Claims Subsystem User Manual

Kentucky MMIS Project

Cabinet for Health and Family Services
Department for Medicaid Services

November 30, 2012

Cabinet for Health and Family Services Department for Medicaid Services	
Role:	Name:
Author	HPES Management
Reviewer	Patti George
HP Enterprise Services Management	HP Enterprise Services
Client	Commissioner Lawrence Kissner Claims Division Director Rhonda Poston Executive Director/CIO Lorna S. Jones Chief Technical Officer Sandeep Kapoor
DELIVERABLE TITLE: KY_MMIS_Service_Authorization_User_Manual	DATE SUBMITTED: August 1, 2012
FILE Name: KY_MMIS_Claims_User_Manual_OPERATIONAL_v5.3_(DMS_Approved-11-29-2012).docx	AUTHORING TOOL: MS Word 2010

Document Change Log

Version	Changed Date	Changed By	Reason
1.0	9/14/2007	Anita Batten	Creation of new document – 1st draft.
2.0	10/25/2007	Anita Batten	Revisions made according to Commonwealth comments.
3.0	11/26/2007	Anita Batten	Revisions made according to walkthrough comment log.
4.0	12/07/2007	Anita Batten	Global walkthrough updates
4.1	12/18/2007	Anita Batten	Revised per comment log
4.2	01/25/2008	Ann Murray	Updated per comment log
4.3	02/05/2008	Cathy Hill	Made revisions per Patti George
4.4	03/05/2008	Cathy Hill	Made revisions per Pam Hershey
4.4	11/03/2008	Cathy Hill	Made revisions per Jackie Washabaugh
4.4	03/10/2009	Cathy Hill	Replaced KyHealth Choices with KY Medicaid per Stayce Towles
4.5	05/12/2009	Ron Chandler	Inserted new report, CLM-0800-S, per CO11210 via Pam Hershey.
4.6	10/29/2009	Ron Chandler	Replace all instances of “EDS” with “HP Enterprise Services”, while NOT changing table names, email addresses, roles and role names.
4.7	06/30/2010	Ron Chandler	Insert PANEL: Category of Service in 3 places per Mike Hudson per defect #14024, DMS approved on 06/25/2010.
4.8	01/19/2012	Mike Hudson Ann Murray	Added Adjustment Reason Code sections 4.2.15, 4.2.49 and 4.2.84 per CO 17091
4.9	06/22/2012	Ann Murray Bonnie Feeback	Updated section 4.9 and added section 4.9.8.
5.0	07/12/2012	Mike Hudson Ann Murray	Added new Encounter and MCO panels per CO 18089, approved by DMS July 9, 2012.
5.1	08/01/2012	Mike Hudson Keri Hicks	Update Panel: DRG Per CO# 15398 DMS approved 07/31/2012..
5.2	09/12/2012	Mike Hudson Keri Hicks	Replace DRG Panel pages per CO 15398, DMS approved 07/31/2012.

Version	Changed Date	Changed By	Reason
5.3	11/30/2012	Mike Hudson Keri Hicks	Added Encounter Resubmission Tracking Search Panels per CO 18524, DMS Approved 11/29/2012.

Table of Contents

1 Introduction 1
1.1 User Manual Audience 1
2 Overview 2
2.1 Data Model 3
2.2 External System Interfaces 4
3 Getting Started 5
3.1 System Access 5
3.2 Accessing the Claims subsystem 5
3.3 The Claims Panels Display 6
3.3.1 Claims Menu Selections 6
4 Pages and Panels 7
4.1 PAGE: Claims Search Page 8
4.1.1 Description 8
4.1.2 Technical Name 8
4.1.3 Web Page Name: 8
4.1.4 Claims Search Page Layout 9
4.1.5 PANEL: Claims Search 11
4.1.6 PANEL: Claims Search Results 17
4.2 PAGE: Claims Information Page 22
4.2.1 Description 22
4.2.2 Web Page Name: 22
4.2.3 Claims Information Page Layout 22
4.2.4 PANEL: Claims Mini Search 23
4.2.5 PANEL: Physician Claim 25
4.2.6 PANEL: Physician Claim Navigation 32
4.2.7 PANEL: Additional Claim Information 35
4.2.8 PANEL: Cash Disposition 38
4.2.9 PANEL: Diagnosis 40
4.2.10 PANEL: Display TCN 42
4.2.11 PANEL: Encounter Data 44
4.2.12 PANEL: Expecting Date 46
4.2.13 PANEL: Medicare Information - Physician 48
4.2.14 PANEL: Service/Prior Authorization 51
4.2.15 PANEL: Adjustment Information - Daughter or Mother 53
4.2.16 PANEL: Adjustment Reason Code 55
4.2.17 PANEL: Check 57
4.2.18 PANEL: Category of Service 60
4.2.19 PANEL: Display TCN 62
4.2.20 PANEL: Health Program 64
4.2.21 PANEL: Member Coinsurance 69
4.2.22 PANEL: Related History 71
4.2.23 PANEL: Attachment 73
4.2.24 PANEL: Data Correction Note 75
4.2.25 PANEL: EOB 79
4.2.26 PANEL: Location 83
4.2.27 PANEL: Member Copay 85
4.2.28 PANEL: Submitted Data - Physician 88
4.2.29 PANEL: CAS Inquiry 90
4.2.30 PANEL: Decision Rules 92
4.2.31 PANEL: Error 95
4.2.32 PANEL: MCO Data 99

4.2.33 PANEL: MCO Detail Information....101
4.2.34 PANEL: Miscellaneous Information....103
4.2.35 PANEL: Physician Claim Detail Navigation....105
4.2.36 PANEL: Detail Health Program....107
4.2.37 PANEL: Detail Related History....112
4.2.38 PANEL: Detail EOB....114
4.2.39 PANEL: Detail Submitted Data - Physician....118
4.2.40 PANEL: Detail Error....122
4.2.41 PANEL: Physician Claim Detail....126
4.2.42 PANEL: UB92 Claim....133
4.2.43 PANEL: UB92 Claim Navigation....140
4.2.44 PANEL: Additional Claim Information....143
4.2.45 PANEL: Cash Disposition....146
4.2.46 PANEL Decision Rules....148
4.2.47 PANEL: EOB....148
4.2.48 PANEL: Location....152
4.2.49 PANEL: Related History....154
4.2.50 PANEL: Adjustment Information - Daughter or Mother....156
4.2.51 PANEL: Adjustment Reason Code....158
4.2.52 PANEL: Check....160
4.2.53 PANEL: Category of Service....162
4.2.54 PANEL: Diagnosis....164
4.2.55 PANEL: Error....166
4.2.56 PANEL: MCO Data....171
4.2.57 PANEL: MCO Detail Information....173
4.2.58 PANEL: Occurrence....175
4.2.59 PANEL: Submitted Data - UB92....178
4.2.60 PANEL: Attachment....180
4.2.61 PANEL: Condition....182
4.2.62 PANEL: Display TCN....184
4.2.63 PANEL: Health Program....186
4.2.64 PANEL: Medicare Information - UB92....191
4.2.65 PANEL: Payer....194
4.2.66 PANEL: Value....197
4.2.67 PANEL: CAS Inquiry....199
4.2.68 PANEL: Data Correction Note....201
4.2.69 PANEL: DRG....205
4.2.70 PANEL: Encounter Data....209
4.2.71 PANEL: ICD-9-CM....211
4.2.72 PANEL: Service/Prior Authorization....214
4.2.73 PANEL: UB92 Claim Detail....216
4.2.74 PANEL: UB92 Claim Detail Navigation....221
4.2.75 PANEL: Detail Health Program....223
4.2.76 PANEL: Detail Related History....228
4.2.77 PANEL: Detail EOB....230
4.2.78 PANEL: Detail Submitted Data - UB92....233
4.2.79 PANEL: Detail Error....237
4.2.80 PANEL: Dental Claim....241
4.2.81 PANEL: Dental Claim Navigation....247
4.2.82 PANEL: PANEL: Additional Claim Information....250
4.2.83 PANEL: Cash Disposition....253
4.2.84 PANEL: Diagnosis....255
4.2.85 PANEL: Health Program....257
4.2.86 PANEL: Member Copay....263
4.2.87 PANEL: Adjustment Information - Daughter or Mother....266
4.2.88 PANEL: Adjustment Reason Code....268

4.2.89 PANEL: Check 270
4.2.90 PANEL: Category of Service 273
4.2.91 PANEL: Display TCN 275
4.2.92 PANEL: Encounter Data 277
4.2.93 PANEL: Location 279
4.2.94 PANEL: Service/Prior Authorization 281
4.2.95 PANEL: Attachment 283
4.2.96 PANEL: Data Correction Note 285
4.2.97 PANEL: EOB 289
4.2.98 PANEL: MCO Data 293
4.2.99 PANEL: MCO Detail Information 295
4.2.100 PANEL: Related History 297
4.2.101 PANEL: CAS Inquiry 299
4.2.102 PANEL: Decision Rules 301
4.2.103 PANEL: Error 303
4.2.104 PANEL: Member Coinsurance 307
4.2.105 PANEL: Submitted Data - Dental 309
4.2.106 PANEL: Dental Claim Detail 311
4.2.107 PANEL: Dental Claim Detail Navigation 317
4.2.108 PANEL: Additional Claim Information 319
4.2.109 PANEL: Detail Quadrant Cavity 322
4.2.110 PANEL: Detail Related History 324
4.2.111 PANEL: Detail EOB 326
4.2.112 PANEL: Detail Error 330
4.2.113 PANEL: Detail Submitted Data - Dental 334
4.2.114 PANEL: Detail Health Program 336
4.2.115 PANEL: Pharmacy Claim 341
4.2.116 PANEL: Pharmacy Claim Navigation 347
4.2.117 PANEL: Encounter Data 350
4.2.118 PANEL: NCPDP Reject Codes 352
4.3 PAGE: Claims Adjustment Search Page 354
4.3.1 Technical Name 354
4.3.2 Web Page Name 354
4.3.3 Claims Adjustment Search Page Layout 355
4.3.4 PANEL: Adjustment Search 356
4.3.5 PANEL: Adjustment Search Results 358
4.4 PAGE: Claims Adjustment Information Page 361
4.4.1 Technical Name 361
4.4.2 Web Page Name 361
4.4.3 Claims Adjustment Information Page Layout 362
4.4.4 PANEL: Adjustment Mini-Search 363
4.4.5 PANEL: Adjustment Information 365
4.4.6 PANEL: Claim Adjustment Navigation 368
4.4.7 PANEL: Adjustment Request 370
4.4.8 PANEL: Net Verification 375
4.5 PAGE: Claims Mass Adjustment Information Page 379
4.5.1 Description 379
4.5.2 Technical Name 379
4.5.3 Web Page Name: 379
4.5.4 Claims Mass Adjustment Information Page Layout 380
4.5.5 PANEL: Mass Adjustment Information 382
4.5.6 PANEL: Mass Claims Adjustment Navigation 385
4.5.7 PANEL: Mass Adjustment Entry 387
4.5.8 PANEL: Mass Adjustment Criteria 392
4.5.9 PANEL: Mass Net Verification 400
4.6 PAGE: Claims Data Correction Page 405

4.6.1 Description 405
4.6.2 Technical Name 405
4.6.3 Web Page Name: 405
4.6.4 Claims Data Correction Page Layout 406
4.6.5 PANEL: Claims Suspense List 408
4.6.6 PANEL: Physician Claim Correction 410
4.6.7 PANEL: UB92 Claim Correction 420
4.6.8 PANEL: Dental Claim Correction 430
4.7 PAGE: Claims Assignment Page 438
4.7.1 Description 438
4.7.2 Web Page Name: 438
4.7.3 Claims Assignment Page Layout 438
4.7.4 PANEL: Assignments Navigation 439
4.7.5 PANEL: Claims Assignment 441
4.7.6 PANEL: Schedule Claims 445
4.7.7 PANEL: QA Review Criteria 448
4.7.8 PANEL: Scheduling Criteria 451
4.8 PAGE: Claims Encounter Page 455
4.8.1 Description 455
4.8.2 Technical Name 455
4.8.3 Web Page Name: 455
4.8.4 Claims Encounter Page Layout 455
4.8.5 PANEL: Encounter Data Navigation 457
4.8.6 PANEL: EDI Encounter Batch Status Search 459
4.8.7 PANEL: EDI Encounter Batch Status Search Results 461
4.8.8 PANEL: Encounter Batch Summary Search 463
4.8.9 PANEL: Encounter Batch Summary Search Results 465
4.8.10 PANEL: Encounter Errors 469
4.8.12 PANEL: Encounter Resubmission Tracking Search 471
4.8.13 PANEL: Encounter Resubmission Tracking Search Results 473
4.8.14 PANEL: Encounter Claims Related Data 475
4.9 PAGE: Claims Related Data Page 477
4.9.1 4.9.1 Description 477
4.9.2 4.9.2 Technical Name 477
4.9.3 4.9.3 Web Page Name: 477
4.9.4 4.9.4 Claims Related Data Page Layout 477
4.9.5 PANEL: Related Data –Other 478
4.9.6 PANEL: Edit Recycle 480
4.9.7 PANEL: Encounter Threshold 483
4.9.8 PANEL: Denied Claim Resubmit 486

5 Reports 488
5.1.1 CLM-0010-D -- Online Adjustment Daily Report 489
5.1.2 CLM-0011-D -- Clerk ID Recycle Claims Report 492
5.1.3 CLM-0012-D -- EOB Listing 494
5.1.4 CLM-0015-D -- ClaimCheck Potential History to Adjust 496
5.1.5 CLM-0016-D -- Claims Processing Daily Summary 500
5.1.6 CLM-0017-D -- Original Claims Processing Daily Summary 509
5.1.7 CLM-0018-D -- Adjustment Credit Claims Processing Daily Summary 518
5.1.8 CLM-0020-D -- Aged Detail Suspense Report 526
5.1.9 CLM-0021-D -- Suspense File Analysis by Error Code 529
5.1.10 CLM-0022-D -- Combined Claim Error 531
5.1.11 CLM-0023-D -- Claims Error Report 547
5.1.12 CLM-0024-D -- Daily Error Summary By Claim Type 555
5.1.13 CLM-0025-D -- Services to be Clerically Denied Report 561
5.1.14 CLM-0026-D -- Claims Paid Due To Force Report 566

5.1.15 CLM-0027-D -- Transaction Register 570
5.1.16 CLM-0031-M -- Suspense File Analysis by Claim Type 2 575
5.1.17 CLM-0046-M -- Potential Schedule 2 Narcotic Drug Abuse 580
5.1.18 CLM-0050-M -- Retro Active Rate Adjustment Report 583
5.1.19 CLM-0051-D -- Aged Detail Adjustment Report 589
5.1.20 CLM-0054-D -- Error Recycle Parameters 591
5.1.21 CLM-0055-D -- Daily Error Summary By Claim Type Original Claims 593
5.1.22 CLM-0056-D -- Daily Error Summary By Claim Type Adjustments 598
5.1.23 CLM-0058-Q -- ClaimCheck Error Report 603
5.1.24 CLM-0060-D -- Suspense File Analysis By Claim Type 3 607
5.1.25 CLM-0064-W -- Suspended Claims by Claim Type - Region 616
5.1.26 CLM-0065-D -- Aged Suspended Claims By Location Report 619
5.1.27 CLM-0130-D -- Claims Submission Statistics - Daily 622
5.1.28 CLM-0130-M -- Claims Submission Statistics - Monthly 630
5.1.29 CLM-0130-W -- Claims Submission Statistics - Weekly 636
5.1.30 CLM-0132-D -- Encounters Submission Statistics - Daily 642
5.1.31 CLM-0132-M -- Encounters Submission Statistics - Monthly 649
5.1.32 CLM-0132-O -- Encounters Submission Statistics - On Request 656
5.1.33 CLM-0800-S – Child Medical Conference Semi-Annual Report 662
5.1.34 CLM-5000-D -- Top Ten Claims Approved For Payment 665
5.1.35 CLM-8600-W -- Pended Claims Aging 669
5.1.36 CLM-9914-Q -- Abortions Procedure Report 673

6 Letters 677

7 Glossary of Terms 678
7.1 Terms and Acronyms 678
7.1.1 A 680
7.1.2 B 685
7.1.3 C 688
7.1.4 D 695
7.1.5 E 701
7.1.6 F 704
7.1.7 G 707
7.1.8 H 709
7.1.9 I 713
7.1.10 J 716
7.1.11 K 717
7.1.12 L 718
7.1.13 M 720
7.1.14 N 724
7.1.15 O 727
7.1.16 P 729
7.1.17 Q 736
7.1.18 R 737
7.1.19 S 741
7.1.20 T 745
7.1.21 U 749
7.1.22 V 750
7.1.23 W 751
7.1.24 X 752
7.1.25 Y 753

8 Appendix A – interChange Navigational Overview 754
8.1 System Navigation Introduction 754
8.1.1 Introduction 754
8.1.2 Screen Display Features 754

8.2 System Wide Common Terminology and Layouts 754
8.2.1 Home Page Layout 756
8.2.2 Page Layout 757
8.2.3 Search Options 759
8.2.4 Panel Layout 765
8.2.5 Related Data 773
8.2.6 Personal Settings 778

9 Appendix B – How To Search for Claims 788
9.1 How to Search for a Claim Using an Internal Control Number 788
9.1.1 Claims/Claim Search Panel Field Descriptions 788
9.1.2 Claims/Claim Search Panel Button Descriptions 789
9.1.3 Claims/Information/Physician Claim Panel Field Descriptions 790
9.2 How to Search for a Claim Using a Provider Number and Member Number 793
9.2.1 Claims/Claim Search Panel Field Descriptions 793
9.2.2 Claims/Claim Search Panel Button Descriptions 794
9.2.3 Claims/Search Results Panel Field Descriptions 795
9.2.4 Claims/Information/Dental Claims Panel Field Descriptions 796
9.3 How to Search for a Claim Using Other Criteria (Advanced Search) 799
9.3.1 Claims/Advanced Search Panel Field Descriptions 800
9.3.2 Claims/Advanced Search Panel Button Descriptions 802
9.3.3 Claims/Information/UB92 Claim Information Panel Field Descriptions 803

10 Appendix C – How To Review Claim Information 806
10.1 Viewing Claim Header Information 806
10.1.1 Claims/Information/Physician Claim Panel Field Descriptions 807
10.2 Viewing Claim Detail Information 810
10.2.1 Claims/Information/Physician Claim/Claim Detail Panel Field Descriptions 811
10.3 Determining a Claim Payment Amount 813
10.3.1 Claims/Information/Dental Claims Panel Field Descriptions 814
10.4 Determining a Reason for Claim Denial 816
10.4.1 Claims/Information/UB92 Claim Information Panel Field Descriptions 816
10.4.2 Claims/Information/UB92 Claim/ Error Panel Field Description 819
10.5 Viewing Additional Information on Professional Claims 820
10.5.1 Viewing Member Copay/Coinsurance Information on Professional Claims 820
10.5.2 Viewing Procedure Codes (HCPCS) on Professional Claims 826
10.5.3 Viewing Claim Related History on Professional Claims 831
10.5.4 Viewing Diagnosis Codes on Professional Claims 835
10.5.5 Viewing Check Information on Professional Claims 839
10.5.6 Viewing Health Program Information on Professional Claims 844
10.5.7 Viewing Medicare Information on Professional Claims 848
10.6 Viewing Additional Information on Institutional Claims 853
10.6.1 Viewing Member Co-Pay / Co-Insurance Information on Institutional Claims 853
10.6.2 Viewing Procedure Codes (HCPCS) on Institutional Claims 858
10.6.3 Viewing Claim Related History Institutional Claims 863
10.6.4 Viewing Diagnosis Codes Institutional Claims 868
10.6.5 Viewing Check Information Institutional Claims 873
10.6.6 Viewing Health Program Information Institutional Claims 878
10.6.7 Viewing Medicare Information Institutional Claims 884
10.7 Viewing Additional Information on Dental Claims 888
10.7.1 Viewing Member Co-Pay/Co-Insurance Information on Dental Claims 888
10.7.2 Viewing Procedure Codes on Dental Claims 891
10.7.3 Claims/Information/Dental Claims Panel Field Descriptions 891
10.7.4 Viewing Claim Related History on Dental Claims 896
10.7.5 Viewing Check Information on Dental Claims 899
10.7.6 Viewing Health Program Information on Dental Claims 904

11 Appendix D – How To Correct Data on Claims 909
11.1 Data Correcting a Physician Claim 909
11.1.1 Accessing the Data Correction Page 909
11.1.2 Determining Why a Claim is Suspended 912
11.1.3 Viewing the Image of a Paper Claim 914
11.1.4 Correcting the Claim Header Information 917
11.1.5 Correcting Detail Information 919
11.1.6 Correcting Information in Other Panels 921
11.1.7 Resubmitting Corrected Claims 924
11.2 Data Correcting a UB92 Claim 926
11.2.1 Accessing the Data Correction Page 926
11.2.2 Determining Why a Claim is Suspended 928
11.2.3 Viewing the Image of a Paper Claim 930
11.2.4 Correcting the Claim Header Information 934
11.2.5 Correcting Detail Information 936
11.2.6 Correcting Information in Other Panels 939
11.2.7 Resubmitting Corrected Claims 942
11.3 Data Correcting a Dental Claim 944
11.3.1 Accessing the Data Correction Page 944
11.3.2 Determining Why a Claim is Suspended 946
11.3.3 Viewing the Image of a Paper Claim 948
11.3.4 Correcting Detail Information 953
11.3.5 Correcting Information in Other Panels 956
11.3.6 Resubmitting Corrected Claims 960

12 Appendix E – How to Adjust Claims 961
12.1 Adjusting a Single Claim 961
12.1.1 Claims/Claim Search Panel Field Descriptions 961
12.1.2 Claims/Claim Search Panel Button Descriptions 962
12.1.3 Adjustment Request Panel Field Descriptions 964
12.1.4 Adjustment Request Panel Field Descriptions 965
12.1.5 Adjustment Request Panel Button Descriptions 966
12.1.6 Adjustment Information Panel Field Descriptions 968
12.2 Setting Up a Mass Adjustment 970
12.2.1 Adjustments Search Panel Field Descriptions 970
12.2.2 Adjustments Search Panel Button Descriptions 971
12.2.3 Mass Adjustment Criteria Panel Field Descriptions 974
12.2.4 Claims/Adjustments/Mass Adjustment Criteria Panel Button Descriptions 974
12.2.5 Claims/Adjustments/Mass Adjustment Entry Panel Field Descriptions 976
12.2.6 Mass Net Verification Panel Field Descriptions 977
12.2.7 Claims/Adjustments/Mass Net Verification Panel Button Descriptions 978

13 Appendix F – How to Schedule and Assign Claims 980
13.1 Scheduling Claims 980
13.1.1 Scheduling Criteria Panel Field Descriptions 981
13.1.2 Claims/Assignments/Scheduling Criteria Panel Button Descriptions 982
13.1.3 Schedule Claims Panel Field Descriptions 983
13.1.4 Schedule Claims Panel Button Descriptions 984
13.2 Assigning Claims 986
13.2.1 Claims Assignment Advanced Search Panel Field Descriptions 987
13.2.2 Claims Assignment Advanced Search Panel Button Descriptions 988
13.2.3 Claims Assignment Search Results Panel Field Descriptions 989
13.2.4 Claims Assignment Search Results Panel Button Descriptions 989

14 Appendix G – Using the Audit Trail 992
14.1 Audit Results Field Descriptions 993

15 Appendix H– Using the Help Functions 995

15.1 Accessing Help for a Field 996
15.2 Accessing Help for a Panel 996

1 Introduction

This is the Claims User Manual.

This manual covers the following areas:

- Subsystem Overview;
- Getting Started;
- Procedures;
- Panels;
- Reports;
- Letters;
- Glossary of Terms;
- interChange Navigational Overview;
- Claims How To Guide;
- How to Use Audit Functionality; and
- How to Use Help Functions.

The Table of Contents (TOC), in the PDF document, contains a user-friendly point and click capability. When the user moves the mouse over a section name in the TOC the pointer changes from a hand to a pointing finger. When the user clicks, while it is a pointing finger, it takes them to that section.

1.1 User Manual Audience

This manual is designed to serve the needs of the following staff:

- System and Functional Area Users; and,
- System Testers.

2 Overview

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

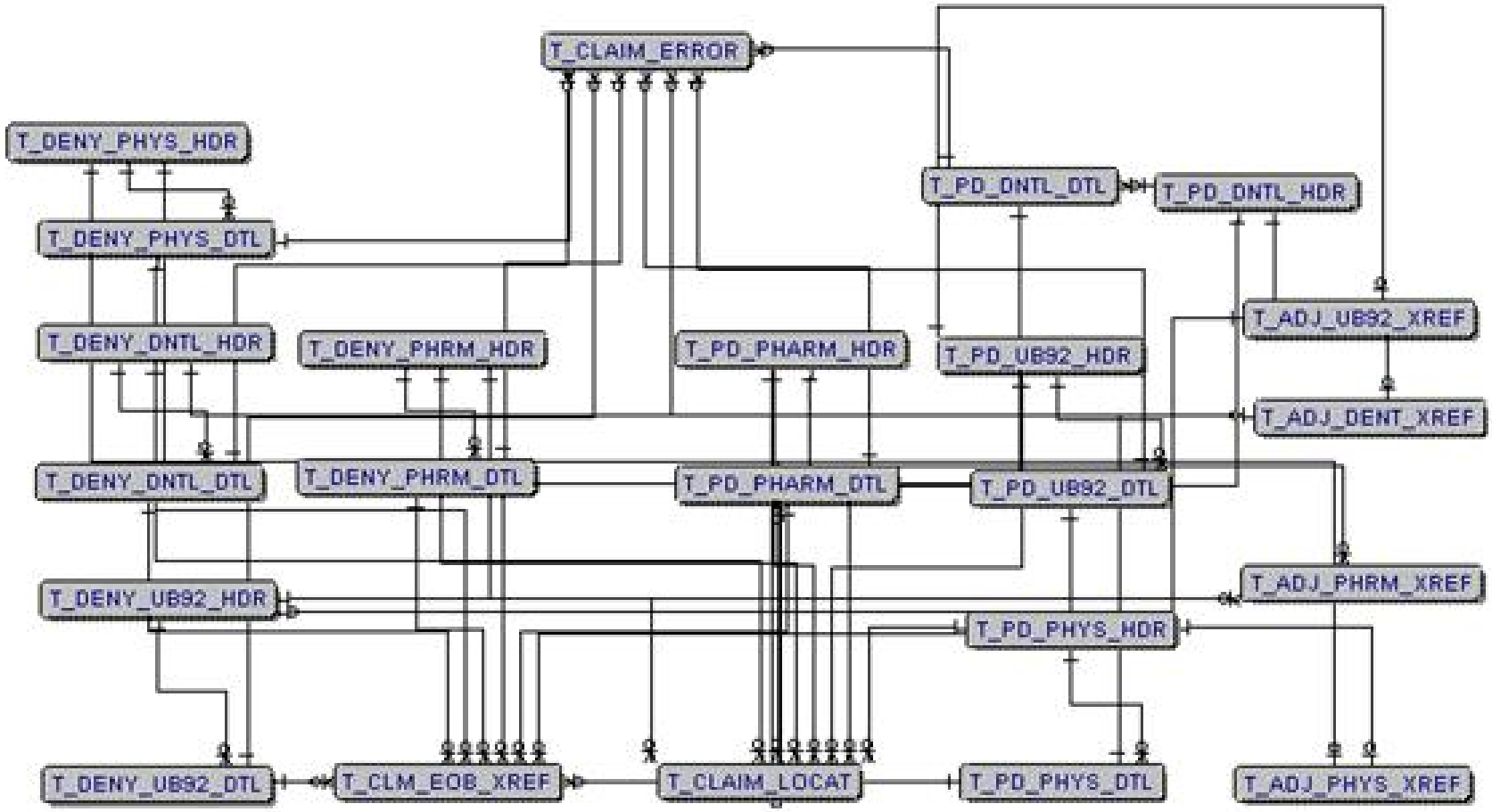
The interChange system provides a user-driven and maintainable claims processing environment. Data elements owned by interChange are captured and stored with a single key name in one physical location within the database and are accessed by all the other interChange processes. A majority of the claims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

The MMIS Claims Processing function includes:

- Claims Entry - ensures the accuracy, reasonableness and integrity of interChange entered data,
- Claims Receipt and Control - ensures all claim records are captured at the earliest possible time and in an accurate manner,
- Edit/Audit Processing - ensures that claim records are processed in accordance with state policy,
- Claims Pricing - calculates the payment amount for each service according to the rules and limitations applicable to each claim type, service, and provider type,
- Claims Resolution - is to support the correction of suspended claims,
- Point of Sale (POS)/Prospective Drug Utilization Review(PRODUR) - provides for the on-line processing of pharmacy claims submitted in real-time by pharmacists and prevents the dispensing of inappropriate drugs through direct intervention. The Commonwealth of Kentucky is not using this functionality. They use a Pharmacy Benefit Manager/Administrator (PBA),
- Adjustment Processing - supports the adjustment of adjudicated claims,
- Claims Disposition – gives information on how to set up dispositioning for edits and audits,
- Claims Reporting – is the claims reporting process, and,
- Claim Check – gives information on claim check.

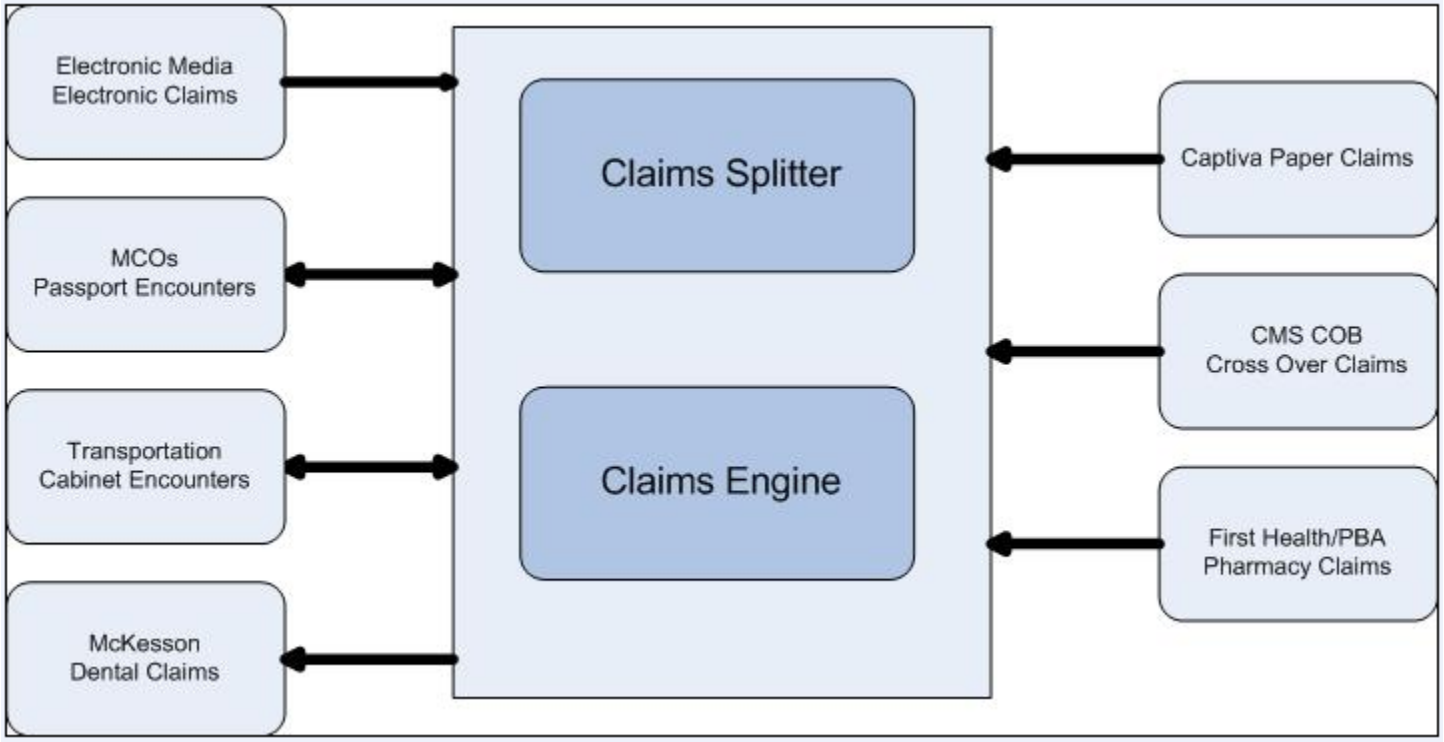
2.1 Data Model

The following data model gives a view of the entities within this subsystem.



2.2 External System Interfaces

The following context diagram gives a view of the entities that this subsystem interfaces with.



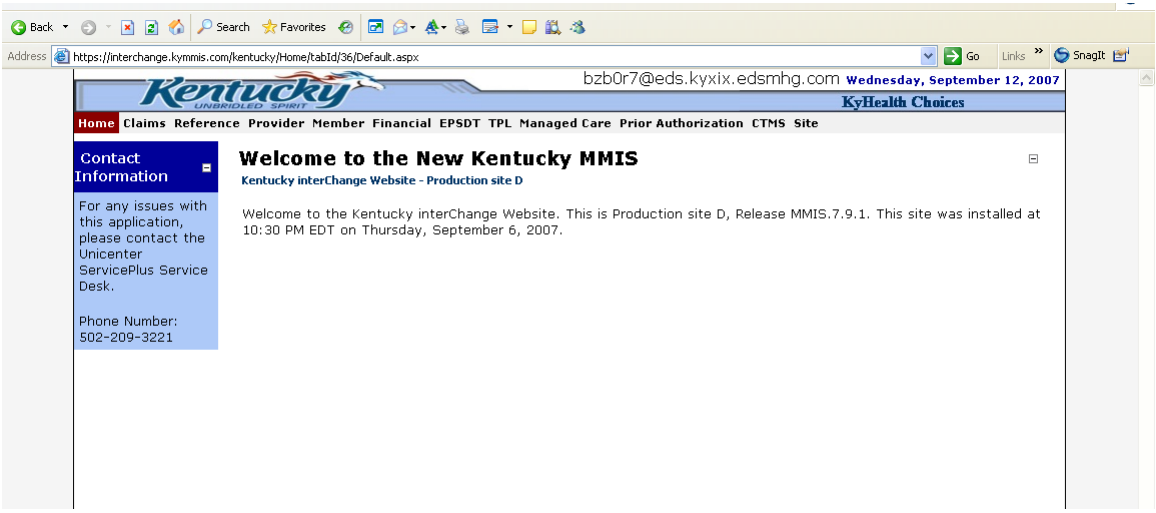
3 Getting Started

3.1 System Access

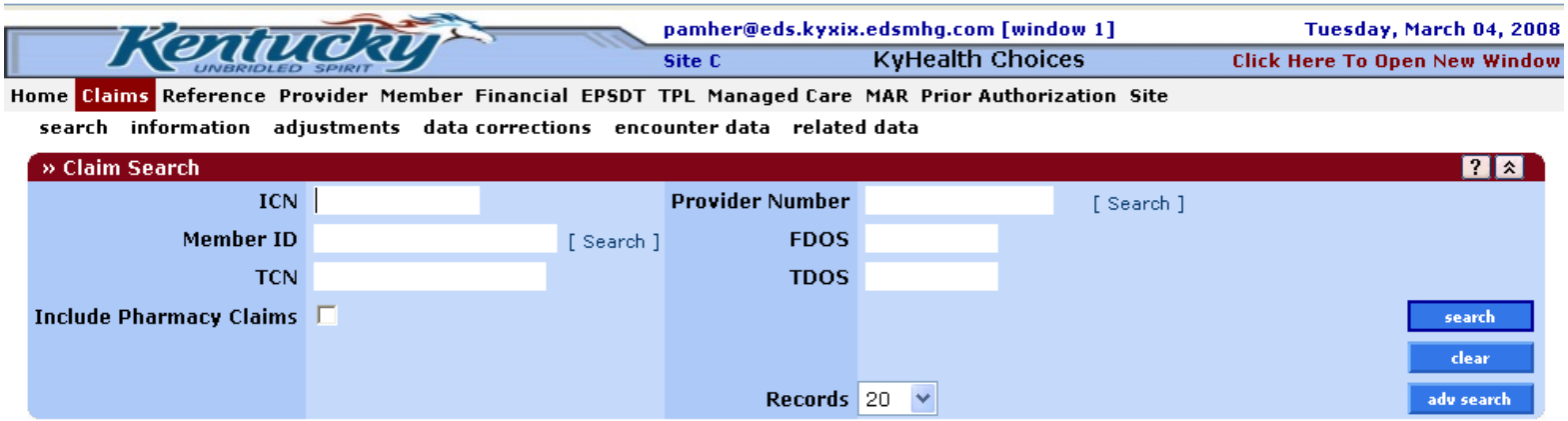
A user with access to the Claims system can access Claims in interChange. If you do not have access and require access please contact your Manager.

3.2 Accessing the Claims subsystem

To access the Claims subsystem in interChange MMIS, click on the interChange icon which takes you to the home page. Click on Claims.



3.3 The Claims Panels Display



3.3.1 Claims Menu Selections

Field	Description
Search	Allows the user to search for claims using many combinations of search criteria. Main search fields are Member ID, Provider Number or ICN.
Information	Allows user to access Abnormalities, Member Comments and Notices.
Adjustments	Use the Adjustment Information Page to access panels to display or create adjustment requests.
Data Corrections	The Claims Data Correction Page provides access to suspended claim header and detail information.
Assignments	Allows user to assign suspended claims to a resolution clerk.
Encounter Data	The Claims Encounter Page contains the Encounter Navigation Panel. From here, access two main search panels, the EDI Batch Status and the Encounter Batch Summary.
Related Data	The Related Data page contains links for the Encounter Threshold panel and the Edit Recycle panel

4 Pages and Panels

The Pages/Panels section is set up to display first the Page, and then all associated Panels. If a panel is accessible through more than one page, it displays multiple times in the document.

Each of the interChange (iCE) panels contain a button on the panel title bar showing a question mark, that provides the user with a hyperlink to the corresponding PWB documentation for the panel that the user has displayed. Information contained in the PWB includes a sample layout and list of the fields with descriptions.

As appropriate, each field with a small arrow next to the drop down list box, allows the user to select or view all values that the field can contain. The majority of the values are also defined in the related data panel for the system area being displayed.

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.

Note to users:

Each panel is numbered, with corresponding field information. The valid values are listed in the New KY MMIS Code Value Book.

4.1 PAGE: Claims Search Page

4.1.1 Description

Use the Search Page for the Claims subsystem to search for and view claims based on selected criteria.

4.1.2 Technical Name

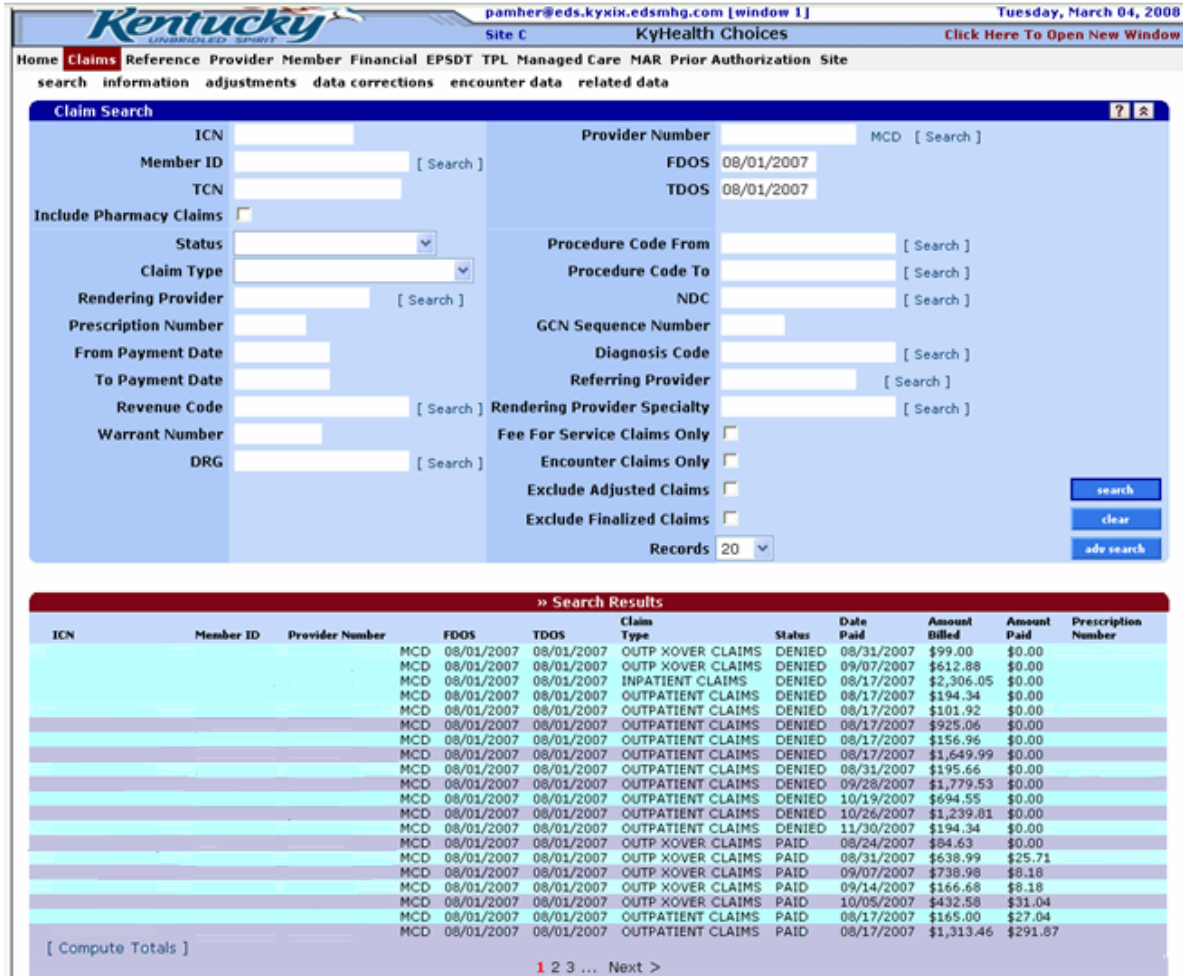
Clm.ClaimSearchPage.ascx

4.1.3 Web Page Name:

Claims Search Page

For readability, the page layout displays on the next page.

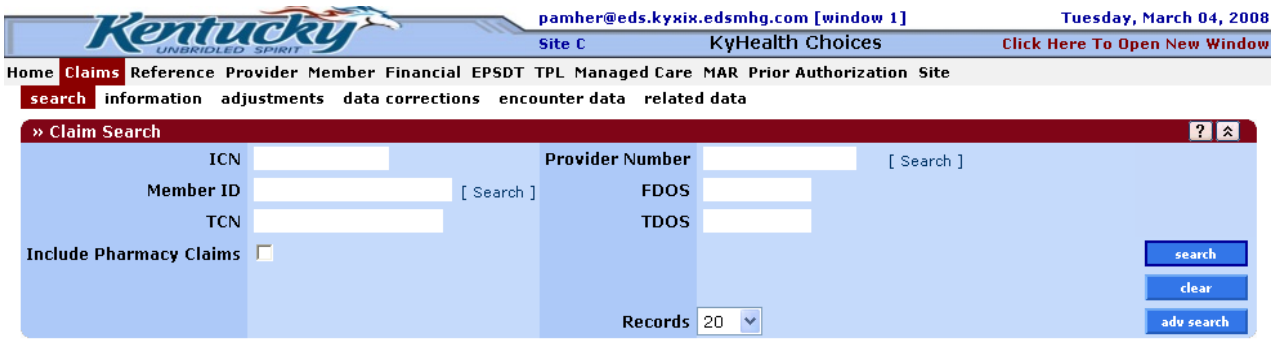
4.1.4 Claims Search Page Layout



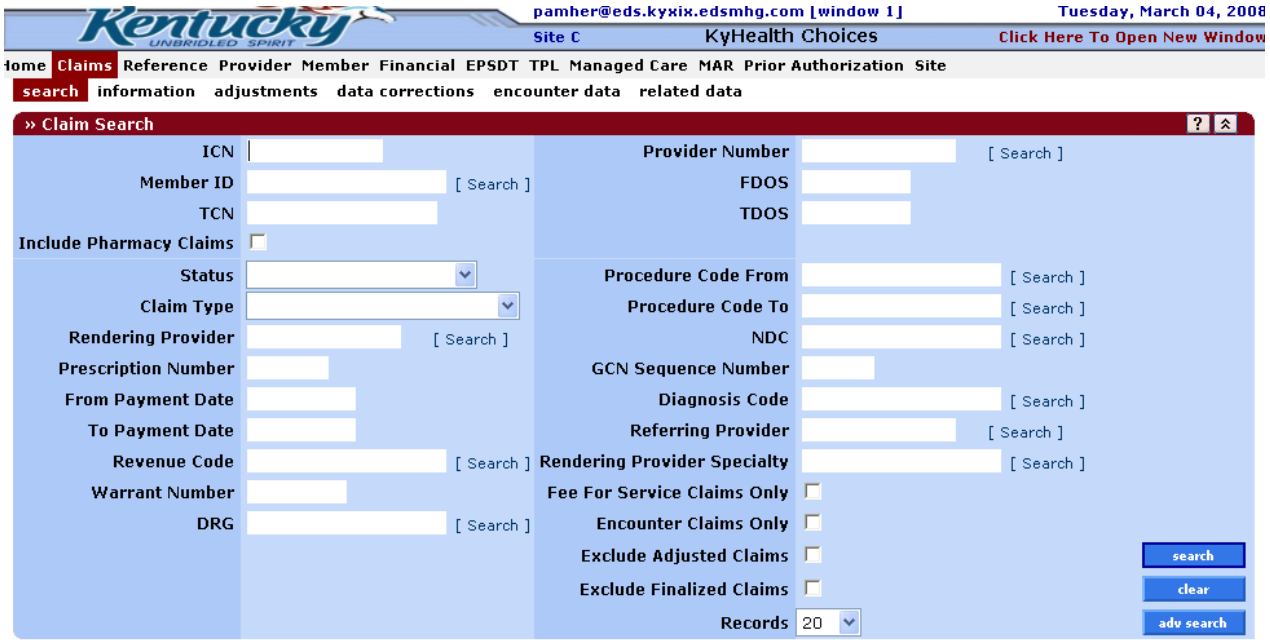
To access this page:

STEP 1. Click on Claims (1) located in the subsystem header listing under the Commonwealth logo “Kentucky Unbridled Spirit”.

STEP 2. Click on Search (2) located under the subsystem header listing. Claim Search panel displays.



STEP 3. Click on Adv Search.



