBER	8	0	N
TME_NOTE	The TIME that the note was entered.	NUMBER	6	0	N
DSC_NOTE	The text of the note.	VARCHAR2	1000	0	N

2.13.195 T_MODIFIER_RSTN

Contains modifiers that are invalid when billed on the same detail of a claim.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROC_MOD	The modifier code used to further describe a procedure.	CHAR	2	0	Y
CDE_MOD_FROM	The lower range of modifier restrictions. Modifiers in the From/To range can not be billed on the same claim detail as the value in CDE_PROC_MOD	CHAR	2	0	Y
CDE_MOD_TO	The upper range of modifier restrictions. Modifiers in the From/To range can not be billed on the same claim detail as the value in CDE_PROC_MOD	CHAR	2	0	Y
DTE_EFFECTIVE	Start date of the procedure/diagnosis restriction.	NUMBER	8	0	N
DTE_END	Stop date of the procedure/diagnosis restriction.	NUMBER	8	0	N

2.13.196 T_MODIFIER_TYPE

A modifier is assigned a modifier type. The modifier types are used to describe the way a modifier will be used in claims processing. A modifier can only be assigned to one type.

Column Name	Description	Type	Length	Precision	Primary Key
CDE	Code used to identify type of modifier.	CHAR	1	0	Y
DSC_25	Text description for a modifier type.	CHAR	25	0	N

2.13.197 T_MOD_GROUP

A grouping of modifier codes

Column Name	Description	Type	Length	Precision	Primary Key
SAK_MOD_TYPE	System assigned key for a unique modifier grouping type, that represents a collection of modifier codes.	NUMBER	9	0	Y
CDE_MOD_FROM	The modifier code used to further describe a procedure.	CHAR	2	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_MOD_TO	The modifier code used to further describe a procedure.	CHAR	2	0	Y
DTE_EFFECTIVE	The date this modifier group/provider type/specialty restriction becomes effective for claims processing.	NUMBER	8	0	N
DTE_END	The date this modifier group stops being effective for claims processing.	NUMBER	8	0	N

2.13.198 T_MOD_GROUP_TYPE

A code table which provides the description of modifier groups.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_MOD_TYPE	System assigned key for a unique modifier grouping type, that represents a collection of modifier codes.	NUMBER	9	0	Y
DSC_50	Describes the modifier group type.	VARCHAR2	50	0	N
DSC_DEFINITION	Definition of where and/or how this modifier group is used.	VARCHAR2	4000	0	N

2.13.199 T_MULT_SURG_PCT

A national multiple surgery processing and payment policy has been established by HCFA for multiple contemporaneous surgeries. Procedures subject to the multiple surgery reductions are identified by a multiple surgery indicator of 1, 2, or 3 on the Medicare Fee Schedule Database. During multiple surgery processing, details of a claim are ranked from highest to lowest based on matching provider, date of service and allowed amount. The type (General Surgery, Dermatology Surgery or Endoscopic Surgery) and ranking of a procedure determines the multiple surgery reduction that is to be applied.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_TYPE	Indicates which payment adjustment rules for multiple surgery procedures apply to a service. 1 = Standard payment adjustment (General Surgery), 2 = Rules for Dermatology services apply, and 3 = Rules for Endoscopic services apply.	CHAR	1	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The date multiple surgery percentages become valid for use in claims processing.	NUMBER	8	0	Y
DTE_END	The date multiple surgery percentages are no longer valid for use in claims processing.	NUMBER	8	0	N
NUM_RANK_LOWER	Lower limit of range of multiple surgery detail rankings. Rankings are used to determine the multiple surgery percentage to apply.	NUMBER	4	0	N
NUM_RANK_UPPER	Upper limit of range of multiple surgery detail rankings. Rankings are used to determine the multiple surgery percentage to apply.	NUMBER	4	0	N
PCT	Multiple surgery percentage to be applied to a claim detail.	NUMBER	3	2	N

2.13.200 T_NCPDP_CONFLICT

Contains NCPDP conflict information

Column Name	Description	Type	Length	Precision	Primary Key
CDE_NCPDP_CONFLICT	The code assigned by NCPDP for the conflict.	CHAR	2	0	Y
DSC_NCPDP_CONFLICT	The text description of the NCPDP conflict code assigned by NCPDP.	VARCHAR2	50	0	N

2.13.201 T_NCPDP_OTH_COV

NCPDP Other Coverage Code Reference Table (AIM partition only)

Column Name	Description	Type	Length	Precision	Primary Key
CDE_OTHER_COVERAGE	Code indicating whether or not the patient has other insurance coverage.	CHAR	2	0	Y
DSC_OTHER_COVERAGE	Description of Other Coverage Code	VARCHAR2	100	0	N

2.13.202 T_NCPDP_RESPONSE

Represents the responses in POS for claims that are rejected by the system.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_ERROR_NCPDP	Unique code number/value assigned to a specific reject message per National council for prescription drug pricing	CHAR	2	0	Y
DSC_50	Text description associated with specific NCPDP response code value	CHAR	50	0	N

2.13.203 T_NDDF_PRICE

This is the National Drug Code (NDC) Price Table received as part of the NDDF update process. The NDC Price Table Type (CDE_NPT_TYPE) defines the type of rate on each row.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG	System assigned key for a unique drug	NUMBER	9	0	Y
CDE_NPT_TYPE	The National Drug Code (NDC) Price Type.	CHAR	2	0	Y
SAK_SEQUENCE	Sequence number of rows used to make a unique key without using the effective date of the row as part of the primary key.	NUMBER	8	0	Y
DTE_EFFECTIVE	Effective date of the associated price.	NUMBER	8	0	N
AMT_NPT_PRICE	NDC Price Table Rate.	NUMBER	12	5	N
DTE_END	End date of the associated price.	NUMBER	8	0	N
IND_STATUS	Indicates whether the pricing segment is in an active ('0') or inactive ('1') status. Only active segments will be used for pricing. Inactive segments will be maintained for historical purposes.	CHAR	1	0	N
DTE_SEG_ADDED	The date the pricing segment was created.	NUMBER	8	0	N

2.13.204 T_NDDF_PRICE_TYPE

NDC Price Type Description Table. Values and definitions are from the NDDF manual.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_NPT_TYPE	The National Drug Code (NDC) Price Type.	CHAR	2	0	Y
DSC_NPT_TYPE	The Abbreviated Description of the National Drug Code Price Type.	CHAR	6	0	N
DSC_NPT_TYPE_DEF	The Definition of the Description of the National Drug Code Price Type.	VARCHAR2	100	0	N

2.13.205 T_OCCURRENCE

Valid values and descriptions of codes which define a significant event relating to a particular UB04 claim that may affect payer processing.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_OCCURRENCE	Code which defines a significant event relating to a particular UB04 claim that may affect payer processing.	CHAR	2	0	Y
DSC_OCCURRENCE	Date on which a significant event relating to a particular UB04 claim that may affect payer processing occurred.	CHAR	50	0	N

2.13.206 T_OUTLIER_THRESHLD

Cost outlier cases for inpatient claims are determined according to a threshold established by the State. The Outlier threshold will be the greater of the DRG Rate multiplied by the Outlier Trim Point or a predetermined dollar amount. For purposes of establishing outlier payment amounts, prospective determination of costs per inpatient stay shall be calculated by multiplying a cost-to-charge ratio by submitted and approved charges. Outlier payment amounts shall be equal to a percentage of the difference between the prospective cost per stay and the outlier threshold amount.

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	Date outlier threshold becomes valid for use in claims pricing.	NUMBER	8	0	N
DTE_END	Date outlier threshold is no longer valid for use in claims pricing.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
NUM_OTLR_THRHLD	Dollar amount used in outlier payment determination. The outlier threshold used in outlier payment calculation will be the greater of the DRG Rate multiplied by the Outlier Trim Point or the predetermined Outlier Threshold dollar amount.	NUMBER	7	2	N
NUM_TRIM_POINT	Factor used in outlier threshold determination. The outlier threshold used in outlier payment calculation will be the greater of the DRG Rate multiplied by the Outlier Trim Point or the predetermined Outlier Threshold dollar amount.	NUMBER	9	0	N

2.13.207 T_OVERHEAD_FEE

The HH Overhead Fee entity is used for new Home Health pricing. If the Occurrence code on the claim exits in this table for the correct date range, then it's associated Overhead amount is added to the detail's allowed amount.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_OCCURRENCE	Code which defines a significant event relating to a particular UB04 claim that may affect payer processing.	CHAR	2	0	Y
DTE_EFFECTIVE	This field contains the beginning date for this Overhead Fee segment.	NUMBER	8	0	Y
DTE_END	This field contains the end date for this Overhead Fee segment.	NUMBER	8	0	N
AMT	This field contains the Overhead amount that is added to the allowed amount when pricing new Home Health.	NUMBER	9	2	N

2.13.208 T_PATIENT_STAT

Indicates all valid patient status values and their descriptions.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PATIENT_STATUS	Indicates the status of the member as of the ending service date of the period covered on a UB04 claim.	CHAR	2	0	Y
DSC_PATIENT_STATUS	Description of the status of the member as of the ending service date of the period covered on a UB04 claim.	CHAR	80	0	N

2.13.209 T_PAYER_HIERARCHY

The PAYER hierarchy contains the threads used to control the order of claim adjudication at the PAYER level. Payer threads are ordered sets of Payers that may cover a member concurrently.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_THREAD_PAYER	System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers for member beneficiaries who are concurrently enrolled under multiple payers.	NUMBER	9	0	Y
DTE_EFFECTIVE	Date the hierarchy thread becomes valid for use in claims processing.	NUMBER	8	0	N
DTE_END	The last date the thread is valid for use in claims processing. The thread may still be used when the date of service on the claim is within the effective dates of the thread. To stop the use of a particular thread altogether the DTE_INACTIVE date must be used.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_INACTIVE	This is the date when the usage of this thread was stopped. From this date onwards the thread will not be used regardless of the date of service billed on a claim.	NUMBER	8	0	N
NUM_PGM_1_32	Bit flags for Financial Payer NUM_HIER_ID 1 - 32. Used as part of the primary key and editing to determine order of processing for a Financial Payer. If NUM_HIER_ID column of T_FINANCIAL_PAYER IS BETWEEN 1 AND 32 for a Payer on the thread, then corresponding bit in this column will be set to 1 otherwise the bit will be set to 0.	NUMBER	10	0	N
NUM_PGM_33_64	Bit flags for Financial Payer NUM_HIER_ID 1 - 32. Used as part of the primary key and editing to determine order of processing for a Financial Payer. If NUM_HIER_ID column of T_FINANCIAL_PAYER IS BETWEEN 33 AND 64 for a Payer on the thread, then corresponding bit in this column will be set to 1 otherwise the bit will be set to 0.	NUMBER	10	0	N

Column Name	Description	Type	Length	Precision	Primary Key
NUM_PGM_65_96	Bit flags for Financial Payer NUM_HIER_ID 1 - 32. Used as part of the primary key and editing to determine order of processing for a Financial Payer. If NUM_HIER_ID column of T_FINANCIAL_PAYER IS BETWEEN 65 AND 96 for a Payer on the thread, then corresponding bit in this column will be set to 1 otherwise the bit will be set to 0.	NUMBER	10	0	N

2.13.210 T_PAYER_NODE

A given thread may have as many participants as required by business policy. This table is used to identify the participating entities as well as the processing sequence within the thread. The entity types in a thread are Payers.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_THREAD_PAYER	System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers for member beneficiaries who are concurrently enrolled under multiple payers.	NUMBER	9	0	Y
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
NUM_SEQUENCE_THREAD	This column determines the processing order for the entities participating in the thread. For example, if the thread is of type 'PAYR', then this sequence number determines which Financial Payer will be processed first, second, and so on.	NUMBER	4	0	N

2.13.211 T_PDL_MASTER

Preferred Drug List (PDL) Master. The purpose of this table is to maintain the historical relationship of an NDC to its PDL status, that is, whether a drug or drug product is preferred or non-preferred.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PDL	System assigned key representing the PDL Master row.	NUMBER	9	0	Y
SAK_DRUG	System assigned key for a unique drug	NUMBER	9	0	N
IND_PDL	PDL Indicator. Indicates the PDL status of the NDC. THAT IS Whether the drug or drug product is preferred (Y) or non-preferred (N).	CHAR	1	0	N
DTE_EFFECTIVE	Effective date. First date the PDL status is effective for the NDC.	NUMBER	8	0	N
DTE_END	End Date. Last date the PDL status is effective for the NDC.	NUMBER	8	0	N

2.13.212 T_PEER_GROUP

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PEER_GROUP	This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.	CHAR	1	0	Y
DSC_PEER_GROUP	This is a thirty byte field used to describe a peer group for DRG pricing. The peer group code and description are determined by the State.	CHAR	30	0	N

2.13.213 T_PEER_GRP_CAPT

Peer group specific capital cost. Capital cost is the adjustment component of the DRG rate calculation to account for a providers expense for new construction or equipment.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PEER_GROUP	This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.	CHAR	1	0	Y
DTE_EFFECTIVE	The date the Peer Group Capital Cost component took effect.	NUMBER	8	0	N
DTE_END	The date the Peer Group Capital Cost is no longer in effect.	NUMBER	8	0	N
AMT	This is the adjustment component of the DRG rate for new construction or equipment. Used for the peer group specific calculation.	NUMBER	9	2	N

2.13.214 T_PEER_GRP_DRGR

The Peer Group DRG Rate contains information used to calculate the total DRG reimbursement rate paid to a provider. The date sensitive information includes the DRG base rate which is specific to a peer group. This is used in conjunction with state-wide DRG variables for the calculation.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_GRP_DRGR	System Assigned Key for the Peer Group Rate.	NUMBER	9	0	Y
CDE_PEER_GROUP	This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.	CHAR	1	0	Y
SAK_DRG	System assigned key for a unique DRG.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date the Peer Group DRG Rate took effect.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_END	The date the Peer Group DRG Rate is no longer in effect.	NUMBER	8	0	N
NUM_BASE_RATE	This is a date sensitive pricing factor expressed in dollars terms, and is one of the primary components for the DRG calculation. This base rate is used for the peer group specific calculation.	NUMBER	10	3	N
NUM_CST_CHRG_RATE	The Cost to charge rate for the group.	NUMBER	6	5	N
AMT_CAPITAL	This is the capital amount utilized to calculate the DRG base rate specific for a provider.	NUMBER	10	4	N
AMT_MED_ED	This is the educational amount utilized to calculate the DRG base rate specific for a provider.	NUMBER	10	2	N
PCT_DISP_SHR	This is the disproportionate share percentage that will be utilized for pricing calculation.	NUMBER	5	5	N
NUM_COST_OUTLIER	This is the outlier threshold. This cost is used in outlier payment determination.	NUMBER	11	2	N
PCT_COST_OUTLIER	Marginal Cost Percentage used to calculate price for cost outlier pricing. (Percent Cost)	NUMBER	5	4	N
PCT_PAID	Percentage used to identify if cost outlier will be applicable for DRG priced claims.	NUMBER	5	4	N

Column Name	Description	Type	Length	Precision	Primary Key
PCT_MED_ED	Medical Education percentage used to determine the base rate for a DRG priced claim. Only providers who receive a medical education add-on will have a value in this field.	NUMBER	7	4	N
PCT_CAPT_MED_ED	Medical Education percentage used to determine the capital cost rate for a DRG priced claim. Only providers who receive a medical education add-on will have a value in this field.	NUMBER	7	4	N
DTE_INACTIVE	Rate segment inactive date. This is the date/time that the rate can no longer be used, regardless of the dates of service on the claim.	DATE	0	0	N
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	N

2.13.215 T_PEER_GRP_EDUC

Peer group specific medical education cost. Medical education costs are costs incurred by a teaching hospital for training physicians, nurses, and other health care professionals. This is an additional add-on payment adjustment used in DRG pricing.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PEER_GROUP	This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.	CHAR	1	0	Y
DTE_EFFECTIVE	The date the Peer Group Medical Education Cost component took effect.	NUMBER	8	0	N
DTE_END	The date the Peer Group Medical Education Cost is no longer in effect.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
AMT	Costs incurred by a teaching hospital for training physicians, nurses, and other health care professionals. Used for the peer group specific calculation.	NUMBER	9	2	N

2.13.216 T_PEER_GRP_FACT

Peer group specific marginal cost factor used in DRG calculation. It represents the marginal cost of care beyond the outlier threshold.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PEER_GROUP	This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.	CHAR	1	0	Y
DTE_EFFECTIVE	The date the Peer Group Marginal Cost Factor component took effect.	NUMBER	8	0	N
DTE_END	The date the Peer Group Marginal Cost Factor is no longer in effect.	NUMBER	8	0	N
NUM_COST_FACTOR	This is the marginal cost of care beyond the outlier threshold. Used for the peer group specific calculation.	NUMBER	4	2	N

2.13.217 T_PEER_GRP_INP_LOC

This entity contains the Inpatient Level of Care Rate for Peer Groups.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_LOC	A unique code identifying a specific provider level of care	CHAR	3	0	Y
CDE_PEER_GROUP	This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.	CHAR	1	0	Y
SAK_SHORT	System assigned key for level of care	NUMBER	4	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The first date that this level of care rate is effective; compared to the actual claim processed	NUMBER	8	0	N
DTE_END	The last date to apply this level of care rate to claims, as compared to the actual claim	NUMBER	8	0	N
AMT	The per diem rate to be paid for the related level of care.	NUMBER	9	2	N

2.13.218 T_PEER_GRP_RTIO

Peer group cost to charge ratio used in DRG cost outlier calculations. This is a percentage based on charges providers have made over a base period of time.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PEER_GROUP	This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.	CHAR	1	0	Y
DTE_EFFECTIVE	The date the Peer Group Cost to Charge Ratio component took effect.	NUMBER	8	0	N
DTE_END	The date the Peer Group Cost to Charge Ratio is no longer in effect.	NUMBER	8	0	N
NUM_RATIO	The percentage of charges over a base period of time. Used for the peer group specific calculation.	NUMBER	6	4	N

2.13.219 T_PGM_CT_XREF

This entity is used in claims editing to determine if a claim type is billable for a specific program. The IND_CT_EDITING attribute on the T_PUB_HLTH_PGM tables indicates what type of editing is to be performed. If the indicator is set to 'N' (non), no claim type to program editing is performed. If the indicator is set to 'I' (include), only the claim types listed are billable for the specified program. If the indicator is set to 'E' (exclude), the claim types listed are not billable for the specified program.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PUB_HLTH	System assigned internal key for a member plan.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_CLM_TYPE	Value for the type of claim that can be processed in the MMIS system.	CHAR	1	0	Y
DTE_EFFECTIVE	The date the claim type to program restriction becomes effective for use in claims editing.	NUMBER	8	0	N
DTE_END	The last date the claim type to program restriction is effective for use in claims editing.	NUMBER	8	0	N

2.13.220 T_PGM_DEPENDENCY

This entity is used to list programs that are dependent and must exist together on member eligibility.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PUB_HLTH	System assigned internal key for a medical assistance program.	NUMBER	9	0	Y
SAK_CHILD_PGM	System assigned internal key for a medical assistance program.	NUMBER	9	0	Y

2.13.221 T_PGM_EXCLUSION

This entity is used to list programs that cannot exist together on member eligibility.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PUB_HLTH	System assigned internal key for a medical assistance program.	NUMBER	9	0	Y
SAK_EXCLUDED_PGM	System assigned internal key for a medical assistance program.	NUMBER	9	0	Y
IND_MC_EXCL	This column is used to indicate which exclusion table rows are for Managed Care exclusions specifically.	CHAR	1	0	N

2.13.222 T_PGM_HIERARCHY

The program hierarchy contains the threads used to control the order of claim adjudication at the Benefit Plan level. The top level is controlled with Payer threads. Payer threads are ordered sets of Payers that may cover a member concurrently. These benefit plan threads are ordered sets of benefit plans that may cover a member concurrently.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_THREAD	System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment Plans for beneficiaries who are enrolled in multiple entities of any of these types..	NUMBER	9	0	Y
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	N
DTE_EFFECTIVE	Date the hierarchy thread becomes valid for use in claims processing.	NUMBER	8	0	N
DTE_END	The last date the thread is valid for use in claims processing. The thread may still be used when the date of service on the claim is within the effective dates of the thread. To stop the use of a particular thread altogether the DTE_INACTIVE date must be used.	NUMBER	8	0	N
DTE_INACTIVE	This is the date when the usage of this thread was stopped. From this date onwards the thread will not be used regardless of the date of service billed on a claim.	NUMBER	8	0	N
NUM_PGM_1_32	Bit flags for T_PUB_HLTH_PGM.NUM_HIER_ID_BNFT 1 to 32. Used as part of the primary key and editing to determine assignment plans order of processing within a Financial Payer. If NUM_HIER_ID_BNFT column of T_PUB_HLTH_PGM IS BETWEEN 1 AND 32 for a benefit plan on the thread, then corresponding bit in this column will be set to 1 otherwise the bit will be set to 0.	NUMBER	10	0	N

Column Name	Description	Type	Length	Precision	Primary Key
NUM_PGM_33_64	Bit flags for T_PUB_HLTH_PGM.NUM_HIER_ID_BNFT 33 to 64. Used as part of the primary key and editing to determine assignment plans order of processing within a Financial Payer. If NUM_HIER_ID_BNFT column of T_PUB_HLTH_PGM IS BETWEEN 33 AND 64 for a benefit plan on the thread, then corresponding bit in this column will be set to 1 otherwise the bit will be set to 0.	NUMBER	10	0	N
NUM_PGM_65_96	Bit flags for T_PUB_HLTH_PGM.NUM_HIER_ID_BNFT 65 to 96. Used as part of the primary key and editing to determine assignment plans order of processing within a Financial Payer. If NUM_HIER_ID_BNFT column of T_PUB_HLTH_PGM IS BETWEEN 65 AND 96 for a benefit plan on the thread, then corresponding bit in this column will be set to 1 otherwise the bit will be set to 0.	NUMBER	10	0	N

2.13.223 T_PLACE_OF_SERVICE

Location where medical services were provided.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_POS	Place of medical assistance service code.	CHAR	2	0	Y
DSC_POS	Description of place where medical assistance service is performed.	CHAR	50	0	N
IND_PROC_IN_EXCLUD	Indicates whether the associated list of procedure codes is valid or invalid for the place of service.	CHAR	1	0	N
IND_DIAG_IN_EXCLUD	Indicates whether the associated list of diagnosis codes is valid or invalid for the place of service.	CHAR	1	0	N

2.13.224 T_POS_TYP_BILL

Contains information used to identify the place of service based on the type of bill.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_TYPE_OF_BILL	Code which indicates a specific type of facility.	CHAR	3	0	Y
CDE_POS	Place of medical assistance service code.	CHAR	2	0	N

2.13.225 T_PRCNG_TYPE_SPEC

This is a list of provider type/specialty combinations that restricts rows of the T_PRICING_METHOD table. A value of 00 or 000 for type or specialty represents no restriction on type or specialty, respectively. For example, if type = 01 and specialty = 000 then the restriction applies only to providers with type = 01 regardless of the specialty.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_REIMB_AGRMNT	Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.	NUMBER	9	0	Y
CDE_PROV_TYPE	Type that a provider is licensed for.	CHAR	2	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROV_SPEC	A code representing the specialized area of practice for a provider.	CHAR	3	0	Y
CDE_PR_ROLE	This code represents the provider role on the claim. For example, a value of BILL REPRESENTS THE BILLING PROVIDER ON THE CLAIM.	CHAR	4	0	Y

2.13.226 T_PREVAILING

Prevailing Charge for a Procedure/Modifier/Locality/Specialty combination (Level II pricing).

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y
CDE_PROC_MOD	Pricing modifier used to further identify the appropriate prevailing charge for a procedure/locality/specialty combination.	CHAR	2	0	Y
CDE_LOCALITY	Locality code indicating the geographic location of a provider.	CHAR	2	0	Y
CDE_PROV_SPEC	Code indicating a provider's medical specialty.	CHAR	3	0	Y
DTE_EFFECTIVE	Date prevailing charge becomes active (effective) for use in claims processing.	NUMBER	8	0	Y
DTE_END	Date a prevailing charge becomes inactive (no longer in effect) for use in claims processing.	NUMBER	8	0	N
AMT	The prevailing charge for a procedure based on the customary charges made by a group of medical providers who share the same geographic locality and medical specialty.	NUMBER	9	2	N

2.13.227 T_PREVAILING_CONV

Prevailing Charge Conversion Factor for a Modifier/Locality/Specialty combination. This conversion factor is used for "Normal" pricing when no UCC, Prevailing Charge or Max Fee amount exists.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROV_SPEC	Code indicating a provider's medical specialty.	CHAR	3	0	Y
CDE_LOCALITY	Locality code indicating the geographic location of a provider.	CHAR	2	0	Y
CDE_PROC_MOD	Pricing modifier used to further identify the appropriate prevailing charge conversion factor for a locality/specialty/modifier combination.	CHAR	2	0	Y
DTE_EFFECTIVE	Date prevailing charge becomes active (effective) for use in claims processing.	NUMBER	8	0	Y
DTE_END	Date a prevailing charge becomes inactive (no longer in effect) for use in claims processing.	NUMBER	8	0	N
NUM_CONV_FACTOR	Conversion factor used in claims processing.	NUMBER	8	3	N

2.13.228 T_PRICING_CLM_TYPE

This allows the restriction of a pricing method to specific claim types. Rows on this tables are used as indicated by IND_PRICE_CLAIM_TYPE on the T_PRICING_METHOD table.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_REIMB_AGRMNT	Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.	NUMBER	9	0	Y
CDE_CLM_TYPE	Value for the type of claim that can be processed in the MMIS system.	CHAR	1	0	Y

2.13.229 T_PRICING_IND

Pricing indicator specifies the payment methodology that should be applied or was applied when determining the payment to be made to a provider for providing a service (procedure).

Column Name	Description	Type	Length	Precision	Primary Key
IND_PRICING	Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced.	CHAR	6	0	Y
DSC_25	Text description of the pricing indicator.	CHAR	25	0	N
IND	Indicates if the pricing indicator value is applicable for HCPC procedures. A value of "Y" signifies the indicator is valid for HCPC procedures and "N" says it is not.	CHAR	1	0	N

2.13.230 T_PRICING_XOVER

This table contains crossover specific pricing methods that will be used to price crossover claims, when indicated by reimbursement rules.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PRICING_XOVER	This is the special pricing method to be used to price crossover claims.	CHAR	6	0	Y
DSC_PRICING_XOVER	Description of the crossover claim pricing method.	VARCHAR2	50	0	N

2.13.231 T_PROC

CPT4 or HCPCS procedure and its descriptions. Procedures are assigned codes that uniquely identify the service performed.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y
CDE_PROC	Code used to identify a medical, dental, or DME procedure.	CHAR	6	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DSC_PROCEDURE	A short medical description of a specific, singular medical or dental service which is performed for the express purpose of identification or treatment of the patient's condition.	CHAR	40	0	N
DSC_LONG	A long medical description of a specific, singular medical or dental service which is performed for the express purpose of identification or treatment of the patient's condition.	VARCHAR2	4000	0	N
DSC_EOMB	Explanation of Medical Benefits description used on Member EOMB.	CHAR	30	0	N
DTE_HCFA_ADD	Defined by HCFA as the date the HCPCS code was added to the HCFA common procedure coding system.	NUMBER	8	0	N
DTE_HCFA_TERM	Defined by HCFA as the last date for which a procedure code may be used by Medicare providers.	NUMBER	8	0	N
CDE_MC_SVC_CLASS	The service class indicates the type of services provided.	CHAR	2	0	N
DSC_LAY	Description of the code in layman terms.	VARCHAR2	100	0	N
CDE_CMS_TOS	The carrier assigned CMS type of service which describes the particular kind(s) of service represented by the procedure code	CHAR	1	0	N
CDE_MCAR_COVRG	A code denoting Medicare coverage status	CHAR	1	0	N

2.13.232 T_PROCESS_DEPT

Department or group of examiners responsible for adjudicating claims.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROC_DEPT	Classification of group responsible for the adjudication of claims.	CHAR	1	0	Y
DSC_PROC_DEPT	Description of group responsible for the adjudication of claims.	CHAR	50	0	N

2.13.233 T_PROCESS_MOD

Processing modifiers are used to change or determine the allowed amount assigned to a procedure. The procedure allowed amount may be calculated or modified with the use of the percentage attribute, amount attribute or quantity attribute.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROC_MOD	The modifier code used to further describe a procedure.	CHAR	2	0	Y
DTE_EFFECTIVE	Start date of the procedure/diagnosis restriction.	NUMBER	8	0	N
DTE_END	Stop date of the procedure/diagnosis restriction.	NUMBER	8	0	N
PCT_MODIFIER	Percentage amount used to change the allowed amount for a procedure.	NUMBER	4	3	N
AMT	Dollar amount used to change the allowed amount for a procedure.	NUMBER	9	2	N
QTY	Unit adjustment for units of service field on a detail.	NUMBER	4	0	N

2.13.234 T_PROC_ASC

Ambulatory Surgical Center code assigned to a procedure. The ASC code is used to determine the ASC rate paid on a claim.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_ASC	Ambulatory Surgical Center (ASC) payment group codes classify procedures into different payment groups that are based on surgical procedure complexity. Rates by ASC payment group are established by CMS.	CHAR	1	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	Y
SAK_SEQUENCE	Sequence number used to uniquely identify a row for an ASC pricing group/ rate type combination.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date a ASC payment group code assignment for a procedure becomes effective for claims processing.	NUMBER	8	0	N
DTE_END	The date an ASC payment group code is no longer in effect for claims processing.	NUMBER	8	0	N

2.13.235 T_PROC_CONV_FACTOR

Total Base RVU for a procedure is multiplied by conversion factor to obtain the base fee schedule payment amount during RBRVS pricing calculation. This entity allows the assignment of a procedure specific conversion factor to be used in place of the "system-wide" conversion factor.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROC_FROM	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y
SAK_PROC_TO	System assigned key used to uniquely identify a procedure. This is the upper end of procedure range.	NUMBER	9	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The date a procedure conversion factor becomes valid for use in claims processing.	NUMBER	8	0	Y
DTE_END	The date a conversion factor is no longer valid for claims processing.	NUMBER	8	0	N
AMT_CONV_FACTOR	Multiplier which transforms relative values into payment amounts during RBRVS pricing calculations.	NUMBER	9	4	N

2.13.236 T_PROC_GLOBAL_LAB

This entity is used by lab pricing logic when building a new detail to replace one or more multichannel lab details. The quantity billed amount accumulated for the multichannel lab details determines the procedure code that will be used on the new detail. This entity is used in conjunction with the PROCEDURE entity to determine the new global procedure code.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y
QTY_UNITS_MIN	Multi channel lab minimum number of units to accumulate	NUMBER	9	0	N
QTY_UNITS_MAX	Multi channel lab maximum number of units to accumulate for pricing purposes	NUMBER	9	0	N

2.13.237 T_PROC_GROUP

Groups procedure codes by procedure type. This will be used by various parts of the system for different processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROC_TYPE	System assigned key for a unique procedure type, that represents a single or collection of procedures.	NUMBER	9	0	Y
SAK_PROCEDURE_FROM	System assigned key used to uniquely identify a procedure. This is the beginning procedure code value.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE_TO	System assigned key used to uniquely identify a procedure. This is the ending procedure code range.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date that the procedure code is to become effective for the procedure type in claims processing.	NUMBER	8	0	Y
DTE_END	The last date that the procedure code is in effect for the procedure type in claims processing.	NUMBER	8	0	N

2.13.238 T_PROC_ICD9

Surgical or diagnostic procedure and its descriptions. Procedures are assigned codes that are used to identify the service performed.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROC_ICD9	System assigned key used to uniquely identify an ICD-9-CM procedure.	NUMBER	9	0	Y
CDE_PROC_ICD9	Code which indicates a specific, surgical or diagnostic procedure which is performed for the express purpose of identification or treatment of the patient's condition.	CHAR	4	0	N
DSC_PROCEDURE	A short medical description of a specific, surgical or diagnostic procedure which is performed for the express purpose of identification or treatment of the patient's condition.	CHAR	40	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DSC_LONG	A long medical description of a specific, surgical or diagnostic procedure which is performed for the express purpose of identification or treatment of the patient's condition.	CHAR	250	0	N
CDE_CLASS	Describes the operative or non operative class of a procedure. 1 = Class 1, surgery, 2 = Class 2, significant procedure, 3 = Class 3 significant procedure, 4 = Class 4, other	CHAR	1	0	N
CDE_MC_SVC_CLASS	The service class indicates the type of services provided.	CHAR	2	0	N
DSC_LAY	Description of the code in layman terms.	VARCHAR2	100	0	N

2.13.239 T_PROC_ICD9_DIA

Diagnosis restrictions for an ICD-9-CM procedure. These restrictions will list diagnosis codes that the procedure is either restricted to (include) or restricted from (exclude).

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROC_ICD9	System assigned key used to uniquely identify an ICD-9-CM procedure.	NUMBER	9	0	Y
SAK_DIAG_FROM	System assigned key of the lower limit of a range of diagnosis codes.	NUMBER	9	0	N
SAK_DIAG_TO	System assigned key of the upper limit of a range of diagnosis codes.	NUMBER	9	0	N
DTE_EFFECTIVE	The date a range of diagnosis restrictions becomes effective.	NUMBER	8	0	N
DTE_END	The date a range of diagnosis restrictions is no longer in effect.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DIAG_FROM	The code identifying the diagnosis that is the lower limit of a range of diagnosis codes which will be used to restrict an ICD-9-CM procedure to a diagnosis.	CHAR	5	0	N
CDE_DIAG_TO	The code identifying the diagnosis that is the upper limit of a range of diagnosis codes which will be used to restrict an ICD-9-CM procedure to a diagnosis.	CHAR	5	0	N
IND_IN_EXCLUDE	Indicator identifying whether the specified range of diagnosis codes should be included or excluded from the procedure during claims processing.	CHAR	1	0	N

2.13.240 T_PROC_ICD9_GROUP

Groups ICD 9 CM procedure codes by procedure type. This will be used by various parts of the system for different processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_SHORT_ICD9_TYP	System assigned key for a unique procedure type, that represents a collection of procedures. NUMBER	NUMBER	9	0	Y
SAK_PROC_ICD9_FROM	System assigned key used to uniquely identify an ICD-9-CM procedure.	NUMBER	9	0	Y
SAK_PROC_ICD9_TO	System assigned key used to uniquely identify an ICD-9-CM procedure.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date that the ICD 9 CM procedure code is to become effective for the ICD 9 CM procedure type in claims processing.	NUMBER	8	0	Y
DTE_END	The last date that the ICD 9 CM procedure code is in effect for the ICD 9 CM procedure type in claims processing.	NUMBER	8	0	N

2.13.241 T_PROC_ICD9_LIM

Describes the limitations and restrictions that will be applied to an ICD-9-CM procedure during claims processing.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	Y
SAK_PROC_ICD9	System assigned key used to uniquely identify an ICD-9-CM procedure.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date procedure limitations become effective for claims processing.	NUMBER	8	0	Y
DTE_END	The date procedure limitations become invalid (no longer active) for claims processing.	NUMBER	8	0	N
IND_COVERED	An indicator used to denote whether an ICD-9-CM procedure is a covered procedure.	CHAR	1	0	N
IND_OPER_ROOM	Used to indicate whether a procedure requires the use of an operating room.	CHAR	1	0	N
IND_ATTACHMENT	Indicates if a special report is necessary for claims processing.	CHAR	1	0	N
CDE_SEX	The member gender that a procedure may be valid for. Valid values are M, F, or blank.	CHAR	1	0	N
CDE_NONSPEC	Identifies an ICD-9-CM procedure as a nonspecific procedure. Nonspecific procedures are used by providers when more precise information is not obtainable.	CHAR	1	0	N
CDE_BIOPSY	Identifies an ICD-9-CM procedure as a biopsy. (O) - Open, (C) - Closed or blank - not applicable.	CHAR	1	0	N
CDE_BI_SURG	Identifies the ICD-9-CM procedure as a bilateral procedure.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
QTY_AGE_MIN	The minimum age a member may be to receive the procedure.	NUMBER	4	0	N
QTY_AGE_MAX	The maximum age a member may be to receive the procedure.	NUMBER	4	0	N

2.13.242 T_PROC_ICD9_NOTES

This table will allow online users to add notes for an ICD-9-CM procedure code.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROC_ICD9	System assigned key used to uniquely identify an ICD-9-CM procedure.	NUMBER	9	0	Y
NUM_SEQ	Sequence number of note.	NUMBER	9	0	Y
ID_CLERK	User ID of person who is logged in.	VARCHAR2	8	0	N
DTE_NOTE	The date that the note was entered.	NUMBER	8	0	N
TME_NOTE	The TIME that the note was entered.	NUMBER	6	0	N
DSC_NOTE	The text of the note.	VARCHAR2	1000	0	N

2.13.243 T_PROC_ICD9_TYPE

A procedure ICD 9 CM type is associated with a group of ICD 9 CM procedure codes. Used to identify ICD 9 CM procedure codes for use in certain processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_SHORT_ICD9_TYP	System assigned key for a unique procedure type, that represents a collection of procedures. NUMBER	NUMBER	9	0	Y
DSC_25	Describes the ICD 9 CM procedure type.	CHAR	25	0	N
DSC_DEFINITION	Definition of where and/or how this ICD-9-CM procedure group is used.	VARCHAR2	4000	0	N

2.13.244 T_PROC_LIMITS

CPT4 or HCPCS procedure restrictions and the effective dates of the restrictions.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date procedure limitations become effective for claims processing.	NUMBER	8	0	Y
DTE_END	The date procedure limitations become invalid (no longer active) for claims processing.	NUMBER	8	0	Y
IND_LIFETIME	Indicates if a procedure can only occur once in the lifetime of a member.	CHAR	1	0	N
IND_FAM_PLAN	Indicates if a medical procedure is related to family planning.	CHAR	1	0	N
IND_PREGNANCY	Indicates if a medical procedure is related to a pregnancy.	CHAR	1	0	N
IND_CLIA	Indicates if a procedure requires CLIA certification.	CHAR	1	0	N
IND_ATTACHMENT	Indicates whether attachments are required for the procedure.	CHAR	1	0	N
CDE_SEX	The member gender that a procedure may be valid for. Valid values are M, F, or blank.	CHAR	1	0	N
QTY_AGE_MIN	The minimum age a member may be to receive the procedure.	NUMBER	4	0	N
QTY_AGE_MAX	The maximum age a member may be to receive the procedure.	NUMBER	4	0	N
QTY_UNITS_MIN	The minimum number of units that may be billed for the procedure.	NUMBER	9	0	N

Column Name	Description	Type	Length	Precision	Primary Key
QTY_UNITS_MAX	The maximum number of units that may be billed for the procedure	NUMBER	9	0	N
IND_CONFIDENTIAL	Indicates a confidential procedure. Confidential procedures will not be printed on a member EOMB.	CHAR	1	0	N
QTY_FOLLOWUP	This field represents the number of days before an E&M (visit) procedure can be paid, since it was included as part of the original surgery that was performed. This field is 3 bytes in length.	NUMBER	4	0	N
CDE_PROV_SPEC_EDIT	Indicates whether and what type of provider specialty editing is to be performed for the procedure during claims processing. An 'N' indicates not editing is to be performed. An 'I' (Include) indicates only the provider specialty listed are acceptable. An 'E' (Exclude) indicates the listed provider specialties cannot bill the procedure. Provider Specialties for editing are listed on the T_PROV_SPEC_LIM entity.	CHAR	1	0	N
IND_DIAG_REQ	A Yes/No indicator used in claims processing to determine if a diagnosis is required for the given procedure.	CHAR	1	0	N
IND_FROM_THRU_OK	Yes/No indicator used in claims process to determine if the procedure may be billed with From and Through dates of service.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DIAG_CMPT_EDIT	Code that indicates whether and what type of editing is to be performed in claims processing on the procedure/diagnosis compatibility groupings. An 'N' indicates not editing is to be performed. An 'I' (Include) indicates only diagnosis codes on the diagnosis compatibility groups listed are acceptable. An 'E' (Exclude) indicates the diagnosis codes in the listed diagnosis compatibility groups cannot be billed with the procedure. Valid Diagnosis Compatibility groups for editing are listed on the T_PROC_DIAG_LIM entity.	CHAR	1	0	N

2.13.245 T_PROC_MODIFIER

Valid Procedure/modifier combinations. Includes the dates that the combinations are in effect.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y
CDE_PROC_MOD	The modifier code used to further describe a procedure.	CHAR	2	0	Y
DTE_EFFECTIVE	The date a MCO procedure's coverage status becomes effective for claims processing.	NUMBER	8	0	N
DTE_END	The date a MCO procedure's coverage status is no longer in effect for claims processing.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_MOD_EDIT	Indicates the type of editing necessary for the procedure/modifier combination. Valid values are 'A' (Allowed), 'N' (Not Allowed), or 'R' (Required). An 'A' indicates the modifier is allowed to be billed with the procedure. An 'N' indicates the modifier can not be billed with the procedure. An 'R' indicates the modifier is required to bill the procedure. If more than 1 'required' modifiers exist for a procedure, the claim only needs 1 of the required modifiers be billed.	CHAR	1	0	N

2.13.246 T_PROC_NOTES

This table will allow online users to add notes for a HCPCS procedure code

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y
NUM_SEQ	Sequence number of note.	NUMBER	9	0	Y
ID_CLERK	User ID of person who is logged in.	VARCHAR2	8	0	N
DTE_NOTE	The date that the note was entered.	NUMBER	8	0	N
TME_NOTE	The TIME that the note was entered.	NUMBER	6	0	N
DSC_NOTE	The text of the note.	VARCHAR2	1000	0	N

2.13.247 T_PROC_TOOTH

For a given procedure, this identifies the tooth number that is restricted to a particular procedure code, along with the effective dates of the restriction.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y
CDE_TOOTH_NBR	The code of the particular tooth that the procedure is restricted to.	CHAR	2	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The date that signifies that the procedure's tooth number restriction is in effect.	NUMBER	8	0	Y
DTE_END	The date that signifies that the procedure's tooth number restriction is no longer in effect.	NUMBER	8	0	N

2.13.248 T_PROC_TOOTH_QUAD

This is a table that will contain the valid HCPC Procedure code\tooth quadrant combinations.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y
CDE_TOOTH_QUAD	Code identifying the tooth quadrant.	CHAR	3	0	Y
DTE_EFFECTIVE	The date that signifies that the procedure's tooth quadrant restriction is in effect.	NUMBER	8	0	Y
DTE_END	The date that signifies that the procedure's tooth quadrant restriction is no longer in effect.	NUMBER	8	0	N

2.13.249 T_PROC_TYPE

A procedure type is associated with a group of procedure codes. Used to identify procedure codes for use in certain processing methodologies. For example, "Collection" is a procedure type.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROC_TYPE	System assigned key for a unique procedure type, that represents a single or collection of procedures.	NUMBER	9	0	Y
DSC_50	Describes the procedure type, for example, "Collection".	CHAR	50	0	N
DSC_DEFINITION	Definition of where and/or how this procedure group is used.	VARCHAR2	4000	0	N

2.13.250 T_PR_CONTRACT_TYPE_SPEC

This defines the relationship between the Provider contract and the allowed Provider Types and Specialties. A contract applies only to those type/specialty combinations on this table. As usual, a type or specialty of 00, or 000, respectively, denotes "all" or not restriction.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROV_PGM	This is the system assigned key to the provider Contract under which Providers may be certified..	NUMBER	9	0	Y
CDE_PROV_TYPE	Type that a provider is licensed for.	CHAR	2	0	Y
CDE_PROV_SPEC	A code representing the specialized area of practice for a provider.	CHAR	3	0	Y
CDE_PR_ROLE	This code represents the provider role on the claim. For example, a value of BILL REPRESENTS THE BILLING PROVIDER ON THE CLAIM.	CHAR	4	0	Y

2.13.251 T_PR_DRG_RATE

The Provider DRG Rate table contains information used to calculate the total DRG reimbursement rate paid to a provider. The date sensitive information includes the DRG base rate and the cost to charge rate. This is used in conjunction with state-wide DRG variables for the calculation.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PR_DRG_RT	System Assigned Key for the Provider Specific DRG Rate.	NUMBER	9	0	Y
SAK_PROV	System assigned key that uniquely identifies the provider enrollment tracking.	NUMBER	9	0	Y
SAK_DRG	System assigned key for a unique DRG.	NUMBER	9	0	Y
CDE_SERVICE_LOC	Unique code suffixed to the provider number to identify the various locations that a provider does business.	CHAR	1	0	Y
DTE_EFFECTIVE	The date the Provider DRG Rate took effect.	NUMBER	8	0	Y
DTE_END	The date the Provider DRG Rate is no longer in effect.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
NUM_BASE_RATE	This is a date sensitive pricing factor expressed in dollars terms, and is one of the primary components for the DRG calculation. This base rate is used for the provider specific calculation.	NUMBER	10	2	N
CST_CHRG_RATE	This is the cost to charge DRG rate for the provider.	NUMBER	5	4	N

2.13.252 T_PR_ENROLL_PGM

This table contains the list of programs that a provider can be enrolled in.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROV_PGM	This is the system assigned key to the provider Contract under which Providers may be certified..	NUMBER	9	0	Y
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	N
CDE_PROV_PGM	Identifies the medical assistance programs that a provider can enroll in.	CHAR	5	0	N
DSC_PROV_PGM	This is the short description to the provider enrollment program.	CHAR	20	0	N
DSC_PROV_PGM_LONG	This is the long description to the provider enrollment program.	VARCHAR2	4000	0	N

Column Name	Description	Type	Length	Precision	Primary Key
IND_CT_EDITING	The IND_CT_EDITING attribute indicates what type of claim type to program editing is to be performed. If the indicator is set to 'N' (non), no claim type to program editing is performed. If the indicator is set to 'I' (include), only the claim types listed are billable for the specified program. If the indicator is set to 'E' (exclude), the claim types listed are not billable for the specified program.	CHAR	1	0	N
DTE_EFFECTIVE	The date the claim type to program restriction becomes effective for use in claims editing.	NUMBER	8	0	N
DTE_END	The last date the claim type to program restriction is effective for use in claims editing.	NUMBER	8	0	N
DTE_INACTIVE		DATE	0	0	N

2.13.253 T_PR_PEER_GROUP

This holds provider peer group information for hospitals.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PEER_GROUP	System Assigned Key for the Peer Group.	NUMBER	9	0	Y
SAK_PROV	System assigned key that uniquely identifies the provider enrollment tracking.	NUMBER	9	0	Y
SAK_PROV_LOC	Service Location SAK	NUMBER	9	0	Y
CDE_PEER_GROUP	This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	Effective date of the peer group.	NUMBER	8	0	N
DTE_END	The date end for the peer group.	NUMBER	8	0	N

2.13.254 T_PR_PGM_CT_XREF

This entity is used in claims editing to determine if a claim type is billable for a specific provider contract. The IND_CT_EDITING attribute on the T_PR_ENROLL_PGM tables indicates what type of editing is to be performed. If the indicator is set to 'N' (non), no claim type to program editing is performed. If the indicator is set to 'I' (include), only the claim types listed are billable for the specified program. If the indicator is set to 'E' (exclude), the claim types listed are not billable for the specified program.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROV_PGM	This is the system assigned key to the provider Contract under which Providers may be certified..	NUMBER	9	0	Y
CDE_CLM_TYPE	Value for the type of claim that can be processed in the MMIS system.	CHAR	1	0	Y
DTE_EFFECTIVE	The date the claim type to program restriction becomes effective for use in claims editing.	NUMBER	8	0	Y
DTE_END	The last date the claim type to program restriction is effective for use in claims editing.	NUMBER	8	0	N

2.13.255 T_PR_PHP_ELIG

The Provider Program Eligibility table is a cross-reference between the providers and the programs for which they are eligible.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROV	System assigned key that uniquely identifies the provider enrollment tracking.	NUMBER	9	0	Y
CDE_SERVICE_LOC	Suffix added to the provider number to identify the various locations that a provider does business.	CHAR	1	0	Y
SAK_SHORT	This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.	NUMBER	4	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROV_PGM	This is the system assigned key to the provider Contract under which Providers may be certified..	NUMBER	9	0	Y
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	N
DTE_EFFECTIVE	This is the effective date when the maximum recoupment amount takes effect.	NUMBER	8	0	N
DTE_END	This is the end date when the maximum recoupment amount ends.	NUMBER	8	0	N
DTE_INACTIVE		DATE	0	0	N
CDE_ENROLL_STATUS	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	0	N

2.13.256 T_PUB_HLTH_PGM

This entity represents the Benefit or Assignment plans defined within a Financial Payer supported by the system. A beneficiary/member will be enrolled in one or more of these plans based on the criteria established by the Financial Payer. The Benefit Plan lists the services for which the beneficiary/member is eligible to receive. A specific service may be subject to different rules and restrictions under different Benefit Plans. An Assignment plan is a generalization of the traditional Lockin concept. A beneficiary/member may be assigned to a provider or provider organization in order to receive certain services. These services must be provided or, in some cases, referred by the assigned provider. The services may be reimbursed on a fee for service or capitation basis. The provider may be compensated for acting as a gate keeper in some instances.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PUB_HLTH	System assigned internal key for a member plan.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	N
CDE_PGM_HEALTH	Identifies the medical assistance program that is supported in the system.	CHAR	5	0	N
DSC_PGM_HEALTH	Describes the medical assistance program.	VARCHAR2	50	0	N
DSC_PGM_DEFINITION	Text definition of program describing who is eligible and what types of services are provided.	VARCHAR2	4000	0	N
CDE_TYPE_PLAN	This is the type of plan. There are two types of Plans. For Benefit Plans, the value in this column is 'BNFT'. For Assignment Plans, the value in this column is 'ASGN'.	CHAR	4	0	N
IND_RECIP_ONLY	Yes/No indicator used to identify programs that are used for member enrollment only. No services are covered by the program.	CHAR	1	0	N
IND_MAJOR_PGM	Yes/No indicator used to identify a program is a major program. A major program is a program that can stand alone. The program needs no other program. A major program can not be combined with any other major program.	CHAR	1	0	N
IND_STAND_ALONE	Yes/No indicator used to identify a program is a stand alone program. A stand alone program can only stand by itself. No other program can exist.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
IND_CT_EDITING	The IND_CT_EDITING attribute indicates what type of claim type to program editing is to be performed. If the indicator is set to 'N' (non), no claim type to program editing is performed. If the indicator is set to 'I' (include), only the claim types listed are billable for the specified program. If the indicator is set to 'E' (exclude), the claim types listed are not billable for the specified program.	CHAR	1	0	N
IND_COPAY	Yes/No indicator used to identify programs that qualify for copay calculations during claims payment determination.	CHAR	1	0	N
IND_DUAL	Yes/No indicator used to identify a program is a Dual program. A dual program is a program that can either stand alone or with another major/dual program.	CHAR	1	0	N
IND_TPL_ACTION	This indicator identifies the action taken for TPL editing based on the OI Plan. Note, we are allowing nulls at this time because panels outside of TPL Matrix will be inserting into this table and will not enter anything into this column. Later (new CO), we will change the other panels and change this column to not null.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
NUM_HIER_ID_BNFT	This is another system assigned identifier that is used to identify a hierarchy thread that contains this benefit plan within a Payer. This column contains only positive values when the CDE_TYPE_PLAN is equal to 'BNFT'. Otherwise the value of this column is zero. The value is maintained as an ascending sequence of numbers starting with 1. There is a sequence for each payer. So Payer 1 may have values 1, 2, 3; and Payer 2 might have values 1,2, 3, 4.	NUMBER	9	0	N
NUM_HIER_ID_ASGN	This is another system assigned identifier that is used to identify a hierarchy thread that contains this assignment plan. This column contains only positive values when the CDE_TYPE_PLAN is equal to 'ASGN'. Otherwise the value of this column is zero. The value is maintained as an ascending sequence of numbers starting with 1. There is a sequence for each payer. So Payer 1 may have values 1, 2, 3; and Payer 2 might have values 1,2, 3, 4.	NUMBER	9	0	N
DTE_EFFECTIVE	The date the claim type to program restriction becomes effective for use in claims editing.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_END	The last date the claim type to program restriction is effective for use in claims editing.	NUMBER	8	0	N
DTE_INACTIVE	This is the date this row becomes inactive. For new claims the system date is compared to this date. If the system date is greater than or equal to this date, the row will not be used to process the claim.	DATE	0	0	N
DTE_ACTIVE	This is the date this row becomes active. For new claims the system date is compared to this date. If the system date is less than this date, the row will not be used to process the claim.	DATE	0	0	N

2.13.257 T_RATE_TYPE

The Rate Type describes the rate to use in determining provider reimbursement. The rate type is used to allow different rates to be applied for various benefit plans.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	Y
DSC_RATE_TYPE	Description of rate type.	VARCHAR2	18	0	N

2.13.258 T_RBRVS

Resource Based Relative Value Scale (RBRVS) pricing methodology information for a procedure. The main source for this data will be the Medicare Fee Schedule Data Base (MFSDB). However, system users may also provide RBRVS pricing information.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROC_MOD	Indicates the technical or professional component of a procedure. A blank will identify a global service. A modifier of 26 will identify professional component and a TC will identify technical component.	CHAR	2	0	N
DTE_EFFECTIVE	The date procedure RBRVS rates become effective for claims processing.	NUMBER	8	0	N
DTE_END	The date procedure RBRVS rates become invalid (no longer active) for claims processing.	NUMBER	8	0	N
IND_PC_TC	This indicates type of professional or technical component.	CHAR	1	0	N
NUM_RVU_W	Work Relative Value Unit used in calculating RBRVS rates for a procedure.	NUMBER	9	2	N
NUM_RVU_PE	Practice expense Relative Value Unit used in calculating RBRVS rates for a procedure.	NUMBER	9	2	N
NUM_RVU_M	The malpractice Relative Value Unit used in calculating RBRVS rates for a procedure.	NUMBER	9	2	N
NUM_GLOBAL_SURG	Provides the timeframes that apply to each surgical procedure.	CHAR	3	0	N
IND_SOS_DIFF	Indicates services subject to payment adjustments based on site of service.	CHAR	1	0	N
CDE_MULTI_SURG	Indicates multiple surgery service payment adjustment rules to use for pricing.	CHAR	1	0	N
CDE_BI_SURG	Indicates bilateral surgery service payment adjustment rule to use for pricing.	CHAR	1	0	N
CDE_ASST_SURG	Indicates assistant at surgery service restriction.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_CO_SURG	Indicates services for which two surgeons, each in a different specialty, may be paid.	CHAR	1	0	N
CDE_TEAM_SURG	Identifies services for which team surgeons may be paid.	CHAR	1	0	N
PCT_PREOP	The Preoperative percentage of the global surgery package.	NUMBER	6	5	N
PCT_INTRAOP	The Intraoperative percentage of the global surgery package.	NUMBER	6	5	N
PCT_POSTOP	The Postoperative percentage of the global surgery package.	NUMBER	6	5	N

2.13.259 T_RBRVS_PR_SPEC

Non-physician practitioners may provider services normally delivered by a physician. In these instances, payment amount will be adjusted by a certain percentage of the schedule amount that would have been paid to a physician for the same service.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROV_SPEC	A code representing the specialized area of practice for a provider.	CHAR	3	0	N
DTE_EFFECTIVE	The date a provider specialty adjustment used in RBRVS pricing is effective for claims processing.	NUMBER	8	0	N
DTE_END	The date a provider specialty adjustment used in RBRVS pricing is no longer valid for claims processing.	NUMBER	8	0	N
PCT	Percentage used to adjust claims payment to a provider based on the providers specialty.	NUMBER	3	2	N

2.13.260 T_RBRVS_UPDATE

Temporary table used in the Resource Based Relative Value Scale (RBRVS) update process. The Medicare Fee Schedule Data Base is loaded into this entity prior to applying the updates to the RBRVS entity..

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROC	The procedure code is a five character code that identifies the service performed.	CHAR	5	0	N
CDE_PROC_MOD	Indicates the technical or professional component of a procedure. A blank will identify a global service. A modifier of 26 will identify professional component and a TC will identify technical component.	CHAR	2	0	N
CDE_STATUS1		CHAR	1	0	N
NUM_RVU_W	Work Relative Value Unit used in calculating RBRVS rates for a procedure.	NUMBER	9	2	N
NUM_RVU_PE	Practice expense Relative Value Unit used in calculating RBRVS rates for a procedure.	NUMBER	9	2	N
NUM_RVU_M	The malpractice Relative Value Unit used in calculating RBRVS rates for a procedure.	NUMBER	9	2	N
IND_SOS_DIFF	Indicates services subject to payment adjustments based on site of service.	CHAR	1	0	N
NUM_GLOBAL_SURG	Provides the timeframes that apply to each surgical procedure.	CHAR	3	0	N
PCT_PREOP	Percentage for the preoperative portion of the global package.	NUMBER	6	5	N
PCT_INTRAOP	The percentage for the intraoperative portion of the global package including postoperative work in the hospital.	NUMBER	6	5	N

Column Name	Description	Type	Length	Precision	Primary Key
PCT_POSTOP	The percentage for the postoperative portion of the global package that is provided in the office after discharge from the hospital.	NUMBER	6	5	N
IND_PC_TC	Identifies the extent to which professional and technical components of a service apply. Valid values and definitions may be found on the Medicare fee schedule record layout.	CHAR	1	0	N
CDE_MULTI_SURG	Indicates multiple surgery service payment adjustment rules to use for pricing.	CHAR	1	0	N
CDE_BI_SURG	Indicates bilateral surgery service payment adjustment rule to use for pricing.	CHAR	1	0	N
CDE_ASST_SURG	Indicates assistant at surgery service restriction.	CHAR	1	0	N
CDE_CO_SURG	Indicates services for which two surgeons, each in a different specialty, may be paid.	CHAR	1	0	N
CDE_TEAM_SURG	Identifies services for which team surgeons may be paid.	CHAR	1	0	N

2.13.261 T_READMIT_PARM

This table contains audit criteria that is specific to the hospital readmission audits.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC		NUMBER	9	0	Y
CDE_TIME_UNIT		CHAR	1	0	N
CDE_BEF_AFT		CHAR	1	0	N
NUM_UNIT_BEFORE		NUMBER	4	0	N
NUM_UNIT_AFTER		NUMBER	4	0	N
CDE_SAM_DIF_DI		CHAR	1	0	N

2.13.262 T_REF_CLIA_LC_PROC

This table contains the procedure code, modifier, and lab certification code for cross reference purposes when checking for CLIA certification during the processing of claims.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROCEDURE	System assigned key that uniquely identifies the procedure code	NUMBER	9	0	Y
CDE_PROC_MOD	Modifier for the procedure code	CHAR	2	0	Y
CDE_LAB_CODE	CLIA Lab Certification Code	CHAR	3	0	Y
DTE_EFFECTIVE	Effective date of the CLIA lab code	NUMBER	8	0	Y
DTE_END	End date of the CLIA lab code	NUMBER	8	0	N

2.13.263 T_REF_UCC

Provider specific usual, customary, and reasonable charge for a procedure based on a historical profile of billed charges a provider typically requests for a procedure.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROV_LOC	Service Location SAK	NUMBER	9	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	Y
SAK_PROCEDURE	System assigned key used to uniquely identify a procedure.	NUMBER	9	0	Y
CDE_PROC_MOD	Further clarifies a procedure.	CHAR	2	0	Y
CDE_MODIFIER_2	Pricing modifier used to identify the appropriate UCC rate for a procedure modifier combination.	CHAR	2	0	Y
CDE_MODIFIER_3	The modifier code used to further describe a procedure.	CHAR	2	0	Y
CDE_MODIFIER_4	The modifier code used to further describe a procedure.	CHAR	2	0	Y
SAK_SHORT	This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.	NUMBER	4	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROV	System assigned key that uniquely identifies the provider enrollment tracking.	NUMBER	9	0	N
DTE_EFFECTIVE	The date that the corresponding UCC became effective.	NUMBER	8	0	N
DTE_END	The date that the corresponding UCC was no longer effective.	NUMBER	8	0	N
AMT_UCC_RATE	The Usual and Customary Charge associated with this procedure code.	NUMBER	9	2	N
DTE_INACTIVE	This is the date this row becomes inactive. For new claims the ICN is compared to this date. I the ICN date is greater than this date, the row will not be used to process the claim.	NUMBER	8	0	N

2.13.264 T_REGION

Number indicating the media in which a claim entered the system.