4.1.5 PANEL: Claims Search

4.1.5.1 Description

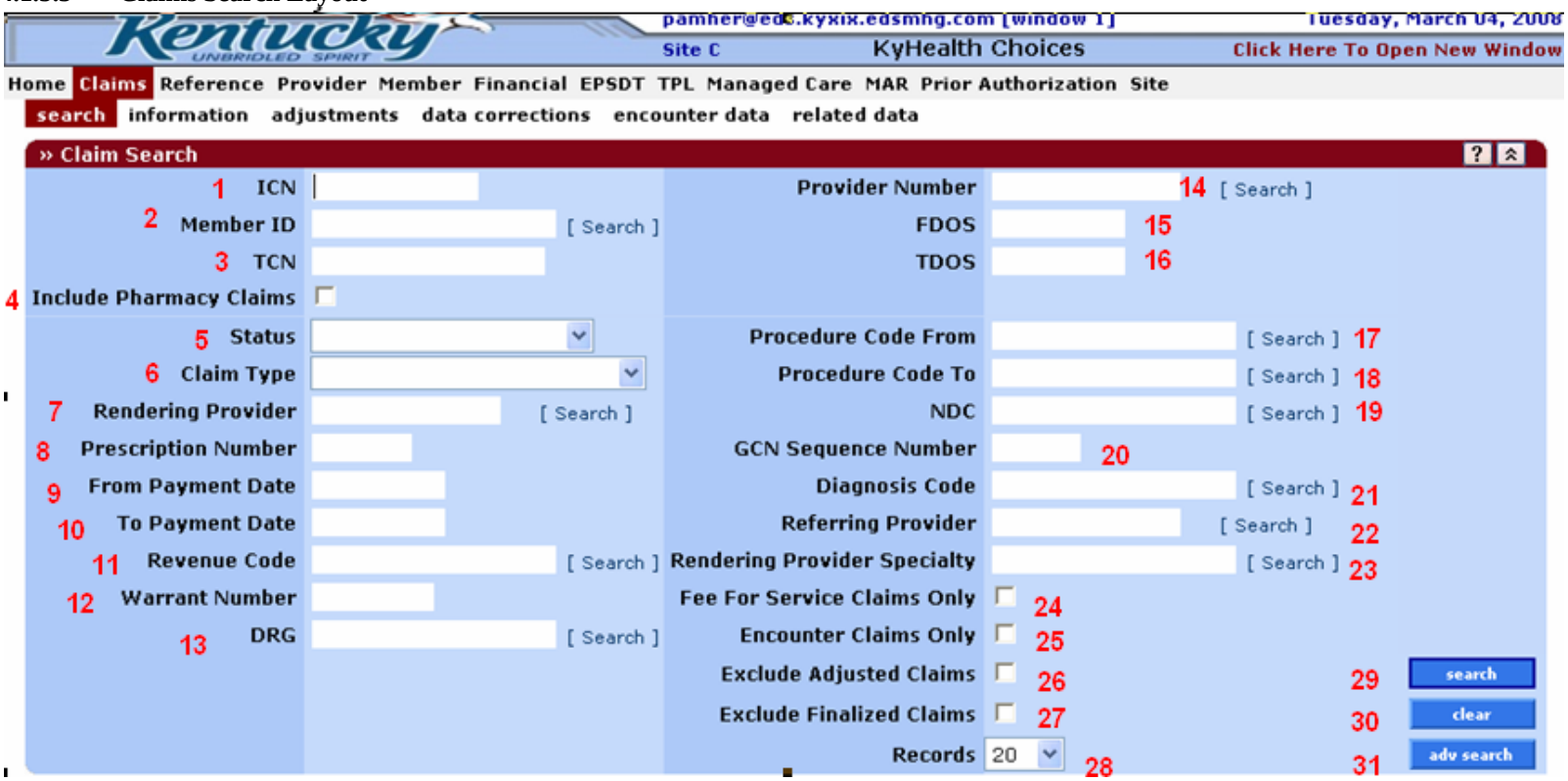
Use various select options on the Claim Search panel to view only the claims required. The primary selection items are ICN, Billing and Rendering Provider, or Member ID. Select claims by using one or all of the primary selection items. Additional search criteria include claim type, claim status, from date of service, to date of service, and payment date. When specific selection criteria are entered, click search to initiate the search. The system searches the database for all claims that meet the criteria and displays all the applicable ICNs on the Claims Search Results display panel.

Navigation Path: [Claims -Search]

4.1.5.2 Panel Name

Claims Search

4.1.5.3 Claims Search Layout



To access this panel:

Access the Claims Search page using the instructions listed for the page. Claims can be searched several ways:

- Using a 13 digit number ICN number and click Search button.
- Clicking the Search button next to the Member ID field to bring up the pop-up window listing and clicking a row to select.
- Clicking the Search button next to the Provider ID field to bring up the pop-up window listing and clicking a row to select.

4.1.5.4 Extra Features

This panel has no extra features.

4.1.5.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	ICN	Internal Control Number which uniquely identifies a claim	Field	Character	13	T_HIS_DIRECTORY	NUM_ICN_FL
2	Member ID	An assigned number which uniquely identifies a Member	Field	Character	12	T_RE_BASE	ID_MEDICAID
3	TCN	The transaction control number used to uniquely identify claims on the previous MMIS	Field	Number	17	T_TCN_XREF	NUM_TCN
4	Include Pharmacy Claims	When selected, will list all claim types including pharmacy claims; when not selected, will list all claim types except pharmacy claims	Field	Check Box	0	N/A	N/A
5	Status (Additional Search Criteria)	Identifies the column names for the sort criteria to be executed	Field	Drop Down List Box	0	T_HIST_DIRECTORY	CDE_CLM_STATUS
6	Claim Type (Additional Search Criteria)	(Additional Search Criteria) Identifies the column names for the sort criteria to be executed	Field	Drop Down List Box	0	T_HIST_DIRECTORY	CDE_CLM_TYPE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
7	Rendering Provider	Provider Identification Number which uniquely identifies the rendering provider and provider's service location	Field	Character	10	T_PR_PROV	ID_PROVIDER
8	Prescription Number	Number assigned by a pharmacy to identify the drug dispensed to a member	Field	Character	7	T_PD_PHARM_HDR	NUM_PRSCRIP
9	From Payment Date	Beginning payment date in a range select option	Field	Date (MM/DD/ CCYY)	8	T_HIST_DIRECTOR Y	DATE_PAID
10	To Payment Date	Ending payment date in a range select option	Field	Date (MM/DD/ CCYY)	8	T_HIST_DIRECTOR Y	DATE_PAID
11	Revenue Code (Additional Search Criteria)	Revenue Code search option. T_PD_UB92_DTL, T_DENY_UB92_DTL or T_SUSP_UB92_DTL	Field	Number	3	T_REVENUE	CDE_REVENUE
12	Warrant Number (Additional Search Criteria)	Warrant number search option	Field	Number	9	N/A	N/A
13	DRG	Diagnosis Related Group for UB92 claims	Field	Character	3	T_DRG	CDE_DRG
14	Provider Number	Provider Identification Number which uniquely identifies the pay to provider	Field	Character	9	T_PR_PROV	ID_PROVIDER
15	FDOS (Additional Search Criteria)	Date of first service on the claim	Field	Date (MM/DD/CC YY)	8	T_HIS_DIRECTORY	DTE_FIRST_SVC

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
16	TDOS (Additional Search Criteria)	Date of last service on the claim	Field	Date (MM/DD/CCYY)	8	T_HIST_DIRECTORY	DTE_TO_DATE
17	Procedure Code From (Additional Search Criteria)	Beginning procedure code in a range selection option	Field	Character	6	T_PROC	CDE_PROC
18	Procedure Code To (Additional Search Criteria)	Ending procedure code in range selection option	Field	Character	6	T_PROC	CDE_PROC
19	NDC (Additional Search Criteria)	National Drug Code search option	Field	Number	11	T_DRUG	CDE_NDC
20	GCN Sequence Number (Additional Search Criteria)	Generic code number search option	Field	Number	5	T_GENERIC_DRUG	NUM_GCN
21	Diagnosis Code (Additional Search Criteria)	Diagnosis code search option	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
22	Referring Provider (Additional Search Criteria)	Provider Identification Number and Location which uniquely identifies the referring provider	Field	Character	10	T_PR_PROV	ID_PROVIDER

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
23	Rendering Provider Specialty (Additional Search Criteria)	Rendering Provider's specialty code. T_PD_DNTL_DTL/T_PD_PHYS_DTL T_DENY_PHYS_DTL/T_DENY_DNTL_DTL T_SUSP_PHYS_DTL T_SUSP_DENTAL_DTL T_DENY_PHYS_HDR/T_DENY_DNTL_HDR	Field	Character	3	T_PR_SPEC	CDE_PROV_SPEC
24	Fee for Service Claims Only (Additional Search Criteria)	List only fee for service claims	Field	Check Box	0	N/A	N/A
25	Encounter Claim Only (Additional Search Criteria)	List only Encounter claims	Field	Check Box	0	N/A	N/A
26	Exclude Adjusted Claims (Additional Search Criteria)	List exclude Adjusted Claims	Field	Check Box	0	N/A	N/A
27	Exclude Finanlized Claims (Additional Search Criteria)	List exclude Finalized Claims	Field	Check Box	0	N/A	N/A
28	Records	This field sets the number of records displayed per page	Field	Drop Down List Box	0	N/A	N/A
29	Search	Performs a query on the database and returns the data for the entered search criteria	Button	N/A	0	N/A	N/A

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
30	Clear	Clears the previous search criteria from the search fields	Button	N/A	0	N/A	N/A
31	Adv Search	Advanced Search Button opens a panel with additional search criteria fields	Button	N/A	0	N/A	N/A

4.1.5.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
9	From Payment Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify format and re-enter.
15	FDOS (Additional Search Criteria)	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify format and re-enter.
16	TDOS (Additional Search Criteria)	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify date and re-enter.
24	Fee for Service Claims Only (Additional Search Criteria)	Field	1	Choose Fee For Service Claim or Encounter Claim.	Only one Fee for Service or Encounter Claims must be checked.

4.1.6 PANEL: Claims Search Results

4.1.6.1 Description

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

Click on a Member ID or Provider ID and the related Base Information panel displays.

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

4.1.6.2 Panel Name

Claims Search Results

4.1.6.3 Claims Search Results Layout

» Search Results

ICN	Member ID	Provider Number		FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid	Prescription Number
			MCD	08/01/2007	08/01/2007	OUTP XOVER CLAIMS	DENIED	08/31/2007	$99.00	$0.00	
			MCD	08/01/2007	08/01/2007	OUTP XOVER CLAIMS	DENIED	09/07/2007	$612.88	$0.00	
			MCD	08/01/2007	08/01/2007	INPATIENT CLAIMS	DENIED	08/17/2007	$2,306.05	$0.00	
			MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$194.34	$0.00	
			MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$101.92	$0.00	
			MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$925.06	$0.00	
			MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$156.96	$0.00	
			MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$1,649.99	$0.00	
			MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/31/2007	$195.66	$0.00	
			MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	09/28/2007	$1,779.53	$0.00	
			MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	10/19/2007	$694.55	$0.00	
			MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	10/26/2007	$1,239.81	$0.00	
			MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	11/30/2007	$194.34	$0.00	
			MCD	08/01/2007	08/01/2007	OUTP XOVER CLAIMS	PAID	08/24/2007	$84.63	$0.00	
			MCD	08/01/2007	08/01/2007	OUTP XOVER CLAIMS	PAID	08/31/2007	$638.99	$25.71	
			MCD	08/01/2007	08/01/2007	OUTP XOVER CLAIMS	PAID	09/07/2007	$738.98	$8.18	
			MCD	08/01/2007	08/01/2007	OUTP XOVER CLAIMS	PAID	09/14/2007	$166.68	$8.18	
			MCD	08/01/2007	08/01/2007	OUTP XOVER CLAIMS	PAID	10/05/2007	$432.58	$31.04	
			MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	08/17/2007	$165.00	$27.04	
			MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	08/17/2007	$1,313.46	$291.87	

[Compute Totals] Claim Count: 316 Total Billed:$333,763.13 Total Paid:$51,997.63

1 2 3 ... Next >

To access this panel:

STEP 1. Access the Claims Search page using the instructions listed for the page.

Claims can be searched several ways:

- Click the Search button next to the Member ID field to bring up the pop-up window listing and click a row to select.
- Click the Search button next to the Provider ID field to bring up the pop-up window listing and click a row to select.

STEP 2. Click on row to select.

4.1.6.4 Extra Features

This panel has no extra features.

4.1.6.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	ICN	Internal control number which uniquely identifies a claim meeting the selection criteria	Field	Character	13	T_HIST_DIRECTORY	NUM_ICN_FL
2	Member Id	An assigned number which uniquely identifies a member	Field	Character	12	T_RE_BASE	ID_MEDICAID
3	Provider Id	The provider identification number that uniquely identifies the pay to provider	Field	Character	9	T_PR_PROV	ID_PROVIDER
4	FDOS	From Dates of Service for the claim	Field	Date (MM/DD/CCYY)	8	T_HIST_DIRECTORY	DATE_FIRST_SVC
5	TDOS	To Dates of Service for the claim	Field	Date (MM/DD/CCYY)	8	T_HIST_DIRECTORY	DTE_TO_DATE
6	Claim Type	Indicates the type of claim	Field	Character	50	T_HIST_DIRECTORY	CDE_CLM_TYPE
7	Status	Identifies the status of the claim within the system	Field	Character	20	T_HIST_DIRECTORY	CDE_CLM_STATUS
8	Date Paid	Date the claim was paid	Field	Date (MM/DD/CCYY)	8	T_HIST_DIRECTORY	DATE_PAID
9	Amount Billed	Amount billed for the claim. Format 999999.99	Field	Number	9	T_HIST_DIRECTORY	AMT_BILLED

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
10	Amount Paid	Amount Paid for the claim. This field is obtained from one of the following tables depending on Claims Type: T_PD_PHARM_HDR, T_PD_DENT_HDR, T_PD_PHYS_HDR, T_PD_UB92_HDR. Format 999999.99. Source for the Amt Paid field varies by Claim Status and Claim Type. Status = Paid(P): Type = Dental(D): T_PD_DNTL_HDR.[AMT_PAID/CDE_SERVI CE_LOC] Type = Pharmacy(P,Q): T_PD_PHARM_HDR.[AMT_TOT_REIMB/CDE_SERVICE_LOC] Type = Physician(B,M): T_PD_PHYS_HDR.[AMT_TOT_REIMB/CDE_ SERVICE_LOC] Type = UB92(A,C,H,I,L,O): T_PD_UB92_HDR.[AMT_PAID/CDE_SERVI CE_LOC] Status = Denied(D): Type = Dental(D): T_DENY_DNTL_HDR.[CDE_SERVICE_LOC] Type = Pharmacy(P,Q): T_DENY_PHRM_HDR.[CDE_SERVICE_LOC] Type = Physician(B,M): T_DENY_PHYS_HDR.[CDE_SERVICE_LOC] Type = UB92(A,C,H,I,L,O): T_DENY_UB92_HDR.[CDE_SE	Field	Number	9	SEE DESCRIPTION	SEE DESCRIPTION

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
		RVICE_LOC] Status = Suspended(S): Type = Dental(D): T_SUSP_DENTAL_HDR.[CDE_SERVICE_LO C] Type = Pharmacy(P,Q): T_SUSP_PHRM_HDR.[CDE_SERVICE_LOC] Type = Physician(B,M): T_SUSP_PHYS_HDR.[CDE_SERVICE_LOC] Type = UB92(A,C,H,I,L,O): T_SUSP_UB92_HDR.[CDE_SERVICE_LOC]					
11	Prescrip Number	The prescription number that applies to the claim.	Field	Number	7	T_PHRM_HDR_KEYS	NUM_PRSCRIP_SUB
12	Claim Count	Number of claims found for the selection criteria	Field	Numeric	5	N/A	N/A
13	Total Amount Billed	Total amount billed of the claims found for the selection criteria. This field is the sum of all the Amount Billed amounts. Format 999999999.99	Field	Numeric	11	N/A	N/A
14	Total Amount Paid	Total amount Paid of the claims found for the selection criteria. This field is the sum of all the Amount Billed amounts. Format 999999999.99	Field	Number	11	N/A	N/A

4.1.6.6 Field Edits

Field	Field Type	Error Code	Error Message	To Correct

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

4.2 PAGE: Claims Information Page

4.2.1 Description

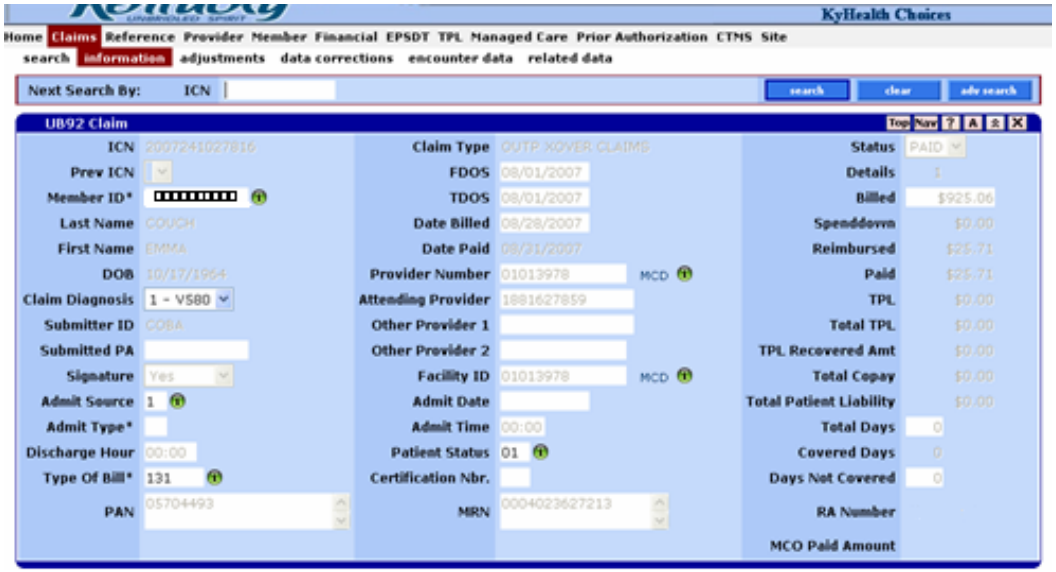
The Claims Information Page contains panels that display claim header and detail information. A navigation panel is displayed with links to related claim information.

4.2.2 Web Page Name:

Claims Information Page

For readability the layout displays on the next page.

4.2.3 Claims Information Page Layout



To access this page:

STEP 1. Click on Claims (1) located in the subsystem header listing under the Commonwealth logo “Kentucky Unbridled Spirit”.

STEP 2. Enter ICN or desired search criteria and select search. Note: If you are searching with criteria other than the ICN a search results list will appear and once you have selected the ICN to view the Claims Information page will open.

4.2.4 PANEL: Claims Mini Search

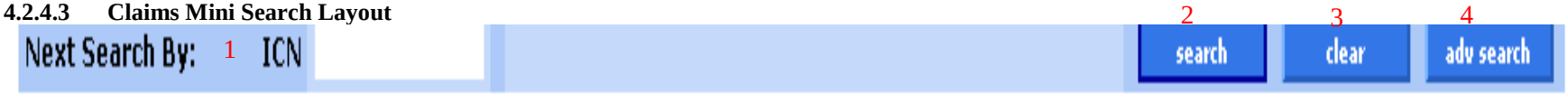
4.2.4.1 Description

Use the Claims Mini Search panel to search the database for all claims by specific ICN. This panel displays at the top of the Claims Information Page.

4.2.4.2 Panel Name

Claims Mini Search

4.2.4.3 Claims Mini Search Layout



To access this panel:

STEP 1. Access the Claims Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

4.2.4.4 Extra Features

This panel has no extra features.

4.2.4.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	ICN	Internal Control Number that uniquely identifies a claim	Field	Character	13	T_HIST_DIRECTORY	NUM_ICN_FL
2	Search	Performs a query on the database and returns the data for the entered search criteria	Button	N/A	0	N/A	N/A
3	Clear	Clears the previous search criteria from the search fields	Button	N/A	0	N/A	N/A
4	Adv Search	Advanced Search Button, opens the Claims Search panel with additional search criteria fields	Button	N/A	0	N/A	N/A

4.2.4.6 Field Edits

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

4.2.5 PANEL: Physician Claim

4.2.5.1 Description

The Physician Claim panel displays the header information on a selected Physician (CMS1500) claim.

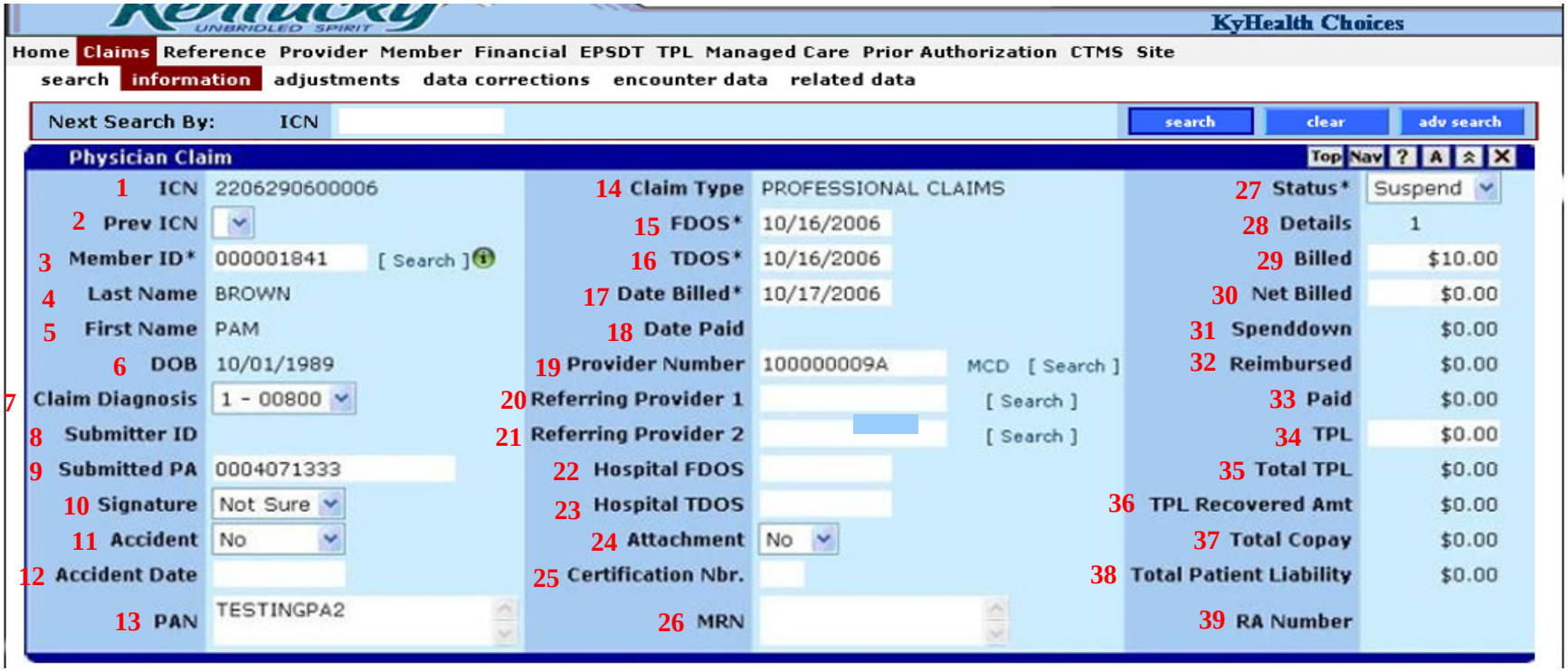
Navigation Path: [Claims -Information] - [Enter an ICN for a Physician claim];

OR - [Claims -Search] - [Enter Criteria] - [Select a Physician claim].

4.2.5.2 Panel Name

Physician Claim

4.2.5.3 Physician Claim Layout



To access this panel:

STEP 1. Access the Claims Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

This panel displays all the non-detail line claim information submitted on the claim.

4.2.5.4 Extra Features

This panel has no extra features.

4.2.5.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	ICN	Internal control number which uniquely identifies a claim	Field	Character	13	SEE NARRATIVE SECTION	NUM_ICN
2	Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	NUM_ICN
3	Member ID	An assigned number which uniquely identifies a Member	Field	Character	12	T_PHYS_HDR_KEY	ID_MEDICAID
4	Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number, the first three characters of the last name that was typed are displayed.	Field	Character	15	T_PHYS_HDR_KEY	CLM_LST_NAM_RECIP

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number, the first character of the first name that was typed is displayed	Field	Character	15	T_PHYS_HDR_KEY	CLM_RECIP_FST_NAM
6	DOB	Member date of birth	Field	Date (MM/DD/CCYY)	8	T_PHYS_HDR_KEY	DTE_SUBSCRIBER_DOB
7	Diagnosis	Code used to identify the primary or other diagnoses	Field	Drop Down List Box	0	T_PD_PHYS_DTL	CDE_DIAG_TREAT_IND
8	Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.	Field	Character	12	T_EDI_INTERCHANGE	CDE_SENDER_ID
9	RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles	Field	Number	12	T_FIN_REMIT_TXN_XREF	SAK_REMIT
10	Signature	Indicates whether the claim was signed by the provider or representative	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	IND_PROV_SIGN
11	Accident	Indicates whether the service performed was as a result of an accident	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	IND_ACCIDENT
12	Accident Dt	Date of accident	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_ACCIDENT

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
13	PAN	Patient's unique identification number assigned by the provider to track the patient's financial records	Field	Character	38	SEE NARRATIVE SECTION	NUM_PAT_ACCT
14	Claim Type	Indicates the type of claim	Field	Character	50	SEE NARRATIVE SECTION	CDE_CLM_TYPE
15	FDOS	Beginning date of service on the claim	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_FIRST_SVC
16	TDOS	Ending date of service on the claim	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_LAST_SVC
17	Date Billed	Date on which claim was submitted for processing	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_BILLED
18	Date Paid	Date on which the claim was paid	Field	Date (MM/DD/CCYY)	8	T_CLM_PGM_ XREF	DTE_FINAL
19	Prov ID/Loc	The pay to provider identification number and location that uniquely identifies the provider of services	Field	Character	10	SEE NARRATIVE SECTION	ID_PROVIDER, CDE_SERVICE_ LOC
20	Ref Prov1 ID/Loc	The license number of the referring physician and location other than the attending physician	Field	Character	10	SEE NARRATIVE	ID_PROV_REFER, CDE_SVC_LOC_ REF_1

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
21	Ref Prov2 ID/Loc	The license number of the second referring physician and location other than the attending physician	Field	Character	10	SEE NARRATIVE	SEE DESCRIPTION
22	Hospital FDOS	First date hospitalized	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_FROM_HOSP
23	Hospital TDOS	Last date hospitalized	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_TO_HOSP
24	Attachment	Indicates whether an attachment is present	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	IND_ATTACHMENT
25	Certification Nbr.	Code used to identify the certification of the member	Field	Character	2	SEE NARRATIVE SECTION	CDE_CERTIFICATE
26	MRN	Code representing the Medical Record Number	Field	Character	30	SEE NARRATIVE SECTION	CDE_MED_REC_NUM
27	Status	This field displays the status of the claim	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	CDE_CLM_STATUS
28	Details	The number of detail service lines on the claim	Field	Number	4	SEE NARRATIVE SECTION	NUM_DTL_TOTAL
29	Billed	Amount requested by the provider for services rendered. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_BILLED

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
30	Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, and so on.). Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_NET_BILLED
31	Spenddown	Amount of money that the member is responsible for paying for services. Format 9999999.99	Field	Number	9	SEE NARRATIVE SECTION	AMT_PATNT_LIAB
32	Reimbursed	Total amount the provider receives. Format 9999999.99	Field	Number	9	T_PD_PHYS_HDR	AMT_TOT_REIM
33	Paid	Amount paid on claim. This value is computed by adding up all the AMT_PAID values for the related details. Format 999999.99	Field	Number	8	T_CLM_PGM_XREF	AMT_PAID
34	TPL	Amount paid by third party for services at the claim header level. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	TPL_AMT
35	Total TPL	The sum of the TPL amounts at the header and detail levels Format 999999.99	Field	Number	8	N/A	N/A
36	TPL Recovered Amt	The recovery amount populated from the settlement panel. Format 9999999.99	Field	Number	9	T_TPL_AR_DISPS	AMT
37	Copay	The sum of all the detail co-pay amounts applicable to the claim. Format 99999.99	Field	Number	7	T_PD_PHYS_HDR	AMT_CO_PAY

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
38	Patient Liability	The amount of patient liability applied to this claim	Field	Number	12	SEE NARRATIVE SECTION	AMT_PATNT_LIAB

4.2.5.6 Field Edits

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

4.2.6 PANEL: Physician Claim Navigation

4.2.6.1 Description

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

Navigation Path: [Claims -Information] - [Enter an ICN for a Physician claim] -;

OR - [Claims -Search] - [Enter Criteria] - [Select a Physician claim];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a Physician claim from the list].

4.2.6.2 Panel Name

Physician Claim Navigation

4.2.6.3 Physician Claim Navigation Layout

To access this panel:

STEP 1. Click a row to select a claim from search results.

When a claim record is selected, the navigation panel will open below the information panel.

4.2.6.4 Extra Features

This panel has no extra features.

4.2.6.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Additional Claim Information	Link to "Additional Claim Information" panel	Hyperlink	N/A	0	N/A	N/A
2	Cash Disposition	Link to "Cash Disposition" panel	Hyperlink	N/A	0	N/A	N/A
3	Diagnosis	Link to "Diagnosis " panel	Hyperlink	N/A	0	N/A	N/A
4	Expecting Date	Link to "Expecting Date" Panel.	Hyperlink	N/A	0	N/A	N/A
5	Medicare Information	Link to "Medicare Information" Panel	Hyperlink	N/A	0	N/A	N/A
6	Prior Authorization	Link to "Service/Prior Authorization" panel	Hyperlink	N/A	0	N/A	N/A
7	Adjustment Information	Link to "Adjustment Information " panel	Hyperlink	N/A	0	N/A	N/A
8	Check	Link to "Check " panel	Hyperlink	N/A	0	N/A	N/A
9	Display TCN	Link to "TCN" panel	Hyperlink	N/A	0	N/A	N/A
10	Health Program	Link to "Health Program" panel.	Hyperlink	N/A	0	N/A	N/A
11	Member Coinsurance	Link to "Member Coinsurance" panel.	Hyperlink	N/A	0	N/A	N/A
12	Related History	Link to "Related History" panel	Hyperlink	N/A	0	N/A	N/A
13	Attachment	Link to "Attachment" panel	Hyperlink	N/A	0	N/A	N/A
14	Data Correction Note	Link to "Data Correction Note" Panel	Hyperlink	N/A	0	N/A	N/A

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
15	EOB	Link to "EOB" panel	Hyperlink	N/A	0	N/A	N/A
16	Location	Link to "Location" panel	Hyperlink	N/A	0	N/A	N/A
17	Member Copay	Link to "Member Copay"	Hyperlink	N/A	0	N/A	N/A
18	Submitted Data	Link to "Submitted Data" panel	Hyperlink	N/A	0	N/A	N/A
19	CAS Inquiry	Link to "CAS Inquiry" panel	Hyperlink	N/A	0	N/A	N/A
20	Decision Rules	Link to "Decision Rules" panel	Hyperlink	N/A	0	N/A	N/A
21	Error	Link to "Error" panel	Hyperlink	N/A	0	N/A	N/A
22	MCO Data	Link to "MCO Data" panel	Hyperlink	N/A	0	N/A	N/A
23	Misc Information	Link to "Misc Information"	Hyperlink	N/A	0	N/A	N/A

4.2.6.6 Button Descriptions

Button No	Button	Description
24	Data Correct	This button displays only for claims in suspended status. Clicking the Data Correct button opens up the displayed suspended claim in Data Correction mode. Changes can be made and the claim can be resubmitted

4.2.6.7 Field Edits

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

4.2.7 PANEL: Additional Claim Information

4.2.7.1 Description

Allows the user to examine additional information submmited on the claim including the information that is used to determine the correct service location to assign to a claim.

Navigation Path: [Claims - Search] - [Enter Criteria] - [Select a Claim] - [Select Additional Claim Information]

Tables: T_CLM_ENTITY, T_PARTY_IDENTIFIER, T_CLM_NAME_N1, T_CLM_ADR_N3_N4

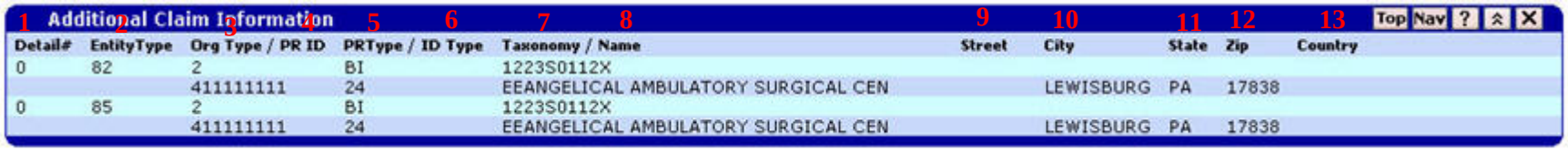
4.2.7.2 Technical Name

Clm.AdditionalClaimInformationPanel.ascx

4.2.7.3 Panel Name

Additional Claim Information

4.2.7.4 Additional Claim Information Layout



Detail#	EntityType	Org Type / PR ID	PRType / ID Type	Taxonomy / Name	Street	City	State	Zip	Country
0	82	2	BI	1223S0112X					
		411111111	24	EEANGELICAL AMBULATORY SURGICAL CEN		LEWISBURG	PA	17838	
0	85	2	BI	1223S0112X					
		411111111	24	EEANGELICAL AMBULATORY SURGICAL CEN		LEWISBURG	PA	17838	

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Additional Claim Information button located in the navigation / maintenance panel.

4.2.7.5 Extra Features

This panel has no extra features.

4.2.7.6 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Detail Number	The number of the detail on the claim record.	4	Number	T_CLM_ENTITY	NUM_DTL

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
2	Entity Type	Indicates the type of the Party Entity.	3	Character	T_CLM_ENTITY	QLF_ENTITY_TYPE
3	Org Type	Indicates whether the entity is a person or a non-person.	2	Character	T_CLM_ENTITY	QLF_TYPE_ORG
4	PR ID	The unique identifier for the entity type specified by the qualifier.	80	Character	T_PARTY_IDENTIFIER	CDE_PARTY_ID
5	PR Type	The type of practice for a provider.	3	Character	T_CLM_ENTITY	CDE_PROVIDER_TYPE
6	ID Type	Indicates the identification code qualifier.	2	Character	T_PARTY_IDENTIFIER	QLF_ID_TYPE
7	Taxonomy	The Referring Provider Taxonomy or Provider Specialty.	30	Character	T_CLM_ENTITY	CDE_PROV_TAXONOMY
8	Name	The last, first, middle & suffix name of the Member/Provider or the name of the Organization.	65	Character	T_CLM_NAME_N1	NAM_LAST, NAM_FIRST, NAM_MIDDLE
9	Street	The address of the Member/Provider.	55	Character	T_CLM_ADR_N3_N4	ADR_STREET_1, ADR_STREET_2
10	City	The city associated with the address for the Member/Provider.	30	Character	T_CLM_ADR_N3_N4	ADR_CITY
11	State	The state associated with the address for the Member/Provider.	2	Character	T_CLM_ADR_N3_N4	ADR_STATE
12	Zip	The zip code associated with the address for the Member/Provider.	15	Character	T_CLM_ADR_N3_N4	ADR_ZIP_CODE

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
13	Country	The country associated with the address for the Member/Provider.	3	Character	T_CLM_ADR_N3_N4	ADR_COUNTRY

4.2.7.7 Field Edits

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

4.2.8 PANEL: Cash Disposition

4.2.8.1 Description

Use the Cash Disposition panel to access cash related information for a particular adjustment. It displays the Cash Control Number (CCN), sequence number, and the refund (disposition) amount of the adjustment claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Cash Disposition link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Cash Disposition link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Cash Disposition link from the displayed panel].

4.2.8.2 Panel Name

Cash Disposition (Correction allows the financial page to save information that populates this panel.)

4.2.8.3 Cash Disposition Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Cash Disposition located in the navigation / maintenance panel.

4.2.8.4 Extra Features

This panel has no extra features.

4.2.8.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	CCN	The cash control number (CCN) associated with the adjustment transaction	Field	Character	11	T_EXPENDITURE	SAK_CASH_RECEIPT
2	Sequence	The disposition sequence number associated with the line. Each individual disposition to a check is given its own sequence number	Field	Number	4	T_CASH_RCPT_XREF	NUM_SEQ_BATCH
3	Disposition Amount	The refund (disposition) amount for the line	Field	Number	10	T_CASH_RCPT_XREF	AMT_DISPOSITION

4.2.8.6 Field Edits

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

4.2.9 PANEL: Diagnosis

4.2.9.1 Description

The Diagnosis panel displays the diagnosis codes applicable to the claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Diagnosis link from the displayed panel];

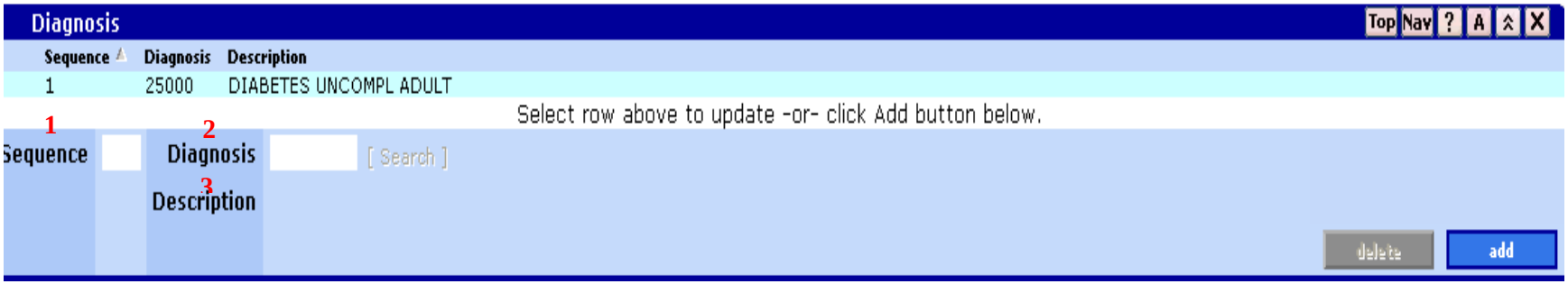
OR - [Claims -Search] - [Enter Criteria] - [[Select a claim] - [Select Diagnosis link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Diagnosis link from the displayed panel].

4.2.9.2 Panel Name

Diagnosis

4.2.9.3 Diagnosis Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Diagnosis button located in the navigation / maintenance panel.

This panel displays the diagnosis codes applicable to the claim.

4.2.9.4 Extra Features

This panel has no extra features.

4.2.9.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Sequence	Sequence numbers for the diagnosis codes. The Admitting diagnosis has a value of 'A' in the Sequence column. Primary diagnosis has a value of '1'. Other diagnosis codes have a value of '2' through '24'. Emergency diagnosis has an 'E' in the Sequence column	Field	Number	2	T_CLM_DIAG_XREF	CDE_DIAG_SEQ
2	Diagnosis	Indicates the diagnosis codes applicable to the claim. Diagnosis code is a code for the condition requiring medical attention	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
3	Description	Description of the diagnosis code	Field	Character	50	T_DIAGNOSIS	DSC_25

4.2.9.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Diagnosis	Field	1	Invalid Diagnosis Code.	Enter a valid diagnosis code or select a code from the [Search] panel.
2	Diagnosis	Field	100	Exceed maximum number of diagnosis codes.	The maximum number of diagnosis codes for this claim type has been exceeded.

4.2.10 PANEL: Display TCN

4.2.10.1 Description

The Display TCN panel shows the Transaction Control Number (TCN) associated with the claim, if the claim was converted from the previous MMIS.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Display TCN link from the displayed panel];

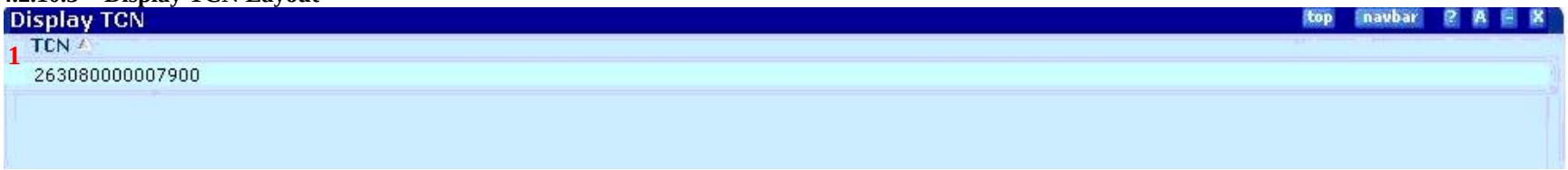
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Display TCN link from the displayed panel;

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Display TCN link from the displayed panel].

4.2.10.2 Panel Name

Display TCN

4.2.10.3 Display TCN Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Display TCN button located in the navigation / maintenance panel.

This panel displays the Transaction Control Number associated with the claim from the previous MMIS system.

4.2.10.4 Extra Features

This panel has no extra features.

4.2.10.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	TCN	The transaction control number used to uniquely identify claims on the previous MMIS	Field	Character	17	T_TCN_XREF	NUM_TCN

4.2.10.6 Field Edits

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

4.2.11 PANEL: Encounter Data

4.2.11.1 Description

The Encounter Data panel displays the name of the Encounter Batch File on which the encounter was received.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Display TCN link from the displayed panel];

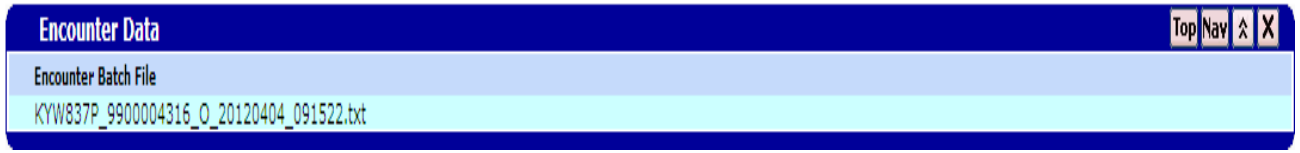
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Display TCN link from the displayed panel;

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Display TCN link from the displayed panel].

4.2.11.2 Panel Name

Encounter Data

4.2.11.3 Encounter Data Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Encounter Data button located in the navigation / maintenance panel.

This panel displays the name of the Encounter Batch File on which the encounter was received.

4.2.11.4 Extra Features

This panel has no extra features.

4.2.11.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Encounter Batch File	The name of the Encounter Batch File on which the encounter was received	Field	Character	40	T_FILE_TRACK	NAME_FILE

4.2.11.6 Field Edits

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

4.2.12 PANEL: Expecting Date

4.2.12.1 Description

The Expecting Date panel displays the expected pregnancy end date.

Navigation Path: [Claims -Information] - [Enter an ICN for a Physician claim] - [Select Expecting Date link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a Physician claim] - [Select Expecting Date link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a Physician claim from the list] - [Select Expecting Date link from the displayed panel].

4.2.12.2 Panel Name

Expecting Date

4.2.12.3 Expecting Date Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Expecting Date button located in the navigation / maintenance panel.

This panel displays the pregnancy due date if applicable to the claim.

4.2.12.4 Extra Features

This panel has no extra features.

4.2.12.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Expecting Date	The expected pregnancy end date	Field	Date (MM/DD/CCYY)	8	T_CLM_HDR_DELIVERY	DTE_DELIVERY

4.2.12.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Expecting Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter the date in the correct format.
1	Expecting Date	Field	2	Expecting Date is required.	Enter a valid date.

4.2.13 PANEL: Medicare Information - Physician

4.2.13.1 Description

The Medicare Information panel displays the Medicare information applicable to the claim.

Navigation Path: [Claims -Information] - [Enter an ICN for a Physician claim] - [Select Medicare Information link from the displayed panel];

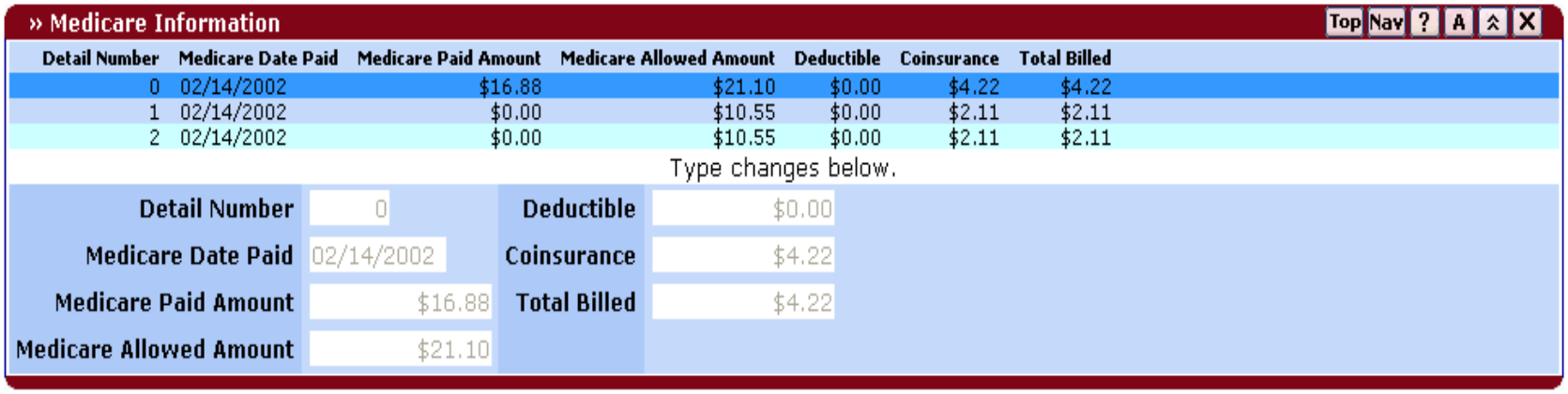
OR - [Claims -Search] - [Enter Criteria] - [Select a Physician claim] - [Select Medicare Information link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a Physician claim from the list] - [Select Medicare Information link from the displayed panel].

4.2.13.2 Panel Name

Medicare Information

4.2.13.3 Medicare Information - Physician Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Medicare Information button located in the navigation / maintenance panel.

This panel displays Medicare information applicable to the claim. In Data Correction page, this panel is updatable.

4.2.13.4 Extra Features

This panel has no extra features.

4.2.13.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The number of the detail on a claim record	Field	Number	8	SEE NARRATIVE SECTION.	NUM_DTL
2	Medicare Allowed Amount	The dollar amount allowed by Medicare for the services. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_ALWD_MCARE
3	Medicare Paid Amount	The dollar amount paid by Medicare for the services. Format 999999.9	Field	Number	8	SEE NARRATIVE SECTION	AMT_PAID_MCARE
4	Deductible	The amount the member must pay before Medicare. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_DEDUCT
5	Coinsurance	Amount which represents the members' coinsurance payment. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_COINSURANCE
6	Total Billed	The amount Medicare has determined that a member must pay. (Sum of Coinsurance + Deductible). Format 999999.99	Field	Number	8	N/A	N/A

4.2.13.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
5	Coinsurance	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
4	Deductible	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
2	Medicare Allowed Amount	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
3	Medicare Paid Amount	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
6	Total Billed	Field	1	Enter a Valid Value.	Enter a numeric value. Format 999999.99.

4.2.14 PANEL: Service/Prior Authorization

4.2.14.1 Description

The Prior Authorization panel displays the prior authorization applicable to the claim. This panel includes the the amount and units used in the claim.

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

Tables: T_PA_ITEM_DTL_XREF, T_PA_PAUTH, T_FINANCIAL_PAYER

4.2.14.2 Technical Name

Clm.ClaimPriorAuth.ascx

4.2.14.3 Panel Name

Prior Authorization

4.2.14.4 Service/Prior Authorization Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Prior Authorization button located in the navigation / maintenance panel.

This panel displays the PA information applicable to the claim.

4.2.14.5 Extra Features

This panel has no extra features.

4.2.14.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	Detail to which Service/Prior Authorization has been applied	Field	Number	9	T_PA_ITEM_DTL_XREF	NUM_DTL
2	PA Number	This is the number assigned by the PA unit to a Service/Prior Authorization request	Field	Character	10	T_PA_PAUTH	PRIOR_AUTH_NUM
3	Line Item	Prior Authorization Line Item number	Field	Character	3	T_PA_ITEM_DTL_XREF	NUM_PA_LINE_ITEM
4	Financial Payer	A code used to identify the financial payer	Field	Number	9	T_FINANCIAL_PAYER	CDE_FIN_PAYER
5	Units Used	Prior Authorization units applied to the claim	Field	Number	6	T_PA_ITEM_DTL_XREF	QTY_UNT_SVC_USD
6	Amount Used	Prior Authorization amount applied to the claim. Format 99999999.99	Field	Number	9	T_PA_ITEM_DTL_XREF	AMT_PA_USED
7	Status	Indicates the status of the claim within the system	Field	Character	1	T_PA_ITEM_DTL_XREF	CDE_STATUS1

4.2.14.7 Field Edits

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

4.2.15 PANEL: Adjustment Information - Daughter or Mother

4.2.15.1 Description

The Adjustment Information panel displays the daughter claim if the claim being displayed has been adjusted. It will display the mother claim if the claim being displayed is an adjustment claim.

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

This panel is populated from the following tables depending on Claim Type: T_ADJ_PHYS_XREF, T_ADJ_PHRM_XREF, T_ADJ_UB92_XREF, T_ADJ_DNTL_XREF, T_SUSP_ADJ_XREF

4.2.15.2 Technical Name

Clm.AdjustmentInformation-DaughterorMother.ascx

4.2.15.3 Panel Name

Adjustment Information

4.2.15.4 Adjustment Information - Daughter or Mother Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Adjustment Information button located in the navigation / maintenance panel.

This panel displays the previous claim information of an adjusted claim or the present claim information if the claim has been adjusted.

4.2.15.5 Extra Features

This panel has no extra features.

4.2.15.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	ICN	Internal control number which uniquely identifies a claim	Field	Character	13	SEE NARRATIVE SECTION	NUM_ICN_FL
2	Date Adjusted	Date on which adjustment request was initiated	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_ADJUSTED
3	Claims Status History Date	Date on which a claim was processed	Field	Date (MM/DD/CCYY)	8	T_HIST_DIRECTORY	DTE_PAID
4	Claim Status	The status of the claim, example "PAID"	Field	Character	10	T_HIST_DIRECTORY	CDE_CLM_STATUS
5	Location	Location code of the claim	Field	Character	2	T_CLAIM_LOCAT	CDE_LOCATION
6	Adjustment Reason	Code identifying the detailed reason the adjustment was made	Field	Character	4	SEE NARRATIVE SECTION	CDE_EOB
7	Adjustment Analyst ID	Identification of the clerk that generated the adjustment request	Field	Character	8	SEE NARRATIVE SECTION	ID_CLERK

4.2.15.7 Field Edits

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

4.2.16 PANEL: Adjustment Reason Code

4.2.16.1 Description

Allows the user to review adjustment reason codes listed on encounters.

Navigation Path: [Claims - Search] - [Enter Criteria] - [Select a Claim] - [Select Adjustment Reason Code]

Tables: T_CLM_CAS, T_CDE_HIPAA_ADJRSN

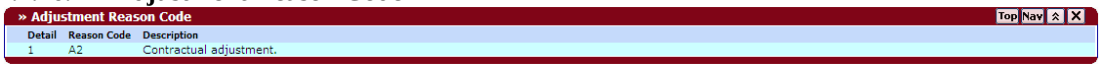
4.2.16.2 Technical Name

Clm.AdditionalClaimInformationPanel.ascx

4.2.16.3 Panel Name

Adjustment Reason Code

4.2.16.4 Adjustment Reason Code



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Adjustment Reason Code button located in the navigation / maintenance panel.

4.2.16.5 Extra Features

This panel has no extra features.

4.2.16.6 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Detail	Encounter detail number.	3	Character	t_clm_cas	NUM_DTL

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
2	Reason Code	Adjustment Reason Codes from MCO/Passport-denied encounters and/or partially paid encounters with denied details.	4	Character	t_clm_cas	CDE_CLM_ADJ_REASON
3	Descreption	Adjustment Reason Code description.	100	Character	t_cde_hipaa_adjrsn	DSC_ADJ_RSN

4.2.16.7 Field Edits

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

4.2.17 PANEL: Check

4.2.17.1 Description

Use the Check panel to view the total amount paid from the Remittance Advice (RA) for a specific claim. To view the detail of the check, click on the row to display the Payment Information panel.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Check link from the displayed panel];

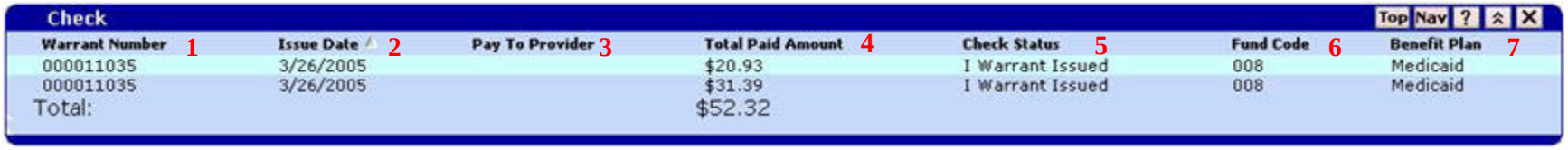
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Check link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Check link from the displayed panel].

4.2.17.2 Panel Name

Check

4.2.17.3 Check Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Check button located in the navigation / maintenance panel.

This panel is populated if the claim is paid.

4.2.17.4 Extra Features

This panel has no extra features.

4.2.17.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Warrant Number	This field displays the number of the check that the provider received, or the number of the Electronic Funds Transfer	Field	Number	9	T_CHECK	NUM_CHECK
2	Issue Date	The date when the check was issued or the EFT was sent	Field	Date (MM/DD/CCYY)	8	T_CHECK	DTE_ISSUE
3	Pay To Provider	The Provider ID who received the check or EFT	Field	Character	9	T_PR_PROV	ID_PROVIDER
4	Total Paid Amount	The total amount that was issued to the provider	Field	Number	11	T_CHECK	TOTAL_AMT_PAID
5	Check Status	The status of the check. Examples are: An 'I' indicates the check has been issued, a 'V' indicates a VOID, an 'R' indicates the check was reissued, a 'C' indicates a check has cleared the bank, an 'S' indicates Stopped and an 'X' for Cancelled by Statute	Field	Character	30	T_CHECK	CDE_STATUS1
6	Fund Code	The Fund Code assigned to the check or EFT	Field	Character	3	T_CHCK_CLM_XREF	SAK_FUND_CODE
7	Benefit Plan	The Benefit Plan associated with the check or EFT	Field	Character	30	T_CHCK_CLM_XREF	SAK_PUB_HLTH

4.2.17.6 Field Edits

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

4.2.18 PANEL: Category of Service

4.2.18.1 Description

The Category of Service panel displays the category of service codes assigned to the claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Category of Service link from the displayed panel];

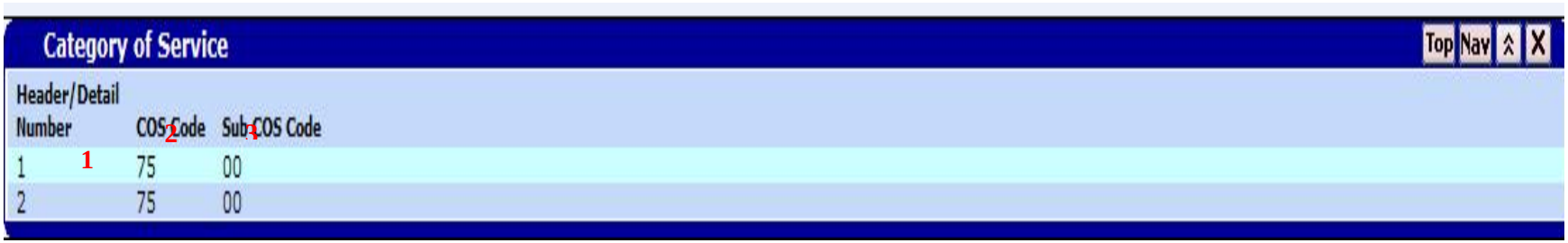
OR - [Claims -Search] - [Enter Criteria] - [[Select a claim] - [Select category of Service link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select category of Service link from the displayed panel].

4.2.18.2 Panel Name

Category of Service

4.2.18.3 Category of Service Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the category of Service button located in the navigation / maintenance panel.

This panel displays the category of service codes assigned to the claim.

Extra Features

This panel has no extra features.

4.2.18.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Sequence	Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.	Field	Number	2	T_COS_DTL_XREF	NUM_DTL
2	COS Code	Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.	Field	Number	2	T_COS_DTL_XREF	CDE_COS_ST
3	Sub COS Code	Code for a sub-category of service (COS) that provides a more detailed State Category of Service classification in MAR state reporting.	Field	Number	2	T_COS_DTL_XREF	CDE_COS_SUB

4.2.18.5 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
None					

4.2.19 PANEL: Display TCN

4.2.19.1 Description

The Display TCN panel shows the Transaction Control Number (TCN) associated with the claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Display TCN link from the displayed panel];

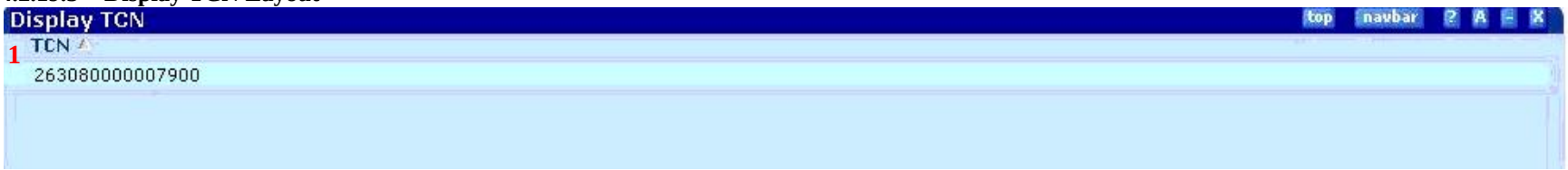
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Display TCN link from the displayed panel;

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Display TCN link from the displayed panel].

4.2.19.2 Panel Name

Display TCN

4.2.19.3 Display TCN Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Display TCN button located in the navigation / maintenance panel.

This panel displays the Transaction Control Number associated with the claim from the previous MMIS system.

4.2.19.4 Extra Features

This panel has no extra features.

4.2.19.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	TCN	The transaction control number used to uniquely identify claims on the previous MMIS	Field	Character	17	T_TCN_XREF	NUM_TCN

4.2.19.6 Field Edits

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

4.2.20 PANEL: Health Program

4.2.20.1 Description

Use the Health Program panel to display the program information for a claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Health Program link from the displayed panel];

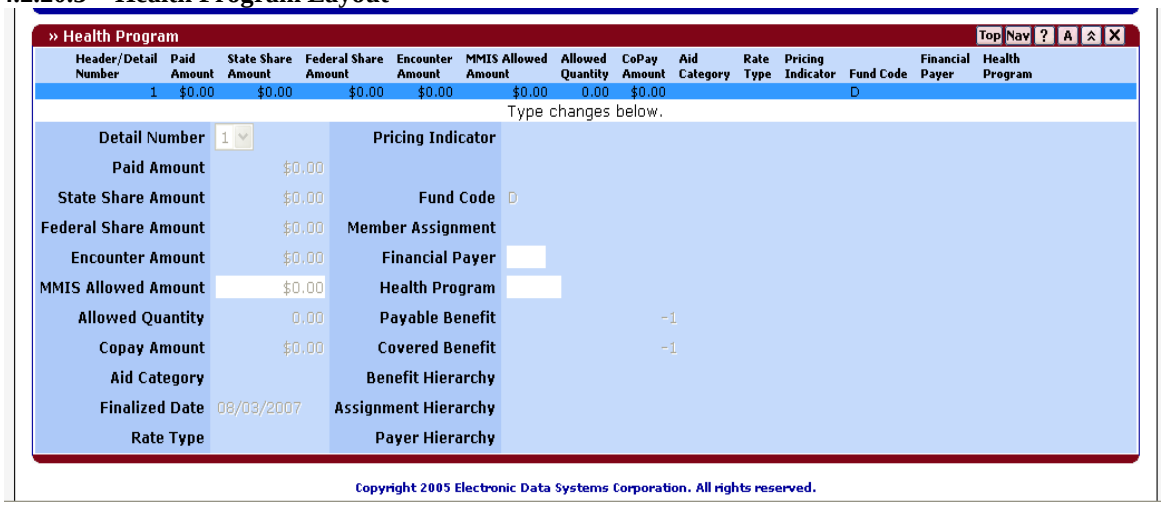
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Health Program link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Health Program link from the displayed panel].

4.2.20.2 Panel Name

Health Program

4.2.20.3 Health Program Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Health Program button located in the navigation / maintenance panel.

This panel displays the program information applicable to the claim. Program information could include copay amounts, Medicare indicators, managed care indicators and financial payers.

4.2.20.4 Extra Features

This panel has no extra features.

4.2.20.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Header/Detail Number	Indicates if the row pertains to the claim header or a claim detail line. The claim header is denoted by a zero	Field	Number	3	T_CLM_PGM_XREF	NUM_DTL
1	Detail Number	Indicates if the row pertains to the claim header or a claim detail line. The claim header is denoted by a zero	Field	Drop Down List Box	0	T_CLM_PGM_XREF	NUM_DTL
2	Paid Amount	This is the amount that is applied toward the check amount. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_PAID
3	State Share Amount	This is the amount that is applied toward the check amount. Format 99999999.99 ‘NOT USED IN KY	Field	Number	10	T_CLM_PGM_XREF	AMT_STATE_SHARE
4	Federal Share Amount	This is the amount of federal share for this payment. Format 99999999.99 ‘NOT USED IN KY	Field	Number	10	T_CLM_PGM_XREF	AMT_FEDERAL_SHARE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Encounter Amount	This contains the amount for encounter services on the claim detail indicated by the detail number on the table. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_ENCOUNTER
6	Allowed Amount	Amount approved to pay for services provided. Format 9999999.99	Field	Number	9	T_CLM_PGM_XREF	AMT_ALWD
7	Allowed Quantity	Number of units of service that are paid under a financial payer/benefit plan. Format 9999.99	Field	Number	6	T_CLM_PGM_XREF	QTY_ALLOWED
8	Copay Amount	This is the amount of copay that is subtracted from the allowed amount. Format 99999.99	Field	Number	7	T_CLM_PGM_XREF	AMT_CO_PAY
9	Aid Category	Aid Category for Medicaid coverage	Field	Number	9	T_CDE_AID	CDE_AID_CATEGORY
10	Finalized Date	Date the financial finalizes the claim for this Payer	Field	Date (MM/DD/CCYY)	8	T_CLM_PGM_XREF	DTE_FINAL
11	Rate Type	Code used to identify the rate type to use in determining provider reimbursement	Field	Character	3	T_CLM_PGM_XREF	CDE_RATE_TYPE
12	Pricing Indicator	Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced	Field	Character	1	T_CLM_PGM_XREF	IND_PRICING

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
13	Managed Care Indicator	Manage care indicator identifies claims and other transactions as to how they affect the manage care program	Field	Drop Down List Box	1	T_CLM_PGM_XREF	IND_MC
14	Fund Code	Indicates the budget category that the funds used to pay this claim/detail came from	Field	Number	9	T_FIN_FUND_CODE	CDE_FUND_CODE
15	Member Assignment	A group of covered services (benefits) where the member is assigned to a provider or provider organization in order to receive covered services (benefits)	Field	Number	9	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
16	Financial Payer	The financial payer description	Field	Number	9	T_FINANCIAL_PAYER	CDE_FIN_PAYER
17	Health Program	Name of program the header/detail was processed and/or paid under	Field	Character	50	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
18	Payable Benefit	This is the unique system-assigned that identifies each row on this table	Field	Number	9	T_CLM_PGM_XREF	SAK_PAYABLE_BNFT
19	Covered Benefit	System-assigned Key used to identify a unique row for a benefit covered by a member plan. This identifies a row to be ignored for this benefit	Field	Number	9	T_CLM_PGM_XREF	SAK_COVERED_BNFT

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
20	Benefit Hierarchy	An assignment hierarchy is an ordered set of assignment plans for which a member/beneficiary may be assigned concurrently. For example, a beneficiary may be assigned to a PCP and to a Waiver Program at overlapping periods of time	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD
21	Assignment Hierarchy	A set of assignment plans for which a member/beneficiary may be assigned concurrently	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD_ASSIGNMENT
22	Payer Hierarchy	Payer Hierarchy identifies 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	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD_PAYER

4.2.20.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
6	Allowed Amount	Field	1	Enter a valid Value.	Allowed Amount must be numeric.
19	Covered Benefit	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select a value form the [Search] panel.
16	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid financial payer or select a value from the [Search] panel.

4.2.21 PANEL: Member Coinsurance

4.2.21.1 Description

Allows the user to examine the Coinsurance accumulation for a member.

Navigation Path: [Claims - Search] - [Enter Criteria] - [Select Member Coinsurance]

Table :T_CLM_COINS_X

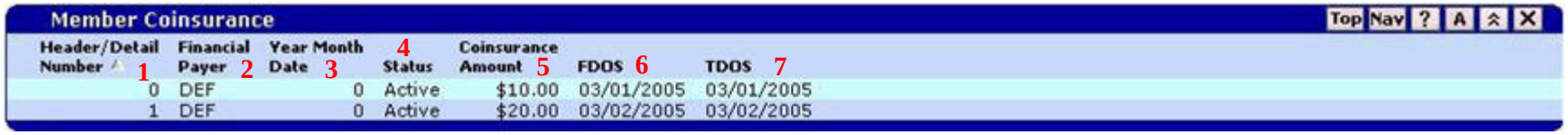
4.2.21.2 Technical Name

Clm.ClaimMemberCoinsuranceHdrPanel.ascx

4.2.21.3 Panel Name

Claim Member Coinsurance

4.2.21.4 Claim Member Coinsurance Layout



Member Coinsurance

Header/Detail Number 1	Financial Payer 2	Year Month Date 3	4 Status	Coinsurance Amount 5	FDOS 6	TDOS 7
0	DEF	0	Active	$10.00	03/01/2005	03/01/2005
1	DEF	0	Active	$20.00	03/02/2005	03/02/2005

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Member Coinsurance button located in the navigation / maintenance panel.

4.2.21.5 Extra Features

This panel has no extra features.

4.2.21.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Header/Detail Number	The number of the detail on the claim record.A zero represents the header	Field	Number	4	T_CLM_COINS_X	NUM_DTL
2	Financial Payer	The system-assigned value that identifies a unique payer within interChange.	Field	Number	9	T_CLM_COINS_X	SAK_FIN_PAYER
3	Year Month Date	This is the year and month of the date of service of the claim that used coinsurance	Field	Number	9	T_CLM_COINS_X	DTE_YEAR_MTH
4	Status	Indicates if the record/row is active or inactive. The row becomes inactive only after an adjustment to the claim is released. Only use active ('A') to accumulate coinsurance. Values are: 'A' - Active; 'I' - Inactive	Field	Character	1	T_CLM_COINS_X	CDE_STATUS1
5	Coinsurance Amount	The coinsurance amount paid by the member for services rendered	Field	Number	9	T_CLM_COINS_X	AMT_COINSURANCE
6	FDOS	The beginning date of service for the claim	Field	Number	8	T_CLM_COINS_X	DTE_FIRST_SVC
7	TDOS	The last date of service for the claim.	Field	Number	8	T_CLM_COINS_X	DTE_LAST_SVC

4.2.21.7 Field Edits

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

4.2.22 PANEL: Related History

4.2.22.1 Description

The Related History panel lists other claims that are related to the current claim. The panel is not updateable and is shared by all claim types. Use this panel to validate medical policy audits, duplicate payment audits, umbrella audits, limitation audits, and bundling and unbundling audits.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Related History link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Related History link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Related History link from the displayed panel].

4.2.22.2 Panel Name

Related History

4.2.22.3 Related History Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Related History button located in the navigation / maintenance panel.

This panel lists other claims associated to the applicable claim.

4.2.22.4 Extra Features

This panel has no extra features.

4.2.22.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Related ICN	Internal control number which uniquely identifies a claim	Field	Character	13	T_HIST_DIRECTORY	NUM_ICN_FL
2	Related Detail	Related detail information to the history claim displayed	Field	Number	3	T_HIST_DIRECTORY	NUM_DTL_RELATED
3	Error Code	Code used to indicate an error was discovered on a claim during processing in the base system	Field	Number	4	T_ERROR_DISP	CDE_ESC
4	Financial Payer	The description used to identify the financial payer for the related ICN	Field	Character	30	T_FINANCIAL_PAYER	CDE_FIN_PAYER
5	Benefit Plan	The medical assistance program associated with the related ICN	Field	Character	5	T_PUB_HLTH_PGM	SAK_PUB_HLTH

4.2.22.6 Field Edits

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

4.2.23 PANEL: Attachment

4.2.23.1 Description

The Attachment panel displays the attachment control numbers that are applicable to the claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Attachments link from the displayed panel];

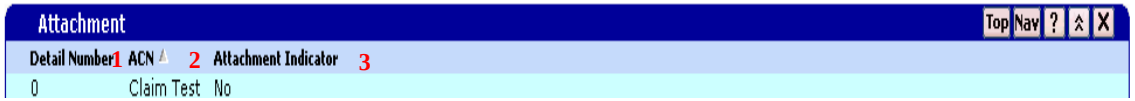
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Attachments link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Attachments link from the displayed panel].

4.2.23.2 Panel Name

Attachment

4.2.23.3 Attachment Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Attachment button located in the navigation / maintenance panel.

This panel is populated if an attachment was received with the claim.

4.2.23.4 Extra Features

This panel has no extra features.

4.2.23.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The detail number of a claim record	Field	Number	4	T_ATTACHMENT_XREF	NUM_DTL
2	ACN	The control number associated with an attachment that is being sent by the provider for an electronically submitted claim	Field	Character	80	T_ATTACHMENT_XREF	CDE_ATTACHMENT_CONTROL
3	Attachment Indicator	Indicates if the attachment has been received	Field	Character	3	T_ATTACHMENT_XREF	IND_ATTACH_RECEIVED

4.2.23.6 Field Edits

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

4.2.24 PANEL: Data Correction Note

4.2.24.1 Description

The Data Correction Note panel will be used by resolutions staff to forward questions to other clerks or to a supervisor. To send a note, the first user will enter a Location Code, type in a Note, and specify a second User ID into the Reviewer Sent To field. When a note is sent, the claim will be assigned to the new location code and the claim will show up in the new user's Data Correction Suspense list. The newly assigned user can display the note and enter a reply. They can send the claim back to the originator by creating a new Note, or they can reply to the first note and keep the claim assigned to themselves. If they do not create a new note and send it back to the originator of the first note, the claim will remain assigned to the second user. If necessary, the second user can send a new note to a third user. There is no limit to how many notes can be created. Each time a new note is created, the claims is assigned to the Reviewer Sent To user id.

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

Table: T_LOCATION_NOTE

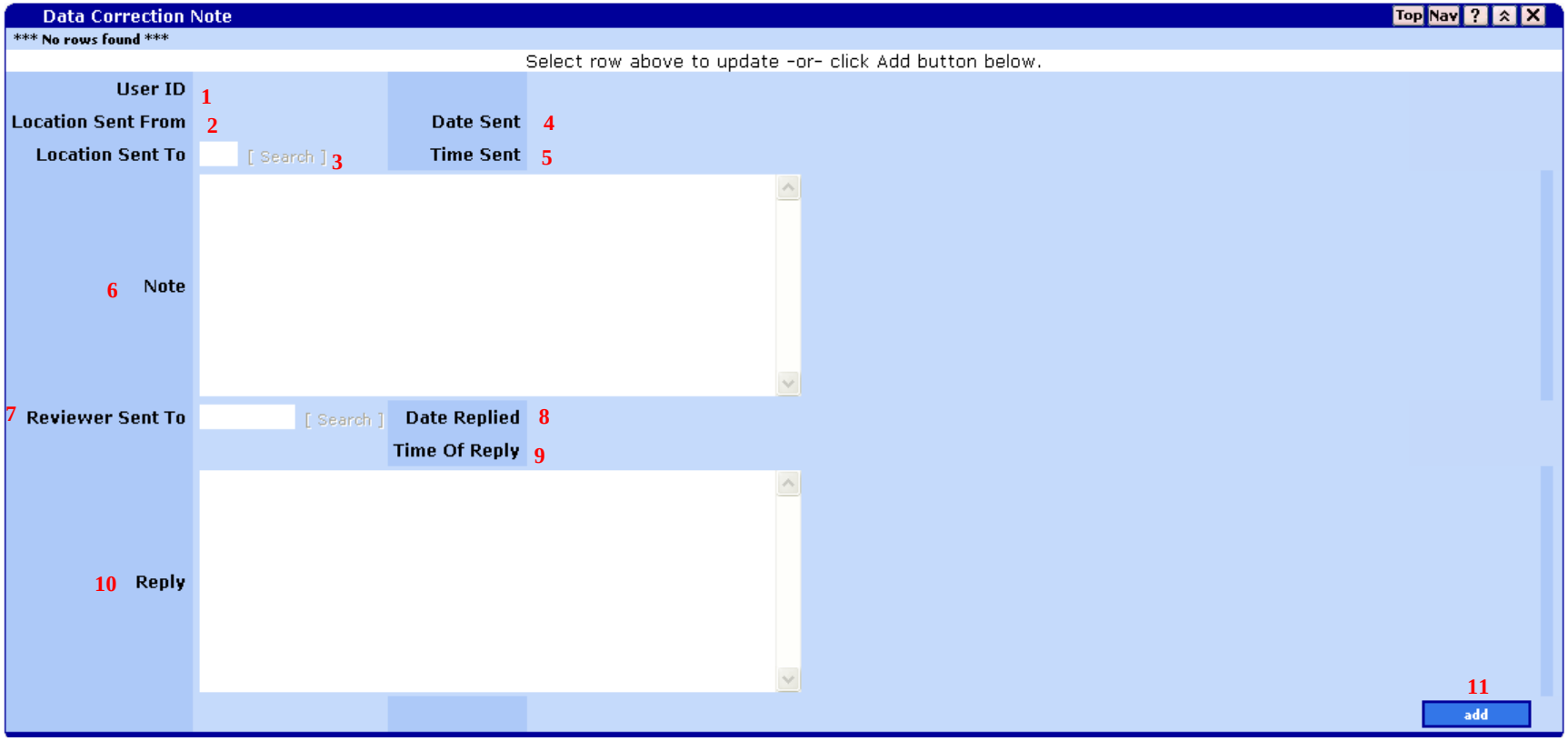
4.2.24.2 Technical Name

Clm.DataCorrectionNotePanel.ascx

4.2.24.3 Panel Name

Data Correction Note

4.2.24.4 Data Correction Note Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Data Correction Note button located in the navigation / maintenance panel.

This panel allows questions to be written and sent by location code to another department. It allows the note originator to access the note when an answer is submitted and take appropriate action to the claim.

4.2.24.5 Extra Features

This panel has no extra features.

4.2.24.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	User ID	The ID of the user (clerk) who originates the note	Field	Character	8	T_LOCATION_NOTE	ID_CLERK
2	Location Sent From	The location that the note originates from. The user is required to use the [Search] to select a value	Field	N/A	0	T_LOCATION_NOTE	CDE_LOC_FROM
3	Location Sent To	The location that the note is being sent to. The user is required to use the [Search] to select a value	Field	N/A	0	T_LOCATION_NOTE	CDE_LOC_TO
4	Date Sent	The date the note is sent	Field	Date (MM/DD/CCYY)	8	T_LOCATION_NOTE	DTE_SENT
5	Time Sent	The time that the note is sent	Field	Character	6	T_LOCATION_NOTE	TME_SENT
6	Note	The note that is sent	Field	Character	256	T_LOCATION_NOTE	DSC_NOTE
7	Reviewer Sent To	The ID of the person who reviews the note. The user is required to use the [Search] to select a value	Field	N/A	0	T_LOCATION_NOTE	ID_REVIEWER
8	Date Replied	The date the reply is sent	Field	Date (MM/DD/CCYY)	8	T_LOCATION_NOTE	DTE_REPLY
9	Time Of Reply	The time that the reply is sent	Field	Character	6	T_LOCATION_NOTE	TME_REPLY
10	Reply	The note containing the reply	Field	Character	256	T_LOCATION_NOTE	DSC_REPLY

4.2.24.7 Button Descriptions

Button No	Button	Description

Button No	Button	Description
11	Add	Add a new location note

4.2.24.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	Location Sent To	Field	1	Location Sent To is required.	Select a value for the Location from the [Search] panel.
6	Note	Field	1	Note is required.	Enter text for the note description.
7	Reviewer Sent To	Field	1	Reviewer Sent to is required.	Select a User ID from the [Search] panel.
8	Date Replied	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter the date in MM/DD/CCYY format.

4.2.25 PANEL: EOB

4.2.25.1 Description

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

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select EOB link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select EOB link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select EOB link from the displayed panel].

4.2.25.2 Panel Name

EOB

4.2.25.3 EOB Layout

EOB

Top Nav ? A

View ◉ All ○ Current ○ Historical

Detail Number	EOB Code	EOB Description	Financial Payer	Benefit Plan	Status	Origin	Hipaa Adj Reason Code	Remark Code	Adjustment Amount	Adjusted Units
0	1945	MULTIPLE SERVICE LOCATIONS FOR			Historical	System Generated			$0.00	0.000
0	3999	CLAIM BILLED WITH INACTIVE MID			Current	System Generated	16		$0.00	0.000
0	1912	TAXONOMY IS MISSING: BILLING P			Historical	System Generated			$0.00	0.000
1	0163	CLAIM DETAIL DENIED. EMPLOYEE			Historical	System Generated	16	M57	$0.00	0.000
1	4801	THIS PROCEDURE IS NOT COVERED	DEF	OCMTW	Current	System Generated			$168.46	0.000

Select row above to update.

Detail Number
EOB Code
EOB Description
Financial Payer
Benefit Plan
Status Current
Origin System Generated
HIPAA Adj Reason Code
Adj Reason Description
Remark Code
Remark Description
Adjustment Amount
Adjusted Units

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the EOB button located in the navigation / maintenance panel.

This panel displays the EOB codes applicable to the claim. In the Data Correction page, this panel allows codes to be added or deleted.

4.2.25.4 Extra Features

This panel has no extra features.

4.2.25.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The detail number to which the EOB message is attached	Field	Number	4	T_CLM_EOB_XREF	NUM_DTL
2	HIPAA Adjustment Reason	The HIPAA reason for the adjustment	Field	Drop Down List Box	0	T_CDE_HIPAA_ADJRSN	CDE_ADJ_RSN
3	EOB Code	Code number attached to an EOB message	Field	Character	4	T_EOB	CDE_EOB
4	Remark Code	The code for the remarks	Field	Drop Down List Box	0	T_CDE_HIPAA_REMRKS	CDE_REMARK
5	EOB Description	First line of text description for EOB code	Field	Character	79	T_EOB	DSC_EOB
6	Adjustment Amount	The dollar amount adjusted on the detail. Format 9999999.99	Field	Number	9	T_CLM_EOB_XREF	AMT_ADJUSTED
7	Financial Payer	A value that identifies a unique payer within interChange	Field	Drop Down List Box	0	T_CLM_EOB_XREF	SAK_FIN_PAYER
8	Adjusted Units	The quantity adjusted on the detail. Format 9999999.999	Field	Number	10	T_CLM_EOB_XREF	QTY_ADJUSTED
9	Benefit Plan	Identifies the medical assistance program that is supported in the system	Field	Drop Down List Box	0	T_CLM_EOB_XREF	SAK_PUB_HLTH
10	Origin	Indicates who generated the EOB code and message	Field	Character	6	T_CLM_EOB_XREF	CDE_STATUS1
11	Status	Indicates whether the EOB is current or history	Field	Character	7	T_CLM_EOB_XREF	CDE_STAT_ERROR

4.2.25.6 Button Descriptions

Button No	Button	Description
12	Delete	Deletes a record
13	Add	Adds a new record

4.2.25.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
7	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer of select one from the [Search] panel.
9	Benefit Plan	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select one from the [Search] panel.

4.2.26 PANEL: Location

4.2.26.1 Description

The Location panel displays claim location information. When opened from an inquiry panel, the Claim Location panel is not updateable. However, when opened from a data correction panel, the new and save buttons are displayed allowing the user to add a location. The user can route the claim to another department for correction. This panel is shared by all claim types.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Location link from the displayed panel];

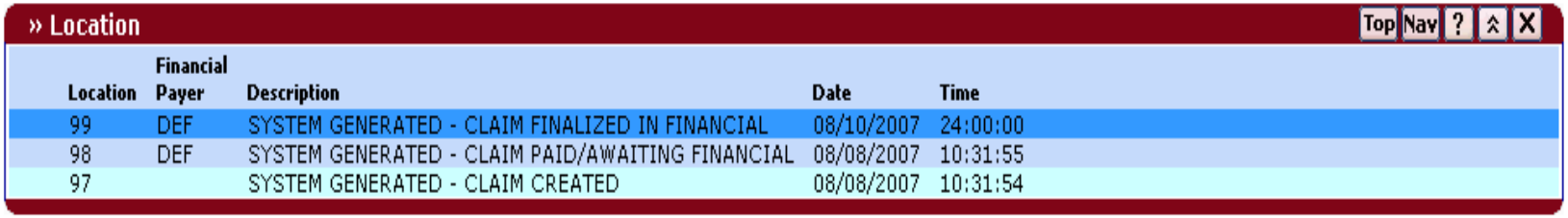
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Location link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Location link from the displayed panel].

4.2.26.2 Panel Name

Location

4.2.26.3 Location Layout



» Location

Top Nav ? X

Location	Financial Payer	Description	Date	Time
99	DEF	SYSTEM GENERATED - CLAIM FINALIZED IN FINANCIAL	08/10/2007	24:00:00
98	DEF	SYSTEM GENERATED - CLAIM PAID/AWAITING FINANCIAL	08/08/2007	10:31:55
97		SYSTEM GENERATED - CLAIM CREATED	08/08/2007	10:31:54

Copyright 2005 Electronic Data Systems Corporation. All rights reserved.

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Location button located in the navigation / maintenance panel.

This panel displays the claim location information pertaining to which department is reviewing claim. In the Data Correction page, this panel allows codes to be added so the claim can be routed to another department for correction.

4.2.26.4 Extra Features

This panel has no extra features.

4.2.26.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Location	Indicates claim location within the claims processing system	Field	Character	2	T_CLAIM_LOCAT	CDE_LOCATION
2	Description	Description of the location from that financial payer	Field	Character	50	T_CLAIM_LOCAT	CDE_CLM_TYPE
3	Financial Payer	The Financial Payer Information	Field	Character	10	T_FINANCIAL_PAYE R	CDE_FIN_PAYER
4	Date	The date that the claim went to this location	Field	Date (MM/DD/CCYY)	8	T_CLAIM_LOCAT	DTE_CLM_LOCAT
5	Time	The time that the claim went to this location	Field	Number	8	T_CLAIM_LOCAT	TIME_SYSTEM
6	Add	Add a location record	Button	N/A	0	N/A	N/A

4.2.26.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Location	Field	1	Invalid Location Code.	Enter a valid Location Code or select a code from the [Search] panel.

4.2.27 PANEL: Member Copay

4.2.27.1 Description

Allows the user to examine the copay accumulation for a member.

Navigation Path: [Claims - Search] - [Enter Criteria] - [Select Member Copay]

Table :T_CLM_COPAY_X

4.2.27.2 Technical name

Clm.ClaimMemberCopayHdrPanel.ascx

4.2.27.3 Panel name

Claim Member Copay

4.2.27.4 Member Copay Panel Layout

Member Copay

Header/Detail Number 1	Financial Payer 2	Year Month Date 3	4 Status	5 Copay Value 6	Copay Amount	7 FDOS	TDOS 8
0	DEF	0	Active	Deduct and Accumulate	$15.00	03/01/2005	03/01/2005
1	DEF	0	Active	Deduct and Accumulate	$30.00	03/02/2005	03/02/2005

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Member Copay button located in the navigation / maintenance panel.

4.2.27.5 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Header/Detail Number	The number of the detail on the claim record.A zero represents the header	4	Number	T_CLM_COPAY_X	NUM_DTL

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
2	Financial Payer	The system-assigned value that identifies a unique payer within interChange.	9	Number	T_CLM_COPAY_X	SAK_FIN_PAYER
3	Year Month Date	This is the year and month of the date of service of the claim that used copay	9	Number	T_CLM_COPAY_X	DTE_YEAR_MTH
4	Status	Indicates if the record/row is active or inactive. The row becomes inactive only after an adjustment to the claim is released. Only use active ('A') to accumulate copay. Values are: 'A' - Active; 'I' - Inactive	1	Character	T_CLM_COPAY_X	CDE_STATUS1
5	Copay Value	Determines if the row has actual copay deducted from the claim or if the copay was just additive and not deducted from the claim. Values are: 'DA' - Deduct and accumulate copay 'OA' - Only accumulate copay	2	Character	T_CLM_COPAY_X	CDE_DEDUCT_ACCUM_ COPAY
6	Copay Amount	The copay amount paid by the member for services rendered	9	Number	T_CLM_COPAY_X	AMT_COPAY
7	FDOS	The beginning date of service for the claim	8	Number	T_CLM_COPAY_X	DTE_FIRST_SVC
8	TDOS	The last date of service for the claim.	8	Number	T_CLM_COPAY_X	DTE_LAST_SVC

4.2.27.6 Field edits

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

4.2.28 PANEL: Submitted Data - Physician

4.2.28.1 Description

The Physician Submitted Data panel displays the submitted information applicable to a physician claim.

Navigation Path: [Claims -Information] - [Enter an ICN for a Physician claim] - [Select Submitted Data link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a Physician claim] - [Select Submitted Data link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a Physician claim from the list] - [Select Submitted Data link from the displayed panel].

4.2.28.2 Panel Name

Submitted Data

4.2.28.3 Submitted Data - Physician Layout

To access this panel:

STEP 1. Access the Physician Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Submitted Data button located in the navigation / maintenance panel.

This panel displays the physician’s patient account number.

4.2.28.4 Extra Features

This panel has no extra features.

4.2.28.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Submitted Patient Account Number	Submitted Identification for a member assigned by a provider and used in their system. This number is not required for processing (information only)	Field	Character	38	T_PHYS_HDR_KEY	NUM_PAT_ACCT_SUB

4.2.28.6 Field Edits

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

4.2.29 PANEL: CAS Inquiry

4.2.29.1 Description

The CAS Inquiry panel displays the Claim Level Adjustment Segments (CAS) information applicable to the claim or encounter.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select CAS Inquiry link from the displayed panel];

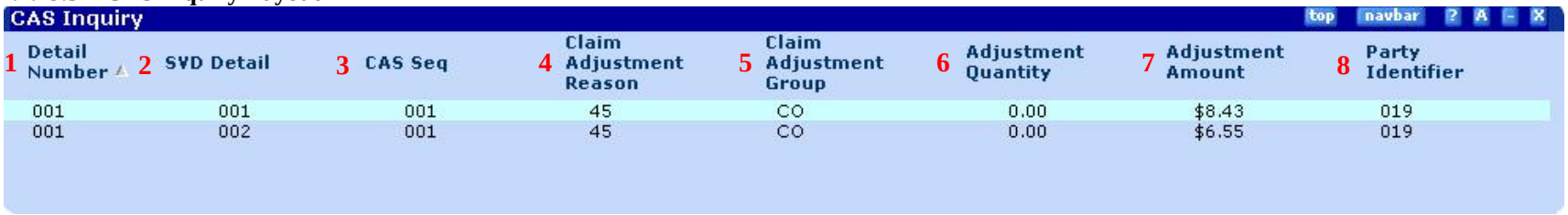
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select CAS Inquiry link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select CAS Inquiry link from the displayed panel].

4.2.29.2 Panel Name

CAS Inquiry

4.2.29.3 CAS Inquiry Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the CAS Inquiry button located in the navigation / maintenance panel.

This panel displays category, reason code and other applicable adjustment information of an adjusted claim.

4.2.29.4 Extra Features

This panel has no extra features.

4.2.29.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The number of the detail on the claim record	Field	Number	4	T_CLM_CAS	NUM_DTL
2	SVD Detail	This is the sequence number of the SVD segment with a claim detail. Up to 25 SVD segments may be related to a detail	Field	Number	4	T_CLM_CAS	NUM_DTL_SVD
3	CAS Seq	This identifies the iteration number for the CAS segment. A maximum of 99 CAS segments are allowed for a claim detail. For the claim header, the maximum is five	Field	Number	4	T_CLM_CAS	NUM_CAS_SEQ
4	Claim Adjustment Reason	This code identifies the detailed reason the adjustment was made	Field	Character	5	T_CLM_CAS	CDE_CLM_ADJ_REASON
5	Claim Adjustment Group	This code identifies the general category of a payment adjustment	Field	Character	2	T_CLM_CAS	CDE_CLM_ADJ_GROUP
6	Adjustment Quantity	Number of units of service being adjusted. Format 999999.99	Field	Number	8	T_CLM_CAS	QTY_ADJUSTMENT
7	Adjustment Amount	Monetary amount of the adjustment. Format $9999999.99	Field	Number	9	T_CLM_CAS	AMT_ADJUSTMENT
8	Party Identifier	Unique identifier for a payer	Field	Character	80	T_PARTY_IDENTIFIER	CDE_PARTY_ID

4.2.29.6 Field Edits

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

4.2.30 PANEL: Decision Rules

4.2.30.1 Description

The Decision Rules Panel displays rules written to the T_CLM_RU_MATCHED table.

Navigation Path: [Claims - Search] - [Enter Criteria] - [Select a Claim] - [Decision Rules]

Table: T_CLM_RU_MATCHED

4.2.30.2 Technical Name

Clm.ClaimRulesPanel.ascx

4.2.30.3 Panel Name

Decision Rules

4.2.30.4 Decision Rules Layout

Decision Rules

Top Nav ? X

Sequence	Detail #	Decision	Rule #	Benefit Plan/Contract for which the rule applies	Benefit	Status
3	0	Provider Contract - Diagnosis	94084	Comm Mental Health	3180	Current
4	0	Provider Contract - Procedure	-1	Comm Mental Health	T2016	Current
5	0	Provider Contract - Diagnosis	92623	Supp for Comm Living	3180	Current
6	0	Provider Contract - Procedure	3901	Supp for Comm Living	T2016	Current
7	0	Provider Contract - Diagnosis	92623	Supp for Comm Living	3180	Current
8	0	Provider Contract - Procedure	3901	Supp for Comm Living	T2016	Current
9	0	Provider Contract - Diagnosis	161695	Global Rules	3180	Current
10	0	Member Plan - Diagnosis	47255	Opt Chc - Man pop - Tgt - with Copay	3180	Current
11	0	Provider Contract - Procedure	153621	Global Rules	T2016	Current
12	0	Member Plan - Procedure	47258	Opt Chc - Man pop - Tgt - with Copay	T2016	Current

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Decision Rules button located in the navigation / maintenance panel.

4.2.30.5 Extra Features

This panel has no extra features.

4.2.30.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Sequence	The order in which the rule was applied for the claim detail.	Field	Number	4	N/A	T_CLM_RU_MATCHED
2	Decision	A short identifier for the decision. Examples, BP (Member Benefit Plan - Procedure), BD (Member Benefit Plan - Diagnosis).	Field	Character	4	N/A	T_CLM_RU_MATCHED
3	Rule #	Primary-Key for this table	Field	Number	9	N/A	T_CLM_RU_MATCHED
4	Benefit Plan/Contract for which the rule applies	Benefit Plan/Contract for which the rule applies	Field	Character	0	N/A	N/A
5	Benefit	System assigned key used to uniquely identify a benefit (procedure, diagnosis, etc).	Field	Character	0	N/A	N/A
6	Status	Code used to indicate if a rule on the claim is a current rule ('C') - a rule that was used in the the most recent processing of the claim, or an historical rule ('H') - a rule that was previously used when the claim previously processed..	Field	Character	0	N/A	T_CLM_RU_MATCHED

4.2.30.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct

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

4.2.31 PANEL: Error

4.2.31.1 Description

Access the Claim Errors panel from the paid, denied, or suspended claim panels. This panel displays the header and/or detail errors applicable to the claim being viewed.

Field edits and the Add / Delete buttons are for Data Correction only.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Error link from the displayed panel];

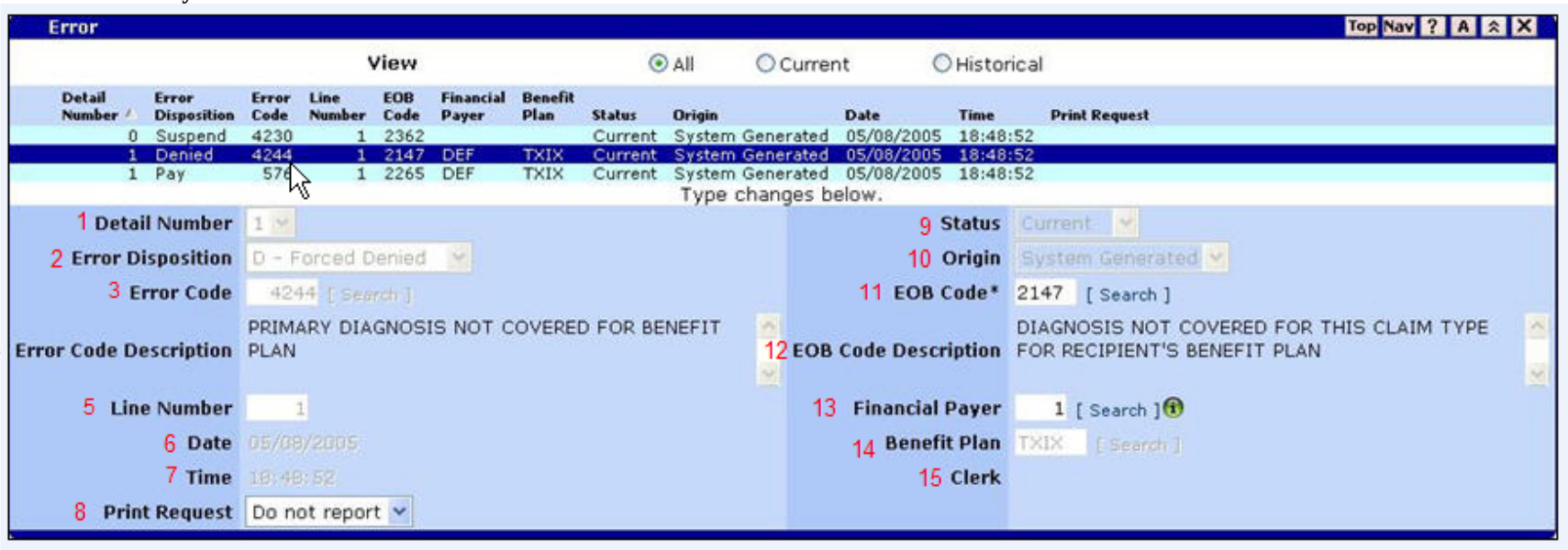
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Error link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Error link from the displayed panel].