Column Name	Description	Type	Length	Precision	Primary Key
NUM_REGION	Classification of the media on which a claim is submitted into the MMIS system or the type of transaction performed on a claim that already exists in the MMIS system.	CHAR	2	0	Y
DSC_REGION	Description of the region code.	CHAR	50	0	N

2.13.265 T_REGION_DISP

This table contains the disposition that should be set for a particular region and edit combination.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
SAK_PUB_HLTH	System assigned internal key for a medical assistance program.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ERROR_DISP	System assigned key used to define an occurrence of an error disposition for a specific edit/audit.	NUMBER	4	0	Y
SAK_EOB	The system assigned key for the EOB table. This key will make it possible to renumber the EOB file in the future without affecting the other tables that carry EOB (such as claim or ESC).	NUMBER	9	0	Y
NUM_REGION	Specific region for which this disposition should be assigned.	CHAR	2	0	Y
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	N
CDE_DISP_STATUS	Code that represents the action (pay, deny, suspend, super suspend, Pay and List) that should be taken on a claim at dispositioning time.	CHAR	1	0	N

2.13.266 T_REGION_GEOGRAPHICAL

Geographical regions are state defined and provide a means of grouping other entities in the data base.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_REGION_GEO	A user defined code that identifies a geographical region.	CHAR	4	0	Y
DSC_REGION_GEO	The description of the region	VARCHAR2	4000	0	N

2.13.267 T_RESO_STATUS

Column Name	Description	Type	Length	Precision	Primary Key
SAK_RESO_STATUS		NUMBER	9	0	Y
DSC_ERR_RESO_STATUS		VARCHAR2	50	0	N

2.13.268 T_REVENUE_CODE

A three digit code which identifies a specific accommodation or ancillary service.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_REVENUE	System assigned key used to uniquely identify a revenue code.	NUMBER	9	0	Y
CDE_REVENUE	This identifies a specific accommodation or ancillary service. Revenue codes are determined by HCFA.	NUMBER	4	0	N
DSC_REV_CODE	This describes a specific accommodation or ancillary service.	CHAR	70	0	N
DTE_EFFECTIVE	This is the date of service that the revenue code became effective.	NUMBER	8	0	N
DTE_END	This is the last date of service that the revenue code is effective.	NUMBER	8	0	N
NUM_RATE_ID	This field represents a grouping of revenue codes. Each revenue code has a rate ID number and more than one revenue code will have the same number. Revenue codes are grouped this way for use in different pricing methodologies.	NUMBER	4	0	N
CDE_MC_SVC_CLASS	The service class indicates the type of services provided.	CHAR	2	0	N
IND_PROC_IN_EXCLUD	This field indicates whether the associated drug, revenue code, or procedure range is included or excluded from the billing restrictions for a provider.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
IND_SPEC_IN_EXCLUD	This field indicates whether the associated provider specialty is included or excluded from the billing restrictions for a revenue code.	CHAR	1	0	N

2.13.269 T_REVENUE_FLAT_FEE

The revenue flat fee entity is used in outpatient pricing for flat fee amounts that relate to a revenue code and emergency indicator.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_REVENUE	System assigned key used to uniquely identify a revenue code.	NUMBER	9	0	Y
CDE	This is an emergency code. Valid values are 'E' or space.	CHAR	1	0	Y
CDE_RATE_TYPE	Code used to identify the rate type to use in determining provider reimbursement.	CHAR	3	0	N
DTE_EFFECTIVE	The effective is the begin date for this segment.	NUMBER	8	0	N
DTE_END	The end date is the last date for this segment.	NUMBER	8	0	N
AMT	This field is the flat fee amount. It is used in new outpatient pricing.	NUMBER	9	2	N

2.13.270 T_REVENUE_NOTES

his table will allow online users to add notes for a revenue code.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_REVENUE	System assigned key used to uniquely identify a revenue code.	NUMBER	9	0	Y
NUM_SEQ	Sequence number of note.	NUMBER	9	0	Y
ID_CLERK	User ID of person who is logged in.	VARCHAR2	8	0	N
DTE_NOTE	The date that the note was entered.	NUMBER	8	0	N
TME_NOTE	The TIME that the note was entered.	NUMBER	6	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DSC_NOTE	The text of the note.	VARCHAR2	1000	0	N

2.13.271 T_REV_GROUP

Groups revenue codes by revenue type. This will be used by various parts of the system for different processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_REV_TYPE	System assigned key for a unique revenue type, that represents a single or collection of revenue codes.	NUMBER	9	0	Y
SAK_REVENUE_FROM	System assigned key used to uniquely identify a revenue code.	NUMBER	9	0	Y
SAK_REVENUE_TO	System assigned key used to uniquely identify a revenue code.	NUMBER	9	0	Y
DTE_EFFECTIVE	The date that the revenue code is to become effective for the revenue type in claims processing.	NUMBER	8	0	Y
DTE_END	The last date that the revenue code is in effect for the revenue type in claims processing.	NUMBER	8	0	N

2.13.272 T_REV_HOSPICE_XWALK

This table contains revenue codes that, when billed on hospice claims, will be crosswalked to price using different revenue codes based on the number of units billed on the claims.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_HOSPICE_XWALK	The system assigned key that uniquely identifies a row in this table.	NUMBER	9	0	Y
SAK_REV_CLAIM	This is the unique key that identifies a revenue code that was submitted on a claim detail.	NUMBER	9	0	N
DTE_EFFECTIVE	The service date that this revenue code crosswalk row becomes effective.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DTE_END	The service date that this revenue code crosswalk row is no longer effective.	NUMBER	8	0	N
DTE_ACTIVE	Crosswalk segment active date. This is the date/time that the crosswalk row can be used, regardless of the dates of service on the claim.	DATE	0	0	N
DTE_INACTIVE	Crosswalk segment inactive date. This is the date/time that the crosswalk row can no longer be used, regardless of the dates of service on the claim.	DATE	0	0	N
QTY_UNITS_MIN	This is the low end of the range of the number of units billed on a claim detail. If the number of units billed on a claim detail is less than this number, then it will not be valid for this row.	NUMBER	9	0	N
QTY_UNITS_MAX	This is the high end of the range of the number of units billed on a claim detail. If the number of units billed on a claim detail is greater than this number, then it will not be valid for this row.	NUMBER	9	0	N
CDE_UNIT_TYPE	This indicates whether only the last unit on the detail should be priced using a different revenue code, or if all units within the range of units on the record should be priced using a different revenue code. Valid values are "L" for last unit only and "A" for all units in range.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
SAK_REV_PRICE	This is the unique key that identifies a revenue code that will be used to price the number of units based on the ind_unit_type and the number of units billed on the detail.	NUMBER	9	0	N

2.13.273 T_REV_TYPE

A revenue type is associated with a group of revenue codes. Used to identify revenue codes for use in certain processing methodologies. For example, "Surgery" is a revenue type.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_REV_TYPE	System assigned key for a unique revenue type, that represents a single or collection of revenue codes.	NUMBER	9	0	Y
DSC_50	Describes the revenue type, for example, "Recovery Room".	CHAR	50	0	N
DSC_DEFINITION	Definition of where and/or how this revenue code group is used.	VARCHAR2	4000	0	N

2.13.274 T_RE_ASSIGNMENT

This table contains the hospice and SCRIPTS beneficiary assignments to a provider.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_RECIP	The system assigned internal key for a unique member.	NUMBER	9	0	Y
SAK_PGM_ELIG	Used along with the SAK RECIP to uniquely identify an eligibility segment for a particular member.	NUMBER	4	0	Y
SAK_PROV	System assigned key that uniquely identifies the provider enrollment tracking.	NUMBER	9	0	N
CDE_SERVICE_LOC	Suffix added to the provider number to identify the various locations that a provider does business.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_ASSIGN_ENT_RSN	Indicates the reason the beneficiary was assigned to a hospice or SCRIPTS provider. SCRIPTS does not presently have assignment reasons.	CHAR	2	0	N
CDE_ASSIGN_EXT_RSN	Indicates the reason the beneficiary's assignment to a hospice or SCRIPTS provider ended. SCRIPTS does not presently have assignment reasons.	CHAR	2	0	N
DTE_SCRIPTS_ORIG	This is the SCRIPTS originated date which is the original assignment start date. This date will be zero for Hospice assignments.	NUMBER	8	0	N

2.13.275 T_RU_ACTION

An action is executed by calling the setter function of the variable and passing in the output value. This assumes an action variable has one and only one argument. SAK_ACTION CDE_VARIABLE CDE_VALUE IND_VALUE_TYPE 10 EDIT 1245 S 11 EDIT 1246 S 12 EDIT 1247 S 13 EDIT 1248 S 14 EDIT 1249 S . 27 PA true S

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ACTION	This is the primary key for this table.	NUMBER	9	0	Y
CDE_VARIABLE	Points to the Transaction variable that is the direct object of the Action.	CHAR	4	0	N
CDE_VALUE	If IND_VALUE_TYPE is "A", then this column is a FK to T_RU_ARRAY. Otherwise it's an arbitrary string value.	VARCHAR2	50	0	N
CDE_VALUE_TYPE	This value is either "S" for Single Value, or "A" for ARRAY.	CHAR	1	0	N

2.13.276 T_RU_ARRAY

This is the array that contains the values for relation type variables such as modifier and modifier type.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_VALUE	Identifier for an array. IMPORTANT: There can be multiple rows with the same PK. Each row is another value of the array..	NUMBER	8	0	Y
SAK_VALUE_CHILD	If the value is -1 then CDE_VALUE contains the value for this array position..	NUMBER	9	0	N
CDE_VALUE_CHILD	If SAK_VALUE_CHILD is -1 this is the value of the array entry. Otherwise it is " ".	VARCHAR2	50	0	N
NUM_ORDER	This is the position within the array of this entry which may be an array in itself.	NUMBER	4	0	N

2.13.277 T_RU_COMPARISON

Comparisons are the leaf nodes of the Rule's Condition tree. A Rule variable is matched against a value. A singly occurring variable (example, member age) that matches a single value will be matched against the value in CDE_VALUE_SET using the operator in CDE_COMPARISON_OP. If the comparison is of type R (range) then two values separated by a "-" will be in CDE_VALUE. A singly occurring variable (example, place of service) that may be matched against a discreet list of values will have the list of values identified by CDE_VALUE_SET and located in the table T_RU_DISCREET_SET. A tuple variable (a variable that may occur multiple times in the transaction such as procedure modifier) will have its tuple set identified by CDE_VALUE_SET and located in the table T_RU_TUPLE_SET. SAK_COMP CDE_VARIABLE IND CDE_VALUE IND_VALUE_TYPE 1 PROC EQ 123 S 2 DOS BW 20010924 - 20050101 S 3 AGE BW 0 - 45 S 4 GRP EQ 8 S 5 DOS BW 19990728 - 22991231 S 6 CT BW 1 S

Column Name	Description	Type	Length	Precision	Primary Key
SAK_COMPARISON	Primary key.	NUMBER	9	0	Y
SAK_RULE	Primary-Key for this table	NUMBER	9	0	N
CDE_VARIABLE	Primary key for this table. The short identifier for the variable. It must be unique for the transaction that owns it.	CHAR	4	0	N
CDE_COMPARISON_OP	Possible values are "EQ", "NE", "GT", "LT", "GE", "LE", "BW", and "IN". Others may be added as needed.	CHAR	2	0	N
CDE_VALUE_COMP	If IND_VALUE_TYPE is "D", then this column is a FK to T_RU_DISCRETE_SET. If the IND is "T", then this column is a FK to T_RU_TUPLE_SET. Otherwise it's an arbitrary string value that's interpreted differently for each domain. A RangedValue (for the "BW" operation) will have two domain values separated by " - ".	VARCHAR2	50	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_VALUE_TYPE	If IND_VALUE_TYPE is "D", then this column is a FK to T_RU_DISCRETE_SET. If the IND is "T", then this column is a FK to T_RU_TUPLE_SET. Otherwise it's an arbitrary string value that's interpreted differently for each domain. A RangedValue (for the "BW" operation) will have two domain values separated by " - ".	CHAR	1	0	N

2.13.278 T_RU_COMPARISON_OP

This is the set of operators that may be used to compare variables against the values configured by the end users.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_COMPARISON_OP	Possible values are "EQ", "NE", "GT", "LT", "GE", "LE", "BW", and "IN". Others may be added as needed.	CHAR	2	0	Y

2.13.279 T_RU_CONDITION

A Condition may be one of two things: 1. Two CONDITIONs identified by SAK_CONDITION_LEFT and SAK_CONDITION_RIGHT AND combined with the logical connective in column CDE_LOGICAL_CONNECTIVE, or: 2. A COMPARISON pointed to by column SAK_COMPARISON. SAK_COND IND SAK_COMP SAK_COND_LEFT SAK_COND_RIGHT 1 AND -1 2 5 2 AND -1 3 4 3 1 -1 -1 4 2 -1 -1 5 3 -1 -1 6 AND -1 7 10 7 AND -1 8 9 8 4 -1 -1 9 5 -1 -1 10 NOT -1 11 -1 11 6 -1 -1

Column Name	Description	Type	Length	Precision	Primary Key
SAK_CONDITION	FK to T_RU_ACTION. It's optional. This will be greater then -1 if some action (for example setting an edit) must occur when the required variables of a rule match a transaction, but this variable does not match the transaction.	NUMBER	9	0	Y
SAK_RULE	Primary-Key for this table	NUMBER	9	0	N
SAK_CONDITION_LEFT	FK to T_RU_CONDITION. If IND_LOGICAL_OP = " ", then this is -1.Otherwise it's > 0.	NUMBER	9	0	N
SAK_CONDITION_RIGHT	FK to T_RU_CONDITION. If IND_LOGICAL_OP = " ", then this is -1.Otherwise it's > 0.	NUMBER	9	0	N
SAK_COMPARISON	Primary key for row on T_RU_COMPARISON.	NUMBER	9	0	N
CDE_LOGICAL_CONNECTIVE	Define the relationship between the left and right conditions. Allowed values are "AND", "OR", "NOT", and " ". The value " " indicates that SAK_COMPARISON > 0.	CHAR	3	0	N

2.13.280 T_RU_DECISION

Any decision point in the transaction can be based on rules. The critical part of a decision within an instance of a transaction is that only 1 rule applies. That means rules within a decision cannot overlap such that a potential transaction exists where the conditions of both rules would match it. This concept of non-overlapping rules is a critical component of rules-based transaction processing. For example, if the transaction is Claim Submission then an instance of such transaction is a claim submitted by a provider. During the processing of that claim there are many decision points - example, is a service on the claim covered? There can only be one rule that can provide the answer. SAK CDE DSC 1 BP Member Plan - Procedure 1 BD Member Plan - Diagnosis 1 PP Provider Contract - Procedure 1 PD Provider Contract - Diagnosis 1 RP Reimbursement Agreement - Procedure 1 RD Reimbursement Agreement - Diagnosis

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DECISION	Primary-Key. A short identifier for the decision. It must be unique within a transaction. Examples, BP (Member Benefit Plan - Procedure), BD (Member Benefit Plan - Diagnosis).	CHAR	4	0	Y
CDE_TRANSACTION	This is the unique identifier for this table. Example, CLMS (Claim Submission).	CHAR	4	0	N
DSC_DECISION	A descriptive name of the decision. It should be unique for a transaction. Example, is the provider allowed to bill the service on the claim?, is the Procedure covered under the Member Benefit Plan?	VARCHAR2	80	0	N
SAK_ACTION_FAILS	FK to T_RU_ACTION. It's optional. This will be greater then -1 if some action (for example setting an edit such as procedure not covered for benefit plan) must occur when all REQUIRED variables of a rule do not match the transaction.	NUMBER	9	0	N
SAK_ACTION_PASS	This is the primary key for this table.	NUMBER	9	0	N

2.13.281 T_RU_DECISION_VAR

The collection of variables used by a decision. This means rules for that decision can be built with comparisons to these variables. Required variables must appear in all rules of a decision,

and thus we can index by required variables (for example, Date of Service and Procedure are required for "Member Plan - Procedure"). CDE_DECISION CDE_VARIABLE IND_REQUIRED SAK_ACTION BP PROC Y -1 BP DOS Y -1 BP AGE N 10 BP QTY N 11 BP MOD N 12 BD DIAG Y -1 BD DOS Y -1 BD AGE N 13 BD QTY N 14 PP PROC Y -1 PP DOS Y -1 PP QTY N 15 PP MOD N 16 PD PDH Y -1 PD DOS Y -1 PD QTY N 17 RP PROC Y -1 RP DOS Y -1 RP QTY N 18 RP MOD N 19 RD PDH Y -1 RD DOS Y -1 RD QTY N 20

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DECISION	Primary-Key. A short identifier for the decision. It must be unique within a transaction. Examples, BP (Member Benefit Plan - Procedure), BD (Member Benefit Plan - Diagnosis).	CHAR	4	0	Y
CDE_VARIABLE	Primary key for this table. The short identifier for the variable. It must be unique for the transaction that owns it.	CHAR	4	0	Y
SAK_ACTION_NOMATCH	This is the primary key for this table.	NUMBER	9	0	Y
IND_REQUIRED	Either "Y" or "N". "Y" means that all rules of this type must have that variable in their condition, which also means we can hash by that variable.	CHAR	1	0	N

2.13.282 T_RU_DISCRETE_SET

A discrete set is a collection of values. Each value in the set is a separate row on this table, all with the same SAK_VALUE.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_VALUE	Primary Key. IMPORTANT: There can be multiple rows with the same PK. Each row is another value in the set.	NUMBER	9	0	Y
CDE_VALUE	This is string of characters. Sometimes it will represent a SAK of a data base row such as the SAK of a procedured code.	VARCHAR2	50	0	N

2.13.283 T_RU_DOMAIN

Domain is equivalent to a data-type. Integer and Date are very common data-types, but MMIS has its own data-types defined as code-tables. Each variable on the transaction has a domain data-type. Examples: Integer DATE Boolean Place of Service Procedure code Member gender.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DOMAIN	The short identifier of the domain, used as a primary key. Examples, INT (integer), DATE, BOOL (boolean), POS (place of service).	CHAR	4	0	Y
DSC_DOMAIN	A descriptive name for the domain. This may appear in the UI. Examples, Integer, Place of Service.	VARCHAR2	40	0	N
NAM_DOMAIN_PLURAL	A plural name of the domain that will be used in the UI to label a listbox of the values in the domain. Examples, Integers, Booleans, Places of Service,	VARCHAR2	40	0	N
NAM_TABLE	If this domain can define its list of values in a code table then this is set to the name of the code table. Otherwise, it is " ".	VARCHAR2	40	0	N
NAM_COLUMN_CDE	If the value in NAM_TABLE is not " " then this is the column name of the CODE value on the source table for the domain values. Otherwise, its " ". Examples, CDE_POS, CDE_CLM_TYPE.	VARCHAR2	40	0	N
NAM_COLUMN_DSC	If the value in NAM_SOURCE_DOMAIN_TBL is not " ", then this is the column name of the DESCRIPTION value on the source table for the domain values. Otherwise, it is " ". Example, DSC_CLM_TYPE, DSC_MODIFIER.	VARCHAR2	40	0	N

2.13.284 T_RU_RELATION

A relation is an ordered collection of named attributes, where each attribute is a subset of a domain or sub-relation. Database tables, views, and query result-sets are examples of a

relation. So are our C structures, or a parameter list to a function. Our rule variables must be based on relations, since getter and setter functions of any programming language can have arbitrarily complex data. While domains hide their internal complexities, relations expose them. So an instance of a relation would be a row (or "tuple"). And an instance of a domain would be an encapsulated object whose internal data-structure we know nothing about. BTW, if CDE_DOMAIN is populated, this row is not really a relation, only a placeholder for a domain. Row examples: SAK DOMAIN MULTIVALUE 1 INT N 2 INT N 3 GND N 4 CT N 5 POS N 6 N 7 N 22 Y 23 MOD N 24 MODT N 25 OCC N

Column Name	Description	Type	Length	Precision	Primary Key
SAK_RELATION	The unique identifier for a row on this table.	NUMBER	9	0	Y
CDE_DOMAIN	This is an optional column. It is equal to " " if the relation has at least two attributes. Otherwise this "Relation" has only one attribute in which case it represents a domain to which it points.	CHAR	4	0	N
IND_MULTIVALUE	Set to "Y" if this variable holds not just one instance of the domain for the TRANSACTION VARIABLE, but an ordered collection of domain instances. Else set to "N". Although the relationship of this table is one to one with T_TRANSACTION_VARIABLE it must be split off from T_TRANSACTION_VARIABLE because of its complex structure.	CHAR	1	0	N

2.13.285 T_RU_RELATION_XREF

This is the common bill of materials structure (parts are made of parts that are made of parts and so on) that relate attributes. Each row represents an attribute of the "Relation" identified by SAK_RELATION. The attributes are identified by SAK_RELATION_CHILD. But SAK_RELATION_CHILD may itself be a Relation. This allows structures of any complexity. Row examples - refer to examples in T_RU_RELATION: SAK NUM_ORDER SAK_RELATION_CHILD 6 0 23 6 1 23 6 2 23 7 0 25 7 1 25 7 2 25 7 3 25 22 0 23 22 1 24 NOTE: Here is what some of the variables would look like in the Claim engine. int get_Age() { . return .; } List *get_Modifiers() { List *list = newList(); list_push(list, mod1); list_push(list, mod2); list_push(list, mod3); list_push(list, mod4); return list; } void set_ModType(List *tuples) { List *tuple; foreach (tuple, tuples) { char *modifierCode = list_item(tuple, 0); char *modifierType = list_item(tuple, 1); . } }

Column Name	Description	Type	Length	Precision	Primary Key

Column Name	Description	Type	Length	Precision	Primary Key
SAK_RELATION	This value groups the attributes of the relation identified by SAK_RELATION.	NUMBER	9	0	Y
SAK_RELATION_CHILD	This identifies each attribute of the RELATION to which SAK_RELATION for a row on this table. this FK points to either a DOMAIN or to another RELATION with more than one attribute.	NUMBER	9	0	Y
NUM_ORDER	This represents the attribute position within the relation..	NUMBER	4	0	N

2.13.286 T_RU_RULE

A rule is made up of a condition tree (that is, logical ANDs, ORs and comparisons) and a collection of actions. If the condition matches a transaction, all the actions are executed for that transaction. Rules also belong to a particular decision and for quick access decisions must mark which variables are required in their rules. All required variables are in the left sub-condition of the root condition, which must be a logical AND. SAK_RULE CDE_DECISION SAK_CONDITION CDE_RULE_EXCEPTION 1 BP 1 -1 2 BP 2 -1 Note: The 1st rule is "If the procedure is 99201, and date-of-service is between 9/24/2001 and 1/1/2005, and the member's age is between 0 and 45; then the procedure is covered". The 2nd rule's condition is "If the group is Anesthesia, and date-of-service is between 7/28/1999 and 12/31/2299, and the claim type is not A or C, then PA is required".

Column Name	Description	Type	Length	Precision	Primary Key
SAK_RULE	Primary-Key for this table	NUMBER	9	0	Y
CDE_DECISION	Primary-Key. A short identifier for the decision. It must be unique within a transaction. Examples, BP (Member Benefit Plan - Procedure), BD (Member Benefit Plan - Diagnosis).	CHAR	4	0	N
SAK_RULE_EXCEPTION	FK to T_RU_RULE. Optional. If it's greater than -1, then it points to a rule that is excluded from the decision making process. This is used to modify or override a rule inherited form a group higher in the classification.	NUMBER	9	0	N

Column Name	Description	Type	Length	Precision	Primary Key
SAK_CONDITION	It it's -1, there's no condition which means the rule never matches and cannot be applied. This is used when excluding a parent rule.	NUMBER	9	0	N

2.13.287 T_RU_RULE_ACTION

A rule can have multiple actions, and are executed when the rule matches a transaction.
SAK_RULE SAK_ACTION SAK_CONDITION 1 27 -1

Column Name	Description	Type	Length	Precision	Primary Key
SAK_RULE	Primary-Key for this table	NUMBER	9	0	Y
SAK_ACTION	This is the primary key for this table.	NUMBER	9	0	Y

2.13.288 T_RU_TRANSACTION

Transaction processing is pairs of requests from and responses to an outside entity. The request is the input-data of a transaction, and the response is the output-data. Both the request and response are structured as a collection of variables. One example transaction in MMIS is "Claim Submission".

Column Name	Description	Type	Length	Precision	Primary Key
CDE_TRANSACTION	This is the unique identifier for this table. Example, CLMS (Claim Submission).	CHAR	4	0	Y
DSC_TRANSACTION	This is a descriptive name for the transaction. Example, Claim submission.	VARCHAR2	4000	0	N

2.13.289 T_RU_TUPLE_SET

A tuple-set value is a collection of rows on this table, all with the same SAK_VALUE. Each row is a requirement of the tuple-set, and all the requirements must match the variable in the comparison, so in that sense they are like logical-ANDs. However, since each requirement may match only part of the variable, the part that matches cannot be reused by another requirement. The whole comparison is true if all minimums of each requirement are met, and the whole variable is been matched up to requirements.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_VALUE	Primary key.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_VALUE_DISCRETE	Primary Key. IMPORTANT: There can be multiple rows with the same PK. Each row is another value in the set.	NUMBER	9	0	Y
NUM_MIN_AXIS	The minimum number of items in the variable array that this requirement must match.	NUMBER	9	0	N
NUM_MAX_AXIS	The MAXIMUM number of items in the variable array that this requirement must match.	NUMBER	9	0	N

2.13.290 T_RU_VARIABLE

A transaction is a collection of variables. Each variable has a name, which is unique within the transaction. And each variable has a domain data-type. For example, a claim has variable called "Date of Service" whose domain is "Date". Variables can be derived; like Member's Age which is based on the member ID from the input-transaction, then is used to look-up the member's date of birth on-file, and then subtracted from the current date to get age. And while a transaction request is essentially a collection of input variables, the transaction response is also a collection output (or "action") variables. Row examples: SAK CDE DSC I SAK_RELATION NAM_FUNCTION NAM_LIBRARY 1 AGE Age I 1 get_Age libclmcomm.so 1 MOD Modifier I 6 get_Modifiers libclmcomm.so 1 PROC ProcedureI 14 get_Procedure libclmcomm.so 1 EDIT Set Edit O 18 set_ClaimEdit libclmcomm.so 1 PA PA RequiredO 19 set_PARequired libclmcomm.so 1 RATE Rate TypeO 21 set_RateType libclmcomm.so 1 MODT Modifier TypeO 22 set_ModType libclmcomm.so

Column Name	Description	Type	Length	Precision	Primary Key
CDE_VARIABLE	Primary key for this table. The short identifier for the variable. It must be unique for the transaction that owns it.	CHAR	4	0	Y
CDE_TRANSACTION	This is the unique identifier for this table. Example, CLMS (Claim Submission).	CHAR	4	0	N
SAK_RELATION	The unique identifier for a row on this table.	NUMBER	9	0	N
DSC_VARIABLE	A descriptive name of the variable. This may be used in the UI to label the variable.	VARCHAR2	40	0	N
CDE_INPUT_OUTPUT	"I" for input, "O" for output. Input variables can be used in a rule's condition. Output variables can be used in rule's action.	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
NAM_FUNCTION	If this variable is input-data on the transaction request, this C function should be a getter that takes no arguments and returns a value of the domain type. If the variable is output action, the function should be a setter which takes one argument of the domain type and returns nothing.	VARCHAR2	50	0	N
NAM_LIBRARY	The library that contains the function identified in NAM_TRAN_FUNCTION.	VARCHAR2	50	0	N

2.13.291 T_SITE_OF_DIFF

Site-of-Service adjustment factor for procedures generally performed in an office setting. The location where a physician's services are performed can have a bearing on practice costs for a provider. Practice costs for physicians are normally less when a service is completed in the outpatient department of a hospital instead of in the physician's office.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_POS	Setting where service was rendered (that is Office, Home, Inpatient Hospital, Outpatient Hospital, and so on). Valid values are maintained on the Place of Service Entity.	CHAR	2	0	N
DTE_EFFECTIVE	The date a site of differential percentage becomes effective for claims processing.	NUMBER	8	0	N
DTE_END	The date a site of differential percentage is no longer valid for use in claims processing.	NUMBER	8	0	N
PCT	Site-of-Service adjustment factor for procedures generally performed in the office setting.	NUMBER	3	2	N

2.13.292 T_SPEC_MOD

This entity is used to restrict modifiers from/to a specific provider specialty. The CDE attribute is used to determine the type of editing to be performed.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROV_SPEC	A code representing the specialized area of practice for a provider.	CHAR	3	0	Y
CDE_PROC_MOD	The modifier code used to further describe a procedure.	CHAR	2	0	Y
CDE	The CDE attribute is used to determine the type of editing to perform. A value of 'R' (Required) indicates the modifier is required to be billed on the claim for providers that have the defined specialty. A value of 'N' (Not allowed), indicates the modifier is not allowed to be billed on claims for the defined provider specialty.	CHAR	1	0	N
DTE_EFFECTIVE	The date the modifier to provider specialty restriction becomes valid for use in claims processing.	NUMBER	8	0	N
DTE_END	The date the modifier to provider specialty restriction ends for use in claims processing.	NUMBER	8	0	N

2.13.293 T_SPEC_TOB_XREF

Contains the type of bill codes that are valid for a particular provider specialty.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROV_SPEC	A code representing the specialized area of practice for a provider.	CHAR	3	0	N
CDE_TYPE_OF_BILL	Indicates the specific type of facility that is billing for services on a UB04 claim form.	CHAR	3	0	N

2.13.294 T_STATE

Definition of the valid states that are used in the system.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_STATE	The two byte state abbreviation.	CHAR	2	0	Y
DSC_STATE	The full name of the state.	CHAR	15	0	N

2.13.295 T_STATE_DESI

Contains the DESI drugs, with state defined effective dates. DESI is enacted by the Federal government and identifies drugs deemed to be less than effective; State's may also add to this listing

Column Name	Description	Type	Length	Precision	Primary Key
SAK_DRUG	System assigned key for a unique drug	NUMBER	9	0	Y
DTE_EFFECTIVE	The date at which the drug became DESI, signified as less than effective	NUMBER	8	0	N
DTE_END	The last date at which this DESI is effective; it is possible for a drug to be removed from DESI non payable status	NUMBER	8	0	N

2.13.296 T_STOP_LOSS_PARMS

Stop Loss is a pricing method that starts when capitated payments do not adequately cover the member's benefits. When a dollar threshold is met, the pricing method changes from encounter to a fee for service.

Column Name	Description	Type	Length	Precision	Primary Key
NUM_SEQUENCE	A number used to uniquely identify the rule	NUMBER	9	0	Y
SAK_FIN_PAYER	The system assigned key that identifies a unique payer within interChange.	NUMBER	9	0	N
SAK_PUB_HLTH	System assigned internal key for a medical assistance program.	NUMBER	9	0	N
CDE_STOP_LOSS_TYPE	Special indicator for special criteria (such aid and/or diag)	CHAR	1	0	N

Column Name	Description	Type	Length	Precision	Primary Key
CDE_DATE_TYPE	A date type: program enrollment date or date of service	CHAR	1	0	N
DTE_FROM	The date the threshold amount becomes effective.	NUMBER	8	0	N
DTE_TO	The last day the threshold amount is effective for claims processing.	NUMBER	8	0	N
AMT_THRESHOLD_FROM	The dollar amount that begins the pricing rule.	NUMBER	9	2	N
AMT_THRESHOLD_TO	The dollar amount of the threshold that ends the pricing rule.	NUMBER	9	2	N
AMT_PERCENTAGE	Percent that applies to the allowed amount.	NUMBER	3	2	N
CDE_METHOD	A choice of encounter or fee for service.	CHAR	1	0	N
DTE_EFFECTIVE	The date the Plan year begins.	NUMBER	8	0	N
DTE_END	The date the Plan year ends.	NUMBER	8	0	N

2.13.297 T_TAXONOMY_GROUP

Groups taxonomies by taxonomy type. This will be used by various parts of the system for different processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_TAXONOMY_TYPE	System assigned key for a unique taxonomy type, that represents a collection of taxonomies	NUMBER	9	0	Y
SAK_TAXONOMY_FROM	This is the system assigned key for the taxonomy code.	NUMBER	9	0	Y
SAK_TAXONOMY_TO	This is the system assigned key for the taxonomy code.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The date that the taxonomy is to become effective for the taxonomy type in claims processing	NUMBER	8	0	Y
DTE_END	The last date that the taxonomy is in effect for the taxonomy type in claims processing	NUMBER	8	0	N

2.13.298 T_TAXONOMY_TYPE

A taxonomy type is associated with a group of taxonomy codes. Used to identify taxonomy groups for use in certain processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_TAXONOMY_TYPE	System assigned key for a unique taxonomy type, that represents a collection of taxonomies	NUMBER	9	0	Y
DSC_50	Describes the taxonomy type	CHAR	50	0	N
DSC_DEFINITION	Definition of where and/or how this taxonomy group is used	VARCHAR2	4000	0	N

2.13.299 T_THERAPEUTIC_GROUP

Definition of where and/or how this taxonomy group is used

Column Name	Description	Type	Length	Precision	Primary Key
SAK_THERA_CLASS_TYPE	System assigned key for a unique therapeutic class type, that represents a collection of specific therapeutic class codes	NUMBER	9	0	Y
SAK_THERA_CLASS_FROM	The system assigned key for a unique drug therapeutic class.	NUMBER	9	0	Y
SAK_THERA_CLASS_TO	The system assigned key for a unique drug therapeutic class.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
DTE_EFFECTIVE	The date that the therapeutic class is to become effective for the therapeutic class type in claims processing	NUMBER	8	0	Y
DTE_END	The last date that the therapeutic class is in effect for the therapeutic class type in claims processing	NUMBER	8	0	N

2.13.300 T_THERAPEUTIC_TYPE

A therapeutic type is associated with a group of specific therapeutic classes. Used to identify specific therapeutic class codes for use in certain processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_THERA_CLASS_TYPE	System assigned key for a unique specific therapeutic class type, that represents a collection of specific therapeutic class codes	NUMBER	9	0	Y
DSC_50	Describes the therapeutic class type	CHAR	50	0	N
DSC_DEFINITION	Definition of where and/or how this specific therapeutic class group is used	VARCHAR2	4000	0	N

2.13.301 T_THERA_AHFS

Therapeutic Class Code, AHFS (AHFS) Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.

Column Name	Description	Type	Length	Precision	Primary Key
NUM_FORMULATION	This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds either the FDB GCN Sequence Number or the Micromedex Generic Formulation Code.	NUMBER	6	0	Y
CDE_THERA_CLS_AHFS	The Therapeutic Class Code, AHFS identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system. For FDB implementations, it is an 8-character field as supplied by ASHP (American Society of Health-System Pharmacists). For MDX implementations, it is a 10-digit code; the first 6 digits represent the AHFS Drug Information Classification System as supplied by ASHP, and the last four digits are a suffix added by Micromedex to differentiate the product's ingredient formulation.	CHAR	10	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_AHFS_REL	The GCN_SEQNO / AHFS Code Relation uses a concatenated key of GCN_SEQNO + AHFS to resolve the many-to-many relationship between GCNSEQNOTBL and AHFS Codes in AHFSDESCTBL. Each instance of this table provides the relative priority of assignment of a specific AHFS Code to its associated GCN_SEQNO (data element AHFS_REL). Each GCN_SEQNO value in GCNSEQNOTBL has at least one corresponding record in AHFSTBL.	CHAR	2	0	N

2.13.302 T_THERA_FDA

The HCFA FDA Therapeutic Equivalency Code (HCFA_FDA) indicates that although the drugs may have a different therapeutic classification, the FDA considers them therapeutically equivalent. The HCFA_FDA is provided on the Health Care Financing Administration's quarterly tape.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_THERA_CLS_FDA	The HCFA FDA Therapeutic Equivalency Code (HCFA_FDA) indicates that although the drugs may have a different therapeutic classification, the FDA considers them therapeutically equivalent. The HCFA_FDA is provided on the Health Care Financing Administration's quarterly tape.	CHAR	2	0	Y
DSC	Text description of the HCFA FDA Therapeutic Equivalency Code.	VARCHAR2	100	0	N

2.13.303 T_TOB_CT_XREF

Associates UB04 claim types (A=crossover part A, C=crossover part C, I=inpatient, O=outpatient, L=nursing home, and H=home health) to type of bill codes which indicate a specific type of facility billing services.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_TYPE_OF_BILL	Code which indicates a specific type of facility.	CHAR	3	0	N
CDE_CLM_TYPE	Value for the type of claim that can be processed in the MMIS system.	CHAR	1	0	N

2.13.304 T_TOB_GROUP

This entity groups together ranges of types of bill. Having this table avoids hard coding types of bill in programs.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_TOB_TYPE	This field is used to identify the type of bill type. It contains a number from 1 to 999 that corresponds to a range of type of bill codes.	NUMBER	9	0	Y
CDE_TYPE_OF_BILL	Type of bill from the UB04 claim form.	CHAR	3	0	N
DTE_EFFECTIVE	Beginning date for the type of bill group entity.	NUMBER	8	0	N
DTE_END	Ending date segment for the type of bill group segment.	NUMBER	8	0	N

2.13.305 T_TOB_TYPE

This entity is used in conjunction with the type of bill group. The type of bill types and their descriptions are on this entity, and the type of bill codes that correspond with each type of bill type are on the type of bill group.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_TOB_TYPE	This field is used to identify the type of bill type. It contains a number from 1 to 999 that corresponds to a range of type of bill codes.	NUMBER	9	0	Y
DSC_50	This contains the description for the type of bill type.	CHAR	50	0	N

Column Name	Description	Type	Length	Precision	Primary Key
DSC_DEFINITION	Definition of where and/or how this TOB groups is used.	VARCHAR2	4000	0	N
DSC_25	This contains the description for the type of bill type.	CHAR	25	0	N

2.13.306 T_TOOTH

These are the valid tooth numbers and their descriptions.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_TOOTH_NBR	The code associated to a particular tooth.	CHAR	2	0	Y
DSC_TOOTH_NBR	This is the description of the tooth.	CHAR	40	0	N

2.13.307 T_TOOTH_QUADRANT

These are the valid tooth quadrants and their descriptions.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_TOOTH_QUAD	Code identifying the tooth quadrant.	CHAR	3	0	Y
DSC_TOOTH_QUAD	Description of tooth quadrant.	VARCHAR2	50	0	N

2.13.308 T_TOOTH_SURFACE

These are the valid tooth surfaces and their descriptions.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_TOOTH_SURFACE	The code used to identify a surface of a tooth.	CHAR	1	0	Y
DSC_TOOTH_SURFACE	Description of the tooth surface.	CHAR	8	0	N

2.13.309 T_TPL_COV_PLAN_XREF

This table allows users to tie TPL coverage codes to benefit plans used as OI Plans and carriers associated with those plans.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_COVERAGE	This code identifies the type of coverage that a TPL policy provides.	CHAR	2	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PUB_HLTH	System assigned internal key for a member plan.	NUMBER	9	0	Y
SAK_CARRIER	This is the system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier ID which is used on all screens and reports.	NUMBER	9	0	Y
DTE_ACTIVE	This is the date that the row becomes active.	DATE	0	0	N
DTE_INACTIVE	The date that the row becomes inactive.	DATE	0	0	N
DTE_EFFECTIVE	Effective date of the row.	NUMBER	8	0	N
DTE_END	End date of the row.	NUMBER	8	0	N

2.13.310 T_TP_SPC_MOD_EXCL

This table provides the capability to enforce certain provider type/specialty/modifier group combinations during claims processing.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_MOD_TYPE	System assigned key for a unique modifier grouping type, that represents a collection of modifier codes.	NUMBER	4	0	Y
CDE_PROV_TYPE	Type that a provider is licensed for.	CHAR	2	0	Y
CDE_PROV_SPEC	A code representing the specialized area of practice for a provider.	CHAR	3	0	Y
DTE_EFFECTIVE	The date this modifier group/provider type/specialty restriction becomes effective for claims processing.	NUMBER	8	0	Y
DTE_END	The date this modifier group/provider type/specialty restriction is no longer effective for claims processing.	NUMBER	8	0	N

Column Name	Description	Type	Length	Precision	Primary Key
IND_EXCL	Indicates if the modifier group is included or excluded as a requirement for the provider type/specialty.	CHAR	1	0	N

2.13.311 T_TYPE_OF_BILL

This table contains the valid types of bills and their description.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_TYPE_OF_BILL	Code which indicates a specific type of facility.	CHAR	3	0	Y
DSC_TYPE_OF_BILL	Describes the specific type of facility.	CHAR	20	0	N
IND_PROC_IN_EXCLUD	Code which indicates whether the associated list of procedure codes is valid or invalid for the type of bill.	CHAR	1	0	N

2.13.312 T_TYPE_SPEC_CODE

A type spec type is associated with a group of type spec codes. Used to identify type spec codes for use in certain processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_TYPE_SPEC	The system assigned key for the type specialty group.	NUMBER	9	0	Y
DSC_50	The description of the provider type specialty group code.	CHAR	50	0	N
DSC_DEFINITION	Definition of where and/or how this type spec group is used.	VARCHAR2	4000	0	N

2.13.313 T_TYPE_SPEC_EXCL

This entity provides the capability to excluded certain provider type/specialty combinations from an edit.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y
CDE_PROV_TYPE	Type that a provider is licensed for.	CHAR	2	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_PROV_SPEC	A code representing the specialized area of practice for a provider.	CHAR	3	0	Y
IND_CODE	A code to indicate the type of exclusion. An 'E' = emergency, 'F" = family planning, and '0' (zero) = general exclusion.	CHAR	1	0	Y

2.13.314 T_TYPE_SPEC_GROUP

Groups type spec codes by type spec type. This will be used by various parts of the system for different processing methodologies.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_TYPE_SPEC	The system assigned key for the type specialty group.	NUMBER	9	0	Y
CDE_PROV_TYPE	Type that a provider is licensed for.	CHAR	2	0	Y
CDE_PROV_SPEC	A code representing the specialized area of practice for a provider.	CHAR	3	0	Y
DTE_EFFECTIVE	The date on which the provider type / specialty group becomes effective.	NUMBER	8	0	Y
CDE_TYPE_SPEC_EI	Identifies if the associated provider type and provider specialty is included or excluded from the group.	CHAR	1	0	N
DTE_END	The date that the provider type / specialty group stops being effective.	NUMBER	8	0	N

2.13.315 T_UMBRELLA_PARM

Auditing performed for services that are included in a global surgery code.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_ESC	System assigned key that uniquely identifies an error number.	NUMBER	9	0	Y

Column Name	Description	Type	Length	Precision	Primary Key
CDE_TIME_UNIT	Indicates whether days, months, or years should be used as the unit of measure for the audit.	CHAR	1	0	N
CDE_BEF_AFT	Indicates whether the time limit specified should be checked for services before history, after history, or both.	CHAR	1	0	N
NUM_UNIT_BEFORE	Specifies the number of units (days, months, years) in history that should be checked before a claim's dates of service.	NUMBER	4	0	N
NUM_UNIT_AFTER	Specifies the number of units (days, months, years) in history that should be checked after a claim's dates of service.	NUMBER	4	0	N
CDE_AUDIT_DIR	Indicates whether the audit checks a surgery on the current claim against a pre- or post- op visit in history or checks a pre- or post- op visit on the current claim against a surgery code in history.	CHAR	1	0	N
NUM_GLOBAL_SURG	The value of the global surgical code of the procedure codes that this audit is checking.	CHAR	3	0	N

2.13.316 T_VALUE

Contains the valid codes and description of those codes which are used to relate values to identified data elements necessary to process a UB04 claim.

Column Name	Description	Type	Length	Precision	Primary Key
CDE_VALUE	Code used to relate values to identified data elements necessary to process a UB04 claim.	CHAR	2	0	Y
DSC_VALUE	Description of the code used to relate values to identified data elements necessary to process a UB04 claim.	CHAR	40	0	N

2.13.317 T_VFC_ADMIN_FEE

Vaccines For Children (VFC) Admin Fee table holds the flat fee reimbursement rates for vaccine administration to Medicaid members ages 18 and under. Effective dates for a particular rate are maintained and are used in the rate selection process (as it relates to the claim's from date of service). Sak short {proc type} relates back to the procedure code type this rate applies to. Sak {vfc admin fee} serves to allow for multiple rates within the same proc type and will aid in audit research.

Column Name	Description	Type	Length	Precision	Primary Key
SAK_PROC_TYPE	System assigned key for a unique procedure type, that represents a single or collection of procedures.	NUMBER	9	0	Y
SAK_VFC_ADMIN_FEE		NUMBER	9	0	N
DTE_EFFECTIVE	Effective date (start) of a particular administrative fee reimbursement amount.	NUMBER	8	0	N
DTE_END	End date of a particular administrative fee reimbursement amount.	NUMBER	8	0	N
AMT	Flat fee rate at which vaccine administration for members ages 18 years and younger are reimbursed.	NUMBER	9	2	N

Security Management Detailed System Design

Kentucky MMIS Project

Cabinet for Health and Family Services
Department for Medicaid Services

March 7, 2008

Cabinet for Health and Family Services Department for Medicaid Services	
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DELIVERABLE TITLE: Security Management Detailed System Design	DATE SUBMITTED: March 7, 2008
FILE NAME: KY_MMIS_Security_Management_DSD_REFRESH_v3.1_FINAL_(03-07-2008).doc	AUTHORING TOOL: MSWord2003

Document Change Log

Version	Changed Date	Changed By	Reason
1.0	9/17/2007	Scott Lowry	Creation of new document.
2.0	10/23/2007	Scott Lowry	Updates after 1st round review
3.0	10/24/2007	Scott Lowry	Updates after Commonwealth walkthrough.
3.1	01/29/2008	Ann Murray	Added section 2.3. per Patti George

Table of Contents

1 Introduction 1

2 Security Management Detailed System Design 2

2.1 Subsystem Flow 2
2.2 PAGE: Roles 2
2.2.1 Description 2
2.2.2 Technical Name 2
2.2.3 Web Page Name 2
2.2.4 User Type and Role Assignment Reference 2
2.2.5 Security Layout 3
2.2.6 Field Descriptions 3
2.2.7 Field Edits 4
2.2.8 Associated Requirements 4
2.2.9 CO / Defects 4
2.3 PAGE: Role Search 5
2.3.1 Description 5
2.3.2 Technical Name 5
2.3.3 Panel Name 5
2.3.4 Role Search Layout 5
2.3.5 Extra Features 5
2.3.6 Field Descriptions 6
2.3.7 Field Edits 6
2.3.8 Associated Requirements 6
2.3.9 CO / Defects 6

1 Introduction

This document provides the interChange .NET security maintenance design information. Information on the Medicaid Enterprise User Provisioning System (MEUPS) was reviewed and approved through a separate process and is not included in this document.

The interChange application is constructed using the concept of controls. A control is a button, a drop down box, or a text box and its associated label. During construction, developers place these controls on containers called panels that provide for logical grouping of related controls. The panel types in interChange include menus, navigation panels, information panels, search panels, search results panels, and data entry panels. Panels are related to each other by placing them on a common page. Through these relationships, a search panel can activate a search results panel, a navigation panel can activate a data entry panel or a variety of other interactions can occur.

After security is applied to a page, panel, or control, the behavior of the related controls, panels, and pages changes. For example, if a user is not allowed to view a particular panel, then the related navigation control makes the menu option unavailable to the user.

The security functions of interchange are controlled through the roles page. The roles page contains a tree control with every page, panel, and control in the system. The roles page is accessed from the roles search page. After a role has been selected from the Roles Search page, the roles page allows the security administrator to configure the security for that role.

2 Security Management Detailed System Design

2.1 Subsystem Flow

2.2 PAGE: Roles

2.2.1 Description

The roles page allows the security administrator to configure the security for a specific role. By navigating the tree control, the administrator can apply the security attributes of “Read Only”, “None”, “Invisible”, or “Editable” to a page, panel, or control. These attributes are described below:

- Read Only – The information contained in this item can be viewed but not edited;
- None - Security is not applied to this item and will be inherited from its parent;
- Invisible - The item will not be seen by the user; and,
- Editable - Information contained in this item may be modified and saved.

If security is set at a container level, such as page or panel, then the security setting cascades to all items in the container. If an item in the container has a security attribute other than “none”, then that attribute will override the attribute on the container.

If a user is assigned two roles with conflicting permissions then the most liberal permissions are granted.

2.2.2 Technical Name

Roles

2.2.3 Web Page Name

Roles

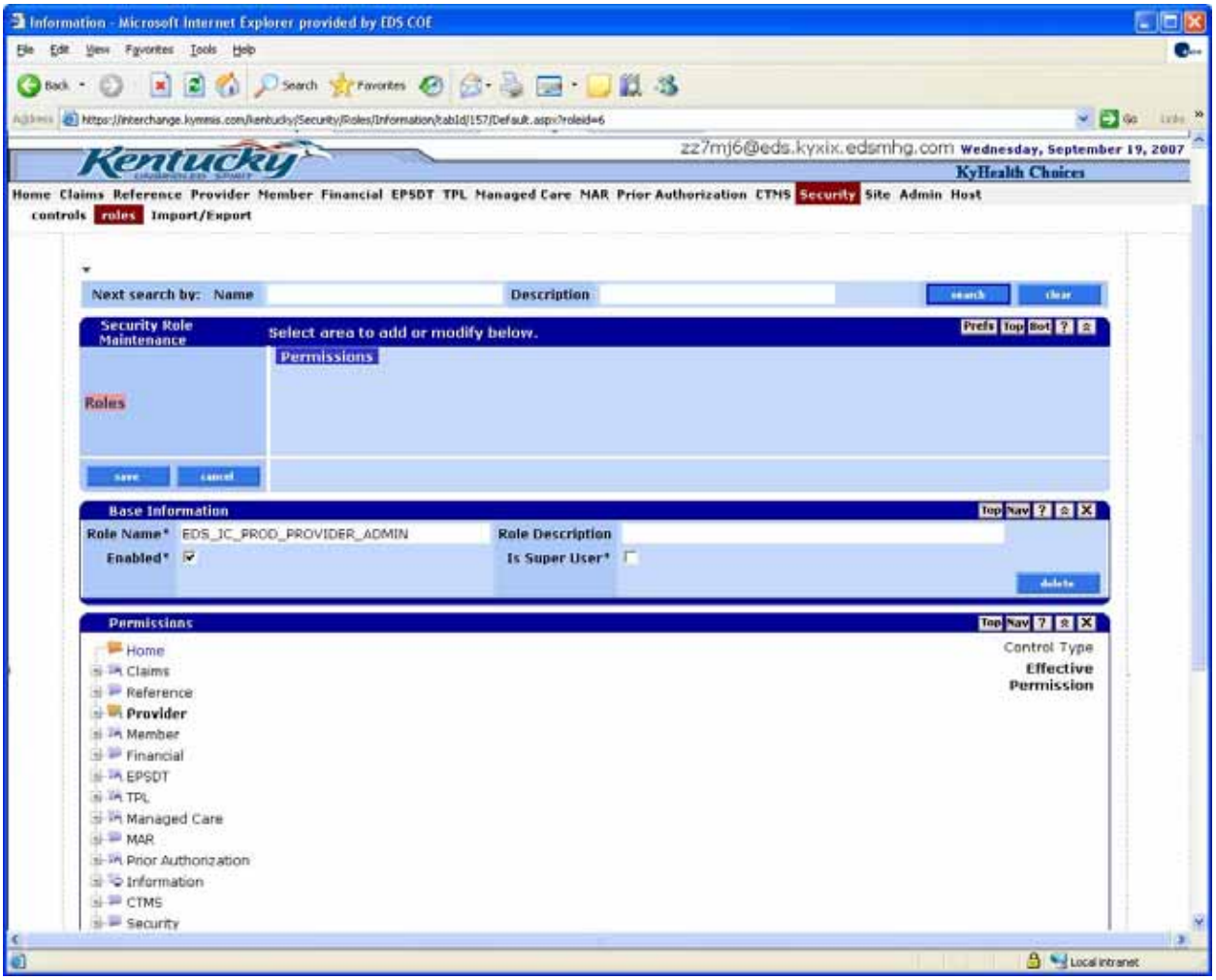
For readability the layout displays on the next page.

2.2.4 User Type and Role Assignment Reference

The User Type and Role Assignment cross reference is maintained in a separate document, which is located on the Project Work Book (PWB). You may access the document via the following link:

https://ddipwb.kymmis.com/KYXIXDDI/ProjMgmt/DeliverableMgmt/Drafts/DSD%20Refresh/MEUPS_Production_Roles/Roles%20In%20Production.xls

2.2.5 Security Layout



2.2.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Role Name	The name of the role being modified. This name must match the name in the ADFS federation server exactly.	Text	Character	N/A	N/A	N/A
Role Description	The description of the role being modified. This role is not used or displayed anywhere in the system except on this page.	Text	Character	N/A	N/A	N/A

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Enabled	This is an indicator that tells whether this role is currently in use. This provides the ability to temporarily disable a role.	Checkbox	Character	N/A	N/A	N/A
Is Super User	This is an indicator that tells whether the role has permissions to affect .NET nuke functions and security functions of the application.	Checkbox	Character	N/A	N/A	N/A

2.2.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
None.				

2.2.8 Associated Requirements

ID
None.

2.2.9 CO / Defects

ID	Type	Name	Description	Current Status
None.				

2.3 PAGE: Role Search

2.3.1 Description

The role search page allows the security administrator to locate a particular role so it may be viewed or modified. After a role name is entered and the search button is clicked, the results will display. The role name field for the search may be a partial name.

2.3.2 Technical Name

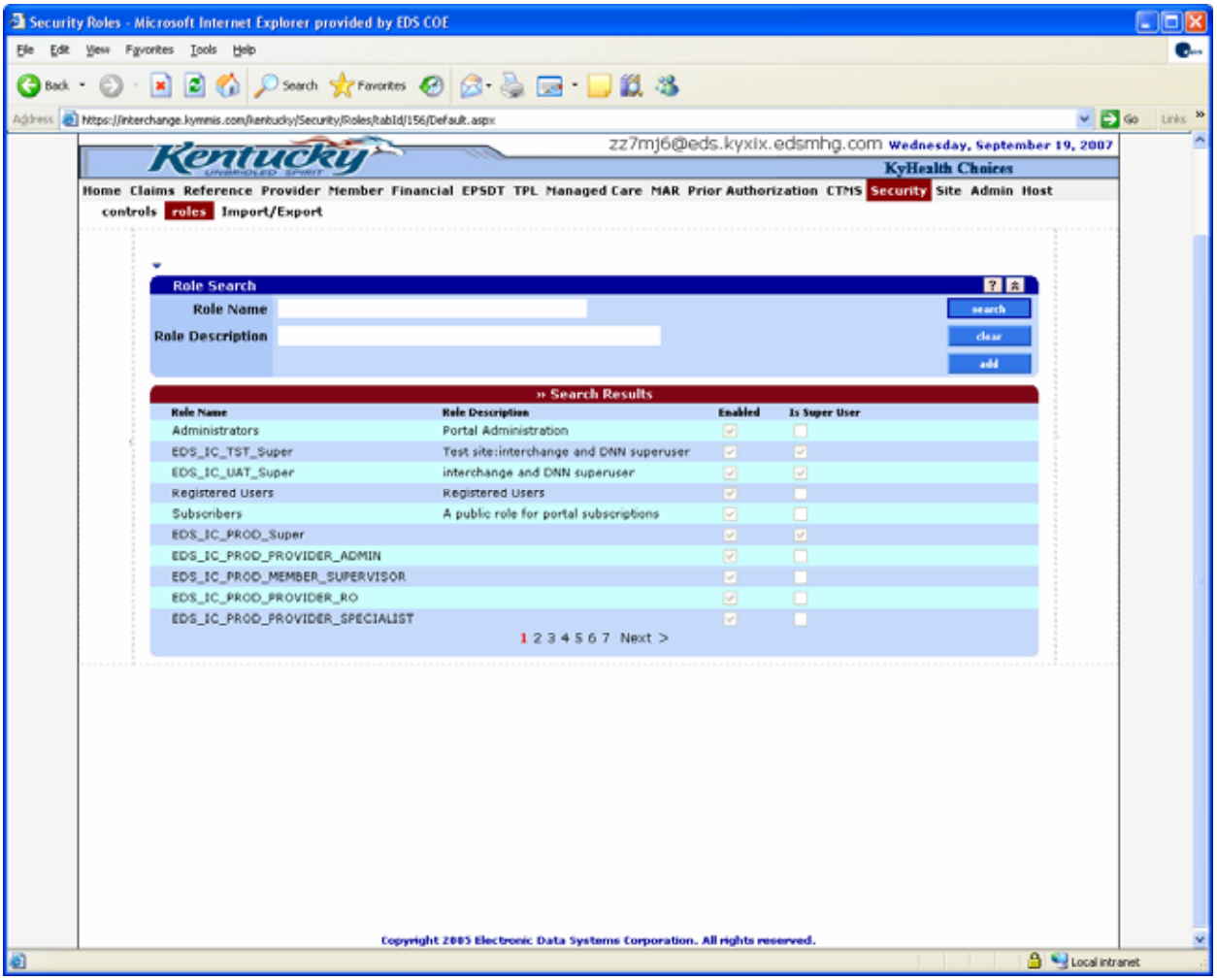
Role Search

2.3.3 Panel Name

Role Search

For readability the layout displays on the next page.