4.2.31.2 Panel Name

Error

4.2.31.3 Error Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Error button located in the navigation / maintenance panel.

This panel displays the Error codes applicable to the claim. In the Data Correction page this panel allows codes to be added or deleted.

4.2.31.4 Extra Features

This panel has no extra features.

4.2.31.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The number of the header or detail that contains an edit or an audit failure	Field	Number	4	T_CLAIM_ERROR	NUM_DTL
2	Error Disposition	Code that represents the action that is taken on a claim at disposition time: pay(P), deny(D), suspend(S), force override(F), reject(J), or batch suspend(B)	Field	Drop Down List Box	0	T_CLAIM_ERROR	CDE_DISP_STATUS
3	Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit	Field	Number	4	T_ERROR_DISP	CDE_ESC
4	Error Code Description	Description of the error	Field	Character	50	T_ERROR_DISP	DSC_ERROR_STAT

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Line Number	Number which indicates the detail of the Error Disposition line item from which the Error Disposition was assigned.	Field	Number	3	T_CLAIM_ERROR	SAK_ERROR_DISP
6	Date	Date of the error code	Field	Date (MM/DD/CCYY)	8	T_CLAIM_ERROR	DTE_GENERIC
7	Time	Time of the error code. Format HH:MM:SS	Field	Number	6	T_CLAIM_ERROR	TME_STAMP
8	Print Request	The valid values are: Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report	Field	Drop Down List Box	1	T_CLAIM_ERROR	IND_RPT
9	Status	Indicates whether the Errors are current or history	Field	Drop Down List Box	7	T_CLAIM_ERROR	CDE_STAT_ERROR
10	Origin	Indicates who generated the error code and message	Field	Drop Down List Box	6	T_CLAIM_ERROR	CDE_STATUS1
11	EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it	Field	Number	4	T_EOB	CDE_EOB
12	EOB Code Description	Description of the EOB	Field	Character	79	T_EOB	DSC_EOB
13	Financial Payer	A value that identifies a unique payer within interChange	Field	Character	4	T_CLAIM_ERROR	SAK_FIN_PAYER

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
14	Benefit Plan	Identifies the medical assistance program that is supported in the system. Use the [Search] panel to select a valid plan	Field	Check Box	5	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
15	Clerk	Number used to identify the user who last updated the error record	Field	Character	8	T_CLAIM_ERROR	ID_CLERK

4.2.31.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
14	Benefit Plan	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select a valid Benefit Plan from the [Search] panel.
11	EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
3	Error Code	Field	1	Invalid Error Code.	Enter a valid Error Code or select a valid code from the [Search] panel.
3	Error Code	Field	2	Error Code XXXX cannot be overridden.	The Error Code entered is a critical error or it cannot be overridden. The Error Disposition cannot be 'F - Force'.
3	Error Code	Field	3	Error Code XXXX cannot have the Error Disposition set to 'Deny'.	The Error Code entered has an Allow Deny Indicator set to 'No'; therefore the Error Disposition cannot be set to Deny.
13	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer or select one from the [Search] panel.

4.2.32 PANEL: MCO Data

4.2.32.1 Description

The MCO Data panel displays Managed Care Organization (MCO) data related to encounter claims.

Navigation Path: [Claims -Information] - [Enter an ICN for an Encounter Claim] - [Select MCO Data link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select an Encounter Claim claim] - [Select MCO Data link from the displayed panel].

4.2.32.2 Panel Name

MCO Data

4.2.32.3 MCO Data Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the MCO Data button located in the navigation / maintenance panel.

4.2.32.4 Extra Features

This panel has no extra features.

4.2.32.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	MCO ICN	Internal Control Number of the MCO claim.(when qlf_reference_id ='D9' and num_dtl = 0).	Field	Number	13	T_CLM_REF	CDE_REF_ID

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
2	MCO Original ICN	Original MCO Internal Control Number for voids and adjustments. (when qlf_reference_id ='F8' and num_dtl = 0).	Field	Number	13	T_CLM_REF	CDE_REF_ID
3	MCO Payment Date	Date the MCO paid encounter claim.	Field	Date (MM/DD/CCYY)	8	T_XXXX_OTH_PYR_HDR	DTE_CLM_ADJUDICATION
4	Encounter Status	Code which indicates the status of the encounter in the system as a result of interChange editing. The values will be T - Threshold, I - Informational or P - paid.	Field	Character	1	T_PD_XXXX_HDR OR T_DENY_XXXX_HDR	CDE_ENC_STATUS
5	MCO Paid Amount	MCO Paid Amount (when qlf_amount='D' and num_dtl = 0).	Field	Number	9	T_CLM_AMT	AMT_MONETARY
6	MCO Allowed Amount	Medicaid allowed amount, the result of re-pricing the encounter claim.(when qlf_amount='B6' and num_dtl = 0).	Field	Number	9	T_CLM_AMT	AMT_MONETARY
7	MCO Capitation	Capitation Indicator.	Field	Character	1	T_CLM_CN1	CDE_CONTRACT_TYPE

4.2.32.6 Field Edits

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

4.2.33 PANEL: MCO Detail Information

4.2.33.1 Description

The MCO Detail Information panel shows the detail MCO paid date(s) of the service(s) submitted on the encounter.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Display TCN link from the displayed panel];

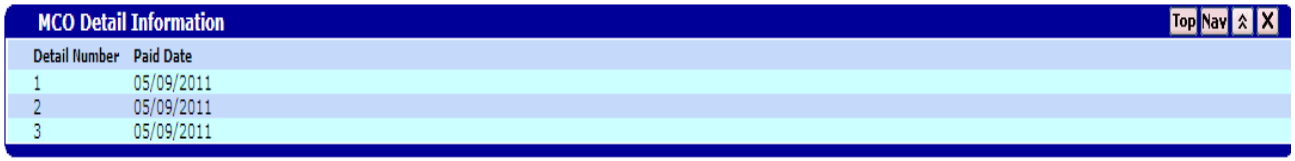
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Display TCN link from the displayed panel;

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Display TCN link from the displayed panel].

4.2.33.2 Panel Name

MCO Detail Information

4.2.33.3 MCO Detail Information Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the MCO Detail Information button located in the navigation / maintenance panel.

This panel displays the detail MCO paid date of the service(s) submitted on the encounter.

4.2.33.4 Extra Features

This panel has no extra features.

4.2.33.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The detail number associated to the MCO Paid Date	Field	Number	4	T_CLM_OTH_PYR_DTL	NUM_DTL
2	Paid Date	The detail MCO paid date of the service(s) submitted on the encounter	Field	Date (MM/DD/CCYY)	8	T_CLM_OTH_PYR_DTL	DTE_SERVICE_ADJUD

4.2.33.6 Field Edits

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

4.2.34 PANEL: Miscellaneous Information

4.2.34.1 Description

The Misc Information panel displays additional claim information.

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

Table: T_CLM_MISC

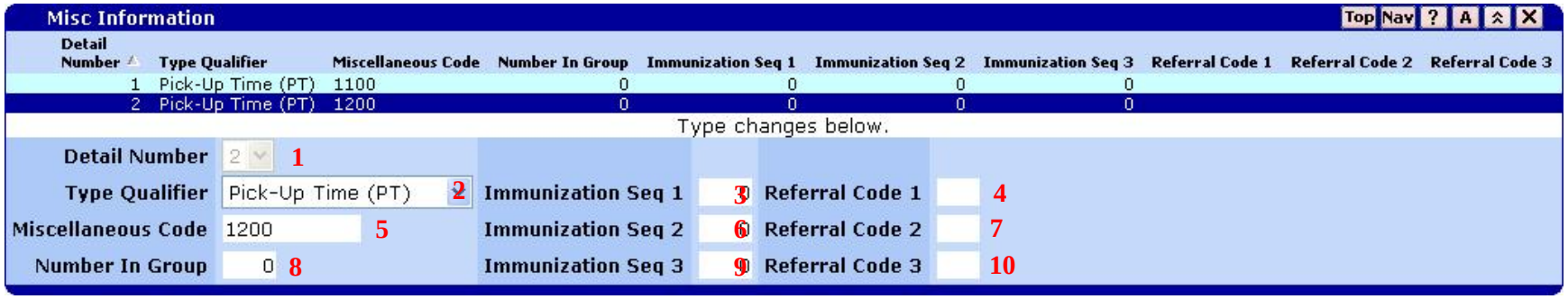
4.2.34.2 Technical Name

Clm.ClaimMiscInfoHdrPnl.ascx

4.2.34.3 Panel Name

Misc Information

4.2.34.4 Miscellaneous Information Layout



STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Miscellaneous Information button located in the navigation / maintenance panel.

4.2.34.5 Extra Features

This panel has no extra features.

4.2.34.6 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Detail Number	The number of the detail on a claim record	4	Number	T_CLM_MISC	NUM_DTL
2	Type Qualifier	This qualifier identifies the type of information under CDE_MISC	5	Character	T_CLM_MISC	QLF_MISC_TYPE
3	Immunization Seq 1	Immunization sequence on a series of vaccinations.	2	Number	T_CLM_MISC	SEQ_NUM_IMMUN
4	Referral Code 1	The referral code identifies the type/reason for a referral.	2	Number	T_CLM_MISC	CDE_REFERRAL_1
5	Miscellaneous Code	A code used in claims processing	11	Character	T_CLM_MISC	CDE_MISC
6	Immunization Seq 2	Immunization sequence on a series of vaccinations.	2	Number	T_CLM_MISC	SEQ_NUM_IMMUN_2
7	Referral Code 2	The referral code identifies the type/reason for a referral.	2	Number	T_CLM_MISC	CDE_REFERRAL_2
8	Number In Group	Number of individuals in a group. Used for group therapy services.	2	Number	T_CLM_MISC	NUM_INDV_GROUP
9	Immunization Seq 3	Immunization sequence on a series of vaccinations.	2	Number	T_CLM_MISC	SEQ_NUM_IMMUN_3
10	Referral Code 3	The referral code identifies the type/reason for a referral.	2	Number	T_CLM_MISC	CDE_REFERRAL_3

4.2.34.7 Field Edits

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

4.2.35 PANEL: Physician Claim Detail Navigation

4.2.35.1 Description

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

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

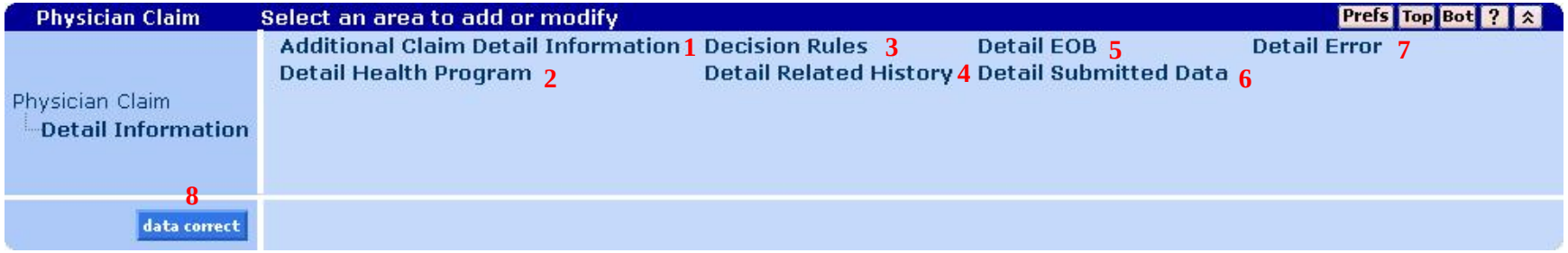
4.2.35.2 Technical Name

Clm.PhysicianClaimPage.ascx - Detail NavGroup

4.2.35.3 Panel Name

Physician Claim Detail Navigation

4.2.35.4 Physician Claim Detail Navigation Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. The Physician Claim Maintance Panel will display.

STEP 5. On the left side of the panel, click “Detail Information”.

The links for the Detail Information will display on the right side of the panel.

4.2.35.5 Extra Features

This panel has no extra features.

4.2.35.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Additional Claim Detail Information	Link to " Additional Claim Detail Information" panel	Hyperlink	N/A	0	N/A	N/A
2	Detail Health Program	Link to "Health Program" panel	Hyperlink	N/A	0	N/A	N/A
3	Decision Rules	Link to "Decision Rules" panel	Hyperlink	N/A	0	N/A	N/A
4	Detail Related History	Link to "Detail Related History" panel	Hyperlink	N/A	0	N/A	N/A
5	Detail EOB	Link to "Detail EOB" panel	Hyperlink	N/A	0	N/A	N/A
6	Detail Submitted Data	Link to "Detail Submitted Data" panel	Hyperlink	N/A	0	N/A	N/A
7	Detail Error	Link to "Detail Error" panel	Hyperlink	N/A	0	N/A	N/A

4.2.35.7 Button Descriptions

Button No	Button	Description
8	Data Correct	This button displays only for claims in suspended status. Clicking the Data Correct button opens up the displayed suspended claim in Data Correction mode. Changes can be made and the claim can be resubmitted

4.2.35.8 Field Edits

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

4.2.36 PANEL: Detail Health Program

4.2.36.1 Description

The Detail Health Program panel can be accessed from the paid, denied, or suspended claim windows. This window displays the health program applicable to the claim detail being viewed.

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

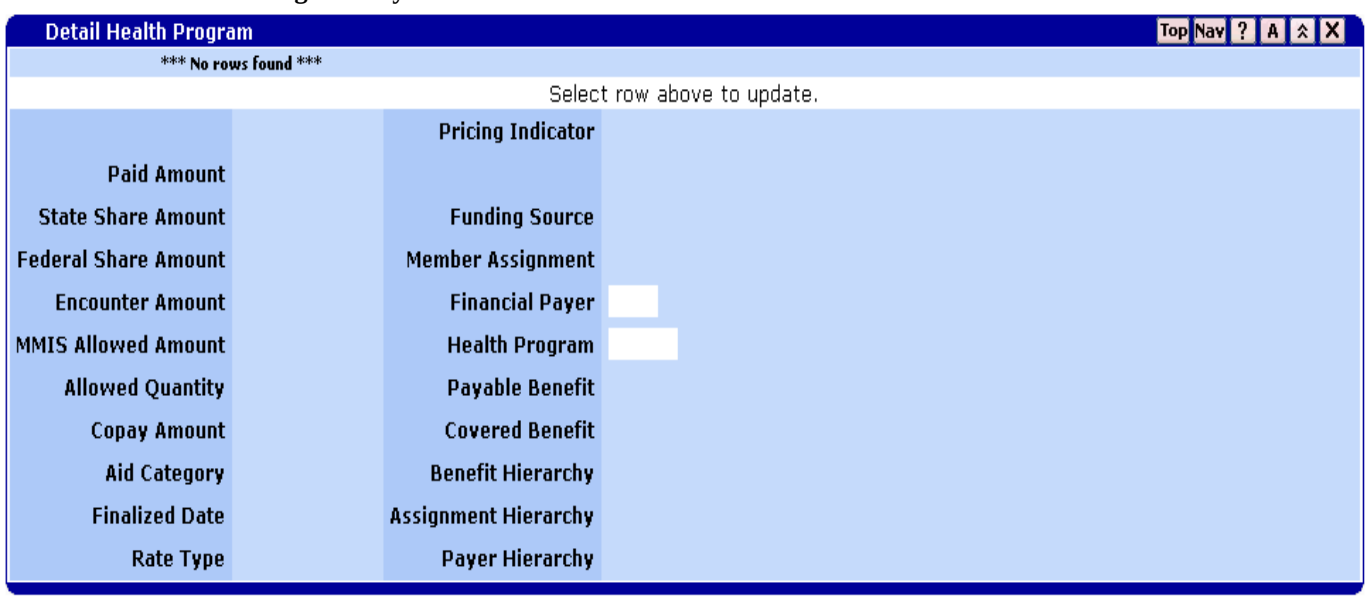
Navigation Path: [Claims -Information] - [Enter an ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail Health Program]

Tables: T_CLM_PGM_XREF, T_CDE_AID, T_FINANCIAL_PAYER, T_PUB_HLTH_PGM

4.2.36.2 Panel Name

Detail Health Program

4.2.36.3 Detail Health Program Layout



To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click on Claim detail line to highlight it.

STEP 2. Click on Detail Information button located above the Save and Cancel buttons or Adjust button.

STEP 3. Click on Detail Health Program button.

This panel displays member coverage information as applicable to the detail line of the claim. In Data Correction page, this panel allows records to be updated but only the Allowed Amount and Financial Payer fields.

4.2.36.4 Extra Features

This panel has no extra features.

4.2.36.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Paid Amount	This is the amount that is applied toward the check amount. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_PAID
2	State Share Amount	This is the amount of state share for this payment. The state share amount plus the amount Paid = Reimbursement amount. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_STATE_SHARE
3	Federal Share Amount	This is the amount of federal share for this payment	Field	Number	10	T_CLM_PGM_XREF	AMT_FEDERAL_SHARE
4	Encounter Amount	Contains the amount for encounter services on the claim detail indicated by the detail number on table. Format 9999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_ENCOUNTER

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Allowed Amount	Allowed Amount that is paid. Format 9999999.99	Field	Number	9	T_CLM_PGM_XREF	AMT_ALWD
6	Allowed Quantity	Number of units of service that are paid under a financial payer/benefit plan. Format 9999.99	Field	Number	6	T_CLM_PGM_XREF	QTY_ALLOWED
7	Copay Amount	Amount paid by member for services rendered. Format 99999.99	Field	Number	7	T_CLM_PGM_XREF	AMT_CO_PAY
8	Aid Category	Aid Category for Medicaid coverage	Field	Number	9	T_CDE_AID	CDE_AID_CATEGORY
9	Finalized Date	Date that financial finalizes the claim for this payer	Field	Date (MM/DD/CCYY)	8	T_CLM_PGM_XREF	DTE_FINAL
10	Rate Type	Code used to identify the rate type to use in determining provider reimbursement	Field	Character	3	T_CLM_PGM_XREF	CDE_RATE_TYPE
11	Pricing Indicator	Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced	Field	Character	1	T_CLM_PGM_XREF	IND_PRICING
12	Managed Care Indicator	Manage care indicator identifies claims and other transactions as to how they affect the manage care program	Field	Drop Down List Box	1	T_CLM_PGM_XREF	IND_MC
13	Fund Source	Indicates the budget category that the funds used to pay this claim/detail came from	Field	Number	9	T_FIN_FUND_CODE	T_FIN_FUND_CODE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
14	Member Assignment	A group of covered services (benefits) where the member is assigned to a provider or provider organization in order to receive covered services (benefits)	Field	Number	9	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
15	Financial Payer	The system-assigned value that identifies a unique payer within interChange	Field	Number	9	T_FINANCIAL_PAYER	CDE_FIN_PAYER
16	Health Program	Identifies the medical assistance program that is supported in the system	Field	Character	5	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
17	Payable Benefit	Unique system-assigned that identifies each row on this table	Field	Number	9	T_CLM_PGM_XREF	SAK_PAYABLE_BNFT
18	Covered Benefit	System-assigned key used to identify a unique row for a benefit covered by a member plan	Field	Number	9	T_CLM_PGM_XREF	SAK_COVERED_BNFT
19	Benefit Hierarchy	Specifies the order in which to process multiple Benefit Plans for a member	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
20	Assignment Hierarchy	An assignment hierarchy is an ordered set of assignment plans for which a member/beneficiary 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	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD_ASSIGNMENT
21	Payer Hierarchy	Payer Hierarchy identifies 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	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD_PAYER

4.2.36.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
5	Allowed Amount	Field	1	Enter a valid value.	Enter only a numeric value in the Allowed Amount field.
15	Financial Payer	Field	1	Enter a valid value.	Enter a valid Financial Payer or select a valid value from the [Search] panel.
16	Health Program	Field	1	Invalid Benefit Plan.	Enter a valid Benefit plan or select a value from the [Search] panel.

4.2.37 PANEL: Detail Related History

4.2.37.1 Description

The Detail Related History panel can be accessed from the paid, denied, or suspended claim windows. This window displays the related hstory applicable to the claim detail being viewed.

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

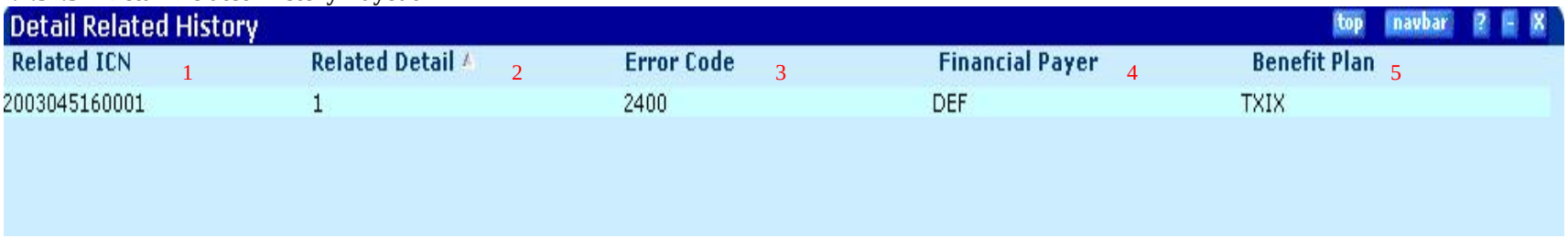
Navigation Path: [Claims -Information] - [Enter an ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail Related History]

Table: T_SUSP_RLHX

4.2.37.2 Panel Name

Detail Related History

4.2.37.3 Detail Related History Layout



To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click on Claim detail line to highlight it.

STEP 2. Click on Detail Information button located above the Save and Cancel buttons or Adjust button.

STEP 3. Click on Detail Related History button.

This panel displays other claims associated with the claim as applicable to the detail line of the claim.

4.2.37.4 Extra Features

This panel has no extra features.

4.2.37.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Related ICN	Internal Control Number of the related claim	Field	Character	13	T_SUSP_RLHX	SAK_RELATED_HX
2	Related Detail	Related detail number on the history claim displayed	Field	Number	4	T_SUSP_RLHX	NUM_DTL_RELATED
3	Error Code	Code used to indicate an error was discovered on a claim during processing in the base system	Field	Number	4	T_SUSP_RLHX	SAK_ESC
4	Financial Payer	The description used to identify the financial payer for the related ICN	Field	Character	30	T_SUSP_RLHX	SAK_FIN_PAYER
5	Benefit Plan	The medical assistance program associated with the related ICN	Field	Character	5	T_SUSP_RLHX	SAK_PUB_HLTH

4.2.37.6 Field Edits

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

4.2.38 PANEL: Detail EOB

4.2.38.1 Description

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

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

The All, Current, Historical radiobutton on the panel allows the user to select which EOB's to view based on the EOB Status. The EOB on the claim is a current EOB ('C'), one that failed in the current cycle, or a historical EOB ('H'), one that previously failed.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail EOB]

Table: T_CLM_EOB_XREF, T_CDE_HIPAA_ADJRSN, T_CDE_HIPAA_REMRKS

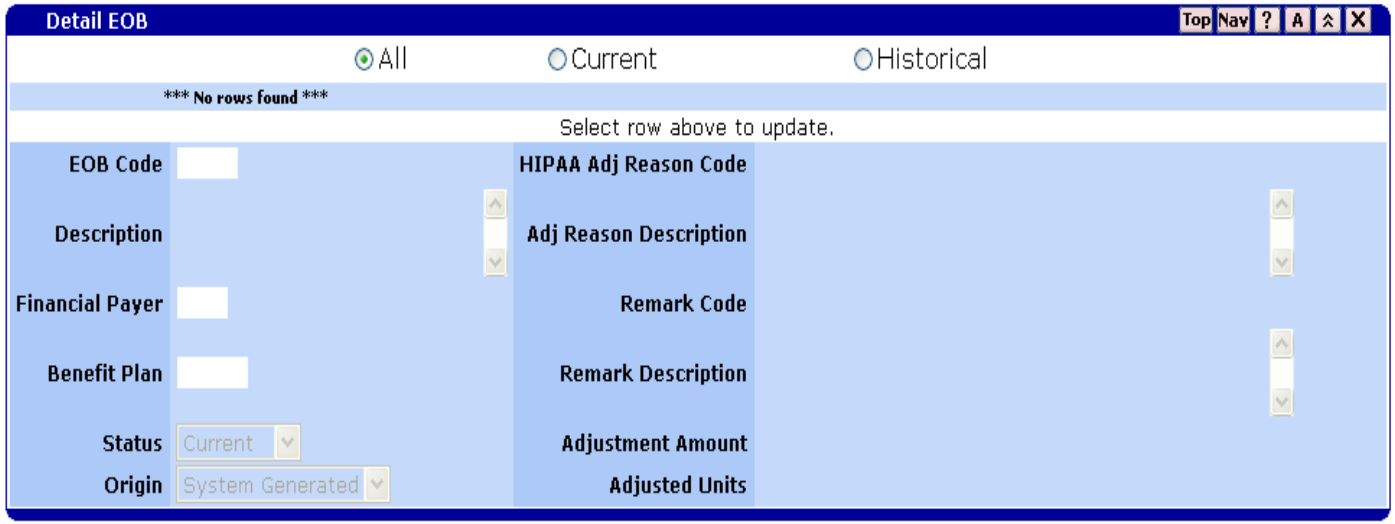
4.2.38.2 Technical Name

Clm.ClaimEobPanel.ascx

4.2.38.3 Panel Name

Detail EOB

4.2.38.4 Detail EOB Layout



Copyright 2005 Electronic Data Systems Corporation. All rights reserved.

To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click a row to select.

STEP 2. Click on Claim detail line to highlight it.

STEP 3. Click on Detail Information button located above the Save and Cancel buttons or Adjust button.

STEP 4. Click on Detail EOB button located next to the Detail Error button.

This panel displays EOB code information as applicable to the detail line of the claim. In Data Correction page, this panel allows records to be updated, added or deleted.

4.2.38.5 Extra Features

This panel has no extra features.

4.2.38.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it	Field	Number	4	T_EOB	CDE_EOB
2	Description	First line of text description for EOB code	Field	Character	79	T_EOB	DSC_EOB
3	Financial Payer	A value that identifies a unique payer within interChange	Field	Drop Down List Box	0	T_CLM_EOB_XREF	SAK_FIN_PAYER
4	Benefit Plan	Identifies the medical assistance program that is supported in the system	Field	Drop Down List Box	0	T_CLM_EOB_XREF	SAK_PUB_HLTH
5	Status	Code used to indicate whether the EOB on the claim is a current EOB ('C'), one that failed in the current cycle, or a historical EOB ('H'), one that previously failed	Field	Drop Down List Box	0	T_CLM_EOB_XREF	CDE_STAT_ERROR
6	HIPAA Adjustment Reason	This is the managed care eligibility reason codes for HIPAA	Field	Character	2	T_CDE_HIPAA_ADJ RSN	CDE_ADJ_RSN
7	Remark Code	HIPAA Remarks code	Field	Character	5	T_CDE_HIPAA_REM RKS	CDE_REMARK
8	Adjustment Amount	The dollar amount adjusted on the detail. Format 9999999.99 “NOT USED IN KY”	Field	Number	9	T_CLM_EOB_XREF	AMT_ADJUSTED

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
9	Adjusted Units	The quantity adjusted on the detail. Format 9999999.999 “NOT USED IN KY”	Field	Number	10	T_CLM_EOB_XREF	QTY_ADJUSTED
10	Origin	Indicates who generated the EOB code and message	Field	Character	6	T_CLM_EOB_XREF	CDE_STATUS1

4.2.38.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
4	Benefit Plan	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select one from the [Search] panel.
1	EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
3	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer of select one from the [Search] panel.

4.2.39 PANEL: Detail Submitted Data - Physician

4.2.39.1 Description

The Detail Submitted Data panel can be accessed from the paid, denied, or suspended claim windows. This panel displays the submitted data applicable to the Physician claim detail being viewed.

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

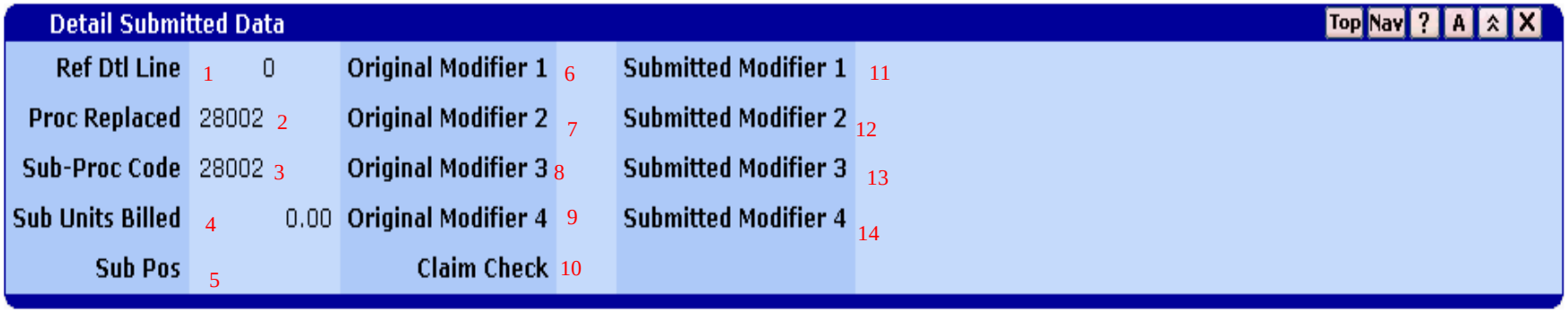
Navigation Path: [Claims -Information] - [Enter a Physician ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a Physician claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a Physician claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail Submitted Data]

Table: T_PHYS_DEXT_KEY

4.2.39.2 Panel Name

Detail Submitted Data

4.2.39.3 Detail Submitted Data - Physician Layout



To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click the row of a physician claim to select.

STEP 2. Click on Claim detail line to highlight it.

STEP 3. Click on Detail Information button located above the Save and Cancel buttons or Adjust button.

STEP 4. Click on Detail Submitted Data button.

This panel displays procedure code and/or modifiers that are replaced with the new code and/or modifier as applicable to the detail line of the claim.

4.2.39.4 Extra Features

This panel has no extra features.

4.2.39.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Ref Dtl Line	A sequence number that points to the original detail	Field	Number	4	T_PHYS_DEXT_KEY	NUM_DTL
2	Proc Replaced	Original/Submitted Procedure Code for HIPAA 835 “NOT USED IN KY”	Field	Character	6	T_PHYS_DEXT_KEY	CDE_PROC
3	Sub-Proc Code	This is also the Original/Submitted Procedure Code for HIPAA 835 “NOT USED IN KY”	Field	Character	6	T_PHYS_DEXT_KEY	CDE_PROC
4	Sub Units Billed	Original billed quantity on the claim detail. Format 9999.99	Field	Number	6	T_PHYS_DEXT_KEY	QTY_BILLED_ORIG
6	Original Modifier 1	Original procedure modifier 1. Is NULL if the original modifier was not changed. If the original modifier was changed, this column retains the value of the original modifier before it was changed	Field	Character	2	T_PHYS_DEXT_KEY	CDE_PROC_MOD1_ORIG
6	Sub POS	Original/Submitted place of service for HIPAA 835	Field	Character	2	T_PHYS_DEXT_KEY	CDE_POS_SUB

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
7	Original Modifier 2	Original procedure modifier 2. Is NULL if the original modifier was not changed. If the original modifier was changed, this column retains the value of the original modifier before it was changed	Field	Character	2	T_PHYS_DEXT_KEY	CDE_PROC_MOD2_ORIG
8	Original Modifier 3	Original procedure modifier 3. Is NULL if the original modifier was not changed. If the original modifier was changed, this column retains the value of the original modifier before it was changed	Field	Character	2	T_PHYS_DEXT_KEY	CDE_PROC_MOD3_ORIG
9	Original Modifier 4	Original procedure modifier 4. Is NULL if the original modifier was not changed. If the original modifier was changed, this column retains the value of the original modifier before it was changed	Field	Character	2	T_PHYS_DEXT_KEY	CDE_PROC_MOD4_ORIG
10	Claim check	Indicates whether or not the detail has been through the Claimcheck program	Field	Character	1	T_DENY_PHYS_DTL	IND_CLAIM_CHECK
11	Submitted Modifier 1	Submitted Procedure Modifier 1 for HIPAA 835	Field	Character	2	T_PHYS_DEXT_KEY	CDE_PROC_MOD1_SUB
12	Submitted Modifier 2	Submitted Procedure Modifier 2 for HIPAA 835	Field	Character	2	T_PHYS_DEXT_KEY	CDE_PROC_MOD2_SUB
13	Submitted Modifier 3	Submitted Procedure Modifier 3 for HIPAA 835	Field	Character	2	T_PHYS_DEXT_KEY	CDE_PROC_MOD3_SUB

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
14	Submitted Modifier 4	Submitted Procedure Modifier 4 for HIPAA 835	Field	Character	2	T_PHYS_DEXT_KEY	CDE_PROC_MOD4_SUB

4.2.39.6 Field Edits

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

4.2.40 PANEL: Detail Error

4.2.40.1 Description

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

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

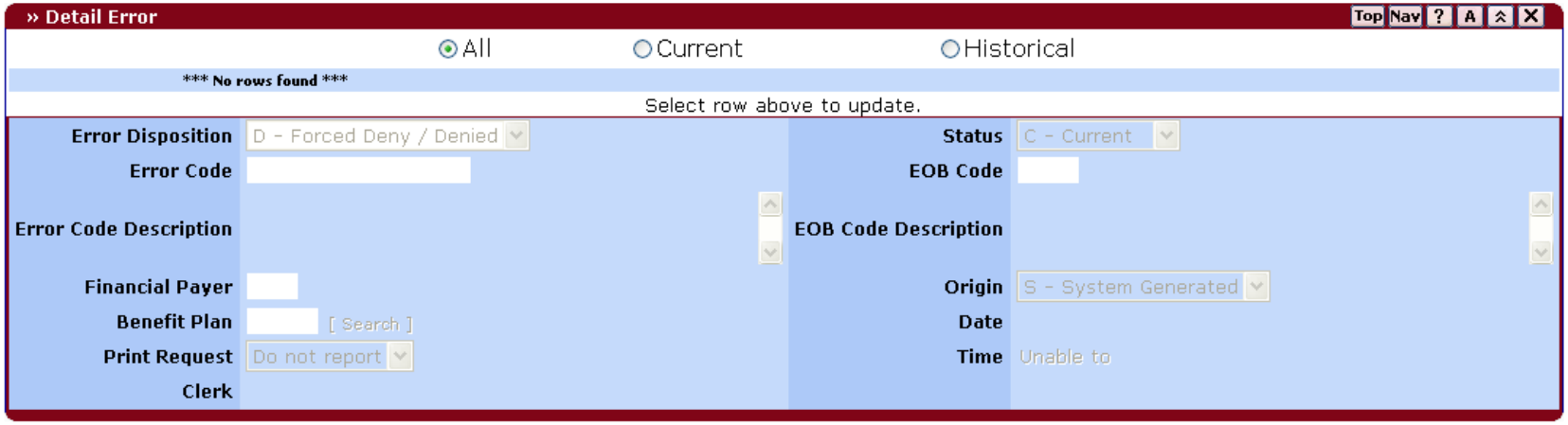
Navigation Path: [Claims -Information] - [Enter an ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail Error]

Tables: T_CLAIM_ERROR, T_ERROR_DISP, T_EOB

4.2.40.2 Panel Name

Detail Error

4.2.40.3 Detail Error Layout



To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click a row to select.

STEP 2. Click on Claim detail line to highlight it.

STEP 3. Click on DetailInformation button located above the Save and Cancel buttons or Adjust button.

STEP 4. Click on Detail Error button located next to the Detail EOB button.

This panel displays Error code information as applicable to the detail line of the claim. In Data Correction page, this panel allows records to be updated, added or deleted.

4.2.40.4 Extra Features

This panel has no extra features.

4.2.40.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Error Disposition	Disposition of the error	Field	Drop Down List Box	0	T_ERROR_DISP	DSC_ERROR_STAT
2	Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit	Field	Character	4	T_ERROR_DISP	CDE_ESC
3	EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it	Field	Number	4	T_EOB	CDE_EOB
4	Financial Payer	A value that identifies a unique payer within interChange	Field	Character	4	T_CLAIM_ERRO R	SAK_FIN_PAYER

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Benefit Plan	Identifies the medical assistance program that is supported in the system. Use the [Search] panel to select a valid plan	Field	Character	5	T_CLAIM_ERROR	SAK_PUB_HLTH
6	Print Request	The valid values for this indicator are Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report	Field	Drop Down List Box	0	T_CLAIM_ERROR	IND_RPT
7	Clerk	Number used to identify the user who last updated the error record	Field	Character	8	T_CLAIM_ERROR	ID_CLERK
8	Status	Indicates if the EOB is current or history	Field	Character	7	T_CLAIM_ERROR	CDE_DISP_STATUS
9	Error Description	Description of the error	Field	Character	50	T_ERROR_DISP	DSC_ERROR_STAT
10	EOB Description	Text description for the EOB code	Field	Character	79	T_EOB	DSC_EOB
11	Origin	Indicates how the EOB Code and message were generated: valid values are 'S - System Generated' or 'U - User Assigned'	Field	Drop Down List Box	0	T_CLAIM_ERROR	CDE_STATUS1
12	Date	Date of the Error code	Field	Date (MM/DD/CCYY)	0	T_CLAIM_ERROR	DTE_GENERIC
13	Time	Time of the error code	Field	Number	8	T_CLAIM_ERROR	TME_STAMP

4.2.40.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Financial Payer	Field	3	Error Code XXXX cannot have the Error Disposition set to 'Deny'.	The Error Code entered has an Allow Deny Indicator set to 'No'; therefore the Error Disposition cannot be set to Deny.
1	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer or select one from the [Search] panel.
2	Error Code	Field	1	Invalid error code.	Enter a valid Error Code or select a valid code from the [Search] panel.
2	Error Code	Field	2	Error Code XXXX cannot be overridden.	The Error Code entered is a critical error or it cannot be overridden. The Error Disposition cannot be 'F - Force'.
3	EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
5	Benefit Plan	Field	1	Invalid Benefit plan.	Enter a valid Benefit Plan or select a valid Benefit Plan from the [Search] panel.

4.2.41 PANEL: Physician Claim Detail

4.2.41.1 Description

Use the Physician Claim Detail panel to view the data entered on the detail portion of a Physician claim. When this panel is displayed in Data Correction mode, use the Add or Delete buttons to add or remove details.

Navigation Path: [Claims -Information] - [Enter an ICN for a Physician claim] - [Select Claim Detail link from the displayed panel];

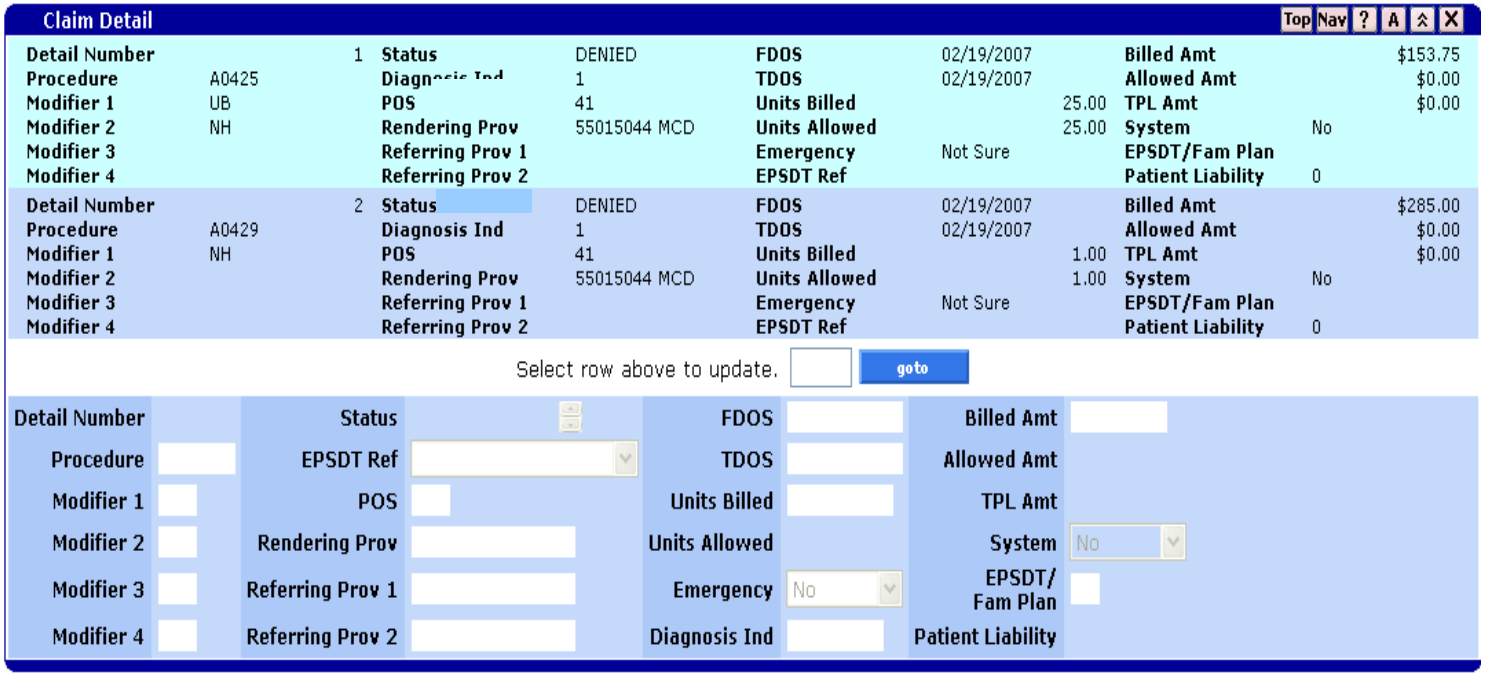
OR - [Claims -Search] - [Enter Criteria] - [Select a Physician claim] - [Select Claim Detail link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a Physician claim from the list] - [Select Claim Detail link from the displayed panel].

4.2.41.2 Panel Name

Claim Detail

4.2.41.3 Physician Claim Detail Layout



To access this panel:

Access the Data Correction page using the instructions listed for the page.

STEP 1. Click on the row of a physician claim to select.

This panel displays the detail lines of a physician claim. In Data Correction page, this panel allows detail lines to be updated, added or deleted.

STEP 2. Click the Add button.

STEP 3. Click the Search button next to the Procedure Code field to bring up the pop-up window listing.

STEP 4. Click on a row to select.

STEP 5. Enter date(s) of service in FDOS and TDOS fields using mm/dd/ccyy format.

STEP 6. Enter any appropriate fields for the service.

STEP 7. Click the Save button or click the detail line panel to highlight it. Edit the fields.

STEP 8. Click the Save button or click the Delete button to delete the current detail information.

4.2.41.4 Extra Features

This panel has no extra features.

4.2.41.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The number of the detail on a claim record	Field	Number	4	SEE NARRATIVE SECTION	NUM_DTL
2	Procedure	System-assigned key for a procedure code on a detail which indicates the service that was provided	Field	Character	6	SEE NARRATIVE SECTION	CDE_PROC
3	Modifier 1	Code used to identify the modifiers connected to the procedure code	Field	Character	2	SEE NARRATIVE SECTION	CDE_PROC_MOD

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
4	Modifier 2	Code used to identify the modifiers connected to the procedure code	Field	Character	2	SEE NARRATIVE SECTION	CDE_MODIFIER_2
5	Modifier 3	Code used to identify the modifiers connected to the procedure code	Field	Character	2	SEE NARRATIVE SECTION	CDE_MODIFIER_3
6	Modifier 4	Code used to identify the modifiers connected to the procedure code	Field	Character	2	SEE NARRATIVE SECTION	CDE_MODIFIER_4
7	Patient Liability	The amount of patient liability applied to this claim	Field	Number	12	T_CLM_PATILIAB_X	AMT_PD_PAT_UB92
8	Status	Detail adjudication status	Field	Character	1	SEE NARRATIVE SECTION	CDE_CLM_STATUS
9	Diagnosis Ind	Indicates which diagnosis (or diagnoses) for which services were provided. Valid values are 1,2,3,4 for paper claims and 1-8 for electronic claims	Field	Number	8	SEE NARRATIVE SECTION	CDE_DIAG_TREAT_IND
10	POS	Place of Service where service was rendered	Field	Character	2	SEE NARRATIVE SECTION	CDE_POS
11	Rend Provider Number	The rendering provider identification number and location that uniquely identifies the provider of services. P> SAK_PROV_PERF, CDE_SVC_LOC_REND	Field	Number	10	SEE NARRATIVE SECTION	SEE DESCRIPTION

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
12	Refer Prov 1 / Loc	Provider Identification Number that uniquely identifies the referring provider and location that uniquely identifies the provider of services. P> SAK_PROV_REFERRING, CDE_SVC_LOC_REF_1	Field	Number	10	SEE NARRATIVE SECTION	SEE DESCRIPTION
13	Refer Prov 2 / Loc	Provider Identification Number that uniquely identifies the referring provider and location that uniquely identifies the provider of services. P> SAK_PROV_REFERRING_2, CDE_SVC_LOC_REF_2	Field	Number	10	SEE NARRATIVE SECTION	SEE DESCRIPTION
14	FDOS	Date on which service was first provided	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_FIRST_SVC
15	TDOS	Last service date	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_LAST_SVC
16	Units Billed	The number of units billed by the provider	Field	Number	6	SEE NARRATIVE SECTION	QTY BILLED
17	Units Allowed	Number of units of service that are paid for	Field	Number	6	SEE NARRATIVE SECTION	QTY_ALLOWED
18	Emergency	Indicates whether the service was provided as result of emergency situation	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	IND_EMERGENCY

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
19	EPSDT Ref	EPSDT referral/treatment information	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	IND_EPSDT_REF
20	Billed Amt	Amount of money requested for payment by a provider for services rendered. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_BILLED
21	Allowed Amt	Amount allowed that is paid. Format 9999999.99	Field	Number	9	SEE NARRATIVE SECTION	AMT_ALWD
22	Copay Amt	Amount paid by member for services rendered. Format 99999.99	Field	Number	7	SEE NARRATIVE SECTION	AMT_CO_PAY
23	TPL Amt	Amount paid by third party for services, at the claim header level. Format 999999.99	Field	Number	9	SEE NARRATIVE SECTION	AMT_DETAIL_TPL
24	System	Indicates whether detail was added by system during claim's processing	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	IND_SYS_GENERATE
25	EPSDT/Fam Plan	A code from the HCFA 1500 claim form block 24 H indicating EPSDT or Family Planning	Field	Character	1	SEE NARRATIVE SECTION	CDE_EPSDT_FP
26	goto	Allows user to view a specific detail	Button	N/A	0	N/A	N/A

4.2.41.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Procedure	Field	1	Invalid Procedure Code.	Enter a valid code or select a code from the [Search] panel.

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	Modifier 1	Field	1	Invalid Modifier 1 Code.	Enter a valid Modifier Code or select a valid value from the [Search] panel.
4	Modifier 2	Field	1	Invalid Modifier 2 Code.	Enter a valid Modifier Code or select a valid value from the [Search] panel.
5	Modifier 3	Field	1	Invalid Modifier 3 Code.	Enter a valid Modifier Code or select a valid value from the [Search] panel.
6	Modifier 4	Field	1	Invalid Modifier 4 Code.	Enter a valid Modifier Code or select a valid value from the [Search] panel.
9	Diagnosis Ind	Field	1	Diagnosis indicator must be less than number of diagnosis on the claim.	Verify the value and re-enter.
10	POS	Field	1	Invalid Place of Service.	Enter a valid code or select a valid POS from the [Search} panel.
11	Rendering Provider	Field	1	Invalid Rendering Provider.	Enter a valid provider or select a provider from the [Search] panel.
11	Rendering Provider	Field	2	Rendering provider ID and service location are required.	If a Rendering Prov value is entered, then a location must also be entered. If the provider location is entered, then the provider ID must be entered.
12	Referring Prov 1	Field	1	Invalid Referring Provider 1.	Enter a valid code or select a valid provider from the [Search] panel.
12	Referring Prov 1	Field	2	Referring Provider 1 ID and service location are required.	If the Refer Prov 1 value is entered, then a location must also be entered. If the provider location is entered, then the provider ID must be entered.
13	Referring Prov 2	Field	1	Invalid Referring Provider 2.	Enter a valid code or select a provider from the [Search] panel.

Field No	Field	Field Type	Error Code	Error Message	To Correct
13	Referring Prov 2	Field	2	Referring Provider 2 ID and service location are required	If the Refer Prov 2 value is entered, then a location must also be entered. If the provider location is entered, then the provider ID must be entered.
14	FDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify format and re-enter.
14	FDOS	Field	2	FDOS must be less than or equal to TDOS.	Ensure the FDOS is less than or equal to the TDOS.
15	TDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify format and re-enter
16	Units Billed	Field	1	Enter a valid value.	Enter a numeric value.
20	Billed Amt	Field	1	Enter a Valid Value.	Enter a numeric value.

4.2.42 PANEL: UB92 Claim

4.2.42.1 Description

The UB92 Claim panel displays the header information on a selected UB92 claim.

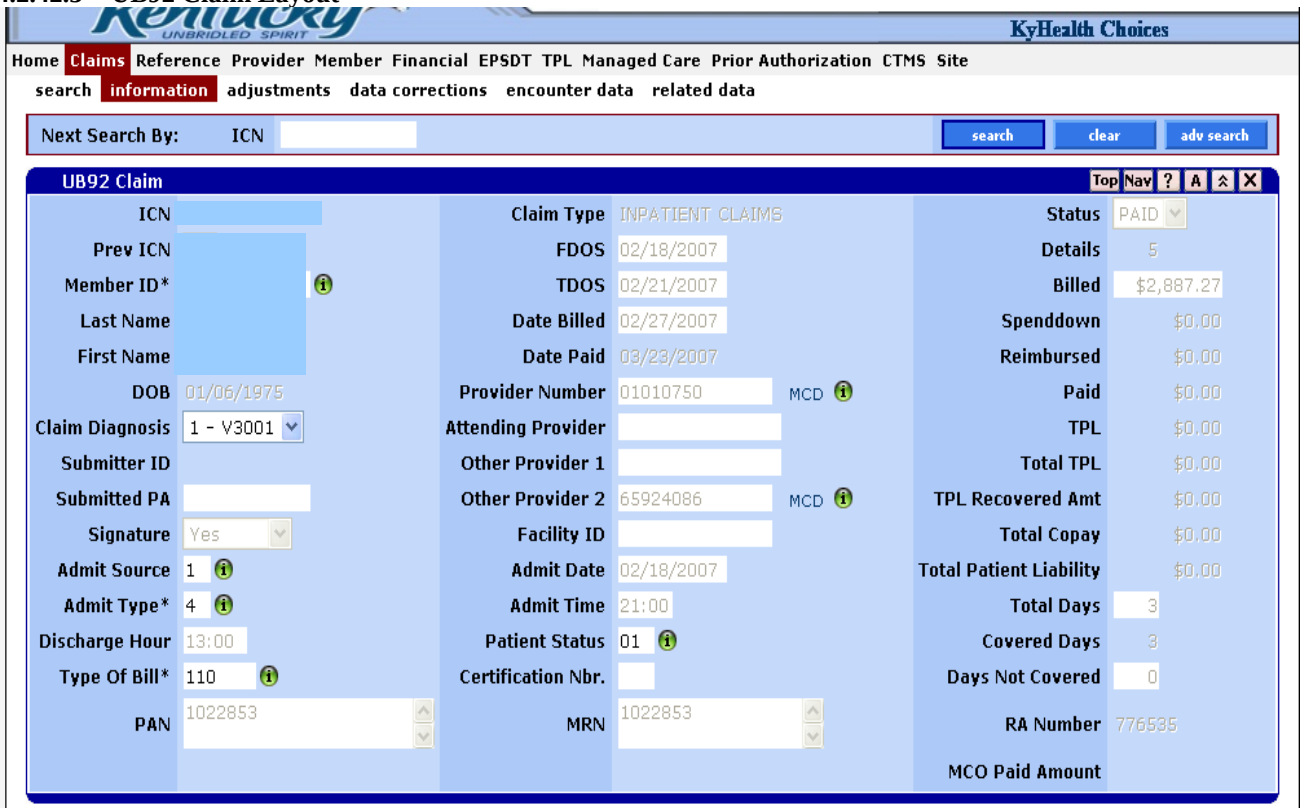
Navigation Path: [Claims -Information] - [Enter an ICN for a UB92 claim];

OR - [Claims -Search] - [Enter Criteria] - [Select a UB92 claim].

4.2.42.2 Panel Name

UB92 Claim

4.2.42.3 UB92 Claim Layout



13

To access this panel:

STEP 1. Access the Claims Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

This panel displays all the non-detail line claim information submitted on the claim.

4.2.42.4 Extra Features

This panel has no extra features.

4.2.42.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	ICN	Internal control number which uniquely identifies a claim	Field	Character	13	SEE NARRATIVE SECTION	NUM_ICN
2	Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	NUM_ICN
3	Member ID	An assigned number which uniquely identifies a member	Field	Character	12	T_UB92_HDR_ EXT_KEY	ID_MEDICAID
4	Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number, the first three characters of the last name that were typed are displayed	Field	Character	15	T_UB92_HDR_ EXT_KEY	CLM_LST_NAME_ RECIP

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number, the first character of the first name that was typed is displayed	Field	Character	15	T_UB92_HDR_EXT_KEY	CLM_RECIP_FST_NAM
6	DOB	Member date of birth	Field	Date (MM/DD/CCYY)	8	T_UB92_HDR_EXT_KEY	DTE_SUBSCRIBER_DOB
7	Diagnosis	Code used to identify the primary, admitting, emergency, or other diagnoses	Field	Drop Down List Box	0	T_DIAGNOSIS	CDE_DIAG
8	Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.	Field	Character	12	T_EDI_INTERCHANGE	CDE_SENDER_ID
9	RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles	Field	Number	12	T_FIN_REMIT_TXN_XREF	SAK_REMIT
10	Signature	Indicates whether the claim was signed by the provider or representative	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	IND_PROV_SIGN
11	Admit Source	Indicates the source of admission	Field	Character	1	SEE NARRATIVE SECTION	CDE_ADMIT_SOURCE
12	Admit Type	Code indicating the type of this admission	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	CDE_ADMIT_TYPE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
13	Discharge Hour	Time that the member is released from the hospital or facility	Field	Number	8	SEE NARRATIVE SECTION	CDE_TME_DISCHARGE
14	Type of Bill	A code indicating the specific type of bill	Field	Character	3	SEE NARRATIVE SECTION	CDE_TYPE_OF_BILL
15	PAN	Patient's unique identification number assigned by the provider to track the patient's financial records	Field	Character	38	SEE NARRATIVE SECTION	NUM_PAT_ACCT
16	Claim Type	Indicates the type of claim	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	CDE_CLM_TYPE
17	FDOS	Beginning date of service on the claim	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_FIRST_SVC
18	TDOS	Ending date of service on the claim	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_LAST_SVC
19	Date Billed	Date on which claim was submitted for processing	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_BILLED
20	Date Paid	Date on which the claim was paid	Field	Date (MM/DD/CCYY)	8	T_CLM_PGM_XREF	DTE_FINAL
21	Prov ID	The pay to provider identification number that uniquely identifies the provider of services	Field	Character	10	T_UB92_HDR_EXT_KEY	ID_PROVIDER, CDE_SERVICE_LOC
22	Attend Prov	Attending physician's prescribing number	Field	Character	10	SEE NARRATIVE SECTION	ID_PROV_ATTEND
23	Other Provider1	The license number of the physician other than the attending physician	Field	Character	10	SEE NARRATIVE SECTION	ID_PROV_OTHER

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
24	Other Provider2	The license number of the physician other than the attending physician	Field	Character	10	SEE NARRATIVE SECTION	ID_PROV_OTHER_2
25	Facility ID	Identification number assigned to the facility provider	Field	Character	11	T_UB92_HDR_ EXT_KEY	ID_PR_FACILITY
26	Admit Date	The date the patient was admitted to the facility for care	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_ADMISSION
27	Admit Time	The time that the member was admitted to the facility for care	Field	Character	4	SEE NARRATIVE SECTION	CDE_ADMIT_HOUR
28	Patient Status	Codes indicating the patient's status as of the ending service date of the period covered on the claim	Field	Character	2	SEE NARRATIVE SECTION	CDE_PATIENT_STAT US
29	Certification Nbr.	Code used to identify the certification of the member	Field	Character	2	SEE NARRATIVE SECTION	CDE_CERTIFICATE
30	MRN	Code representing the Medical Record Number	Field	Character	30	SEE NARRATIVE SECTION	CDE_MED_REC_NUM
31	Status	Identifies the status of the claim within the system	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	CDE_CLM_STATUS
32	Details	The number of detail service lines on the claim	Field	Number	9	SEE NARRATIVE SECTION	NUM_DTL_TOTAL
33	Billed	Amount requested by the provider for services rendered. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_BILLED
34	Spenddown	Spend down amount. Format 9999999.99	Field	Number	9	T_CLM_PATLIAB _X	AMT_PD_PAT_UB92

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
35	Reimbursed	Total amount the provider receives. Format 9999999.99	Field	Number	9	T_PD_UB92_HDR	AMT_PAID
36	Paid	Amount paid on claim. This value is computed by adding up all the AMT_PAID values for the related details. Format 999999.99	Field	Number	8	T_CLM_PGM_ XREF	AMT_PAID
37	TPL	Amount paid by third party for services at the claim header level. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	TPL_AMT
38	Total TPL	The sum of the TPL amounts at the header and detail levels. Format 999999.99	Field	Number	8	N/A	N/A
39	TPL Recovered Amt	The recovery amount populated from the settlement panel. Format 9999999.99	Field	Number	9	T_TPL_AR_DISPS	AMT
40	Total Copay	The sum of all the detail co-pay amounts applicable to the claim. Format 99999.99	Field	Number	7	N/A	N/A
41	Patient Liability	The amount of patient liability applied to this claim	Field	Number	12	SEE NARRATIVE SECTION	AMT_PATNT_LIAB
42	Total Days	The total number of days that were billed on the claim	Field	Number	4	SEE NARRATIVE SECTION	NUM_DAYS_COVD
43	Covered Days	Number of days covered by the primary payer	Field	Number	4	SEE NARRATIVE SECTION	NUM_DAYS_COVD - NUM_DAYS_NCOVD
44	Days Not Covered	The number of days that were not covered	Field	Number	4	SEE NARRATIVE SECTION	NUM_DAYS_NCOVD

4.2.42.6 Field Edits

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

4.2.43 PANEL: UB92 Claim Navigation

4.2.43.1 Description

The UB92 Claim Navigation panel provides access to the various panels through which UB92 Claims data can be viewed and/or corrected.

Navigation Path: [Claims -Information] - [Enter an ICN for a UB92 claim];

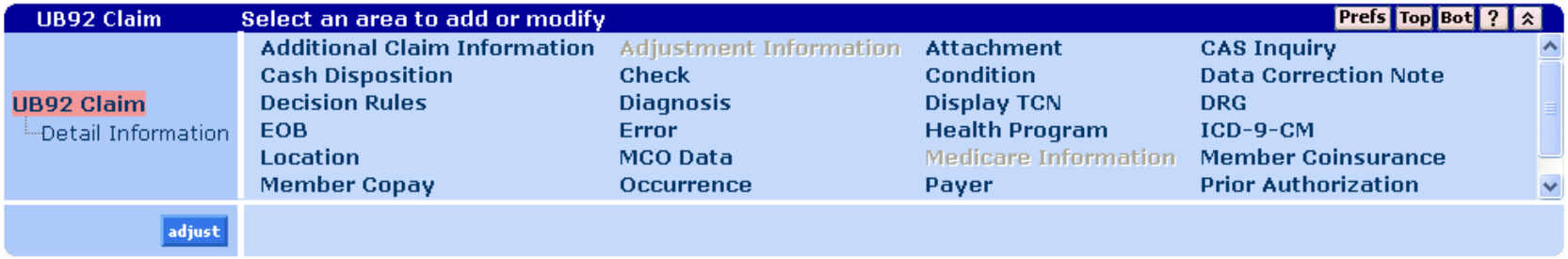
OR - [Claims -Search] - [Enter Criteria] - [Select a UB92 claim];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a UB92 claim from the list].

4.2.43.2 Panel Name

UB92 Claim Navigation

4.2.43.3 UB92 Claim Navigation Layout



To access this panel:

STEP 1. Select a row from claim search results.

STEP 2. The navigation panel will open below the claim information panel.

4.2.43.4 Extra Features

This panel has no extra features.

4.2.43.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Additional Claim Information	Link to "Additional Claim Information"	Hyperlink	N/A	0	N/A	N/A
2	Cash Disposition	Link to "Cash Disposition" panel	Hyperlink	N/A	0	N/A	N/A
3	Decision Rules	Link to "Decision Rules" panel	Hyperlink	N/A	0	N/A	N/A
4	EOB	Link to "EOB" panel	Hyperlink	N/A	0	N/A	N/A
5	Location	Link to "Location" panel	Hyperlink	N/A	0	N/A	N/A
6	Member Copay	Link to "Member Copay"	Hyperlink	N/A	0	N/A	N/A
7	Related History	Link to "Related History" panel	Hyperlink	N/A	0	N/A	N/A
8	Adjustment Information	Link to "Adjustment Information" panel	Hyperlink	N/A	0	N/A	N/A
9	Check	Link to "Check" panel	Hyperlink	N/A	0	N/A	N/A
10	Diagnosis	Link to "Diagnosis" panel	Hyperlink	N/A	0	N/A	N/A
11	Error	Link to "Error" panel	Hyperlink	N/A	0	N/A	N/A
12	MCO Data	Link to "MCO Data"	Hyperlink	N/A	0	N/A	N/A
13	Occurrence	Link to "Occurrence" panel	Hyperlink	N/A	0	N/A	N/A
14	Attachment	Link to "Attachment" panel	Hyperlink	N/A	0	N/A	N/A
14	Submitted Data	Link to "Submitted Data" panel	Hyperlink	N/A	0	N/A	N/A
15	Condition	Link to "Condition" panel	Hyperlink	N/A	0	N/A	N/A
16	Display TCN	Link to "Display TCN" panel	Hyperlink	N/A	0	N/A	N/A
17	Health Program	Link to "Health Program" panel	Hyperlink	N/A	0	N/A	N/A
18	Medicare Information	Link to "Medicare Information"	Hyperlink	N/A	0	N/A	N/A

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
19	Payer	Link to "Payer" panel	Hyperlink	N/A	0	N/A	N/A
20	Value	Link to "Value"	Hyperlink	N/A	0	N/A	N/A
21	CAS Inquiry	Link to "CAS Inquiry" panel	Hyperlink	N/A	0	N/A	N/A
22	Data Correction Note	Link to "Data Correction Note" panel	Hyperlink	N/A	0	N/A	N/A
23	DRG	Link to “DRG” panel	Hyperlink	N/A	0	N/A	N/A
24	ICD-9-CM	Link to "ICD-9-CM" panel	Hyperlink	N/A	0	N/A	N/A
25	Member Coinsurance	Link to "Member Coinsurance"	Hyperlink	N/A	0	N/A	N/A
26	Prior Authorization	Link to "Service/Prior Authorization" panel	Hyperlink	N/A	0	N/A	N/A

4.2.43.6 Button Descriptions

Button No	Button	Description
27	Data Correct	This button displays for claims in suspended status. Clicking the Data Correct button opens up the displayed suspended claim in Data Correction mode. Changes can be made and the claim can be resubmitted

4.2.43.7 Field Edits

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

4.2.44 PANEL: Additional Claim Information

4.2.44.1 Description

Allows the user to examine additional information submmited on the claim including the information that is used to determine the correct service location to assign to a claim.

Navigation Path: [Claims - Search] - [Enter Criteria] - [Select a Claim] - [Select Additional Claim Information]

Tables: T_CLM_ENTITY, T_PARTY_IDENTIFIER, T_CLM_NAME_N1, T_CLM_ADR_N3_N4

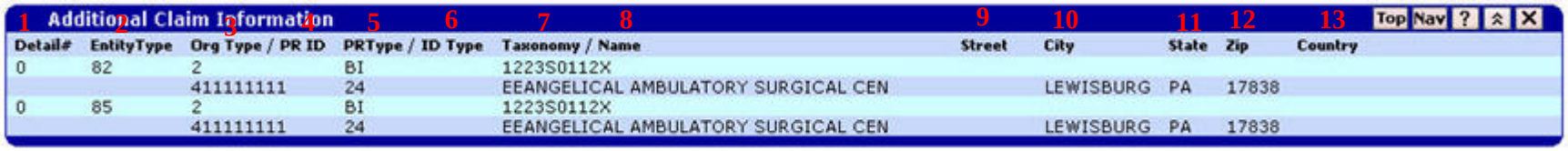
4.2.44.2 Technical Name

Clm.AdditionalClaimInformationPanel.ascx

4.2.44.3 Panel Name

Additional Claim Information

4.2.44.4 Additional Claim Information Layout



Detail#	EntityType	Org Type / PR ID	PRType / ID Type	Taxonomy / Name	Street	City	State	Zip	Country
0	82	2	BI	1223S0112X					
		411111111	24	EEANGELICAL AMBULATORY SURGICAL CEN		LEWISBURG	PA	17838	
0	85	2	BI	1223S0112X					
		411111111	24	EEANGELICAL AMBULATORY SURGICAL CEN		LEWISBURG	PA	17838	

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Additional Claim Information button located in the navigation / maintenance panel.

4.2.44.5 Extra Features

This panel has no extra features.

4.2.44.6 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Detail Number	The number of the detail on the claim record.	4	Number	T_CLM_ENTITY	NUM_DTL

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
2	Entity Type	Indicates the type of the Party Entity.	3	Character	T_CLM_ENTITY	QLF_ENTITY_TYPE
3	Org Type	Indicates whether the entity is a person or a non-person.	2	Character	T_CLM_ENTITY	QLF_TYPE_ORG
4	PR ID	The unique identifier for the entity type specified by the qualifier.	80	Character	T_PARTY_IDENTIFIER	CDE_PARTY_ID
5	PR Type	The type of practice for a provider.	3	Character	T_CLM_ENTITY	CDE_PROVIDER_TYPE
6	ID Type	Indicates the identification code qualifier.	2	Character	T_PARTY_IDENTIFIER	QLF_ID_TYPE
7	Taxonomy	The Referring Provider Taxonomy or Provider Specialty.	30	Character	T_CLM_ENTITY	CDE_PROV_TAXONOMY
8	Name	The last, first, middle & suffix name of the Member/Provider or the name of the Organization.	65	Character	T_CLM_NAME_N1	NAM_LAST, NAM_FIRST, NAM_MIDDLE
9	Street	The address of the Member/Provider.	55	Character	T_CLM_ADR_N3_N4	ADR_STREET_1, ADR_STREET_2
10	City	The city associated with the address for the Member/Provider.	30	Character	T_CLM_ADR_N3_N4	ADR_CITY
11	State	The state associated with the address for the Member/Provider.	2	Character	T_CLM_ADR_N3_N4	ADR_STATE

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
12	Zip	The zip code associated with the address for the Member/Provider.	15	Character	T_CLM_ADR_N3_N4	ADR_ZIP_CODE
13	Country	The country associated with the address for the Member/Provider.	3	Character	T_CLM_ADR_N3_N4	ADR_COUNTRY

4.2.44.7 Field Edits

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

4.2.45 PANEL: Cash Disposition

4.2.45.1 Description

Use the Cash Disposition panel to access cash related information for a particular adjustment. It displays the Cash Control Number (CCN), sequence number, and the refund (disposition) amount of the adjustment claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Cash Disposition link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Cash Disposition link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Cash Disposition link from the displayed panel].

4.2.45.2 Panel Name

Cash Disposition (Correction allows the financial page to save information that populates this panel.)

4.2.45.3 Cash Disposition Layout

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Cash Disposition button located in the navigation / maintenance panel.

4.2.45.4 Extra Features

This panel has no extra features.

4.2.45.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	CCN	The cash control number (CCN) associated with the adjustment transaction	Field	Character	11	T_EXPENDITURE	SAK_CASH_RECEIPT
2	Sequence	The disposition sequence number associated with the line. Each individual disposition to a check is given its own sequence number	Field	Number	4	T_CASH_RCPT_XREF	NUM_SEQ_BATCH
3	Disposition Amount	The refund (disposition) amount for the line	Field	Number	10	T_CASH_RCPT_XREF	AMT_DISPOSITION

4.2.45.6 Field Edits

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

4.2.46 PANEL Decision Rules

Missing- same missing in physician section

4.2.47 PANEL: EOB

4.2.47.1 Description

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

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select EOB link from the displayed panel];

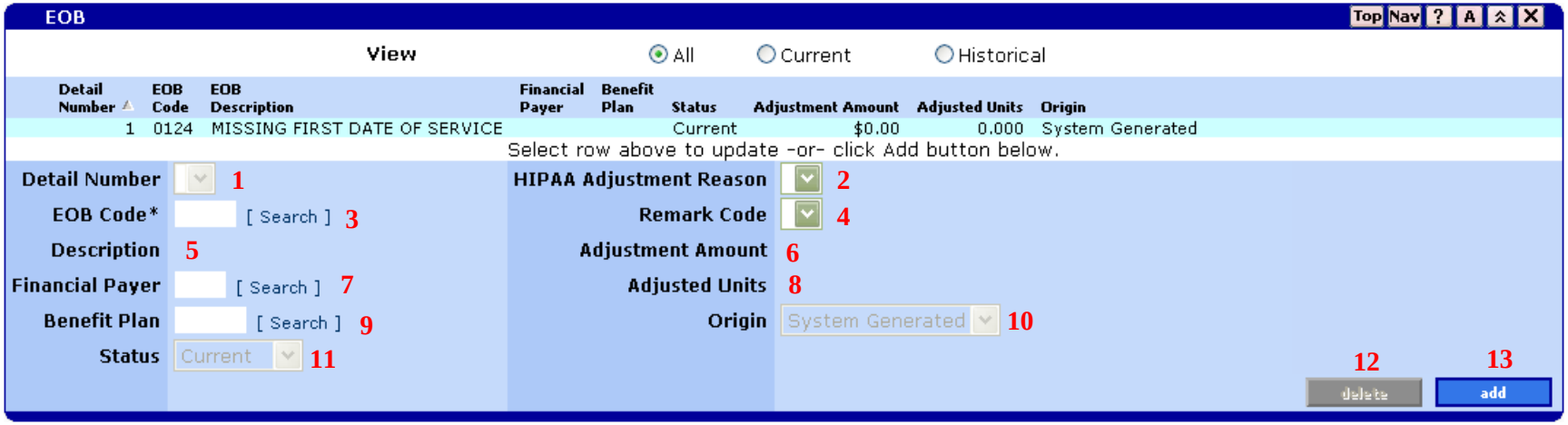
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select EOB link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select EOB link from the displayed panel].

4.2.47.2 Panel Name

EOB

4.2.47.3 EOB Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the EOB button located in the navigation / maintenance panel.

This panel displays the EOB codes applicable to the claim. In the Data Correction page, this panel allows codes to be added or deleted.

4.2.47.4 Extra Features

This panel has no extra features.

4.2.47.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The detail number to which the EOB message is attached	Field	Number	4	T_CLM_EOB_XREF	NUM_DTL

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
2	HIPAA Adjustment Reason	The HIPAA reason for the adjustment	Field	Drop Down List Box	0	T_CDE_HIPAA_ADJRSN	CDE_ADJ_RSN
3	EOB Code	Code number attached to an EOB message	Field	Character	4	T_EOB	CDE_EOB
4	Remark Code	The code for the remarks	Field	Drop Down List Box	0	T_CDE_HIPAA_REMRKS	CDE_REMARK
5	EOB Description	First line of text description for EOB code	Field	Character	79	T_EOB	DSC_EOB
6	Adjustment Amount	The dollar amount adjusted on the detail. Format 9999999.99	Field	Number	9	T_CLM_EOB_XREF	AMT_ADJUSTED
7	Financial Payer	A value that identifies a unique payer within interChange	Field	Drop Down List Box	0	T_CLM_EOB_XREF	SAK_FIN_PAYER
8	Adjusted Units	The quantity adjusted on the detail. Format 9999999.999	Field	Number	10	T_CLM_EOB_XREF	QTY_ADJUSTED
9	Benefit Plan	Identifies the medical assistance program that is supported in the system	Field	Drop Down List Box	0	T_CLM_EOB_XREF	SAK_PUB_HLTH
10	Origin	Indicates who generated the EOB code and message	Field	Character	6	T_CLM_EOB_XREF	CDE_STATUS1
11	Status	Indicates whether the EOB is current or history	Field	Character	7	T_CLM_EOB_XREF	CDE_STAT_ERROR

4.2.47.6 Button Descriptions

Button No	Button	Description

Button No	Button	Description
12	Delete	Deletes a record
13	Add	Adds a new record

4.2.47.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
7	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer of select one from the [Search] panel.
9	Benefit Plan	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select one from the [Search] panel.

4.2.48 PANEL: Location

4.2.48.1 Description

The Location panel displays claim location information. When opened from an inquiry panel, the Claim Location panel is not updateable. However, when opened from a data correction panel, the new and save buttons are displayed allowing the user to add a location. The user can route the claim to another department for correction. This panel is shared by all claim types.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Location link from the displayed panel];

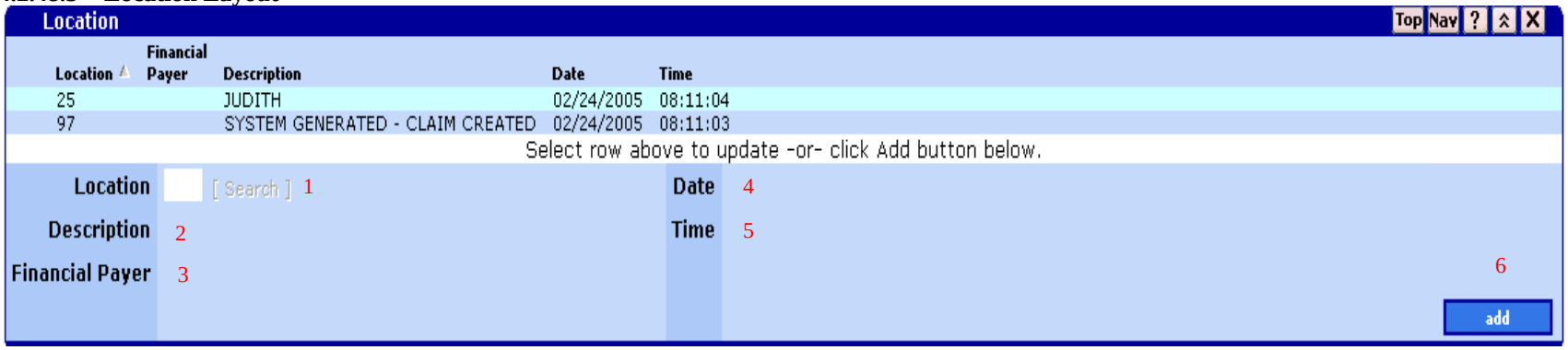
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Location link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Location link from the displayed panel].

4.2.48.2 Panel Name

Location

4.2.48.3 Location Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Location button located in the navigation / maintenance panel.

This panel displays the claim location information pertaining to which department is reviewing claim. In the Data Correction page, this panel allows codes to be added so the claim can be routed to another department for correction.

4.2.48.4 Extra Features

This panel has no extra features.

4.2.48.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Location	Indicates claim location within the claims processing system	Field	Character	2	T_CLAIM_LOCAT	CDE_LOCATION
2	Description	Description of the location from that financial payer	Field	Character	50	T_CLAIM_LOCAT	CDE_CLM_TYPE
3	Financial Payer	The Financial Payer Information	Field	Character	10	T_FINANCIAL_PAYE R	CDE_FIN_PAYER
4	Date	The date that the claim went to this location	Field	Date (MM/DD/CCYY)	8	T_CLAIM_LOCAT	DTE_CLM_LOCAT
5	Time	The time that the claim went to this location	Field	Number	8	T_CLAIM_LOCAT	TIME_SYSTEM
6	Add	Add a location record	Button	N/A	0	N/A	N/A

4.2.48.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Location	Field	1	Invalid Location Code.	Enter a valid Location Code or select a code from the [Search] panel.

4.2.49 PANEL: Related History

4.2.49.1 Description

The Related History panel lists other claims that are related to the current claim. The panel is not updateable and is shared by all claim types. Use this panel to validate medical policy audits, duplicate payment audits, umbrella audits, limitation audits, and bundling and unbundling audits.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Related History link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Related History link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Related History link from the displayed panel].

4.2.49.2 Panel Name

Related History

4.2.49.3 Related History Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Related History button located in the navigation / maintenance panel.

This panel lists other claims associated to the applicable claim.

4.2.49.4 Extra Features

This panel has no extra features.

4.2.49.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Related ICN	Internal control number which uniquely identifies a claim	Field	Character	13	T_HIST_DIRECTORY	NUM_ICN_FL
2	Related Detail	Related detail information to the history claim displayed	Field	Number	3	T_HIST_DIRECTORY	NUM_DTL_RELATED
3	Error Code	Code used to indicate an error was discovered on a claim during processing in the base system	Field	Number	4	T_ERROR_DISP	CDE_ESC
4	Financial Payer	The description used to identify the financial payer for the related ICN	Field	Character	30	T_FINANCIAL_PAYER	CDE_FIN_PAYER
5	Benefit Plan	The medical assistance program associated with the related ICN	Field	Character	5	T_PUB_HLTH_PGM	SAK_PUB_HLTH

4.2.49.6 Field Edits

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

4.2.50 PANEL: Adjustment Information - Daughter or Mother

4.2.50.1 Description

The Adjustment Information panel displays the daughter claim if the claim being displayed has been adjusted. It will display the mother claim if the claim being displayed is an adjustment claim.

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

This panel is populated from the following tables depending on Claim Type: T_ADJ_PHYS_XREF, T_ADJ_PHRM_XREF, T_ADJ_UB92_XREF, T_ADJ_DNTL_XREF, T_SUSP_ADJ_XREF

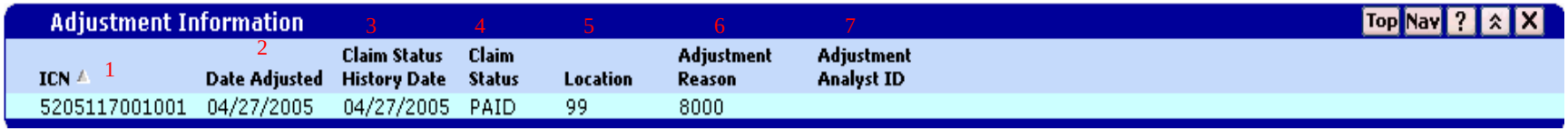
4.2.50.2 Technical Name

Clm.AdjustmentInformation-DaughterorMother.ascx

4.2.50.3 Panel Name

Adjustment Information

4.2.50.4 Adjustment Information - Daughter or Mother Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Adjustment Information button located in the navigation / maintenance panel.

This panel displays the previous claim information of an adjusted claim or the present claim information if the claim has been adjusted.

4.2.50.5 Extra Features

This panel has no extra features.

4.2.50.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	ICN	Internal control number which uniquely identifies a claim	Field	Character	13	SEE NARRATIVE SECTION	NUM_ICN_FL
2	Date Adjusted	Date on which adjustment request was initiated	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_ADJUSTED
3	Claims Status History Date	Date on which a claim was processed	Field	Date (MM/DD/CCYY)	8	T_HIST_DIRECTORY	DTE_PAID
4	Claim Status	The status of the claim, example "PAID"	Field	Character	10	T_HIST_DIRECTORY	CDE_CLM_STATUS
5	Location	Location code of the claim	Field	Character	2	T_CLAIM_LOCAT	CDE_LOCATION
6	Adjustment Reason	Code identifying the detailed reason the adjustment was made	Field	Character	4	SEE NARRATIVE SECTION	CDE_EOB
7	Adjustment Analyst ID	Identification of the clerk that generated the adjustment request	Field	Character	8	SEE NARRATIVE SECTION	ID_CLERK

4.2.50.7 Field Edits

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

4.2.51 PANEL: Adjustment Reason Code

4.2.51.1 Description

Allows the user to review adjustment reason codes listed on encounters.

Navigation Path: [Claims - Search] - [Enter Criteria] - [Select a Claim] - [Select Adjustment Reason Code]

Tables: T_CLM_CAS, T_CDE_HIPAA_ADJRSN

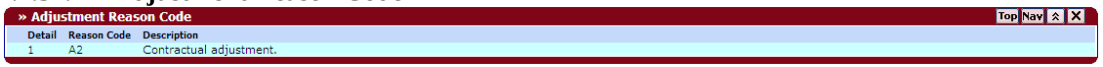
4.2.51.2 Technical Name

Clm.AdditionalClaimInformationPanel.ascx

4.2.51.3 Panel Name

Adjustment Reason Code

4.2.51.4 Adjustment Reason Code



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Adjustment Reason Code button located in the navigation / maintenance panel.

4.2.51.5 Extra Features

This panel has no extra features.

4.2.51.6 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Detail	Encounter detail number.	3	Character	t_clm_cas	NUM_DTL

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
2	Reason Code	Adjustment Reason Codes from MCO/Passport-denied encounters and/or partially paid encounters with denied details.	4	Character	t_clm_cas	CDE_CLM_ADJ_REASON
3	Descreption	Adjustment Reason Code description.	100	Character	t_cde_hipaa_adjrsn	DSC_ADJ_RSN

4.2.51.7 Field Edits

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

4.2.52 PANEL: Check

4.2.52.1 Description

Use the Check panel to view the total amount paid from the Remittance Advice (RA) for a specific claim. To view the detail of the check, click on the row to display the Payment Information panel.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Check link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Check link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Check link from the displayed panel].

4.2.52.2 Panel Name

Check

4.2.52.3 Check Layout

Check

Top Nav ? X

1 Warrant Number	2 Issue Date	3 Pay To Provider	4 Total Paid Amount	5 Check Status	6 Fund Code	7 Benefit Plan
000000045	8/12/2006	100097859B	$17.04	I Warrant Issued	B	Title 19
Total:			$17.04			

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Check button located in the navigation / maintenance panel.

This panel is populated if the claim is paid.

4.2.52.4 Extra Features

This panel has no extra features.

4.2.52.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Warrant Number	This field displays the number of the check that the provider received, or the number of the Electronic Funds Transfer	Field	Number	9	T_CHECK	NUM_CHECK
2	Issue Date	The date when the check was issued or the EFT was sent	Field	Date (MM/DD/CCYY)	8	T_CHECK	DTE_ISSUE
3	Pay To Provider	The Provider ID who received the check or EFT	Field	Character	9	T_PR_PROV	ID_PROVIDER
4	Total Paid Amount	The total amount that was issued to the provider	Field	Number	11	T_CHECK	TOTAL_AMT_PAID
5	Check Status	The status of the check. Examples are: An 'I' indicates the check has been issued, a 'V' indicates a VOID, an 'R' indicates the check was reissued, a 'C' indicates a check has cleared the bank, an 'S' indicates Stopped and an 'X' for Cancelled by Statute	Field	Character	30	T_CHECK	CDE_STATUS1
6	Fund Code	The Fund Code assigned to the check or EFT	Field	Character	3	T_CHCK_CLM_XREF	SAK_FUND_CODE
7	Benefit Plan	The Benefit Plan associated with the check or EFT	Field	Character	30	T_CHCK_CLM_XREF	SAK_PUB_HLTH

4.2.52.6 Field Edits

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

4.2.53 PANEL: Category of Service

4.2.53.1 Description

The Category of Service panel displays the category of service codes assigned to the claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Category of Service link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [[Select a claim] - [Select category of Service link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select category of Service link from the displayed panel].

4.2.53.2 Panel Name

Category of Service

4.2.53.3 Category of Service Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the category of Service button located in the navigation / maintenance panel.

This panel displays the category of service codes assigned to the claim.

Extra Features

This panel has no extra features.

4.2.53.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Sequence	Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.	Field	Number	2	T_COS_DTL_XREF	NUM_DTL
2	COS Code	Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.	Field	Number	2	T_COS_DTL_XREF	CDE_COS_ST
3	Sub COS Code	Code for a sub-category of service (COS) that provides a more detailed State Category of Service classification in MAR state reporting.	Field	Number	2	T_COS_DTL_XREF	CDE_COS_SUB

4.2.53.5 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
None					

4.2.54 PANEL: Diagnosis

4.2.54.1 Description

The Diagnosis panel displays the diagnosis codes applicable to the claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Diagnosis link from the displayed panel];

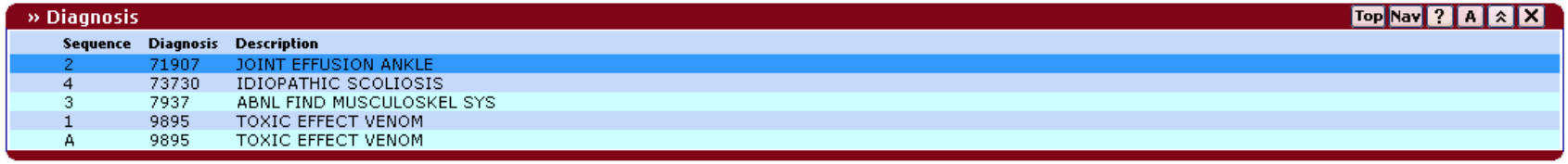
OR - [Claims -Search] - [Enter Criteria] - [[Select a claim] - [Select Diagnosis link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Diagnosis link from the displayed panel].

4.2.54.2 Panel Name

Diagnosis

4.2.54.3 Diagnosis Layout



Sequence	Diagnosis	Description
2	71907	JOINT EFFUSION ANKLE
4	73730	IDIOPATHIC SCOLIOSIS
3	7937	ABNL FIND MUSCULOSKEL SYS
1	9895	TOXIC EFFECT VENOM
A	9895	TOXIC EFFECT VENOM

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Diagnosis button located in the navigation / maintenance panel.

This panel displays the diagnosis codes applicable to the claim.

4.2.54.4 Extra Features

This panel has no extra features.

4.2.54.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Sequence	Sequence numbers for the diagnosis codes. The Admitting diagnosis has a value of 'A' in the Sequence column. Primary diagnosis has a value of '1'. Other diagnosis codes have a value of '2' through '24'. Emergency diagnosis has an 'E' in the Sequence column	Field	Number	2	T_CLM_DIAG_XREF	CDE_DIAG_SEQ
2	Diagnosis	Indicates the diagnosis codes applicable to the claim. Diagnosis code is a code for the condition requiring medical attention	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
3	Description	Description of the diagnosis code	Field	Character	50	T_DIAGNOSIS	DSC_25

4.2.54.6 Button Descriptions

Button No	Button	Description
4	Delete	Clicking on the Delete button deletes the content.
5	Add	Clicking on the Add button adds the content.

4.2.54.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Diagnosis	Field	1	Invalid Diagnosis Code.	Enter a valid diagnosis code or select a code from the [Search] panel.
2	Diagnosis	Field	100	Exceed maximum number of diagnosis codes.	The maximum number of diagnosis codes for this claim type has been exceeded.

4.2.55 PANEL: Error

4.2.55.1 Description

Access the Claim Errors panel from the paid, denied, or suspended claim panels. This panel displays the header and/or detail errors applicable to the claim being viewed.

Field edits and the Add / Delete buttons are for Data Correction only.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Error link from the displayed panel];

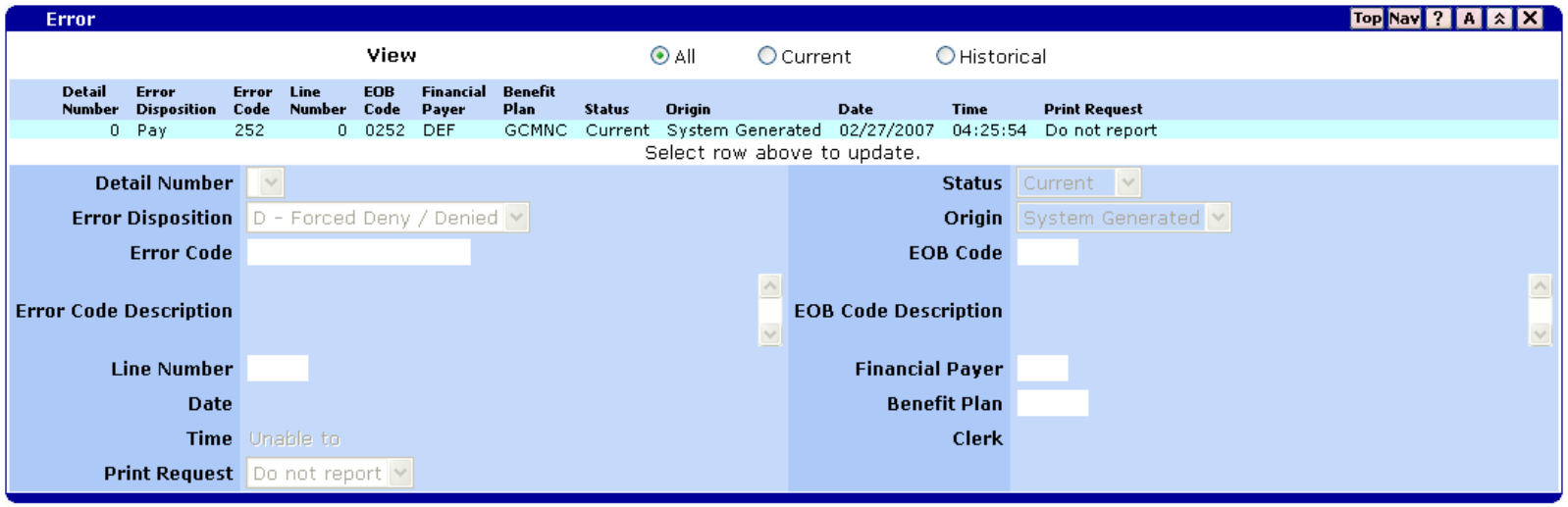
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Error link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Error link from the displayed panel].

4.2.55.2 Panel Name

Error

4.2.55.3 Error Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Error button located in the navigation / maintenance panel.

This panel displays the Error codes applicable to the claim. In the Data Correction page this panel allows codes to be added or deleted.

4.2.55.4 Extra Features

This panel has no extra features.

4.2.55.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The number of the header or detail that contains an edit or an audit failure	Field	Number	4	T_CLAIM_ERROR	NUM_DTL
2	Status	Indicates whether the Errors are current or history	Field	Drop Down List Box	7	T_CLAIM_ERROR	CDE_STAT_ERROR
3	Error Disposition	Code that represents the action that is taken on a claim at disposition time: pay(P), deny(D), suspend(S), force override(F), reject(J), or batch suspend(B)	Field	Drop Down List Box	0	T_CLAIM_ERROR	CDE_DISP_STATUS
4	Origin	Indicates who generated the error code and message	Field	Drop Down List Box	6	T_CLAIM_ERROR	CDE_STATUS1

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit	Field	Number	4	T_ERROR_DISP	CDE_ESC
6	Error Code Description	Description of the error	Field	Character	50	T_ERROR_DISP	DSC_ERROR_STAT
7	EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it	Field	Number	4	T_EOB	CDE_EOB
8	EOB Description	Description of the EOB	Field	Character	79	T_EOB	DSC_EOB
9	Line Number	Number which indicates the detail of the Error Disposition line item from which the Error Disposition was assigned.	Field	Number	3	T_CLAIM_ERROR	SAK_ERROR_DISP
10	Financial Payer	A value that identifies a unique payer within interChange	Field	Character	4	T_CLAIM_ERROR	SAK_FIN_PAYER
11	Date	Date of the error code	Field	Date (MM/DD/CCYY)	8	T_CLAIM_ERROR	DTE_GENERIC
12	Benefit Plan	Identifies the medical assistance program that is supported in the system. Use the [Search] panel to select a valid plan	Field	Check Box	5	T_PUB_HLTH_PGM	CDE_PGM_HEALTH

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
13	Time	Time of the error code. Format HH:MM:SS	Field	Number	6	T_CLAIM_ERROR	TME_STAMP
14	Clerk	Number used to identify the user who last updated the error record	Field	Character	8	T_CLAIM_ERROR	ID_CLERK
15	Print Request	The valid values are: Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report	Field	Drop Down List Box	1	T_CLAIM_ERROR	IND_RPT

4.2.55.6 Button Descriptions

Button No	Button	Description
16	Delete	Deletes a record
17	Add	Adds a new record

4.2.55.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
5	Error Code	Field	1	Invalid Error Code.	Enter a valid Error Code or select a valid code from the [Search] panel.
5	Error Code	Field	2	Error Code XXXX cannot be overridden.	The Error Code entered is a critical error or it cannot be overridden. The Error Disposition cannot be 'F - Force'.