2.3.4 Role Search Layout



2.3.5 Extra Features

This page has no extra features.

2.3.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Role Name	The name of the role to search for in the security files.	Text	Character	40	N/A	N/A
Role Description	The description of the security roles.	Text	Character	60	N/A	N/A

2.3.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
None.				

2.3.8 Associated Requirements

ID
None.

2.3.9 CO / Defects

2.3.9.1 Modify Clerk Role Management - 374

Identifier	Type	Level	Subsystem	Computed	Estimated	Priority
374	Change Order		Security			19

2.3.9.2 Desired Solution

Modify dropdown to allow multiple selections before selecting the Add Role button. As items are moved from the dropdown, remove selected entries from dropdown, also provide same service in reverse. Update the underlying tables to contain entries in addition to the existing values for:

- Presumptive Eligibility
- KENPAC
- Regional Brokers
- Nursing Facility
- QIT
- NEMT
- RAs

2.3.9.3 Business Impact

No specific business impact identified. No business design changes are incorporated by

2.3.9.4 Clarifications

No associated clarifications found.

2.3.9.5 Associated Requirements

Requirement ID	Type
30.050.003.002.13	RFP Requirement

2.3.9.6 Associated System Objects

Technical Name	Object Type	Title
Clerk Role Management	Window	Clerk Role Management

2.3.9.7 Change Order Status

Status	Date
Change Order Written	08/01/2005
Cancelled	06/21/2007

Service/ Prior Authorization Detailed System Design

Kentucky MMIS Project

Cabinet for Health and Family Services
Department for Medicaid Services

March 7, 2008

Cabinet for Health and Family Services Department for Medicaid Services	
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DELIVERABLE TITLE: Service/ Prior Authorization Detailed System Design	DATE SUBMITTED: March 7, 2008
FILE NAME: KY_MMIS_Service_Prior_Authorization_DSD_REFRESH_v3.2_FINAL_(03-07-2008).doc	AUTHORING TOOL: MSWord2003

Document Change Log

Version	Changed Date	Changed By	Reason
1.0	9/14/2007	Cynthia Warner	Creation of new document – 1st draft.
2.0	9/20/2007	Cynthia Warner	Revisions made according to internal review comments.
3.0	12/6/2007	Cynthia Warner	Revisions made according to Commonwealth comments.
3.1	01/28/2008	Ann Murray	Updated Internal and External Interfaces section.
3.2	01/29/2008 01/30/2008 01/31/2008	Cathy Hill	Made revisions made per Patti George according to Commonwealth requests.

Table of Contents

1 Introduction 1

2 Service/Prior Authorization Detailed System Design 2

2.1 System Flow 2
2.1.1 interChange System Architecture 2
2.1.2 System Flow 3
2.2 Subsystem Description 4
2.2.1 Introduction to Service/Prior Authorization 4
2.3 Service/Prior Authorization Processes 5
2.3.1 Maintain Service/Prior Authorization Data 5
2.3.2 Generate Prior Authorization Letters 11
2.3.3 End Date PAs of Members going into Managed Care 13
2.3.4 Orthodontic Case Tracking Process 13
2.3.5 Generate EPSDT First Time Letter 14
2.3.6 Automated Mass Update Process 14
2.3.7 Produce Service/Prior Authorization Reports Flow Diagram 17
2.4 Data Model 18
2.4.1 Data Model Diagram 19
2.4.2 Subsystem Primary Entities 20
2.4.3 External System Interfaces 21
2.5 Job Scripts 22
2.5.1 PAUJD001 - Produce PA Notices 22
2.5.2 PAUJD200 - Create First-time EPSDT Services Letter 23
2.5.3 PAUJD278 - PA 278 Batch processing 24
2.5.4 PAUJM001 - Update the PAUMONTH Date Parms 25
2.5.5 PAUJM130 - End Date Prior Authorizations for Members in Managed Care 26
2.5.6 PAUJM151 - Delete Pending PA's 27
2.5.7 PAUJM210 - First-time EPSDT services monthly report job 28
2.5.8 PAUJM220 - PA orthodontic case tracking process 29
2.5.9 PAUJR140 - Mass Update - Old Provider 31
2.5.10 PAUJR141 - Mass Update - New Provider 32
2.5.11 PAUJR142 - Prior Authorization Mass Update For Rates And Service Codes 33
2.5.12 PAUJW150 - Impact Plus Extract 34
2.6 Programs 35
2.6.1 libpacomm.so -- Transaction routines for PA. 35
2.6.2 paup278 -- PA 278 Transaction Processor 38
2.6.3 paup278d -- PA 278 driver program 40
2.6.4 paupd001 -- Select PA Notices for printing by the Letter Generator 42
2.6.5 paupd152 -- Add Pending PA with transaction from the web 44
2.6.6 paupd200 -- Insert letter requests for PA 1st time EPSDT notification 46
2.6.7 paupdXML -- PA xmlpunld Hooks for Batch Interfaces 48
2.6.8 paupedit -- Prior Authorization Request and Update Engine 49
2.6.9 paupm001 -- Update system parm table for monthly PA cycle 51
2.6.10 paupm130 -- End Date Prior Auths 52
2.6.11 paupm151 -- Delete Old Pending PAs from the database 54
2.6.12 paupm210 -- Create monthly first-time EPSDT services report 56
2.6.13 paupm220 -- PA Orthodontic Case Tracking Process Reports and Letters 58
2.6.14 paupr140 -- Mass update - old provider 60
2.6.15 paupr141 -- Mass update - new provider 63
2.6.16 paupr142 -- Rate Service Code Mass Update Report 65
2.6.17 paupw150 -- Impact Plus Interface 67
2.6.18 -- AddLoad pending PA into database 69
2.7 Pages/Panels 70

2.7.1 PAGE: Prior Authorization Information Page ... 70
2.7.2 PANEL: Prior Authorization Mini Search ... 72
2.7.3 PANEL: Prior Authorization Internal Text ... 74
2.7.4 PANEL: Prior Authorization Line Item ... 77
2.7.5 PANEL: Additional Diagnosis Codes ... 90
2.7.6 PANEL: Prior Authorization Maintenance ... 92
2.7.7 PANEL: Prior Authorization Mass Updates ... 94
2.7.8 PANEL: Prior Authorization Information ... 97
2.7.9 PANEL: Prior Authorization Related Documents ... 106
2.7.10 PANEL: Prior Authorization Base Information ... 108
2.7.11 PANEL: Prior Authorization Paid Claim List ... 118
2.7.12 PAGE: Prior Authorization Mass Update Search Page ... 121
2.7.13 PANEL: Prior Authorization Mass Update Search Panel ... 122
2.7.14 PAGE: Prior Authorization Related Data ... 125
2.7.15 PANEL: Prior Authorization Category Provider Xref ... 126
2.7.16 PANEL: Prior Authorization Media Type ... 129
2.7.17 PANEL: Prior Authorization Decision Status ... 132
2.7.18 PANEL: Prior Authorization Category Information ... 135
2.7.19 PANEL: Prior Authorization Reason ... 139
2.7.20 PAGE: Prior Authorization Search Page ... 141
2.7.21 PANEL: Prior Authorization Search ... 142
2.7.22 PANEL: Prior Authorization Search Results ... 147
2.7.23 PAGE: Prior Authorization Pending Information Page ... 151
2.7.24 PANEL: Pending Prior Authorization Diagnosis Panel ... 151
2.7.25 PANEL: Pending Prior Authorization Information Panel ... 154
2.7.26 PANEL: Pending Prior Authorization Line Item Panel ... 158
2.7.27 PANEL: Pending Prior Authorization Text Panel ... 162
2.7.28 PAGE: Prior Authorization Pending Search Page ... 164
2.7.29 PANEL: Pending Prior Authorization Search ... 165
2.7.30 PANEL: Prior Authorization Administrative Review ... 169
2.7.31 PANEL: Prior Authorization Appeals ... 172
2.7.32 PANEL: Prior Authorization External Text ... 176
2.7.33 PANEL: Prior Authorization Non Medicaid Provider ... 178
2.7.34 PANEL: Super PA ... 182
2.8 Reports ... 185
2.8.1 PAU-0130-M -- End Date PA for Member in MC ... 185
2.8.2 PAU-0140-R -- Mass Update Old Provider ... 189
2.8.3 PAU-0141-R -- Mass Update New Provider ... 194
2.8.4 PAU-0142-R -- Mass Update Rate Service Code ... 198
2.8.5 PAU-0210-M -- EPSDT First Time Prior Authorizations ... 201
2.8.6 PAU-0220-M1 -- Orthodontic Six Month Progress Report Not Received ... 205
2.8.7 PAU-0220-M2 -- Orthodontic Final Case Tracking ... 208
2.9 Letters ... 211
2.9.1 PAU-001A-D -- Waiver Member Letter ... 211
2.9.2 PAU-001B-D -- Waiver Provider Letter ... 214
2.9.3 PAU-001D-D -- Home Health Provider Letter ... 218
2.9.4 PAU-001E-D -- Home Health Member Letter ... 221
2.9.5 PAU-001F-D -- Impact Plus Provider Letter ... 225
2.9.6 PAU-001G-D -- Other PA Types Provider Letter ... 229
2.9.7 PAU-001H-D -- Inpatient NF Provider Letter ... 233
2.9.8 PAU-0140-RL -- Mass Update Old Provider Letter ... 237
2.9.9 PAU-0141-RL -- Mass Update New Provider Letter ... 241
2.9.10 PAU-0142-RL -- Mass Update Rate Service Code Letter ... 245
2.9.11 PAU-0200-DL -- EPSDT First Time Prior Authorization Letter ... 249
2.9.12 PAU-0220-1L -- Orthodontic Six Month Progress Report Letter ... 251
2.9.13 PAU-0220-2L -- Orthodontic Six Month Progress Report Follow Up Letter ... 256

2.9.14 PAU-0220-3L -- Orthodontic Final Case Letter 261
2.9.15 PAU-0220-4L -- Orthodontic Final Case Follow Up Letter 266
2.10 Internal and External Interfaces 271
2.10.1 Output – Impact Plus Interface – Interface ID 465 271
2.10.2 PA 278 Request and Response 273
2.11 Requirement Matrix and Cross Reference 309
2.12 Change Orders 318
2.12.1 Modify PA Administrative Panel - 321 318
2.12.2 Change Table T_PA_PAUTH - 508 320
2.12.3 Define Edits for Prior Auth - 509 321
2.12.4 Modify PA Appeals Panel - 571 322
2.12.5 Modify PA Information Panel - 572 324
2.12.6 Modify PA Base Panel - 573 326
2.12.7 Modify PA Line Item Panel - 574 328
2.12.8 Modify PA Internal Text Panel - 575 330
2.12.9 Modify PA External Text Panel - 576 331
2.12.10 Modify PA Non Med Prov Panel - 577 332
2.12.11 Modify Super PA Panel - 578 334
2.12.12 Produce Prior Auth Reports - 620 336
2.12.13 Operate Service Auth Function - 621 337
2.12.14 Provide Service Auth Training - 622 338
2.12.15 Prior Auth Mass Updates - 1055 339
2.12.16 Create PA Diagnosis Panel - 1779 341
2.12.17 Modify PA Claim List Panel - 1780 343
2.12.18 Modify PA Assignment Panel - 1781 345
2.12.19 Modify PA Decision Panel - 1782 346
2.12.20 Modify PA Reason Code Panel - 1783 347
2.12.21 Modify PA Media Panel - 1784 348
2.12.22 Modify PA Search Panel - 1785 349
2.12.23 Modify PA Search Results Panel - 1786 351
2.12.24 Modify PA Related Data Panel - 1801 353
2.12.25 Change Table T_PA_INT_TEXT - 1954 354
2.12.26 Change Table T_PA_ESC - 1956 355
2.12.27 Create Table T_PA_APPEAL_STATE – 1957 356
2.12.28 Create Table T_PA_DIAGNOSIS - 2063 358
2.12.29 Change Table T_PA_ADMIN_REV - 2124 359
2.12.30 End Date PA if Mmbr goes to MC - 2125 360
2.12.31 Modify T_PA_PAUTH_STATE - dates - 2128 362
2.12.32 CORE MOD T_PA_LINE_ITEM - 2158 363
2.12.33 Modify T_PA_PAUTH_STATE - 2203 364
2.12.34 Modify Base and Informtn Panels - 2209 365
2.12.35 Create Table T_PA_CAT_PT_XREF - 2221 366
2.12.36 Create Category/Prov Type Panel - 2222 367
2.12.37 Create Prior Auth Letters - 2224 368
2.12.38 KYAmend Process SHPS Trxs – 2261 370
2.12.39 Manually loaded tables - 2265 371
2.12.40 Retrofit for NPI - 2372 372
2.12.41 Modify T_PA_PAUTH for NPI - 2491 373
2.12.42 KYAmend Display PA Documents – 2514 374
2.12.43 KYAmend Case Nbr- panel changes - 2516 376
2.12.44 KYAmend Load PAs for Pending Elg – 2518 378
2.12.45 KYAmend PA Orthodontic Process - 2519 380
2.12.46 KYAmend PA EPSDT Process - 2520 383
2.12.47 KYAmend Create Add'l PA Letters - 2521 385
2.12.48 KYAmend Process PA 278 trxs - 2697 387
2.12.49 CORE 12741 - Reason Code panel - 2751 388

2.12.50 CORE 12747 Line Item panel - 2752 389
2.12.51 CORE updates - 2753 390
2.12.52 KYAmend Pending PA table - 2754 392
2.12.53 KYAmend Delete Old Pending PAs – 2755 394
2.12.54 Mass Updates - New Provider - 2756 396
2.12.55 Mass Updates - Rate - Panel - 2757 399
2.12.56 Create T_PA_MASS_UPD - 2758 400
2.12.57 Mass Updt - load new rates/serv - 2759 402
2.12.58 Mass Updates - Search Panel - 2769 404
2.12.59 KYAmend Table Change Impact Plus - 2770 405
2.12.60 KYAmend Table Change - Case Nbr - 2771 407
2.12.61 KYAmend Create Pend Search Panel – 2772 409
2.12.62 AVR XML Transaction - 2778 411
2.12.63 KYAmend PASRR - 2788 413
2.12.64 CORE 12825 PA Search Panel - 2810 415
2.12.65 CORE 12824 Admin Review panel - 2812 416
2.12.66 CORE 12778 Line Item Paid Claim - 2813 417
2.12.67 CORE 12818 Line Item panel edits - 2818 418
2.12.68 KYAmend MHMR Impact Plus Extract - 2874 419
2.12.69 KYAmend Process Web PAs - 2935 421
2.12.70 Mass Updates - Old Provider - 2936 422
2.12.71 KYAmend Ortho Status Code - 2988 424
2.12.72 KYAmend Add Tax ID to Line Item - 2993 426
2.12.73 KYAmend Ortho Status for Panels - 3139 428
2.12.74 KYAmend Create Pend LItem panel – 3322 430
2.12.75 KYAmend Create Pend PAInfo Panel – 3323 431
2.12.76 KYAmend Create Pend Diag Panel – 3325 433
2.12.77 KYAmend Create Pend Text Panel – 3326 434
2.12.78 KYAmend Modify table Case Number - 3378 435
2.12.79 KYAmend Add Case Nbr to Search - 3480 436
2.12.80 DCR989-CO3646 Update AVR XML Txn - 3646 437
2.12.81 KYAmend Modify T_PA_LINE_ITEM - 3708 438
2.12.82 KYAmend-Add Frequency to Panels - 3709 440
2.12.83 KYAmend Modify evsppa - 3723 442
2.12.84 KYAmend Modify Mass Updt Pgms - 3724 443
2.12.85 kYAmend Modify Pending Litem – 3726 444
2.12.86 KYAmend Modify Pend Litem Panel - 3728 446
2.12.87 KYAmend Send mass upd to SHPS - 3832 447
2.12.88 KYAmend Update Pending PA Status - 3905 448
2.12.89 KYAmend Auto PA Table - 3915 449
2.12.90 KYAmend PA XML Translator - 4393 451
2.12.91 KYAmend - LITEM trn ld for SHPS - 4476 452
2.12.92 KYAmend - Litem add txn field - 4477 453
2.12.93 KYAmend - PA Pend XREF table – 4480 454
2.12.94 KYAmend - New Prov Mass Updt - 4481 455
2.12.95 KYAmend - Modify T_PA_AUTO_CRIT - 4496 456
2.12.96 KYAmend - Remove unused links - 4592 458
2.12.97 KYAmend - T_PA_PEND_XREF – 4891 459
2.12.98 Create T_PA_MASS_UPD_PROV - 5211 460
2.12.99 REL2-Dental PA Diag Fld Not Reqd - 5309 462
2.12.100 KYAmend - Modify interface job - 5877 463
2.12.101 Send iCe updates to maxMC - 6109 464
2.12.102 DCR1005 REL2- Tbl Chg:School PAs - 6476 465
2.12.103 DCR1005 REL2 Internet Interface - 6491 467
2.12.104 KYAmend - Pending Line Item – 6603 469
2.12.105 KYAmend T_PA_PEND_PAUTH ID type – 6626 470

2.12.106 KYAmend T_PA_PEND_PAUTH – 6630 471
2.12.107 Create PRO Cert xref tble - 7120 472
2.12.108 Add PRO Cert dup XREF PA Nbr - 7121 474
2.12.109 Lookup dup PRO Cert xref nbr - 7122 476
2.12.110 KYAmend iCe maxMC txn accting – 7253 477
2.12.111 Correct T_PA_SCHOOL - 7723 478
2.12.112 Audit T_PA_IAC_XREF - 7725 479
2.12.113 Mass Updates Reporting - 7730 480
2.12.114 Permit psych for m/c - 7958 481
2.12.115 School PA proc code XREF - 7959 483
2.12.116 Permit psych for m/c - batch - 7960 484
2.12.117 runtime improvement code changes - 8236 486
2.12.118 Add index to id_case - 8346 488
2.12.119 Letters - Duplex - 8442 489
2.12.120 PA Txn - turn off edits - 8514 490
2.12.121 Add original member id - 8520 491
2.12.122 All PA Letters format changes - 8589 493
2.12.123 Font size on all PA Letters - 8659 494
2.12.124 PA txn - modifier edit SC - 8735 495
2.12.125 DCR1401 Exclude procs for M/C - 8825 496
2.12.126 I3469 - 8872 498
2.12.127 PA prod data correction - 8929 500
2.12.128 Add synch code to line item pane - 9002 501
2.12.129 I3486 - 9034 502
2.13 Data Element Dictionary 503
2.13.1 T_CDE_HIPAA 503
2.13.2 T_PA_ASSIGN_CODE 503
2.13.3 T_PA_CAT_PT_XREF 504
2.13.4 T_PA_DIAGNOSIS 504
2.13.5 T_PA_IAC_TEXT 505
2.13.6 T_PA_IAC_XREF 505
2.13.7 T_PA_INT_TEXT 506
2.13.8 T_PA_ITEM_DTL_XREF 506
2.13.9 T_PA_LINEITEM_STAT 507
2.13.10 T_PA_LINE_ITEM 508
2.13.11 T_PA_MASS_UPD 512
2.13.12 T_PA_MEDIA 514
2.13.13 T_PA_PAUTH 514
2.13.14 T_PA_PAUTH_STATE 518

3 Appendix A – interChange Overview 520

1 Introduction

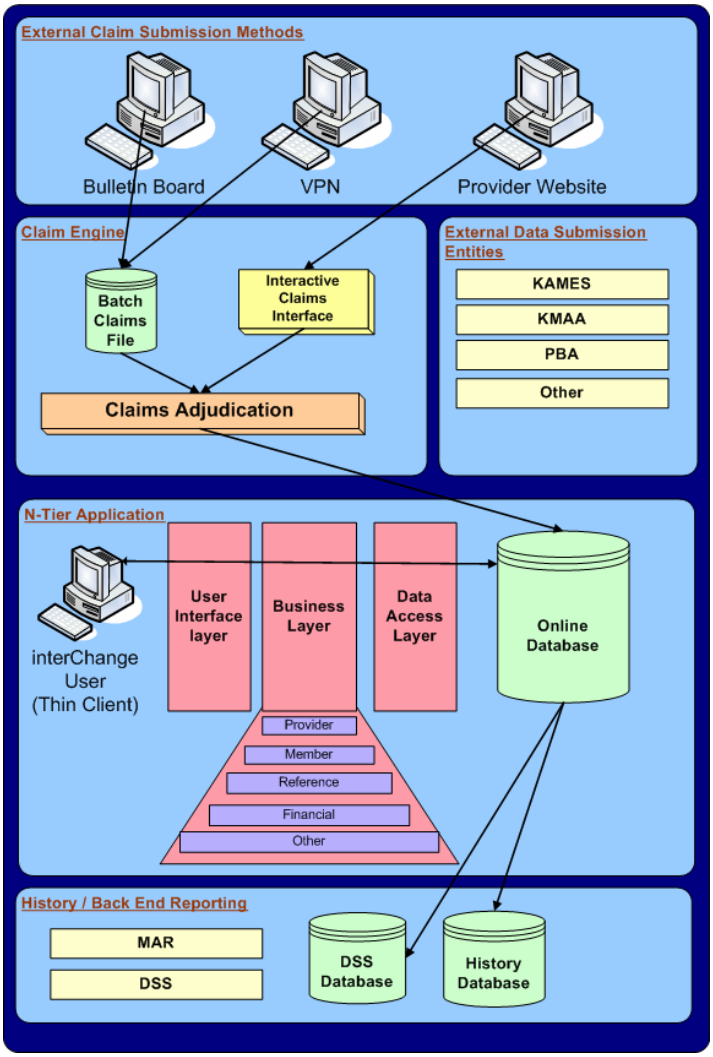
This document provides the Service/Prior Authorization Detailed System Design (DSD). The DSD validates the design process and approach to solution, and identifies those items as specified in the Kentucky MMIS (KY MMIS) Request for Proposal (RFP) and as specified by The Department for Medicaid Services.

2 Service/Prior Authorization Detailed System Design

2.1 System Flow

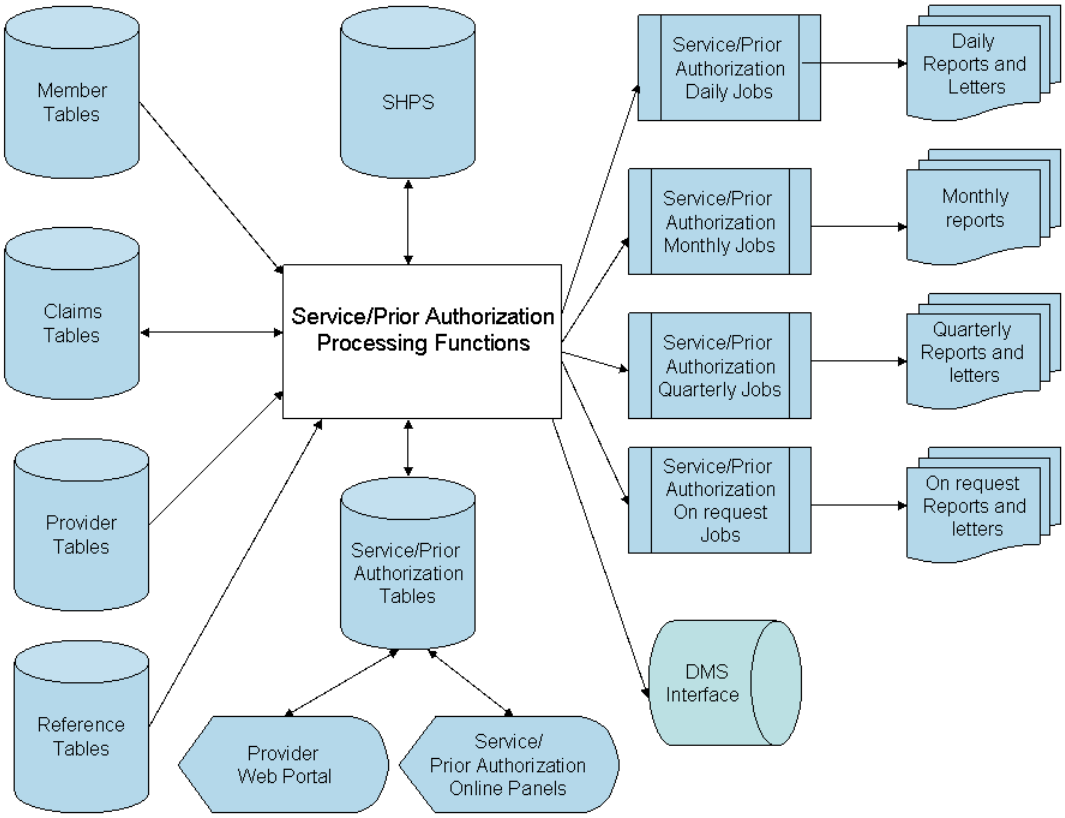
2.1.1 interChange System Architecture

The system is logically divided into four primary components: Claims engine, User Interface, Batch, and the History and Back End Reporting. The Claims engine is responsible for receiving interactive transactions from external sources, adjudicating them, and returning the appropriate response. The User Interface is an N-tier application providing segregated and loosely coupled presentation, business logic, and data logic layers. The user interface provides access to the online subsystem functions through a thin client, the web browser. The Batch component is responsible for maintaining and reporting on data contained within the online database. The History and Back End reporting component is responsible for analyzing, reporting, and supporting the management of the activities that have occurred in the two front end systems. The system interfaces with a variety of data sources which influence processing within the system. The External data submission entities are organizations that supply information to the Medicaid Management Information System (MMIS).



2.1.2 System Flow

The following diagram represents Service/Prior Authorization input/output processing in a production context (job, jils, directories, and data).



2.2 Subsystem Description

2.2.1 Introduction to Service/Prior Authorization

The Service/Prior Authorization subsystem is a mechanism to review, assess, and approve or deny the Department for Medicaid Services (DMS) identified medical services prior to claims adjudication. It serves as a cost containment and utilization review mechanism for the Commonwealth, and enables the Medicaid Management Information System (MMIS) to approve payment for only those treatments and services that are medically necessary, appropriate, and cost effective.

The EDS Quality Improvement Organization (QIO) has responsibility for performing authorization screenings, medically necessary review approvals or denials, and managing all DMS identified approved services requiring Prior Authorization. The MMIS is responsible for the correct payment of authorized services.

2.3 Service/Prior Authorization Processes

2.3.1 Maintain Service/Prior Authorization Data

Connected via	Connected to	Src	Dst
Soap Server	Provider Web Portal	X	
BizTalk	SHPS	X	
Biz Talk (HIPAA transactions)	Provider Web Portal	X	

2.3.1.1 Process Description

Service/prior authorization data is received from the Provider Internet and SHPS. The data is edited and valid data is added to the MMIS database making it available for Claims Processing.

Level of care is determined for enrolled Medicaid members as well as pending eligibles and sent to KAMES for the determination of financial eligibility.

2.3.1.2 interChange Narrative

Service/prior authorization data is received from the following sources: provider data entry on the Provider Web Portal, HIPAA 278 transactions, SHPS data entry into maxMC, and data entry into the interChange online panels. The data is edited and valid data is added to the MMIS database making it available for Claims Processing. SHPS sends pending eligibles and level of care for selected PA Categories which is sent on to KAMES by the Member subsytem.

2.3.1.2.1 PA Category Code

The PA Category code is used to group service/prior authorizations. It is also used to determine the type of PA letter to generate for the PA and the payment method to be used for pricing the PA. Below is the PA Category Table for a list of valid PA Categories used in interChange.

PA Category Table

PA Category	PA Category Description	Payment Method	Level of Care	Primary Data Entry Method
02	In-Patient Hospital	system rate	no	SHPS Interface
03	Mental Hospital	system rate	yes	SHPS Interface
07	Model Waiver 2	system rate	yes	SHPS Interface
08	PRTF - Psychiatric Residential Treatment Facility	system rate	yes	SHPS Interface
12	Out-Patient Hospital	system rate	no	SHPS Interface

PA Category	PA Category Description	Payment Method	Level of Care	Primary Data Entry Method
16	Impact Plus	price from PA	no	SHPS Interface
26	ICF/MR - Institutional Care Facility/Mental Retardation	system rate	yes	SHPS Interface
27	Nursing Facility	system rate	yes	SHPS Interface
32	EPSDT-Related Services	price from PA	no	SHPS Interface
36	Other Lab & X-Ray	system rate	no	SHPS Interface
40	DME Supplier	price from PA	no	SHPS Interface
41	Primary Care Center	system rate	no	SHPS Interface
43	Rural Health Clinic	system rate	no	SHPS Interface
46	Home Health	system rate	no	SHPS Interface
50	SCL-Support For Community Living	system rate/ audit cap amount	yes	SHPS entry into panels
52	Home & Community Base Waiver	system rate/ audit cap amount	yes	SHPS Interface
53	Home & Community Adult Day Care	system rate/ audit cap amount	yes	SHPS Interface
60	Acquired Brain Injury	system rate/ audit cap amount	yes	SHPS entry into panels
72	Dental	system rate	no	SHPS Interface
73	Orthodontia	capitated rate	no	SHPS Interface
74	Physician	system rate	no	SHPS Interface

PA Category	PA Category Description	Payment Method	Level of Care	Primary Data Entry Method
76	IMD – Institute For Mental Disease	system rate	yes	SHPS Interface
77	School Based	system rate	no	Provider Web Portal
92	Psychiatric DPU	system rate	no	SHPS Interface
93	Rehab DPU	system rate	no	SHPS Interface

2.3.1.2.2 Provider Submits School Based PAs on the Web

Providers submit School Based PA requests on the MMIS Provider Web Portal. The PAs are sent to the MMIS Service/Prior Authorization subsystem where they are edited and valid PAs are added to the database. Line items are automatically set to an approved status. There are no approval letters generated for School Based PAs. The PAs reside only in the MMIS. SHPS has no responsibility for these PAs.

2.3.1.2.3 Maintain SCL and ABI Service/Prior Authorizations

SHPS determines the level of care and required services for a member for SCL and ABI PA Categories. SHPS performs direct data entry of service/prior authorizations into interChange panels for these PA Categories. LOC and pending eligible information is sent to KAMES in a manual process.

2.3.1.2.4 Provider submits PAs for Member or Pending Eligible to SHPS

A provider may submit a PA request to SHPS by telephone, fax, mail, e-mail or in person. The following describes PA processes when a PA is submitted for either a Member or a Pending Eligible.

- **Provider submits PA request for Member to SHPS**

  When SHPS receives the PA request the following occurs:

  1. SHPS enters the PA into maxMC. SHPS also enters transactions with Level of Care updates for existing members;
  2. SHPS reviewer adjudicates the PA;
  3. PA transaction is sent to MMIS PA with a Case Number. LOC information for Long Term Care type PAs is also sent to MMIS PA. LOC information is forwarded to the MMIS Member subsystem for transmission to KAMES;
  4. MMIS returns a PA number to maxMC; and,
  5. A letter is generated by the MMIS for approved PAs and by SHPS for denied PAs.

- **Provider submits PA request for Pending Eligible to SHPS**

  The following occurs when a provider submits a PA request for a Pending Eligible to SHPS:

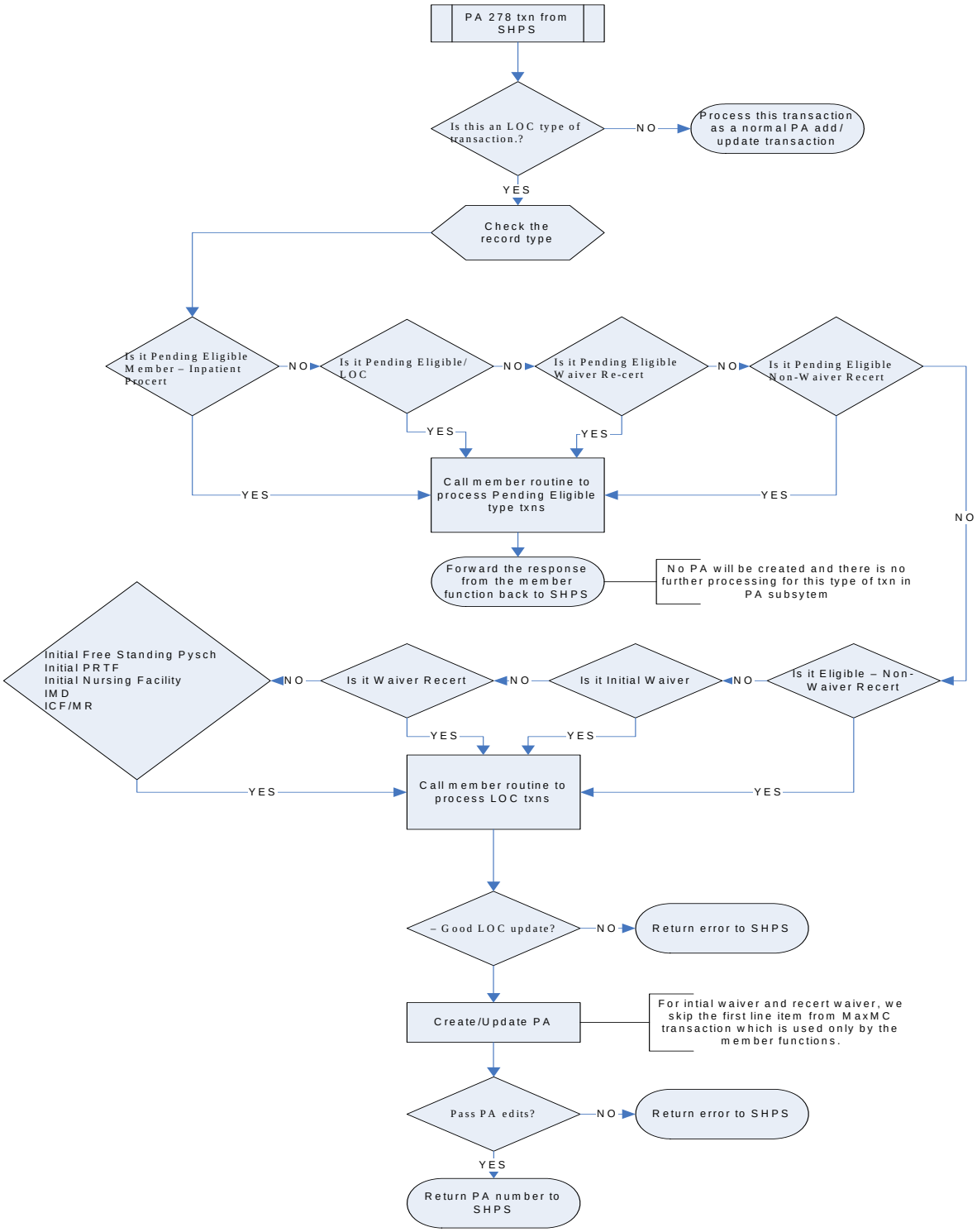
  1. Demographic information for the Pending Eligible and the pending PA is entered into maxMC;
  2. SHPS determines LOC if required and adjudicates PA;
  3. SHPS sends pending eligible and LOC information for Long Term Care type PAs. This information is forwarded to the MMIS Member subsystem;
  4. MMIS sends LTC pending eligible and LOC information to KAMES in nightly Member subsystem interface file;
  5. KAMES sends MMIS Member subsystem Medicaid ID for pending eligible in nightly interface file;
  6. MMIS Member subsystem sends maxMC Member updates in nightly interface file;
  7. SHPS updates Pending Eligible's PA with a Medicaid ID and the PA is sent to the MMIS;
  8. MMIS returns PA Number to maxMC; and,
  9. A letter is generated by the MMIS for approved PAs and by SHPS for denied PAs.

- **SHPS Transaction Processing**

  The MMIS processes an incoming SHPS transaction based on a "Process Status" and "Record Type" in the transaction. The table below lists the Process Status/Record Type combinations with how it processes (Transaction Description Column).

Process Status	Txn type	Record type	Description
P	Add/Update	Not Applicable	New PA or update existing PA
K	Add/Update	I	Pending Eligible Member – Inpatient Procert
		P	Pending Eligible/LOC
		A	Pending Eligible Waiver Recert
		B	Pending Eligible Non-Waiver Recert
		R	Eligible - Non-Waiver Recert
		L	Initial Free Standing Pysch; Initial PRTF; Initial Nursing Facility; IMD; and, ICF/MR
		M	Initial Waiver
		W	Waiver Recert
A	Add/Update	Not Applicable	Resubmitting the pending eligible with a member ID

The following flowchart details the path of pending eligible and LOC transactions sent by SHPS in the PA interface.


PA 278 txn from SHPS
Is this an LOC type of transaction.?
NO
Process this transaction as a normal PA add/ update transaction
YES
Check the record type
Is it Pending Eligible Member – Inpatient Procert
NO
Is it Pending Eligible/ LOC
NO
Is it Pending Eligible Waiver Re-cert
NO
Is it Pending Eligible Non-Waiver Recert
YES
YES
YES
YES
Call member routine to process Pending Eligible type txns
NO
Forward the response from the member function back to SHPS
No PA will be created and there is no further processing for this type of txn in PA subsytem
Initial Free Standing Pysch
Initial PRTF
Initial Nursing Facility
IMD
ICF/MR
NO
Is it Waiver Recert
NO
Is it Initial Waiver
NO
Is it Eligible – Non-Waiver Recert
YES
YES
YES
YES
Call member routine to process LOC txns
– Good LOC update?
NO
Return error to SHPS
Create/Update PA
For intial waiver and recert waiver, we skip the first line item from MaxMC transaction which is used only by the member functions.
Pass PA edits?
NO
Return error to SHPS
YES
Return PA number to SHPS

2.3.2 Generate Prior Authorization Letters

2.3.2.1 Process Description

Prior Authorization approval letters are sent to members, providers and a member's local Department for Community Based Services (DCBS) office where appropriate.

2.3.2.2 interChange Narrative

When all requested services on a PA have been placed in a finalized status (Approved or Denied), an indicator is set to trigger printing of PA Notification letter(s). Batch job PAUJD001 creates letter requests for the letter generator and resets the letter indicator. The letter generator nightly batch job actually creates the letters sent to members, providers and DCBS. If changes are made to a service for authorized dates or amounts, the indicator is again set to print and a notification letter generated. PA letters and letter recipients are listed below. See the Letters section (Chapter 2.9) for specific letter formats.

PA Category	MMIS Letter Formats
Waivers - • SCL-Supports for Community Living; • Acquired Brain Injury; • Home & Community Based Waiver; • Home & Community Adult Day Care; and, • Model Waiver 2.	Member – PAU-001A-D Provider – PAU-001B-D
Home Health	Provider – PAU-001D-D Member – PAU-001E-D
Impact Plus	Provider – PAU-001F-D

PA Category	MMIS Letter Formats
Other - for remaining PA types e.g. • Primary Care Center; • Rural Health Clinic; • Other Lab & X-Ray; • Out-Patient Hospital; • EPSDT; • Dental; • Orthodontics; • Physician; and, • DME.	Provider – PAU-001G-D
Inpatient /Nursing Facility • In Patient Hospital; • Nursing Facility; • IMD – Institute for Mental Disease; • Mental Hospital; • PRTF – Psychiatric Residential Treatment Facility; and ICF/MR	Provider – PAU-001H-D

The following letters are generated by SHPS:

- Medical Necessity Denial;
- Nursing Facility & Waiver Medical;
- Necessity Denial-Initial and CSR;
- Psych Freestanding & Psych PRTF Denial;
- Impact Plus Service Denial;
- Impact Plus Eligibility Approval;
- Impact Plus Service Approval;
- Impact Plus Eligibility Denial 915;

- Lack of Information Denial;
- Request for Information;
- Technical Denial;
- Durable Medical Equipment Technical Denial;
- Reconsideration Request Out of Timeframe Notice;
- Reconsideration DateScheduled Notice;
- Reconsideration Denial Overturned;
- Psych Freestanding & Psych PRTF Approval (LO2); and,
- Physician Services Confirmation of Consent Part1

2.3.3 End Date PAs of Members going into Managed Care

2.3.3.1 Process Description

Members may enroll in Managed Care and still have open PAs for services that are provided by the managed care organization. Open PAs are end dated for services that will be provided by the MCO.

2.3.3.2 interChange Narrative

Monthly process (job PAUJM130) accesses Managed Care data looking for enrolled members. If a member with a PA is found to be enrolled in Managed Care, there is a check to see if the PA services are for services covered by the MCO. If the services are covered by the MCO, the PAs are end-dated.

2.3.4 Orthodontic Case Tracking Process

2.3.4.1 Process Description

Providers are required to submit documentation during the span of a member's orthodontic treatment. Reminder letters are sent to providers when documentation is overdue. If the reminder letters do not generate a response from the provider, the PA authorizing treatment is included on reports tracking overdue documentation.

2.3.4.2 interChange Narrative

The Utilization Management Organization monitors timely submission of progress reports for orthodontia work authorized on service/prior authorizations. An Orthodontic Status Code on the service/prior authorization is maintained by the UMO indicating when documentation has been received. The status code, along with the authorized begin date for a service, is used to determine the generation of provider reminder letters and inclusion of the PA on overdue reports. The following reports and letters are created in quarterly job PAUJM220.

Reports:

- Prior Authorization Case Tracking Six Month Progress Report Not Received (PAU-0220-M1);
- Prior Authorization Case Tracking Final Case Submission Form Not Received (PAU-0220-M2); and,

- Ad hoc report is created in the Data Warehouse to aid in PA research for a specific provider. The DSS report is "Orthodontic Prior Authorization Case Tracking".

Letters Sent To Providers:

- Prior Authorization Orthodontic Six Month Progress Report Letter (PAU-0220-1L);
- Prior Authorization Orthodontic Six Month Progress Report Follow Up Letter (PAU-0220-2L);
- Prior Authorization Orthodontic Final Case Letter (PAU-0220-3L); and,
- Prior Authorization Orthodontic Final Case Follow Up Letter (PAU-0220-4L).

2.3.5 Generate EPSDT First Time Letter

2.3.5.1 Process Description

The EPSDT Special Services Program provides services for a member from birth through age 21. The first time a member requests an EPSDT service through a PA, a letter is sent to the member with notification that the services are no longer available when the member reaches 21 years of age.

2.3.5.2 interChange Narrative

Daily job PAUJD200 generates letter requests (PAU-0200-DL) for the letter generator. The letters are sent to members when an EPSDT service/prior authorization is requested for the first time. The letter notifies the member that EPSDT services are no longer available when the member reaches 21 years of age. Monthly process (PAUJM210) generates report PAU-210-M listing members with EPSDT prior authorization requests for the first time in the preceding month.

2.3.6 Automated Mass Update Process

2.3.6.1 Process Description

There are situations that call for a mass update of a significant number of PAs. The updates come under two categories: 1) provider updates and 2) rate and service code updates. In the case of provider mass updates, the PAs are end dated for the original provider and outstanding services are transferred to the new provider on a new PA. For rate and service code mass updates, an override entry with a rate or service code is created for Claims to access during claims processing.

2.3.6.2 interChange Narrative

Mass updates are split into two automated processes: a provider mass update and a service/rate mass update. The processes are detailed below.

2.3.6.2.1 Automated Provider Mass Updates Solution

Mass update of providers is a two-step process. The first step end dates the old provider's PAs so that claims will not pay past the effective date for the new provider. The old provider is given time to submit claims for payment. The second step updates authorized units and amounts for the old provider with what has been used to date. PAs are then created for the new provider with the remaining authorized units and amounts from the original PA. Details of each step are given below.

Step1 (job PAUJD140):

- End-date the old provider's PAs with the effective date of the provider change less one day. The prior auth numbers are saved for later use in Step 2. The old provider submits claims for processing and payment within a specified amount of time;
- Create and send letter of notification to old provider;
- Send SHPS transactions of PA changes;
- Create report of PAs selected for mass change; and,
- Only end-date PAs where there are units left on a line item. Put the PA on the report with **** at the end of the report line.

Step 2 (job PAUJD141):

- After sufficient time has passed for the old provider to have claims submitted and processed, authorized units and amounts are updated on the old provider's PAs with total to date of used units and amounts. PAs for the old provider are now considered used up;
- PAs are now transferred to the new provider by creating a new PA for each of the end dated PAs. Authorized units and amounts are calculated based on original units and amounts less used units and amounts by the old provider. The authorized effective date is the effective date of the provider change and the authorized end date is the original end date of the PA. The new provider is now able to bill claims with the new PA and has authorized units and amounts available;
- Create and send PA letter to new provider;
- Send SHPS transactions of PA changes; and,
- Create report with old and new PA information.

2.3.6.2.2 Automated Rate Mass Change - (job PAUJD142)

Create and maintain new PA line item rates in the MMIS: Rate changes for a PA line item are created by an automated process and maintained on a new PA table in the MMIS. PA line items may be selected to receive a rate change based on PA category, service code and provider ID. Rate change information include the PA number, line item number, service code, the new rate, and effective begin end dates for the new rate. The effective begin date is the date the new rate is effective for claim payment. The end date for the rate is the end date of the PA line item;

Claims and the new rate: Claims processing will choose the rate to pay based on the service dates on the claim from either the line item or the override line item rate change, whichever is in effect at that time. Units and amounts paid will be recorded and tracked against the original line item units and amounts and provide an audit trail and an accounting of units and amounts used. If a rate is retroactive and a claim has already been paid, the claim must be manually adjusted to pay at the new rate;

Provider notification of the new rate: Letters are generated notifying providers of the new rate to be paid on a PA and the effective begin and end dates for the new rate;

Reporting affected line items: A report is created detailing line items where a rate change was generated; and

SHPS: Maintenance transactions are sent to SHPS with the rate change.

2.3.6.2.3 Automated Service Code Mass Change - (job PAUJD142)

Create and maintain new PA line item service codes in the MMIS: Service code changes for a PA are created by an automated process and maintained on a new PA table in the MMIS. PA line items will be selected to receive a service code change based on PA category and existing service code. Service code change information includes the PA number, line item number, the new service code, and effective begin end dates for the new service code. The effective begin date is the date the new service code is effective for claim payment. The end date for the new service code is the end date of the PA line item;

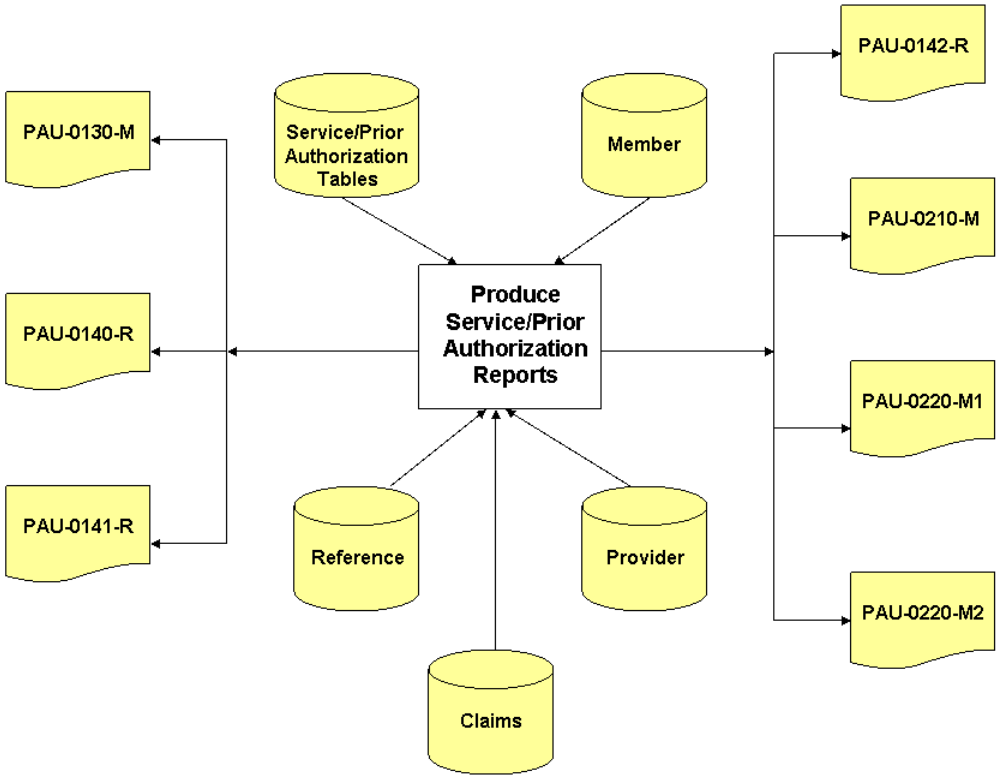
Claims and the new service code: Claims processing will choose the service code to pay based on the service dates on the claim from either the line item or the override line item service code change, whichever is in effect at that time. Units and amounts paid will be recorded and tracked against the original line item units and amounts and provide an audit trail and an accounting of units and amounts used. If a service code is retroactive and a claim has already been paid, the claim must be manually adjusted to pay with the new service code;

Provider notification of the new service code: Letters are generated notifying providers of the new service code to be paid on a PA and the effective begin and end dates for the new service code; and,

Reporting affected line items: A report is created detailing line items where a service code change was generated.

2.3.7 Produce Service/Prior Authorization Reports Flow Diagram

The Report Process Flow Diagram is displayed below.



2.3.7.1 Diagram Abstract

The process flow diagram provides a visual representation of how the Service/Prior Authorization processing area reports are generated. All reports are stored and accessible in COLD. The data for the Service/Prior Authorization reports is extracted from the Prior Authorization, Member, Reference, Claims and Provider Tables. A layout of each report may be found in the report section of this DSD.

2.4 Data Model

The Service/Prior Authorization subsystem maintains information on requested services for Medicaid members. The service requests are reviewed and updated with a determination of approved or denied and a reason is assigned for the decision. The requests are then available during claims processing to provide an authorization or denial for the payment of services. Service usage data is captured during claims processing and tracked to ensure that unit quantity and amounts do not exceed amounts approved on the service authorization request.

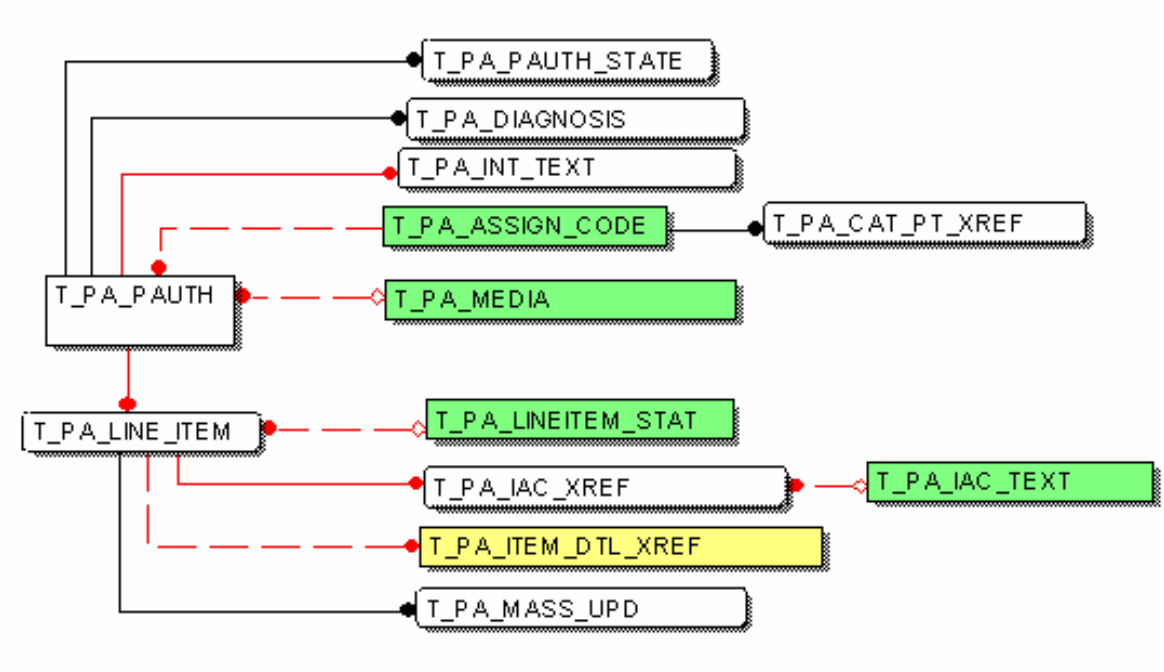
The Service/Prior Authorization process is supported by SHPS, which provides utilization management services.

SHPS maintains review information in maxMC. The data is available for reporting from the DSS.

Information is also maintained for the tracking of various types of reviews: The reviews have been defined as follows by the UM organization - reconsideration, appeals and administrative.

2.4.1 Data Model Diagram

The following data model gives a view of the primary entities within the Prior Authorization Subsystem.



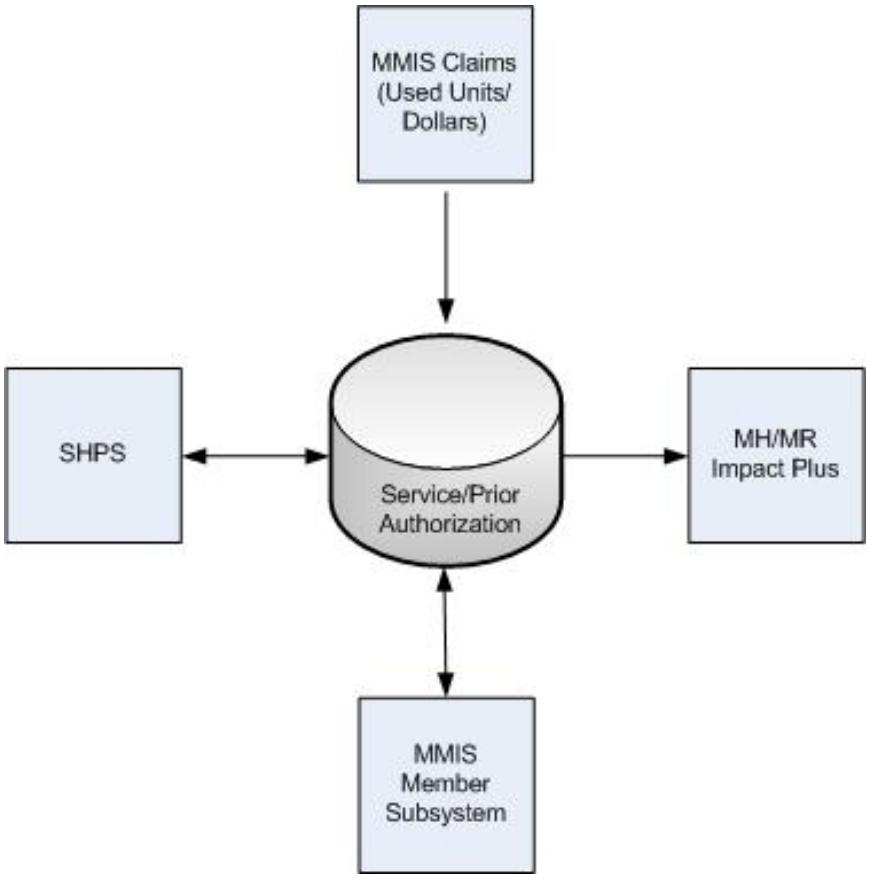
2.4.2 Subsystem Primary Entities

The following table provides a high level description of the primary entities that are used within the Service/Prior Authorization subsystem.

Entity	Description
T_PA_ASSIGN_CODE	This entity contains category codes and their descriptions. A category code is assigned to a PA as a way to group or classify requests. The category code is recorded on the PA header.
T_PA_IAC_TEXT	This entity contains reason codes to document the reason for a decision on a service/prior authorization request.
T_PA_IAC_XREF	This entity associates one or more reason codes with a service/authorization request and is printed on the PA notice.
T_PA_INT_TEXT	This entity contains free form text that is entered for a service/authorization request. Internal text is intended for use within the Service/Prior Authorization unit. The text is not printed on the PA notice.
T_PA_ITEM_DTL_XREF	This entity contains units and amounts used on a service/prior authorization. The entity is accessed by claims processing to determine whether there are units or dollars available for a service that has been prior authorized. Entries are made into this table by claims processing when a PA is used to authorize payment of a claim.
T_PA_LINE_ITEM	This entity contains information about the requested services on a PA. It holds the requested service code, requested and authorized amounts, as well as the requested and authorized effective and end dates.
T_PA_LINITEM_STAT	This entity contains the status codes that may be associated with a PA line item.
T_PA_MEDIA	This entity contains the media code that represents the type of media that was used to submit a PA request. The media type for a PA is recorded on the PA header.
T_PA_PAUTH	This entity contains information about a service/prior authorization request such as the member for which the request was made, the requesting and servicing provider and the type or category of the request.
T_PA_PAUTH_STATE	This entity contains additional information about a service/prior authorization such as Case Number, Nursing Facility Indicator, and Admission and Discharge Dates.

2.4.3 External System Interfaces

The following context diagram gives a view of the entities with which this subsystem interfaces.



2.5 Job Scripts

2.5.1 PAUJD001 - Produce PA Notices

2.5.1.1 Detailed Job Script Information

Unix Script:	PAUJD001
Description:	This job creates PA notification letter requests for the nightly letter generation process. PA letter notification requests are created for PAs with approved services. SHPS creates letters for PAs with denied services. If a PA has both approved and denied services, a letter request is generated. A letter request is generated for the following letters: • Waivers (for Member, Provider) • Home Health (for Member, Provider) • Impact Plus (for Provider) • Inpatient, Long Term Care type PAs (for Provider) • Other (for example: DME, EPSDT, Dental, Orthodontics) (for Providers)
Job Step:	js 010-paupd001
Description:	Read PA, Provider, and Member tables to produce PA Notices.
Input/Output Files:	

2.5.2 PAUJD200 - Create First-time EPSDT Services Letter

2.5.2.1 Detailed Job Script Information

Unix Script:	PAUJD200
Description:	This job script inserts letter requests PAU-200-DL into the letter generator the first time a provider requests EPSDT services for a child. The EPSDT Special Services Program provides services for a member from birth through age 21. The letter is notification that the services are no longer available after the last day of the month in which the member becomes 21 years of age.
Job Step:	js 010-paupd200
Description:	Insert PAU-200-DL letter requests into letter generator table when EPSDT services are requested for the first time
Input/Output Files:	

2.5.3 PAUJD278 - PA 278 Batch processing

2.5.3.1 Detailed Job Script Information

Unix Script:	PAUJD278
Description:	This job searches the EDI input directory for 278 xml requests. If a file is detected, it executes paup278d which runs each request through the PA verification process (paup278 and paupedit). If a request is valid, it is added to the database and a prior authorization number is returned. The request is sent to SHPS for review. If a request is invalid, an error is returned. Input files are placed in the $FTPDIR/priorauth/inbound/278 directory by the EDI translator. Output files are placed in the $FTPDIR/priorauth/outbound/278r directory by the PA 278 process. The PA 278 process uses the PriorAuth278.xsd schema.