Field No	Field	Field Type	Error Code	Error Message	To Correct
5	Error Code	Field	3	Error Code XXXX cannot have the Error Disposition set to 'Deny'.	The Error Code entered has an Allow Deny Indicator set to 'No'; therefore the Error Disposition cannot be set to Deny.
7	EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
10	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer or select one from the [Search] panel.
12	Benefit Plan	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select a valid Benefit Plan from the [Search] panel.

4.2.56 PANEL: MCO Data

4.2.56.1 Description

The MCO Data panel displays Managed Care Organization (MCO) data related to encounter claims.

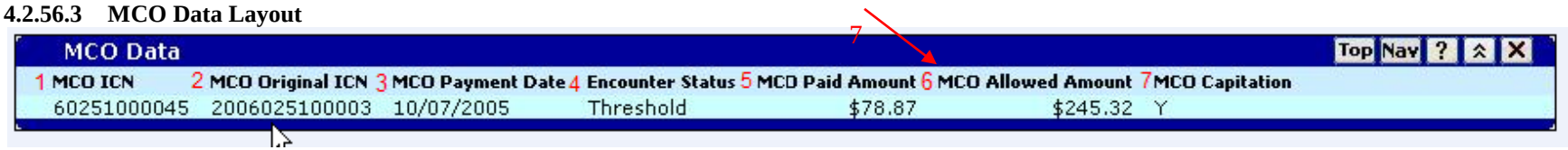
Navigation Path: [Claims -Information] - [Enter an ICN for an Encounter Claim] - [Select MCO Data link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select an Encounter Claim claim] - [Select MCO Data link from the displayed panel].

4.2.56.2 Panel Name

MCO Data

4.2.56.3 MCO Data Layout



STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the MCO Data button located in the navigation / maintenance panel.

4.2.56.4 Extra Features

This panel has no extra features.

4.2.56.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	MCO ICN	Internal Control Number of the MCO claim.(when qlf_reference_id ='D9' and num_dtl = 0).	Field	Number	13	T_CLM_REF	CDE_REF_ID

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
2	MCO Original ICN	Original MCO Internal Control Number for voids and adjustments. (when qlf_reference_id ='F8' and num_dtl = 0).	Field	Number	13	T_CLM_REF	CDE_REF_ID
3	MCO Payment Date	Date the MCO paid encounter claim.	Field	Date (MM/DD/CCYY)	8	T_XXXX_OTH_PYR_HDR	DTE_CLM_ADJUDICATION
4	Encounter Status	Code which indicates the status of the encounter in the system as a result of interChange editing. The values will be T - Threshold, I - Informational or P - paid.	Field	Character	1	T_PD_XXXX_HDR OR T_DENY_XXXX_HDR	CDE_ENC_STATUS
5	MCO Paid Amount	MCO Paid Amount (when qlf_amount='D' and num_dtl = 0).	Field	Number	9	T_CLM_AMT	AMT_MONETARY
6	MCO Allowed Amount	Medicaid allowed amount, the result of re-pricing the encounter claim.(when qlf_amount='B6' and num_dtl = 0).	Field	Number	9	T_CLM_AMT	AMT_MONETARY
7	MCO Capitation	Capitation Indicator.	Field	Character	1	T_CLM_CN1	CDE_CONTRACT_TYPE

4.2.56.6 Field Edits

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

4.2.57 PANEL: MCO Detail Information

4.2.57.1 Description

The MCO Detail Information panel shows the detail MCO paid date(s) of the service(s) submitted on the encounter.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Display TCN link from the displayed panel];

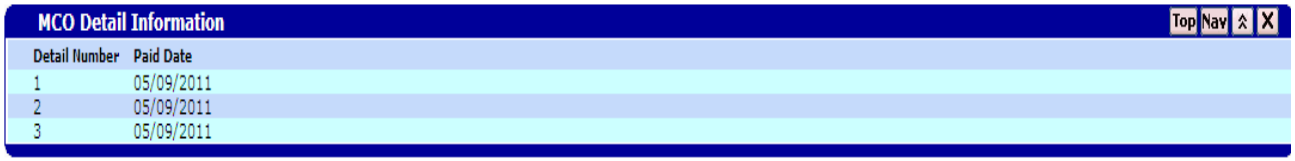
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Display TCN link from the displayed panel;

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Display TCN link from the displayed panel].

4.2.57.2 Panel Name

MCO Detail Information

4.2.57.3 MCO Detail Information Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the MCO Detail Information button located in the navigation / maintenance panel.

This panel displays the detail MCO paid date of the service(s) submitted on the encounter.

4.2.57.4 Extra Features

This panel has no extra features.

4.2.57.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The detail number associated to the MCO Paid Date	Field	Number	4	T_CLM_OTH_PYR_DTL	NUM_DTL
2	Paid Date	The detail MCO paid date of the service(s) submitted on the encounter	Field	Date (MM/DD/CCYY)	8	T_CLM_OTH_PYR_DTL	DTE_SERVICE_ADJUD

4.2.57.6 Field Edits

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

4.2.58 PANEL: Occurrence

4.2.58.1 Description

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

Navigation Path: [Claims -Information] - [Enter an ICN for a UB92 claim] - [Select Occurrence link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a UB92 claim] - [Select Occurrence link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a UB92 claim from the list] - [Select Occurrence link from the displayed panel].

4.2.58.2 Panel Name

Occurrence

4.2.58.3 Occurrence Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Occurrence button located in the navigation / maintenance panel.

This panel displays the occurrence codes applicable to the UB92 claim. In the Data Correction page, this panel allows codes to be added, deleted or updated.

4.2.58.4 Extra Features

This panel has no extra features.

4.2.58.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Occurrence Code Qualifier	BH indicates 'Regular Occurrence Code; BI indicates Occurrence span code. The field is now a drop-down with a choice between Regular (BH) and Span (BI)	Field	Drop Down List Box	0	T_UB92_HDR_OCC	QLF_CODE_LIST
2	Sequence	The sequence number as they appeared on the claim	Field	Number	4	T_UB92_HDR_OCC	NUM_SEQ
3	Occurrence Code	The code identifying a significant event relating to this bill that may affect payer processing	Field	Character	2	T_UB92_HDR_OCC	CDE_OCCURRENCE
4	Description	Description of the occurrence code	Field	Character	50	T_OCCURRENCE	DSC_OCCURRENCE
5	Effective Date	The date when the occurrence code began	Field	Date (MM/DD/CCYY)	8	T_UB92_HDR_OCC	DTE_OCCURENCE
6	End Date	The date when the occurrence code ended	Field	Date (MM/DD/CCYY)	8	T_UB92_HDR_OCC	DTE_OCC_TO

4.2.58.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Occurrence Code Qualifier	Field	1	QualifierCodeList is required.	Select an Occurrence Code Qualifier from the drop down box.
2	Sequence	Field	1	Enter a Valid Value.	Enter a numeric value.
2	Sequence	Field	100	Sequence number can not exceed number of occurrence codes.	Verify value and re-enter.

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	Occurrence Code	Field	1	A valid Occurrence is required.	Enter a valid Occurrence Code.
3	Occurrence Code	Field	107	Exceed maximum number of occurrence codes.	The maximum number of occurrence codes allowed is 24.
5	Effective Date	Field	1	From Date is required.	Enter a valid Effective Date.
5	Effective Date	Field	2	Invalid Date. Format is MM/DD/CCYY.	Enter the date in MM/DD/CCYY format.
6	End Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter the date in MM/DD/CCYY format.

4.2.59 PANEL: Submitted Data - UB92

4.2.59.1 Description

Access the Submitted Data panel from the paid, denied, or suspended claim panels. This panel displays the submitted data applicable to the UB92 claim header being viewed.

Navigation Path: [Claims -Information] - [Enter an ICN for a UB92 claim] - [Select Submitted Data link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a UB92 claim] - [Select Submitted Data link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a UB92 claim from the list] - [Select Submitted Data link from the displayed panel].

4.2.59.2 Panel Name

Submitted Data

4.2.59.3 Submitted Data - UB92 Layout

To access this panel:

STEP 1. Access the UB92 Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Submitted Data button located in the navigation / maintenance panel.

This panel displays the type of bill and patient account number to the applicable claim.

4.2.59.4 Extra Features

This panel has no extra features.

4.2.59.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Submitted Type of Bill	Submitted type of Bill for HIPAA 837I	Field	Character	3	T_UB92_HDR_EXT_KEY	TOB_SUB
2	Submitted Patient Account Number	Identification for a member assigned by a provider and used in their system	Field	Character	38	T_UB92_HDR_EXT_KEY	NUM_PAT_ACCT_SUB

4.2.59.6 Field Edits

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

4.2.60 PANEL: Attachment

4.2.60.1 Description

The Attachment panel displays the attachment control numbers that are applicable to the claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Attachments link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Attachments link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Attachments link from the displayed panel].

4.2.60.2 Panel Name

Attachment

4.2.60.3 Attachment Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Attachment button located in the navigation / maintenance panel.

This panel is populated if an attachment was received with the claim.

4.2.60.4 Extra Features

This panel has no extra features.

4.2.60.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The detail number of a claim record	Field	Number	4	T_ATTACHMENT_XREF	NUM_DTL
2	ACN	The control number associated with an attachment that is being sent by the provider for an electronically submitted claim	Field	Character	80	T_ATTACHMENT_XREF	CDE_ATTACHMENT_CONTROL
3	Attachment Indicator	Indicates if the attachment has been received	Field	Character	3	T_ATTACHMENT_XREF	IND_ATTACH_RECEIVED

4.2.60.6 Field Edits

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

4.2.61 PANEL: Condition

4.2.61.1 Description

The UB92 Condition Codes panel displays the Condition Codes applicable to the claim. These codes are generated to identify conditions relating to this bill that may affect payer processing.

Navigation Path: [Claims -Information] - [Enter an ICN for a UB92 claim] - [Select Condition link from the displayed panel];

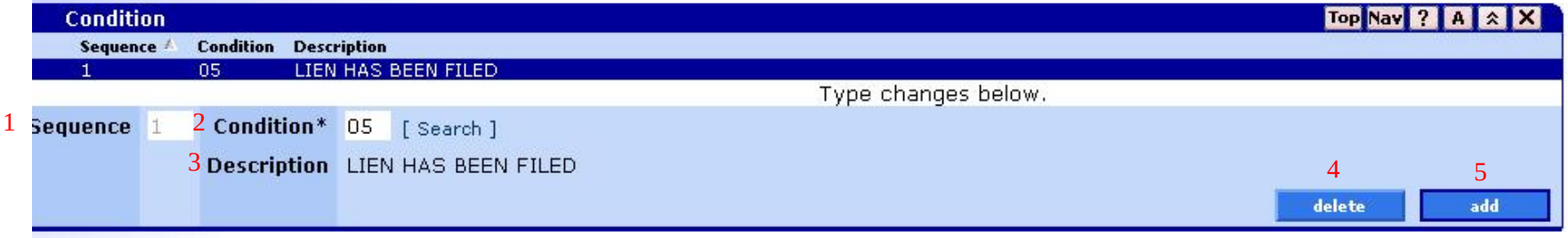
OR - [Claims -Search] - [Enter Criteria] - [Select a UB92 claim] - [Select Condition link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a UB92 claim from the list] - [Select Condition link from the displayed panel].

4.2.61.2 Panel Name

Condition

4.2.61.3 Condition Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Condition button located in the navigation / maintenance panel.

This panel is populated if the UB92 claim has condition codes that may affect payer processing.

4.2.61.4 Extra Features

This panel has no extra features.

4.2.61.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Sequence	Sequence numbers as they appeared on the claim	Field	Number	2	T_UB92_HDR_COND_X	CDE_COND_SEQ
2	Condition	A code used to identify conditions relating to this bill that may affect payer processing	Field	Number	2	T_UB92_HDR_COND_X	CDE_COND
3	Description	Description of the condition	Field	Character	50	T_UB92_HDR_COND_X	QLF_CODE_LIST
4	Delete	Deletes a Record	Button	N/A	0	N/A	N/A
5	Add	Adds a new Record	Button	N/A	0	N/A	N/A

4.2.61.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Condition	Field	107	Exceed maximum number of condition codes.	The maximum number of condition codes is 24.

4.2.62 PANEL: Display TCN

4.2.62.1 Description

The Display TCN panel shows the TCN associated with the claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Display TCN link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Display TCN link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Display TCN link from the displayed panel].

4.2.62.2 Panel Name

Display TCN

4.2.62.3 Display TCN Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Display TCN button located in the navigation / maintenance panel.

This panel displays the Transaction Control Number associated with the claim from the previous MMIS system.

4.2.62.4 Extra Features

This panel has no extra features.

4.2.62.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	TCN	The transaction control number used to uniquely identify claims on the previous MMIS	Field	Character	17	T_TCN_XREF	NUM_TCN

4.2.62.6 Field Edits

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

4.2.63 PANEL: Health Program

4.2.63.1 Description

Use the Health Program panel to display the program information for a claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Health Program link from the displayed panel];

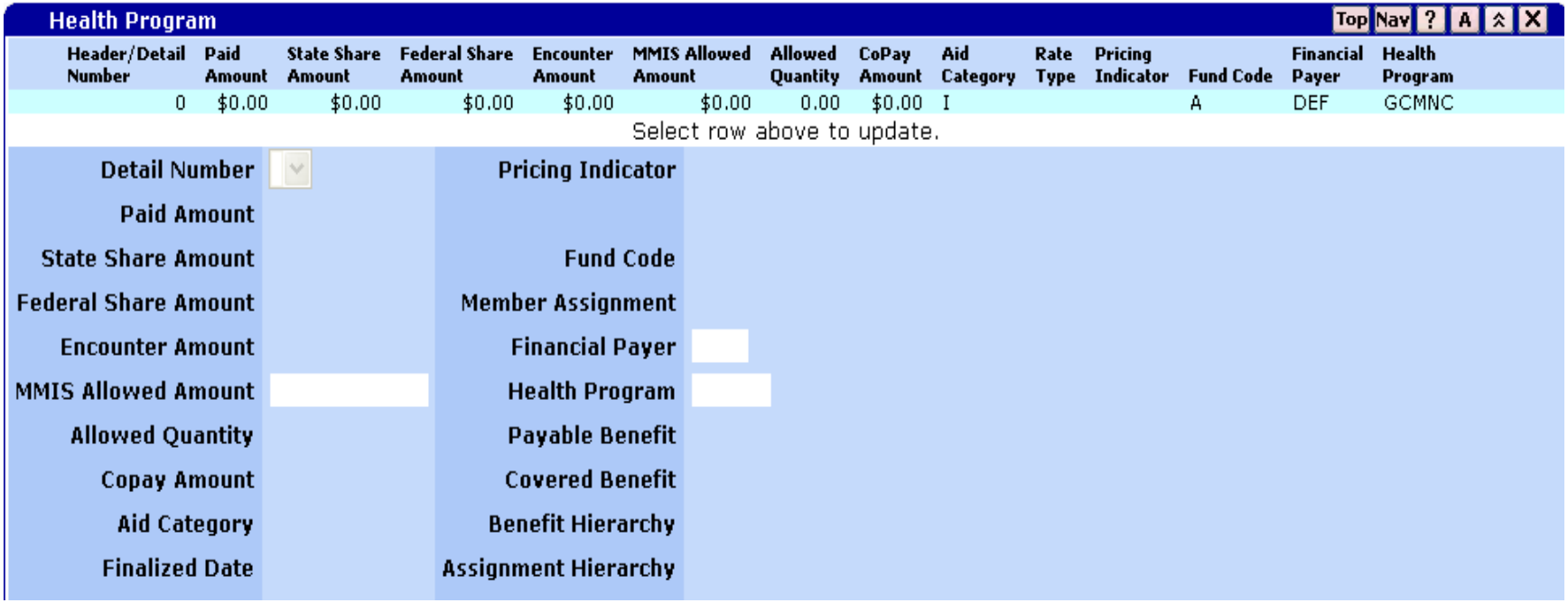
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Health Program link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Health Program link from the displayed panel].

4.2.63.2 Panel Name

Health Program

4.2.63.3 Health Program Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Health Program button located in the navigation / maintenance panel.

This panel displays the program information applicable to the claim. Program information includes copay amounts, Medicare indicators, managed care indicators and financial payers.

4.2.63.4 Extra Features

This panel has no extra features.

4.2.63.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Header/ Detail Number	Indicates if the row pertains to the claim header or a claim detail line. The claim header is denoted by a zero	Field	Number	3	T_CLM_PGM_XREF	NUM_DTL
2	Detail Number	Indicates if the row pertains to the claim header or a claim detail line. The claim header is denoted by a zero	Field	Drop Down List Box	0	T_CLM_PGM_XREF	NUM_DTL
3	Paid Amount	This is the amount that is applied toward the check amount. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_PAID
4	State Share Amount	This is the amount that is applied toward the check amount. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_STATE_SHARE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Federal Share Amount	This is the amount of federal share for this payment. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_FEDERAL_SHARE
6	Encounter Amount	This contains the amount for encounter services on the claim detail indicated by the detail number on the table. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_ENCOUNTER
7	Allowed Amount	Amount approved to pay for services provided. Format 9999999.99	Field	Number	9	T_CLM_PGM_XREF	AMT_ALWD
8	Allowed Quantity	Number of units of service that is paid under a financial payer/benefit plan. Format 9999.99	Field	Number	6	T_CLM_PGM_XREF	QTY_ALLOWED
9	Copay Amount	This is the amount of copay that is subtracted from the allowed amount. Format 99999.99	Field	Number	7	T_CLM_PGM_XREF	AMT_CO_PAY
10	Aid Category	Aid Category for Medicaid coverage	Field	Number	9	T_CDE_AID	CDE_AID_CATEGORY
11	Finalized Date	Date the financial finalizes the claim for this Payer	Field	Date (MM/DD/CCYY)	8	T_CLM_PGM_XREF	DTE_FINAL
12	Rate Type	Code used to identify the rate type to use in determining provider reimbursement	Field	Character	3	T_CLM_PGM_XREF	CDE_RATE_TYPE
13	Pricing Indicator	Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced	Field	Character	1	T_CLM_PGM_XREF	IND_PRICING

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
14	Managed Care Indicator	Manage care indicator identifies claims and other transactions as to how they affect the manage care program	Field	Drop Down List Box	1	T_CLM_PGM_XREF	IND_MC
15	Fund Code	Indicates the budget category that the funds used to pay this claim/detail came from	Field	Number	9	T_FIN_FUND_CODE	CDE_FUND_CODE
16	Financial Payer	The financial payer description	Field	Number	9	T_FINANCIAL_PAYER	CDE_FIN_PAYER
17	Health Program	Name of program the header/detail was processed and/or paid under	Field	Character	50	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
18	Payable Benefit	This is the unique system-assigned that identifies each row on this table	Field	Number	9	T_CLM_PGM_XREF	SAK_PAYABLE_BNFT
19	Covered Benefit	System-assigned Key used to identify a unique row for a benefit covered by a member plan. This identifies a row to be ignored for this benefit	Field	Number	9	T_CLM_PGM_XREF	SAK_COVERED_BNFT
20	Benefit Hierarchy	An assignment hierarchy is an ordered set of assignment plans for which a member/beneficiary 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	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
21	Assignment Hierarchy	A set of assignment plans for which a member/beneficiary may be assigned concurrently	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD_ASSIGNMENT
22	Payer Hierarchy	Payer Hierarchy identifies 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	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD_PAYER

4.2.63.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
7	Allowed Amount	Field	1	Enter a valid Value.	Allowed Amount must be numeric.
16	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid financial payer or select a value from the [Search] panel.
19	Covered Benefit	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select a value form the [Search] panel.

4.2.64 PANEL: Medicare Information - UB92

4.2.64.1 Description

The Medicare Information panel displays the Medicare information applicable to the UB92 crossover claim. Field Edits are for Data correction only.

Navigation Path: [Claims -Information] - [Enter an ICN for a UB92 Crossover claim] - [Select Medicare Information link from the displayed panel];

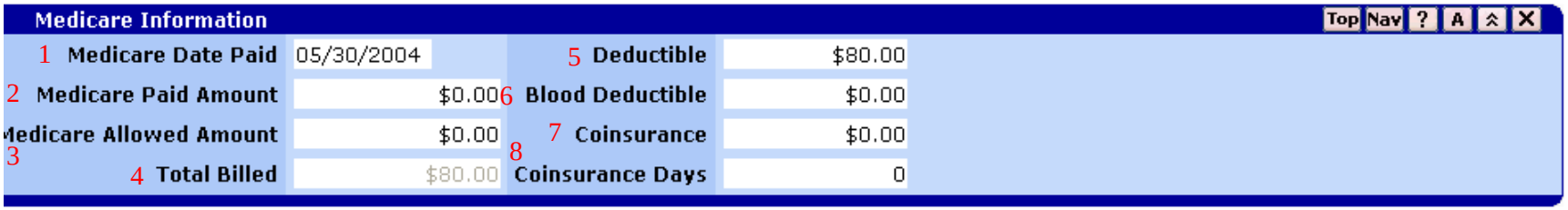
OR - [Claims -Search] - [Enter Criteria] - [Select a UB92 Crossover claim] - [Select Medicare Information link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a UB92 Crossover claim from the list] - [Select Medicare Information link from the displayed panel].

4.2.64.2 Panel Name

Medicare Information

4.2.64.3 Medicare Information - UB92 Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page. .

STEP 2. Click the row of a UB92 claim to select.

STEP 3. Click Medicare Information button (this button does not display if there is no coverage involved).

This panel displays Medicare information applicable to the claim. In Data Correction page, this panel is updatable.

4.2.64.4 Extra Features

This panel has no extra features.

4.2.64.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Medicare Date Paid	The date Medicare pay for the services	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_MCARE_PAID
2	Medicare Paid Amount	The dollar amount paid by Medicare for the services. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_PAID_MCARE
3	Medicare Allowed Amount	The dollar amount allowed by Medicare for the services. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_ALWD_MCARE
4	Total Billed	The amount Medicare has determined that a member must pay. This is a calculated value. (sum of Coinsurance + Deductible). Format 999999.99	Field	Number	8	N/A	N/A
5	Deductible	The amount the member must pay before Medicare. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_DEDUCT
6	Blood Deductible	The amount Medicare has determined that a member must pay for blood procedures performed. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_DEDUCT_BLOOD
7	Coinsurance	Dollar amount which represents the member's coinsurance payment. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_COINSURANCE
8	Coinsurance Days	The number of coinsurance days billed on the claim	Field	Number	8	SEE NARRATIVE SECTION	COINSURANCE_DAYS

4.2.64.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Medicare Date Paid	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
5	Deductible	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
6	Blood Deductible	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
7	Coinsurance	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.

4.2.65 PANEL: Payer

4.2.65.1 Description

The Claims Payer Information panel displays the payer information applicable to the claim. This panel includes the payer's code, prior payment amount, and the estimated amount due.

Field Edits are for Data Correction only.

Navigation Path: [Claims -Information] - [Enter an ICN for a UB92 claim] - [Select Payer link from the displayed panel];

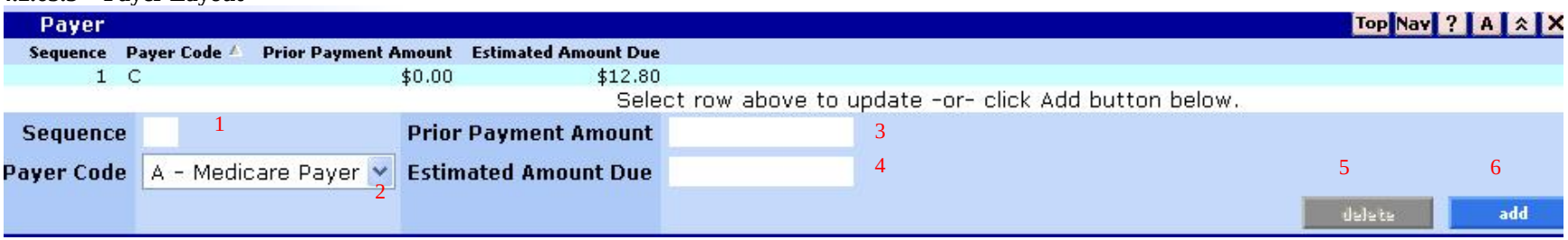
OR - [Claims -Search] - [Enter Criteria] - [Select a UB92 claim] - [Select Payer link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a UB92 claim from the list] - [Select Payer link from the displayed panel].

4.2.65.2 Panel Name

Payer

4.2.65.3 Payer Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Payer button located in the navigation / maintenance panel.

This panel displays the payer information applicable to the claim which could include payer's code, prior payment amount, and estimated amount due. In the Data Correction page, this panel allows fields to be added, deleted or updated.

4.2.65.4 Extra Features

This panel has no extra features.

4.2.65.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Sequence	The sequence of the payer information as they appeared on the claim	Field	Number	4	T_UB92_HDR_PAYER	NUM_SEQ
2	Payer Code	The code that identifies each organization from which the provider might expect some payment for the bill	Field	Drop Down List Box	0	T_UB92_HDR_PAYER	CDE
3	Prior Payment Amount	The amount the hospital has received toward payment of this bill prior to the billing date by the payer. Format 99999999.99	Field	Number	9	T_UB92_HDR_PAYER	AMT_PRIOR_PAYMENT
4	Estimated Amount Due	The amount estimated by the hospital that is due from the payer. Format 99999999.99	Field	Number	9	T_UB92_HDR_PAYER	AMT_DUE_EST
5	Delete	Deletes a Record	Button	N/A	0	N/A	N/A
6	Add	Adds a New Record	Button	N/A	0	N/A	N/A

4.2.65.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Payer Code	Field	1	Payer Code is a required field.	Select a Payer Code from the drop down box.
2	Payer Code	Field	108	Exceed maximum number of payer codes.	The maximum number of payers allowed is three.
3	Prior Payment Amount	Field	1	Enter a valid value.	Enter a numeric value.

Field No	Field	Field Type	Error Code	Error Message	To Correct
4	Estimated Amount Due	Field	1	Enter a valid value.	Enter a numeric value.

4.2.66 PANEL: Value

4.2.66.1 Description

The Claim Value Codes panel displays the Value Codes applicable to the claim. This panel includes the value code and the amount of the value.

Field Edits are for Data correction only.

Navigation Path: [Claims -Information] - [Enter an ICN for a UB92 claim] - [Select Value link from the displayed panel];

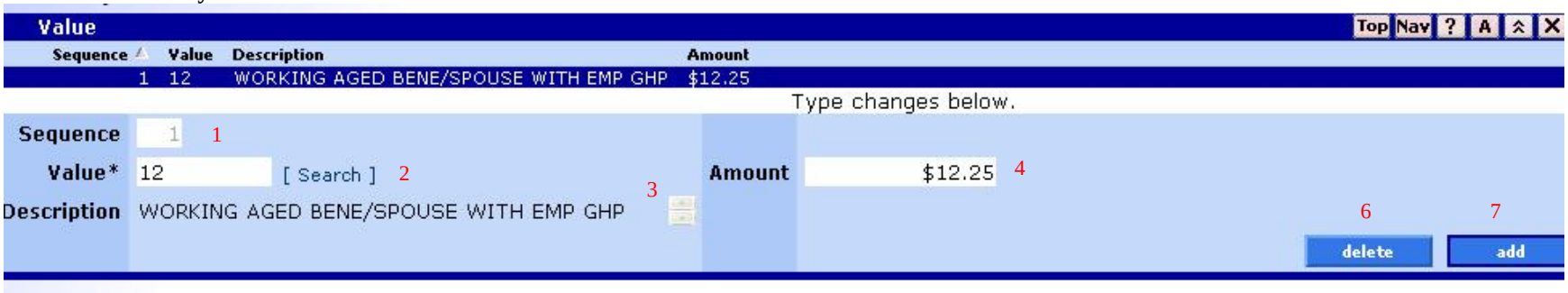
OR - [Claims -Search] - [Enter Criteria] - [Select a UB92 claim] - [Select Value link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a UB92 claim from the list] - [Select Value link from the displayed panel].

4.2.66.2 Panel Name

Value

4.2.66.3 Value Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Value button located in the navigation / maintenance panel.

This panel displays the value code used to process the UB92 claim. In Data Correction page, this panel allows the fields to be updated or added.

4.2.66.4 Extra Features

This panel has no extra features.

4.2.66.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Sequence	Sequence numbers as they appeared on the claim	Field	Number	4	T_UB92_HDR_VALUE _VALUE	NUM_SEQ
2	Value	A code that relates the value used to identify data elements that are necessary to process the claim	Field	Character	2	T_UB92_HDR_VALUE	CDE_VALUE
3	Description	Description of the value	Field	Character	50	T_VALUE	DSC_VALUE
4	Amount	The amount of the value code used to identify data elements that are necessary to process the claim. Format 99999999.99	Field	Number	9	T_UB92_HDR_VALUE	AMT_VALUE

4.2.66.6 Button Descriptions

Button No	Button	Description
5	Delete	Deletes a record
6	Add	Adds a new Record

4.2.66.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
4	Amount	Field	1	Enter a Valid Value.	Enter a numeric value in the Amount field.
2	Value	Field	1	Invalid Value Code.	Enter a valid Value Code or select a code from the [Search] panel.
2	Value	Field	105	Exceed maximum number of value codes.	The number of value codes must not exceed more then 24.

4.2.67 PANEL: CAS Inquiry

4.2.67.1 Description

The CAS Inquiry panel displays the Claim Level Adjustment Segments (CAS) information applicable to the claim or encounter.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select CAS Inquiry link from the displayed panel];

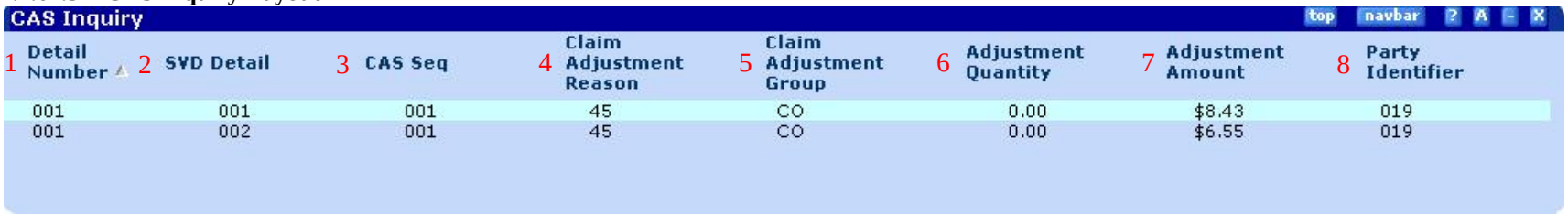
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select CAS Inquiry link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select CAS Inquiry link from the displayed panel].

4.2.67.2 Panel Name

CAS Inquiry

4.2.67.3 CAS Inquiry Layout



CAS Inquiry

1 Detail Number	2 SVD Detail	3 CAS Seq	4 Claim Adjustment Reason	5 Claim Adjustment Group	6 Adjustment Quantity	7 Adjustment Amount	8 Party Identifier
001	001	001	45	CO	0.00	$8.43	019
001	002	001	45	CO	0.00	$6.55	019

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the CAS Inquiry button located in the navigation / maintenance panel.

This panel displays category, reason code and other applicable adjustment information of an adjusted claim.

4.2.67.4 Extra Features

This panel has no extra features.

4.2.67.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The number of the detail on the claim record	Field	Number	4	T_CLM_CAS	NUM_DTL
2	SVD Detail	This is the sequence number of the SVD (Service line adjudication) Segment. Up to 25 SVD segments may be related to a detail.	Field	Number	4	T_CLM_CAS	NUM_DTL_SVD
3	CAS Seq	This identifies the iteration number for the CAS segment. A maximum of 99 CAS segments are allowed for a claim detail. For the claim header, the maximum is five. The CAS segment gives the user payment adjustment detail information.	Field	Number	4	T_CLM_CAS	NUM_CAS_SEQ
4	Claim Adjustment Reason	This code identifies the detailed reason the adjustment was made	Field	Character	5	T_CLM_CAS	CDE_CLM_ADJ_REASON
5	Claim Adjustment Group	This code identifies the general category of a payment adjustment	Field	Character	2	T_CLM_CAS	CDE_CLM_ADJ_GROUP
6	Adjustment Quantity	Number of units of service being adjusted. Format 999999.99	Field	Number	8	T_CLM_CAS	QTY_ADJUSTMENT
7	Adjustment Amount	Monetary amount of the adjustment. Format $9999999.99	Field	Number	9	T_CLM_CAS	AMT_ADJUSTMENT
8	Party Identifier	Unique identifier for a payer	Field	Character	80	T_PARTY_IDENTIFIER	CDE_PARTY_ID

4.2.67.6 Field Edits

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

4.2.68 PANEL: Data Correction Note

4.2.68.1 Description

The Data Correction Note panel will be used by resolutions staff to forward questions to other clerks or to a supervisor. To send a note, the first user will enter a Location Code, type in a Note, and specify a second User ID into the Reviewer Sent To field. When a note is sent, the claim will be assigned to the new location code and the claim will show up in the new user's Data Correction Suspense list. The newly assigned user can display the note and enter a reply. They can send the claim back to the originator by creating a new Note, or they can reply to the first note and keep the claim assigned to themselves. If they do not create a new note and send it back to the originator of the first note, the claim will remain assigned to the second user. If necessary, the second user can send a new note to a third user. There is no limit to how many notes can be created. Each time a new note is created, the claims is assigned to the Reviewer Sent To user id.

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

Table: T_LOCATION_NOTE

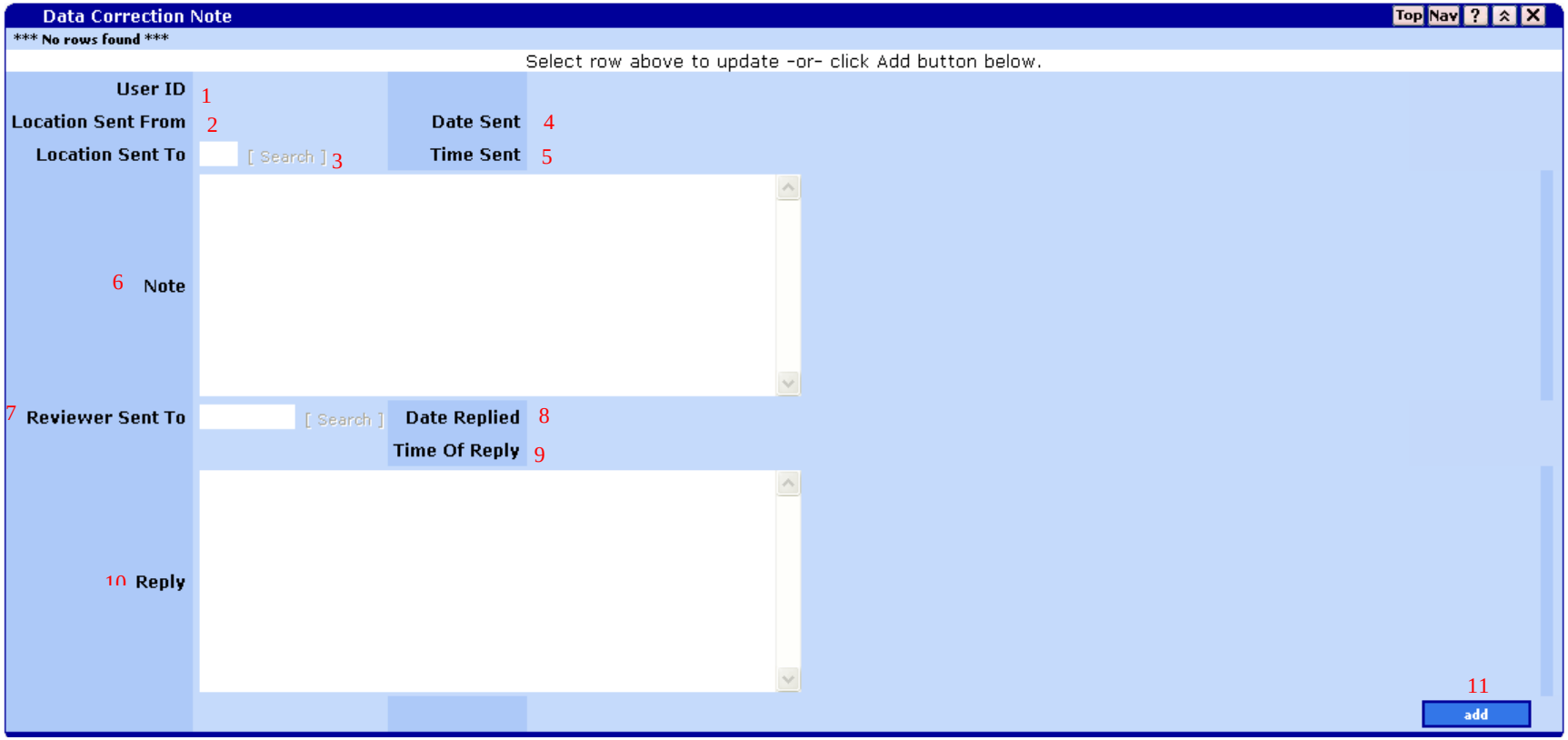
4.2.68.2 Technical Name

Clm.DataCorrectionNotePanel.ascx

4.2.68.3 Panel Name

Data Correction Note

4.2.68.4 Data Correction Note Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Data Correction Note button located in the navigation / maintenance panel.

In Data Correction, this panel allows questions to be written and sent by location code to another department. It allows the note originator to access the note when an answer is submitted and take appropriate action to the claim.

4.2.68.5 Extra Features

This panel has no extra features.

4.2.68.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	User ID	The ID of the user (clerk) who originates the note	Field	Character	8	T_LOCATION_NOTE	ID_CLERK
2	Location Sent From	The location that the note originates from. The user is required to use the [Search] to select a value	Field	N/A	0	T_LOCATION_NOTE	CDE_LOC_FROM
3	Location Sent To	The location that the note is being sent to. The user is required to use the [Search] to select a value	Field	N/A	0	T_LOCATION_NOTE	CDE_LOC_TO
4	Date Sent	The date the note is sent	Field	Date (MM/DD/CCYY)	8	T_LOCATION_NOTE	DTE_SENT
5	Time Sent	The time that the note is sent	Field	Character	6	T_LOCATION_NOTE	TME_SENT
6	Note	The note that is sent	Field	Character	256	T_LOCATION_NOTE	DSC_NOTE
7	Reviewer Sent To	The ID of the person who reviews the note. The user is required to use the [Search] to select a value	Field	N/A	0	T_LOCATION_NOTE	ID_REVIEWER
8	Date Replied	The date the reply is sent	Field	Date (MM/DD/CCYY)	8	T_LOCATION_NOTE	DTE_REPLY
9	Time Of Reply	The time that the reply is sent	Field	Character	6	T_LOCATION_NOTE	TME_REPLY
10	Reply	The note containing the reply	Field	Character	256	T_LOCATION_NOTE	DSC_REPLY

4.2.68.7 Button Descriptions

Button No	Button	Description
11	Add	Add a new location note

4.2.68.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	Location Sent To	Field	1	Location Sent To is required.	Select a value for the Location from the [Search] panel.
6	Note	Field	1	Note is required.	Enter text for the note description.
7	Reviewer Sent To	Field	1	Reviewer Sent to is required.	Select a User ID from the [Search] panel.
8	Date Replied	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter the date in MM/DD/CCYY format.

4.2.69 PANEL: DRG

4.2.69.1 Description

Use the DRG panel to view the Diagnosis Related Group (DRG) data for a UB92 claim.

Navigation Path: [Claims - Search] - [select a UB92 claim] - [DRG];

OR - [Claims - Data Correction] - [enter a clerk ID] - [select a UB92 claim from the search result] - [DRG];

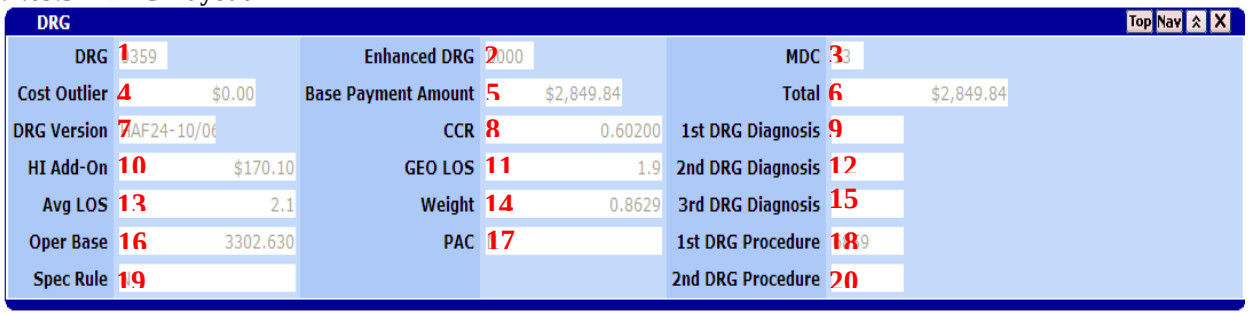
OR - [Claims - Information] - [enter ICN for a UB92 claim] - [DRG];

OR - [Claims - Data Correction] - [Enter Clerk ID, then select a UB92 claim from the list] - [Select DRG link from the displayed panel].

4.2.69.2 Panel Name

DRG

4.2.69.3 DRG Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the DRG button located in the navigation / maintenance panel.

This Panel displays Diagnosis Related Group data applicable to the claim.

4.2.69.4 Extra Features

This panel has no extra features.

4.2.69.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	DRG	Diagnosis Related Group. A code identifying the classification of diagnoses in which patients demonstrate similar resource consumption and length of stay patterns	Field	Character	4	T_DRG	CDE_DRG
2	Enhanced DRG	System assigned key for the enhanced DRG code utilized during the DRG pricing process.	Field	Number	9	T_UB92_HDR_INP	SAK_DRG_ENHANCED
3	MDC	Major Diagnosis Category. A broad classification of diagnoses which group DRGs into one of the mutually exclusive MDCs	Field	Character	2	T_MDC	CDE_MDC
4	Cost Outlier	Costs associated with the capital costs of the facility. Capital costs include depreciation, interest, property taxes, and other costs. Format 9999999.99	Field	Number	9	T_UB92_HDR_INP	AMT_COST_OUTLIER
5	Base Payment Amount	Base payment amount for an inpatient claim prior to any payment adjustments such as outliers or medical education costs.	Field	Number	9	T_UB92_HDR_INP	AMT_BASE_DRG
6	Total	Sum of the Base Payment Amount, Day Outlier and Cost Outlier. Format 9999999.99	Field	Number	9	N/A	N/A

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
7	DRG Version	Grouper version in use	Field	Character	20	T_UB92_HDR_INP	NUM_VERSION_DRG
8	CCR	This is the cost to charge ratio for the provider.	Field	Number	6	T_UB92_HDR_INP	CST_CHRG_RATE
9	1st DRG Diagnosis	First diagnosis code that influenced DRG assignment	Field	Character	7	T_UB92_HDR_INP	CDE_DIAG
10	HI Add-on	High intensity add on computed amount.	Field	Number	10	T_UB92_HDR_INP	AMT_HIGH_INTENSITY
11	GEO LOS	Geometric average length of stay.	Field	Number	5	T_UB92_HDR_INP	NUM_GEOMETRIC_LOS
12	2nd DRG Diagnosis	Secondary diagnosis code that influenced DRG assignment	Field	Character	7	T_UB92_HDR_INP	CDE_DIAG_2
13	Avg LOS	Average Length of Stay	Field	Number	5	T_UB92_HDR_INP	NUM_MEAN_LOS
14	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.	Field	Number	7	T_UB92_HDR_INP	NUM_WEIGHT
15	3rd DRG Diagnosis	Third diagnosis code that influenced DRG assignment	Field	Character	7	T_UB92_HDR_INP	DIAG_CODE_3
16	Oper Base	Provider Operating Base Rate	Field	Number	10	T_UB92_HDR_INP	NUM_BASE_RATE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
17	PAC	Indicator used to identify when transfer to post-acute care pricing logic should be applied when determining the DRG allowed amount. Valid values are ‘Y’ or 'N'.	Field	Character	1	T_UB92_HDR_INP	IND_PAC
18	DRG Procedure 1	First operating room procedure that influenced DRG assignment	Field	Character	7	T_UB92_HDR_INP	CDE_PROC1
19	Spec Rule	Indicator used to identify when special pricing logic should be applied when determining the DRG allowed amount. Valid values are 'Y' or ‘N’.	Field	Character	1	T_UB92_HDR_INP	IND_SPEC_RULE
20	DRG Procedure 2	Second operating room procedure that influenced DRG assignment	Field	Character	7	T_UB92_HDR_INP	CDE_PROC2

4.2.69.6 Field Edits

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

4.2.70 PANEL: Encounter Data

4.2.70.1 Description

The Encounter Data panel displays the name of the Encounter Batch File on which the encounter was received.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Display TCN link from the displayed panel];

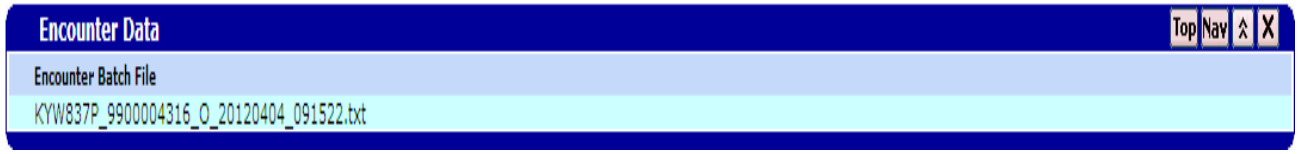
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Display TCN link from the displayed panel;

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Display TCN link from the displayed panel].

4.2.70.2 Panel Name

Encounter Data

4.2.70.3 Encounter Data Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Encounter Data button located in the navigation / maintenance panel.

This panel displays the name of the Encounter Batch File on which the encounter was received.

4.2.70.4 Extra Features

This panel has no extra features.

4.2.70.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Encounter Batch File	The name of the Encounter Batch File on which the encounter was received	Field	Character	40	T_FILE_TRACK	NAME_FILE

4.2.70.6 Field Edits

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

4.2.71 PANEL: ICD-9-CM

4.2.71.1 Description

The ICD-9-CM Procedure Codes panel displays the ICD-9-CM Procedure Codes applicable to the claim. This panel includes both the principal and other ICD-9-CM procedure codes. The principal procedure code is the ICD-9-CM code that identifies the procedure performed during the period covered by this bill and the date on which the principal procedure was performed. The other procedure codes are the ICD-9-CM codes that identify all significant procedures other than the principal procedure and the dates on which they were performed.

Navigation Path: [Claims -Information] - [Enter an ICN for a UB92 claim] - [Select ICD-9-CM link from the displayed panel];

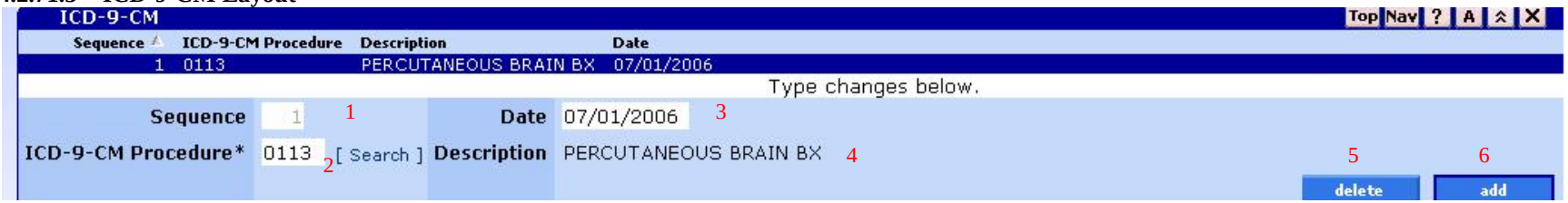
OR - [Claims -Search] - [Enter Criteria] - [Select a UB92 claim] - [Select ICD-9-CM link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a UB92 claim from the list] - [Select ICD-9-CM link from the displayed panel].

4.2.71.2 Panel Name

ICD-9-CM

4.2.71.3 ICD-9-CM Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the ICD-9-CM button located in the navigation / maintenance panel.

This panel displays the ICD-9-CM codes applicable to the UB92 claim which would include the principal procedure, the date it was performed, other significant procedures and the dates performed. In the Data Correction page, this panel allows codes to be added or deleted.

4.2.71.4 Extra Features

This panel has no extra features.

4.2.71.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Sequence	This column contains the sequence number of the surgical procedure code. The principle procedure is always sequence 1	Field	Number	4	T_UB92_HDR_ICD9CM	NUM_SEQ
2	ICD-9-CM Procedure	Code used to identify the surgical procedure code principle or other	Field	Number	4	T_UB92_HDR_ICD9CM	CDE_PROC_ICD9
3	Date	Date the ICD-9-CM procedure was performed	Field	Date (MM/DD/CCYY)	8	T_UB92_HDR_ICD9CM	DTE_CDE_9_CM_PROC
4	Description	Description of the surgical procedure code	Field	Character	50	T_PROC_ICD9	DSC_PROCEDURE

4.2.71.6 Button Descriptions

Button No	Button	Description
5	Delete	Deletes a record
6	Add	Adds a new record

4.2.71.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	ICD-9-CM Procedure	Field	1	Invalid Procedure ICD9 Code.	Enter a valid ICD-9-CM Procedure code or select a code from the [Search] panel.
2	ICD-9-CM Procedure	Field	104	Exceed maximum number of ICD9 codes.	The maximum number of ICD9 codes is 24.
3	Date	Field	1	Invalid Date. Format MM/DD/CCYY.	Enter the date in the correct format, MM/DD/CCYY.

4.2.72 PANEL: Service/Prior Authorization

4.2.72.1 Description

The Prior Authorization panel displays the prior authorization applicable to the claim. This panel includes the the amount and units used in the claim.

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

Tables: T_PA_ITEM_DTL_XREF, T_PA_PAUTH, T_FINANCIAL_PAYER

4.2.72.2 Technical Name

Clm.ClaimPriorAuth.ascx

4.2.72.3 Panel Name

Prior Authorization

4.2.72.4 Service/Prior Authorization Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Prior Authorization button located in the navigation / maintenance panel.

This panel displays the PA information applicable to the claim.

4.2.72.5 Extra Features

This panel has no extra features.

4.2.72.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	Detail to which Service/Prior Authorization has been applied	Field	Number	9	T_PA_ITEM_DTL_XREF	NUM_DTL
2	PA Number	This is the number assigned by the PA unit to a Service/Prior Authorization request	Field	Character	10	T_PA_PAUTH	PRIOR_AUTH_NUM
3	Line Item	Prior Authorization Line Item number	Field	Character	3	T_PA_ITEM_DTL_XREF	NUM_PA_LINE_ITEM
4	Financial Payer	A code used to identify the financial payer	Field	Number	9	T_FINANCIAL_PAYER	CDE_FIN_PAYER
5	Units Used	Prior Authorization units applied to the claim	Field	Number	6	T_PA_ITEM_DTL_XREF	QTY_UNT_SVC_USD
6	Amount Used	Prior Authorization amount applied to the claim. Format 99999999.99	Field	Number	9	T_PA_ITEM_DTL_XREF	AMT_PA_USED
7	Status	Indicates the status of the claim within the system	Field	Character	1	T_PA_ITEM_DTL_XREF	CDE_STATUS1

4.2.72.7 Field Edits

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

4.2.73 PANEL: UB92 Claim Detail

4.2.73.1 Description

Use the UB92 Claim Detail panel to view the data entered on the detail portion of a UB92 claim. When this panel is displayed in Data Correction mode, use the Add or Delete button to add or remove details.

Navigation Path: [Claims -Information] - [Enter an ICN for a UB92 claim] - [Select Claim Detail link from the displayed panel];

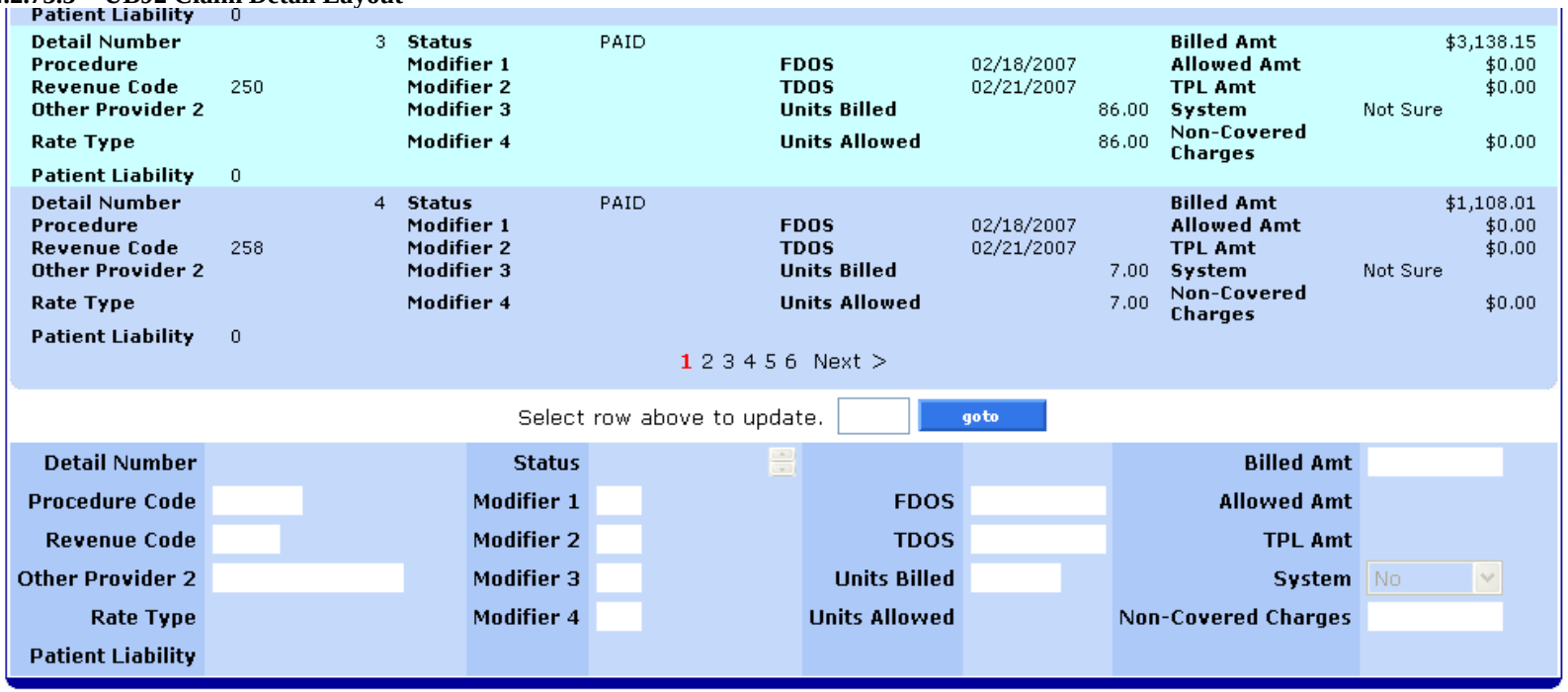
OR - [Claims -Search] - [Enter Criteria] - [Select a UB92 claim] - [Select Claim Detail link from the displayed panel]

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a UB92 claim from the list] - [Select Claim Detail link from the displayed panel].

4.2.73.2 Panel Name

Claim Detail

4.2.73.3 UB92 Claim Detail Layout



To access this panel:

STEP 1. Access the Claims Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. This panel displays the detail lines of a UB92 claim.

4.2.73.4 Extra Features

This panel has no extra features.

4.2.73.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	goto	Allows user to view a specific detail	Button	N/A	0	N/A	N/A
2	Detail Number	The detail number of a claim record	Field	Number	4	SEE NARRATIVE SECTION	NUM_DTL
3	Procedure Code	System-assigned key for a procedure code on a detail which indicates the service that was provided	Field	Character	6	T_UB92_HDR_EXT_KEY	CDE_PROC
4	Revenue Code	System-assigned key used to uniquely identify a revenue code	Field	Number	4	SEE NARRATIVE SECTION	CDE_REVENUE
5	Other Prov2 ID/Loc	Other Provider 2 and location. LOC=location that uniquely identifies the provider of services	Field	Character	10	T_UB92_DTL_EXT_KEY	ID_PROV_OTHER_2
6	Patient Liability	The amount of patient liability applied to this claim	Field	Number	12	T_CLM_PATLIAB_X	AMT_PD_PAT_UB92
7	Status	Identifies the status of the claim within the system	Field	Character	1	SEE NARRATIVE SECTION	CDE_CLM_STATUS

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
8	Modifier 1	Original/Submitted Procedure Modifier 1 for HIPAA 837I	Field	Character	2	T_CLM_MODIFIER	CDE_MODIFIER
9	Modifier 2	Original/Submitted Procedure Modifier 2 for HIPAA 837I	Field	Character	2	T_CLM_MODIFIER	CDE_MODIFIER
10	Modifier 3	Original/Submitted Procedure Modifier 3 for HIPAA 837I	Field	Character	2	T_CLM_MODIFIER	CDE_MODIFIER
11	Modifier 4	Original/Submitted Procedure Modifier 4 for HIPAA 837I	Field	Character	2	T_CLM_MODIFIER	CDE_MODIFIER
12	FDOS	Date on which service was first provided	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_FIRST_SVC
13	TDOS	Date on which service was last provided	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_LAST_SVC
14	Units Billed	Units billed that were serviced	Field	Number	6	SEE NARRATIVE SECTION	QTY_UNITS_BILLED
15	Units Allowed	Number of units of service that are paid for	Field	Number	6	SEE NARRATIVE SECTION	QTY_UNITS_ALWD
16	Billed Amt	Amount of money requested for payment by a provider for services rendered. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_BILLED_UB92
17	Allowed Amt	Amount allowed that is paid for. Format 9999999.99	Field	Number	9	SEE NARRATIVE SECTION	AMT_REIMBURSEMENT
18	Copay Amt	Copay Amount. Format 99999.99	Field	Number	7	SEE NARRATIVE SECTION	AMT_CO_PAY

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
19	TPL Amt	Amount paid by third party for services, at the claim header level. Format 999999.99	Field	Number	9	SEE NARRATIVE SECTION	AMT_DETAIL_TPL
20	System	Indicates whether detail was added by system during claim's processing	Field	Drop Down List Box	1	SEE NARRATIVE SECTION	IND_SYS_GENERATE

4.2.73.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	Procedure Code	Field	1	Invalid Procedure.	Enter a valid procedure or select a value from the [Search] panel.
4	Revenue Code	Field	1	Enter a valid value.	Revenue code must be numeric.
4	Revenue Code	Field	2	Invalid Revenue Code.	Enter a valid Revenue code or select a value from the [Search] panel.
5	Other Prov2 ID/Loc	Field	1	Invalid Rendering Provider.	Enter a valid Rendering Provider or select a value from the [Search] panel.
5	Other Prov2 ID/Loc	Field	2	Rendering Provider ID and service location are required.	Enter a valid Id/service location or select a value from the [Search] panel.
8	Modifier 1	Field	1	Invalid Modifier 1 Code.	Enter a valid Modifier 1 Code or select a value from the [Search] panel.
9	Modifier 2	Field	1	Invalid Modifier 2 Code.	Enter a valid Modifier 2 Code or select a value from the [Search] panel.
10	Modifier 3	Field	1	Invalid Modifier 3 Code.	Enter a valid Modifier 3 Code or select a value from the [Search] panel.
11	Modifier 4	Field	1	Invalid Modifier 4 Code.	Enter a valid Modifier 4 Code or select a value from the [Search] panel.

Field No	Field	Field Type	Error Code	Error Message	To Correct
12	FDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid Date in the MM/DD/CCYY format.
13	TDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid Date in the MM/DD/CCYY format.
14	Units Billed	Field	1	Enter a valid value.	Units Billed must be numeric.
16	Billed Amt	Field	1	Enter a Valid Value.	Billed Amount must be numeric.

4.2.74 PANEL: UB92 Claim Detail Navigation

4.2.74.1 Description

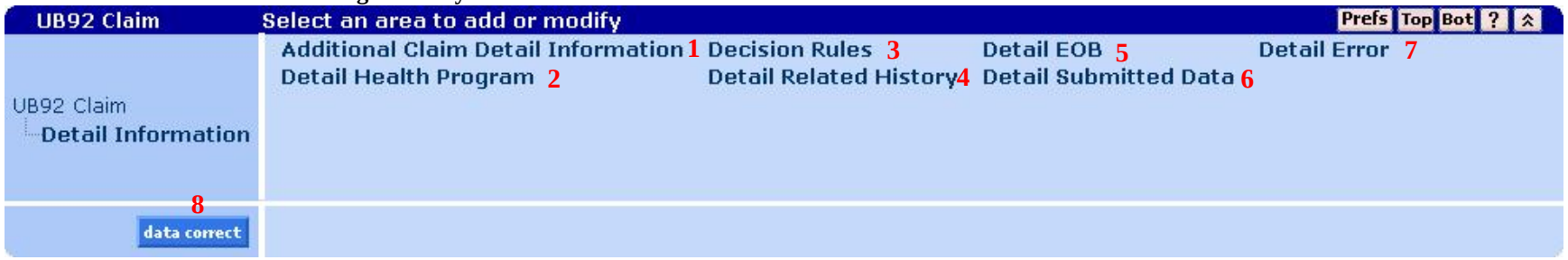
The UB92 Claim Detail Navigation panel provides access to the various panels through which UB92 Claims detail information can be viewed. Panels accessed from the Detail Navigation panel are not updateable.

Navigation Path: [Claims -Information] - [Enter an ICN for a UB92 claim] - OR - [Claims -Search] - [Enter Criteria] - [Select a UB92 claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a UB92 claim from the list] -THEN [Click on Detail Information on the Navigation Panel]

4.2.74.2 Panel Name

UB92 Claim Detail Navigation

4.2.74.3 UB92 Claim Detail Navigation Layout



To access this panel:

Access the Data Correction page using the instructions listed for the page.

STEP 1. Click the row of a UB92 claim to select.

STEP 2. Click the Detail Information button located on the left side of the UB92 Claim Maintenance panel.

The links for the UB92 Detail Information maintenance panel will display.

STEP 3. Click the Adjust button to send a paid claim to the Adjustment Request panel to begin process for adjustment.

4.2.74.4 Extra Features

This panel has no extra features.

4.2.74.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Additional Claim Detail Information	Links to "Additional Claim Detail Information" panel	Hyperlink	N/A	0	N/A	N/A
2	Detail Health Program	Links to "Detail Health Program" panel	Hyperlink	N/A	0	N/A	N/A
3	Decision Rules	Link to "Decision Rules" panel	Hyperlink	N/A	0	N/A	N/A
4	Detail Related History	Links to "Detail Related History" panel	Hyperlink	N/A	0	N/A	N/A
5	Detail EOB	Links to "Detail EOB" panel	Hyperlink	N/A	0	N/A	N/A
6	Detail Submitted Data	Links to "Detail Submitted Data" panel	Hyperlink	N/A	0	N/A	N/A
7	Detail Error	Links to "Detail Error" panel	Hyperlink	N/A	0	N/A	N/A

4.2.74.6 Button Descriptions

Button No	Button	Description
8	Data Correct	This button displays for claims in suspended status. Clicking the Data Correct button opens up the displayed suspended claim in Data Correction mode. Changes can be made and the claim can be resubmitted

4.2.74.7 Field Edits

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

4.2.75 PANEL: Detail Health Program

4.2.75.1 Description

The Detail Health Program panel can be accessed from the paid, denied, or suspended claim windows. This window displays the health program applicable to the claim detail being viewed.

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail Health Program]

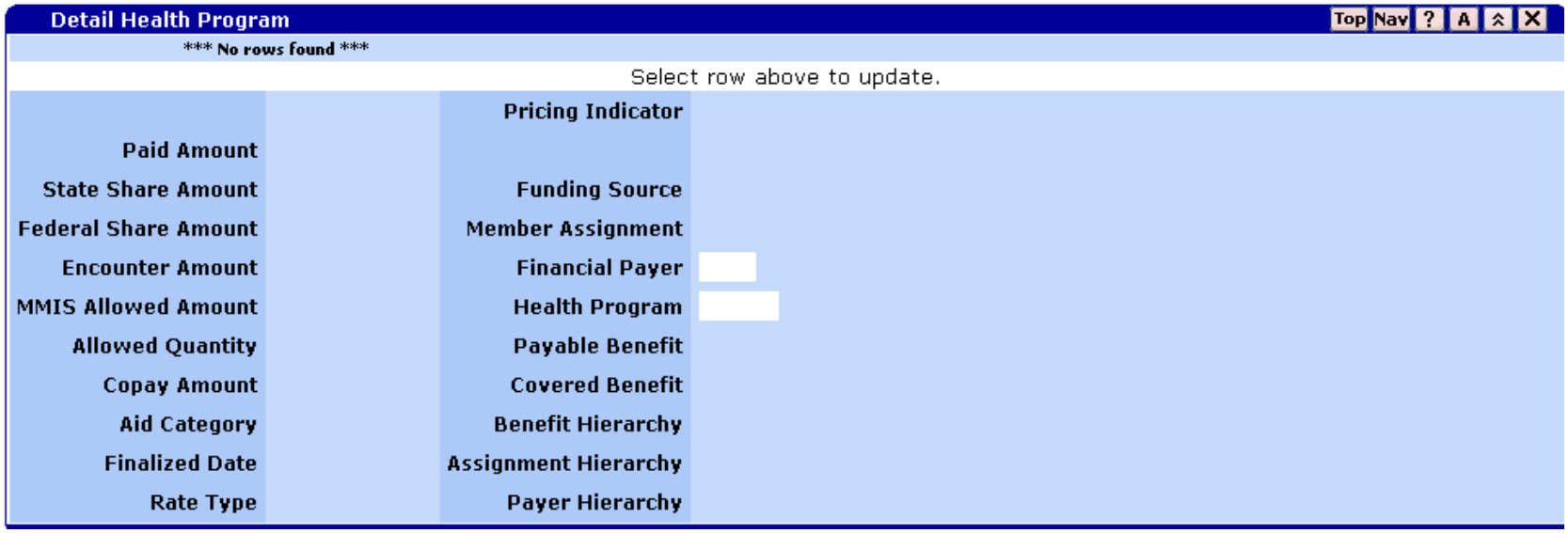
Tables: T_CLM_PGM_XREF, T_CDE_AID, T_FINANCIAL_PAYER, T_PUB_HLTH_PGM

4.2.75.2 Panel Name

Detail Health Program

For readability, the layout displays on the next page.

4.2.75.3 Detail Health Program Layout



To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click on Claim detail line to highlight it.

STEP 2. Click on Detail Information button located above the Save and Cancel buttons or Adjust button.

STEP 3. Click on Detail Health Program button.

This panel displays member coverage information as applicable to the detail line of the claim. In Data Correction page, this panel allows records to be updated but only the Allowed Amount and Financial Payer fields.

4.2.75.4 Extra Features

This panel has no extra features.

4.2.75.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Paid Amount	This is the amount that is applied toward the check amount. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_PAID
2	State Share Amount	This is the amount of state share for this payment. The state share amount plus the amount Paid = Reimbursement amount. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_STATE_SHARE
3	Federal Share Amount	This is the amount of federal share for this payment	Field	Number	10	T_CLM_PGM_XREF	AMT_FEDERAL_SHARE
4	Encounter Amount	Contains the amount for encounter services on the claim detail indicated by the detail number on table. Format 9999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_ENCOUNTER

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Allowed Amount	Allowed Amount that is paid. Format 9999999.99	Field	Number	9	T_CLM_PGM_XREF	AMT_ALWD
6	Allowed Quantity	Number of units of service that are paid under a financial payer/benefit plan. Format 9999.99	Field	Number	6	T_CLM_PGM_XREF	QTY_ALLOWED
7	Copay Amount	Amount paid by member for services rendered. Format 99999.99	Field	Number	7	T_CLM_PGM_XREF	AMT_CO_PAY
8	Aid Category	Aid Category for Medicaid coverage	Field	Number	9	T_CDE_AID	CDE_AID_CATEGORY
9	Finalized Date	Date that financial finalizes the claim for this payer	Field	Date (MM/DD/CCYY)	8	T_CLM_PGM_XREF	DTE_FINAL
10	Rate Type	Code used to identify the rate type to use in determining provider reimbursement	Field	Character	3	T_CLM_PGM_XREF	CDE_RATE_TYPE
11	Pricing Indicator	Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced	Field	Character	1	T_CLM_PGM_XREF	IND_PRICING
12	Managed Care Indicator	Manage care indicator identifies claims and other transactions as to how they affect the manage care program	Field	Drop Down List Box	1	T_CLM_PGM_XREF	IND_MC

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
13	Fund Source	Indicates the budget category that the funds used to pay this claim/detail came from	Field	Number	9	T_FIN_FUND_CODE	T_FIN_FUND_CODE
14	Member Assignment	A group of covered services (benefits) where the member is assigned to a provider or provider organization in order to receive covered services (benefits)	Field	Number	9	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
15	Financial Payer	The system-assigned value that identifies a unique payer within interChange	Field	Number	9	T_FINANCIAL_PAYER	CDE_FIN_PAYER
16	Health Program	Identifies the medical assistance program that is supported in the system	Field	Character	5	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
17	Payable Benefit	Unique system-assigned that identifies each row on this table	Field	Number	9	T_CLM_PGM_XREF	SAK_PAYABLE_BNFT
18	Covered Benefit	System-assigned key used to identify a unique row for a benefit covered by a member plan	Field	Number	9	T_CLM_PGM_XREF	SAK_COVERED_BNFT
19	Benefit Hierarchy	Specifies the order in which to process multiple Benefit Plans for a member	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
20	Assignment Hierarchy	An assignment hierarchy is an ordered set of assignment plans for which a member/beneficiary 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	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD_ASSIGNMENT
21	Payer Hierarchy	Payer Hierarchy identifies 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	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD_PAYER

4.2.75.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
5	Allowed Amount	Field	1	Enter a valid value.	Enter only a numeric value in the Allowed Amount field.
15	Financial Payer	Field	1	Enter a valid value.	Enter a valid Financial Payer or select a valid value from the [Search] panel.
16	Health Program	Field	1	Invalid Benefit Plan.	Enter a valid Benefit plan or select a value from the [Search] panel.

4.2.76 PANEL: Detail Related History

4.2.76.1 Description

The Detail Related History panel can be accessed from the paid, denied, or suspended claim windows. This window displays the related hstory applicable to the claim detail being viewed.

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

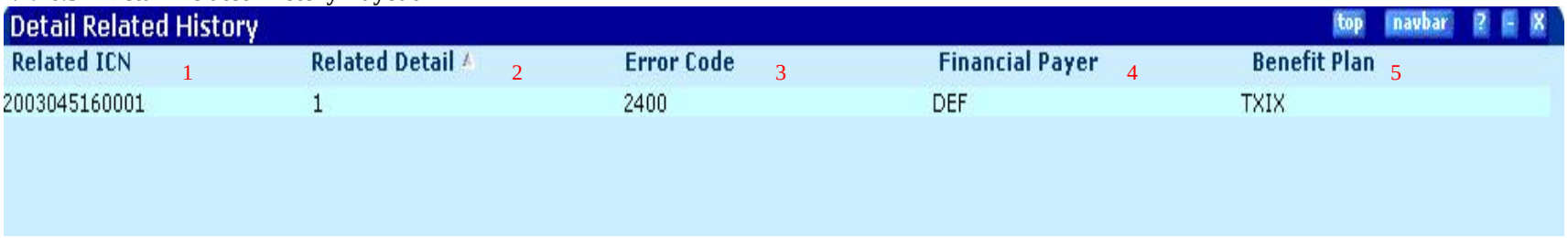
Navigation Path: [Claims -Information] - [Enter an ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail Related History]

Table: T_SUSP_RLHX

4.2.76.2 Panel Name

Detail Related History

4.2.76.3 Detail Related History Layout



To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click on Claim detail line to highlight it.

STEP 2. Click on Detail Information button located above the Save and Cancel buttons or Adjust button.

STEP 3. Click on Detail Related History button.

This panel displays other claims associated with the claim as applicable to the detail line of the claim.

4.2.76.4 Extra Features

This panel has no extra features.

4.2.76.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Related ICN	Internal Control Number of the related claim	Field	Character	13	T_SUSP_RLHX	SAK_RELATED_HX
2	Related Detail	Related detail number on the history claim displayed	Field	Number	4	T_SUSP_RLHX	NUM_DTL_RELATED
3	Error Code	Code used to indicate an error was discovered on a claim during processing in the base system	Field	Number	4	T_SUSP_RLHX	SAK_ESC
4	Financial Payer	The description used to identify the financial payer for the related ICN	Field	Character	30	T_SUSP_RLHX	SAK_FIN_PAYER
5	Benefit Plan	The medical assistance program associated with the related ICN	Field	Character	5	T_SUSP_RLHX	SAK_PUB_HLTH

4.2.76.6 Field Edits

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

4.2.77 PANEL: Detail EOB

4.2.77.1 Description

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

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

The All, Current, Historical radiobutton on the panel allows the user to select which EOB's to view based on the EOB Status. The EOB on the claim is a current EOB ('C'), one that failed in the current cycle, or a historical EOB ('H'), one that previously failed.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail EOB]

Table: T_CLM_EOB_XREF, T_CDE_HIPAA_ADJRSN, T_CDE_HIPAA_REMRKS

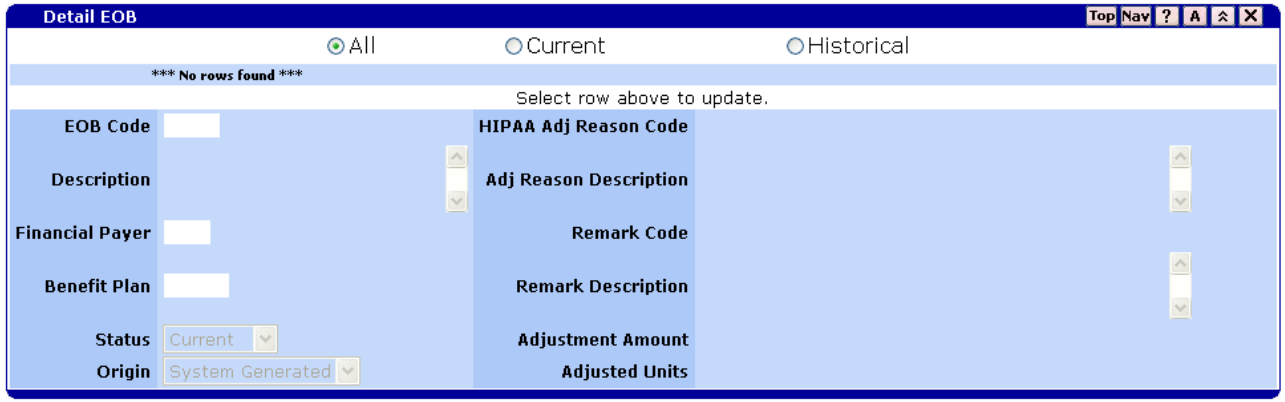
4.2.77.2 Technical Name

Clm.ClaimEobPanel.ascx

4.2.77.3 Panel Name

Detail EOB

4.2.77.4 Detail EOB Layout



To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click a row to select.

STEP 2. Click on Claim detail line to highlight it.

STEP 3. Click on Detail Information button located above the Save and Cancel buttons or Adjust button.

STEP 4. Click on Detail EOB button located next to the Detail Error button.

This panel displays EOB code information as applicable to the detail line of the claim. In Data Correction page, this panel allows records to be updated, added or deleted.

4.2.77.5 Extra Features

This panel has no extra features.

4.2.77.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it	Field	Number	4	T_EOB	CDE_EOB
2	Description	First line of text description for EOB code	Field	Character	79	T_EOB	DSC_EOB
3	Financial Payer	A value that identifies a unique payer within interChange	Field	Drop Down List Box	0	T_CLM_EOB_XREF	SAK_FIN_PAYER
4	Benefit Plan	Identifies the medical assistance program that is supported in the system	Field	Drop Down List Box	0	T_CLM_EOB_XREF	SAK_PUB_HLTH
5	Status	Code used to indicate whether the EOB on the claim is a current EOB ('C'), one that failed in the current cycle, or a historical EOB ('H'), one that previously failed	Field	Drop Down List Box	0	T_CLM_EOB_XREF	CDE_STAT_ERROR

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
6	HIPAA Adjustment Reason	This is the managed care eligibility reason codes for HIPAA	Field	Character	2	T_CDE_HIPAA_ADJ RSN	CDE_ADJ_RSN
7	Remark Code	HIPAA Remarks code	Field	Character	5	T_CDE_HIPAA_REM RKS	CDE_REMARK
8	Adjustment Amount	The dollar amount adjusted on the detail. Format 9999999.99 “NOT USED IN KY”	Field	Number	9	T_CLM_EOB_XREF	AMT_ADJUSTED
9	Adjusted Units	The quantity adjusted on the detail. Format 9999999.999 “NOT USED IN KY”	Field	Number	10	T_CLM_EOB_XREF	QTY_ADJUSTED
10	Origin	Indicates who generated the EOB code and message	Field	Character	6	T_CLM_EOB_XREF	CDE_STATUS1

4.2.77.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
3	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer of select one from the [Search] panel.
4	Benefit Plan	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select one from the [Search] panel.

4.2.78 PANEL: Detail Submitted Data - UB92

4.2.78.1 Description

The Detail Submitted Data panel can be accessed from the paid, denied, or suspended claim panels. This panel displays the submitted data applicable to the UB92 claim detail being viewed.

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

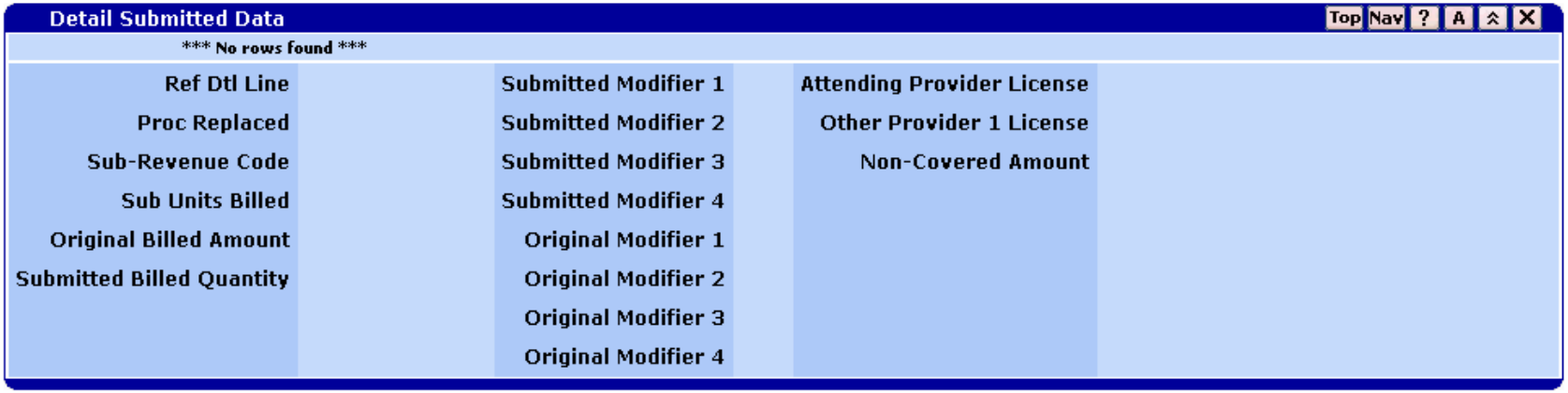
Navigation Path: [Claims -Information] - [Enter a UB92 ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a UB92 claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a UB92 claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail Submitted Data]

Table: T_UB92_DTL_EXT_KEY

4.2.78.2 Panel Name

Detail Submitted Data

4.2.78.3 Detail Submitted Data - UB92 Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Click the row of a UB92 claim to select.

STEP 3. Click on Claim detail line to highlight it.

STEP 4. Click on Detail Information button located above the Save and Cancel buttons or Adjust button.

STEP 5. Click on Detail Submitted Data button.

This panel displays procedure code and/or modifiers that are replaced with the new code and/or modifier as well as attending provider license number and non-covered amount as applicable to the detail line of the claim.

4.2.78.4 Extra Features

This panel has no extra features.

4.2.78.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Ref Dtl Line	A sequence number that points to the original detail	Field	Number	4	T_UB92_DTL_EXT_KEY	NUM_DTL
2	Submitted Modifier 1	Submitted Procedure Modifier 1 for HIPAA 835.	Field	Character	2	T_UB92_DTL_EXT_KEY	CDE_PROC_MOD1_SUB
3	Attending Provider License	The number of the licensed physician who would be expected to certify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment	Field	Character	11	T_UB92_DTL_EXT_KEY	ID_PROV_ATTEND
4	Proc Replaced	Submitted Procedure Code for HIPAA 835	Field	Character	6	T_UB92_DTL_EXT_KEY	CDE_PROC_SUB
5	Submitted Modifier 2	Submitted Procedure Modifier 2 for HIPAA 835.	Field	Character	2	T_UB92_DTL_EXT_KEY	CDE_PROC_MOD2_SUB

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
6	Other Provider 1 License	License number of the physician who performed the procedure	Field	Character	11	T_UB92_DTL_EXT_KEY	ID_PROV_OTHER
7	Sub-Revenue Code	Submitted Revenue code for HIPAA 835	Field	Character	4	T_UB92_DTL_EXT_KEY	CDE_REV_SUB
8	Submitted Modifier 3	Submitted Procedure Modifier 3 for HIPAA 835.	Field	Character	2	T_UB92_DTL_EXT_KEY	CDE_PROC_MOD3_SUB
9	Non-Covered Amount	Non-Covered Amount, Line Item Denied Charge or Non-Covered Charge Amount.	Field	Number	9	T_UB92_DTL_EXT_KEY	AMT_NON_COVERED
10	Sub Units Billed	Submitted Units Billed for HIPAA 835. Format 9999999.99	Field	Number	9	T_UB92_DTL_EXT_KEY	QTY_BILLED_SUB
11	Submitted Modifier 4	Submitted Procedure Modifier 4 for HIPAA 835.	Field	Character	2	T_UB92_DTL_EXT_KEY	CDE_PROC_MOD4_SUB
12	Original Billed Amount	Original billed amount on the claim detail.	Field	Number	8	T_UB92_DTL_EXT_KEY	AMT_BILLED_ORIG
13	Original Modifier 1	Submitted Procedure Modifier 1 for HIPAA 835	Field	Character	2	T_UB92_DTL_EXT_KEY	CDE_PROC_MOD1_SUB
14	Sub-Revenue Code	Submitted Revenue code for HIPAA 835	Field	Character	4	T_UB92_DTL_EXT_KEY	CDE_REV_SUB
15	Original Modifier 2	Original Procedure Modifier 2 for HIPAA 835	Field	Character	2	T_UB92_DTL_EXT_KEY	CDE_PROC_MOD2_SUB
17	Original Modifier 3	Original Procedure Modifier 3 for HIPAA 835	Field	Character	2	T_UB92_DTL_EXT_KEY	CDE_PROC_MOD3_SUB
18	Original Modifier 4	Original Procedure Modifier 4 for HIPAA 835	Field	Character	2	T_UB92_DTL_EXT_KEY	CDE_PROC_MOD4_SUB

4.2.78.6 Field Edits

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

4.2.79 PANEL: Detail Error

4.2.79.1 Description

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

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

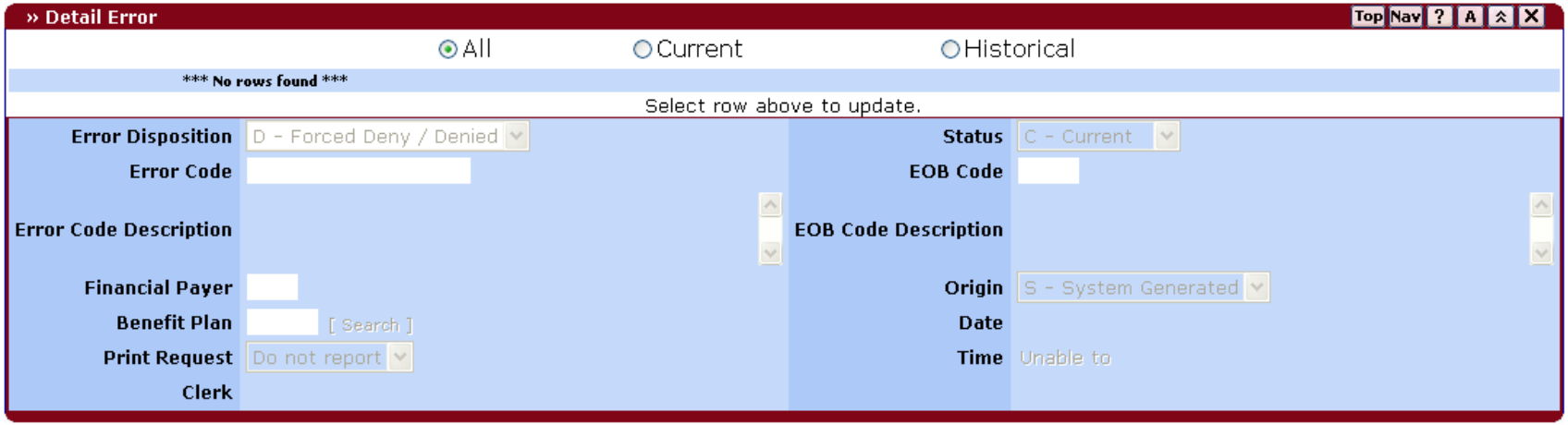
Navigation Path: [Claims -Information] - [Enter an ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail Error]

Tables: T_CLAIM_ERROR, T_ERROR_DISP, T_EOB

4.2.79.2 Panel Name

Detail Error

4.2.79.3 Detail Error Layout



To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click a row to select.

STEP 2. Click on Claim detail line to highlight it.

STEP 3. Click on DetailInformation button located above the Save and Cancel buttons or Adjust button.

STEP 4. Click on Detail Error button located next to the Detail EOB button.

This panel displays Error code information as applicable to the detail line of the claim. In Data Correction page, this panel allows records to be updated, added or deleted.

4.2.79.4 Extra Features

This panel has no extra features.

4.2.79.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Error Disposition	Disposition of the error	Field	Drop Down List Box	0	T_ERROR_DISP	DSC_ERROR_STAT
2	Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit	Field	Character	4	T_ERROR_DISP	CDE_ESC
3	EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it	Field	Number	4	T_EOB	CDE_EOB
4	Financial Payer	A value that identifies a unique payer within interChange	Field	Character	4	T_CLAIM_ERROR	SAK_FIN_PAYER

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Benefit Plan	Identifies the medical assistance program that is supported in the system. Use the [Search] panel to select a valid plan	Field	Character	5	T_CLAIM_ERROR	SAK_PUB_HLTH
6	Print Request	The valid values for this indicator are Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report	Field	Drop Down List Box	0	T_CLAIM_ERROR	IND_RPT
7	Clerk	Number used to identify the user who last updated the error record	Field	Character	8	T_CLAIM_ERROR	ID_CLERK
8	Status	Indicates if the EOB is current or history	Field	Drop Down List Box	7	T_CLAIM_ERROR	CDE_DISP_STATUS
9	Error Description	Description of the error	Field	Character	50	T_ERROR_DISP	DSC_ERROR_STAT
10	EOB Description	Text description for the EOB code	Field	Character	79	T_EOB	DSC_EOB
11	Origin	Indicates how the EOB Code and message were generated: valid values are 'S - System Generated' or 'U - User Assigned'	Field	Drop Down List Box	0	T_CLAIM_ERROR	CDE_STATUS1
12	Date	Date of the Error code	Field	Date (MM/DD/CCYY)	0	T_CLAIM_ERROR	DTE_GENERIC

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
13	Time	Time of the error code	Field	Number	8	T_CLAIM_ERROR	TME_STAMP

4.2.79.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Error Code	Field	1	Invalid error code.	Enter a valid Error Code or select a valid code from the [Search] panel.
2	Error Code	Field	2	Error Code XXXX cannot be overridden.	The Error Code entered is a critical error or it cannot be overridden. The Error Disposition cannot be 'F - Force'.
2	Error Code	Field	3	Error Code XXXX cannot have the Error Disposition set to 'Deny'.	The Error Code entered has an Allow Deny Indicator set to 'No'; therefore the Error Disposition cannot be set to Deny.
3	EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
4	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer or select one from the [Search] panel.
5	Benefit Plan	Field	1	Invalid Benefit plan.	Enter a valid Benefit Plan or select a valid Benefit Plan from the [Search] panel.

4.2.80 PANEL: Dental Claim

4.2.80.1 Description

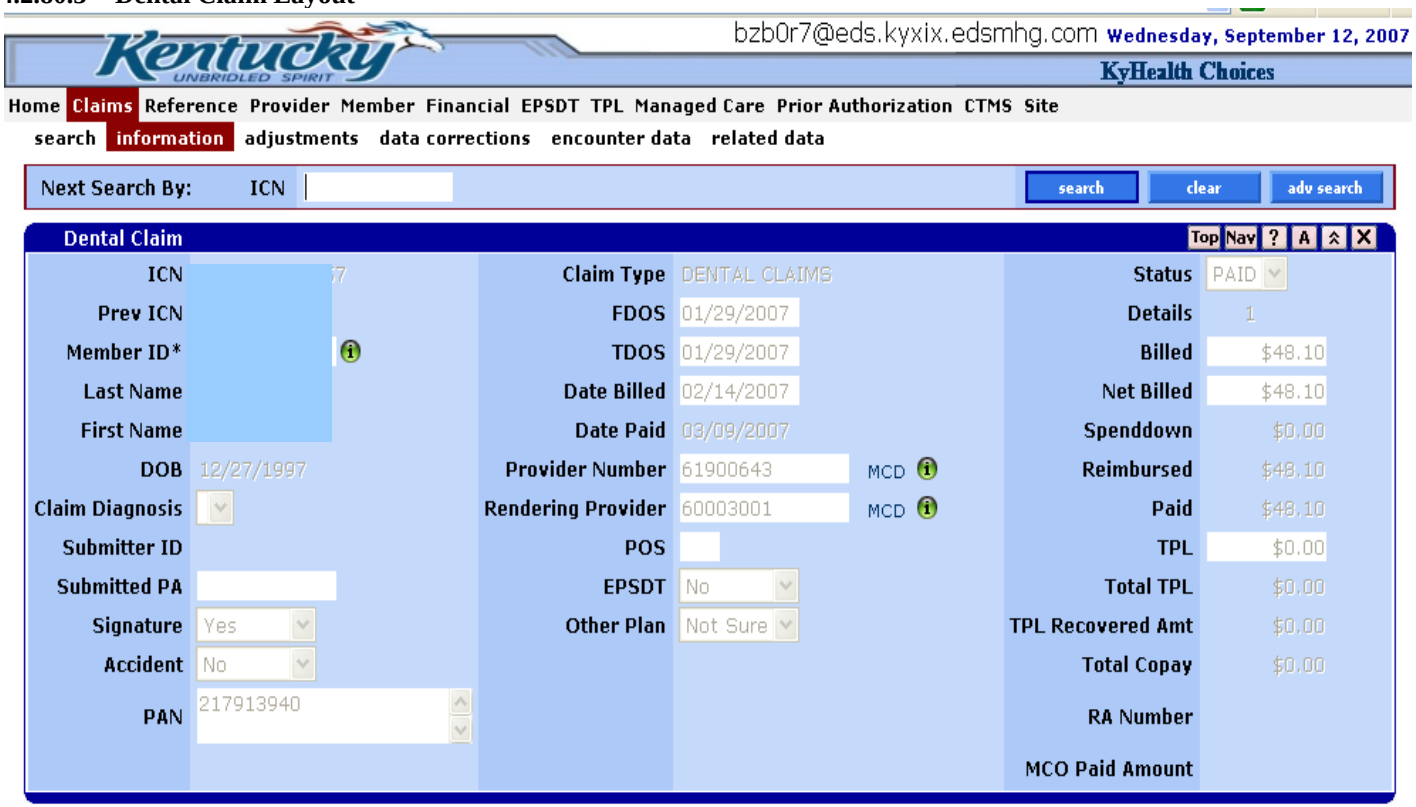
The Dental Claim panel displays the header information on a selected Dental claim.

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

4.2.80.2 Panel Name

Dental Claim

4.2.80.3 Dental Claim Layout



To access this panel:

STEP 1. Access the Claims Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

This panel displays all the non-detail line claim information submitted on the claim.

4.2.80.4 Extra Features

This panel has no extra features.