Job Step:		js 010-paup278d
Description:		Driver for the 278 process
Input/Output Files:		
278X12BATCH.xml	B	Prior Auth HIPAA 278 file that has been converted from the X12 format to the PriorAuth278.xsd schema

2.5.4 PAUJM001 - Update the PAUMONTH Date Parms

2.5.4.1 Detailed Job Script Information

Unix Script:	PAUJM001
Description:	The job script updates the system parameters table with the monthly dates for the PA monthly reporting cycle. The Prior Authorization monthly date parameters are maintained on t_system_parms where the nam_program = "PAUMONTH".

Job Step:	js 010-paupm001
Description:	Execute PAUPM001
Input/Output Files:	

2.5.5 PAUJM130 - End Date Prior Authorizations for Members in Managed Care

2.5.5.1 Detailed Job Script Information

Unix Script:	PAUJM130
Description:	This job script end dates prior authorization services for members entering managed care or receiving a Member Status of "M7" or "P7". Report PAU-130-M "Prior Authorization End Date Report" is created listing the end dated PAs. The job is run monthly.

Job Step:		js 010-paupm130
Description:		End date prior authorization services for members entering managed care and create report PAU-130-M.
Input/Output Files:		
pam01301.rpt	O	Report lists prior authorizations that have been end dated because the member has gone into managed care.
Job Step:		js 020-copy2routedir
Description:		Produce a COLD copy of the End Date Report
Input/Output Files:		
pam01301.rpt	I	Report lists prior authorizations that have been end dated because the member has gone into managed care.

2.5.6 PAUJM151 - Delete Pending PA's

This job script is not currently used in Kentucky.

2.5.6.1 Detailed Job Script Information

Unix Script:	PAUJM151
Description:	Pending PA's are awaiting assignment of a Medicaid ID to a pending eligible. When a Medicaid ID is assigned, the pending PA is flagged for processing so that the provider may submit it for adjudication and deleted from the pending tables. Delete old pending PA's from the database after three months. This job runs monthly.

Job Step:	js 010-paupm151
Description:	This job step deletes old pending PA's from the database.
Input/Output Files:	

2.5.7 PAUJM210 - First-time EPSDT services monthly report job

2.5.7.1 Detailed Job Script Information

Unix Script:	PAUJM210
Description:	This job script creates report EPSDT Members - 1st Time Prior Authorizations (PAU-0210-M). The EPSDT Special Services Program provides services for a member from birth through age 21. This report lists members for which EPSDT services have been requested for the first time during the previous month.

Job Step:		js 010-paupm210
Description:		Generate report PAU-210-M listing members where EPSDT services have been requested for the first time
Input/Output Files:		
pam0210.rpt	O	Report listing member data for each first-time EPSDT services letter request within the chosen month
Job Step:		js 020-copy2routedir
Description:		Copy report PAU-210-M to COLD
Input/Output Files:		
pam0210.rpt	I	Report listing member data for each first-time EPSDT services letter request within the chosen month

2.5.8 PAUJM220 - PA orthodontic case tracking process

2.5.8.1 Detailed Job Script Information

Unix Script:	PAUJM220
Description:	This job creates reports and letter requests for the Orthodontic Case Tracking Process. The Ortho Status Code at the PA Header is used by SHPS to record the receipt of Orthodontic Case documentation. Based on the Ortho Status Code and the length of time from the authorized begin date on a PA, reminder letters are sent to providers or the PA is placed on a report if documentation has not been received within a defined amount of time. Letter requests are printed in the nightly batch letter generation process. The following reports and letters are generated by this job: REPORTS: • Prior Authorization Case Tracking Six Month Progress Report Not Received • Prior Authorization Case Tracking Final Case Submission Form Not Received LETTERS: • Prior Authorization Case Tracking Six Month Progress Report Not Received • Prior Authorization Case Tracking Six Month Progress Report Not Received Follow-up • Prior Authorization Case Tracking Final Progress Report Not Received • Prior Authorization Case Tracking Final Progress Report Not Received Follow-up

Job Step:		js 010-paupm220
Description:		Generate letters and reports
Input/Output Files:		
pam02201.rpt	O	This is the report file generated for providers who have not sent the six month progress report.
pam02202.rpt Final Case Submission Form Not Received	O	This is the report generated for providers who have not sent the final case submission form.
Job Step:		js 020-copy2routedir
Description:		Copy reports to COLD

Input/Output Files:		
pam02201.rpt	I	This is the report file generated for providers who have not sent the six month progress report.
pam02202.rpt Final Case Submission Form Not Received	I	This is the report generated for providers who have not sent the final case submission form.

2.5.9 PAUJR140 - Mass Update - Old Provider

2.5.9.1 Detailed Job Script Information

Unix Script:	PAUJR140
Description:	This job performs the first step in the PA Provider Mass Update process by end dating the original provider's PAs. The job also sends transactions to SHPS with the updates, creates letters to notify the original provider of the updates and creates a report of the updates. Mass update of providers is a two-step process. The first step (job PAUJR140) end dates the original provider's PAs so that claims do not pay past the effective date for the new provider. The original provider is given time to submit claims for payment. The second step (job PAUJR141) updates authorized units and amounts for the original provider with what has been used to date. PAs are then created for the new provider with the remaining authorized units and amounts from the original PA. There is an input parameter for this job that provides the ability to do a preliminary run to verify what updates would be made based on the input parameters. No updates are made in a preliminary run, only a report is created displaying what updates are made based on the input parameters.

Job Step:		js 010-paupr140
Description:		This step executes program paupr140 for mass PA updates.
Input/Output Files:		
par01401.rpt	O	Old Provider Mass Update Results (PAU-0140-R)
Job Step:		js 020-copy2routedir
Description:		This step copies the report to COLD
Input/Output Files:		
par01401.rpt	O	Old Provider Mass Update Results (PAU-0140-R)

2.5.10 PAUJR141 - Mass Update - New Provider

2.5.10.1 Detailed Job Script Information

Unix Script:	PAUJR141
Description:	This job performs a mass update for the new provider. New PAs are created based on remaining units transferred from the original provider. Provider letter requests are created for the new PAs, transactions with the new PAs are sent to SHPS and a report of the new PAs is generated. Mass update of providers is a two step process. The first step (job PAUJR140) end dates the old provider's PAs so that claims are not pay past the effective date for the new provider. The old provider is given time to submit claims for payment. The second step (job PAUJR141) updates authorized units and amounts for the old provider with what has been used to date. PAs are then created for the new provider with the remaining authorized units and amounts from the original PA.

Job Step:		js 010-paupr141
Description:		This step executes program paupr141 for mass PA updates for new provider.
Input/Output Files:		
par01411.rpt	O	New provider mass update results
Job Step:		js 020-copy2routedir
Description:		This step copies the report to COLD
Input/Output Files:		
par01411.rpt	O	New provider mass update results

2.5.11 PAUJR142 - Prior Authorization Mass Update For Rates And Service Codes

2.5.11.1 Detailed Job Script Information

Unix Script:	PAUJR142
Description:	This job generates mass PA rate and service code changes that are maintained on table T_PA_MASS_UPD. In addition to the table updates, PA letter requests are generated to notify providers, transactions are sent to SHPS and a report is created with the changes. PA line items may be selected to receive a rate or service code change based on PA category, service code and provider ID. There is an input parameter for this job that provides the ability to do a preliminary run to verify what updates would be made based on the input parameters. No updates are made in a preliminary run, only a report is created displaying what updates are be made based on the input parameters.

Job Step:		js 010-paupr142
Description:		This step executes program paupr142 for mass PA updates for rates and service codes on a PA line item.
Input/Output Files:		
par01421.rpt	O	This is the output of the rate/service code mass update program
Job Step:		js 020-copy2routedir
Description:		This step copies the report to COLD
Input/Output Files:		
par01421.rpt	I	This is the output of the rate/service code mass update program

2.5.12 PAUJW150 - Impact Plus Extract

2.5.12.1 Detailed Job Script Information

Unix Script:	PAUJW150	
Description:	Create an extract of Impact Plus service/prior authorizations for the Department of Mental Health and Mental Retardation.	
Job Step:		js 010-paupw150
Description:		Creates an extract of Impact Plus prior authorizations.
Input/Output Files:		
paw0150.dat	O	Extract of Impact Plus prior authorizations
Job Step:		js 020-cp
Description:		Copy the paw0150.dat output file to the $FTPDIR/priorauth/outbound/impactplus directory from the $DATADIR
Input/Output Files:		
paw0150.dat	I	Extract of Impact Plus prior authorizations
PriorAuthorization.dat	O	Output file of Impact Plus PAs

2.6 Programs

2.6.1 libpacomm.so -- Transaction routines for PA.

Technical Name:	libpacomm.so
Program Title:	Transaction routines for PA.
Programming Language:	C
Description:	An executable that contains a collection of transaction routines for prior authorization soap, online transactions, and so on. The executable contains: • paupdXML.sc (reformats dates and numeric fields in prior authorization XML schema) • paupedit.sc (edits data in prior authorization XML schema) • paup278.sc (edits prior authorizatoin HIPAA 278 transaction) • paupposr.sc (processes ncpdp 5.1 request transaction) • paupposi.sc (processes ncpdp 5.1 inquiry transaction) **Input Parameters**: N/A **Exit Values:** N/A **Input Files:** N/A **Output Files:** N/A **Input Tables:** N/A **Output Tables:** N/A **Sort Criteria:** N/A **Switches**: None **Link Procedure:** lmrpf, lgutils, levs **Special Logic Notes:** None

2.6.1.1 Change Orders

ID	NAME	DESCRIPTION
8238	PA txn - Fix Provider IDs	Defect identified in the PA transaction program. When claims are paid, the provider ID rather than the sak_prov_loc is being pulled to populate the requesting provider and service provider ID fields. The data is being repaired to populate the appropriate sak_prov_loc in the provider fields. The program is being modified to correct the problem.
8286	PA txn - School PA Denied Status	School Based PAs are all getting a denied status. School Based PAs should all be set to an 'Approved' status.
8317	PA txn - Line item matching	Modify matching of Legacy and InterChange line items. Legacy PA line items don't have a synch-code. Synch-code is a field that SHPS uses to identify the line items for a PA. Paupedit uses this value to match a particular line item. Since legacy PA doesn't have this, they cannot be updated. The line item for legacy PAs needs to follow the line numbers that SHPS sends in the txn.
8414	PA txn program - clerk ID	PA txn program is creating internal text with diagnosis codes. It is causing the panel to fail. Data clean up is required. Set id_clerk = 99999999 as a default. Correct retrieval of payment method of pay audit amount for Waivers (Adult Day and HCB) with respite or minor home adaptation services.
8436	PA txn - correct sak_fin_payer	Set t_pa_pauth.sak_fin_payer = 1. PA txn program was setting it to -1. Data was converted correctly.
8485	PA txn - Waiver data error	SHPS sent Waiver LOC data incorrectly. iCe looks for revenue codes of 100 - 219 on the first line item to indicate the row is LOC and should be skipped for the PA. PA transactions were created with only a 100. iCe interpreted these as a valid line item and added them to the database. A data fix is required to set these line items to "V"oid so they are not included on PA letters. A data fix is also required to reset t_pa_pauth.ind_letter to "B" to reprint Waiver letters.

ID	NAME	DESCRIPTION
8686	PA txn - Error messages	Add the synch code to the SHPS PA transaction error message when it is available. The synch code links a line item on maxMC with a line item on interChange.
8872	I3469	To allow PA overlaps for certain EPSDT procedures
9146	Enforce limit for 1000 new PAs	Enforce a limit for 1000 new PAs created per day and correct the PA line items already updated incorrectly in PROD

2.6.2 paup278 -- PA 278 Transaction Processor

Technical Name:	paup278
Program Title:	PA 278 Transaction Processor
Programming Language:	C
Description:	The program processes a PA request and formats a response. The program processes both HIPAA 278 PAs and PAs from SHPS using schema PriorAuth278.xsd. BizTalk converts HIPAA XI2 transactions to the PriorAuth278 schema. EDI picks up PA transactions from the SHPS PA transaction database and converts them to the PriorAuth278 schema. **Input Parameters:** Pointer to an XML element that contains Prior Authorization transactions **Exit Values:** • EXIT_SUCCESS - Normal termination • EXIT_FAILURE - Abnormal termination because of open, read, allocation, or input errors **Input Files:** PA XML Request **Output Files:** PA XML Response **Output XML:** Prior Authorization Number or error codes that are interpreted and converted to a HIPAA or SHPS error **Input Tables:** None **Output Tables:** None **Sort Criteria:** None **Switches:** None **Link Procedure:** None **Special Logic Notes:** None

2.6.2.1 Change Orders

ID	NAME	DESCRIPTION
2697	KYAmend Process PA 278 trxs	Process Prior Auth 278 transaction

2.6.3 paup278d -- PA 278 driver program

Technical Name:	paup278d
Program Title:	PA 278 driver program
Programming Language:	C
Description:	This program reads an XML document into memory and passes it to the PA 278 processor (paup278). This program then saves the output and returns the formatted XML response document **Input Parameters:** Pointer to an XML element that contains a Prior Authorization 278 transaction **Exit Values:** • EXIT_SUCCESS - Normal termination • EXIT_FAILURE - Abnormal termination because of open, read, allocation, or input errors **Input Files:** PA XML request **Output Files:** PA XML response **Input Tables:** None **Output Tables :** T_PA_PAUTH T_PA_LINE_ITEM T_PA_IAC_XREF T_PA_DIAGNOSIS T_PA_INT_TEXT **Sort Criteria:** N/A **Switches:** None **Link Procedure:** None **Special Logic Notes:** None

2.6.3.1 Change Orders

ID	NAME	DESCRIPTION
No associated Change Orders found		

2.6.4 paupd001 -- Select PA Notices for printing by the Letter Generator

Technical Name:	paupd001
Program Title:	Select PA Notices for printing by the Letter Generator
Programming Language:	C
Description:	This program generates the letter requests for PA notices sent to members and providers. Prior Authorizations are selected for print when the T_PA_PAUTH.IND_LETTER = "B". The indicator is updated to "N" once the letter request has been added to the letter generator database. The letter generator job uses the letter requests to create the actual letters for mailing. **Input Parameters:** None **Exit Values:** • EXIT_SUCCESS - Normal termination • EXIT_FAILURE - Abnormal termination because of read, allocation, or input errors **Input Files:** None **Output Files:** None **Input Tables:** T_PA_PAUTH T_PA_ASSIGN_CODE T_PA_LINEITEM_STAT T_PA_LINE_ITEM T_RE_BASE T_PR_IDENTIFIER T_PR_ID_TYPE **Tables Updated:** T_PA_PAUTH T_LG_LETTER_REQUEST **Sort Criteria:** None **Switches:** None **Link Procedure:** None

	Special Logic Notes: None

2.6.4.1 Change Orders

ID	NAME	DESCRIPTION
2224	Create Prior Auth Letters	MHMR adjudicates and enters service/prior authorizations into the MMIS for SCL and ABI Waivers. Produce PA notices for the member, provider, and for the member's Department of Community Based Services (DCBS) office.
2521	KYAmend Create Add'l PA Letters	Create PA approval letters excluding Waivers (completed in a separate CO2224)
6660	Modify PA letters program	Modify program paupd001 that creates Prior Auth letters
8441	Letters - skip letter request	Since line items are excluded if they are not current - do not include a letter request for the PA if there are no line items to print. When there is no detail data for the PA letter, blank pages are created. Sort by provider ID so that a provider's letters can be sent in a single envelope.

2.6.5 paupd152 -- Add Pending PA with transaction from the web

This program is not currently used in Kentucky.

Technical Name:	paupd152
Program Title:	Add Pending PA with transaction from the Web
Programming Language:	C
Description:	Add Pending PA from transaction received from the Provider Web Portal. **Input Parameters:** Pointer to an XML element that contains a Pending Prior Authorization **Exit Values:** EXIT_SUCCESS - Normal termination EXIT_FAILURE - Abnormal termination because of open, read, allocation, or input errors **Input Files:** None **Output Files:** None **Input Tables:** None **Output Tables:** T_PA_PAUTH T_PA_PEND_LITEM T_PA_PEND_DIAG T_PA_PEND_TEXT **Sort Criteria:** None **Switches:** None **Link Procedure:** None **Special Logic Notes:** None

2.6.5.1 Change Orders

ID	NAME	DESCRIPTION
2261	KYAmend Process SHPS Transactions	Receive and process PA adds and updates, pending eligibles and LOC (level of care) from SHPS (maxMC).
2518	KYAmend Load PAs for Pending Elg	Providers may enter PAs for pending eligibles. When a member receives a Medicaid ID, the provider submits the pending PA for processing. At that time the PA is adjudicated if it is eligible for the automated review process, otherwise it is sent to SHPS for second level review. This change order receives the pending PA XML file and writes it to the pending PA tables.

2.6.6 paupd200 -- Insert letter requests for PA 1st time EPSDT notification

Technical Name:	paupd200
Program Title:	Insert letter requests for PA 1st time EPSDT notification
Programming Language:	C
Description:	Inserts requests into letter request table for PA letters for notification of EPSDT services ending at 21. **Input Parameters:** None **Exit Values:** • 0 - Normal termination • -1 - Abnormal termination because of read, allocation, or input errors **Input Files:** None **OutPut Files:** None **Input Tables:** T_PA_PAUTH **Tables Updated:** T_LG_LETTER_REQUEST **Sort Criteria:** None **Switches:** None **Link Procedure:** None **Special Logic Notes:** None

2.6.6.1 Change Orders

ID	NAME	DESCRIPTION
2520	KYAmend PA EPSDT Process	The first time a member receives prior authorization approval for EPSDT services, create a letter of notification that services are no longer available when the member turns 21. Create a report listing members receiving EPSDT services for the first time.

2.6.7 paupdXML -- PA xmlpunld Hooks for Batch Interfaces

Technical Name:	paupdXML
Program Title:	PA xmlpunld Hooks for Batch Interfaces
Programming Language:	C
Description:	This Program is called from the pacomm share library. It is used in conjunction with xmlpunld to extract the batch update transactions and reformat date and numeric data. **Input Parameters:** Pointer to an XML element that contains a Prior Authorization **Exit Values:** • EXIT_SUCCESS - Normal termination • EXIT_FAILURE - Abnormal termination because of open, read, allocation, or input errors **Input Files:** None **Output Files:** None **Input Tables:** None **Output Tables:** None **Sort Criteria:** None **Switches:** None **Link Procedure:** None **Special Logic Notes:** None

2.6.7.1 Change Orders

ID	NAME	DESCRIPTION
No associated Change Orders found		

2.6.8 paupedit -- Prior Authorization Request and Update Engine

Technical Name:	paupedit
Program Title:	Prior Authorization Request and Update Engine
Programming Language:	C
Description:	This program is executed from the pacomm share library. It accepts the priorAuthorization.xsd format XML document for a Prior Authorization request or update transaction. The transaction is edited, error nodes are added if appropriate, and the document is returned to the calling program. **Input Parameters:** A pointer to an XML Element that contains a prior authorization (schema priorAuthorization.xsd) **Exit Values:** EXIT_SUCCESS - Normal termination EXIT_FAILURE - Abnormal termination because of open, read, allocation, input errors or an error is encountered for an edit **Input Files:** None **Output Files:** None **Input Tables:** None **Output Tables:** Update T_SYSTEM_KEYS with new prior authorization number T_PA_PAUTH T_PA_LINE_ITEM T_PA_PAUTH_STATE T_PA_DIAGNOSIS T_PA_IAC_XREF T_PA_INT_TEXT **Sort Criteria:** None **Switches:** None **Link Procedure:** None **Special Logic Notes:** None

2.6.8.1 Change Orders

ID	NAME	DESCRIPTION
2935	KYAmend Process Web PAs	Process PAs received from the Provider Web Portal.
6491	DCR1005 REL2 Internet Interface	Modify priorAuthorization schema and batch program that processes Internet PA transactions to accommodate fields for School Based PAs. See Business Design in Supplemental Documentation

2.6.9 paupm001 -- Update system parm table for monthly PA cycle

Technical Name:	paupm001
Program Title:	Update system parm table for monthly PA cycle
Programming Language:	C
Description:	Update Prior Authorization report parameters (T_SYSTEM_PARMS where NAM_PROGRAM = 'PAUMONTH'). The dates are updated to reflect the first and last day of the monthly reports. **Input Parameters:** None **Exit Values:** EXIT_SUCCESS - Normal termination EXIT_FAILURE - Abnormal termination because of read, allocation, or input errors **Input Files:** None **OutPut Files:** None **Input Tables:** None **Output Tables:** T_SYSTEM_PARMS **Sort Criteria:** None **Switches:** None **Link Procedure:** None **Special Logic Notes:** None

2.6.9.1 Change Orders

ID	NAME	DESCRIPTION
No associated Change Orders found		

2.6.10 paupm130 -- End Date Prior Auths

Technical Name:	paupm130
Program Title:	End Date Prior Auths
Programming Language:	C
Description:	The program end dates prior authorization services for a member when the member enters managed care or Member Status is "M7" or "P7". See CO 2125 for situations where a PA should not be end dated. **Input Parameters:** None **Exit Values:** EXIT_SUCCESS - Normal termination EXIT_FAILURE - Abnormal termination because of read, allocation, or input errors **Input Files:** None **Output Files:** pam01301.rpt **Input Tables:** T_RE_PMP_ASSIGN T_PA_PAUTH T_PA_LINE_ITEM T_REVENUE_CODE T_PROC T_DRUG T_RE_BASE T_PR_PROV T_PUB_HLTH_PGM T_PA_LINEITEM_STAT T_PA_ASSIGN_CODE T_PA_IAC_TEXT **Output Tables:** T_PA_LINE_ITEM **Sort Criteria:** DSC_PA_ASSIGN, ID_PROVIDER, PRIOR_AUTH_NUM **Switches:** None **Link Procedure:** None

	Special Logic Notes: See CO 2125 for logic

2.6.10.1 Change Orders

ID	NAME	DESCRIPTION
2125	End Date PA if Mmbr goes to MC	Create a monthly process to end date active prior authorizations for a member, if the member goes into managed care or has a member status of "M7" or "P7". When member goes into Managed Care: • Do not end date PAs in any one of the following PA Categories: Impact Plus and PAs that are currently considered Pro Certs (Inpatient, Psych DPU, Rehab DPU, Nursing Facility, Mental Hospital) • Do not end date PA, if the provider specialty = "psychiatry" • Do not end date PA, If PA Category = "EPSDT" and service code is for a behavioral service Member may or may not be in managed care and member status is "P7" OR "M7" : • Do end date PA, if PA Category = "EPSDT" and member status = "P7" (KCHIP 3 - Uninsured Children under 19 w/ income 3/30/2007 - per Beth Jennings, If a member is in M7 or P7, AND also in managed care AND the PA is for EPSDT services, the services should be end dated. This overrides the exclusion of end dating behavioral health services for EPSDT PAs when the member is only in managed care. (Cynthia Warner) 3/30/2007 - per Beth Jennings, exclude pharmacy PAs (PA Category = 64) from end dating process (Cynthia Warner).

2.6.11 paupm151 -- Delete Old Pending PAs from the database

This program is not currently used in Kentucky.

Technical Name:	paupm151
Program Title:	Delete Old Pending PAs from the database
Programming Language:	C
Description:	Pending PAs are awaiting assignment of a Medicaid ID to a pending eligible. When a Medicaid ID is assigned, the pending PA is flagged for processing so that the provider may submit it for adjudication and delete it from the pending tables. Delete old pending PAs from the database when system date is three months later than pending PA received date (T_PA_PEND_PAUTH.DTE_RECEIVED). **Input Parameters:** None **Exit Values:** EXIT_SUCCESS - Normal termination EXIT_FAILURE - Abnormal termination because of open, read, allocation, or input errors **Input Files:** None **Output Files:** None **Input Tables:** T_PA_PEND_PAUTH T_PA_PEND_LITEM T_PA_PEND_DIAG T_PA_PEND_TEXT **Output Tables:** T_PA_PEND_PAUTH T_PA_PEND_LITEM T_PA_PEND_DIAG T_PA_PEND_TEXT **Sort Criteria:** None **Switches:** None **Link Procedure:** None

	Special Logic Notes: None

2.6.11.1 Change Orders

ID	NAME	DESCRIPTION
2755	KYAmend Delete Old Pending PAs	Remove pending PAs from the database if a MAID has not been assigned within three months of entry of the pending PA.

2.6.12 paupm210 -- Create monthly first-time EPSDT services report

Technical Name:	paupm210
Program Title:	Create monthly first-time EPSDT services report
Programming Language:	C
Description:	Members receiving EPSDT services for the first time are sent letters informing them that EPSDT services expire when they reach 21. This program creates a report listing members receiving the services for the first time in the previous month. The PAUPD200 job runs daily to insert letter generator requests for members meeting this criteria. PAUPM210 scans the T_LG_LETTER_REQUEST table and uses those requests to build the report. **Input Parameters:** T_SYSTEM_PARMS where NAM_PROGRAM = 'PAUMONTH' **Exit Values:** EXIT_SUCCESS - Normal termination EXIT_FAILURE - Abnormal termination because of read, allocation, or input errors **Input Files:** None **OutPut Files:** pam0210.rpt **Input Tables:** T_PA_PAUTH T_PA_LINE_ITEM T_REVENUE_CODE T_PROC T_DRUG T_RE_BASE T_LG_LETTER_TEMPLATE T_LG_LETTER_REQUEST **Output Tables:** None **Sort Criteria:** ID_MEDICAID **Switches:** None **Link Procedure:** None **Special Logic Notes:** None

2.6.12.1 Change Orders

ID	NAME	DESCRIPTION
2520	KYAmend PA EPSDT Process	The first time a member receives prior authorization approval for EPSDT services, create a letter of notification that services are no longer available when the member turns 21. Create a report listing members receiving EPSDT services for the first time.

2.6.13 paupm220 -- PA Orthodontic Case Tracking Process Reports and Letters

Technical Name:	paupm220
Program Title:	PA Orthodontic Case Tracking Process Reports and Letters
Programming Language:	C
Description:	Prior Authorization orthodontic case tracking reports and letters. This program creates four letters using the letter generator and two reports. **Input Parameters:** None **Exit Values:** 0 - Normal termination -1 - Abnormal termination because of read, allocation, or input errors **Input Files:** None **OutPut Files:** pam02201.rpt pam02202.rpt **Input Tables:** T_PA_PAUTH T_PA_ITEM_DTL_XREF T_HIST_DIRECTORY T_PA_LINE_ITEM T_PA_PAUTH_STATE T_PR_IDENTIFIER T_RE_BASE T_PROC **Tables Updated:** T_LG_LETTER_REQUEST **Sort Criteria:** None **Switches:** None **Link Procedure:** None **Special Logic Notes:** None

2.6.13.1 Change Orders

ID	NAME	DESCRIPTION
2519	KYAmend PA Orthodontic Process	The Orthodontic Case Tracking process monitors the submission of required documentation for an Orthodontic service/prior authorization. The automated process identifies overdue documentation and sends reminder letters to providers. In cases where providers have not responded to reminder letters, the overdue documentation is reported for follow-up by the KYMMIS Orthodontic Staff.

2.6.14 paupr140 -- Mass update - old provider

Technical Name:	paupr140
Program Title:	Mass update - old provider
Programming Language:	C
Description:	This program end dates prior authorizations for providers. Parameters are used to determine PAs that should be transferred to a new provider. A reason code is written for why the PA was end dated. A letter request is inserted to notify the provider that the request was end dated. A report is written displaying the updated PAs. SHPS' PA transaction tables are updated with updates to the PA. Input parameters may be set to create a preliminary report of PAs that are selected for update. No updates are made, only a report of PAs that are updated based on the input parameters is created. **Input Parameters:** Provider ID Category Effective date, Reason code Indicator (Y or N) to indicate if data should appear on the report only or if the data should commit. **Exit Values:** EXIT_SUCCESS - Normal termination EXIT_FAILURE - Abnormal termination because of read, allocation, or input errors **Input Files:** None **OutPut Files:** par01401.rpt **Input Tables:** T_SYSTEM_PARMS T_PA_PAUTH T_PA_ASSIGN_CODE T_PA_ITEM_DTL_XREF T_PA_LINE_ITEM T_RE_BASE T_PR_IDENTIFER T_PROC T_REVENUE_CODE **Tables Updated:** T_PA_LINE_ITEM T_PA_TEMP_MASS_UPD

	T_PA_IAC_XREF MCPROD.U_PRIOR_AUTH_HEADER (SHPS/maxMC table) MCPROD.U_PRIOR_AUTH_SERVICES (SHPS/maxMC table) **Sort Criteria:** Prior Auth Number **Switches:** None **Link Procedure:** None **Special Logic Notes:** None

2.6.14.1 Change Orders

ID	NAME	DESCRIPTION
2936	Mass Updates - Old Provider	Mass updates of providers are a two-step process. The first step end dates the old provider's PA so that the claims are not paid past the effective date for the new provider. The old provider is given time to submit claims for payment. The second step updates authorized units and amounts for the old provider with what has been used to date. PAs are then created for the new provider with the remaining authorized units and amounts from the original PA. This change order is for the first step in the process of end dating the old provider's PAs. • The old provider's PAs are end dated with the effective date of the provider change less one day. The prior auth numbers are saved for later use in Step 2; • Create reason code record for the PA to explain end dating the PA (the reason code is on the input parameters); • Create letter of notification to old provider; • Create SHPS transactions of PA changes; and, • Create report of PAs selected for mass change.
3832	KYAmend Send mass upd to SHPS	Modify mass update programs to create XML transactions of Prior Auth mass updates.
2757	Mass Updates – Rate - Panel	Create panel to display rate changes for a PA.

ID	NAME	DESCRIPTION
2769	Mass Updates – Search - Panel	Create a panel to search for rate/service code changes by service code, effective date and provider.

2.6.15 paupr141 -- Mass update - new provider

Technical Name:	paupr141
Program Title:	Mass update - new provider
Programming Language:	C
Description:	This program creates PAs for the remaining services for the new provider. Using PA info for the old provider on the T_PA_TEMP_MASS_UPD table, PAs are created for the new provider with the remaining units and amount and the revised effective date. The original provider's PAs are updated with the used units and amounts. A reason code for the mass update is inserted, a report is created, a letter request is inserted and a SHPS trx is written to the SHPS PA transaction database. **Input Parameters:** new provider indicator (Y or N) indicates if the data should appear on the report only or if the data should commit. **Exit Values:** • EXIT_SUCCESS - Normal termination • EXIT_FAILURE - Abnormal termination because of read, allocation, or input errors **Input Files:** None **OutPut Files:** par01411.rpt par01412.dat **Input Tables:** T_PA_PAUTH T_PA_ASSGN_CODE T_SYSTEM_PARMS T_PA_LINE_ITEM T_RE_BASE T_PA_IAC_TEXT T_PA_TEMP_MASS_UPD T_PA_ITEM_DTL_XREF T_SYSTEM_KEYS T_PROC T_REVENUE_CODE **Tables Updated:** T_PA_PAUTH T_PA_LINE_ITEM T_PA_INT_TEXT T_PA_IAC_XREF

	T_SYSTEM_KEYS MCPROD.U_PRIOR_AUTH_HEADER (SHPS/maxMC table) MCpROD.U_PRIOR_AUTH_SERVICES (SHPS/maxMC table) **Sort Criteria:** None **Switches:** None **Link Procedure:** None **Special Logic Notes:** None

2.6.15.1 Change Orders

ID	NAME	DESCRIPTION
2756	Mass Updates - New Provider	Mass updates of providers is a two step process. The first step end dates the old provider's PAs so that claims are not paid past the effective date for the new provider. The old provider is given time to submit claims for payment. The second step updates authorized units and amounts for the old provider with what has been used to date. PAs are then created for the new provider with the remaining authorized units and amounts from the original PA. This change order is for the second step in the process of creating PAs for the new provider. • Update used units and amounts for old provider; • Create PA for new provider; • Create reason code record for the PA to explain end dating the PA (the reason code is on the input parameters); • Create letter of notification to new provider; • Create SHPS transactions of PA changes; and, • Create report of PAs created for new provider.
3832	KYAmend Send mass upd to SHPS	Modify mass update programs to create XML transactions of Prior Auth mass updates.

2.6.16 paupr142 -- Rate Service Code Mass Update Report

Technical Name:	paupr142
Program Title:	Rate Service Code Mass Update Report
Programming Language:	C
Description:	This program takes in parameters from the T_SYSTEM_PARMS table and creates a mass update with overrides for rates and service codes on a PA line item that Claims access during processing. A report is generated listing the overrides. Letters are created for providers notifying them of the overrides. An input parameter is available to run a preliminary report for review of updates that would be made based on the mass update criteria. **Input Parameters:** t_sytem_parms where nam_program = PAUJ142A, PAUJ142B, PAUJ142C Indicator (Y or N) indicates if the data should appear on the report only or if the data should commit Reason code Effective Date (The service code/ rate effective date) Provider - limit mass update to a specific provider or all providers Mass Update Type (1=revenue, 2= procedure, 3= rev/rate, 4= proc/rate) Old service code New Service Code New Rate Category Codes **Exit Values:** EXIT_SUCCESS - Normal termination EXIT_FAILURE - Abnormal termination because of read, allocation, or input errors **Input Files:** None **OutPut Files:** par01421.rpt **Input Tables:** T_PA_PAUTH T_PR_IDENTIFIER T_PA_LINE_ITEM T_PA_ASSIGN_CODE T_PA_IAC_XREF T_PROC T_REVENUE_CODE T_SYSTEM_PARMS

	Tables Updated: T_PA_MASS_UPD T_PA_IAC_XREF MCPROD.U_PRIOR_AUTH_HEADER (SHPS/maxMC table) MCPROD.U_PRIOR_AUTH_SERVICES (SHPS/maxMC table) **Sort Criteria:** Prior Authorization Number **Switches:** None **Link Procedure:** None **Special Logic Notes:** None

2.6.16.1 Change Orders

ID	NAME	DESCRIPTION
2759	Mass Updt - load new rates/serv	The mass update process for rates and service codes provide the following: • Ability to mass update rates on prior auth line items where the service is priced on the PA; • Ability to select rates for mass update by provider; • Ability to mass update service codes on prior auth line items; • Correct accounting for units authorized and used on the line items that have been updated with a rate or service code change. (also see Claims CO 3102); • Provider letters for notification of rate or service code change; • Report on PAs with rate or service code change; • Transactions to SHPS with rate or service code change; and, • Change orders 2757 and 2769 create panels for viewing, updating and searching rate and service code changes.
3832	KYAmend Send mass upd to SHPS	Modify mass update programs to create XML transactions of Prior Auth mass updates.

2.6.17 paupw150 -- Impact Plus Interface

Technical Name:	paupw150
Program Title:	Impact Plus Interface
Programming Language:	C
Description:	Creates extract of Impact Plus prior authorizations (category of service = 16) with any paid claim amounts to date **Input Parameters:** None **Exit Values:** 0 - Normal termination -1 - Abnormal termination because of read, allocation, or input errors **Input Files:** None **OutPut Files:** paw0150.dat **Input Tables:** T_PA_PAUTH T_PR_IDENTIFIER T_PA_LINE_ITEM A_T_PA_LINE_ITEM T_PA_ITEM_DTL_XREF T_PA_PAUTH_STATE T_REVENUE_CODE T_PROC T_RE_BASE T_ANALYST **Tables Updated:** None **Sort Criteria:** None **Switches:** None **Link Procedure:** None **Special Logic Notes:** None

2.6.17.1 Change Orders

ID	NAME	DESCRIPTION
2874	KYAmend MHMR Impact Plus Extract	Create an extract of Impact Plus prior authorizations for MHMR. Send extract bi-weekly.
8497	MHMR extract	Some of the Impact Plus providers are setup with an ID type of 'VND'. Currently only Impact Plus records where the servicing provider has an ID type of 'MCD' are included on the extract. Query also selects where PA date received is between provider ID begins and end dates. Modify program paupw150 to include all provider types and remove check for provider ID effective dates.

2.6.18 -- AddLoad pending PA into database

This program is not currently used in Kentucky.

Technical Name:	
Program Title:	AddLoad pending PA into database
Programming Language:	C
Description:	

2.6.18.1 Change Orders

ID	NAME	DESCRIPTION
No associated Change Orders found		

2.7 Pages/Panels

The Pages/Panels section is set up to display first the Page then all associated Panels. If a panel is accessible through more than one page, it displays multiple times in the document.

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

2.7.1 PAGE: Prior Authorization Information Page

2.7.1.1 Description

The Prior Authorization Information page displays a summary of information about a Service/Prior Authorization. A checked box next to fields "Additional Diagnosis Codes" and "Internal Text" indicates the presence of additional diagnosis codes and/or text for the PA. Access this data through links on the Prior Authorization Maintenance panel.

Navigation Path: [Prior Authorization] - [Information]

2.7.1.2 Technical Name

PA.PaPauthInformation

2.7.1.3 Web Page Name

Information Page

2.7.1.4 Prior Authorization Information Page Layout

Next search by: Prior Authorization Number [ ] search clear

Prior Authorization Information

PA Number		Member ID		Requesting Provider Number	
Legacy PRO Cert Number		Member Last Name		Servicing Provider Number	
Authorizer		Member First Name		Service Provider Check	All Service Providers
		Member Date Of Birth			
Received Date	05/22/2007	Clerk Keyed		PA Category Code	
Review Date		Date Keyed	05/22/2007	Case Number	
Update Received Date				Fund Code	
Update Reviewed Date		Admission Date		Primary Diagnosis Code	
Date Mailed		Discharge Date			
		Accident	NO	Case Management	NO
Additional Diagnosis Codes	☐	Special Considerations	NO	Disease Management	NO
Internal Text	☐	Emergency	NO		
Super PA	☐	Nursing Facility Type		Media Type	
		Ortho Status Code		Print Option	NO PRINT

Prior Authorization Maintenance - Complete the Panels below then select Save to add the new Prior Authorization. Prefs Top Bot ? ^

Prior Authorization

Additional Diagnosis Codes | Base Information | Internal Text
Line Item | Paid Claim List | Related Documents
Super PA

save cancel

2.7.2 PANEL: Prior Authorization Mini Search

2.7.2.1 Description

Use the Prior Authorization Mini Search panel to search by service/prior authorization number. Using the Mini Search, the user can access a service/prior authorization directly rather than selecting from a list on the Search panel.

Navigation Path: [Prior Authorization] - [Information]

2.7.2.2 Technical Name

PA.PaMiniSearchPanel.ascx

2.7.2.3 Panel Name

Pa Mini Search

2.7.2.4 Prior Authorization Mini Search Layout

2.7.2.5 Extra Features

Global ERL

2.7.2.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Prior Authorization Number	Unique number assigned to a service/prior authorization request.	Field	Character	10	T_PA_PAUTH	PRIOR_AUTH_NUM

2.7.2.7 Field Edits

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

2.7.2.8 Associated Requirements

ID
No associated requirements found.

2.7.2.9 CO / Defects

ID	Type	Name	Description	Current Status
No associated change orders found.				

2.7.3 PANEL: Prior Authorization Internal Text

2.7.3.1 Description

The Prior Authorization Internal Text panel provides for the entry of free form text concerning a service/prior authorization. A block of 500 characters may be entered at one time in the Notes field. There may be as many as 9,999 blocks of characters entered for a service/prior authorization. The text may be added, updated or deleted.

The table holds converted data brought over with Legacy PAs and comments entered for SCL and ABI Prior Authorizations.

Navigation Path: [Prior Authorization] - [Information] - [Internal Text]

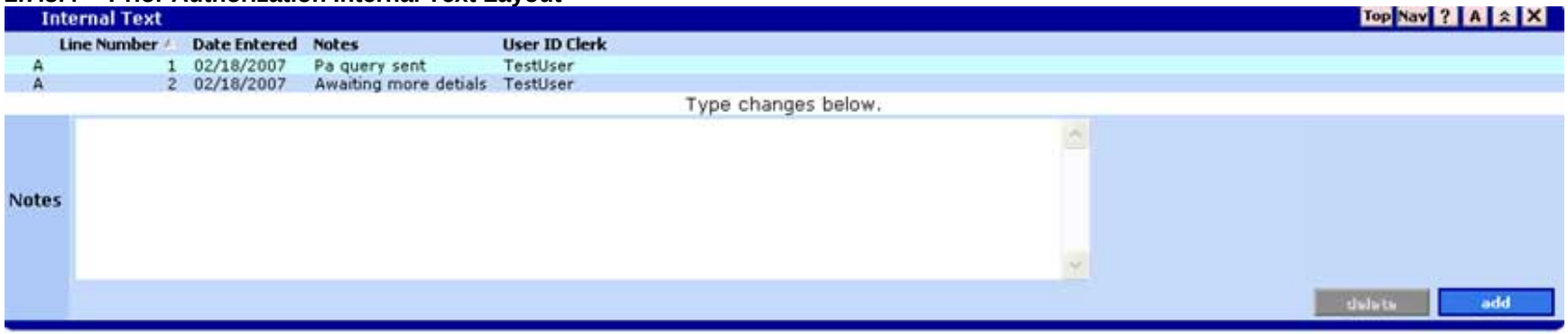
2.7.3.2 Technical Name

WebUI.EntityMaintenancePanel.ascx (Int)

2.7.3.3 Panel Name

PaIntText

2.7.3.4 Prior Authorization Internal Text Layout



2.7.3.5 Extra Features

PA Internal Text ERL

2.7.3.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Notes	Free form text entered to provide additional information about a service/prior authorization. The Notes area holds 500 characters of text. There can be 9,999 entries of 500 character blocks of text.	Field	Character	500	T_PA_INT_TEXT	DSC_PA_TEXT
Date Entered	Date a row of text was entered for a service/prior authorization.	Listview	Number	8	T_PA_INT_TEXT	DTE_SENT
Line Number	Sequential number assigned to each 500 character block of text.	Listview	Number	4	T_PA_INT_TEXT	NUM_LINE_NUMBER
User ID Clerk	Identifier for the person entering the text.	Listview	Character	8	T_PA_INT_TEXT	ID_CLERK

2.7.3.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Notes	Field	5001	Notes entry is required.	Enter up to 500 characters of text into the Notes field.

2.7.3.8 Associated Requirements

ID
30.090.005.002.4
30.090.005.003.2

2.7.3.9 CO / Defects

ID	Type	Name	Description	Current Status

ID	Type	Name	Description	Current Status
575	Change Order	Modify PA Internal Text Panel	There is a requirement to add a field to the Prior Authorization PA Internal Text Panel to capture the ID of the person entering a note.	Prod Implemented

2.7.4 PANEL: Prior Authorization Line Item

2.7.4.1 Description

Use the Prior Authorization Line Item panel to enter, view, and adjudicate services requested on a service/prior authorization. There must be at least 1 and may be up to 99 services entered on a service/prior authorization.

Navigation Path: [Prior Authorization] - [Information] - [Line Item]

2.7.4.2 Technical Name

PA.PaLineItemPanel.ascx

2.7.4.3 Panel Name

PaLineItem

2.7.4.4 Prior Authorization Line Item Layout

Line Item

Line Item Number	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Revenue Code From	Revenue Code To	Procedure Code From	Procedure Code To	Modifier 1	Modifier 2	Modifier 3	Modifier 4	NDC Code	Pa Line Item Status	Subcontractor Tax ID
01	0	$150.00	0	$15.00			W4764							Pending	
02	1	$1.00	1	$0.00			W4764							Pending	
03	0	$5.00	0	$0.00	100									Pending	
04	0	$15.00	0	$0.00			W4764							Pending	

Type changes below.

Line Item Number	02			Requested Effective Date*	10/10/2005
Service Type Code*	Procedure Code			Requested End Date*	10/10/2005
Revenue Code		Revenue Code To		Requested Frequency	
				Requested Frequency Units	
Procedure Code From	W4764 [Search]	Procedure Code To	[Search]	Requested Units	1
Modifier 1	[Search]	Quad	[Search]	Requested Dollars	$1.00
Modifier 2	[Search]	Tooth	[Search]	Authorized Effective Date	10/10/2005
Modifier 3	[Search]	NDC Lock		Authorized End Date	10/10/2005
Modifier 4	[Search]	NDC Code		Authorized Frequency	
PA Line Item Status*	P - Pending	Subcontractor Tax ID		Authorized Frequency Units	
				Authorized Units	1
				Authorized Dollars	
				Payment Method*	Pay System Price
				Quantity Used Units	0
				Quantity Used Dollars	
				Balance Units	
				Balance Dollars	

add

-Reason Code- Select row below to update -or- type data below to add.

*** No rows found ***

Reason Code Reason Description

delete add

2.7.4.5 Extra Features

PA Line Item ERL

2.7.4.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
NDC Lock	If 'Yes', the prior authorization is locked into to the NDC that is listed. If 'No', then the authorization is for the GCN sequence number represented by the NDC entered in the service code. This field is hidden unless the service code is an NDC.	Combo Box	Character	1	T_PA_LINE_ITEM	IND_NDC_LOCK
PA Line Item Status	Status (such as, pending) or decision (approved or denied) for a service.	Combo Box	Character	20	T_PA_LINEITEM_STAT	DSC_STATUS
Payment Method	Payment method is used during claim adjudication to determine how a claim should be paid. Valid payment methods are: pay unit fee price specified on the service request, pay system price specified on a fee schedule, pay up to capitated amount specified on line item, pay audit cap amount set in claims.	Combo Box	Character	1	T_PA_LINE_ITEM	CDE_PYMT_METHOD
Reason Code	Code indicating the reason the decision on the line item was chosen.	Combo Box	Character	3	T_PA_IAC_TEXT	CDE_IAC

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Service Type Code	Indicates the code set to use for validation of the requested service: procedure, revenue, or drug.	Combo Box	Character	1	T_PA_LINE_ITEM	CDE_SVC_TYPE
Authorized Dollars	Dollar amount authorized for a service.	Field	Number	9	T_PA_LINE_ITEM	AMT_PA_AUTH
Authorized Effective Date	Begin date of the date range for which the service is approved for use by a member.	Field	Date (MM/DD/CCYY)	8	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Authorized End Date	Date showing the last date an authorized service can be used by a member.	Field	Date (MM/DD/CCYY)	8	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Authorized Frequency	The field is used for waiver service/prior authorizations in conjunction with the Authorized Quantity field to specify rate of usage. The field is informational only and displays on waiver letters. Valid values are M = Month and W = Week.	Field	Character	1	T_PA_LINE_ITEM	CDE_FREQ_AUTH

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Authorized Frequency Units	The field is used for waiver service/prior authorizations in conjunction with the Authorized Frequency field to indicate rate of usage. The field is informational and displays on waiver letters.	Field	Number	9	T_PA_LINE_ITEM	QTY_FREQ_AUTH
Authorized Units	Units approved for payment for a service on a service/prior authorization line item.	Field	Number	9	T_PA_LINE_ITEM	QTY_UNT_SVC_AT H
Balance Dollars	Remaining dollars of a service available for use by a member.	Field	Number	9	CALCULATED FIELD	N/A
Balance Units	Number of units remaining on a service/prior authorization line item.	Field	Number	9	CALCULATED FIELD	N/A
Line Item Number	Two characters that sequentially lists the items pertaining to the service/prior authorization. The characters are 01 through 99. The line item number is automatically generated.	Field	Character	2	T_PA_LINE_ITEM	NUM_PA_LINE_ITE M
Modifier (1 - 4)	Four occurrences of codes used in combination with a procedure code to provide more information.	Field	Character	2	T_MODIFIER	CDE_PROC_MOD

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
NDC Code	National Drug Code used to uniquely identify a drug.	Field	Character	11	T_DRUG	CDE_NDC
Procedure Code From	Code that uniquely identifies a procedure.	Field	Character	6	T_PROC	CDE_PROC
Procedure Code To	Procedure code ending the procedure code range used at the line item level on a service/prior authorization.	Field	Character	6	T_PROC	CDE_PROC
Quad	Tooth quadrant used in combination with a tooth number and procedure code to provide more information concerning the service.	Field	Character	2	T_TOOTH_QUADRANT	CDE_TOOTH_QUAD
Quantity Used Dollars	Dollar amount of an approved service used by a member.	Field	Number	9	T_PA_ITEM_DTL_XREF	AMT_PA_USED
Quantity Used Units	Number of units used by a member of an approved service.	Field	Number	9	T_PA_ITEM_DTL_XREF	QTY_UNT_SVC_USD
Reason Description	Text describing a reason code.	Field	Character	500	T_PA_IAC_TEXT	DSC_IAC
Requested Dollars	Dollar amount requested for a service for a member.	Field	Number	9	T_PA_LINE_ITEM	AMT_PA_REQ

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Requested Effective Date	Requested date the authorization is effective.	Field	Date (MM/DD/CCYY)	8	T_PA_LINE_ITEM	DTE_PA_REQ_EFF
Requested End Date	Date requested that a service would end for a member.	Field	Date (MM/DD/CCYY)	8	T_PA_LINE_ITEM	DTE_PA_REQ_END
Requested Frequency	The field is used for waiver service/prior authorizations in conjunction with the Requested Quantity field to specify rate of usage. The field is informational only and displays on waiver letters. Valid values are M = Month and W = Week.	Field	Character	1	T_PA_LINE_ITEM	CDE_FREQ_REQ
Requested Frequency Units	The field is used for waiver service/prior authorizations in conjunction with the Requested Frequency field to indicate rate of usage. The field is informational only and displays on waiver letters.	Field	Number	9	T_PA_LINE_ITEM	QTY_FREQ_REQ
Requested Units	Number of units requested of a product or service.	Field	Number	9	T_PA_LINE_ITEM	QTY_UNT_SVC_REQ
Revenue Code	Code identifying a specific accommodation or ancillary service.	Field	Character	4	T_REVENUE_CODE	CDE_REVENUE

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Revenue Code To	Revenue code that ends the range of revenue code specified for a service.	Field	Character	4	T_REVNUE_CODE	CDE_REVENUE
Subcontractor Tax ID	View only field used for converted Impact Plus service/prior authorizations received before 11/1/2002 to designate actual Service Provider since all service/prior authorizations were initially issued for providers '29000015' (DMS) or '29000023' (DCBS).	Field	Character	9	T_PA_LINE_ITEM	ID_IMPACT_TAX
Tax ID sub	This view-only field is present for converted Impact Plus service/prior authorizations received before 11/1/2002. For service/prior authorizations after 11/1/2002, the field will be spaces.	Field	Character	2	T_PA_LINE_ITEM	ID_IMPACT_SUB
Tooth	Tooth number used in combination with a procedure code to provide more information concerning the service.	Field	Character	2	T_TOOTH	CDE_TOOTH_NBR

2.7.4.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
PA Line Item Status	Combo Box	5029	A valid Status is required.	Select item from list.
Payment Method	Combo Box	5001	Payment Method is required.	Select item or cancel transaction.
Authorized Effective Date	Field	5013	Authorized Effective Date must be greater than or equal to 1/1/1900.	Enter date greater than or equal to 1/1/1900.
Authorized End Date	Field	5115	Authorized End Date must be greater than or equal to 1/1/1900.	Enter date greater than or equal to 1/1/1900.
Authorized End Date	Field	5501	Invalid date. Format is MM/DD/YYYY.	Enter date greater than or equal to 1/1/1900.
Authorized Effective Date	Field	15501	Authorized Effective Date is required	Enter appropriate date value.
Authorized End Date	Field	15502	Authorized End Date is required	Enter appropriate date value.
Requested Effective Date	Field	15503	Requested Effective Date is required	Enter appropriate date value.
Requested End Date	Field	15504	Requested End Date is required	Enter appropriate date value.
PA Line Item Status	Field	15505	A valid PA Line Item Status is required	Choose a valid line item status.

Field	Field Type	Error Code	Error Message	To Correct
Procedure Code From	Field	15506	Warning: There is no matching Procedure Code	Enter a valid procedure code or check the ignore check box.
Modifier 1 - 4	Field	15507	Warning: There is no matching Modifier	Enter a valid procedure code or check the ignore check box.
Modifier 1 - 4	Field	15508	Procedure Code To invalid with Modifiers or Tooth	Enter valid modifiers or tooth.
Authorized Units	Field	15509	Authorized Units must be present.	Enter a valid value for authorized units.
Authorized Dollars	Field	15510	Authorized Dollars must be present.	Enter a valid value for authorized dollars.
Authorized Units	Field	15511	Authorized Units must be 0.	Enter a valid value for authorized units.
Reason Code	Field	15513	Please specify a reason code	Enter a valid reason code.
NDC Code	Field	15514	NDC Code must be present.	Enter a valid NDC code.
Authorized Effective Date	Field	15515	Line Item cannot overlap each other	Service code with same date range already exists. Change the effective/end dates.
Authorized Units	Field	15517	Invalid Authorized Units - Units must be greater than units already used	Enter a valid value.
Authorized Dollars	Field	15518	Invalid Authorized Dollars - Dollars must be greater than dollars already used	Enter a valid value.

Field	Field Type	Error Code	Error Message	To Correct
Authorized Effective Date	Field	15519	Invalid Authorized Effective Date - cannot exclude a paid claim	Enter a valid value.
Authorized End Date	Field	15520	Invalid Authorized End Date - cannot exclude a paid claim	Enter a valid value.
NDC Code	Field	15521	NDC Lock is required when NDC Code entered	Choose an appropriate value.
Authorized Units	Field	2	Authorized Units must be present.	Enter value for units.
Authorized Dollars	Field	3	Authorized Dollars must be present	Enter value for units.
Authorized Units	Field	4	Authorized Units must be 0.	Enter value for units.
Authorized Dollars	Field	5014	Authorized Dollars must be greater than or equal to 0.01.	Enter value for units.
Authorized Units	Field	5500	Enter a valid value.	Enter value for units.
Line Item Number	Field	5001	Line Item is required.	Enter value or cancel transaction.
Requested Effective Date	Field	5015	Requested Eff Date must be greater than or equal to 1/1/1900.	Enter date greater than or equal to 1/1/1900.

Field	Field Type	Error Code	Error Message	To Correct
Requested End Date	Field	5115	Requested End Date must be greater than or equal to 1/1/1900.	Enter date greater than or equal to 1/1/1900.
Authorized End Date	Field	5501	Invalid date. Format is mm/dd/yyyy.	Enter date greater than or equal to 1/1/1900.
Requested Dollars	Field	5012	Requested Dollars must be greater than or equal to 0.01.	Enter value greater than or equal to 0.01.
Authorized Units	Field	5500	Enter a valid value.	Enter value greater than or equal to 0.01.

2.7.4.8 Associated Requirements

ID
30.090.005.003.2

2.7.4.9 CO / Defects

ID	Type	Name	Description	Current Status
2993	Change Order	KYAmend Add Tax ID to Line Item	For Impact Plus PAs before 11/1/2002, the provider Medicaid ID on the PA was either '29000015' (DMS) or '29000023' (DCBS). The Tax/Sub ID is the subcontractor that actually performs the service on the PA. Display a Tax/Sub ID field labeled "Subcontractor Tax ID" on the PA Line Item for Impact Plus PAs initiated before 11/1/2002.	Prod Implemented
4476	Change Order	KYAmend - LITEM trn Id for SHPS	Add field that points to a corresponding line item on maxMC to T_PA_LINE_ITEM. The field is used to keep line items in synch between interChange and maxMC. The field is populated through the interface with maxdMC.	Prod Implemented
4477	Change Order	KYAmend - LITEM add txn field	Add field T_PA_LINE_ITEM.CDE_SYNCH to insert on the Line Item panel. The field is for processing only and is not displayed on the panel.	Prod Implemented
574	Change Order	Modify PA Line Item Panel	There is a need to add new fields in the Line Item Panel. Also, the labels displayed on the panel need to be updated.	Prod Implemented

2.7.5 PANEL: Additional Diagnosis Codes

2.7.5.1 Description

Use the Additional Diagnosis Codes panel to maintain any secondary, tertiary and so on, diagnosis codes for a member. The primary diagnosis is entered on the Base Information panel. There may be up to 9,999 additional diagnoses entered. Diagnosis codes may be added, updated, or deleted.

Navigation Path: [Prior Authorization] - [Information] - [Diagnosis Codes]

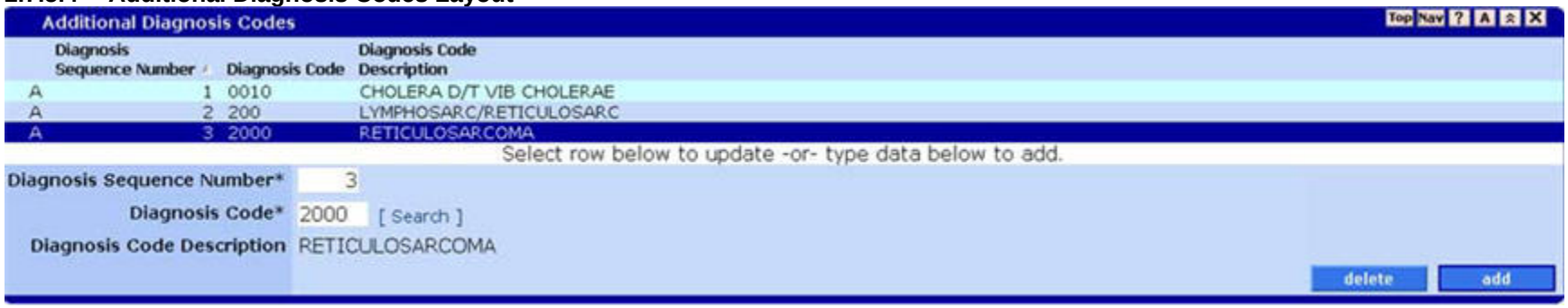
2.7.5.2 Technical Name

PA.DiagnosisCodesPanel.ascx

2.7.5.3 Panel Name

Additional Diagnosis Codes

2.7.5.4 Additional Diagnosis Codes Layout



2.7.5.5 Extra Features

This panel has no extra features.

2.7.5.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Diagnosis Code	A code designating a particular diagnosis.	Field	Character	5	T_DIAGNOSIS	CDE_DIAG

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Diagnosis Code Description	Description of the diagnosis code.	Field	Character	40	T_DIAGNOSIS	DSC_25
Diagnosis Sequence Number	Unique number assigned to the diagnosis. There may be 1 - 9,999 additional diagnosis codes.	Field	Number	4	T_PA_DIAGNOSIS	NUM_SEQ

2.7.5.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Diagnosis Code	Field	100	Diagnosis Code is invalid.	Enter a valid Diagnosis Code or select valid code from the list.
Diagnosis Code	Field	200	Diagnosis Sequence Number is invalid.	Enter a number between 1 and 9,999.

2.7.5.8 Associated Requirements

ID
30.090.005.003.2

2.7.5.9 CO / Defects

ID	Type	Name	Description	Current Status
1779	Change Order	Create PA Diagnosis Panel	There is a business need to add a new panel, Diagnosis Codes Panel, in the PA Subsystem. This panel will allow the addition and viewing of an unlimited number of diagnosis codes.	Prod Implemented

2.7.6 PANEL: Prior Authorization Maintenance

2.7.6.1 Description

The Prior Authorization Maintenance panel has links to view data associated with a specific service/prior authorization. A checked box on the Information panel next to Additional Diagnosis codes or internal text indicates data for the service/prior authorization is available at the corresponding links on the Maintenance panel.

Navigation Path: [Prior Authorization] - [Information]

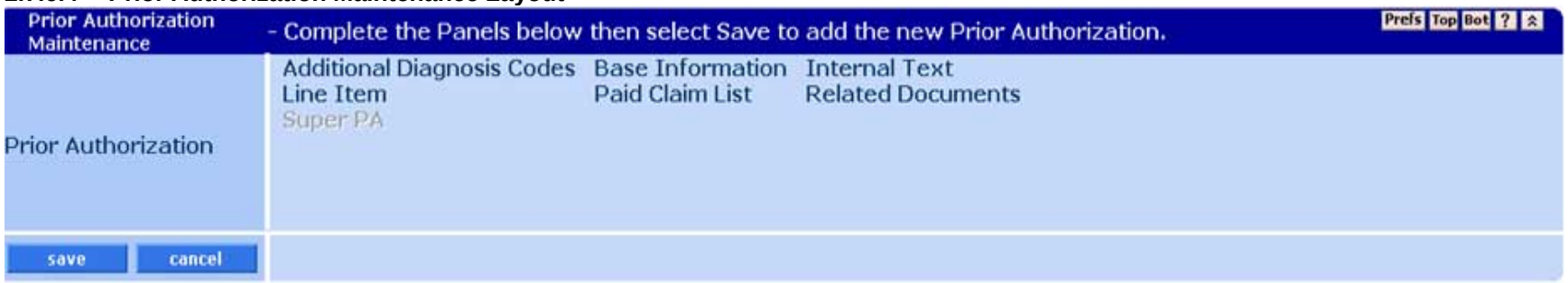
2.7.6.2 Technical Name

PA.PaPauthInformation.ascx (Maintenance)

2.7.6.3 Panel Name

Maintenance

2.7.6.4 Prior Authorization Maintenance Layout



2.7.6.5 Extra Features

Global ERL

2.7.6.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Additional Diagnosis Codes	Activates the Diagnosis Codes display and update panel.	Hyperlink	N/A	0	N/A	N/A

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Base Information	Activates the Base Information display, and update panel.	Hyperlink	N/A	0	N/A	N/A
Internal Text	Activates the Internal Text display, and update panel.	Hyperlink	N/A	0	N/A	N/A
Line Item	Activates the Line Item display, and update panel.	Hyperlink	N/A	0	N/A	N/A
Paid Claim List	Activates the Paid Claim List display panel.	Hyperlink	N/A	0	N/A	N/A
Related Documents	Activates the Related Documents panel for display of documents associated with the service/prior authorization or case number.	Hyperlink	N/A	0	N/A	N/A

2.7.6.7 Field Edits

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

2.7.6.8 Associated Requirements

ID
30.090.005.003.2

2.7.6.9 CO / Defects

ID	Type	Name	Description	Current Status
No associated change orders found.				

2.7.7 PANEL: Prior Authorization Mass Updates

2.7.7.1 Description

This is a sub panel of the Line Item panel. It is populated as a result of a batch mass update process of service/prior authorization line item rates or service codes. The mass update produces what is basically an override for a line item. The override may be viewed, modified, or deleted on this panel. Claims processing accesses the override and if the claim's service dates fall within the effective dates of the override, the override rate or service code is used to process the claim.

When a change is made on the Mass Update Change panel, it must be made within the original mass update type (procedure code change, revenue code change, rate change for a revenue code, or rate change for a procedure code). The service dates must also fall within the line item authorized effective and end dates.

Navigation Path: [Prior Authorization] - [Information] - [Line Item] – [Mass Update Change]

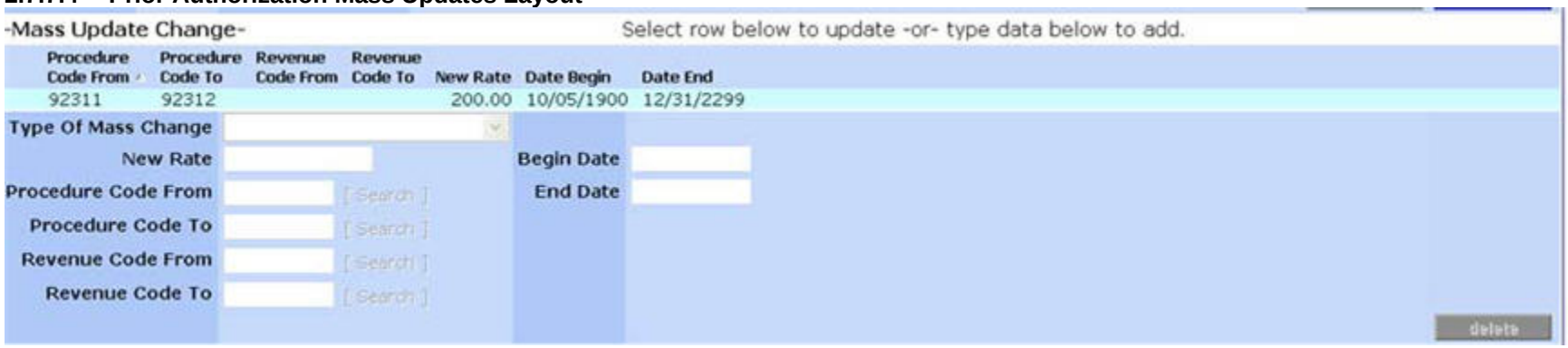
2.7.7.2 Technical Name

PA.PaMassUpdateRatePanel.ascx

2.7.7.3 Panel Name

PAMassUpdate

2.7.7.4 Prior Authorization Mass Updates Layout



2.7.7.5 Extra Features

This panel has no extra features.

2.7.7.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Begin Date	Date the override takes effect	Field	Number	8	T_PA_MASS_UPD	DTE_EFFECTIVE
End Date	Date the override ends.	Field	Number	8	T_PA_MASS_UPD	DTE_END
New Rate	Override rate associated with this service/prior authorization line item.	Field	Number	9	T_PA_MASS_UPD	AMT_NEW_RATE
Procedure Code From	Override beginning range Procedure Code.	Field	Character	5	T_PROC	CDE_PROC
Procedure Code To	Override ending range procedure code.	Field	Character	5	T_PROC	CDE_PROC
Revenue Code From	Override beginning range revenue code.	Field	Number	4	T_REVENUE	CDE_REVENUE
Revenue Code To	Override ending range revenue code.	Field	Number	4	T_REVENUE	CDE_REVENUE
Type of Mass Change	Indicates the type of mass update that generated the entry for the service/prior authorization line item. Mass update types are: revenue code, rate change for a revenue code, procedure code, and rate change for a procedure code.	Listview	Character	1	T_PA_MASS_UPD	CDE_TYPESAKS

2.7.7.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
End Date	Field	1	Revenue Code From is Required.	Enter a valid revenue code.
End Date	Field	2	Procedure Code From is Required.	Enter a valid procedure code.
End Date	Field	3	Begin Date can not be less than End Date	Check the dates.
End Date	Field	4	Begin Date is required	Enter a valid date.
End Date	Field	5	End Date is required	Enter a valid date.
End Date	Field	6	Dates can not overlap	Dates overlap with another row for this line item number. Correct the dates.

2.7.7.8 Associated Requirements

ID
No associated requirements found.

2.7.7.9 CO / Defects

ID	Type	Name	Description	Current Status
No associated change orders found.				

2.7.8 PANEL: Prior Authorization Information

2.7.8.1 Description

The Prior Authorization Information panel is view only and displays basic information about a service/prior authorization such as the type, the member for whom it is requested, and the provider who will be rendering the requested service(s). A check box for additional diagnosis codes or internal text indicates additional information is available at those links on the Prior Authorization Maintenance panel.

Navigation Path: [Prior Authorization] - [Information]

2.7.8.2 Technical Name

PA.PaPauthInformation.ascx

2.7.8.3 Panel Name

PaPauthPanel

2.7.8.4 Prior Authorization Information Layout

Prior Authorization Information

PA Number		Member ID		Requesting Provider Number	
Legacy PRO Cert Number		Member Last Name		Servicing Provider Number	
Authorizer		Member First Name		Service Provider Check	All Service Providers
		Member Date Of Birth			
Received Date	05/22/2007	Clerk Keyed		PA Category Code	
Review Date		Date Keyed	05/22/2007	Case Number	
Update Received Date				Fund Code	
Update Reviewed Date		Admission Date		Primary Diagnosis Code	
Date Mailed		Discharge Date			
		Accident	NO	Case Management	NO
Additional Diagnosis Codes	☐	Special Considerations	NO	Disease Management	NO
Internal Text	☐	Emergency	NO		
Super PA	☐	Nursing Facility Type		Media Type	
		Ortho Status Code		Print Option	NO PRINT

2.7.8.5 Extra Features

Global ERL

2.7.8.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Internal Text	A checked internal text box indicates there is internal text for the service/prior authorization.	Check Box	Check Box	0	N/A	
Accident	A checked box indicates the service/prior authorization is the result of the member's involvement in an accident.	Field	Character	1	T_PA_PAUTH	IND_ACCIDENT
Admission Date	Date a member was admitted to a facility.	Field	Date (MM/DD/CCYY)	8	T_PA_PAUTH_STATE	DTE_ADMISSION
Authorizer	Unique identifier for person authorizing services on the PA.	Field	Character	8	T_PA_PAUTH	ID_CLERK_REV
Case Management	Field is set to "YES" if there is case management program information available in the Member subsystem for this member. If there is no information, the field is set to "NO".	Field	Character	3	T_RE_CSE_DIS_STATE	CDE_PROGRAM_TYPE

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Case Number	The case number used in maxMC is being brought over to interChange to group service/prior authorizations by an episode of care.	Field	Character	25	T_PA_PAUTH_STATE	ID_CASE
Clerk Keyed	ID of the clerk who entered the PA.	Field	Character	8	T_ANALYST	ID_CLERK
Date Keyed	Date the service/prior authorization was entered.	Field	Number Saved in the MM/DD/CCYY format	8	T_PA_PAUTH	DTE_PA_KEYED
Date Mailed	Date a service/prior authorization notice was sent to the provider and member for either an original request or an update.	Field	Number Saved in the MM/DD/CCYY format	8	T_PA_PAUTH	DTE_SENT
Discharge Date	Date a member was released from a facility.	Field	Saved in the MM/DD/CCYY format	8	T_PA_PAUTH_STATE	DTE_DISCHARGE
Disease Management	Field is set to "YES" if there is disease management program information available in the Member subsystem for this member. If there is no information, the field is set to "NO".	Field	Character	3	T_RE_CSE_DIS_STATE	CDE_PROGRAM_TYPE

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Emergency	Indicator is set to “Y” when a member’s condition requires an emergency or urgent service.	Field	Character	1	T_PA_PAUTH	IND_EMERG
Fund Code	Source of funds for payment of the authorized services - the field is not used.	Field	Character	3	T_PA_PAUTH	CDE_FIN_FUND
Media Type	Description of the source of a service/prior authorization request (for example, Internet, SHPS, HIPAA 278). CONVERSN is the default value at the time of conversion.	Field	Character	1	T_PA_MEDIA	DSC_MEDIA_TYPE
Member Date of Birth	Date of birth of the member.	Field	Number	8	T_RE_BASE	DTE_BIRTH
Member First Name	First name of the member for whom services are requested on the service/prior authorization.	Field	Character	15	T_RE_BASE	NAM_FIRST
Member ID	Unique identifier for the member for whom services are requested on the service/prior authorization.	Field	Character	12	T_RE_BASE	ID_MEDICAID

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Member Last Name	Last name of the member for whom services are requested on the service/prior authorization.	Field	Character	20	T_RE_BASE	NAM_LAST
Ortho Status Code	The service/prior authorization Orthodontic Status code is used to track receipt of the documentation from the provider.	Field	Character	1	T_PA_PAUTH_STATE	CDE_ORTHO_STATUS
PA Category Code	Code that groups a service/prior authorization's requested services under a type such as dental, inpatient, or nursing facility.	Field	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
PA Number	Prior Authorization number is a unique identifier for a service/prior authorization.	Field	Character	10	T_PA_PAUTH	PRIOR_AUTH_NUM
Primary Diagnosis Code	A member's primary diagnosis.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
Print Option	Print option for the service/prior authorization notice. Options are Batch (B) and (N) No Print.	Field	Character	1	T_PA_PAUTH	IND_LETTER

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Received Date	Date service/prior authorization request was received by the Service/Prior Authorization team.	Field	Number Saved in the MM/DD/CCYY format	8	T_PA_PAUTH	DTE_RECEIVED
Requesting Provider Number	Unique identifier for the provider requesting services for a member on a service/prior authorization request.	Field	Character	15	T_PR_IDENTIFIER	ID_PROVIDER
Review Date	Review date of the service/prior authorization.	Field	Number Saved in the MM/DD/CCYY format	8	T_PA_PAUTH	DTE_REVIEW
Servicing Provider Number	Unique identifier for the provider performing the services for a member specified on a service/prior authorization request.	Field	Character	15	T_PR_IDENTIFIER	ID_PROVIDER
Special Considerations	Indicates if there are special considerations concerning the service/prior authorization.	Field	Character	1	T_PA_PAUTH	IND_SPECIAL_CONSID
Update Received Date	Date SHPS received a service/prior authorization update request from the provider.	Field	Number Saved in the MM/DD/CCYY format	8	T_PA_PAUTH	DTE_UPDATE_REC

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Update Reviewed Date	Date SHPS reviewed a service/prior authorization update request from the provider.	Field	Number Saved in the MM/DD/CCYY format	8	T_PA_PAUTH	DTE_UPDATE_REV

2.7.8.7 Field Edits

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

2.7.8.8 Associated Requirements

ID
30.090.005.002.5
30.090.005.003.2

2.7.8.9 CO / Defects

ID	Type	Name	Description	Current Status
2209	Change Order	Modify Base and Information Panels	Add "Nursing Facility Type" code to Base and Information panels. It gives information as to the type of services provided for nursing facility type stays. The code is used for editing in claims processing.	Prod Implemented
2372	Change Order	Retrofit for NPI	Modifications required as a result of NPI	Prod Implemented

ID	Type	Name	Description	Current Status
2514	Change Order	KYAmend Display PA Documents	Display documents associated with a service/prior authorization. Add buttons to the PA Information Panel that when clicked will bring up the corresponding documents.	Prod Implemented
2516	Change Order	KYAmend Case Mbr- panel changes	The Commonwealth would like to group PAs for a member that are a result of a specific episode of care. maxMC issues a Case Number for this purpose. The Commonwealth has requested that the maxMC Case Number be displayed with a service/prior authorization in interChange. The Case Number assigned in macMC will be included on the interface of PAs from maxMC to the MMIS. It has also been requested that Case and Disease Management indicators be displayed in Service/Prior Authorization. The Member Subsystem Case and Disease Management indicators will be checked to see if there are any in effect for the Member. If there are, a "Yes" will be displayed for the field, otherwise "No" will be displayed.	Prod Implemented

ID	Type	Name	Description	Current Status
3139	Change Order	KYAmend Ortho Status for Panels	Providers are required to submit specific documentation during the span of a member's orthodontic treatment. The PA Orthodontic Status Code is used to track receipt of the documentation from the provider. Based on the code and the service begin date of the PA, reminder letters are sent to providers and reports created of PAs with overdue documentation. The combination of the PA Orthodontic Status Code and the PA service begin date determine what letters are generated and what PAs are displayed on a report. Add the Orthodontic Status Code to the PA Base Panel for update and to the PA Information panel for display. Label for the nursing facility indicator is misleading. Change label to "Nursing Facility Type" on the Base and Information panels.	Prod Implemented
5309	Change Order	REL2-Dental PA Diag Fld Not Reqd	The PA panels require a diagnosis code for all input PA information. Dental claims do not require a diagnosis code.	Prod Implemented
572	Change Order	Modify PA Information Panel	There is a need to modify the PA Information Panel.	Prod Implemented

2.7.9 PANEL: Prior Authorization Related Documents

2.7.9.1 Description

This panel provides for the display of documents in OnBase that are related to the service/prior authorization.

Navigation Path: [Prior Authorization] - [Information] - [Related Documents]

2.7.9.2 Technical Name

PA.OnBaseReportsPanel.ascx

2.7.9.3 Panel Name

Related Documents

2.7.9.4 Prior Authorization Related Documents Layout

2.7.9.5 Extra Features

This panel has no extra features.

2.7.9.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Claims Documents	The Claims Documents button displays paid paper claims in OnBase that are associated with the service/prior authorization.	Button	N/A	0	N/A	N/A
PA Documents	The PA Documents button displays letters in OnBase generated by interChange for the service/prior authorization.	Button	N/A	0	N/A	N/A

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
SHPS Documents	The SHPS Documents button displays letters and other documents (for example: faxes, clinical documentation) created by SHPS and sent to OnBase that are associated with the case number.	Button	N/A	0	N/A	N/A

2.7.9.7 Field Edits

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

2.7.9.8 Associated Requirements

ID
No associated requirements found.

2.7.9.9 CO / Defects

ID	Type	Name	Description	Current Status
No associated change orders found.				

2.7.10 PANEL: Prior Authorization Base Information

2.7.10.1 Description

Use the Base Information panel to enter basic information about a service/prior authorization such as the type, the requesting and servicing providers, the member for whom it was requested, and the member diagnosis.

Navigation Path: [Prior Authorization] - [Information] - [Base Information]

Specifics about the Provider Fields:

Requesting/Servicing Provider ID fields - search boxes: The search box appears if an invalid provider ID is entered.

Service Provider Check: If the Provider Required indicator on the PA Category panel is set to No, then the Service Provider check defaults to All Service Providers. Example: PA Category Code = Physician Services

If PA Category code has a Provider Required indicator as Yes (the default) then the Service Provider check is enabled and the user must specify the Service Provider ID. The behavior changes based on which field is entered first.

If the Service Provider check is chosen first, the Service Provider ID (once entered) will automatically default to the check indicated in the "service provider check" field. Similarly, if the Service Provider ID field is entered first, the Service Provider check will automatically change to the type of ID entered in the Service Provider ID field.

2.7.10.2 Technical Name

PA.BaseInformationPanel.ascx

2.7.10.3 Panel Name

PABaseInfo

2.7.10.4 Prior Authorization Base Information Layout

2.7.10.5 Extra Features

PA Base Edit ERL

2.7.10.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Fund Code	Funding source assigned for payment of the authorized services. Fund code is not used by the Kentucky MMIS.	Combo Box	Character	30	T_FIN_FUND_CODE	T_FIN_FUND_CODE

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
PA Category	Service/prior authorization category used to batch requests (for example, Waiver, Inpatient, DME and Physician).	Combo Box	Drop Down List Box	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
Print Option	Print option for the service/prior authorization notice. Options are Batch (B) and (N) No Print.	Combo Box	Drop Down List Box	8	T_PA_PAUTH	IND_LETTER
Service Provider Check	Field indicates type of service provider validation required. S = Specified Service Loc, N = Any Service Loc, B = Any Service Loc with the same Base Provider, A = All Service Locations	Combo Box	Character	1	T_PA_PAUTH	CDE_SERV_PROV_CHK
Accident	Indicator is set to "Y" when a member's condition is related to an accident and may need to seek recovery for costs through third party liability (TPL).	Field	Drop Down List Box	1	T_PA_PAUTH	IND_ACCIDENT
Admission Date	First date of an institutional stay.	Field	Date (MM/DD/CCYY)	8	T_PA_PAUTH_STATE	DTE_ADMISSION

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Authorizer	The ID of the person who authorized services on the service/prior authorization.	Field	Character	8	T_PA_PAUTH	ID_CLERK_REV
Diagnosis Code	Primary diagnosis code for the member's condition.	Field	Character	7	T_PA_PAUTH	CDE_DIAG
Discharge Date	Last date of an institutional stay.	Field	Date (MM/DD/CC YY)	8	T_PA_PAUTH_STATE	DTE_DISCHARGE
Emergency	Indicator is set to “Y” when a member’s condition requires an emergency or urgent service.	Field	Drop Down List Box	1	T_PA_PAUTH	IND_EMERG
Member ID	Unique identifier for a member.	Field	Character	12	T_RE_BASE	ID_MEDICAID
Nursing Facility Type	Code used for nursing facility service/prior authorizations. Valid values are: H = Brain Injury, B = BI Locked Unit, Y = Nursing Facility, V = Ventilator.	Field	Drop Down List Box	1	T_PA_PAUTH_STATE	CDE_TOS

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Ortho Status Code	The service/prior authorization Orthodontic Status code is used to track receipt of the documentation from the provider. Based on the code and the service begin date of the service/prior authorization, reminder letters are sent to providers and reports created of PAs with overdue documentation.	Field	Drop Down List Box	1	T_PA_PAUTH_STATE	CDE_ORTHO_STATUS
Received Date	Date service/prior authorization request was received by the Service/Prior Authorization team.	Field	Number Saved in the MM/DD/CC YY format	8	T_PA_PAUTH	DTE_RECEIVED
Requesting Provider Number	Identifier for the provider requesting the service/prior authorization for a member.	Field	Character	15	T_PR_IDENTIFIER	ID_PROVIDER
Servicing Provider Number	Identifier for the provider specified to perform the service on a service/prior authorization request.	Field	Character	15	T_PR_IDENTIFIER	ID_PROVIDER
Special Considerations	Indicator used to identify that the service/prior authorization should receive special consideration.	Field	Drop Down List Box	1	T_PA_PAUTH	IND_SPECIAL_CONSI D

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Update Received Date	Last update of key fields on the service/prior authorization such as provider, member, and services.	Field	Date (MM/DD/CCYY)	8	T_PA_PAUTH	DTE_UPDATE_REC
Update Reviewed Date	Last update of key fields on the service/prior authorization such as provider, member, and services. This field stays in synch with the Update Received field.	Field	Date (MM/DD/CCYY)	8	T_PA_PAUTH	DTE_UPDATE_REV

2.7.10.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
PA Category	Combo Box	5	PA Assignment requires a service provider to be entered	Enter a valid provider number.
PA Category	Combo Box	5029	A valid PA Assignment is required.	Select a PA category from the drop down list.
Print Option	Combo Box	5001	Print Option is required.	Select item from list.
Admission Date	Field	10	Admission Date must be greater than or equal to 1/1/1900.	Invalid date. Format is MM/DD/YYYY. Verify date is greater than or equal to 1/1/1900.
Admission Date	Field	15	Invalid Date. Format is MM/DD/YYYY.	Invalid date. Format is MM/DD/YYYY.
Discharge Date	Field	10	Discharge Date must be greater than or equal Admission Date and greater than or equal to 1/1/1900.	Invalid date. Format is MM/DD/YYYY.
Discharge Date	Field	15	Invalid Date. Format is MM/DD/YYYY.	Invalid Date. Format is MM/DD/YYYY.
Member ID	Field	5027	A valid Member ID is required.	Enter valid ID or select one from search list.
Member ID	Field	5030	PA Line Item Number is not allowed – member has Presumptive Eligibility	Member is of type PE and has overlapping dates for line item. Discard line item or change authorized effective and end dates.

Field	Field Type	Error Code	Error Message	To Correct
Member ID	Field	5031	PA not allowed – member is KCHIP III	Member is of type P7 or M7. Change member ID or discard PA.
Member ID	Field	5032	PA Line Item Number is not allowed – member is in Managed Care	Member has overlapping line item dates with active managed care dates. Either discard line item or change authorized effective and end dates.
Member ID	Field	5033	PA Line Item Number has Procedure Code – member is in Managed Care	Member has overlapping line item dates with active managed care dates and the procedure code is not allowed to override the validation.
Member ID	Field	5034	PA Line Item Number has Revenue Code – member is in Managed Care	Member has overlapping line item dates with active managed care dates, and the revenue code is not allowed to override the validation.
Nursing Facility Type	Field	5000	Nursing Facility Type is required for Nursing Facility PA	Select nursing facility type from drop down list.
Requesting Provider Number	Field	5028	A valid Requesting Provider Number is required.	Enter a valid provider number or select one from search list.
Servicing Provider Number	Field	17001	A valid Servicing Provider Number is required.	Enter a valid provider number or select one from search list.
PA Category	Field	17002	At least one Line Item must be added.	Add a line item before attempting to save the panel.
Member ID	Field	17003	A valid Member ID is required	Enter ID or select one from search list.

Field	Field Type	Error Code	Error Message	To Correct
Authorizer	Field	17004	A valid Authorizer is required	Enter ID or select one from search list. Authorizer must be present for finalized services.
PA Category	Field	17005	A valid PA Category is required	Choose a value from the drop down list.
Servicing Provider Number	Field	17006	The PA Category requires a servicing provider to be entered	Enter ID or select one from search list.
Servicing Provider Number	Field	17007	Cannot change Servicing Provider, a claim has been paid.	Undo changes or cancel.
Servicing Provider Number	Field	7001	A Servicing Provider Number is required	Enter a valid provider number or select one from search list.
Servicing Provider Number	Field	7002	Servicing Provider type is invalid for PA Category	Enter an acceptable service provider number.
Update Received Date	Field	5015	Update Received must be greater than or equal to 1/1/1900.	Verify date is greater than or equal to 1/1/1900.
Update Received Date	Field	5505	Invalid Date. Format is MM/DD/YYYY.	Verify date is greater than or equal to 1/1/1900.
Update Reviewed Date	Field	5013	Update Reviewed must be greater than or equal to 1/1/1900.	Verify date is greater than or equal to 1/1/1900.
Update Reviewed Date	Field	5503	Invalid Date. Format is MM/DD/YYYY.	Verify date is greater than or equal to 1/1/1900.

2.7.10.8 Associated Requirements

ID
30.090.005.002.5
30.090.005.003.2

2.7.10.9 CO / Defects

ID	Type	Name	Description	Current Status
3139	Change Order	KYAmend Ortho Status for Panels	Providers are required to submit specific documentation during the span of a member's orthodontic treatment. The PA Orthodontic Status Code is used to track receipt of the documentation from the provider. Based on the code and the service begin date of the PA, reminder letters are sent to providers and reports created of PAs with overdue documentation. The combination of the PA Orthodontic Status Code and the PA service begin date determine what letters are generated and what PAs are displayed on a report. Add the Orthodontic Status Code to the PA Base Panel for update and to the PA Information panel for display. Label for the nursing facility indicator is misleading. Change label to "Nursing Facility Type" on the Base and Information panels.	Prod Implemented
573	Change Order	Modify PA Base Panel	There is a need to add new fields in the Base Information Panel. Also, field labels need to be changed according to the state business needs.	Prod Implemented

2.7.11 PANEL: Prior Authorization Paid Claim List

2.7.11.1 Description

The Paid Claim List displays paid claims associated with a service/prior authorization. Available information includes claim number, itemized claim line, service/prior authorization line item number, paid units, paid dollar amount, and status. A status of "Active" indicates an adjudicated claim. The claim may or may not have been through the financial cycle. A status of "Inactive" indicates an adjudicated claim that has been adjusted. The units and amounts for the "Inactive" claim are not counted toward used units and amounts for a service/prior authorization.

Navigation Path: [Prior Authorization] - [Information] - [Claim List]

2.7.11.2 Technical Name

PA.ClaimListPanel.ascx

2.7.11.3 Panel Name

Paid Claim List

2.7.11.4 Prior Authorization Paid Claim List Layout

2.7.11.5 Extra Features

PA Claim List ERL

2.7.11.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Claim Line Detail	Number of claim detail that has paid units and dollars authorized by a service/prior authorization line item.	Listview	Number	4	T_PA_ITEM_DTL_XREF	NUM_DTL

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Claim Status	Indicates whether the record of paid units and amounts is active or inactive. A record is created with an active status when a claim is paid. The status is changed to inactive when a claim is adjusted. Records with a status of inactive are not included in the calculation of used units and amounts.	Listview	Character	1	T_PA_ITEM_DTL_XREF	CDE_STATUS1
ICN	Internal control number is a unique identifier for a claim.	Listview	Number	13	T_HIST_DIRECTORY	NUM_ICN_FL
PA Amount Paid	Dollar amount paid for by the claim detail and authorized by the service/prior authorization line item.	Listview	Number	9	T_PA_ITEM_DTL_XREF	AMT_PA_USE D
PA Line Item Number	Unique identifier for a service/prior authorization line item. The number ranges from 01 through 99.	Listview	Character	2	T_PA_ITEM_DTL_XREF	NUM_PA_LINE _ITEM
PA Units Paid	Number of units paid for by the claim detail that were authorized by the service/prior authorization line item.	Listview	Number	9	T_PA_ITEM_DTL_XREF	QTY_UNT_SV C_USD

2.7.11.7 Field Edits

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

2.7.11.8 Associated Requirements

ID
30.090.005.003.2

2.7.11.9 CO / Defects

ID	Type	Name	Description	Current Status
1780	Change Order	Modify PA Claim List Panel	Modify labels on the Paid Claim List Panel. Add a claim line detail field to the panel.	Prod Implemented

2.7.12 PAGE: Prior Authorization Mass Update Search Page

2.7.12.1 Description

Use the Prior Authorization Mass Update Search Page to search rate and service code mass updates by specific search criteria.

Navigation Path: [Prior Authorization] - [Mass Update Search]

2.7.12.2 Technical Name

PriorAuthMassUpdateSearch

2.7.12.3 Web Page Name

Prior Authorization Mass Update Search Page

2.7.12.4 Prior Authorization Mass Update Search Page Layout

2.7.13 PANEL: Prior Authorization Mass Update Search Panel

2.7.13.1 Description

Data on this panel is generated during a Mass Update of service/prior authorization line item rates or service codes. An entry for a line item acts as an override during claims processing for a rate or service code. The panel provides for searches on service/prior authorization line items affected by a mass update on rate, service code, and effective and end dates of an override.

Navigation Path: [Mass Update Search]

2.7.13.2 Technical Name

PA.PaMassUpdSearchPage.ascx

2.7.13.3 Panel Name

PaMassUpdateSearch

2.7.13.4 Prior Authorization Mass Update Search Panel Layout

2.7.13.5 Extra Features

This panel has no extra features.

2.7.13.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Begin Date	Date the override begins.	Field	Date (MM/DD/CCYY)	8	T_PA_MASS_UPD	DTE_EFFECTIVE
End Date	Date the override ends.	Field	Date (MM/DD/CCYY)	8	T_PA_MASS_UPD	DTE_END
Procedure Code	New replacement procedure code in a mass update.	Field	Character	9	T_PROC	CDE_PROC
Procedure Code Thru	New replacement procedure code Thru Field in a mass update.	Field	Character	9	T_PROC	CDE_PROC
Provider Number	Field to search using the service provider number as a search criteria.	Field	Character	10	T_PR_IDENTIFIER	ID_PROVIDER
Rate	New replacement rate in a mass update.	Field	Number	9	T_PA_MASS_UPD	AMT_NEW_RATE
Revenue Code	New replacement revenue code in a mass update.	Field	Character	9	T_REVENUE_CODE	CDE_REVENUE
Revenue Code Thru	New replacement revenue code thru field in a mass update.	Field	Character	9	T_REVENUE_CODE	CDE_REVENUE
Type Change	Indicates the type of mass update that generated the entry for the service/prior authorization line item. Mass update types are: revenue code, rate change for a revenue code, procedure code, and rate change for a	Field	Character	1	T_PA_MASS_UPD	CDE_TYPE

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
	procedure code.					

2.7.13.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Begin Date	Field	5000	Invalid date. Format is MM/DD/CCYY.	Enter a valid date in the format of MM/DD/CCYY.
End Date	Field	5001	Invalid date. Format is MM/DD/CCYY.	Enter a valid date in the format of MM/DD/CCYY.

2.7.13.8 Associated Requirements

ID
No associated requirements found.

2.7.13.9 CO / Defects

ID	Type	Name	Description	Current Status
No associated change orders found.				

2.7.14 PAGE: Prior Authorization Related Data

2.7.14.1 Description

The Prior Authorization Related data page displays links to panels used to perform maintenance on code tables. The links are described as follows:

- PA Category Information - maintains the service/prior authorization types or classifications
- Decision Status - maintains the decision and status codes (that is, approved, denied, pending) used on a line item.
- Reason - maintains reason codes for the line item decision or status.
- Media Type - maintains the means (for example, Web, online, SHPS, HIPAA 278 transaction) used to submit a service/prior authorization.

Navigation Path: [Prior Authorization] - [Related Data]

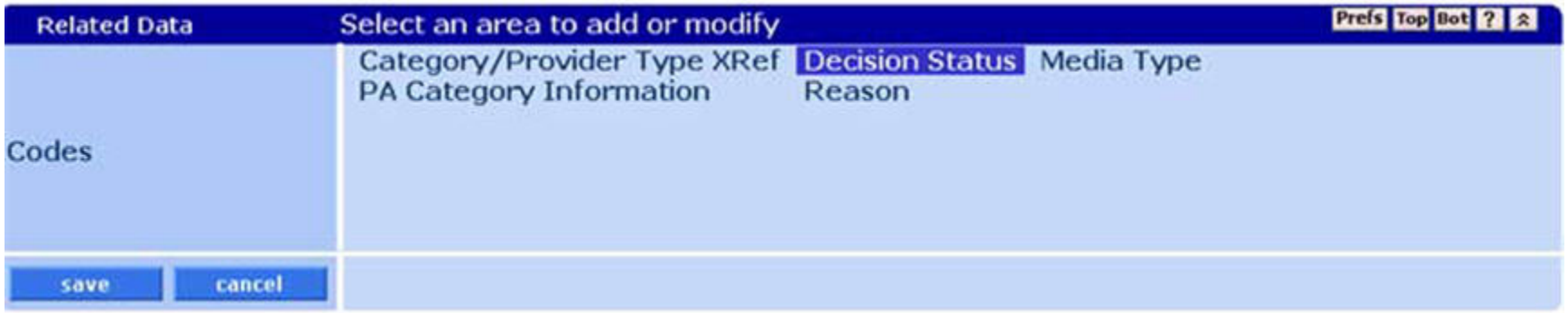
2.7.14.2 Technical Name

PA.RelatedData

2.7.14.3 Web Page Name

PARelatedData

2.7.14.4 Prior Authorization Related Data Layout



2.7.15 PANEL: Prior Authorization Category Provider Xref

2.7.15.1 Description

The Category Provider Xref panel creates a cross reference of a category code with a provider type for editing.

Navigation Path: [Prior Authorization] - [Related Data] - [Category/Provider Xref]

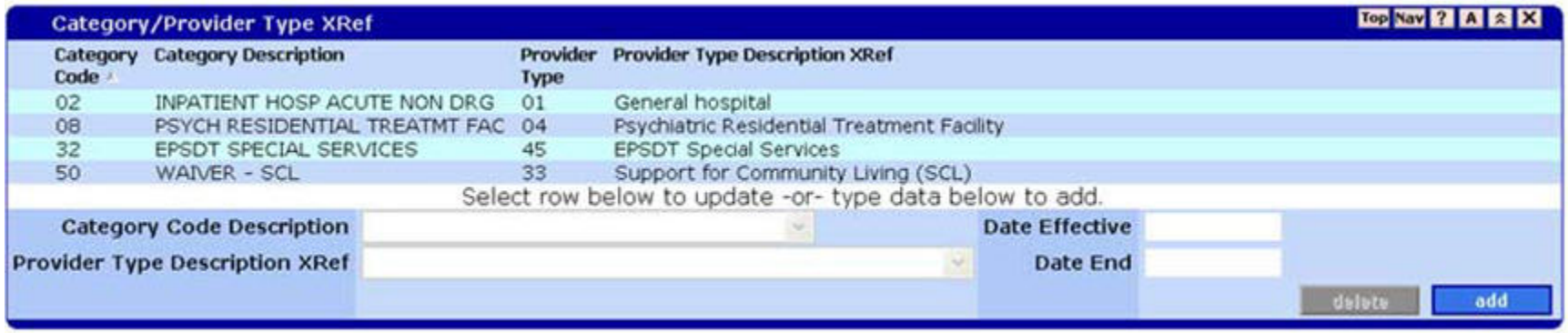
2.7.15.2 Technical Name

PA.ProvTypeXrefPanel.ascx

2.7.15.3 Panel Name

ProvTypeXrefPanel

2.7.15.4 Prior Authorization Category Provider Xref Layout



2.7.15.5 Extra Features

This panel has no extra features.

2.7.15.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Category Code	The category code.	Field	Character	2	T_PA_CAT_PT_XREF	CDE_PA_ASSIGN
Category Code Description	The category code description.	Field	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Date Effective	The effective date of the cross-reference.	Field	Date (MM/DD/CCYY)	8	T_PA_CAT_PT_XREF	DTE_EFFECTIVE
Date End	The end date of the cross-reference.	Field	Date (MM/DD/CCYY)	8	T_PA_CAT_PT_XREF	DTE_END
Provider Type	The provider type code cross-reference.	Field	Character	2	T_PA_CAT_PT_XREF	CDE_PROV_TYPE
Provider Type Description Xref	The cross-reference description of the provider type code.	Field	Character	50	T_PR_TYPE_CDE	DSC_PROV_TYPE

2.7.15.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Category Code Description	Field	50765	A valid Category Code is required	Select a category code description from the drop down list.
Date Effective	Field	50767	Date Effective is required	Enter a valid date.
Date End	Field	50768	Date End is required	Enter a valid date.
Provider Type Description Xref	Field	50766	A valid Provider Type is required	Select a provider type description from the drop down list.

2.7.15.8 Associated Requirements

ID
No associated requirements found.

2.7.15.9 CO / Defects

ID	Type	Name	Description	Current Status
2222	Change Order	Create Category/Prov Type Panel	Create panel to maintain the cross reference between category codes and provider types.	Prod Implemented

2.7.16 PANEL: Prior Authorization Media Type

2.7.16.1 Description

The Media Type panel maintains codes describing the source of the service/prior authorization. Media Type codes may be added, modified, or deleted.

Navigation Path: [Prior Authorization] - [Related Data] - [Media Type]

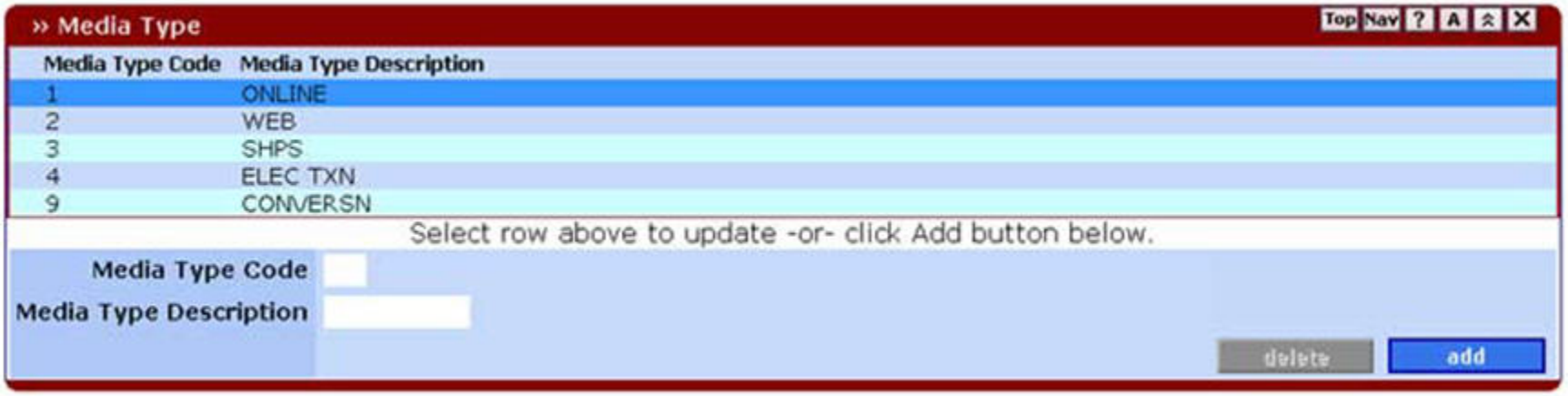
2.7.16.2 Technical Name

WebUI.EntityMaintenanceSearchPanel.ascx (Media)

2.7.16.3 Panel Name

PAMediaType

2.7.16.4 Prior Authorization Media Type Layout



2.7.16.5 Extra Features

This panel has no extra features.

2.7.16.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Media Type Code	Code signifying the source of the service/prior authorization.	Field	Character	1	T_PA_MEDIA	CDE_MEDIA_TYPE
Media Type Description	Description for the source of the service/prior authorization. "CONVERSN" was assigned to converted service/prior authorizations since this field was not carried in the Legacy MMIS.	Field	Character	9	T_PA_MEDIA	DSC_MEDIA_TYPE

2.7.16.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Media Type Code	Field	6000	Media Type Code is required.	Enter a unique media type code.
Media Type Description	Field	5000	Media Type - Delete was unsuccessful. Unable to delete the current item.	The media type code has been assigned to line items. The media type code on the line items would have to be changed to another valid code.
Media Type Description	Field	5001	Media Type Description is required.	Enter a description for the media type code.

2.7.16.8 Associated Requirements

ID
No associated requirements found.

2.7.16.9 CO / Defects

ID	Type	Name	Description	Current Status
1784	Change Order	Modify PA Media Panel	There is a need to modify the labels on the PA Media Panel.	Prod Implemented

2.7.17 PANEL: Prior Authorization Decision Status

2.7.17.1 Description

The Decision Status panel maintains codes describing the adjudication or status of a service request. A decision or status may be added, modified or deleted. A decision or status may not be deleted if it has been assigned to any line items.

Navigation Path: [Prior Authorization] - [Related Data] - [Decision Status]

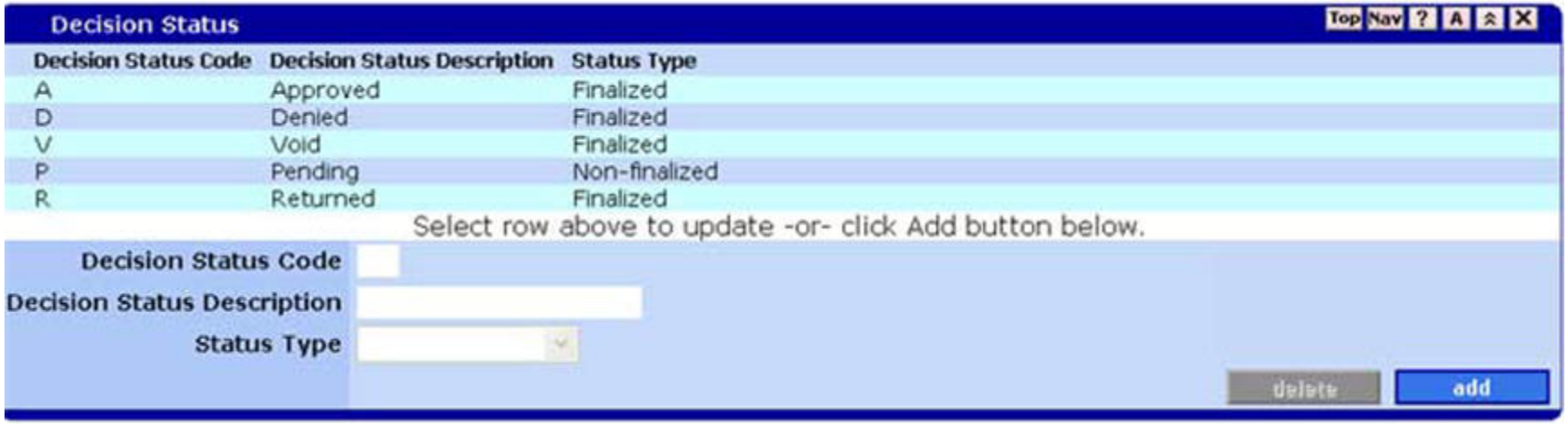
2.7.17.2 Technical Name

WebUI.EntityMaintenanceSearchPanel.ascx (Decision)

2.7.17.3 Panel Name

PADecisionStatus

2.7.17.4 Prior Authorization Decision Status Layout



2.7.17.5 Extra Features

This panel has no extra features.

2.7.17.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Decision Status Code	Code signifying the adjudicated decision or the processing status of a line item.	Field	Character	1	T_PA_LINEITEM_STAT	CDE_PA_STATUS
Decision Status Description	Text describing the decision or processing status of a line item.	Field	Character	20	T_PA_LINEITEM_STAT	DSC_STATUS
Status Type	Status type of finalized indicates a status used for adjudication (for example:, Approved, Denied). Status type non-finalized indicates a processing status (for example:, Pending).	Field	Drop Down List Box	1	T_PA_LINEITEM_STAT	CDE_STATUS_TYPE

2.7.17.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Decision Status Code	Field	5000	Decision Status Code Is required.	Enter a unique Decision Status code.
Decision Status Code	Field	5001	Delete Error: Decision Status Code record cannot be deleted - Status Code in use.	The Decision Status code has been assigned to line items. The Decision Status code on those line items would have to be changed to a new Decision Status code.
Decision Status Description	Field	5003	Decision Status Description is required.	Enter a description for the Decision Status code.

Field	Field Type	Error Code	Error Message	To Correct
Status Type	Field	5002	Status Type is required.	Select a status type from the drop down list.

2.7.17.8 Associated Requirements

ID
No associated requirements found.

2.7.17.9 CO / Defects

ID	Type	Name	Description	Current Status
No associated change orders found.				

2.7.18 PANEL: Prior Authorization Category Information

2.7.18.1 Description

The Category Information panel maintains codes that assign a type to a service/prior authorization such as physician, dental, orthodontics, DME, Impact Plus, or EPSDT. Codes may be added, modified, or deleted.

The code is used in service/prior authorization processing. For example, if a service/prior authorization category code is orthodontics, the service/prior authorization is included for review in the Orthodontic Case Tracking process. If the category code is set to EPSDT, the PA is included for review in the EPSDT process that sends the member a letter at the first use of an EPSDT service. The category code is also used in determining which format to select for printing a service/prior authorization letter.

Category code indicator “Servicing Provider Required" is used during claims processing. When the indicator is set to “Y”, the service provider on the claim must match the service provider on the service/prior authorization request.

Navigation Path: [Prior Authorization] - [Related Data] - [Category]

2.7.18.2 Technical Name

PA.PaAssignCodePanel.ascx

2.7.18.3 Panel Name

PACategory

2.7.18.4 Prior Authorization Category Information Layout

PA Category Information

PA Category Code	PA Category Description	PA Category Group	Servicing Provider Required
01	INPATIENT HOSP ACUTE CARE DRG	03	Yes
02	INPATIENT HOSP ACUTE NON DRG	03	Yes
03	ACUTE IN-PATIENT PSYCHIATRIC	03	Yes
04	RENAL DIALYSIS	03	Yes
05	INACTIVE - MODEL WAIVER 1	05	Yes
07	WAIVER - MODIFIED WAIVER 2	01	Yes
08	PSYCH RESIDENTIAL TREATMT FAC	03	Yes
12	OUTPATIENT HOSPITAL	03	Yes
13	AMBULATORY SURGERY CENTER	03	Yes
15	HANDS	03	Yes

1 2 3 4 5 Next >

Select row above to update -or- click Add button below.

PA Category Code
PA Category Group
PA Category Description
Servicing Provider Required No
delete add

2.7.18.5 Extra Features

This panel has no extra features.

2.7.18.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
PA Category Code	Code signifying the type of service/prior authorization request (for example:, dental, inpatient, home health).	Field	Character	2	T_PA_ASSIGN_CODE	CDE_PA_ASSIGN
PA Category Description	Text describing the category code.	Field	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
PA Category Group	Code used to group types of service/prior authorizations. For example, waiver type service/prior authorizations are grouped under code '01'.	Field	Character	2	T_PA_ASSIGN_CODE	CDE_PA_GRP_ASSIGN
Servicing Provider Required	Field indicates that for the service/prior authorization category, in addition to a service/prior authorization and claim matching on service code and date range, there must also be matching service providers.	Field	Character	1	T_PA_ASSIGN_CODE	IND_SERV_PROV_REQ

2.7.18.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
PA Category Code	Field	5001	PA Category Code is required.	Enter a unique PA Category code.
PA Category Description	Field	5002	PA Category Description is required.	Enter a PA Category code description.
PA Category Group	Field	5004	PA Category Group is required.	Enter a two-character group code.
Servicing Provider Required	Field	5000	Servicing Provider is required.	Select the Yes or No indicator.

2.7.18.8 Associated Requirements

ID
No associated requirements found.

2.7.18.9 CO / Defects

ID	Type	Name	Description	Current Status
1781	Change Order	Modify PA Assignment Panel	There is a need to modify the labels on the PA Category Information Panel (formerly known as Assignment Panel).	Prod Implemented

2.7.19 PANEL: Prior Authorization Reason

2.7.19.1 Description

Use the Reason panel to maintain codes and descriptions that provide justification for a service/prior authorization decision or information on a processing status. Reason codes may be added, updated, or deleted.

Navigation Path: [Prior Authorization] - [Related Data] - [Reason]

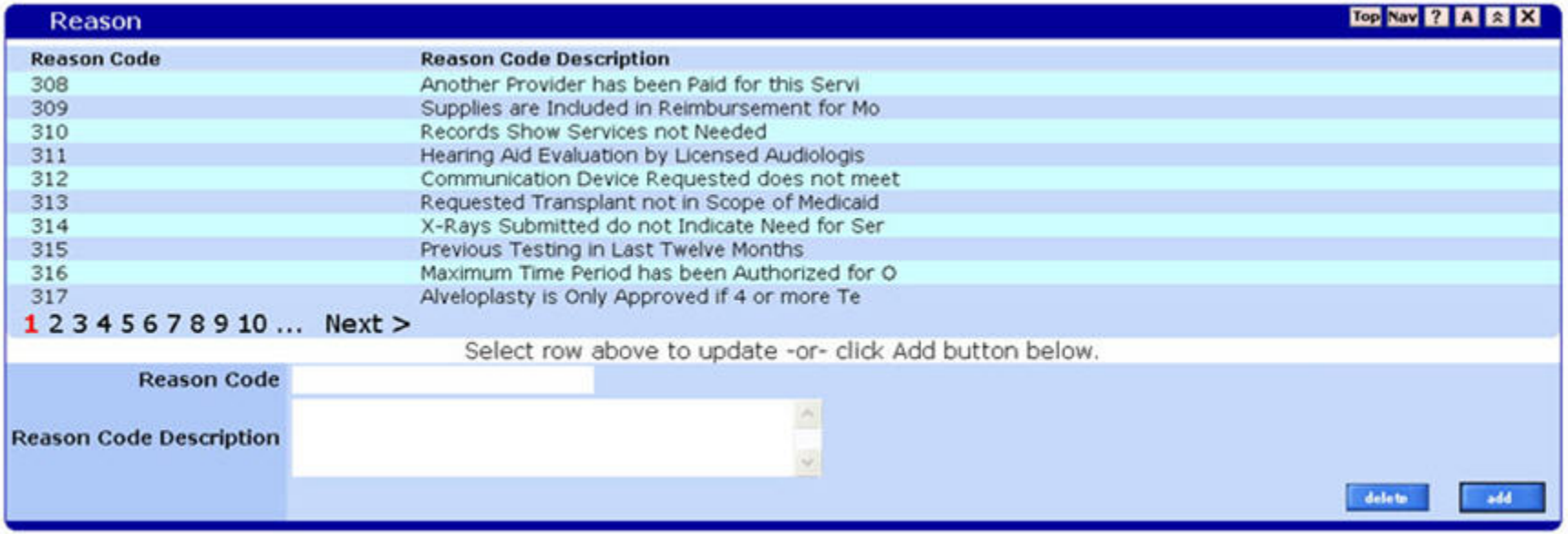
2.7.19.2 Technical Name

WebUI.EntityMaintenanceSearchPanel.ascx (Reason)

2.7.19.3 Panel Name

PAReason

2.7.19.4 Prior Authorization Reason Layout



2.7.19.5 Extra Features

This panel has no extra features.

2.7.19.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Reason Code	Code indicating reason for a decision by an authorizer on a service/prior authorization line item. The code may also give information for a processing status.	Field	Character	25	T_PA_IAC_TEXT	CDE_IAC
Reason Code Description	Text describing the reason for a decision or processing status.	Field	Character	500	T_PA_IAC_TEXT	DSC_IAC

2.7.19.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Reason Code	Field	5000	Reason Code is required.	Enter a unique reason code.
Reason Code Description	Field	5001	Reason Code Description is required.	Enter a description for the reason code in the Reason Code Description field.

2.7.19.8 Associated Requirements

ID
No associated requirements found.

2.7.19.9 CO / Defects

ID	Type	Name	Description	Current Status
1783	Change Order	Modify PA Reason Code Panel	There is a need to modify the labels on the PA Reason Code Panel.	Prod Implemented

2.7.20 PAGE: Prior Authorization Search Page

2.7.20.1 Description

Use the Prior Authorization Search Page to view service/prior authorizations that meet specified criteria. One or more criteria may be entered. Service/prior authorizations meeting all entered criteria display in the Search Results section. Double-click a row in the Search Results frame to display the Information panel giving details about the selected service/prior authorization. Use the "adv search" button to display additional search criteria.

Navigation Path: [Prior Authorization] - [Search]

2.7.20.2 Technical Name

PriorAuthSearch

2.7.20.3 Web Page Name

PaSearch

2.7.20.4 Prior Authorization Search Page Layout

Search Results

PA Number	Line Item	Authorization Effective Date	Authorization End Date	PA Category Code	Requesting Provider ID	Servicing Provider ID	Servicing Code Number From	Servicing Code Number To	PA Status	Member ID	Case Number	Legacy PRO Cert Number
0102203001	01	01/10/2007	02/10/2007	Inpatient Hospital			D8210		Approved	000001261	TEST1234567890	00123
0102203001	02	02/20/2007	02/20/2007	Inpatient Hospital			204		Approved	000001261	TEST1234567890	00123
0102203001	03	03/30/2007	03/30/2007	Inpatient Hospital			D8210		Denied	000001261	TEST1234567890	00123
0102203001	04	04/14/2007	04/14/2007	Inpatient Hospital			204		Denied	000001261	TEST1234567890	00123
1005208001	01	07/27/2005	12/31/2005	Orthodontia			00009009403		Approved	000001261		00123
1005208001	02	0	0	Orthodontia			100	101	Pending	000001261		00123

2.7.21 PANEL: Prior Authorization Search

2.7.21.1 Description

Use the Prior Authorization Search panel to search by specific criteria. The panel first displays an abbreviated list of search criteria. Click the "adv search" button to expand the choice of criteria.

Navigation Path: [Prior Authorization] - [Search]

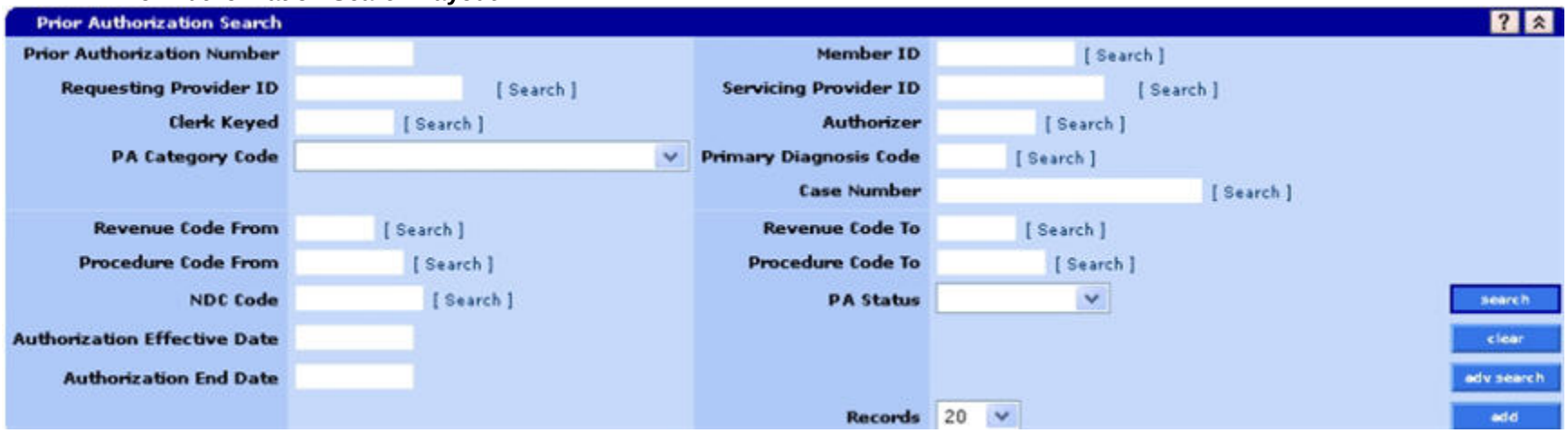
2.7.21.2 Technical Name

PA.PaSearchPage.ascx (PA.PaSearchPanel.ascx)

2.7.21.3 Panel Name

PA PrAuthSrch

2.7.21.4 Prior Authorization Search Layout



2.7.21.5 Extra Features

This panel has no extra features.

2.7.21.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Authorization Effective Date	Begin date of the date range for which the service is approved for use by a member.	Field	Date (MM/DD/CCYY)	8	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Authorization End Date	Last date an authorized service can be used by a member.	Field	Date (MM/DD/CCYY)	8	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Authorizer	Unique identifier for person authorizing services on the service/prior authorization if it is authorized on-line. If it is authorized by SHPS the ID is 99999999.	Field	Character	8	T_PA_PAUTH	ID_CLERK_REV
Case Number	Number used to group service/prior authorizations for a member under a specific episode of care. The case number is issued by maxMC.	Field	Character	25	T_PA_PAUTH_STATE	ID_CASE
Clerk Keyed	Unique identifier for the provider who enters a service/prior authorization through the Provider Web Portal or user ID for person who enters a service/prior authorization on-line. PAs entered on maxMC have an ID of 99999999.	Field	Character	8	T_PA_PAUTH	ID_CLERK_ENTRY

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Member ID	Unique identifier for the member for whom services are requested on the PA.	Field	Character	12	T_RE_BASE	ID_MEDICAID
NDC Code	National Drug Code used to uniquely identify a drug.	Field	Character	11	T_DRUG	CDE_NDC
PA Category Code	Code that groups a PA's requested services under a type such as dental, inpatient and physician.	Field	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
PA Status	Status (for example:, pending) or decision (for example:, approved, denied) for a line item.	Field	Character	20	T_PA_LINEITEM_STAT	DSC_STATUS
Primary Diagnosis Code	A member's primary diagnosis.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
Prior Authorization Number	Unique identifier for a service/prior authorization.	Field	Character	10	T_PA_PAUTH	PRIOR_AUTH_NUM
Procedure Code	Code that uniquely identifies a procedure.	Field	Character	6	T_PROC	CDE_PROC
Procedure Code Thru	The ending range of procedure codes specified on a service/prior authorization line item.	Field	Character	6	T_PROC	CDE_PROC

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Records	The maximum number of records displayed on the panel when the search results are displayed.	Field	Number	0	N/A	N/A
Requesting Provider Number	Unique identifier for the provider requesting services for a member on a service/prior authorization.	Field	Character	15	T_PR_IDENTIFIER	ID_PROVIDER
Revenue Code	Code identifying a specific accommodation or ancillary service.	Field	Character	6	T_REVENUE_CODE	CDE_REVENUE
Revenue Code Thru	The ending range of revenue codes specified on a service/prior authorization line item.	Field	Character	6	T_REVENUE_CODE	CDE_REVENUE
Servicing Provider Number	Unique identifier for the provider performing the services for a member specified on a service/prior authorization.	Field	Character	15	T_PR_IDENTIFIER	ID_PROVIDER

2.7.21.7 Field Edits

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

2.7.21.8 Associated Requirements

ID
No associated requirements found.

2.7.21.9 CO / Defects

ID	Type	Name	Description	Current Status
1785	Change Order	Modify PA Search Panel	Modify field labels in the PA Search panel. Add field "Revenue To" to search the "Revenue To" field on a line item.	Prod Implemented

2.7.22 PANEL: Prior Authorization Search Results

2.7.22.1 Description

The Prior Authorization Search Results panel lists service/prior authorizations that met the criteria specified in the Search panel fields. Click a row in the Search Results panel to display the Prior Authorization Information and Maintenance panels for viewing details of the selected service/prior authorization.

Navigation Path: [Prior Authorization] - [Search Panel] - [Search Button]

2.7.22.2 Technical Name

PA.PaSearchPanel.ascx (results)

2.7.22.3 Panel Name

PASearchResults

2.7.22.4 Prior Authorization Search Results Layout

» Search Results

PA Number	Line Item	Authorization Effective Date	Authorization End Date	PA Category Code	Requesting Provider ID	Servicing Provider ID	Servicing Code Number From	Servicing Code Number To	PA Status	Member ID	Case Number	Legacy PRO Cert Number
0102203001	01	01/10/2007	02/10/2007	Inpatient Hospital			D8210		Approved	000001261	TEST1234567890	00123
0102203001	02	02/20/2007	02/20/2007	Inpatient Hospital			204		Approved	000001261	TEST1234567890	00123
0102203001	03	03/30/2007	03/30/2007	Inpatient Hospital			D8210		Denied	000001261	TEST1234567890	00123
0102203001	04	04/14/2007	04/14/2007	Inpatient Hospital			204		Denied	000001261	TEST1234567890	00123
1005208001	01	07/27/2005	12/31/2005	Orthodontia			00009009403		Approved	000001261		00123
1005208001	02	0	0	Orthodontia			100	101	Pending	000001261		00123

2.7.22.5 Extra Features

PriorAuthSearch_ERL.doc

2.7.22.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Authorization Effective Date	Begin date of the date range for which the service is approved for use by a member.	Listview	Date (MM/DD/CCYY)	8	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Authorization End Date	Date showing the last date an authorized service can be used by a member.	Listview	Date (MM/DD/CCYY)	8	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Line Item	Two characters that sequentially list the services included on a service/prior authorization. The characters are 01 through 99. The line item is automatically generated.	Listview	Character	2	T_PA_LINE_ITEM	NUM_PA_LINE_ITEM
Member ID	Unique identifier for the member for whom services are requested on the service/prior authorization.	Listview	Alphanumeric	12	T_RE_BASE	ID_MEDICAID
PA Category Code	Code that groups a service/prior authorization's requested services under a type such as dental, in-patient, or physician.	Listview	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
PA Number	Prior Authorization Number is a unique identifier for a service/prior authorization.	Listview	Character	10	T_PA_PAUTH	PRIOR_AUTH_NUM
PA Status	Status (pending, void) or a decision (approved, denied) on a line item.	Listview	Character	20	T_PA_LINEITEM_STAT	DSC_STATUS

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Requesting Provider Number	Unique identifier for the provider requesting services for a member.	Listview	Character	15	T_PR_IDENTIFIER	ID_PROVIDER
Servicing Code Number From	Revenue or procedure code for the requested service on a line item	Listview	Character	6	T_REVENUE_CODE,T_PROC	REVENUE_CODE,CDE_PROC
Servicing Code Number To	Ending range for the requested service on a line item	Listview	Character	4	T_REVENUE_CODE,T_PROC	CDE_REVENUE,CDE_PROC
Servicing Provider Number	Unique identifier for the provider performing the services for a member.	Listview	Character	15	T_PR_IDENTIFIER	ID_PROVIDER

2.7.22.7 Field Edits

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

2.7.22.8 Associated Requirements

ID
30.020.002

2.7.22.9 CO / Defects

ID	Type	Name	Description	Current Status
1786	Change Order	Modify PA Search Results Panel	There is a need to modify the field labels in the search results panel.	Prod Implemented
2810	Change Order	CORE 12825 PA Search Panel	PA Search panel errors	Prod Implemented

2.7.23 PAGE: Prior Authorization Pending Information Page

This page is not currently used in Kentucky.

2.7.23.1 Description:

The Prior Authorization Information Page contains all information pertaining to a Pending PA.

Navigation Path: [Prior Authorization] - [Pending information]

2.7.23.2 Technical Name:

PriorAuthorizationPendingInformation

2.7.23.3 Web Page Name:

2.7.23.4 Prior Authorization Pending Information Page Layout

Prior Authorization Information - Pending

Pending PA Number	000210008	SSN	999-99-9999	Requesting Provider ID	100674459A MCD
		Member Last Name	PRITCHARD	Servicing Provider ID	100674459A MCD
		Member First Name	HANK	Service Provider Check	Specified Service Provider
Admission Date	06/04/2001	Member Date Of Birth	01/01/1929		
Discharge Date	06/05/2001	Clerk Keyed		PA Category Code	ACUTE IN-PATIENT PSYCHIATRIC
		Date Keyed	06/04/2001	Primary Diagnosis Code	311
Accident	NO	Time Keyed			
Special Considerations	NO				
Emergency	NO			Media Type	ONLINE
Nursing Facility Type					

2.7.24 PANEL: Pending Prior Authorization Diagnosis Panel

This panel is not currently used in Kentucky.

2.7.24.1 Description:

Providers may enter PAs for Pending Eligibles through the Provider Web Portal. When a Medicaid ID is issued to a Pending Eligible, the Pending PA is available for submission by the provider for adjudication. This panel displays additional diagnosis codes for the Pending PA request. The panel is view only.

Navigation Path: [Prior Authorization] - [Pending Information]

2.7.24.2 Technical Name:

PA.PendingDiagnosisPanel.ascx

2.7.24.3 Panel Name:

Pending Diagnosis Codes

2.7.24.4 Pending Prior Authorization Diagnosis Panel Layout

Diagnosis Codes - Pending

Diagnosis Sequence Number	Diagnosis Code	Diagnosis Code Description
0001	200	LYMPHOSARCOMA AND RETICULOSARCOMA
0002	2000	RETICULOSARCOMA
0003	20000	RETCLSRC UNSP XTRNDL ORG

Diagnosis Sequence Number	0001
Diagnosis Code	200
Diagnosis Code Description	LYMPHOSARCOMA AND RETICULOSARCOMA

2.7.24.5 Extra Features

This panel has no extra features.

2.7.24.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Diagnosis Code	A list of diagnosis codes associated with a particular authorization.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
Diagnosis Code Description	Describes the diagnosis codes listed for a prior authorization.	Field	Character	40	T_DIAGNOSIS	DSC_25
Diagnosis Sequence Number	Unique number that may be used to indicate the order of importance of the diagnosis.	Field	Number	4	T_PA_PEND_DIAG	NUM_SEQ

2.7.24.7 Field Edits

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

2.7.24.8 Associated Requirements

ID
No associated requirements found

2.7.24.9 CO / Defects

ID	TYPE	NAME	DESCRIPTION	Current Status
3325	Change Order	KYAmend Create Pend Diag Panel	Create the Pending PA Diagnosis panel to display additional diagnosis codes for a Pending PA. The Primary Diagnosis Code is displayed on the PA Pending Information panel.	Construction in Progress

2.7.25 PANEL: Pending Prior Authorization Information Panel

This panel is not currently used in Kentucky.

2.7.25.1 Description:

Providers may enter PAs for Pending Eligibles through the Provider Web Portal. When a Medicaid ID is issued to a Pending Eligible, the Pending PA is available for submission by the provider for adjudication. This panel displays the Information panel for the Pending PA request. The panel is view only.

2.7.25.2 Technical Name:

PA.PaPendingInformationPanel.ascx

2.7.25.3 Panel Name:

Pending Prior Authorization Information

2.7.25.4 Pending Prior Authorization Information Panel Layout

Prior Authorization Information - Pending

Pending PA Number	000210008	SSN	999-99-9999	Requesting Provider ID	100674459A MCD
		Member Last Name	PRITCHARD	Servicing Provider ID	100674459A MCD
		Member First Name	HANK	Service Provider Check	Specified Service Provider
Admission Date	06/04/2001	Member Date Of Birth	01/01/1929		
Discharge Date	06/05/2001	Clerk Keyed		PA Category Code	ACUTE IN-PATIENT PSYCHIATRIC
		Date Keyed	06/04/2001	Primary Diagnosis Code	311
Accident	NO	Time Keyed			
Special Considerations	NO				
Emergency	NO				
Nursing Facility Type				Media Type	ONLINE

2.7.25.5 Extra Features

This panel has no extra features.

2.7.25.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Emergency Supply	Manually checked and identifies the PA as an emergency 72-hour supply of drugs that does not count towards limitations.	Check Box	Character	1	T_PA_PEND_PAUTH	IND_EMERG
Accident	A checked box indicates the PA is the result of the member's involvement in an accident.	Field	Character	1	T_PA_PEND_PAUTH	IND_ACCIDENT
Admission Date	Date a member was admitted to a facility.	Field	Date (CCYYMMDD)	8	T_PA_PEND_PAUTH	DTE_ADMISSION
Clerk Keyed	ID of the clerk who entered the PA.	Field	Character	8	T_PA_PEND_PAUTH	ID_CLERK_ENTRY
Date Keyed	Date the PA was entered.	Field	Number	8	T_PA_PEND_PAUTH	DTE_ENTERED
Diagnosis Code	A checked Diagnosis box indicates there are additional diagnosis codes for the PA.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
Discharge Date	Date a member was released from a facility.	Field	Date (CCYYMMDD)	8	T_PA_PEND_PAUTH	DTE_DISCHARGE
Media Type	Description of the medium by which a PA request is received.	Field	Character	1	T_PA_MEDIA	DSC_MEDIA_TYPE
Member Date of Birth	Date of birth of the member.	Field	Number	8	T_RE_PEND_MEMBER	DTE_BIRTH

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Member First Name	First name of the member for whom services are requested on the PA.	Field	Character	15	T_RE_PEND_MEMBER	NAM_FIRST
Member Last Name	Last name of the member for whom services are requested on the PA.	Field	Character	20	T_RE_PEND_MEMBER	NAM_LAST
Member SSN	Unique identifier for the member for whom services are requested on the PA.	Field	Character	9	T_RE_PEND_MEMBER	NUM_SSN
PA Category Code	Code that groups a PA's requested services under a type such as dental, inpatient, PT, OT.	Field	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
PA Number	The Pending Prior Authorization Number	Field	Character	10	T_PA_PEND_PAUTH	PRIOR_AUTH_NUM
Primary Diagnosis Code	A member's primary diagnosis.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
Requesting Provider Number	Unique identifier for the provider requesting services for a member on a PA request.	Field	Character	15	T_PR_PROV	ID_PROVIDER
Servicing Provider Number	Unique identifier for the provider performing the services for a member specified on a PA request.	Field	Character	15	T_PR_PROV	ID_PROVIDER
Special Considerations	Indicates if there are special considerations concerning the PA.	Field	Character	1	T_PA_PEND_PAUTH	IND_SPECIAL_CONSID

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Time Keyed	Time the PA was entered.	Field	Number	8	T_PA_PEND_PAUTH	TME_ENTERED

2.7.25.7 Field Edits

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

2.7.25.8 Associated Requirements

ID
No associated requirements found

2.7.25.9 CO / Defects

ID	TYPE	NAME	DESCRIPTION	Current Status
3323	Change Order	KYAmend Create Pend PAInfo Panel	The Pending PA Information panel will display general information about a PA that was entered for a member awaiting eligibility for Medicaid.	Construction in Progress

2.7.26 PANEL: Pending Prior Authorization Line Item Panel

This panel is not currently used in Kentucky.

2.7.26.1 Description:

Providers may enter PAs for Pending Eligibles through the Provider Web Portal. When a Medicaid ID is issued to a Pending Eligible, the Pending PA is available for submission by the provider for adjudication. This panel displays the line item or service request information for a Pending PA request. The panel is view only.

2.7.26.2 Technical Name:

PA.PaPendingLineItemPanel.ascx

2.7.26.3 Panel Name:

Pending Line Item

2.7.26.4 Pending Prior Authorization Line Item Panel Layout

Line Item - Pending

Line Item Number	Requested Units	Requested Dollars	Revenue Code From	Revenue Code To	Procedure Code From	Procedure Code To	Modifier 1	Modifier 2	Modifier 3	Modifier 4
01	5	$0.00			B4176					
02	1	$0.00			B4172					

Line Item Number	01			Requested Effective Date*	06/08/2001
Service Type Code*	Procedure Code			Requested End Date*	06/09/2001
				Requested Units	5
Revenue Code		Revenue Code To		Requested Dollars	
Procedure Code From	B4176	Procedure Code To		Frequency	
Modifier 1		Quad		Frequency Units*	
Modifier 2		Tooth		Payment Method*	Pay System Price
Modifier 3					
Modifier 4					

2.7.26.5 Extra Features

This panel has no extra features.

2.7.26.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Payment Method	Payment method is used during claim adjudication to determine how a claim should be paid. Valid payment methods are: 2 = pay price specified on the service request, 1 = pay system price specified on a fee schedule, 3 = pay up to capitated amount specified on the service request.	Combo Box	Character	1	T_PA_PEND_LITEM	CDE_PYMT_METHOD
Service Type Code	Indicates the code set to use for validation of the requested service: procedure, revenue.	Combo Box	Character	1	T_PA_PEND_LITEM	CDE_SVC_TYPE
Line Item Number	Two characters that sequentially lists the items pertaining to the Pending PA.	Field	Character	2	T_PA_PEND_LITEM	NUM_PA_LINE_ITEM
Modifier (1 - 4)	Four occurrences of codes used in combination with a procedure code to provide more information.	Field	Character	2	T_MODIFIER	CDE_PROC_MOD
Procedure Code From	Code that uniquely identifies a procedure.	Field	Character	6	T_PROC	CDE_PROC
Procedure Code To	Procedure code ending the procedure code range used at the line item level on a Pending PA.	Field	Character	6	T_PROC	CDE_PROC

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Quad	Tooth quadrant used in combination with a tooth number and procedure code to provide more information concerning the service.	Field	Character	2	T_TOOTH_QUADRANT	CDE_TOOTH_QUAD
Requested Dollars	Dollar amount requested for a service for a member.	Field	Number	9	T_PA_PEND_LITEM	AMT_PA_REQ
Requested Effective Date	Requested date the authorization is effective.	Field	Date (MM/DD/CCYY)	8	T_PA_PEND_LITEM	DTE_PA_REQ_EFF
Requested End Date	Date requested that a service would end for a member.	Field	Date (MM/DD/CCYY)	8	T_PA_PEND_LITEM	DTE_PA_REQ_END
Requested Units	Number of units requested of a product or service.	Field	Number	9	T_PA_PEND_LITEM	QTY_UNT_SVC_REQ
Revenue Code	Code identifying a specific accommodation or ancillary service.	Field	Character	4	T_REVENUE_CODE	CDE_REVENUE
Revenue Code To	Revenue code that ends the range of revenue code specified for a service.	Field	Character	4	T_REVNUE_CODE	CDE_REVENUE
Tooth	Tooth number used in combination with a procedure code to provide more information concerning the service.	Field	Character	2	T_TOOTH	CDE_TOOTH_NBR

2.7.26.7 Field Edits

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

2.7.26.8 Associated Requirements

ID
No associated requirements found

2.7.26.9 CO / Defects

ID	TYPE	NAME	DESCRIPTION	Current Status
2752	Change Order	CORE 12747 Line Item panel	Line Item should not be requiring the user to enter Authorized Effective/End Dates without checking for the appropriate Status first.	Model Office Implemented
2813	Change Order	CORE 12778 Line Item Paid Claim	Prior Auth Line Item Paid Claim Updating Issue	Model Office Implemented
3322	Change Order	KYAmend Create Pend LItem panel	Create the Pending Line Item panel to display requested services for a pending PA.	Construction in Progress

2.7.27 PANEL: Pending Prior Authorization Text Panel

This panel is not currently used in Kentucky.

2.7.27.1 Description:

Providers may enter PAs for Pending Eligibles through the Provider Web Portal. When a Medicaid ID is issued to a Pending Eligible, the Pending PA is available for submission by the provider for adjudication. This panel displays free form text for a Pending PA entered by the provider. The panel is view only.

2.7.27.2 Technical Name:

WebUI.EntityMaintenancePanel.ascx

2.7.27.3 Panel Name:

Pending Text

Pending Prior Authorization Text Panel Layout

2.7.27.4 Extra Features

This panel has no extra features.

2.7.27.5 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Text Description	Free form text.	Field	Character	500	T_PA_PEND_TEXT	DSC_TEXT

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Text Line Number	Line number of the Prior Authorization free form text. It is generated automatically to identify a block of free form text.	Field	Number	4	T_PA_PEND_TEXT	NUM_TEXT_ENTRY

2.7.27.6 Field Edits

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

2.7.27.7 Associated Requirements

ID
No associated requirements found

2.7.27.8 CO / Defects

ID	TYPE	NAME	DESCRIPTION	Current Status
3326	Change Order	KYAmend Create Pend Text Panel	Create the Pending PA Text panel to display free form text for a Pending PA.	Construction in Progress

2.7.28 PAGE: Prior Authorization Pending Search Page

This page is not currently used in Kentucky.

2.7.28.1 Description:

The Prior Authorization Pending Search Page provides for searches of Pending PAs with specific criteria.

Navigation Path: [Prior Authorization] - [Pending Search]

2.7.28.2 Technical Name:

PriorAuthorizationPendingSearch

2.7.28.3 Web Page Name:

2.7.28.4 Prior Authorization Pending Search Page Layout

2.7.29 PANEL: Pending Prior Authorization Search

This panel is not currently used in Kentucky.

2.7.29.1 Description:

Use this search panel to search pending PA's. This search Panel searches the Pending PA's which have not been assigned a Medicaid Member ID. The search is performed on the Prior Auth Pending Tables and results are based on the search criteria entered by the user.

Navigation Path: [Prior Authorization] - [Pending Search]

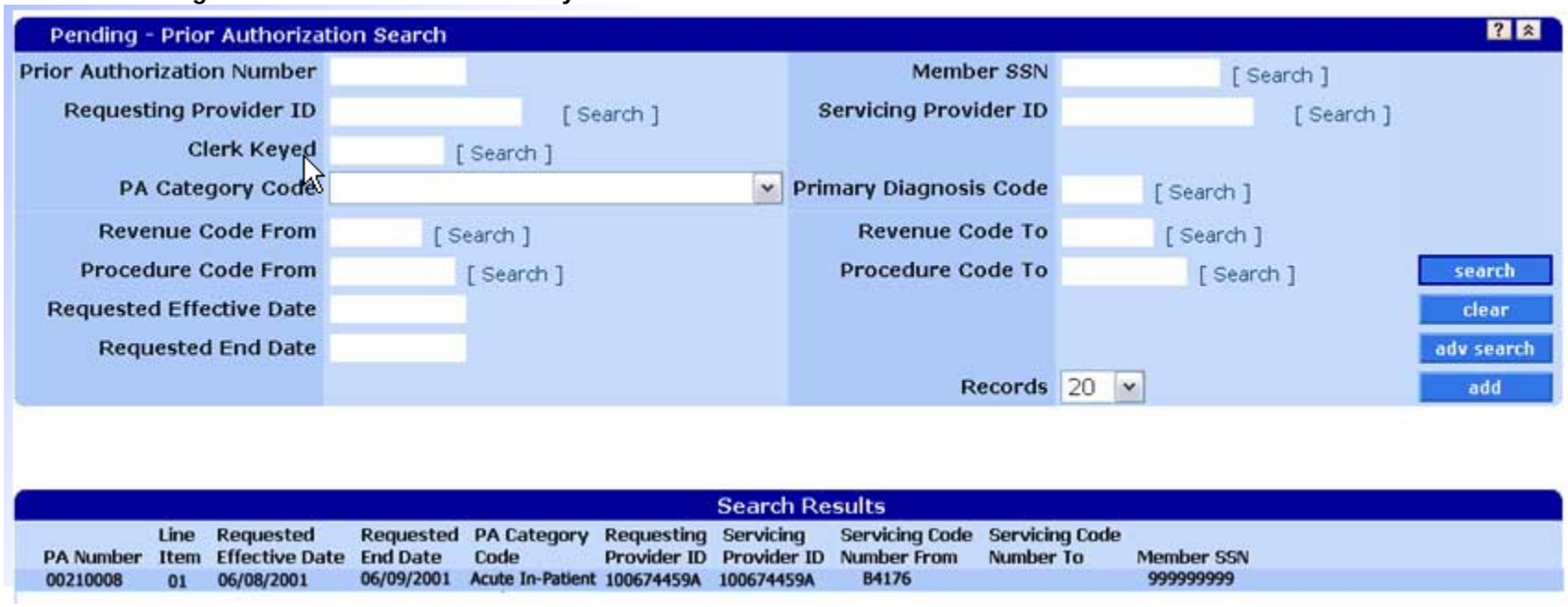
2.7.29.2 Technical Name:

PA.PaPendingSearchPage.ascx

2.7.29.3 Panel Name:

Pending Prior Authorization Search

2.7.29.4 Pending Prior Authorization Search Layout



2.7.29.5 Extra Features

The advanced search button expands the search criteria. Only Revenue Code or Procedure Code fields can be present for any given search. A validation check is done before presenting the results.

2.7.29.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Clerk Keyed	Unique identifier for the clerk who entered the Pending PA.	Field	Character	8	T_PA_PEND_PAUTH	ID_CLERK_ENTRY
Member SSN	The member SSN for whom services are requested on the Pending PA.	Field	Character	9	T_RE_PENDING_MEMBER	NUM_SSN
PA Category Code	Code that groups a Pending PA's requested services under a type such as dental, inpatient, and physician.	Field	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
Primary Diagnosis Code	A member's primary diagnosis.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
Prior Authorization Number	The Pending Prior Authorization Number assigned to the record	Field	Character	9	T_PA_PEND_PAUTH	PA_NUM_PEND
Procedure Code	Code that uniquely identifies a procedure.	Field	Character	6	T_PROC	CDE_PROC
Procedure Code To	The ending range of procedure codes specified on a PA line item.	Field	Character	6	T_PROC	CDE_PROC
Records	The maximum number of records displayed on the panel when the search results are displayed.	Field	Number	0	N/A	N/A

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Requested Effective Date	Begin date of the date range for which the service is requested for use by a member.	Field	Date (CCYYMMDD)	8	T_PA_PEND_LITEM	DTE_PA_REQ_EFF
Requested End Date	Last date the requested service can be used by a member.	Field	Date (CCYYMMDD)	8	T_PA_PEND_LITEM	DTE_PA_REQ_END
Requesting Provider Number	Unique identifier for the provider requesting services for a member on a Pending PA.	Field	Character	15	T_PR_PROV	ID_PROVIDER
Revenue Code	Code identifying a specific accommodation or ancillary service	Field	Character	6	T_REVENUE_CODE	CDE_REVENUE
Revenue Code To	The ending range of revenue codes specified on a PA line item.	Field	Character	6	T_REVENUE_CODE	CDE_REVENUE
Servicing Provider Number	Unique identifier for the provider performing the services for a member specified on a Pending PA.	Field	Character	15	T_PR_PROV	ID_PROVIDER

2.7.29.7 Field Edits

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

2.7.29.8 Associated Requirements

ID
No associated requirements found

2.7.29.9 CO / Defects

ID	TYPE	NAME	DESCRIPTION	Current Status
2772	Change Order	KYAmend Create Pend Search Panel	Create panel to search and display results for prior authorizations entered for pending eligibles through the Provider Web portal. Design the following read only panels to display information for a single pending prior authorization: • PA Information; • Line item; • Reason Code; • Diagnosis; and, • Text.	Model Office Implemented

2.7.30 PANEL: Prior Authorization Administrative Review

2.7.30.1 Description

The Administrative Review panel is available for use by MHMR to capture information concerning informal reviews of a Prior Authorization. The "Date Received" field holds the date an informal review request was received. The "Mailed Date" field holds the date the results of the informal review were mailed.

NOTE: This panel is currently not used.

Navigation Path: [Prior Authorization] - [Information] - [Administrative Review]

2.7.30.2 Technical Name

PA.AdminReviewPanel.ascx

2.7.30.3 Panel Name

Admin Review

2.7.30.4 Prior Authorization Administrative Review Layout

2.7.30.5 Extra Features

PA Administrative Review ERL

2.7.30.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Mailed Date	Date the notice of Prior Authorization Administrative Review was mailed.	Field	Date (CCYYMMDD)	8	T_PA_ADMIN_REV	DTE_PA_ADM_MLD
Received Date	Date a request for Administrative Review of a Prior Authorization request was received by KMAA.	Field	Date (CCYYMMDD)	8	T_PA_ADMIN_REV	DTE_PA_ADM_REC

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Review Determination	Ruling made in the Administrative Review.	Field	Character	1	T_PA_ADMIN_REV_STATE	CDE_PA_REV_DEC
Review Findings Sent Date	Date the decision of the Administrative Review is mailed.	Field	Date (CCYYMMDD)	8	T_PA_ADMIN_REV_STATE	DTE_PA_DEC_MLD

2.7.30.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Mailed Date	Field	5015	Mailed Date must be greater than or equal to 1/1/1900.	Verify and re-enter date.
Mailed Date	Field	5501	Invalid date. Format is mm/dd/yyyy.	Verify and re-enter date.
Received Date	Field	5015	Received Date must be greater than or equal to 1/1/1900.	Verify and re-enter date.
Received Date	Field	5501	Invalid date. Format is mm/dd/yyyy.	Verify and re-enter date.
Review Findings Sent Date	Field	6000	Review Findings Sent Date must be greater than or equal to 1/1/1900.	Verify and re-enter date.
Review Findings Sent Date	Field	6001	Invalid date. Format is mm/dd/yyyy.	Verify and re-enter date.

2.7.30.8 Associated Requirements

ID
30.090.005.003.2

2.7.30.9 CO / Defects

ID	Type	Name	Description	Current Status
2812	Change Order	CORE 12824 Admin Review panel	Admin Review panel edit issues	Prod Implemented
321	Change Order	Modify PA Administrative Panel	Add fields "Review Findings Sent Date" and "Review Determination" to the Administrative Review panel.	Prod Implemented

2.7.31 PANEL: Prior Authorization Appeals

2.7.31.1 Description

The Appeals panel is available for use by MHMR to track Reconsideration and Appeal information for Support for Community Living and Acquired Brain Injury PAs. Appeal information for other PA types is maintained by SHPS and available for reporting in the Data Warehouse.

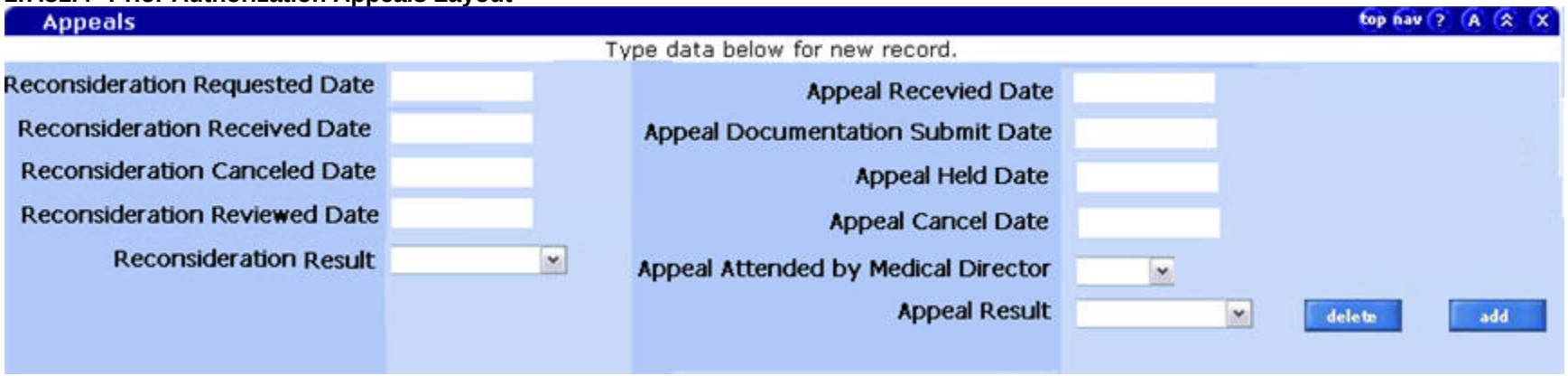
NOTE: This panel is currently not used.

Navigation Path: [Prior Authorization] - [Information] - [Appeals]

2.7.31.2 Technical Name
PA.AppealsPanel.ascx

2.7.31.3 Panel Name
Prior Authorization Appeals

2.7.31.4 Prior Authorization Appeals Layout



2.7.31.5 Extra Features
PA Appeal ERL

2.7.31.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Appeal Result	Ruling on the appeal.	Field	Character	1	T_PA_APPEAL_STATE	DTE_PA_APP_RESULT
Appeal Cancel Date	Date Prior Authorization appeal was dismissed.	Field	Date (CCYYMMDD)	8	T_PA_APPEAL	DTE_PA_APP_DISMIS
Appeal Held Date	Date Prior Authorization appeal was held.	Field	Date (CCYYMMDD)	8	T_PA_APPEAL	DTE_PA_APPEAL
Appeal Documentation Submit Date	Date the Prior Authorization appeal packet was mailed.	Field	Date (CCYYMMDD)	8	T_PA_APPEAL	DTE_PA_APP_MAIL
Appeal Received Date	Date the Prior Authorization appeal was received by KMAA.	Field	Date (CCYYMMDD)	8	T_PA_APPEAL	DTE_PA_APP_RECV
Reconsideration Canceled Date	Date of provider request to cancel reconsideration.	Field	Date (CCYYMMDD)	8	T_PA_APPEAL_STATE	DTE_PA_RECON_CANCEL
Reconsideration Result	Ruling on the reconsideration.	Field	Character	1	T_PA_APPEAL_STATE	CDE_PA_RECON_RESULT
Reconsideration Received Date	Date provider request letter was received by KMAA.	Field	Date (CCYYMMDD)	8	T_PA_APPEAL_STATE	DTE_PA_RECON_RECV

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Reconsideration Requested Date	Date of provider reconsideration request letter.	Field	Date (CCYYMMDD)	8	T_PA_APPEAL_STATE	DTE_PA_RECON_REQ
Reconsideration Reviewed Date	Date KMAA Physician Reviewer completed reconsideration review.	Field	Date (CCYYMMDD)	8	T_PA_APPEAL_STATE	DTE_PA_RECON_COMPL

2.7.31.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Appeal Dismiss Date	Field	5015	Dismiss Date must be greater than or equal to 1/1/1900.	Verify and re-enter date.
Appeal Dismiss Date	Field	5501	Invalid date. Format is mm/dd/yyyy.	Verify and re-enter date.
Appeal Hearing Date	Field	5015	Appeal Date must be greater than or equal to 1/1/1900.	Verify and re-enter date.
Appeal Hearing Date	Field	5501	Invalid date. Format is mm/dd/yyyy.	Verify and re-enter date.
Appeal Notice Sent Date	Field	5015	Mailed Date must be greater than or equal to 1/1/1900.	Verify and re-enter date.
Appeal Notice Sent Date	Field	5501	Invalid date. Format is mm/dd/yyyy.	Verify and re-enter date.
Appeal Received Date	Field	5015	Received Date must be greater than or equal to 1/1/1900.	Verify and re-enter date.
Appeal Received Date	Field	5501	Invalid date. Format is mm/dd/yyyy.	Verify and re-enter date.

2.7.31.8 Associated Requirements

ID
30.090.005.003.2

2.7.31.9 CO / Defects

ID	Type	Name	Description	Current Status
4780	Defect	PA Search Panel	Two field changes on PA Search Results panel fails. 1. Service Code Number to Service Code From. 2. Add "Service Code To" field after "Service Code From" field. This will hold the end range for revenue and procedure codes	Defect Corrected
571	Change Order	Modify PA Appeals Panel	There is a need to add new fields in the Appeals panel. Also, panel labels need to be modified. The new fields to be added are based on the business need to reconsider the appeals in the PA.	Prod Implemented

2.7.32 PANEL: Prior Authorization External Text

2.7.32.1 Description

This panel is not used. All free form text is viewed and maintained on the Internal Text panel.

The External Text panel displays free form text for a Prior Authorization for printing on the PA letter. KMAA is sending free form text to the MMIS that is displayed on the Internal Text panel.

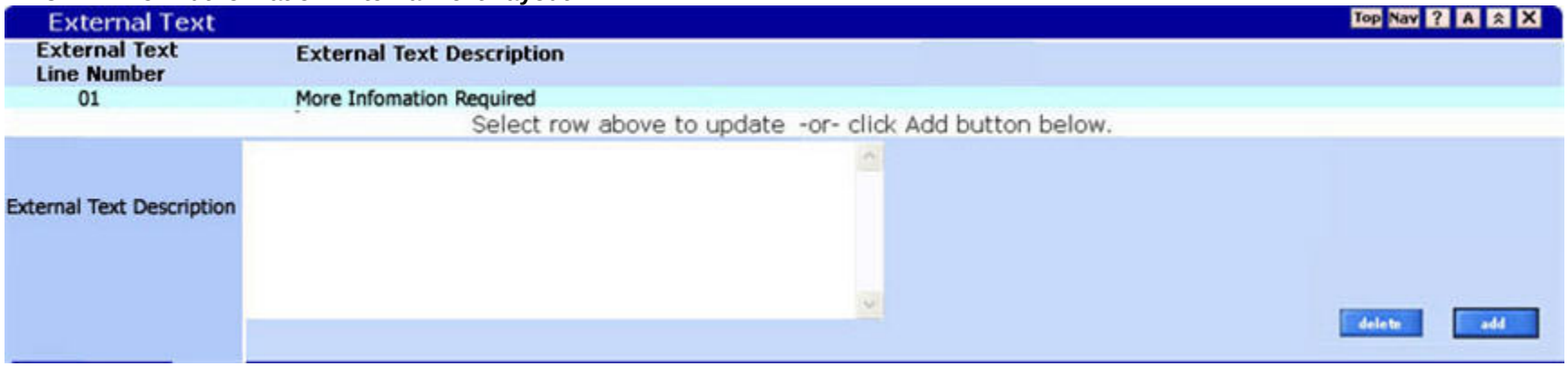
NOTE: This panel is currently not used.

Navigation Path: [Prior Authorization] - [Information] - [External Text]

2.7.32.2 Technical Name
WebUI.EntityMaintenancePanel.ascx (Ext)

2.7.32.3 Panel Name
PaExt Text

2.7.32.4 Prior Authorization External Text Layout



2.7.32.5 Extra Features
Global ERL

2.7.32.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
External Text Description	Free form text.	Field	Character	500	T_PA_EXT_TEXT	DSC_PA_TEXT
External Text Line Number	Line number of the Prior Authorization external free form text. It is generated automatically to identify a block of free form text.	Field	Number	4	T_PA_EXT_TEXT	NUM_LINE_NUMBER

2.7.32.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
External Text Description	Field	5001	Description is required.	Enter a description for the PA external free text.

2.7.32.8 Associated Requirements

ID
30.090.005.002.4

2.7.32.9 CO / Defects

ID	Type	Name	Description	Current Status
576	Change Order	Modify PA External Text Panel	There is a business need to add fields in the data list of the External Text Panel. Also, the existing field label needs to be modified.	Prod Implemented

2.7.33 PANEL: Prior Authorization Non Medicaid Provider

2.7.33.1 Description

This panel is not used. The purpose of the panel is to allow a non Medicaid provider to be specified as a requesting provider. All providers on a Prior Authorization request will have valid Medicaid provider eligibility.

NOTE: This panel is currently not used.

Navigation Path: [Prior Authorization] - [Information] - [Non Medicaid Provider]

2.7.33.2 Technical Name
PA.PANonMedicaidProviderPanel.ascx

2.7.33.3 Panel Name
Prior Authorization Non Medicaid Provider

2.7.33.4 Prior Authorization Non Medicaid Provider Layout

2.7.33.5 Extra Features
Global ERL

2.7.33.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Address Type	Indicates the non Medicaid provider is the requesting provider on the PA.	Combo Box	Character	20	T_PA_NONMED_PROV	IND_ADDR_TYPE
State	The mailing address state for the non Medicaid provider requesting a PA.	Combo Box	Character	2	T_PA_NONMED_PROV	ADR_MAIL_STATE
Address 1	First line of a street address for the non Medicaid provider.	Field	Character	30	T_PA_NONMED_PROV	ADR_MAIL_STRT1
Address 2	Second line of a street address of the non Medicaid provider.	Field	Character	30	T_PA_NONMED_PROV	ADR_MAIL_STRT2
City	The mailing address city for the non Medicaid provider requesting the PA.	Field	Character	15	T_PA_NONMED_PROV	ADR_MAIL_CITY
License Number	The non Medicaid provider's license number.	Field	Character	10	T_PA_NONMED_PROV	NUM_PROV_LIC
Phone Number/Ext	The10-digit required phone number (including area code), and the optional phone extension of the non Medicaid provider requesting Prior Authorization.	Field	Character	14	T_PA_NONMED_PROV	NUM_PHONE + NUM_PHO_EXT

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Provider Name	The name of the non-Medicaid provider requesting a PA.	Field	Character	39	T_PA_NONMED_PROV	NAME

2.7.33.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Address Type	Combo Box	5001	Address Type is required.	Select a valid address type from the list.
State	Combo Box	5029	A valid State is required.	Select a state from the list.
Address 1	Field	91006	Address 1 is required	Type the provider address.
Provider Name	Field	91007	Provider Name can only contain alphabetic characters and spaces.	Enter a Valid Provider Name.
Provider Name	Field	91008	Maximum of two Non-Medicaid Provider records allowed.	Delete or Update existing record.
License Number	Field	91009	License Number is required.	Enter a Valid License Number.
City	Field	91010	City is required.	Enter a Valid City.
Zip	Field	91011	Zip is required.	Enter a Valid Zip.
State	Field	910012	A valid State is required.	Enter a Valid State.
State	Field	910013	Both Non-Medicaid Provider records have the same Address Type	Change Address type.

Field	Field Type	Error Code	Error Message	To Correct
Provider Name	Field	910014	Only one Servicing Provider allowed.	Base Information already has a Valid Servicing Provider. Change Value
City	Field	5001	City is required.	Enter a city name.
License Number	Field	5010	License Number must be Numeric.	Ensure value is numeric.
License Number	Field	5013	License Number must be at least 5 character(s) in length.	Ensure value is numeric.

2.7.33.8 Associated Requirements

ID
30.090.005.003.2

2.7.33.9 CO / Defects

ID	Type	Name	Description	Current Status
577	Change Order	Modify PA Non Med Prov Panel	There is a need to change the field labels on the Non Medicaid Provider Panel.	Prod Implemented

2.7.34 PANEL: Super PA

2.7.34.1 Description

This panel is not in use at this time.

The purpose of the Super PA panel is to provide for the override of any errors generated during the adjudication of pharmacy claims. The panel provides for the association of an error code with a pharmacy Prior Authorization. During the adjudication of a pharmacy claim, errors are overridden if an error override record is found for the Prior Authorization.

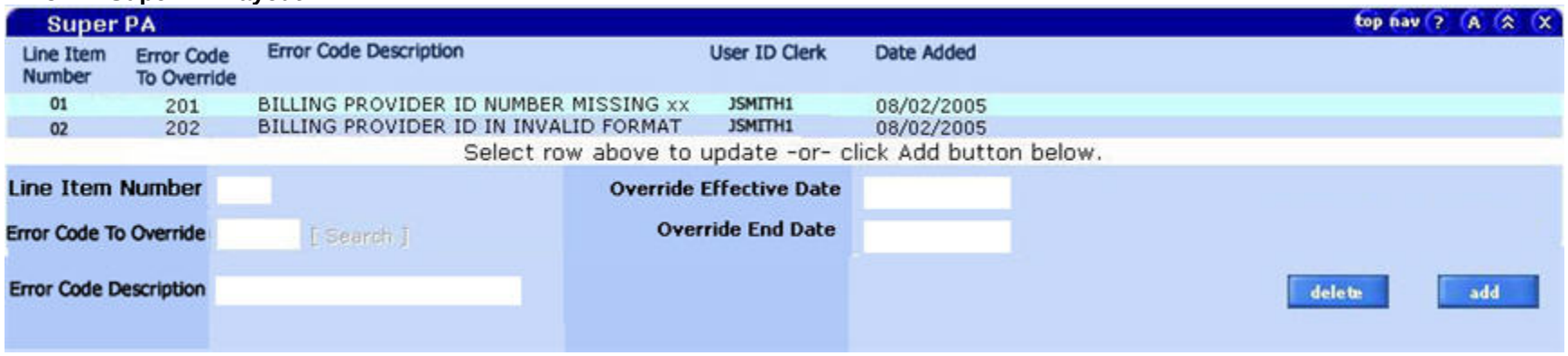
NOTE: This panel is currently not used.

Navigation Path: [Prior Authorization] - [Information] - [Super PA]

2.7.34.2 Technical Name
PA.SuperPAPanel.ascx

2.7.34.3 Panel Name
Super PA

2.7.34.4 Super PA Layout



2.7.34.5 Extra Features
PA Super Pa ERL

2.7.34.6 Field Descriptions

Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
Date Added	Date the edit override was added to the PA.	Field	Date (MM/DD/CCYY)	8	T_PA_ESC	DTE_ESC_ADD
Error Code Description	Description of the error status code.	Field	Character	50	T_ERROR_DISP	DSC_ERROR_STAT
Error Code to Override	Error status code overridden for this PA line item.	Field	Integer	4	T_ERROR_DISP	CDE_ESC
Line Item Number	Number of detail to override	Field	Numeric	2	T_CLAIM_ERROR	NUM_DTL
Override Effective Date	N/A	N/A	N/A	N/A	N/A	N/A
Override End Date	N/A	N/A	N/A	N/A	N/A	N/A

2.7.34.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Date Added	Field	15001	A valid Error Code is required	Enter a Valid Error Code.
Error Code to Override	Field	5029	A valid Error Code is required.	Enter value or select valid code from search popup.
Error Code to Override	Field	5200	A duplicate record cannot be saved.	Enter value or select valid code from search popup.

Field	Field Type	Error Code	Error Message	To Correct
Error Code to Override	Field	5500	Enter a valid value.	Enter value or select valid code from search popup.

2.7.34.8 Associated Requirements

ID
30.090.005.003.2

2.7.34.9 CO / Defects

ID	Type	Name	Description	Current Status
578	Change Order	Modify Super PA Panel	The state requirements specify the addition of new fields to the Super PA Panel. Also, there is a need to modify the labels of existing fields. 2/20/2006 Per conversation Dean Taunton had with Bala Sivamohan, this CO is deferred until after go-live due to the potential impact on the Claims engine.	Deferred

2.8 Reports

The following section provides a description and sample layout for each Report associated to the Service/Prior Authorization subsystem.

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

2.8.1 PAU-0130-M -- End Date PA for Member in MC

This report lists service/prior authorizations end-dated because a member has either entered into managed care and will now receive services from the managed care organization (MCO) or the authorization was for EPSDT services and the member was placed in a status of "M7" or "P7" (KCHIP).

Authorizations for a member entering managed care are excluded from end-dating if one of the following conditions exists:

- The authorization category is for waiver, Impact Plus, inpatient, or one of the long term care authorization types;
- The service provider has an active specialty of psychiatry;
- The authorization category is EPSDT and the requested service is for behavioral health; and,
- The PA Category is 'Inpatient' (02) and the reason code is 'Pysch Service Provided in an Acute Hospital' (741).

All service/prior authorizations are end dated if the authorization category is EPSDT and the member is in a status of "M7" or "P7'.

2.8.1.1 Technical Name

PAU-0130-M

2.8.1.2 Sort Order

PA Type, Provider ID, Medicaid ID, PA Number, PA Line Item Number.

For readability, the layout appears on the following page.

2.8.1.3 End Date PA for Member in MC Layout

```
Report  : PAU-0130-M                          COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process : PAUJM130                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   99:99:99
Location: PAUPM130                       PRIOR AUTHORIZATION END DATE REPORT                                Page:        999
                                              MONTH OF XXXXXXXXXXXX 9999

 PA CATEGORY : xxxxxxxxxxxxxxxxxxxxxxxxxxxx

-------------------------------------------------------------------------------------------------------------------------------
     SERVICING                        PRIOR AUTH    LINE    MC/Elig     MC/Elig      SERVICE      LINE          LINE
 PROVIDER NUMBER      MEMBER ID         NUMBER      NBR    BEGIN DATE  END DATE      CODE        STATUS      REASON CODE
-------------------------------------------------------------------------------------------------------------------------------

    XXXXXXXXX         XXXXXXXXX       XXXXXXXXXX   XX      XXXXXXXX    XXXXXXXX    XXXXX       XXXXXXXXX        XXX
    XXXXXXXXX         XXXXXXXXX       XXXXXXXXXX   XX      XXXXXXXX    XXXXXXXX    XXXXX       XXXXXXXXX        XXX
    XXXXXXXXX         XXXXXXXXX       XXXXXXXXXX   XX      XXXXXXXX    XXXXXXXX    XXXXX       XXXXXXXXX        XXX
    XXXXXXXXX         XXXXXXXXX       XXXXXXXXXX   XX      XXXXXXXX    XXXXXXXX    XXXXX       XXXXXXXXX        XXX

                                        *** END OF REPORT ***
                                      *** NO DATA THIS REPORT ***
```

2.8.1.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Line Item Reason Code	Reason service was end dated. 300 - Member became eligible for M/C. 301 - Member became eligible for KCHIP III.	3	Character	T_PA_IAC_TEXT	CDE_IAC
Line Item Status	Status of requested service on a service/prior authorization.	20	Character	T_PA_LINEITEM_STAT	DSC_STATUS
Line Nbr	Unique number associated with a service on a service/prior authorization.	2	Character	T_PA_LINE_ITEM	NUM_PA_LINE_ITEM

Field	Description	Length	Data Type	DB Table	DB Attributes
MC/Elig Begin Date	Date enrollment in a managed care organization or status of M7 or P7 begins.	8	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN, T_RE_AID_ELIG	DTE_EFFECTIVE
MC/Elig End Date	Date enrollment in a managed care organization or status of M7 or P7 ends.	8	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN, T_RE_AID_ELIG	DTE_END
Member ID	Member's Medicaid identification number.	10	Character	T_RE_BASE	ID_MEDICAID
Month of XXXXXXXXXXXX 9999	Reporting period.	17	Character	N/A	CALCULATED FIELD
PA Category	Description for a service/prior authorization type (e.g., inpatient, dental, physician).	30	Character	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
Prior Auth Number	Unique number assigned to a service/prior authorization.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Service Code	Service requested on a service/prior authorization.	5	Character	T_PA_LINE_ITEM || T_REVENUE || T_PROC || T_DRUG	CDE_SVC_TYPE CDE_REVENUE || CDE_PROC || CDE_NDC
Servicing Provider Number	ID of the service provider on a service/prior authorization.	10	Character	T_PR_IDENTIFIER	ID_PROVIDER

2.8.1.5 Associated Programs

Program	Description
paupm130	End Date Prior Auths
copy2routedir	Copy Reports to Router

2.8.1.6 Associated Requirements

ID
No associated Requirements found.

2.8.1.7 Change Orders

ID	Name	Description
No associated Change Orders found.		

2.8.2 PAU-0140-R -- Mass Update Old Provider

The mass update of providers on service/prior authorizations is a two step process. This report is generated out of the first step in the process. The report lists service/prior authorizations that are end-dated for the original provider. A program input parm provides a preview of results without making actual updates to the service/prior authorizations. 'Preliminary Report' in the report title indicates no PAs were end dated. 'Final Report' in the report title indicates the original provider's PAs were end dated.

The first step in the prior auth provider mass update process end-dates the original provider's service/prior authorizations with a date that is one day before the effective take-over date of the new provider. End dating the PA ensures that the original provider is paid for the correct time period. The original provider is given time to submit claims for payment.

The second step updates authorized units and amounts on the PA for the original provider with what has been used to date. Authorizations are then created for the new provider with the remaining authorized units and amounts from the original service/prior authorization.

2.8.2.1 Technical Name

PAU-0140-R

2.8.2.2 Sort Order

PA Number, PA Line Item Number.

For readability, the layout appears on the following page.

2.8.2.3 Mass Update Old Provider Layout

```
Report   : PAU-0140-R                          COMMONWEALTH OF KENTUCKY                          RUN DATE:  MM/DD/CCYY
Process  : PAUJR140                       MEDICAID MANAGEMENT INFORMATION SYSTEM                 RUN TIME:    99:99:99
Location : PAUPR140                           OLD PROVIDER MASS UPDATE RESULTS                       PAGE:         999

                                              ********* FINAL REPORT *********

PA NUMBER   LINE   SERVICE CODE   -------  UNITS -------    ------- AMOUNT -------   -- DATES ORIGINAL--  ---- DATES NEW ----
            ITEM   FROM     TO    AUTHORIZED   REMAINING   AUTHORIZED    REMAINING    BEGIN       END       BEGIN       END
XXXXXXXXXX  XX     XXXXX  XXXXX   9,999,999    9,999,999 9,999,999.99 9,999,999.99 XX/XX/XX   XX/XX/XX   XX/XX/XX   XX/XX/XX
XXXXXXXXXX  XX     XXXXX  XXXXX   9,999,999    9,999,999 9,999,999.99 9,999,999.99 XX/XX/XX   XX/XX/XX   XX/XX/XX   XX/XX/XX
XXXXXXXXXX  XX     XXXXX  XXXXX   9,999,999    9,999,999 9,999,999.99 9,999,999.99 XX/XX/XX   XX/XX/XX   XX/XX/XX   XX/XX/XX
XXXXXXXXXX  XX     XXXXX  XXXXX   9,999,999    9,999,999 9,999,999.99 9,999,999.99 XX/XX/XX   XX/XX/XX   XX/XX/XX   XX/XX/XX
XXXXXXXXXX  XX     XXXXX  XXXXX   9,999,999    9,999,999 9,999,999.99 9,999,999.99 XX/XX/XX   XX/XX/XX   XX/XX/XX   XX/XX/XX
XXXXXXXXXX  XX     XXXXX  XXXXX   9,999,999    9,999,999 9,999,999.99 9,999,999.99 XX/XX/XX   XX/XX/XX   XX/XX/XX   XX/XX/XX
XXXXXXXXXX  XX     XXXXX  XXXXX   9,999,999    9,999,999 9,999,999.99 9,999,999.99 XX/XX/XX   XX/XX/XX   XX/XX/XX   XX/XX/XX
XXXXXXXXXX  XX     XXXXX  XXXXX   9,999,999    9,999,999 9,999,999.99 9,999,999.99 XX/XX/XX   XX/XX/XX   XX/XX/XX   XX/XX/XX

                                          *** END OF REPORT ***
                                       *** NO DATA THIS REPORT ***
```

2.8.2.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Amount Authorized	Dollar amount authorized for the service/prior authorization line item service.	9	Number (Decimal)	T_PA_LINE_ITEM	AMT_PA_AUTH
Amount Remaining	Dollar amount that remains to be used on the line item service. The field is calculated by subtracting PA line item used amounts on T_PA_ITEM_DTL_XREF from the authorized line item amount.	9	Number (Decimal)		Calculated Field

Field	Description	Length	Data Type	DB Table	DB Attributes
Dates New Begin	Original authorization start date for the line item.	8	Character Saved in the MM/DD/CCYY format	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Dates New End	Mass update effective date less one day as new authorized end date for the line item.	8	Character Saved in the MM/DD/CCYY format	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Dates Original Begin	Original authorized start date for the line item.	8	Character Saved in the MM/DD/CCYY format	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Dates Original End	Original authorized end date for the line item.	8	Character Saved in the MM/DD/CCYY format	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Line Item	Line item associated with the service/prior authorization number.	2	Character	T_PA_LINE_ITEM	NUM_PA_LINE_ITEM
PA Number	Unique number assigned to a service/prior authorization.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Service Code From	Service code for the authorization.	5	Character	T_PA_LINE_ITEM/T_PROC/T_REVENUE_CODE/T_DRUG	CDE_SVC_TYPE/CDE_PROC/CDE_REVENUE/CDE_DRUG
Service Code To	Ending range for a service code request.	5	Character	T_PA_LINE_ITEM/T_PROC/T_REVENUE_CODE/T_DRUG	CDE_SVC_TYPE/CDE_PROC/CDE_REVENUE/CDE_DRUG
Units Authorized	Number of units authorized for the service.	9	Number (Integer)	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH

Field	Description	Length	Data Type	DB Table	DB Attributes
Units Remaining	Number of services that remain to be used on the line item. The field is calculated by subtracting used service/prior authorization line item amounts on T_PA_ITEM_DTL_XREF from authorized line item units.	9	Number (Integer)		Calculated Field

2.8.2.5 Associated Programs

Program	Description
No associated Programs found.	

2.8.2.6 Associated Requirements

ID
No associated Requirements found.

2.8.2.7 Change Orders

ID	Name	Description
2936	Mass Updates - Old Provider	Mass updates of providers will be a two-step process. The first step end dates the old provider's PAs so that claims will not pay past the effective date for the new provider. The old provider is given time to submit claims for payment. The second step updates authorized units and amounts for the old provider with what has been used to date. PAs are then created for the new provider with the remaining authorized units and amounts from the original PA. This change order is for the first step in the process of end dating the old provider's PAs. • The old provider's PAs are end dated with the effective date of the provider change less one day. The prior auth numbers are saved for later use in Step 2;

ID	Name	Description
		• Create reason code record for the PA to explain end dating the PA (the reason code is on the input parm); • Create letter of notification to old provider; • Create SHPS transactions of PA changes; and, • Create report of PAs selected for mass change.

2.8.3 PAU-0141-R -- Mass Update New Provider

The mass update of prior auth providers is a two-step process. This report is generated out of the second step in the process. The report lists authorizations that are created for the new provider with remaining units/amounts of PA services that are being transferred from the original provider to the new provider.

The first step in the PA provider mass update process end-dates the original provider's service/prior authorizations so that claims do not pay past the effective date for the new provider. The original provider is given time to submit claims for payment against the original PA. Used units/amounts are recorded at the time a claim is paid. The second step updates a PA's authorized units and amounts for the original provider with what has been used to date. A new service/prior auth is then created for the new provider with the remaining unused authorized units and amounts from the original service/prior authorization.

2.8.3.1 Technical Name

PAU-0141-R

2.8.3.2 Sort Order

PA Number, PA Line Item Number.

2.8.3.3 Mass Update New Provider Layout

```
Report    : PAU-0141-R                          COMMONWEALTH OF KENTUCKY                          RUN DATE : MM/DD/CCYY
Process   : PAUJR141                       MEDICAID MANAGEMENT INFORMATION SYSTEM               RUN TIME:    99:99:99
Location  : PAUPR141                           NEW PROVIDER MASS UPDATE RESULTS                     PAGE:         999

                                               ********* FINAL REPORT *********

          ------ PA NUMBER ----   LINE   SERVICE CODE    ------ TRANFERRED -------      AUTHORIZED DATES
             NEW          OLD     ITEM   FROM     TO        UNITS        AMOUNT         BEGIN       END

           XXXXXXXXXX  XXXXXXXXXX   XX    XXXXX   XXXXX   9,999,999    9,999,999.99    XX/XX/XX   XX/XX/XX
           XXXXXXXXXX  XXXXXXXXXX   XX    XXXXX   XXXXX   9,999,999    9,999,999.99    XX/XX/XX   XX/XX/XX
           XXXXXXXXXX  XXXXXXXXXX   XX    XXXXX   XXXXX   9,999,999    9,999,999.99    XX/XX/XX   XX/XX/XX
           XXXXXXXXXX  XXXXXXXXXX   XX    XXXXX   XXXXX   9,999,999    9,999,999.99    XX/XX/XX   XX/XX/XX
           XXXXXXXXXX  XXXXXXXXXX   XX    XXXXX   XXXXX   9,999,999    9,999,999.99    XX/XX/XX   XX/XX/XX

                                          *** END OF REPORT ***
                                        *** NO DATA THIS REPORT ***
```

2.8.3.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Authorized Dates Begin	Authorized start date for the service/prior authorization line item for the new provider.	8	Character	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Authorized Dates End	Authorized end date for the service/prior authorization line item for the new provider.	8	Character	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Line Item	Line item number associated with the new service/prior authorization number.	2	Character	T_PA_LINE_ITEM	NUM_PA_LINE_ITEM
PA Number New	Prior authorization number for the PA created for the services transferred from the original provider to the new provider.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUMBER
PA Number Old	Original service/prior authorization number.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUMBER
Service Code From	Beginning range for a service code on a service/prior authorization.	5	Character	T_PA_LINE_ITEM / T_REVENUE_CODE / T_PROC	CDE_SVC_TYPE/ CDE_REVENUE / CDEPROC
Service Code To	Ending range for a service code on a service/prior authorization.	5	Character	T_PA_LINE_ITEM / T_REVENUE_CODE / T_PROC	CDE_SVC_TYPE/ CDE_REVENUE / CDE_PROC
Transferred Amount	Dollar amount for the service/prior authorization line item service transferred to the new provider from the original provider.	9	Number (Decimal)	T_PA_LINE_ITEM	AMT_PA_AUTH

Field	Description	Length	Data Type	DB Table	DB Attributes
Transferred Units	Number of units transferred from the original provider to the new provider.	9	Number (Integer)	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH

2.8.3.5 Associated Programs

Program	Description
paupr141	Mass update - new provider
copy2routedir	Copy Reports to Router

2.8.3.6 Associated Requirements

ID
30.090.005.002.13

2.8.3.7 Change Orders

ID	Name	Description
2756	Mass Updates - New Provider	Mass updates of providers will be a two step process. The first step end dates the old provider's PAs so that claims will not pay past the effective date for the new provider. The old provider is given time to submit claims for payment. The second step updates authorized units and amounts for the old provider with what has been used to date. PAs are then created for the new provider with the remaining authorized units and amounts from the original PA. This change order is for the second step in the process of creating PAs for the new provider. • Update used units and amounts for old provider; • Create PA for new provider; • Create reason code record for the PA to explain end dating the PA (the reason code is on the input parm); • Create letter of notification to new provider; • Create SHPS transactions of PA changes; and, • Create report of PAs created for new provider.

2.8.4 PAU-0142-R -- Mass Update Rate Service Code

Rate and service code changes for a service/prior authorization line item may be made by an automated mass update process. The process generates this report which lists overrides for either a rate or service code on a service/prior authorization line item. Claims access the override when paying a claim using a service/prior authorization.

A heading of 'Preliminary Report' indicates the report is for a preliminary run to verify the correct updates are being made. No database updates are made or letters generated on a preliminary run. A heading of 'Final Report' indicates all updates were made and letters were generated during the mass update process.

2.8.4.1 Technical Name

PAU-0142-R

2.8.4.2 Sort Order

PA Number, PA Line Item Number.

2.8.4.3 Mass Update Rate Service Code Layout

```
Report    : PAU-0142-R                          COMMONWEALTH OF KENTUCKY                          RUN DATE: MM/DD/CCYY
Process   : PAUJR142                       MEDICAID MANAGEMENT INFORMATION SYSTEM               RUN TIME:   99:99:99
Location  : PAUPR142                            RATE/SERVICE CODE MASS UPDATE                       PAGE:        999

                                      ************  FINAL REPORT  *************

 PA NUMBER     LINE      ------- RATE --------      --------------- SERVICE CODE -----------      -----EFFECTIVE DATES -----
               ITEM       OLD              NEW      OLD FROM   NEW FROM   OLD THRU  NEW THRU        BEGIN            END

 XXXXXXXXXX     XX      9.999.999  9,999,999.99     XXXXX      XXXXX      XXXXX     XXXXX        XX/XX/XXXX       XX/XX/XXXX
 XXXXXXXXXX     XX      9.999.999  9,999,999.99     XXXXX      XXXXX      XXXXX     XXXXX        XX/XX/XXXX       XX/XX/XXXX
 XXXXXXXXXX     XX      9.999.999  9,999,999.99     XXXXX      XXXXX      XXXXX     XXXXX        XX/XX/XXXX       XX/XX/XXXX
 XXXXXXXXXX     XX      9.999.999  9,999,999.99     XXXXX      XXXXX      XXXXX     XXXXX        XX/XX/XXXX       XX/XX/XXXX
 XXXXXXXXXX     XX      9.999.999  9,999,999.99     XXXXX      XXXXX      XXXXX     XXXXX        XX/XX/XXXX       XX/XX/XXXX
 XXXXXXXXXX     XX      9.999.999  9,999,999.99     XXXXX      XXXXX      XXXXX     XXXXX        XX/XX/XXXX       XX/XX/XXXX
 XXXXXXXXXX     XX      9.999.999  9,999,999.99     XXXXX      XXXXX      XXXXX     XXXXX        XX/XX/XXXX       XX/XX/XXXX
 XXXXXXXXXX     XX      9.999.999  9,999,999.99     XXXXX      XXXXX      XXXXX     XXXXX        XX/XX/XXXX       XX/XX/XXXX

                                         *** END OF REPORT ***
                                       *** NO DATA THIS RUN ***
```

2.8.4.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
EFFECTIVE BEGIN DATE	Start date for either the rate or service code mass change that acts as an override for a line item authorized begin date. Claims first check these begin and end dates to see if an override is in effect during a claim's service dates.	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD	DTE_EFFECTIVE
EFFECTIVE END DATE	End date for either the rate or service code mass change that acts as an override for a line item authorized end date. Claims first check these begin and end dates to see if an override is in effect during a claim's service dates.	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD	DTE_END
LINE ITEM	The line item number associated with the service/prior authorization number.	2	Character	T_PA_LINE_ITEM	NUM_PA_LINE_ITEM
NEW RATE	Current dollar amount authorized for the service/prior authorization line item service (input parameter).	9	Number (Decimal)	T_SYSTEM_PARMS	DSC_30 (INPUT PARM)
OLD RATE	Previous dollar amount authorized for the service/prior authorization line item service.	9	Number (Decimal)	T_PA_LINE_ITEM	AMT_PA_AUTH
PA NUMBER	Unique number assigned to a service/prior authorization.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
SERVICE CODE - NEW FROM	Line item service code that is the replacement service code for a service code mass update.	5	Character	T_SYSTEM_PARMS	DSC_30 (INPUT PARM)

Field	Description	Length	Data Type	DB Table	DB Attributes
SERVICE CODE - NEW THRU	Ending range for the new service code. If there is no ending range, the default is -1.	5	Character	T_SYSTEM_PARMS	DSC_30 (INPUT PARM)
SERVICE CODE - OLD FROM	Line Item Service code that matches the input parameter for either a rate or service code change.	5	Character	T_SYSTEM_PARMS	DSC_30 (INPUT PARM)
SERVICE CODE - OLD THRU	Ending range that matches the input parameter for the original service code. If there is no ending range, the default is -1.	5	Character	T_SYSTEM_PARMS	DSC_30 (INPUT PARM)

2.8.4.5 Associated Programs

Program	Description
paupr142	Rate Service Code Mass Update Report
copy2routedir	Copy Reports to Router

2.8.4.6 Associated Requirements

ID
No associated Requirements found.

2.8.4.7 Change Orders

ID	Name	Description
No associated Change Orders found.		

2.8.5 PAU-0210-M -- EPSDT First Time Prior Authorizations

The report displays service/prior authorizations of members with an approved EPSDT service/prior authorization request during the preceding month, who have had no previously approved EPSDT requests.

2.8.5.1 Technical Name

PAU-0210-M

2.8.5.2 Sort Order

Medicaid ID

2.8.5.3 Distribution

OnBase

For readability, the layout displays on the next page.

2.8.5.4 EPSDT First Time Prior Authorizations Layout

```
Report   : PAU-0210-M                    COMMONWEALTH OF KENTUCKY                    RUN DATE: MM/DD/CCYY
Process  : PAUJM210                  MEDICAID MANAGEMENT INFORMATION SYSTEM          RUN TIME:   99:99:99
Location : PAUPM210              EPSDT MEMBERS - 1ST TIME PRIOR AUTHORIZATIONS           PAGE:        999
                                      FOR THE MONTH OF XXXXXXXX CCYY

                                                                  PROVIDER     SERVICE   APPROVED
 MEMBER ID          MEMBER NAME                  PA NUMBER         NUMBER       CODE      UNITS

XXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX  XXXXXXXXXX  XXXXX  9,999,999
XXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX  XXXXXXXXXX  XXXXX  9,999,999
XXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX  XXXXXXXXXX  XXXXX  9,999,999
XXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX  XXXXXXXXXX  XXXXX  9,999,999
XXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX  XXXXXXXXXX  XXXXX  9,999,999
XXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX  XXXXXXXXXX  XXXXX  9,999,999
XXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX  XXXXXXXXXX  XXXXX  9,999,999
XXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX  XXXXXXXXXX  XXXXX  9,999,999
XXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX  XXXXXXXXXX  XXXXX  9,999,999

    TOTAL MEMBERS: 9,999,999

                                   *** END OF REPORT ***
                                 *** NO DATA THIS REPORT ***
```

2.8.5.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Approved Units	Quantity of authorized service units.	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
Member ID	Member Medicaid identification number.	12	Number	T_RE_BASE	ID_MEDICAID

Field	Description	Length	Data Type	DB Table	DB Attributes
Member Name	Name of the member.	37	Character	T_RE_BASE	NAM_LAST, NAM_FIRST
Month of XXXXXXXXXXXX CCYY	Reporting period.	17	Character	N/A	Calculated Field
PA Number	Service/prior authorization number associated with the member.	10	Number	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Number	Medicaid provider identification number.	10	Character	T_PR_IDENTIFIER	ID_PROVIDER
Service Code	Line item service code.	6	Character	T_REVENUE_CODE, T_PROC	CDE_REVENUE, CDE_PROC
Total Members	A count of unique members listed on the report.	9	Number	N/A	Calculated Field

2.8.5.6 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
paupm210	Create monthly first-time EPSDT services report

2.8.5.7 Associated Requirements

ID
No associated Requirements found.

2.8.5.8 Change Orders

ID	Name	Description
2520	KYAmend PA EPSDT Process	The first time a member receives prior authorization approval for EPSDT services, create a letter of notification that services are no longer available when the member turns 21. Create a report listing members receiving EPSDT services for the first time.

2.8.6 PAU-0220-M1 -- Orthodontic Six Month Progress Report Not Received

This report supports Orthodontic Case Management as part of the service/prior authorization Orthodontic Case Tracking Process. It lists Six Month Orthodontic Progress Reports that have not been received by the Utilization Management unit.

Providers are required to submit specific documentation during the span of a member's orthodontic treatment. The service/prior authorization Orthodontic Status Code is used to track receipt of the documentation from the provider. Based on the code and the service begin date of the authorization, reminder letters are sent to providers and reports created of service/prior authorizations with overdue documentation. The combination of the service/prior authorization Orthodontic Status Code and the service/prior authorization service begin date determine what letters are generated and what service/prior authorizations are displayed on an Ortho Tracking report.

2.8.6.1 Technical Name

PAU-0220-M1

2.8.6.2 Sort Order

Provider ID, Medicaid ID, PA Number, First DOS, Ortho Status, Procedure Code.

2.8.6.3 Distribution

OnBase

2.8.6.4 Orthodontic Six Month Progress Report Not Received Layout

```
Report  :  PAU-0220-M1                          COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process :  PAUJM220                          MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location:  PAUP220                        ORTHODONTIC PRIOR AUTHORIZATION CASE TRACKING                   Page    :      9,999
                                             SIX MONTH PROGRESS REPORT NOT RECEIVED


                          PROVIDER      MEMBER      PRIOR AUTH     FIRST DATE     CLAIM PAID
                           NUMBER       NUMBER        NUMBER        OF SERVICE       AMOUNT

                         XXXXXXXXXX   XXXXXXXXXX   XXXXXXXXXX     MM/DD/CCYY    9,999,999.99
                         XXXXXXXXXX   XXXXXXXXXX   XXXXXXXXXX     MM/DD/CCYY    9,999,999.99
                         XXXXXXXXXX   XXXXXXXXXX   XXXXXXXXXX     MM/DD/CCYY    9,999,999.99
                         XXXXXXXXXX   XXXXXXXXXX   XXXXXXXXXX     MM/DD/CCYY    9,999,999.99


                                          *** END OF REPORT ***
                                       *** NO DATA THIS REPORT ***
```

2.8.6.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Claim Paid Amount	Total amount of paid claims associated with a service/prior authorization.	9	Number (Decimal)	T_PA_ITEM_DTL_XREF	AMT_PA_USED
First Date of Service	Date of first service on a claim associated with a service/prior authorization.	10	Date (MM/DD/CCYY)	T_HIST_DIRECTORY	DTE_FIRST_SVC
Member Number	Member Medicaid identification number.	12	Character	T_RE_BASE	ID_MEDICAID
Prior Auth Number	Unique identifier assigned to a service/prior authorization request.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Number	Unique identifier assigned to a provider.	10	Character	T_PR_IDENTIFIER	ID_PROVIDER

2.8.6.6 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
paupm220	PA Orthodontic Case Tracking Process Reports and Letters

2.8.6.7 Associated Requirements

ID
30.090.005.003.1

2.8.6.8 Change Orders

ID	Name	Description
2519	KYAmend PA Orthodontic Process	The Orthodontic Case Tracking process monitors the submission of required documentation for an Orthodontic service/prior authorization. The automated process identifies overdue documentation and sends reminder letters to providers. In cases where providers have not responded to reminder letters, the overdue documentation is reported for follow-up by the KYMMIS Orthodontic Staff.

2.8.7 PAU-0220-M2 -- Orthodontic Final Case Tracking

This report supports Orthodontic Case Management as part of the service/prior authorization Orthodontic Case Tracking Process. The report lists PAs where the Final Ortho Case documentation has not been received.

Providers are required to submit specific documentation during the span of a member's orthodontic treatment. The service/prior authorization Orthodontic Status Code is used to track receipt of the documentation from the provider. Based on the code and the service begin date of the authorization, reminder letters are sent to providers and reports created of service/prior authorizations with overdue documentation. The combination of the service/prior authorization Orthodontic Status Code and the service/prior authorization service begin date determine what letters are generated and what service/prior authorizations are displayed on a report.

2.8.7.1 Technical Name

PAU-0220-M2

2.8.7.2 Sort Order

PA Number, PA Line Item Number.

2.8.7.3 Distribution

OnBase

For readability, the layout displays on the next page.

2.8.7.4 Orthodontic Final Case Tracking Layout

```
Report  :  PAU-0220-M2                          COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process :  PAUJM220                          MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location:  PAUPM220                       ORTHODONTIC PRIOR AUTHORIZATION CASE TRACKING                       Page:      9,999
                                               FINAL CASE SUBMISSION FORM NOT RECEIVED

                          PROVIDER       MEMBER      PRIOR AUTH     FIRST DATE       CLAIM PAID
                           NUMBER        NUMBER        NUMBER       OF SERVICE         AMOUNT

                          XXXXXXXXXX   XXXXXXXXXX   XXXXXXXXXX     MM/DD/CCYY      9,999,999.99
                          XXXXXXXXXX   XXXXXXXXXX   XXXXXXXXXX     MM/DD/CCYY      9,999,999.99
                          XXXXXXXXXX   XXXXXXXXXX   XXXXXXXXXX     MM/DD/CCYY      9,999,999.99
                          XXXXXXXXXX   XXXXXXXXXX   XXXXXXXXXX     MM/DD/CCYY      9,999,999.99
                          XXXXXXXXXX   XXXXXXXXXX   XXXXXXXXXX     MM/DD/CCYY      9,999,999.99
                          XXXXXXXXXX   XXXXXXXXXX   XXXXXXXXXX     MM/DD/CCYY      9,999,999.99

                                        *** END OF REPORT ***
                                      *** NO DATA THIS REPORT ***
```

2.8.7.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Claim Paid Amount	Total of paid claim amounts associated with a service/prior authorization.	9	Number (Decimal)	T_PA_ITEM_DTL_XREF	AMT_PA_USED
First Date of Service	Date of first service on a claim associated with a service/prior authorization.	10	Date (MM/DD/CCYY)	T_HIST_DIRECTORY	DTE_FIRST_SVC
Member Number	Member Medicaid identification number.	12	Character	T_RE_BASE	ID_MEDICAID
Prior Auth Number	Unique identifier assigned to a service/prior authorization request.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM

Field	Description	Length	Data Type	DB Table	DB Attributes
Provider Number	Unique identifier assigned to a provider.	10	Character	T_PR_IDENTIFIER	ID_PROVIDER

2.8.7.6 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
paupm220	PA Orthodontic Case Tracking Process Reports and Letters

2.8.7.7 Associated Requirements

ID
30.090.005.003.1

2.8.7.8 Change Orders

ID	Name	Description
2519	KYAmend PA Orthodontic Process	The Orthodontic Case Tracking process monitors the submission of required documentation for an Orthodontic service/prior authorization. The automated process identifies overdue documentation and sends reminder letters to providers. In cases where providers have not responded to reminder letters, the overdue documentation is reported for follow-up by the KYMMIS Orthodontic Staff.

2.9 Letters

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

2.9.1 PAU-001A-D -- Waiver Member Letter

This letter is generated for waiver service/prior authorizations. It is created and sent to a member when all requested services on the service/prior authorization are in a finalized status (Approved or Denied).

2.9.1.1 Technical Name

PAU-001A-D

2.9.1.2 Waiver Member Letter Layout

Current Date Provider Number

Member Name
Member Address Line1
Member Address Line2
City, State Zip-Zip4

Subject: Prior Authorization of waiver services
Member Name : XXXXXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXX Member ID : XXXXXXXXX
Level of Care From Effective Date To End Date

Dear Member Name:

The authorization for waiver services by Provider XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, Provider Number, has been reviewed.

The following service units have been requested:

Service Code	Service Name	Monthly # Units	Service Begin	Service End
1. XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXX	9,9999,999	MM/DD/CCYY	MM/DD/CCYY
2. XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXX	9,9999,999	MM/DD/CCYY	MM/DD/CCYY

The following service units have been requested and approved on PA# XXXXXXXXXX:

Service Code	Service Name	Monthly # Units	Service Begin	Service End
1. XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXX	9,9999,999	MM/DD/CCYY	MM/DD/CCYY
2. XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXX	9,9999,999	MM/DD/CCYY	MM/DD/CCYY

The following service units have been requested and denied:

Service Code	Service Name	Monthly # Units	Service Begin	Service End
1.	N/A			
Reason:			NONE	

Sincerely,

KYMMIS Prior Authorization Unit

2.9.1.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
City	Member's mailing address city.	18	Character	T_RE_MULTI_ADDRESS	ADR_CITY
Current Date	The date the letter was generated.	8	Date (Month DD, CCYY)	N/A	CALCULATED FIELD
Effective Date	Begin date of the level of care.	8	Date (MM/DD/CCYY)	T_RE_ASSIGN_PLAN	DTE_EFFECTIVE
End Date	End date of the level of care	8	Date (MM/DD/CCYY)	T_RE_ASSIGN_PLAN	DTE_END
Member Address Line1	Member's mailing address line 1.	30	Character	T_RE_MULTI_ADDRESS	ADR_STREET_1
Member Address Line2	Member's mailing address line 2.	30	Character	T_RE_MULTI_ADDRESS	ADR_STREET_2
Member ID	The member Medicaid identification number.	12	Character	T_RE_BASE	ID_MEDICAID
Monthly Units	The number of units approved for the service/prior authorization.	9	Number	T_PA_PAUTH	QTY_UNT_SVC_ATH
PA #	The service/prior authorization number associated with the letter.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Name	The provider name.	50	Character	T_PR_NAM	NAME
Provider Number	The provider identification number.	15	Character	T_PR_IDENTIFIER	ID_PROVIDER
Member Name	The member name.	36	Character	T_RE_BASE	NAM_FIRST + NAME_MID_INIT+ NAM_LAST

Field	Description	Length	Data Type	DB Table	DB Attributes
Service Begin	The date the service/prior authorization begins.	8	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_PA_AUTH_EFF
Service Code	The service code.	5	Character	T_PROC/T_REVENUE	CDE_PROC/ CDE_REVENUE
Service End	The date the service/prior authorization ends.	8	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_PA_AUTH_END
Service Name	The service code description.	40	Character	T_PROC/T_REVENUE	DSC_PROCECURE/DSC_REV_CODE
State	Member's mailing address state.	2	Character	T_RE_MULTI_ADDRESS	ADR_STATE
Zip	Member's mailing address zip.	5	Character	T_RE_MULTI_ADDRESS	ADR_ZIP_CODE
Zip 4	Member's mailing address zip-4.	4	Character	T_RE_MULTI_ADDRESS	ADR_ZIP_CODE_4

2.9.1.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.1.5 Associated Requirements

ID
30.050.005.002.14

2.9.1.6 Change Orders

ID	Name	Description
2224	Create Prior Auth Letters	MHMR adjudicates and enters service/prior authorizations into the MMIS for SCL and ABI Waivers. Produce PA notices for the member, provider, and for the member's Department of Community Based Services (DCB) office.

2.9.2 PAU-001B-D -- Waiver Provider Letter

This letter is generated for waiver service/prior authorizations. It is created and sent to a provider when all requested services on the service/prior authorization are in a finalized status (Approved or Denied).

2.9.2.1 Technical Name

PAU-001B-D

2.9.2.2 Waiver Provider Letter Layout

Current Date

Provider Name
Provider Address Line1
Provider Address Line2
City, State Zip-Zip4

Subject: Prior Authorization of waiver services
Member Name : XXXXXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXX New Member ID : XXXXXXXXX
Level of Care From Effective Date To End Date Original ID: XXXXXXXXXX

Dear Provider Name:

The authorization for waiver services by Provider XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, Provider Number, has been reviewed.

The following service units have been requested:

Service Code	Service Name	Monthly # Units	Service Begin	Service End
1. XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	9,9999,999	MM/DD/CCYY	MM/DD/CCYY
2. XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	9,9999,999	MM/DD/CCYY	MM/DD/CCYY

The following service units have been requested and approved, PA# XXXXXXXXXX:

Service Code	Service Name	Monthly # Units	Service Begin	Service End
1. XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	9,9999,999	MM/DD/CCYY	MM/DD/CCYY
2. XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	9,9999,999	MM/DD/CCYY	MM/DD/CCYY

The following service units have been requested and denied:

Service Code	Service Name	Monthly # Units	Service Begin	Service End
1.		N/A		
Reason			None	

Sincerely,

KYMMIS Prior Authorization Unit

2.9.2.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
City	Provider address city.	18	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	The date the letter was generated.	8	Date (Month DD, CCYY)	N/A	CALCULATED FIELD
Effective Date	The begin date of the level of care	8	Date (MM/DD/CCYY)	T_RE_ASSIGN_PLAN	DTE_EFFECTIVE
End Date	The end date of the level of care.	8	Date (MM/DD/CCYY)	P_RE_ASSIGN_PLAN	DTE_END
New Member ID	The Member Medicaid identification number.	9	Character	T_RE_BASE	ID_MEDICAID
Monthly Units	The number of units approved for the service/prior authorization.	9	Number	T_PA_LINE_ITEM	QTY_FREQ_AUTH
PA #	The service/prior authorization associated with the letter.	9	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Address Line1	Provider address line 1.	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Provider Address Line2	Provider address line 2.	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Provider Name	The provider name.	50	Character	T_PR_NAM	NAME
Provider Number	The provider identification number.	15	Number	T_PR_IDENTIFIER	ID_PROVIDER
Reason	Denial reason code description.	509	Character	T_PA_IAC_XREF	CDE_IAC + DSC_IAC
Reason Code	Reason code for denial.	9	Character	T_PA_IAC_XREF	CDE_IAC

Field	Description	Length	Data Type	DB Table	DB Attributes
Member Name	Member associated with the service/prior authorization letter.	20	Character	T_RE_BASE	NAM_LAST +NAM_FIRST + NAM_MID_INIT
Original ID	First ID issued to a Member	12	Character	T_RE_OLD_PCN	ID_MED_RECIP_ PREV
Service Begin	The date the service/prior authorization begins.	8	Date (MM/DD/CC YY)	T_PA_PAUTH	DTE_PA_AUTH_ EFF
Service Code	The service code.	6	Character	T_PROC/T_REVE NUE/T_DRUG	CDE_PROC/ CDE_REVENUE/ CDE_NDC
Service End	The date the service/prior authorization ends.	8	Date (MM/DD/CC YY)	T_PA_PAUTH	DTE_PA_AUTH_ END
Service Name	The service code description.	40	Character	T_PROC/T_REVE NUE/T_DRUG	DSC_PROCECU RE/DSC_REV_C ODE/DSC_NDC
State	Provider address state.	2	Character	T_PR_ADR	ADR_MAIL_STAT E
Zip	Provider address zip code.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
Zip4	Provider address zip-4.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

2.9.2.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.2.5 Associated Requirements

ID
30.050.005.002.14

2.9.2.6 Change Orders

ID	Name	Description
2224	Create Prior Auth Letters	MHMR adjudicates and enters service/prior authorizations into the MMIS for SCL and ABI Waivers. Produce PA notices for the member, provider, and for the member's Department of Community Based Services (DCB) office.

2.9.3 PAU-001D-D -- Home Health Provider Letter

This letter is generated for service providers specified on Home Health service/prior authorizations. It is created and sent to the service provider when all requested services on the service/prior authorization are in a finalized status (Approved).

2.9.3.1 Technical Name

PAU-001D-D

2.9.3.2 Home Health Provider Letter Layout

Current Date

Provider Name
Address 1
Address 2
City, State Zip-Zip4

Subject: Prior Authorization of Home Health Services
Member Name: XXXXXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXX
New Member ID: XXXXXXXXXX
Original Member ID: XXXXXXXXXX

Dear Provider Name:

The authorization for Home Health Services has been reviewed.

The following service units have been requested and approved on PA # XXXXXXXXX

	Code	Procedure Name	#Units	Service Begin	Service End
1.	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	9,9999,999	MM/DD/CCYY	MM/DD/CCYY

Sincerely,

KYMMIS Prior Authorization Unit

2.9.3.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
#Units	The number of units approved for the service/prior authorization.	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
Address1	Provider address line 1.	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Address2	Provider address line 2.	30	Character	T_PR_ADR	ADR_MAIL_STRT2
City	Provider address city.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Code	The service code.	6	Character	T_PROC/T_REVENUE_CODE/T_DRUG	CDE_PROC/CDE_REVENUE/CDE_NDC
Current Date	The date the letter was generated.	8	Date (Month DD, CCYY)	N/A	CALCULATED FIELD
PA #	The service/prior authorization associated with the letter.	9	Number	T_PA_PAUTH	PRIOR_AUTH_NUM
Procedure Name	The service code description.	40	Character	T_PROC/T_REVENUE_CODE/T_DRUG	DSC_PROCEDURE/DSC_REV_CODE/DSC_NDCc
Provider Name	The provider name.	50	Character	T_PR_NAM	NAME
Provider Number	The provider identification number.	15	Character	T_PR_IDENTIFIER	ID_PROVIDER
Member Name	Member associated with the service/prior authorization letter.	20	Character	T_RE_BASE	NAM_FIRST+ NAM_MID_INIT + NAM_LAST
New Member ID	Current Member Medicaid ID	12	Character	T_RE_BASE	ID_MEDICAID
Original ID	First ID issued to a Member	12	Character	T_RE_OLD_PCN	ID_MED_RECIP_PREV

Field	Description	Length	Data Type	DB Table	DB Attributes
Service Begin	The date the service/prior authorization begins.	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Service End	The date the service/prior authorization ends.	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_END
State	Provider address state.	2	Character	T_PR_ADR	ADR_MAIL_STATE
Zip	Provider address zip code.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
Zip4	Provider address zip-4.	4	Number	T_PR_ADR	ADR_MAIL_ZIP_4

2.9.3.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.3.5 Associated Requirements

ID
30.050.005.002.14

2.9.3.6 Change Orders

ID	Name	Description
2521	KYAmend Create Add'l PA Letters	Create PA approval letters excluding Waivers (completed in a separate CO2224)

2.9.4 PAU-001E-D -- Home Health Member Letter

This letter is generated for a member specified on a Home Health service/prior authorization. It is created and sent to the member when all requested services on the service/prior authorization are in a finalized status (Approved).

2.9.4.1 Technical Name

PAU-001E-D

For readability, the layout displays on the next page.

2.9.4.2 Home Health Member Letter Layout

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
275 E. Main Street, 6W-A
Frankfort, Kentucky 40621
(502) 564-4321 Voice - (502) 564-0509 Fax
www.chfs.ky.gov

Ernie Fletcher
Governor

Mark D. Birdwhistell
Secretary

Shawn M. Crouch
Commissioner

DECEMBER 04, 2007
JANE DOE
100 ANY STREET
ANYWHERE, KY 00000-0000

Subject: Prior Authorization of Home Health Services

Dear JANE DOE:
The authorization for Home Health Services by Provider XXXXX HEALTH DEPARTMENT, 34000000 has been reviewed.

The following service units have been requested and approved on PA #0000000000

Code	Service Name	# Units	Service Begin	Service End
1. 550	SKILLED NURSING GERERAL CLASSIFICATION	2	11/30/2007	01/28/2008
2. 570	HOME HEALTH AIDE GENERAL CLASSIFICATION	45	11/30/2007	01/28/2008
3. 270	MEDICAL SUPPLIES GENERAL CLASSIFICATION	320	11/30/2007	01/28/2008

Sincerely,

KYMMIS Prior Authorization Unit

KentuckyUnbridledSpirit.com

Kentucky UNBRIDLED SPIRIT

An Equal Opportunity Employer M/F/D

2.9.4.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	The member's mailing address line 1.	30	Character	T_RE_MULTI_ADDRESS	ADR_STREET_1
Address2	The member's mailing address line 2.	30	Character	T_RE_MULTI_ADDRESS	ADR_STREET_2
City	The member's mailing address city.	18	Character	T_RE_MULTI_ADDRESS	ADR_CITY
Code	The service code.	6	Character	T_PROC/T_REVENUE_CODE/T_DRUG	CDE_PROC/ CDE_REVENUE/ CDE.NDC
Current Date	The date the letter was generated.	8	Date (Month DD, CCYY)	N/A	CALCULATED
PA #	The service/prior authorization associated with the letter	9	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Procedure Name	The service code description.	40	Character	T_PROC/T_REVENUE_CODE/T_DRUG	DSC_PROCECURE/DSC_REV_CODE/DSC_NDC
Provider Name	The provider name.	50	Character	T_PR_NAM	NAME
Provider Number	The provider identification number.	15	Character	T_PR_IDENTIFIER	ID_PROVIDER
Member Name	Member associated with the service/prior authorization.	20	Character	T_RE_BASE	NAM_FIRST + NAM_LAST
Service Begin	The date the service/prior authorization begins.	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Service End	The date the service/prior authorization ends.	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_END
State	The member's mailing address state.	2	Character	T_RE_MULTI_ADDRESS	ADR_STATE

Field	Description	Length	Data Type	DB Table	DB Attributes
Units	The number of units approved for the service/prior authorization.	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_AUTH
Zip	The member's mailing address zip.	5	Number	T_RE_MULTI_ADDRESS	ADR_ZIP_CODE
Zip 4	The member's mailing address zip-4.	4	Number	T_RE_MULTI_ADDRESS	ADR_ZIP_CODE_4

2.9.4.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.4.5 Associated Requirements

ID
30.050.005.002.14

2.9.4.6 Change Orders

ID	Name	Description
2521	KYAmend Create Add'l PA Letters	Create PA approval letters excluding Waivers (completed in a separate CO2224)

2.9.5 PAU-001F-D -- Impact Plus Provider Letter

This letter is generated for a service provider specified on an Impact Plus service/prior authorization. It is created and sent to the service provider when all requested services on the service/prior authorization are in a finalized status (Approved or Denied).

2.9.5.1 Technical Name

PAU-001F-D

2.9.5.2 Impact Plus Provider Letter Layout

Current Date Provider Number

Provider Name
Address 1
Address 2
City, State Zip-Zip4

Subject: Prior Authorization Approval/Denial
New Member ID: XXXXXXXXXX Original Member ID: XXXXXXXXXX

Dear Provider Name:

The authorization for Services submitted Received Date, for Member Name, Member ID, has been reviewed. The service(s) requested are listed below:

Procedure	--- Mod ---	Tax ID
XXXXXX	XXXXX	999999999 XX
XXXXXX	XXXXX	999999999 XX
XXXXXX	XXXXX	999999999 XX

The following item(s) have been approved:

Procedure	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX	XX XX XX XX	Approved	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY
XXXXX	XX XX XX XX	Denied	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY
XXXXX	XX XX XX XX	Denied	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY

If approved your prior authorization number is XXXXXXXXXX

The following item(s) have been denied:

Procedure	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
None						

This prior authorization does not guarantee payment. In order for you to receive payment, the recipient must be eligible on the date of service. Always check the recipient's Medicaid card to verify eligibility.

If you, as the provider, have any questions regarding this prior authorization approval/denial, contact KYMMIS Prior Authorization unit.

Sincerely,

2.9.5.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Amount	Amount authorized.	9	Number	T_PA_LINE_ITEM	AMT_PA_AUTH
Begin Date	The date the service/prior authorization begins.	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Current Date	The date the letter was generated.	8	Date (Month DD, CCYY)		CALCULATED FIELD
End Date	The date the service/prior authorization ends.	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Member ID	The member Medicaid identification number.	9	Character	T_RE_BASE	ID_MEDICAID
Member Name	Member associated with the service/prior authorization letter.	20	Character	T_RE_BASE	NAM_LAST +NAM_FIRST + NAM_MID_INIT
Mod	The modifiers.	8	Character	T_PA_LINE_ITEM	CDE_PROC_MOD+CDE_PROC_MOD2+CDE_PROC_MOD3+CDE_PROC_MOD4
New Member ID	Current Member Medicaid ID	12	Character	T_RE_BASE	ID_MEDICAID
Original ID	First ID issued to a Member	12	Character	T_RE_OLD_PCN	ID_MED_RECIP_PREV
Prior Authorization Number	The service/prior authorization number associated with the letter.	9	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Procedure	The service code.	6	Character	T_PROC/T_REVENUE/T_DRUG	CDE_PROC/ CDE_REVENUE/ CDE.NDC
Provider Address1	Provider address line 1.	30	Character	T_PR_ADR	ADR_MAIL_STRT1

Field	Description	Length	Data Type	DB Table	DB Attributes
Provider Address2	Provider address line 2.	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Provider City	Provider address city.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Provider Name	The provider name.	50	Character	T_PR_NAM	NAME
Provider Number	The provider identification number.	9	Number	T_PR_IDENTIFIER	ID_PROVIDER
Provider State	Provider address state.	2	Character	T_PR_ADR	ADR_MAIL_STATE
Provider Zip	Provider address zip code.	5	Number	T_PR_ADR	ADR_MAIL_ZIP
Provider Zip4	Provider address zip-4.	4	Number	T_PR_ADR	ADR_MAIL_ZIP_4
Quantity	The number of units approved for the service/prior authorization.	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
Reason	Reason code and description of denial (if any).	509	Character	T_PA_IAC_XREF	CDE_IAC + DSC_IAC
Received Date	The date the Impact Plus was submitted.	8	Number	T_PA_PAUTH	DTE_RECEIVED
Services	The description of the service.	30	Character	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
Status	The line item status.	20	Character	T_PA_LINEITEM_STAT	DSC_STATUS
Tax ID	The Tax ID and Sub ID - use the converted Tax and Sub ID if available. If not, use the Provider ID for "Vendor".	11	Character	T_PA_LINE_ITEM/T_PR_IDENTIFIER	ID_IMPACT_TAX +ID_IMPACT_SUB/ID_PROVIDER

2.9.5.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.5.5 Associated Requirements

ID
30.050.005.002.14

2.9.5.6 Change Orders

ID	Name	Description
2521	KYAmend Create Add'l PA Letters	Create PA approval letters excluding Waivers (completed in a separate CO2224)

2.9.6 PAU-001G-D -- Other PA Types Provider Letter

This letter is generated for a service provider specified on a service prior authorization for other PA Category types (for example, Physician, EPSDT, or DME). It is created and sent to the service provider when all requested services on the service/prior authorization are in a finalized status (Approved or Denied).

2.9.6.1 Technical Name

PAU-001G-D

2.9.6.2 Other PA Types Provider Letter Layout

Current Date Provider Number

Provider Name
Address 1
Address 2
City, XX XXXXX-XXXX

Subject: Prior Authorization Approval/Denial
New Member ID: XXXXXXXXXX Original Member ID: XXXXXXXXXX

Dear Provider Name:

The authorization for Services submitted Month Name DD, CCYY, for Member Name, Member ID, has been reviewed. The service(s) requested are listed below:

Procedure	-- Mod --	Quantity	Amount
XXXXX - XXXXX	XX XX XX XX	9,999,999	9.999.999.00
XXXXX - XXXXX	XX XX XX XX	9,999,999	9.999.999.00
XXXXX - XXXXX	XX XX XX XX	9,999,999	9.999.999.00

The following item(s) have been approved:

Procedure	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX - XXXXX	XX XX XX XX	Approved	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY
XXXXX - XXXXX	XX XX XX XX	Denied	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY
XXXXX - XXXXX	XX XX XX XX	Denied	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY

If approved your prior authorization number is XXXXXXXXXX.

The following item(s) have been denied:

Procedure	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
None						

This prior authorization does not guarantee payment. In order for you to receive payment, the recipient must be eligible on the date of service. Always check the recipient's Medicaid card to verify eligibility.

If you, as the provider, have any questions regarding this prior authorization approval/denial, contact KYMMIS Prior Authorization Unit.

Sincerely,

KYMMIS Prior Authorization Unit

2.9.6.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Amount	Amount authorized.	9	Number (Decimal)	T_PA_LINE_ITEM	AMT_PA_AUTH
Begin Date	The date the service/prior authorization begins.	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Current Date	The date the letter was generated.	8	Date (Month DD, CCYY)		CALCULATED FIELD
End Date	The date the service/prior authorization ends.	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Member ID	The member Medicaid identification number.	9	Character	T_RE_BASE	ID_MEDICAID
Member Name	Member associated with the service/prior authorization letter.	20	Character	T_RE_BASE	NAM_LAST +NAM_FIRST + NAM_MID_INIT
Mod	The modifiers.	8	Character	T_PA_LINE_ITEM	CDE_PROC_MOD+CDE_PROC_MOD2+CDE_PROC_MOD3+CDE_PROC_MOD4
New Member ID	Current Member Medicaid ID	12	Character	T_RE_BASE	ID_MEDICAID
Original ID	First ID issued to a Member	12	Character	T_RE_OLD_PCN	ID_MED_RECIP_PREV
Prior Authorization Number	The service/prior authorization associated with the letter.	9	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Procedure	The service code.	6	Character	T_PROC/T_REVENUE/T_DRUG	CDE_PROC/ CDE_REVENUE/ CDE.NDC
Provider Address1	Provider address line 1.	30	Character	T_PR_ADR	ADR_MAIL_STRT1

Field	Description	Length	Data Type	DB Table	DB Attributes
Provider Address2	Provider address line 2.	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Provider City	Provider address city.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Provider Name	The provider name.	50	Character	T_PR_NAM	NAME
Provider Number	The provider identification number.	9	Number	T_PR_IDENTIFIER	ID_PROVIDER
Provider State	Provider address state.	2	Character	T_PR_ADR	ADR_MAIL_STATE
Provider Zip	Provider address zip code.	5	Number	T_PR_ADR	ADR_MAIL_ZIP
Provider Zip4	Provider address zip-4.	4	Number	T_PR_ADR	ADR_MAIL_ZIP_4
Quantity	The number of units approved for the service/prior authorization.	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
Reason	Reason code description of denial (if any).	503	Character	T_PA_IAC_XREF	CDE_IAC + DSC_IAC
Received Date	The date the EPSDT Special Services was submitted.	8	Number	T_PA_PAUTH	DTE_RECEIVED
Services	The description of the service	30	Character	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
Status	The line item status.	20	Character	T_PA_LINEITEM_STAT	DSC_STATUS

2.9.6.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.6.5 Associated Requirements

ID
30.050.005.002.14

2.9.6.6 Change Orders

ID	Name	Description
2521	KYAmend Create Add'l PA Letters	Create PA approval letters excluding Waivers (completed in a separate CO2224)

2.9.7 PAU-001H-D -- Inpatient NF Provider Letter

This letter is generated for the service provider specified on an Inpatient/Nursing Facility type of service/prior authorization. It is created and sent to the service provider when all requested services are in a finalized status.

2.9.7.1 Technical Name

PAU-001H-D

2.9.7.2 Inpatient NF Provider Letter Layout

Kentucky Department For Medicaid Services
Prior Authorization Notice

Current Date

Service Provider Name;
Service Provider Address Line1
Service Provider Address Line2
Service City, State Zip-Zip4

Subject: Prior Authorization for (PA Category Description) stay
Prior Authorization Number: XXXXXXXXXX

Member Name : XXXXXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXX
Member ID : XXXXXXXXX
Admit Date: XXXX/XXXX

Stay authorized for 9,999 (authorized quantity) days from MM/DD/CCYY (authorized begin date) through MM/DD/CCYY (authorized end date)
Requesting Provider: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Requesting Provider ID:
Requesting Provider Address Line1
Requesting Provider Address Line2
Requesting City, State Zip-Zip4

This prior authorization does not guarantee payment. In order for you to receive payment, the recipient must be eligible on the date of service. Always check the recipient's medical card to verify eligibility.

Sincerely,

KYMMIS Prior Authorization Unit

2.9.7.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Admit Date	Date member admitted to a facility.	8	Number	T_PA_PAUTH_STATE	DTE_ADMISSION
Authorized Begin Date	Authorized date for stay to begin in in-patient facility.	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Authorized Date End	In-patient stay is authorized through this date.	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Authorized Quantity	Authorized number of days for a stay in an in-patient facility.	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
Current Date	Date the letter was generated.	8	Date (MM/CCYY)		CALCULATED FIELD
Member ID	Member's Medicaid identification number.	10	Character	T_RE_BASE	ID_MEDICAID
Member Name First	Member's name: first, middle initial and last name.	36	Character	T_RE_BASE	NAM_FIRST,NAM_MID_INIT,NAM_LAST
PA Category Description	Type of service/prior authorization being requested.	30	Character	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
Prior Authorization Number	Unique number identifying the service/prior authorization.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Requesting Provider Address 1	Requesting provider address line 1.	50	Character	T_PR_ADR	ADR_MAIL_STR1
Requesting Provider Address 2	Requesting provider address 2.	50	Character	T_PR_ADR	ADR_MAIL_STR2
Requesting Provider City	Requesting provider address city.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Requesting Provider ID	Requesting provider Medicaid identifier.	10	Character	T_PR_IDENTIFIER	ID_IDENFITIER
Requesting Provider	Requesting	50	Character	T_PR_NAM	NAME

Field	Description	Length	Data Type	DB Table	DB Attributes
Name	provider's name.				
Requesting Provider State	Requesting provider state.	20	Character	T_PR_ADR	ADR_MAIL_STATE
Requesting Provider Zip	Requesting provider zip code.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
Requesting Provider Zip 4	Requesting provider zip code +4.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4
Service Provider Address 2	Service provider address line 2.	30	Character	T_PR_ADR	ADR_MAIL_STR2
Service Provider Address1	Service provider address line 1.	30	Character	T_PR_ADR	ADR_MAIL_STR1
Service Provider City	Service provider city.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Service Provider Name	Name of the rendering provider.	50	Character	T_PR_NAM	NAME
Service Provider State	Service provider state.	30	Character	T_PR_ADR	ADR_MAIL_STATE
Service Provider Zip	Service provider zip code.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
Service Provider Zip 4	Service provider zip code + 4.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

2.9.7.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.7.5 Associated Requirements

ID
No associated Requirements found.

2.9.7.6 Change Orders

ID	Name	Description
No associated Change Orders found.		

2.9.8 PAU-0140-RL -- Mass Update Old Provider Letter

This letter is generated out of the first step in the service/prior authorization provider mass update process. The letter notifies the original service provider on the service/prior authorization that the services have been end dated effective the date of transfer less one day.

2.9.8.1 Technical Name

PAU-0140-RL

2.9.8.2 Mass Update Old Provider Letter Layout

Current Date (Month DD, CCYY)

Provider Name
Address 1
Address 2
City, State Zip-Zip4

Subject: Prior Authorization XXXXXXXXXX

Dear Provider Name:

Due to [*Reason Code Description e.g. Provider transfer of ownership*] previously authorized service(s) submitted Received Date (MM/DD/CCYY), for Member Name, Member ID, have been end dated as of End Dated (MM/DD/CCYY) . The service(s) affected are listed below:

The following item(s) were originally approved:

Service	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX	XX XX XX XX	Approved	XXXXXXX	XXXXXX.XX	MM/DD/CCYY	MM/DD/CCYY
XXXXX	XX XX XX XX	Approved	XXXXXXX	XXXXXX.XX	MM/DD/CCYY	MM/DD/CCYY

The following item(s) are currently approved:

Service	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX	XX XX XX XX	Approved	XXXXXXX	XXXXXX.XX	MM/DD/CCYY	MM/DD/CCYY
XXXXX	XX XX XX XX	Approved	XXXXXXX	XXXXXX.XX	MM/DD/CCYY	MM/DD/CCYY

The amounts shown above reflect amounts on the original approved prior authorization. They do not reflect amounts that have been billed and paid on claims.

This prior authorization does not guarantee payment. In order for you to receive payment, the recipient must be eligible on the date of service. Always check the recipient's Medicaid card to verify eligibility.

If you, as the provider, have any questions regarding this prior authorization approval/denial, contact the KYMMIS Prior Authorization unit.

Sincerely,

KYMMIS Prior Authorization Unit

2.9.8.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Amount	Dollar amount authorized.	0	Number (Decimal)	T_PA_LINE_ITEM	AMT_PA_AUTH
City	Provider city.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Current date	8	Date (Month DD, CCYY)		CALCULATED FIELD
Dates Begin (New)	New service/prior authorization start date for the line item.	8	Date (MM/DD/CCYY)	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Dates Begin (Original)	Service/prior authorization start date for the line item.	8	Date (MM/DD/CCYY)	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Dates End (Original)	Authorized prior authorization end date for the line item	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD_PROV	DTE_ORIG_END
Dates End (New)	New authorized prior authorization end date for the line item	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD_PROV	DTE_EFF - 1
End dated	Date service/prior authorization end dated.	8	Date (MM/DD/CCYY)	T_PA_TEMP_MASS_UPD	DTE_EFF -1
Member Id	Member Medicaid identification number.	12	Character	T_RE_BASE	ID_MEDICAID
Member first name	Member first name.	15	Character	T_RE_BASE	NAM_FIRST
Member last name	Member last name.	20	Character	T_RE_BASE	NAM_LAST
Member middle initial	Member middle initial.	1	Character	T_RE_BASE	NAM_MID_INIT
Mod	Modifiers	8	Character	T_PA_LINE_ITEM	CDE_PROC_MOD/CDE_PROC_MOD2/CDE_PROC_MOD3/CDE_PROC_MOD4

Field	Description	Length	Data Type	DB Table	DB Attributes
Prior Authorization Number	The service/prior authorization number associated with the member.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider address 1	First line of provider address.	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Provider address2	Second line of provider address.	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Provider name	The provider name.	50	Character	T_PR_NAM	NAME
Quantity	Quantity authorized.	9	Number (Integer)	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
Reason Code	Reason service/prior authorization was end dated.	500	Character	T_PA_IAC_TEXT	DSC_IAC
Received date	Date service/prior authorization received.	17	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_RECEIVED
Service Code	The service code for the authorization.	5	Character	T_PA_LINE_ITEM / T_REVENUE_CODE / T_PROC	CDE_SVC_TYPE/ CDE_REVENUE/CDE_PROC
State	Provider state.	2	Character	T_PR_ADR	ADR_MAIL_STATE
Status	Service/prior authorization status.	20	Character	T_PA_LINE_ITEM	DSC_STATUS
Zip	Provider zip.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
Zip + 4	Provider zip +4.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

2.9.8.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.8.5 Associated Requirements

ID
No associated Requirements found.

2.9.8.6 Change Orders

ID	Name	Description
2936	Mass Updates - Old Provider	Mass updates of providers will be a two-step process. The first step end dates the old provider's PAs so that claims will not pay past the effective date for the new provider. The old provider is given time to submit claims for payment. The second step updates authorized units and amounts for the old provider with what has been used to date. PAs are then created for the new provider with the remaining authorized units and amounts from the original PA. This change order is for the first step in the process of end dating the old provider's PAs. • The old provider's PAs are end dated with the effective date of the provider change less one day. The prior auth numbers are saved for later use in Step 2; • Create reason code record for the PA to explain end dating the PA (the reason code is on the input parameter); • Create letter of notification to old provider; • Create SHPS transactions of PA changes; and, • Create report of PAs selected for mass change.

2.9.9 PAU-0141-RL -- Mass Update New Provider Letter

This letter is generated out of the second step in the service/prior authorization provider mass update process. The letter notifies the new service provider of the transferred services. The transferred services have an effective date of the date of transfer and calculated units and/or amounts (original units/amounts less used units/amounts).

2.9.9.1 Technical Name

PAU-0141-RL

2.9.9.2 Mass Update New Provider Letter Layout

Current Date (Month DD, CCYY)

Provider Name
Address 1
Address 2
City, City, State Zip-Zip4

Subject: Prior Authorization XXXXXXXXXX

Dear Provider Name:

Due to [*Reason Code Description*] effective MM/DD/CCYY, services previously authorized on Prior Authorization XXXXXXXXXX for Provider XXXXXXXXXX and Member Name, Medicaid Number, have been transferred to you on this Prior Authorization. Approved units and amounts are the difference between the original authorized amounts and the balance that has not been paid to Provider XXXXXXXXXX.

The following item(s) are the remaining balance on the original approved prior authorization:

Service	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX	XX XX XX XX	Approved	XXXXXXX	XXXXXX.XX	MM/DD/CCYY	MM/DD/CCYY
XXXXX	XX XX XX XX	Approved	XXXXXXX	XXXXXX.XX	MM/DD/CCYY	MM/DD/CCYY

This prior authorization does not guarantee payment. In order for you to receive payment, the recipient must be eligible on the date of service. Always check the recipient's Medicaid card to verify eligibility.

If you, as the provider, have any questions regarding this prior authorization approval/denial, contact the KYMMIS Prior Authorization unit.

Sincerely,

KYMMIS Prior Authorization Unit

2.9.9.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Amount	Dollar amount authorized.	9	Number (Decimal)	T_PA_LINE_ITEM	AMT_PA_AUTH
Begin date	Service/prior authorization begin date per service for the new provider.	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD_PROV	DTE_EFF
City	Provider city.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Current date.	8	Date (Month DD, CCYY)		CALCULATED FIELD
Effective date	Effective date.	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD_PROV	DTE_EFF
End date	Service/prior authorization end date per service for the new provider.	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD_PROV	DTE_ORIG_END
Medicaid Number	Member Medicaid identification number.	12	Character	T_RE_BASE	ID_MEDICAID
Member first name	Member first name.	15	Character	T_RE_BASE	NAM_FIRST
Member last name	Member last name.	20	Character	T_RE_BASE	NAM_LAST
Member middle initial	Member middle initial.	1	Character	T_RE_BASE	NAM_MID_INIT
Mod	Modifiers	8	Character	T_PA_LINE_ITEM	CDE_PROC_MOD/CDE2/CDE_PROC_MOD3/CDE_PROC_MOD4
Prior Authorization Number	Service/prior authorization number.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider address 1	First line of provider address.	30	Character	T_PR_ADR	ADR_MAIL_STRT1

Field	Description	Length	Data Type	DB Table	DB Attributes
Provider address 2	Second line of provider address.	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Provider name	The provider name.	50	Character	T_PR_NAM	NAME
Quantity	Quantity authorized.	0	Number (Integer)	T_PR_LINE_ITEM	QTY_UNT_SVC_ATH
Reason Code	Reason service/prior authorization was end dated.	500	Character	T_PA_IAC_TEXT	DSC_IAC
Service	The service code of the service/prior authorization line item.	5	Character	T_PA_LINE_ITEM/T_PROC/T_REVENUE_CODE/T_DRUG	CDE_SVC_TYPE/CDE_PROC/CDE_REVENUE/CDE_DRUG
State	Provider state.	20	Character	T_PR_ADR	ADR_MAIL_STATE
Status	PA status	20	Character	T_PA_LINE_ITEM	DSC_STATUS
Zip	Provider zip.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
Zip + 4	Provider zip +4.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

2.9.9.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.9.5 Associated Requirements

ID
30.090.005.002.13

2.9.9.6 Change Orders

ID	Name	Description
2756	Mass Updates - New Provider	Mass updates of providers will be a two step process. The first step end dates the old provider's PAs so that claims will not pay past the effective date for the new provider. The old provider is given time to submit claims for payment. The second step updates authorized units and amounts for the old provider with what has been used to date. PAs are then created for the new provider with the remaining authorized units

ID	Name	Description
		and amounts from the original PA. This change order is for the second step in the process of creating PAs for the new provider. • Update used units and amounts for old provider; • Create PA for new provider; • Create reason code record for the PA to explain end dating the PA (the reason code is on the input parameter); • Create letter of notification to new provider; • Create SHPS transactions of PA changes; and, • Create report of PAs created for new provider.

2.9.10 PAU-0142-RL -- Mass Update Rate Service Code Letter

This letter is generated out of the service/prior authorization mass update for rates and service codes. It notifies the service provider of a modified rate or service.

2.9.10.1 Technical Name

PAU-0142-RL

2.9.10.2 Mass Update Rate Service Code Letter Layout

Current Date (Month DD, CCYY)

Provider Name
Address 1
Address 2
City, State Zip-Zip4

Subject: Prior Authorization XXXXXXXXXX

Dear Provider Name:

Due to [*Reason Code Description*] previously authorized service(s) submitted Received Date (MM/DD/CCYY), for Member Name, Medicaid Number, have been modified as of *Effective Mass Update* (MM/DD/CCYY). The service(s) affected are listed below:

The following item(s) were originally approved:

Service	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX	XX XX XX XX	Approved	XXXXXXX	XXXXXX.XX	MM/DD/CCYY	MM/DD/CCYY
XXXXX	XX XX XX XX	Approved	XXXXXXX	XXXXXX.XX	MM/DD/CCYY	MM/DD/CCYY

The following item(s) are currently approved:

Service	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX	XX XX XX XX	Approved	XXXXXXX	XXXXXX.XX	MM/DD/CCYY	MM/DD/CCYY
XXXXX	XX XX XX XX	Approved	XXXXXXX	XXXXXX.XX	MM/DD/CCYY	MM/DD/CCYY

The amounts shown above reflect amounts on the original approved prior authorization. They do not reflect amounts that have been billed and paid on claims.

This prior authorization does not guarantee payment. In order for you to receive payment, the recipient must be eligible on the date of service. Always check the recipient's Medicaid card to verify eligibility.

If you, as the provider, have any questions regarding this prior authorization approval, contact the KYMMIS Prior Authorization unit.

Sincerely,

KYMMIS Prior Authorization Unit

2.9.10.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	The address street1 of the service provider.	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Address2	The address street2 of the service provider.	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Amount	Amount authorized for the service/prior authorization line-item service.	9	Number	T_PA_LINE_ITEM	AMT_PA_AUTH
Begin Date	Service/prior authorization new start date for the line-item.	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD	DTE_EFFECTIVE
City / Town	The address city/town of the service provider.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Date letter was generated.	8	Date (Month DD, CCYY)		CALCULATED FIELD
Effective Mass Update	Date new rate or service code is effective.	8	Date (MM/DD/CCYY)	T_SYSTEM_PARMS	DTE_EFFECTIVE
End Date	Service/prior authorization end date.	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD	DTE_END
Member Name	The member name.	36	Character	T_RE_BASE	NAM_LAST / NAME_FIRST
Member Number	Member Medicaid identification number.	12	Character	T_RE_BASE	ID_MEDICAID
Mod	Procedure code modifiers.	5	Character	T_PA_LINE_ITEM	CDE_PROC_MOD,CDE_PROC_MOD2,CDE_PROC_MOD3,CDE_PROC_MOD4
Prior Authorization Number	The service/prior authorization number associated with the member.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM

Field	Description	Length	Data Type	DB Table	DB Attributes
Provider Name	The name of the service provider.	50	Character	T_PR_NAM	NAME
Quantity	Number of units authorized for the service/prior authorization line item service.	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
Reason Code Description	The reason code description.	500	Character	T_PA_IAC_TEXT	DSC_IAC
Received Date	The submission date of the previously authorized service.	8	Date (Month DD, CCYY)	T_PA_PAUTH	DTE_RECEIVED
Service	The service code (procedure or revenue code).	5	Character	T_PROC/T_REVENUE_CODE	CDE_PROC/CDE_REVENUE
Status	Status indicating approval.	8	Character	DSC_STATUS	T_PA_LINEITEM_STAT
ZIP Code	The address zip code of the service provider.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
ZIP Code 4	The address zip code last 4 digits of the service provider.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

2.9.10.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.10.5 Associated Requirements

ID
30.090.005.002.13

2.9.10.6 Change Orders

ID	Name	Description
2759	Mass Updt - load new rates/serv	The mass update process for rates and service codes will provide the following: • Ability to mass update rates on prior auth line items where the service is priced on the PA; • Ability to select rates for mass update by provider; • Ability to mass update service codes on prior auth line items; • Correct accounting for units authorized and used on the line items that have been updated with a rate or service code change. (also see Claims CO 3102); • Provider letters for notification of rate or service code change; • Report on PAs with rate or service code change; • Transactions to SHPS with rate or service code change; and, • Change orders 2757 and 2769 create panels for viewing, updating and searching rate and service code changes.

2.9.11 PAU-0200-DL -- EPSDT First Time Prior Authorization Letter

The EPSDT Special Services Program provides services for a member from birth to the member's 21st birthday. This letter is generated the first time a member receives EPSDT services. It is notification that the services will no longer be available after the last day of the month in which the member becomes 21 years of age.

2.9.11.1 Technical Name

PAU-0200-DL

2.9.11.2 EPSDT First Time Prior Authorization Letter Layout

Current Date (Month DD, CCYY)

Member Name
Address 1
Address 2
City, State Zip-Zip4

Dear Parent/Guardian,

Based on our records, Member Name is receiving services through Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Special Services Program. The Kentucky Medicaid program is pleased to provide coverage for these services. Please be aware that services through the EPSDT Special Services Program are covered for children from birth up to 21 years of age. These services will be covered when medically necessary and appropriate until the last day of the month during Member Name becomes twenty-one (21) years of age.

A few months before Member Name's twenty-first (21st) birthday, you may need information about other services that may be available. At that time you may want to contact the Division of Medical Management and Quality Assurance at 502-564-9444.

Member Name may or may not lose Medicaid eligibility at any time prior to his/her 21st birthday. If you have any questions about Medicaid eligibility, please contact your local Department for Community Based Services office.

Sincerely,

Department for Medicaid Services

2.9.11.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	Member address line 1.	30	Character	T_RE_BASE	ADR_STREET1
Address2	Member address line 2.	30	Character	T_RE_BASE	ADR_STREET2
Current Date	The current date.	8	Date (Month DD, CCYY)		Calculated Field
Member Name	The member name.	36	Character	T_RE_BASE	NAM_FIRST/NAM_LAST
State	Member state	2	Character	T_RE_BASE	ADR_STATE
ZIP4	Member zip+4.	4	Character	T_RE_BASE	ADR_ZIP_CODE_4
Zip	Member zip code.	5	Character	T_RE_BASE	ADR_ZIP_CODE

2.9.11.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.11.5 Associated Requirements

ID
30.050.005.002.14

2.9.11.6 Change Orders

ID	Name	Description
2520	KYAmend PA EPSDT Process	The first time a member receives prior authorization approval for EPSDT services, create a letter of notification that services are no longer available when the member turns 21. Create a report listing members receiving EPSDT services for the first time.
6362	PA Orthodontic letters	Letters are displaying the term Recipient on OnBase and on the Letter Generator instead of Member as shown in The Project Workbook

2.9.12 PAU-0220-1L -- Orthodontic Six Month Progress Report Letter

This letter is sent to providers as notification that required documentation of progress on approved orthodontic services has not been received by the Orthodontic Program Department. The letter is generated 8 months from the service begin date if the Orthodontic Status Code = spaces or after 14 months if the Ortho Status Code = "I". A Code of "I" indicates the provider has notified the department that treatment is still in progress.

2.9.12.1 Technical Name

PAU-0220-1L

For readability, the layout displays on the next page.

2.9.12.2 Orthodontic Six Month Progress Report Letter Layout

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
275 E. Main Street, 6W-A
Frankfort, Kentucky 40621
(502) 564-4321 Voice - (502) 564-0509 Fax
www.chfs.ky.gov

Ernie Fletcher
Governor

Mark D. Birdwhistell
Secretary

Shawn M. Crouch
Commissioner

60000000

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, KENTUCKY 40621

DECEMBER 04, 2007

Dear DR. XXXXX XXXX X
100 ANY STREET
ANYWHERE, KY 00000 - 0000

The submission of a six (6) month orthodontic progress report (MAP-559) accompanied by a prior authorization form (MAP-9) is necessary to receive prior authorization for your final third payment for fixed appliance therapy. This documentation is due when six (6) monthly visits have been completed and no more than twelve (12) months after the banding date or placement of appliances. One third of the total fee for fixed appliance therapy (D8670) listed on your original prior authorization form (MAP-9) should be listed as your final third payment. The procedure code for this should reflect the treatment progress from the initial visit through the present time. Providers who fail to comply with this policy may receive a request for recoupment of funds on each unaccounted case.

If the patient's treatment status has changed, please notify the staff of the KYMMIS Orthodontic Program immediately. Otherwise, please submit the above mentioned documentation (MAP-559 and MAP-9). If treatment has ceased, please submit a letter outlining 1) dates seen, 2) treatment given, and 3) progress made with prorated fee. If treatment is progressing as scheduled, please indicate with a brief notation beside the patient's name.

1

Ernie Fletcher
Governor

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
275 E. Main Street, 6W-A
Frankfort, Kentucky 40621
(502) 564-4321 Voice - (502) 564-0509 Fax
www.chfs.ky.gov

Mark D. Birdwhistell
Secretary

Shawn M. Crouch
Commissioner

The information on each case must be received by the KYMMIS Orthodontic Program, 9200 Shelbyville Road Suite 100, Louisville, KY 40222 within thirty (30) days of the date of this letter. Claims or request for prior authorization for dates of service over a year old can no longer be overridden by the Medicaid program.

If the patient is enrolled with a managed care partnership on the date of banding or when case is finalized, please submit records to the appropriate partnership. Beside the patient's name please note the date and name of partnership where records were submitted.

We appreciate your cooperation with the Kentucky Medicaid Orthodontic Program. If you have questions regarding this matter, please contact KYMMIS Orthodontic Staff at 1-800-805-6465 MON-FRI, 8:00 AM through 6:00 PM EST. If you have questions regarding policy issues please contact the Physician and Specialty Services Branch at 502-564-2687.

MEDICAID NUMBER	MEMBER NAME	PA NUMBER	RECEIPT DATE
0000000000	John Doe	0000000000	06/22/2006

2

2.9.12.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	Mailing address street 1 for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Address2	Mailing address street 2 for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_STRT2
City	Mailing address city for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Date letter was generated.	8	Date (MM/DD/CCYY)		CALCULATED FIELD
Medicaid Number	Member Medicaid identification number.	12	Character	T_RE_BASE	ID_MEDICAID
Member Name	The member name.	36	Character	T_RE_BASE	NAM_FIRST/NAME_LAST
Prior Authorization Number	The service/prior authorization number.	10	Character	T_PA-PAUTH	PRIOR_AUTH_NUM
Provider Name	The name of the service provider.	50	Character	T_PR_NAM	NAME
Provider Number	The unique identifier for a service provider.	10	Character	T_PR_IDENTIFIER	ID_PROVIDER
Receipt Date	The date a service/prior authorization request was received.	8	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_RECEIVED
State	Mailing address state for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_STATE
ZIP Code	Mailing address zip code for a service provider.	5	Character	T_PR_ADR	ADR_MAIL_ZIP

Field	Description	Length	Data Type	DB Table	DB Attributes
ZIP Code 4	Mailing address zip+4 for a service provider.	4	Character	T_PR_ADR	ADR_MAIL_ZIP _4

2.9.12.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.12.5 Associated Requirements

ID
30.050.005.002.14

2.9.12.6 Change Orders

ID	Name	Description
2519	KYAmend PA Orthodontic Process	The Orthodontic Case Tracking process monitors the submission of required documentation for an Orthodontic service/prior authorization. The automated process identifies overdue documentation and sends reminder letters to providers. In cases where providers have not responded to reminder letters, the overdue documentation is reported for follow-up by the KYMMIS Orthodontic Staff.
6362	PA Orthodontic letters	Letters are displaying the term Recipient on OnBase and on the Letter Generator instead of Member as shown in The Project Workbook

2.9.13 PAU-0220-2L -- Orthodontic Six Month Progress Report Follow Up Letter

This letter is sent to providers as notification that required documentation of progress on approved orthodontic services has not been received by the Orthodontic Program Department. The letter is generated 11 months from the service begin date if the Orthodontic Status Code = spaces or after 17 months if the Ortho Status Code = "I". A Code of "I" indicates the provider has notified the department that treatment is still in progress.

2.9.13.1 Technical Name

PAU-0220-2L

For readability, the layout displays on the next page.

2.9.13.2 Orthodontic Six Month Progress Report Follow Up Letter Layout

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
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Ernie Fletcher
Governor

Mark D. Birdwhistell
Secretary

Shawn M. Crouch
Commissioner

FOLLOW UP 60000000

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, KENTUCKY 40621

DECEMBER 04, 2007

Dear DR. XXXXXX XXXX X
100 ANY STREET
ANYWHERE, KY 00000 - 0000

A letter was previously sent requesting a six (6) month orthodontic progress report. This is the final notice, and if no response is received within thirty (30) days, the orthodontic cases(s) will be closed and any monies paid for treatment will be recouped.

The submission of a six (6) month orthodontic progress report (MAP-559) accompanied by a prior authorization form (MAP-9) is necessary to receive prior authorization for your final third payment for fixed appliance therapy. This documentation is due when six (6) monthly visits have been completed and no more than twelve (12) months after the banding date or placement of appliances. One third of the total fee for fixed appliance therapy (D8670) listed on your original prior authorization form (MAP-9) should be listed as your final third payment. The procedure code for this should reflect the treatment progress from the initial visit through the present time. Providers who fail to comply with this policy may receive a request for recoupment of funds on each unaccounted case.

If the patient's treatment status has changed, please notify the staff of the KYMMIS Orthodontic Program immediately. Otherwise, please submit the above mentioned documentation (MAP-559 and MAP-9). If treatment has ceased, please submit a letter outlining 1) dates seen, 2) treatment

1

Ernie Fletcher
Governor

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Mark D. Birdwhistell
Secretary

Shawn M. Crouch
Commissioner

given, and 3) progress made with prorated fee. If treatment is progressing as scheduled, please indicate with a brief notation beside the patient's name.

The information on each case must be received by the KYMMIS Orthodontic Program, 9200 Shelbyville Road Suite 100, Louisville, KY 40222 within thirty (30) days of the date of this letter. Claims or request for prior authorization for dates of service over a year old can no longer be overridden by the Medicaid program.

If the patient is enrolled with a managed care partnership on the date of banding or when case is finalized, please submit records to the appropriate partnership. Beside the patient's name please note the date and name of partnership where records were submitted.

We appreciate your cooperation with the Kentucky Medicaid Orthodontic Program. If you have questions regarding this matter, please contact KYMMIS Orthodontic Staff at 1-800-805-6465 MON-FRI, 8:00 AM through 6:00 PM EST. If you have questions regarding policy issues please contact the Physician and Specialty Services Branch at 502-564-2687.

MEDICAID NUMBER	MEMBER NAME	PA NUMBER	RECEIPT DATE
0000000000	John Doe	0000000000	02/19/2006

2

2.9.13.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	Mailing address street 1 for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_STR1
Address2	Mailing address street 2 for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_STR2
City	Mailing address city for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Date letter was generated.	8	Date (Month DD, CCYY)		CALCULATED FIELD
Medicaid Number	Member Medicaid identification number.	12	Character	T_RE_BASE	ID_MEDICAID
Member Name	The member name.	36	Character	T_RE_BASE	NAM_FIRST/NAM_LAST
Prior Authorization Number	The service/prior authorization number.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Name	The name of the service provider.	50	Character	T_PR_NAM	NAME
Provider Number	Unique identifier for the service provider.	10	Character	T_PR_IDENTIFIER	ID_PROVIDER
Receipt Date	The date a service/prior authorization request was received.	8	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_RECEIVED
State	Mailing address state for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_STATE
ZIP Code	Mailing address zip code for a service provider.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
ZIP Code 4	Mailing address zip+4 for a service provider.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

2.9.13.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.13.5 Associated Requirements

ID
30.050.005.002.14

2.9.13.6 Change Orders

ID	Name	Description
2519	KYAmend PA Orthodontic Process	The Orthodontic Case Tracking process monitors the submission of required documentation for an Orthodontic service/prior authorization. The automated process identifies overdue documentation and sends reminder letters to providers. In cases where providers have not responded to reminder letters, the overdue documentation is reported for follow-up by the KYMMIS Orthodontic Staff.
6362	PA Orthodontic letters	Letters are displaying the term Recipient on OnBase and on the Letter Generator instead of Member as shown in The Project Workbook

2.9.14 PAU-0220-3L -- Orthodontic Final Case Letter

This letter is sent to providers as notification that required documentation of progress on approved orthodontic services has not been received by the Orthodontic Program Department. The letter is generated 14 months from the service begin date if the Orthodontic Status Code = spaces or 'L', and after 24 months if the Ortho Status Code = "I". An Orthodontic Status Code of 'I' indicates the provider has notified the department that treatment is still in progress. A Status Code of 'L' indicates one lump sum payment was made to the provider rather than the usual split of one third and two thirds payment.

2.9.14.1 Technical Name

PAU-0220-3L

For readability, the layout displays on the next page.

2.9.14.2 Orthodontic Final Case Letter Layout

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Shawn M. Crouch
Commissioner

60000000

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, KENTUCKY 40621

DECEMBER 04, 2007

Dear DR. XXXXXX XXXX X
100 ANY STREET
ANYWHERE, KY 00000 - 0000

The submission of an orthodontic final case form (MAP-700) accompanied by a prior authorization form (MAP-9) is necessary to receive prior authorization for your final case submission and payment for your final records (D8660). This documentation is due when the case has been completed and no more than twenty-four (24) months after the six (6) month orthodontic progress report has been submitted. The orthodontic final case submission form (MAP-700) should reflect the treatment progress from the initial visit through the present time. Providers who fail to comply with this policy may receive a request for recoupment of funds on each unaccounted case.

If the patient's treatment status has changed, please notify the staff of the KYMMIS Orthodontic Program immediately otherwise, please submit a letter outlining 1) dates seen, 2) treatment given, and 3) progress made with prorated fee. If treatment is progressing on schedule, please indicate with a brief notation beside the patient's name.

The information on each case must be received by the KYMMIS Orthodontic Program, 9200 Shelbyville Road Suite 100, Louisville, KY 40222 within thirty (30) days of the date of this letter. Claims or request for prior authorization for dates of service over a year old can no longer

1

Ernie Fletcher
Governor

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be overridden by the Medicaid program.

If the patient is enrolled with a managed care partnership on the date of banding or when case is finalized, please submit records to the appropriate partnership. Beside the patient?s name please note the date and name of partnership where records were submitted.

We appreciate your cooperation with the Kentucky Medicaid Orthodontic Program. If you have questions regarding this matter, please contact KYMMIS Orthodontic Staff at 1-800-805-6465 MON-FRI, 8:00 AM through 6:00 PM EST. If you have questions regarding policy issues please contact the Physician and Specialty Services Branch at 502-564-2687.

MEDICAID NUMBER	MEMBER NAME	PA NUMBER	RECEIPT DATE
0000000000	Jane Doe	0000000000	12/07/2006

2

2.9.14.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	Mailing address street 1 for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_STR1
Address2	Mailing address street 2 for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_STR2
City	Mailing address city for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Date letter was generated.	8	Date (Month DD, CCYY)		CALCULATED FIELD
Medicaid Number	Member Medicaid identification number.	12	Character	T_RE_BASE	ID_MEDICAID
Member Name	The Member Name	36	Character	T_RE_BASE	NAM_FIRST/NAM_LAST
Prior Authorization Number	The service/prior authorization number associated with the member.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Name	The name of the service provider.	50	Character	T_PR_NAM	NAME
Provider Number	Unique identifier for the service provider.	10	Character	T_PR_PROVIDER	ID_PROVIDER
Receipt Date	The date a service/prior authorization request was received.	10	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_RECEIVED
State	Mailing address state for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_STATE
ZIP Code	Mailing address zip code for a service provider.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
ZIP Code	Mailing address zip+4 for a service provider.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

2.9.14.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.14.5 Associated Requirements

ID
30.050.005.002.14

2.9.14.6 Change Orders

ID	Name	Description
2519	KYAmend PA Orthodontic Process	The Orthodontic Case Tracking process monitors the submission of required documentation for an Orthodontic service/prior authorization. The automated process identifies overdue documentation and sends reminder letters to providers. In cases where providers have not responded to reminder letters, the overdue documentation is reported for follow-up by the KYMMIS Orthodontic Staff.
6362	PA Orthodontic letters	Letters are displaying the term Recipient on OnBase and on the Letter Generator instead of Member as shown in The Project Workbook

2.9.15 PAU-0220-4L -- Orthodontic Final Case Follow Up Letter

This letter is sent to providers as notification that required documentation of progress on approved orthodontic services has not been received by the Orthodontic Program Department. The letter is generated 17 months from the service begin date if the Orthodontic Status Code = spaces or 'L', and after 27 months if the Ortho Status Code = "I". An Orthodontic Status Code of 'I' indicates the provider has notified the department that treatment is still in progress. A Status Code of 'L' indicates one lump sum payment was made to the provider rather than the usual split of one third and two thirds payment.

2.9.15.1 Technical Name

PAU-0220-4L

For readability, the layout displays on the next page.

2.9.15.2 Orthodontic Final Case Follow Up Letter Layout

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Commissioner

FOLLOWUP

60000000

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, KENTUCKY 40621

DECEMBER 04, 2007

Dear Dr. XXXXXX XXXXX X
100 ANY STREET
ANYWHERE, KY 00000 - 0000

A letter was previously sent requesting final case submission. This is the final notice, and if no response is received within thirty (30) days, the orthodontic cases(s) will be closed and any monies paid for treatment will be recouped.

The submission of an orthodontic final case form (MAP-700) accompanied by a prior authorization form (MAP-9) is necessary to receive prior authorization for your final case submission and payment for your final records (D8660). This documentation is due when the case has been completed and no more than twenty-four (24) months after the six (6) month orthodontic progress report has been submitted. The orthodontic final case submission form (MAP-700) should reflect the treatment progress from the initial visit through the present time. Providers who fail to comply with this policy may receive a request for recoupment of funds on each unaccounted case.

If the patient's treatment status has changed, please notify the staff of the KYMMIS Orthodontic Program immediately otherwise, please submit a letter outlining 1) dates seen, 2) treatment given, and 3) progress made with prorated fee. If treatment is progressing on schedule, please indicate with a brief notation beside the patient's name.

1

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The information on each case must be received by the KYMMIS Orthodontic Program, 9200 Shelbyville Road Suite 100, Louisville, KY 40222 within thirty (30) days of the date of this letter. Claims or request for prior authorization for dates of service over a year old can no longer be overridden by the Medicaid program.

If the patient is enrolled with a managed care partnership on the date of banding or when case is finalized, please submit records to the appropriate partnership. Beside the patient?s name please note the date and name of partnership where records were submitted.

We appreciate your cooperation with the Kentucky Medicaid Orthodontic Program. If you have questions regarding this matter, please contact KYMMIS Orthodontic Staff at 1-800-805-6465 MON-FRI, 8:00 AM through 6:00 PM EST. If you have questions regarding policy issues please contact the Physician and Specialty Services Branch at 502-564-2687.

MEDICAID NUMBER	MEMBER NAME	PA NUMBER	RECEIPT DATE
0000000000	Jane Doe	0000000000	01/24/2006

2

2.9.15.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	Mailing address street 1 for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_STR1
Address2	Mailing address street 2 for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_STR2
City	Mailing address city for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Date letter was generated.	8	Date (Month DD, CCYY)		CALCULATED FIELD
Medicaid Number	Member Medicaid identification number.	12	Character	T_RE_BASE	ID_MEDICAID
Member Name	The member name.	36	Character	T_RE_BASE	NAM_FIRST/NAM_LAST
Prior Authorization Number	The service/prior authorization number associated with the member.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Name	The name of the service provider.	50	Character	T_PR_NAM	NAME
Provider Number	The unique identifier for a service provider.	10	Character	T_PR_PROVIDER	ID_PROVIDER
Receipt Date	The date a service/prior authorization request was received.	8	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_RECEIVED
State	Mailing address state for a service provider	30	Character	T_PR_ADR	ADR_MAIL_STATE
ZIP Code	Mailing address zip code for a service provider.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
ZIP Code	Mailing address zip+4 for a service provider.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

2.9.15.4 Associated Programs

Program	Description
No associated Programs found.	

2.9.15.5 Associated Requirements

ID
30.050.005.002.14

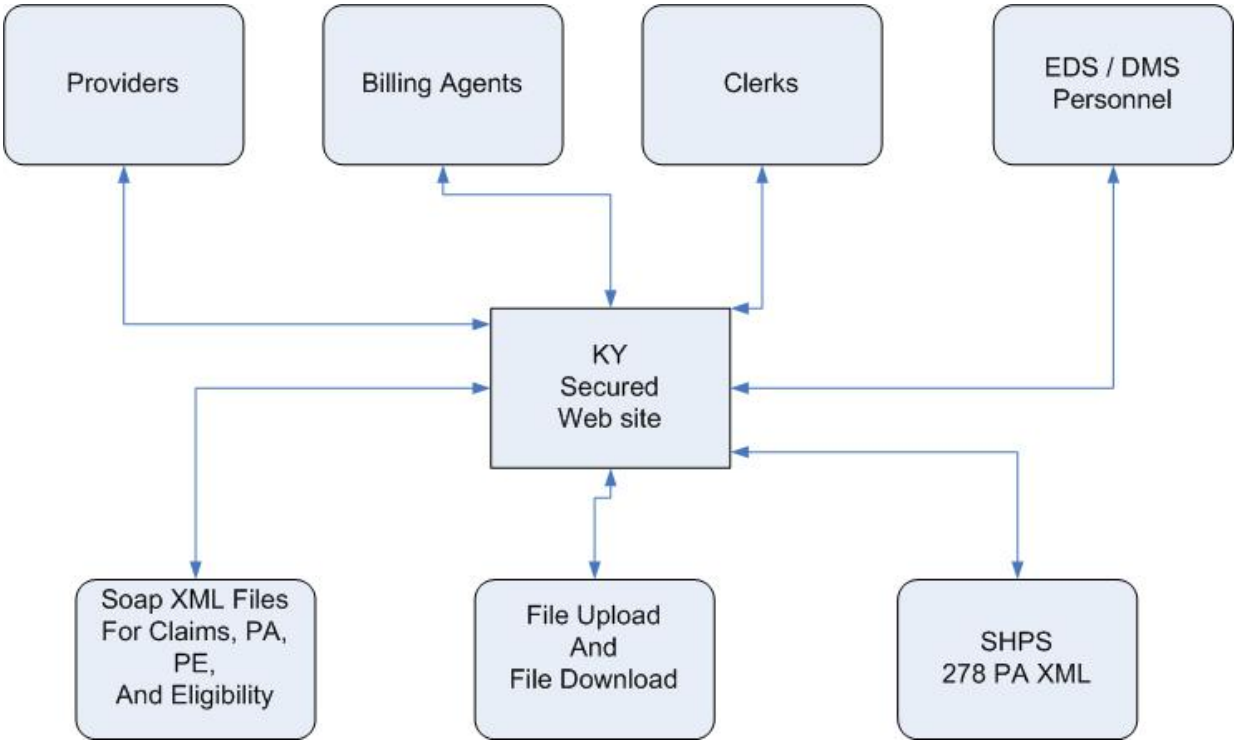
2.9.15.6 Change Orders

ID	Name	Description
2519	KYAmend PA Orthodontic Process	The Orthodontic Case Tracking process monitors the submission of required documentation for an Orthodontic service/prior authorization. The automated process identifies overdue documentation and sends reminder letters to providers. In cases where providers have not responded to reminder letters, the overdue documentation is reported for follow-up by the KYMMIS Orthodontic Staff.

2.10 Internal and External Interfaces

The Service/Prior Authorization Functional Area Input and Output files folder contains a list of all subsystem external input and output files, as well as who sends or receives the file and the frequency with which it is transacted. It also contains the file layouts for each of the external files in this subsystem.

The following diagram documents the SHPS to interChange prior authorization interface.



2.10.1 Output – Impact Plus Interface – Interface ID 465

This is a bi-weekly interface containing Impact Plus service/prior authorizations received on or after 1/1/1998 that goes to DMHMR.

Field Name	Data Type	Length	Precision	Description
Prior Authorization Number	Character	10	0	Prior Authorization Number for the Impact Plus PA
Authorizer ID	Character	8	0	ID of person authorizing the PA
Member ID	Character	10	0	Member's Medicaid ID

Field Name	Data Type	Length	Precision	Description
Update Date	Character	8	0	Last date service information was updated, format is MMDDCCYY
Provider ID	Number	10	0	Service Provider ID
Received Date	Number	8	0	Date PA was received for processing, format is MMDDCCYY
Modifier 1	Character	2	0	First modifier associated with a service
Modifier 2	Character	2	0	Second modifier associated with a service
Modifier 3	Character	2	0	Third modifier associated with a service
Modifier 4	Character	2	0	Fourth modifier associated with a service
Status	Character	1	0	Status of a PA service
Tax ID	Character	9	0	Impact Plus tax ID for a line item
Sub ID	Character	3	0	Impact Plus sub ID for a line item
Units	Character	9	0	The units requested for a service
Amount	Character	9	2	The total dollar amount requested for a service
Begin Date Authorized	Character	8	0	Service authorized effective date, format is MMDDCCYY
End Date Authorized	Character	8	0	Service authorized end date; format is MMDDCCYY
Service Code	Character	5	0	Requested service procedure code

2.10.2 PA 278 Request and Response

This interface is both input and output.

PA MaxMC Interface Specifications – Interface ID 706

The following is mapping of interChange Prior Auth tables to PA Interface XML Schema.

2.10.2.1 PA Header Data

Fields	Table Location	For-mat	Size	Required	Source: maxMc	Notes	Schema node
Case Nbr	t_p_pauth_state id_case	Character	25	Yes	assigns Case Nbr	No edit – Will be assigned in maxMC	priorAuths278 \ priorAuth278 \ caseNum
Member's Medicaid ID	t_pa_pauth sak_recip	Character	10	Yes	convert Medicaid ID to sak_recip	Medicaid ID is converted to sak_recip	priorAuths278 \ priorAuth278 \ paSubscriberLoop \ paSubscriberNameLoop \ paSubscriber \ idCode
Requesting Provider ID	t_pa_pauth sak_prov_loc	Character	15	Yes	receive: Provider ID convert Provider ID to sak_prov_loc	Requesting Provider ID converted to sak_prov, sak_prov_loc	priorAuths278 \ priorAuth278 \ paRequesterLoop \ paRequester \ idCode
Service Provider ID	t_pa_pauth sak_prov_loc_2	Character	15	Yes	Service Provider ID converted to sak_pa_serv_pro v sak_prov_loc_2	Service Provider ID converted to sak_pa_serv_ prov, sak_prov_loc _2	priorAuths278 \ priorAuth278 \ paServiceProviderLoop \ paServiceProv \ idCode

Fields	Table Location	For-mat	Size	Required	Source: maxMc	Notes	Schema node
Prior Authorization Type	t_pa_pauth cde_pa_assign	Character	2	Yes	PA Category code – validate against code table	validate against t_pa_cde_assign	priorAuths278 \ priorAuth278 \ paServiceLoop \ paServiceInfo \ serviceType
Media	t_pa_pauth cde_media_type	Character	1	Yes	3 = SHPS	PA source 2 = web 3 = SHPS 4 = 278/electronic txn 9 = Conversion	priorAuths278 \ priorAuth278 \ paMedia
Date PA Received	t_pa_pauth dte_received	Num	8	Yes	Date initiated at SHPS	Format CCYYMMDD	priorAuths278 \ priorAuth278 \ systemDate
Date PA Entered	t_pa_pauth dte_pa_keyed	Num	8	Yes	System date	Format CCYYMMDD	priorAuths278 \ priorAuth278 \ creationDate
Time PA Entered	t_pa_pauth tme_received	Num	8	Yes	System time	Time PA entered into system. Format HHMMSS	priorAuths278 \ priorAuth278 \ creationTime

Fields	Table Location	For-mat	Size	Required	Source: maxMc	Notes	Schema node
Date Assigned for Review **Field is not used**	t_pa_pauth dte_reviewed	Num	8		Date initiated at SHPS	Field is not used	priorAuths278 \ priorAuth278 \ reviewDate
User ID – entry	t_pa_pauth id_clerk_entry	Character	8	Yes	SHPS default of 99999999	Person who entered PA	priorAuths278 \ priorAuth278 \ userID
User ID – authorizer	t_pa_pauth id_clerk_review	Character	8		SHPS default of 99999999	Source for adjudicating PA	priorAuths278 \ priorAuth278 \ userIDAuth
Emergency Indicator		Character	1	Yes	“Y”es or “N”o default = “N”o	“Y”es or “N”o default = “N”o	priorAuths278 \ priorAuth278 \ paServiceLoop \ paServiceInfo \ serviceLevelCode
Accident Indicator	t_pa_pauth ind_accident	Character	1	Yes	“Y”es or “N”o default = “N”o		priorAuths278 \ priorAuth278 \ paSubscriberLoop \ dteAccident
Special Consideratio ns Indicator	t_pa_pauth ind_special_con sid	Character	1	Yes	“Y”es or “N”o default = “N”o	“Y”es or “N”o default = “N”o	priorAuths278 \ priorAuth278 \ specialConsiderationInd

Fields	Table Location	For-mat	Size	Required	Source: maxMc	Notes	Schema node
Admission Date	t_pa_pauth.state dte_admiission	Num	8		default = 0	Format CCYYMMDD	priorAuths278 \ priorAuth278 \ paServiceLoop \ paDates \ AdmissionFromDate priorAuths278 \ priorAuth278 \ paServiceLoop \ paDates \ AdmissionToDate
Discharge Date	t_pa_pauth.state dte_discharge	Num	8		discharge date default = 0	Format CCYYMMDD	priorAuths278 \ priorAuth278 \ paServiceLoop \ paDates \ dischargeDate
Nursing facility indicator	t_pa_pauth.state cde_tos	Character	1	Yes if Cat = NF	Required if PA Category = Nursing Facility (27)	Required if PA Category = NF (27) Valid values: Y = Nursing facility V = Ventilator B = BI Locked Unit H = Brain Injury	priorAuths278 \ priorAuth278 \ nursingFacilityInd

Fields	Table Location	For-mat	Size	Required	Source: maxMc	Notes	Schema node
Orthodontic Status Code	t_pa_pauth.state cde_ortho_status	Character	1		Only applies to PA Category Orthodontics (73) Validate value	SHPS maintains code Valid values: space = initial setup C = Complete I = In progress P = Prorated L = Lump Sum	priorAuths278 \ priorAuth278 \ orthodonticStatusCode

Fields	Table Location	For-mat	Size	Required	Source: maxMc	Notes	Schema node
Service Provider Check	t_pa_pauth cde_serv_prov_ chk	Character	1		S = Apply only to Specified Service Provider N = Apply to any Service Provider with the same NPI	S = Apply only to Specified Service Provider N = Apply to any Service Provider with the same NPI B = Apply to any Service Provider with same Base Provider A = Apply to all Service Providers	priorAuths278 \ priorAuth278 \ serviceProvChk

2.10.2.2 PA Line Item Data

Fields	Table Location	For-mat	Size	Required	Source: maxMc	Notes	New Schema
Line Item Number	t_pa_line_item num_pa_line_ite m	Character	2	Yes	MMIS assigns	Format 01 - 99	priorAuths278 \ priorAuth278 \ paServiceLoop \ lineItemNum

Fields	Table Location	For-mat	Size	Required	Source: maxMc	Notes	New Schema
Service Code Type	t_pa_line_item. cde_svc_type	Character	2	Yes	Must be “1” or “2”	Code set for service code Revenue = 1 Procedure = 2	priorAuths278 \ priorAuth278 \ paServiceLoop \ paProcedures \ paProcedureHealthCare \ codeQualifier
Service Code	t_pa_line_item. sak_revenue or sak_procedure depending on cde_svc_type	Character	5	Yes	service code – translate to sak_revenue or sak_procedure t_pa_line_item.c de_svc_type = 1 then must have sak_revenue t_pa_line_item.c de_svc_type = 2 then must have sak_procedure	Code for requested service.	priorAuths278 \ priorAuth278 \ paServiceLoop \ paProcedures \ paProcedureHealthCare \ service
Service Code Thru	t_pa_line_item. sak_revenue_thru or sak_procedure_th ru	Character	5		service code – translate to sak_revenue or sak_procedure		priorAuths278 \ priorAuth278 \ paServiceLoop \ paProcedures \ paProcedureHealthCare \ serviceThru
Modifier for service 1	t_pa_line_item. cde_proc_mod	Character	2		Validate against t_modiifier		priorAuths278 \ priorAuth278 \ paServiceLoop \ paServmsg \ message

Fields	Table Location	For-mat	Size	Required	Source: maxMc	Notes	New Schema
Modifier for service 2	t_pa_line_item. cde_proc_mod2	Character	2		Validate against t_modiifier		priorAuths278 \ priorAuth278 \ paServiceLoop \ paServmsg \ message
Modifier for service 3	t_pa_line_item. cde_proc_mod3	Character	2		Validate against t_modiifier		priorAuths278 \ priorAuth278 \ paServiceLoop \ paServmsg \ message
Modifier for service 4	t_pa_line_item. cde_proc_mod4	Character	2		Validate against t_modiifier		priorAuths278 \ priorAuth278 \ paServiceLoop \ paServmsg \ message
Tooth Nbr	t_pa_line_item. cde_tooth	Character	2		Only applies to PA Category Dental (72) – if there is a value validate against t_proc_tooth		priorAuths278 \ priorAuth278 \ paServiceLoop \ paProcedures \ paProcedureHealthCare \ paToothDesignation \ toothNum
Tooth Quadrant	t_pa_line_item. cde_tooth_quad	Character	2		if there is a value validate against t_proc_tooth		priorAuths278 \ priorAuth278 \ paServiceLoop \ paProcedures \ paProcedureHealthCare \ paToothDesignation \ toothQuadrant

Fields	Table Location	For-mat	Size	Required	Source: maxMc	Notes	New Schema
Payment Method	t_pa_line_item. cde_pymt_metho d	Character	1	Yes	Get PA Category from header assign payment method using table t_pa_auto_crit.c de_pymt_metho d	1 = Pay system price (qty is required) 2 = Pay unit fee price (qty + amt is required) 4 = Pay cap amount 5 = Pay audit amount	priorAuths278 \ priorAuth278 \ paServiceLoop \ paymentMethod
Requested start date for the service.	t_pa_line_item dte_pa_req_eff	Num	8	Yes	Edit for valid date	format CCYYMMDD	priorAuths278 \ priorAuth278 \ paServiceLoop \ paProcedures \ paProcedureHealthCare \ fromDate
Requested end date for the service	t_pa_line_item dte_pa_req_end	Num	8	Yes	Edit for valid date	format CCYYMMDD	priorAuths278 \ priorAuth278 \ paServiceLoop \ paProcedures \ paProcedureHealthCare \ toDate
Requested units of service	t_pa_line_item qty_unt_svc_req	Num	9	Yes	Must be > 0		priorAuths278 \ priorAuth278 \ paServiceLoop \ paProcedures \ paProcedureHealthCare \ quantityReq

Fields	Table Location	For-mat	Size	Required	Source: maxMc	Notes	New Schema
Requested amount for the service	t_pa_line_item amt_pa_req	Num	9	Req when price from PA	Must be 0 if payment method = 1 Must be > 0 if payment method = 2 Payment method = 4, qty will be 0 and amount must be > 0	Must be 0 if payment method = 1 Must be > 0 if payment method = 2 Payment method = 4, qty will be 0 and amount must be > 0	priorAuths278 \ priorAuth278 \ paServiceLoop \ paProcedures \ paProcedureHealthCare \ amountReq
Requested Frequency Code	t_pa_line_item cde_freq_req	Character	1	Req if Waiver	receive: always – Yes per Pam Smith SHPS	W = Weekly M = Monthly	priorAuths278 \ priorAuth278 \ paServiceLoop \ paHSD \ UnitCodeReq
Reqqested Frequency Units	t_pa_line_item qty_freq_req	Num	9	Req if Waiver	receive: always – Yes per Pam Smith SHPS		priorAuths278 \ priorAuth278 \ paServiceLoop \ paHSD \ serviceUnitCountReq
Authorized start date for the service	t_pa_line_item dte_pa_auth_eff	Num	8	Req when approved	If cde_pa_status = “A” must be > 0	format CCYYMMDD	priorAuths278 \ priorAuth278 \ paServiceLoop \ paDates \ certEffectiveFromDate

Fields	Table Location	For-mat	Size	Required	Source: maxMc	Notes	New Schema
Authorized end date for the service	t_pa_line_item dte_pa_auth_end	Num	8	Req when approved	If cde_pa_status = “A” must be > 0	format CCYYMMDD	priorAuths278 \ priorAuth278 \ paServiceLoop \ paDates \ certEffectiveTo Date
Authorized units of service	t_pa_line_item qty_unt_svc_ath	Num	9	Req when approved	If cde_pa_status = “A”pproved must be > 0		priorAuths278 \ priorAuth278 \ paServiceLoop \ paProcedures \ paProcedureHealthCare \ quantityAuth
Authorized amount for the service	t_pa_line_item amt_pa_auth	Num	9	Req when price from PA	Must be 0 if paymet method = 1 Must be > 0 if payment method = 2	Default 0 if payment method = 1 (pay system price) Required if payment method = 2 (Price off of the PA)	priorAuths278 \ priorAuth278 \ paServiceLoop \ paProcedures \ paProcedureHealthCare \ amountAuth
Authorized Frequency Code	t_pa_line_item. cde_freq_auth	Character	1	Req if Waiver	receive: frequency if waiver	W = Weekly M = Monthly	priorAuths278 \ priorAuth278 \ paServiceLoop \ paHSD \ UnitCodeAuth

Fields	Table Location	For-mat	Size	Required	Source: maxMc	Notes	New Schema
Authorized Frequency Units	t_pa_line_item qty_freq_auth	Num	9	Req if Waiver	receive: frequency qty if waiver		priorAuths278 \ priorAuth278 \ paServiceLoop \ paHSD \ serviceUnitCountAuth
Status or Decision of service for a line item	t_pa_line_item cde_pa_status	Character	1	Yes	Must be valid status code or default to "P"ending	"A"pproved, "D"enied, "P"ending Review, "Ready for Submission" "V"oid	priorAuths278 \ priorAuth278 \ paServiceLoop \ paServiceReview \ actionCode (will contain HIPAA values – internet will not need to populate this attribute) and priorAuths278 \ priorAuth278 \ paServiceLoop \ paReviewStatus (will contain non-HIPAA values)
Synch Code	t_pa_line_item cde_synch	Character	25		maxMC sends for every line item	Populated by maxMC – used to synch up line items between systems Case Nbr + line number	priorAuths278 \ priorAuth278 \ paServiceLoop \ lineItemCdeSynch

2.10.2.3 Diagnosis Codes

Fields	Table Location	Format	Size	Required	Source: maxMc	Notes	New Schema
Sequence Number	t_pa_diagnosis num_seq	Num	9	Yes	maxMC assigns	Values – 1 - 9999	priorAuths278 \ priorAuth278 \ paDiagnosis \ seqNum
Diagnosis Code	t_pa_diagnosis sak_diag	Num	9	Yes	Will send at least 1	Must have at least 1 diagnosis code	priorAuths278 \ priorAuth278 \ paDiagnosis \ diagnosisCode

2.10.2.4 Reason Codes

Fields	Table Location	Format	Size	Required	Source: maxMc	Notes	New Schema
Line Item Number	t_pa_iac_xref num_pa_line_item	Character	2	Yes	line item number	maxMC keeps at detail line. Will only send 1 per detail line	priorAuths278 \ priorAuth278 \ paServiceLoop\ paReason \ lineItemNum
Sak Reason Code	t_pa_iac_xref sak_rc	Num	9	Yes	sak for reason code	should be reason code instead of reason code	priorAuths278 \ priorAuth278 \ paServiceLoop\ paReason \ sakReasonCode
Reason Code	t_pa_iac_xref dsc_iac	Character	500	Yes	Get description for reason code		priorAuths278 \ priorAuth278 \ paServiceLoop\ paReason \ reasonCode

Fields	Table Location	Format	Size	Required	Source: maxMc	Notes	New Schema
Date created	t_pa_iac_xref dte_sent	Num	8	Yes	System date		priorAuths278 \ priorAuth278 \ paServiceLoop\ paReason \ sentDate

2.10.2.5 Pending Eligibles and LOC

Fields	Table Location	Format	Size	Required	Source: maxMc	Notes	New Schema
Member ID	t_re_pend_member id_medicaid	Character	10		Member ID		priorAuths278 \ priorAuth278 \ paSubscriberLoop \ paSubscriberNameLoop \ paSubscriber \ idCode
SSN	t_re_pend_member num_ssn	Character	9	Yes	SSN		priorAuths278 \ priorAuth278 \ paSubscriberLoop \ paSubscriberNameLoop \ paSubscriberRef \ refIdQual – where value equal SY – actual SSN would be mapped to priorAuths278 \ priorAuth278 \ paSubscriberLoop \ paSubscriberNameLoop \ paSubscriberRef \ refId

Fields	Table Location	Format	Size	Required	Source: maxMc	Notes	New Schema
LOC	t_pa_pend_loc cde_type_care	Character	2		01 - Nursing Facility 08 - ICF/MR/DD 09 - Mental Health/Psych Hospita 10 - PRTF 12 - IMD 02 - HCBS 05 - SCL 07 - Model Waiver II 11 - Adult Day Care 16 - ABI	SHPS will convert code for KAMES	priorAuths278 \ priorAuth278 \ paSubscriberLoop \ locCode
LOC Met Date	t_pa_pend_loc dte_loc_met	Num	8		LOC met date	format CCYYMMDD	priorAuths278 \ priorAuth278 \ paSubscriberLoop \ locMetDate
Admission Date	t_pa_pend_loc dte_admit	Num	8		Admission date	format CCYYMMDD	priorAuths278 \ priorAuth278 \ paServiceLoop \ paDates \ AdmissionFromDate

Fields	Table Location	Format	Size	Required	Source: maxMc	Notes	New Schema
Provider ID	t_pa_pend_loc sak_prov_loc	Character	15		Provider ID		priorAuths278 \ priorAuth278 \ paServiceProviderLoop \ paServiceProv \ idCode
Date of Birth	t_re_pend_mem ber dte_birth	Num	8		Date of Birth	format CCYYMMDD	priorAuths278 \ priorAuth278 \ paSubscriberLoop \ paSubscriberNameLoop \ paSubscriberDmg \ dteBirth
Gender	t_re_pend_mem ber cde_sex	Character	1		Gender Code	M – Male F – Female U – Unknown	priorAuths278 \ priorAuth278 \ paSubscriberLoop \ paSubscriberNameLoop \ paSubscriberDmg \ gender
Provider Type		Character	2		Provider Type		priorAuths278 \ priorAuth278 \ paServiceProviderLoop \ paServiceProvSuppId \ refId
Last Name	t_re_pend_mem ber nam_last	Character	15		Last Name		priorAuths278 \ priorAuth278 \ paSubscriberLoop \ paSubscriberNameLoop \ paSubscriber \ entityIdQualifier \ name
First Name	t_re_pend_mem ber nam_first	Character	9		First Name		priorAuths278 \ priorAuth278 \ paSubscriberLoop \ paSubscriberNameLoop \ paSubscriber \ entityIdQualifier \ firstName

Fields	Table Location	Format	Size	Required	Source: maxMc	Notes	New Schema
Middle Initial	t_re_pend_member nam_mid_init	Character	1		Middle Initial		priorAuths278 \ priorAuth278 \ paSubscriberLoop \ paSubscriberNameLoop \ paSubscriber \ entityIdQualifier \ middleName
Address 1	t_re_pend_member adr_street_1	Character	25		Address1		paSubscriberAddress \ address1
Address 2	t_re_pend_member adr_street_2	Character	25		Address2		paSubscriberAddress \ address2
City	t_re_pend_member adr_city	Character	22		City		paSubscriberAddress \ city
State	t_re_pend_member adr_state	Character	2		State		paSubscriberAddress \ state
Zip	t_re_pend_member adr_zip_code	Character	5		Zip		paSubscriberAddress \ zip
Zip 4	t_re_pend_member adr_zip _zip_code_4	Character	4		Zip4		paSubscriberAddress \ zip Not in new schema – Substr zip to pull out last 4 digits if any are available

Fields	Table Location	Format	Size	Required	Source: maxMc	Notes	New Schema
County Number	t_re_pend_member cde_county	Character	3		County		paSubscriberAddress \ county

2.10.2.6 PA 278 Interface Response

Fields	Notes	New Schema
Process status	E = Error P = Returning PA nbr D = Done – no further processing required W = Waiting until pending eligible receives Medicaid ID	<priorAuths278>\ <priorAuth278 processField="?">
Error Message Header		<priorAuths278>\ <priorAuth278 processField="E">\ <paError responseCode="X reasonCode="99" actionCode="X" errorDesc="MMIS XX –Error message [node]" />
Error Message Line Item		<priorAuths278>\ <priorAuth278 processField="E">\ <paServiceLoop >\ <paError responseCode="X reasonCode="99" actionCode="X" errorDesc="MMIS XX –Error message [node]" /></paServiceLoop >

2.10.2.7 PA Interface Transaction Processing Version 6.0

Process Status	Transaction Type	Return Process Status	Description
N	A	P	A new Prior authorization (PA) from SHPS
N	U	P	An updated PA from SHPS. Prior authorization transaction may not have a PA if the original add transaction has not made it to interChange and back to MaxMC with a PA number. Look up Case number and Provider number, to see if it exists. If it does exist, update the matching PA, otherwise add the PA.
A	A or U	P	A pending eligible was originally submitted on this transaction. The pending eligible has received a Medicaid ID and now the PA can be submitted with a valid Medicaid ID. This is to pick up the PA and add it to interChange.
K	A, U	See chart below **Process Status "K" Record Types**	Pending eligible or Level of Care transactions. See chart below for processing for each type. The record type is used to determine the type of Pending eligible or Level of Care transaction.

2.10.2.8 Process Status "K" Record Types

PA Txn Record Type	Member processing	Send to KAMES (Y or N)	PA PROCESSING Create PA (Y or N)	Return Process Status to MAX
Pending Eligibles – LOC/Waiver				
I	Inpatient Pending Eligible	N	N	W
P	Add Pending Eligible for Institutional or Waiver	Y	N	W
A	Pending Eligible Waiver Re-Cert – Update LOC dates for the pending eligible	N	N	W
B	Pending Eligible Non-Waiver Re-Cert - Update LOC dates for the pending eligible	N	N	W
LOC/Waiver for Member LOC PA Types = Nursing Facility, IMD, Mental Hospital, PRTF, ICF/MR Waiver PA Types = SCL, ABI, Model Waiver II, HCB, Adult Day Care				

PA Txn Record Type	Member processing	Send to KAMES (Y or N)	PA PROCESSING Create PA (Y or N)	Return Process Status to MAX
L get PA nbr	LOC Facility - new LOC or provider update PA Notes: revenue codes will be 100-219. Take PA info, create a PA and return PA nbr. This is an ADD, error if receive a PA nbr	Y	Y	"P" (PA #) need to set status to "P"
M	Waiver LOC - Strip off first service create PA with line items > 1. If no line items > 1, do not create a PA. This is an ADD, error if receive a PA nbr	Y	Y	"D" if no PA P if PA #
R	Eligible Member **Non-Waiver** Recert **– Update LOC** for a member PA Note: Will pick up the PA **with existing PA number** and update with new extended dates This is an UPDATE/ADD if no PA nbr then will have to first try to match on case nbr, provider nbr and member id. then if no match, create the PA	N	N	P (PA #)

PA Txn Record Type	Member processing	Send to KAMES (Y or N)	PA PROCESSING Create PA (Y or N)	Return Process Status to MAX
W	Eligible Member **Waiver** Re-cert – **Update Waiver** info for a member PA Notes: Strip off first service create PA with line items > 1. If no line items > 1, do not create a PA may not get a PA nbr This is an UPDATE/ADD, if no PA nbr then, will have to first try to match on case nbr, provider nbr and member id otherwise create the PA.	N	Y	"D" if no PA P if PA #

2.10.2.9 PA 278 Interface Error Messages

PA Header				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Prior Auth Number	No	Required	Validate PA number	Invalid Prior Authorization Number
Requesting Provider Number	Can't update if claim paid	Required	Validate ID	Invalid or missing requesting provider ID

PA Header				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Servicing Provider Number	Can't update if claim paid	Required	Validate ID Cannot change if claim has been paid. Check T_PA_ITEM_DTL_XREF to see if a claim has been paid.	Invalid servicing provider ID Claim has paid against this PA. Cannot change servicing provider
Member ID	Can't update if claim paid	Required	Validate Medicaid ID If member status = 'M7" or "P7" and PA Category = '32', do not allow PA If member enrolled in M/C (check t_re_pmp_assign) do not allow PA exceptions are: PA Category = Inpatient, Pysch DPU, Rehab DPU, Impact Plus, NF, Mental Hospital allow for provider specialty 339 (psychiatry) allow if PA Cat = 32 and Procedure is a behavioral health code (see codes under line item edits section) Can't change if claim has paid. Check T_PA_ITEM_DTL_XREF for sak_pa, num_pa_line_item	Invalid Member ID PA not allowed for Member Status M7 and P7 Member is enrolled in Managed Care Cannot change Member ID claim has been paid

PA Header				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
PA Category	Can't update if claim paid	Required	Validate on T_PA_ASSIGN_CODE On a change, verify claim has not paid Validate that the provider type for the service provider on t_pr_type is valid for the PA Category on t_pa_cat_pt_xref	PA Category Code XX Invalid Claim has paid against PA - cannot update PA Category Code Provider Type Not Valid for PA Category Code
Emergency Ind	Can't update if claim paid	Required	Must be "Y" or "N"	Invalid emergency indicator – must be Y or N
Accident Ind	Can't update if claim paid	Required	Must be "Y" or "N"	Invalid accident indicator – must be Y or N
Special Considerations	Can't update if claim paid	Required	Must be "Y" or "N"	Invalid special considerations indicator – must be Y or N
Authorizer	Can't update if claim paid	Required if status is "'A" or "D"	IF SHPS, value = 999999999	Invalid Authorizer ID
Clerk Keyed	No	Required	SHPS, code s/b 999999999	Invalid Entry Clerk ID

PA Header				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Media Type	No	Required	Validate against T_PA_MEDIA 2 = web 3 = SHPS 4 = 278/electronic txn 9 = Conversion	Invalid Media Type
Print Option		Default	Default to “N” If add and approved or denied default to “Y” for certain PA letters If update, set to “Y” for certain PA letters	None
Date Received	No	Required	Must be in CCYYMMDD format Received date <= System date	Invalid Date Received Date format Date cannot be a future date
Time Received -	No	Required	Must be in HHMMSS format	Invalid Time Received
Date PA Keyed	No	Default	System date	None
Admission Date	Can’t update if claim paid		Must be in CCYYMMDD format	Invalid Admission Date format
Discharge Date	Can’t update if claim paid		Must be in CCYYMMDD format	Invalid Discharge Date format

PA Header				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Nursing Facility Indicator	Can't update if claim paid	Required if PA Category = 27	Valid values: Y = Nursing facility V = Ventilator B = BI Locked Unit H = Brain Injury	Invalid Nursing Facility Indicator – value is XX
Orthodontic Status Code Indicator	YES – THIS IS NOT EXCLUDED IFA CLAIM HAS PAID		Only valid for PA Category 73 - Orthodontics Valid values: space = initial setup C = Complete I = In progress P = Prorated L = Lump Sum	Invalid Orthodontic Status Code – value is XX
Service Provider Check	Can't update if claim paid		S = Apply only to Specified Service Provider N = Apply to any Service Provider with the same NPI	Invalid Service Provider Check Code – value is XX

PA Line Item				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Line Item Number	No	Required	Must be at least 1 line item for a PA Line item nbr 01 – 99 Match SHPS' line items with MMIS line items with the T_PA_LINE_ITEM_CDE_SYNCH = priorAuths278 \ priorAuth278 \ paServiceLoop \ lineItemCdeSynch	PA must have at least one line Item. Line item number XX invalid Line item number XX already exists
Service Type Code	Can't update if claim paid	Required	Valid codes are: 1 = Revenue 2 = Procedure Cannot update if a claim has paid on t_pa_item_dtl_xref	Invalid service type code, must be 1 or 2 Claim has paid against PA - cannot update Service Type Code
Procedure code	Can't update if claim paid	Depends on Service Type Code	If service type code = 2 check T_PROC_CODE Cannot update if a claim has paid on t_pa_item_dtl_xref	Invalid procedure code Claim has paid against PA - cannot update Procedure Code

PA Line Item				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Procedure code thru	Can't update if claim paid	Optional	If service type code = 2 and proc thru > spaces T_PROC_CODE Cannot update if a claim has paid on t_pa_item_dtl_xref	Invalid procedure thru code Claim has paid against PA - cannot update Procedure Thru Code
Modifiers	Can't update if claim paid	Optional	Check T_PROC_MOD Validate against other modifiers Cannot update if a claim has paid	Invalid Modifier for procedure code Modifier XX is a duplicate Claim has paid against PA - cannot update Procedure Thru Code
Revenue code from	Can't update if claim paid	Depends on Service Type Code	If service type code = 1 check T_REVENUE_CODE Cannot update if a claim has paid	Invalid Revenue Code Claim has paid against PA - cannot update Revenue Code
Revenue code to	Can't update if claim paid	Optional	If service type code = 1 and revenue thru > spaces T_REVENUE_CODE Cannot update if a claim has paid	Invalid Revenue Code Thru Claim has paid against PA - cannot update Revenue Thru Code

PA Line Item				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Proc Code or Revenue Code	Can't update if claim paid	Required	Do not allow procedure IF member is in M/C and PA Category = 32 allow procedure codes H0005', 'H0015', 'H0017', 'H0018','H0031', 'H0046', 'H0047', 'H2020','H2029' 'H2036','H5050', 'H5170', 'J8499', 'S8990', 'S9480', 'T2048','X0050', 'X0051', 'ZR121', 'ZR124', 'ZR128', 'ZR158', '90801', '90804', '90844', '90853', '90862', '97139', '97150','99450'	Service not allowed for member in Managed Care.
PA Line Item Status	Can't update if claim paid	Required	Valid Codes: A = Approved D = Denied P = Pending V = Void S = Ready for Submission Cannot update if a claim has paid	Invalid Line Item Status Code Claim has paid against PA - cannot update Line Item Status Code

PA Line Item				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Quadrant	Can't update if claim paid	Optional	Check T_PROC_TOOTH_QUAD Cannot update if a claim has paid	Invalid tooth quadrant Claim has paid against PA - cannot update Quadrant
Tooth Number	Can't update if claim paid	Optional	Check T_PROC_TOOTH Cannot update if a claim has paid	Invalid Tooth for Procedure Code Claim has paid against PA - cannot update Tooth Number

PA Line Item				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Payment Method For SHPS and 278 trx get payment method from t_pa_auto_crit (using cde_pa_assign)	Can't update if claim paid	Required if status is 'A'	Valid codes: 1 = Pay system price 2 = Pay unit fee price 4 = Pay cap amount 5 = Pay audit amount	Invalid payment method code
			If payment method = 1 Authorized Dollars must be 0	Authorized dollars must be 0 when payment method Pay System Price is selected.
			If payment method = 2 or 4 Authorized dollars must be greater than 0	Authorized dollars must be greater than 0 if payment method is Pay Unit Fee Price or Pay Cap Amount
			If payment method = 1 or 2 Authorized units must be greater than 0	Authorized units must be greater than 0 if payment method is Pay System Price or Pay Unit Fee Price.
			If payment method = 5 Authorized units and amount must be 0	Authorized units and amount must be 0 when payment method is pay audit amount. Amounts are taken from Claims audit information.
			Cannot update if a claim has paid	Claim has paid against PA - cannot update Payment Method

PA Line Item				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Requested Effective Date	Can't update if claim paid	Required	Must be in CCYYMMDD format Date > 1/1/1900	Requested Effective Date - Invalid date format Requested Begin Date must be > 1/1/1900.
Requested End Date	Can't update if claim paid	Required	Must be in CCYYMMDD format Date must be >= Requested Effective Date	Requested Effective Date - Invalid date format Requested End Date must be >= Requested Effective Date
Requested Units	Can't update if claim paid	If payment method = 1 or 2 Required	If payment method = 1 or 2, units must be > 0	Requested units must be > 0 for payment method specified
Requested Dollars	Can't update if claim paid	If payment method = 2 or 4 Required	If payment method = 4 dollars must be > 0	Requested dollars must be > 0 for payment method specified
Requested Frequency Code	Can't update if claim paid	Required if Waiver PA	Applies to Waivers only W = Weekly M = Monthly Identify Waiver PA by: t_pa_assign_code.cde_pa_grp_assign = '01' where cde_pa_assign = t_pa_pauth.cde_pa_assign	Invalid Requested Frequency Code - Value is X
Requested Frequency Units	Can't update if claim paid	Required if Waiver PA	Applies to Waivers only Units must be > 0	Waiver PA – Requested Frequency Units must be > 0

PA Line Item				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Authorized Effective Date		Required if status = A	Must be in CCYYMMDD format Date > 1/1/1900 If date adjusted forward, look for paid claim on T_PA_ITEM_DTL_XREF and T_HIST_DIRECTORY.DTE_FIRST_SVC can't adjust later than Auth_Eff Date	Invalid date format Authorized Effective Date must be > 1/1/1900 Authorized Effective Date cannot exclude a paid claim – claim has paid against this PA
Authorized End Date		Required if status = A	Must be in CCYYMMDD format Date >= Authorized Effective Date If date adjusted backward, look for paid claim on T_PA_ITEM_DTL_XREF and T_HIST_DIRECTORY.DTE_TO_SVC Can't adjust earlier later than Auth_End_Date Compare t_re_base.dte_death to Auth End Date	Authorized End Date -Invalid date format Authorized End Date must be >= Authorized Effective Date Authorized End Date cannot exclude a paid claim – claim has paid against this PA Authorized end date is after member's date of death

PA Line Item				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Authorized Units		Required if status = A and payment method = 1 or 2 Required	Validate number If units adjusted, look for paid claim on T_PA_ITEM_DTL_XREF. Cannot adjust lower than units already paid If payment method = 1 or 2, units must be > 0	Authorized Units must be numeric Invalid Authorized Units - Units must be greater than units already used Authorized units must be greater than 0 if payment method is Pay System Price or Pay Unit Fee Price
Authorized Frequency Code		Required if Waiver PA and status = A	Applies to Waivers only W = Weekly M = Monthly Identify Waiver PA by: t_pa_assign_code.cde_pa_grp_assign = '01' where cde_pa_assign = t_pa_pauth.cde_pa_assign Cannot update if a claim has paid	Invalid Authorized Frequency Code - Value is X Claim has paid against PA - cannot update Authorized Frequency Code

PA Line Item				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Authorized Frequency Units		Required if Waiver PA and status = A	Applies to Waivers only Units must be > 0 Cannot update if a claim has paid	Waiver PA – Authorized Frequency Units must be > 0 Claim has paid against PA - cannot update Authorized Frequency Units
Authorized Dollars		Required if status = A and payment method = 4	If payment method = 2 or 4, authorized dollars must be > 0 If payment method = 4, and amount is reduced, look for paid claim on T_PA_ITEM_DTL_XREF. Cannot adjust lower than dollars already paid.	Authorized Dollars must be >= 0.01 if Pay Unit Fee Price or Pay Cap Amount are selected. Invalid Authorized Dollars - Dollars must be greater than dollars already used
Synch Code			No edits - will come in on SHPS transaction with Case Number will update with whatever SHPS sends	

Reason Code				
Field	**Updateable**	**Optional/Required**	**Edit Performed**	**Error Message**
Reason Code		Required – If status is A or D	Validate reason code on T_PA_IAC_TEXT Cannot update if a claim has paid	Invalid reason code XXX

Additional Diagnosis Codes				
Field		**Optional/Required**	**Edit Performed**	**Error Message**
Sequence of Diagnosis	Cannot update if a claim has paid	Required	There must be a least 1 diagnosis code For a SHPS' update - If do not find code, delete; If find new code, add; and, If duplicate, don't' add Must be between 1 – 9,999	Diagnosis Code is required for this PA. (Diagnosis code is required for all PAs except where provider type = 60 or 61 or if dte_pa_keyed earlier than go-live date) Diagnosis sequence number must between 1 and 9999
Diagnosis Code		Required	Must be on T_DIAGNOSIS	Diagnosis Code XXXXXXX Invalid

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
2868	Open		3326 - KYAmend Create Pend Text Panel 2775 - Add KY Edit 953 - iC 3343 3322 - KYAmend Create Pend LItem panel 3325 - KYAmend Create Pend Diag Panel 3726 - kYAmend Modify Pending Litem 2518 - KYAmend Load PAs for Pending Elg 2772 - KYAmend Create Pend Search Panel 3323 - KYAmend Create Pend PAInfo Panel 2755 - KYAmend Delete Old Pending PAs 2754 - KYAmend Pending PA table
2873	Open		2935 - KYAmend Process Web PAs
2908	Completed		2514 - KYAmend Display PA Documents
2928	Open		2788 - KYAmend PASRR
30.030.005	No mapping required		
30.030.005.001	No mapping required		
30.030.005.001.1	No mapping required		
30.030.005.001.10	No mapping required		
30.030.005.001.11	No mapping required		
30.030.005.001.2	No mapping required		
30.030.005.001.3	No mapping required		