4.2.80.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	ICN	Internal control number which uniquely identifies a claim	Field	Character	13	SEE NARRATIVE SECTION	NUM_ICN
2	Prev ICN	This field allows the user to select any of the other previous ICNs for the claim and view that information. The MCO Original ICN for an encounter claim. Not used on claims other than encounters.	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	NUM_ICN
3	Member ID	A system-assigned number which uniquely identifies a member	Field	Character	12	T_DENTAL_HDR_KEYS	ID_MEDICAID
4	Last Name	The last name of the member associated with the Member ID number. If there is no association between the last name and the Member ID number, the first three characters of the last name that were typed are displayed	Field	Character	15	T_DENTAL_HDR_KEYS	CLM_LST_NAM_RECIP

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	First Name	The first name of the member associated with the Member ID number. If there is no association between the first name and the Member ID number, the first character of the first name that was typed is displayed	Field	Character	15	T_DENTAL_HDR_KEYS	CLM_RECIP_FST_NAM
6	DOB	Member date of birth	Field	Date (MM/DD/CCYY)	8	T_DENTAL_HDR_KEYS	DTE_SUBSCRIBER_DOB
7	Diagnosis	A code for the condition requiring medical attention	Field	Drop Down List Box	7	T_DIAGNOSIS	CDE_DIAG
8	Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.	Field	Character	12	SEE NARRATIVE SECTION	ID_SUBMITTER
9	RA Number	Remittance Advice number uniquely identifies remittance advice sent to providers during payment cycles	Field	Number	12	T_CHECK	NUM_CHECK
10	Signature	Indicates whether the claim was signed by the provider or representative	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	IND_PROV_SIGN
11	Accident	Indicates whether the service was provided as a result of an accident	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	IND_ACCIDENT
12	PAN	Identification for a member assigned by a provider. (Patient Account Number)	Field	Character	38	SEE NARRATIVE SECTION	NUM_PAT_ACCT

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
13	Claim Type	Indicates the type of claim	Field	Character	50	SEE NARRATIVE SECTION	CDE_CLM_TYPE
14	FDOS	First Data of Service on the claim	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_FIRST_SVC
15	TDOS	Date of last service on the claim	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_LAST_SVC
16	Date Billed	Date on which claim was submitted for processing	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_BILLED
17	Date Paid	Date on which the claim was paid	Field	Date (MM/DD/CCYY)	8	T_PD_DNTL_HDR	DTE_FINAL
18	Provider Numner	The provider identification number and location that uniquely identifies the provider of services	Field	Character	10	T_DENTAL_HDR_KEYS	ID_PROVIDER
19	Rendering Provider	The Rendering provider identification number and location that uniquely identifies the provider of services	Field	Character	10	T_DENTAL_DTL_KEYS	ID_PROV_PERF
20	POS	Place of Service where service was rendered	Field	Character	2	SEE NARRATIVE SECTION	CDE_POS
21	EPSDT	Indicates whether claim is EPSDT	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	CDE_EPSDT_FP
22	Other Plan	Indicates if another form of insurance was used	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	IND_ANOTHER_ PLAN
23	Emergency	Indicates whether service was provided as a result of an emergency situation	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	IND_EMERGENCY

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
24	Status	This field displays the status of the claim	Field	Drop Down List Box	20	SEE NARRATIVE SECTION	CDE_CLM_STATUS
25	Details	Indicates the number of detail service lines on the claim	Field	Number	9	SEE NARRATIVE SECTION	NUM_DTL_TOTAL
26	Billed	Amount of money requested for payment by a provider for services rendered. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_BILLED
27	Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, and so on.). Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_NET_BILLED
28	Spenddown	Amount of money that the member is responsible for paying for services. Format 9999999.99	Field	Number	9	SEE NARRATIVE SECTION	AMT_PATNT_LIAB
29	Reimbursed	Total amount the provider receives. Format 9999999.99	Field	Number	9	T_PD_DNTL_HDR	AMT_PAID
30	Paid	Amount paid on claim. This value is computed by adding up all the AMT_PAID values on the related details. Format 999999.99	Field	Number	8	T_CLM_PGM_XREF	AMT_PAID
31	TPL	Amount paid by third party for services. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	TPL_AMT
32	Total TPL	The total Claim TPL amount equals the sum of the Header and Detail amounts. Format 999999.99	Field	Number	8	N/A	N/A

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
33	TPL Recovered Amt	The recovery amount populated from the settlement panel. Format 9999999.99	Field	Number	9	T_TPL_AR_CLM_XREF	AMT
34	Total Copay	Total Copay Amount. Format 9999999.99	Field	Number	9	SEE NARRATIVE SECTION	AMT_CO_PAY

4.2.80.6 Field Edits

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

4.2.81 PANEL: Dental Claim Navigation

4.2.81.1 Description

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

Navigation Path: [Claims -Information] - [Enter an ICN for a Dental claim];

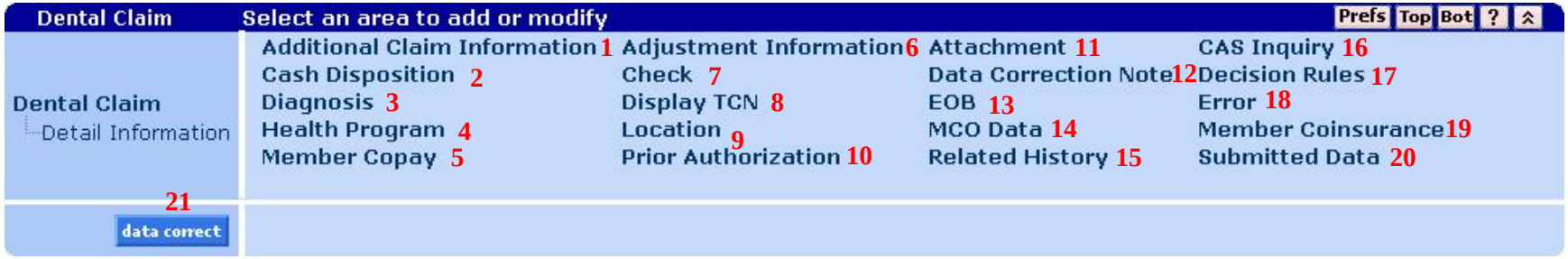
OR - [Claims -Search] - [Enter Criteria] - [Select a Dental claim];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a Dental claim from the list].

4.2.81.2 Panel Name

Dental Claim Navigation

4.2.81.3 Dental Claim Navigation Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

The Dental Claim Maintenance panel will display.

4.2.81.4 Extra Features

This panel has no extra features.

4.2.81.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Additional Claim Information	Link to "Additional Claim Information" panel	Hyperlink	N/A	0	N/A	N/A
2	Cash Disposition	Link to "Cash Disposition" panel	Hyperlink	N/A	0	N/A	N/A
3	Diagnosis	Link to "Diagnosis" panel	Hyperlink	N/A	0	N/A	N/A
4	Health Program	Link to "Health Program" panel	Hyperlink	N/A	0	N/A	N/A
5	Member Copay	Link to "Member Copay" panel	Hyperlink	N/A	0	N/A	N/A
6	Adjustment Information	Link to "Adjustment Information" panel	Hyperlink	N/A	0	N/A	N/A
7	Check	Link to "Check" panel	Hyperlink	N/A	0	N/A	N/A
8	Display TCN	Link to "Display TCN" panel	Hyperlink	N/A	0	N/A	N/A
9	Location	Link to "Location" panel	Hyperlink	N/A	0	N/A	N/A
10	Service/Prior Authorization	Link to "Service/Prior Authorization" panel	Hyperlink	N/A	0	N/A	N/A
11	Attachment	Link to "Attachment" panel	Hyperlink	N/A	0	N/A	N/A
12	Data Correction Note	Link to "Data Correction Note"	Hyperlink	N/A	0	N/A	N/A
13	EOB	Link to "EOB" panel	Hyperlink	N/A	0	N/A	N/A
14	MCO Data	Link to "MCO Data"	Hyperlink	N/A	0	N/A	N/A

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
15	Related History	Link to "Related History" panel	Hyperlink	N/A	0	N/A	N/A
16	CAS Inquiry	Link to "CAS Inquiry"	Hyperlink	N/A	0	N/A	N/A
17	Decision Rules	Link to "Decision Rules"	Hyperlink	N/A	0	N/A	N/A
18	Error	Link to "Error" panel	Hyperlink	N/A	0	N/A	N/A
19	Member Coinsurance	Link to "Member Coinsurance"	Hyperlink	N/A	0	N/A	N/A
20	Submitted Data	Link to "Submitted Data" panel	Hyperlink	N/A	0	N/A	N/A

4.2.81.6 Button Descriptions

Button No	Button	Description
21	Data Correct	This button displays for claims in suspended status. Clicking the Data Correct button opens up the displayed suspended claim in Data Correction mode. Changes can be made and the claim can be resubmitted

4.2.81.7 Field Edits

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

4.2.82 PANEL: PANEL: Additional Claim Information

4.2.82.1 Description

Allows the user to examine additional information submmited on the claim including the information that is used to determine the correct service location to assign to a claim.

Navigation Path: [Claims - Search] - [Enter Criteria] - [Select a Claim] - [Select Additional Claim Information]

Tables: T_CLM_ENTITY, T_PARTY_IDENTIFIER, T_CLM_NAME_N1, T_CLM_ADR_N3_N4

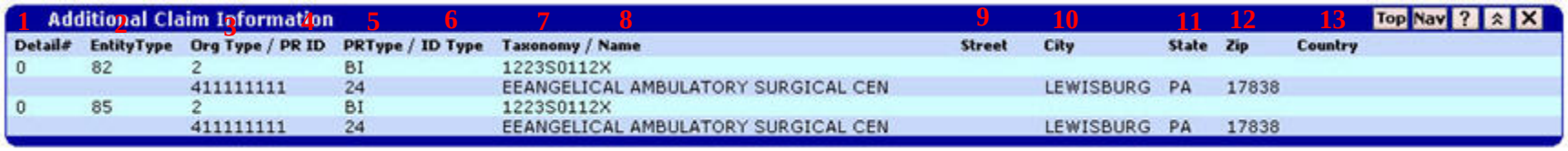
4.2.82.2 Technical Name

Clm.AdditionalClaimInformationPanel.ascx

4.2.82.3 Panel Name

Additional Claim Information

4.2.82.4 Additional Claim Information Layout



Detail#	EntityType	Org Type / PR ID	PRType / ID Type	Taxonomy / Name	Street	City	State	Zip	Country
0	82	2	BI	1223S0112X					
		411111111	24	EEANGELICAL AMBULATORY SURGICAL CEN		LEWISBURG	PA	17838	
0	85	2	BI	1223S0112X					
		411111111	24	EEANGELICAL AMBULATORY SURGICAL CEN		LEWISBURG	PA	17838	

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Additional Claim button located in the navigation / maintenance panel.

4.2.82.5 Extra Features

This panel has no extra features.

4.2.82.6 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Detail Number	The number of the detail on the claim record.	4	Number	T_CLM_ENTITY	NUM_DTL
2	Entity Type	Indicates the type of the Party Entity.	3	Character	T_CLM_ENTITY	QLF_ENTITY_TYPE
3	Org Type	Indicates whether the entity is a person or a non-person.	2	Character	T_CLM_ENTITY	QLF_TYPE_ORG
4	PR ID	The unique identifier for the entity type specified by the qualifier.	80	Character	T_PARTY_IDENTIFIER	CDE_PARTY_ID
5	PR Type	The type of practice for a provider.	3	Character	T_CLM_ENTITY	CDE_PROVIDER_TYPE
6	ID Type	Indicates the identification code qualifier.	2	Character	T_PARTY_IDENTIFIER	QLF_ID_TYPE
7	Taxonomy	The Referring Provider Taxonomy or Provider Specialty.	30	Character	T_CLM_ENTITY	CDE_PROV_TAXONOMY
8	Name	The last, first, middle & suffix name of the Member/Provider or the name of the Organization.	65	Character	T_CLM_NAME_N1	NAM_LAST, NAM_FIRST, NAM_MIDDLE
9	Street	The address of the Member/Provider.	55	Character	T_CLM_ADR_N3_N4	ADR_STREET_1, ADR_STREET_2

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
10	City	The city associated with the address for the Member/Provider.	30	Character	T_CLM_ADR_N3_N4	ADR_CITY
11	State	The state associated with the address for the Member/Provider.	2	Character	T_CLM_ADR_N3_N4	ADR_STATE
12	Zip	The zip code associated with the address for the Member/Provider.	15	Character	T_CLM_ADR_N3_N4	ADR_ZIP_CODE
13	Country	The country associated with the address for the Member/Provider.	3	Character	T_CLM_ADR_N3_N4	ADR_COUNTRY

4.2.82.7 Field Edits

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

4.2.83 PANEL: Cash Disposition

4.2.83.1 Description

Use the Cash Disposition panel to access cash related information for a particular adjustment. It displays the Cash Control Number (CCN), sequence number, and the refund (disposition) amount of the adjustment claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Cash Disposition link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Cash Disposition link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Cash Disposition link from the displayed panel].

4.2.83.2 Panel Name

Cash Disposition (Correction allows the financial page to save information that populates this panel.)

4.2.83.3 Cash Disposition Layout

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Cash Disposition button located in the navigation / maintenance panel.

4.2.83.4 Extra Features

This panel has no extra features.

4.2.83.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	CCN	The cash control number (CCN) associated with the adjustment transaction	Field	Character	11	T_EXPENDITURE	SAK_CASH_RECEIPT

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
2	Sequence	The disposition sequence number associated with the line. Each individual disposition to a check is given its own sequence number	Field	Number	4	T_CASH_RCPT_XREF	NUM_SEQ_BATCH
3	Disposition Amount	The refund (disposition) amount for the line	Field	Number	10	T_CASH_RCPT_XREF	AMT_DISPOSITION

4.2.83.6 Field Edits

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

4.2.84 PANEL: Diagnosis

4.2.84.1 Description

The Diagnosis panel displays the diagnosis codes applicable to the claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Diagnosis link from the displayed panel];

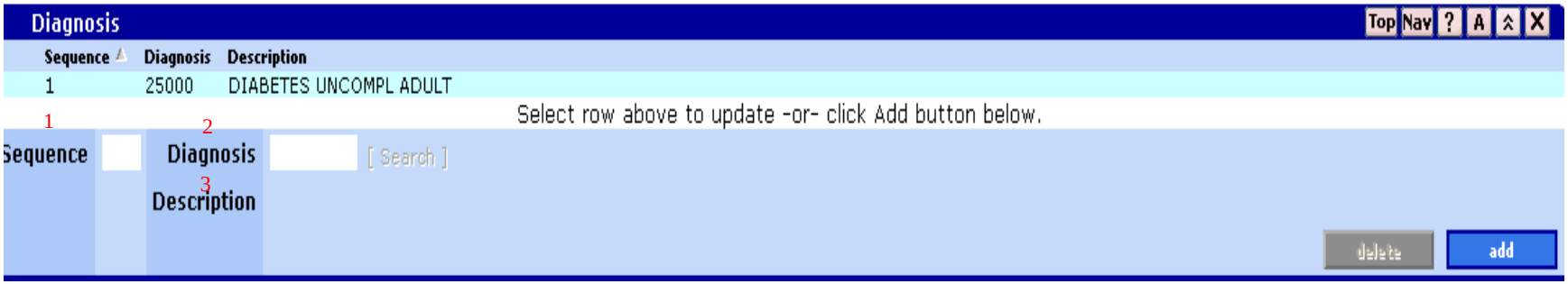
OR - [Claims -Search] - [Enter Criteria] - [[Select a claim] - [Select Diagnosis link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Diagnosis link from the displayed panel].

4.2.84.2 Panel Name

Diagnosis

4.2.84.3 Diagnosis Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Diagnosis button located in the navigation / maintenance panel.

This panel displays the diagnosis codes applicable to the claim.

4.2.84.4 Extra Features

This panel has no extra features.

4.2.84.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Sequence	Sequence numbers for the diagnosis codes. The Admitting diagnosis has a value of 'A' in the Sequence column. Primary diagnosis has a value of '1'. Other diagnosis codes have a value of '2' through '24'. Emergency diagnosis has an 'E' in the Sequence column	Field	Number	2	T_CLM_DIAG_XREF	CDE_DIAG_SEQ
2	Diagnosis	Indicates the diagnosis codes applicable to the claim. Diagnosis code is a code for the condition requiring medical attention	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
3	Description	Description of the diagnosis code	Field	Character	50	T_DIAGNOSIS	DSC_25

4.2.84.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Diagnosis	Field	1	Invalid Diagnosis Code.	Enter a valid diagnosis code or select a code from the [Search] panel.
2	Diagnosis	Field	100	Exceed maximum number of diagnosis codes.	The maximum number of diagnosis codes for this claim type has been exceeded.

4.2.85 PANEL: Health Program

4.2.85.1 Description

Use the Health Program panel to display the program information for a claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Health Program link from the displayed panel];

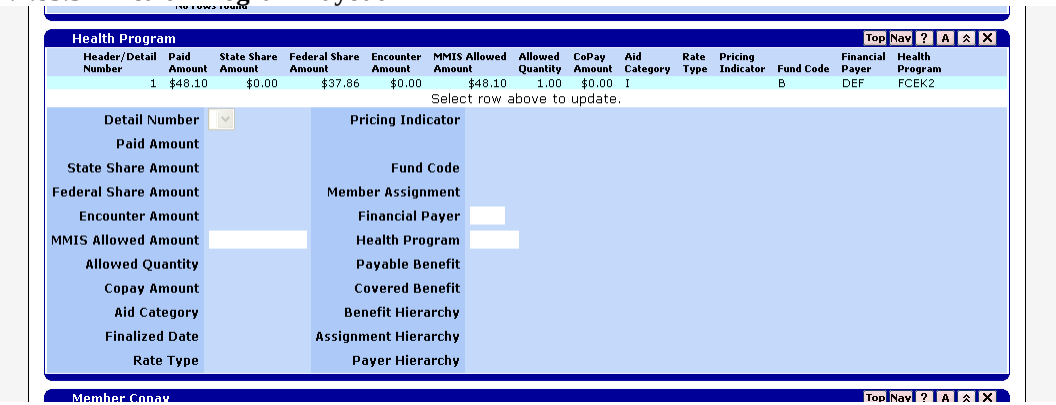
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Health Program link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Health Program link from the displayed panel].

4.2.85.2 Panel Name

Health Program

4.2.85.3 Health Program Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Health Program button located in the navigation / maintenance panel.

This panel displays the program information applicable to the claim. Program information could include copay amounts, Medicare indicators, managed care indicators and financial payers. In the Data Correction page, this panel allows codes to be added.

4.2.85.4 Extra Features

This panel has no extra features.

4.2.85.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Header/Detail Number	Indicates if the row pertains to the claim header or a claim detail line. The claim header is denoted by a zero	Field	Number	3	T_CLM_PGM_XREF	NUM_DTL
1	Detail Number	Indicates if the row pertains to the claim header or a claim detail line. The claim header is denoted by a zero	Field	Drop Down List Box	0	T_CLM_PGM_XREF	NUM_DTL
2	Paid Amount	This is the amount that is applied toward the check amount. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_PAID
3	State Share Amount	This is the amount that is applied toward the check amount. Format 99999999.99 ‘‘NOT USED IN KY”	Field	Number	10	T_CLM_PGM_XREF	AMT_STATE_SHARE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
4	Federal Share Amount	This is the amount of federal share for this payment. Format 99999999.99 ‘‘NOT USED IN KY”	Field	Number	10	T_CLM_PGM_XREF	AMT_FEDERAL_SHARE
5	Encounter Amount	This contains the amount for encounter services on the claim detail indicated by the detail number on the table. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_ENCOUNTER
6	Allowed Amount	Amount approved to pay for services provided. Format 9999999.99	Field	Number	9	T_CLM_PGM_XREF	AMT_ALWD
7	Allowed Quantity	Number of units of service that are paid under a financial payer/benefit plan. Format 9999.99	Field	Number	6	T_CLM_PGM_XREF	QTY_ALLOWED
8	Copay Amount	This is the amount of copay that is subtracted from the allowed amount. Format 99999.99	Field	Number	7	T_CLM_PGM_XREF	AMT_CO_PAY
9	Aid Category	Aid Category for Medicaid coverage	Field	Number	9	T_CDE_AID	CDE_AID_CATEGORY
10	Finalized Date	Date the financial finalizes the claim for this Payer	Field	Date (MM/DD/CCYY)	8	T_CLM_PGM_XREF	DTE_FINAL

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
11	Rate Type	Code used to identify the rate type to use in determining provider reimbursement	Field	Character	3	T_CLM_PGM_XREF	CDE_RATE_TYPE
12	Pricing Indicator	Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced	Field	Character	1	T_CLM_PGM_XREF	IND_PRICING
13	Managed Care Indicator	Manage care indicator identifies claims and other transactions as to how they affect the manage care program	Field	Drop Down List Box	1	T_CLM_PGM_XREF	IND_MC
14	Fund Code	Indicates the budget category that the funds used to pay this claim/detail came from	Field	Number	9	T_FIN_FUND_CODE	CDE_FUND_CODE
15	Member Assignment	A group of covered services (benefits) where the member is assigned to a provider or provider organization in order to receive covered services (benefits)	Field	Number	9	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
16	Financial Payer	The financial payer description	Field	Number	9	T_FINANCIAL_PAYER	CDE_FIN_PAYER

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
17	Health Program	Name of program the header/detail was processed and/or paid under	Field	Character	50	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
18	Payable Benefit	This is the unique system-assigned that identifies each row on this table	Field	Number	9	T_CLM_PGM_XREF	SAK_PAYABLE_BNFT
19	Covered Benefit	System-assigned Key used to identify a unique row for a benefit covered by a member plan. This identifies a row to be ignored for this benefit	Field	Number	9	T_CLM_PGM_XREF	SAK_COVERED_BNFT
20	Benefit Hierarchy	An assignment hierarchy is an ordered set of assignment plans for which a member/beneficiary 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	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD
21	Assignment Hierarchy	A set of assignment plans for which a member/beneficiary may be assigned concurrently	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD_ASSIGNMENT

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
22	Payer Hierarchy	Payer Hierarchy identifies 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	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD_PAYER

4.2.85.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
6	Allowed Amount	Field	1	Enter a valid Value.	Allowed Amount must be numeric.
16	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid financial payer or select a value from the [Search] panel.
19	Covered Benefit	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select a value form the [Search] panel.

4.2.86 PANEL: Member Copay

4.2.86.1 Description

Allows the user to examine the copay accumulation for a member.

Navigation Path: [Claims - Search] - [Enter Criteria] - [Select Member Copay]

Table :T_CLM_COPAY_X

4.2.86.2 Technical name

Clm.ClaimMemberCopayHdrPanel.ascx

4.2.86.3 Panel name

Claim Member Copay

4.2.86.4 Member Copay Panel Layout

Member Copay

Header/Detail Number 1	Financial Payer 2	Year Month Date 3	4 Status	5 Copay Value 6	Copay Amount	7 FDOS	TDOS 8
0	DEF	0	Active	Deduct and Accumulate	$15.00	03/01/2005	03/01/2005
1	DEF	0	Active	Deduct and Accumulate	$30.00	03/02/2005	03/02/2005

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Member Copay button located in the navigation / maintenance panel.

4.2.86.5 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Header/Detail Number	The number of the detail on the claim record.A zero represents the header	4	Number	T_CLM_COPAY_X	NUM_DTL

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
2	Financial Payer	The system-assigned value that identifies a unique payer within interChange.	9	Number	T_CLM_COPAY_X	SAK_FIN_PAYER
3	Year Month Date	This is the year and month of the date of service of the claim that used copay	9	Number	T_CLM_COPAY_X	DTE_YEAR_MTH
4	Status	Indicates if the record/row is active or inactive. The row becomes inactive only after an adjustment to the claim is released. Only use active ('A') to accumulate copay. Values are: 'A' - Active; 'I' - Inactive	1	Character	T_CLM_COPAY_X	CDE_STATUS1
5	Copay Value	Determines if the row has actual copay deducted from the claim or if the copay was just additive and not deducted from the claim. Values are: 'DA' - Deduct and accumulate copay 'OA' - Only accumulate copay	2	Character	T_CLM_COPAY_X	CDE_DEDUCT_ACCUM_COPAY
6	Copay Amount	The copay amount paid by the member for services rendered	9	Number	T_CLM_COPAY_X	AMT_COPAY

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
7	FDOS	The beginning date of service for the claim	8	Number	T_CLM_COPAY_X	DTE_FIRST_SVC
8	TDOS	The last date of service for the claim.	8	Number	T_CLM_COPAY_X	DTE_LAST_SVC

4.2.86.6 Field edits

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

4.2.87 PANEL: Adjustment Information - Daughter or Mother

4.2.87.1 Description

The Adjustment Information panel displays the daughter claim if the claim being displayed has been adjusted. It will display the mother claim if the claim being displayed is an adjustment claim.

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

This panel is populated from the following tables depending on Claim Type: T_ADJ_PHYS_XREF, T_ADJ_PHRM_XREF, T_ADJ_UB92_XREF, T_ADJ_DNTL_XREF, T_SUSP_ADJ_XREF

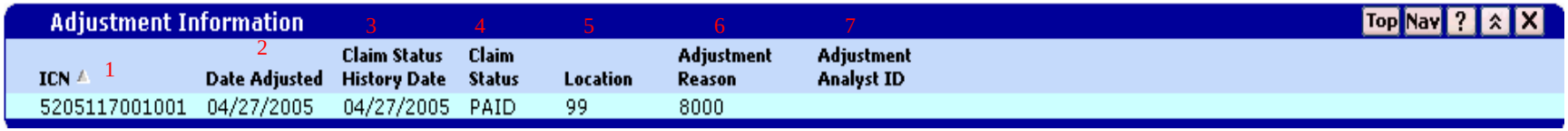
4.2.87.2 Technical Name:

Clm.AdjustmentInformation-DaughterorMother.ascx

4.2.87.3 Panel Name

Adjustment Information

4.2.87.4 Adjustment Information - Daughter or Mother Layout



Adjustment Information

ICN (1)	Date Adjusted (2)	Claim Status History Date (3)	Claim Status (4)	Location (5)	Adjustment Reason (6)	Adjustment Analyst ID (7)
5205117001001	04/27/2005	04/27/2005	PAID	99	8000	

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Adjustment Information button located in the navigation / maintenance panel.

This panel displays the previous claim information of an adjusted claim or the present claim information if the claim has been adjusted.

4.2.87.5 Extra Features

This panel has no extra features.

4.2.87.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	ICN	Internal control number which uniquely identifies a claim	Field	Character	13	SEE NARRATIVE SECTION	NUM_ICN_FL
2	Date Adjusted	Date on which adjustment request was initiated	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_ADJUSTED
3	Claims Status History Date	Date on which a claim was processed	Field	Date (MM/DD/CCYY)	8	T_HIST_DIRECTORY	DTE_PAID
4	Claim Status	The status of the claim, example "PAID"	Field	Character	10	T_HIST_DIRECTORY	CDE_CLM_STATUS
5	Location	Location code of the claim	Field	Character	2	T_CLAIM_LOCAT	CDE_LOCATION
6	Adjustment Reason	Code identifying the detailed reason the adjustment was made	Field	Character	4	SEE NARRATIVE SECTION	CDE_EOB
7	Adjustment Analyst ID	Identification of the clerk that generated the adjustment request	Field	Character	8	SEE NARRATIVE SECTION	ID_CLERK

4.2.87.7 Field Edits

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

4.2.88 PANEL: Adjustment Reason Code

4.2.88.1 Description

Allows the user to review adjustment reason codes listed on encounters.

Navigation Path: [Claims - Search] - [Enter Criteria] - [Select a Claim] - [Select Adjustment Reason Code]

Tables: T_CLM_CAS, T_CDE_HIPAA_ADJRSN

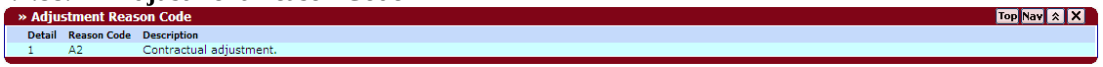
4.2.88.2 Technical Name

Clm.AdditionalClaimInformationPanel.ascx

4.2.88.3 Panel Name

Adjustment Reason Code

4.2.88.4 Adjustment Reason Code



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Adjustment Reason Code button located in the navigation / maintenance panel.

4.2.88.5 Extra Features

This panel has no extra features.

4.2.88.6 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Detail	Encounter detail number.	3	Character	t_clm_cas	NUM_DTL

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
2	Reason Code	Adjustment Reason Codes from MCO/Passport-denied encounters and/or partially paid encounters with denied details.	4	Character	t_clm_cas	CDE_CLM_ADJ_REASON
3	Descreption	Adjustment Reason Code description.	100	Character	t_cde_hipaa_adjrsn	DSC_ADJ_RSN

4.2.88.7 Field Edits

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

4.2.89 PANEL: Check

4.2.89.1 Description

Use the Check panel to view the total amount paid from the Remittance Advice (RA) for a specific claim. To view the detail of the check, click on the row to display the Payment Information panel.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Check link from the displayed panel];

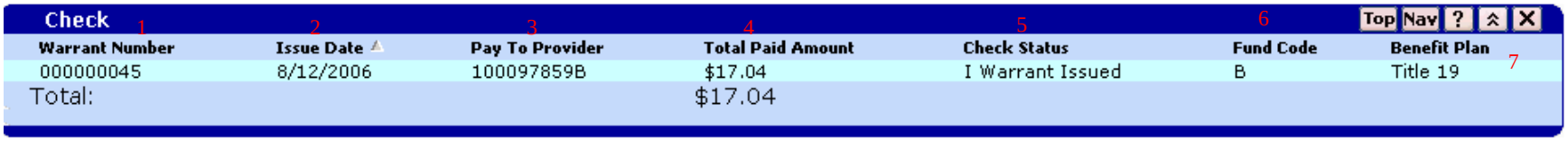
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Check link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Check link from the displayed panel].

4.2.89.2 Panel Name

Check

4.2.89.3 Check Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Check button located in the navigation / maintenance panel.

This panel is populated if the claim is paid.

4.2.89.4 Extra Features

This panel has no extra features.

4.2.89.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
	Service Location	The pay to provider's service location code	Field	Character	1	T_CHECK	CDE_SERVICE_LOC
1	Warrant Number	This field displays the number of the check that the provider received, or the number of the Electronic Funds Transfer	Field	Number	9	T_CHECK	NUM_CHECK
2	Issue Date	The date when the check was issued or the EFT was sent	Field	Date (MM/DD/CCYY)	8	T_CHECK	DTE_ISSUE
3	Pay To Provider	The Provider ID who received the check or EFT	Field	Character	9	T_PR_PROV	ID_PROVIDER
4	Total Paid Amount	The total amount that was issued to the provider	Field	Number	11	T_CHECK	TOTAL_AMT_PAID
5	Check Status	The status of the check. Examples are: An 'I' indicates the check has been issued, a 'V' indicates a VOID, an 'R' indicates the check was reissued, a 'C' indicates a check has cleared the bank, an 'S' indicates Stopped and an 'X' for Cancelled by Statute	Field	Character	30	T_CHECK	CDE_STATUS1
6	Fund Code	The Fund Code assigned to the check or EFT	Field	Character	3	T_CHCK_CLM_XREF	SAK_FUND_CODE
7	Benefit Plan	The Benefit Plan associated with the check or EFT	Field	Character	30	T_CHCK_CLM_XREF	SAK_PUB_HLTH

4.2.89.6 Field Edits

Field	Field Type	Error Code	Error Message	To Correct

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

4.2.90 PANEL: Category of Service

4.2.90.1 Description

The Category of Service panel displays the category of service codes assigned to the claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Category of Service link from the displayed panel];

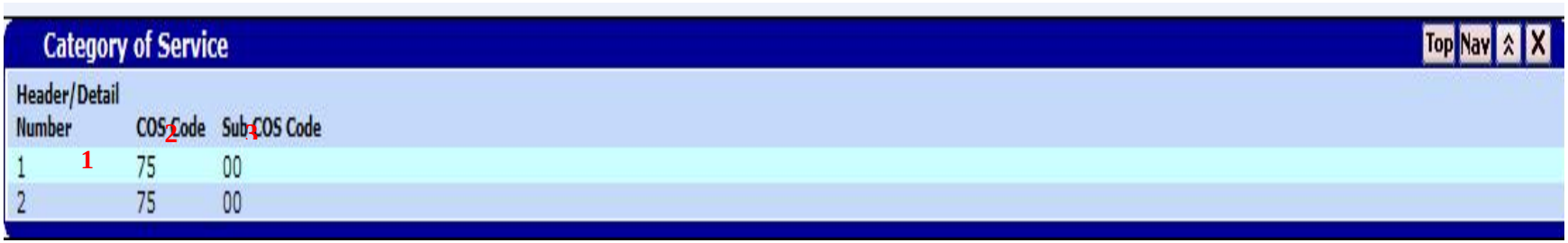
OR - [Claims -Search] - [Enter Criteria] - [[Select a claim] - [Select category of Service link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select category of Service link from the displayed panel].

4.2.90.2 Panel Name

Category of Service

4.2.90.3 Category of Service Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the category of Service button located in the navigation / maintenance panel.

This panel displays the category of service codes assigned to the claim.

Extra Features

This panel has no extra features.

4.2.90.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Sequence	Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.	Field	Number	2	T_COS_DTL_XREF	NUM_DTL
2	COS Code	Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.	Field	Number	2	T_COS_DTL_XREF	CDE_COS_ST
3	Sub COS Code	Code for a sub-category of service (COS) that provides a more detailed State Category of Service classification in MAR state reporting.	Field	Number	2	T_COS_DTL_XREF	CDE_COS_SUB

4.2.90.5 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
None					

4.2.91 PANEL: Display TCN

4.2.91.1 Description

The Display TCN panel shows the Transaction Control Number (TCN) associated with the claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Display TCN link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Display TCN link from the displayed panel;

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Display TCN link from the displayed panel].

4.2.91.2 Panel Name

Display TCN

4.2.91.3 Display TCN Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Display TCN button located in the navigation / maintenance panel.

This panel displays the Transaction Control Number associated with the claim from the previous MMIS system.

4.2.91.4 Extra Features

This panel has no extra features.

4.2.91.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	TCN	The transaction control number used to uniquely identify claims on the previous MMIS	Field	Character	17	T_TCN_XREF	NUM_TCN

4.2.91.6 Field Edits

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

4.2.92 PANEL: Encounter Data

4.2.92.1 Description

The Encounter Data panel displays the name of the Encounter Batch File on which the encounter was received.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Display TCN link from the displayed panel];

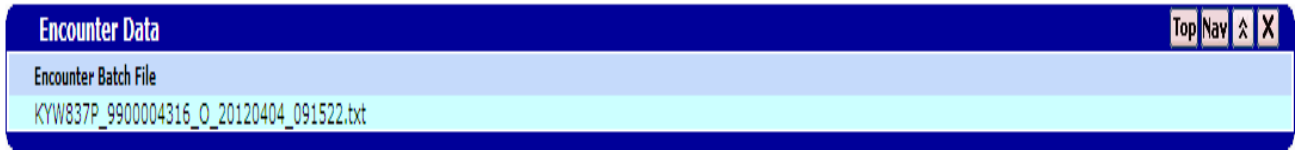
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Display TCN link from the displayed panel;

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Display TCN link from the displayed panel].

4.2.92.2 Panel Name

Encounter Data

4.2.92.3 Encounter Data Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Encounter Data button located in the navigation / maintenance panel.

This panel displays the name of the Encounter Batch File on which the encounter was received.

4.2.92.4 Extra Features

This panel has no extra features.

4.2.92.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Encounter Batch File	The name of the Encounter Batch File on which the encounter was received	Field	Character	40	T_FILE_TRACK	NAME_FILE

4.2.92.6 Field Edits

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

4.2.93 PANEL: Location

4.2.93.1 Description

The Location panel displays claim location information. When opened from an inquiry panel, the Claim Location panel is not updateable. However, when opened from a data correction panel, the new and save buttons are displayed allowing the user to add a location. The user can route the claim to another department for correction. This panel is shared by all claim types.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Location link from the displayed panel];

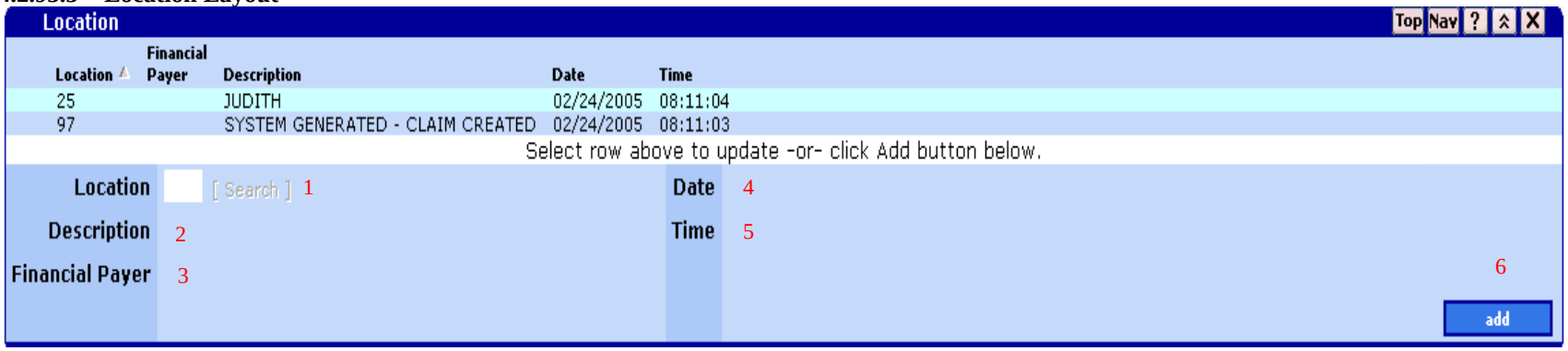
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Location link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Location link from the displayed panel].

4.2.93.2 Panel Name

Location

4.2.93.3 Location Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Location button located in the navigation / maintenance panel.

This panel displays the claim location information pertaining to which department is reviewing claim. In the Data Correction page, this panel allows codes to be added so the claim can be routed to another department for correction.

4.2.93.4 Extra Features

This panel has no extra features.

4.2.93.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Location	Indicates claim location within the claims processing system	Field	Character	2	T_CLAIM_LOCAT	CDE_LOCATION
2	Description	Description of the location from that financial payer	Field	Character	50	T_CLAIM_LOCAT	CDE_CLM_TYPE
3	Financial Payer	The Financial Payer Information	Field	Character	10	T_FINANCIAL_PAYER	CDE_FIN_PAYER
4	Date	The date that the claim went to this location	Field	Date (MM/DD/CCYY)	8	T_CLAIM_LOCAT	DTE_CLM_LOCAT
5	Time	The time that the claim went to this location	Field	Number	8	T_CLAIM_LOCAT	TIME_SYSTEM
6	Add	Add a location record	Button	N/A	0	N/A	N/A

4.2.93.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Location	Field	1	Invalid Location Code.	Enter a valid Location Code or select a code from the [Search] panel.

4.2.94 PANEL: Service/Prior Authorization

4.2.94.1 Description

The Prior Authorization panel displays the prior authorization applicable to the claim. This panel includes the the amount and units used in the claim.

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

Tables: T_PA_ITEM_DTL_XREF, T_PA_PAUTH, T_FINANCIAL_PAYER

4.2.94.2 Technical Name

Clm.ClaimPriorAuth.ascx

4.2.94.3 Panel Name

Prior Authorization

4.2.94.4 Service/Prior Authorization Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Prior Authorization button located in the navigation / maintenance panel.

This panel displays the PA information applicable to the claim.

4.2.94.5 Extra Features

This panel has no extra features.

4.2.94.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	Detail to which Service/Prior Authorization has been applied	Field	Number	9	T_PA_ITEM_DTL_XREF	NUM_DTL
2	PA Number	This is the number assigned by the PA unit to a Service/Prior Authorization request	Field	Character	10	T_PA_PAUTH	PRIOR_AUTH_NUM
3	Line Item	Prior Authorization Line Item number	Field	Character	3	T_PA_ITEM_DTL_XREF	NUM_PA_LINE_ITEM
4	Financial Payer	A code used to identify the financial payer	Field	Number	9	T_FINANCIAL_PAYER	CDE_FIN_PAYER
5	Units Used	Prior Authorization units applied to the claim	Field	Number	6	T_PA_ITEM_DTL_XREF	QTY_UNT_SVC_USD
6	Amount Used	Prior Authorization amount applied to the claim. Format 99999999.99	Field	Number	9	T_PA_ITEM_DTL_XREF	AMT_PA_USED
7	Status	Indicates the status of the claim within the system	Field	Character	1	T_PA_ITEM_DTL_XREF	CDE_STATUS1

4.2.94.7 Field Edits

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

4.2.95 PANEL: Attachment

4.2.95.1 Description

The Attachment panel displays the attachment control numbers that are applicable to the claim.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Attachments link from the displayed panel];

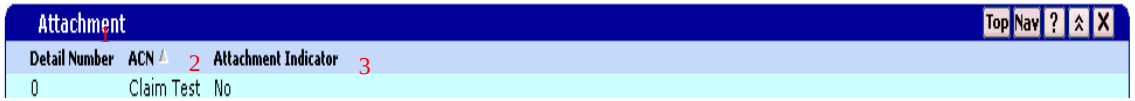
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Attachments link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Attachments link from the displayed panel].

4.2.95.2 Panel Name

Attachment

4.2.95.3 Attachment Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Attachment button located in the navigation / maintenance panel.

This panel is populated if an attachment was received with the claim.

4.2.95.4 Extra Features

This panel has no extra features.

4.2.95.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The detail number of a claim record	Field	Number	4	T_ATTACHMENT_XREF	NUM_DTL

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
2	ACN	The control number associated with an attachment that is being sent by the provider for an electronically submitted claim	Field	Character	80	T_ATTACHMENT_XREF	CDE_ATTACHMENT_CONTROL
3	Attachment Indicator	Indicates if the attachment has been received	Field	Character	3	T_ATTACHMENT_XREF	IND_ATTACH_RECEIVED

4.2.95.6 Field Edits

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

4.2.96 PANEL: Data Correction Note

4.2.96.1 Description

The Data Correction Note panel will be used by resolutions staff to forward questions to other clerks or to a supervisor. To send a note, the first user will enter a Location Code, type in a Note, and specify a second User ID into the Reviewer Sent To field. When a note is sent, the claim will be assigned to the new location code and the claim will show up in the new user's Data Correction Suspense list. The newly assigned user can display the note and enter a reply. They can send the claim back to the originator by creating a new Note, or they can reply to the first note and keep the claim assigned to themselves. If they do not create a new note and send it back to the originator of the first note, the claim will remain assigned to the second user. If necessary, the second user can send a new note to a third user. There is no limit to how many notes can be created. Each time a new note is created, the claims is assigned to the Reviewer Sent To user id.

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

Table: T_LOCATION_NOTE

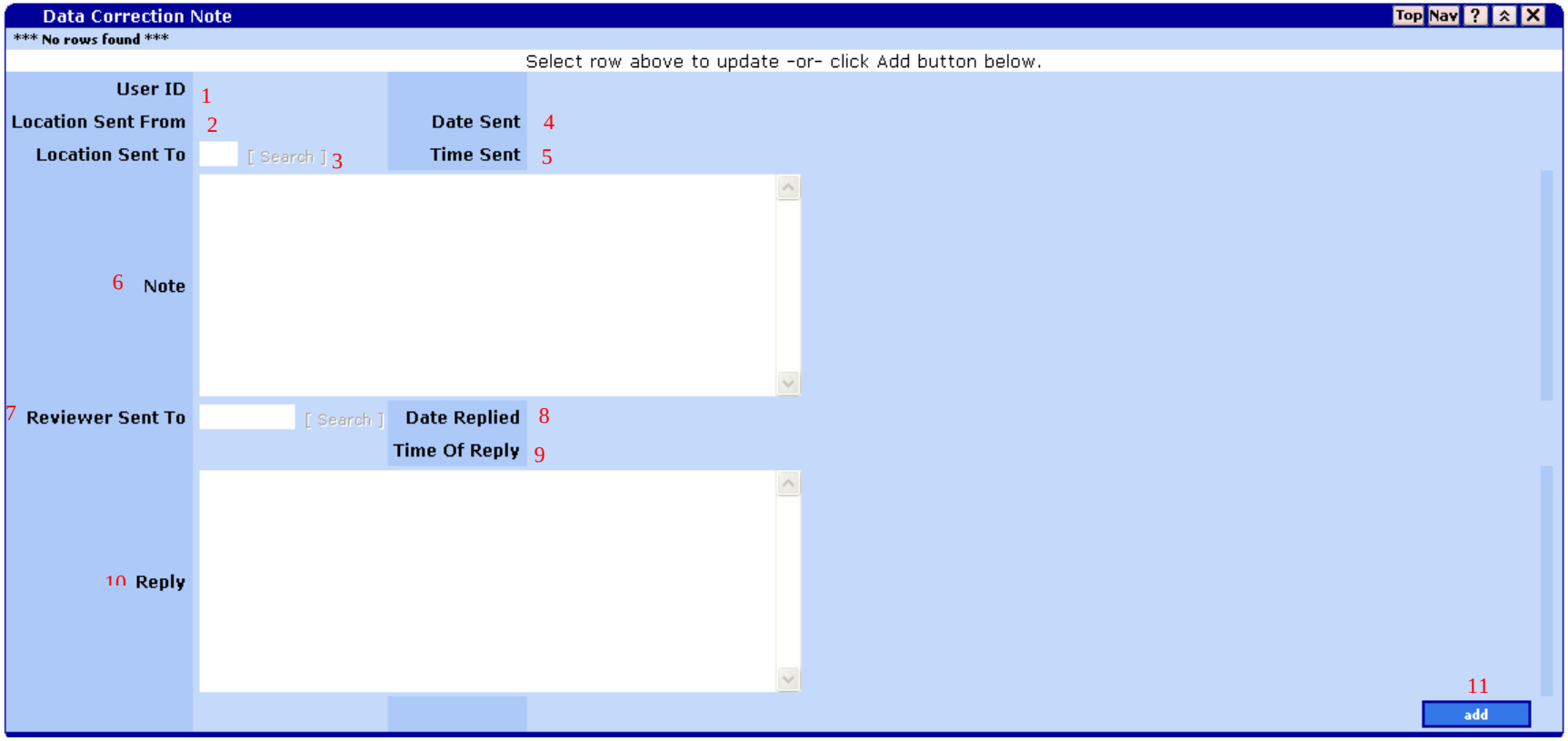
4.2.96.2 Technical Name

Clm.DataCorrectionNotePanel.ascx

4.2.96.3 Panel Name

Data Correction Note

4.2.96.4 Data Correction Note Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Data Correction Note button located in the navigation / maintenance panel.

In Data Corrections, this panel allows questions to be written and sent by location code to another department. It allows the note originator to access the note when an answer is submitted and take appropriate action to the claim.

4.2.96.5 Extra Features

This panel has no extra features.

4.2.96.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	User ID	The ID of the user (clerk) who originates the note	Field	Character	8	T_LOCATION_NOTE	ID_CLERK
2	Location Sent From	The location that the note originates from. The user is required to use the [Search] to select a value	Field	N/A	0	T_LOCATION_NOTE	CDE_LOC_FROM
3	Location Sent To	The location that the note is being sent to. The user is required to use the [Search] to select a value	Field	N/A	0	T_LOCATION_NOTE	CDE_LOC_TO
4	Date Sent	The date the note is sent	Field	Date (MM/DD/CCYY)	8	T_LOCATION_NOTE	DTE_SENT
5	Time Sent	The time that the note is sent	Field	Character	6	T_LOCATION_NOTE	TME_SENT
6	Note	The note that is sent	Field	Character	256	T_LOCATION_NOTE	DSC_NOTE
7	Reviewer Sent To	The ID of the person who reviews the note. The user is required to use the [Search] to select a value	Field	N/A	0	T_LOCATION_NOTE	ID_REVIEWER
8	Date Replied	The date the reply is sent	Field	Date (MM/DD/CCYY)	8	T_LOCATION_NOTE	DTE_REPLY
9	Time Of Reply	The time that the reply is sent	Field	Character	6	T_LOCATION_NOTE	TME_REPLY

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
10	Reply	The note containing the reply	Field	Character	256	T_LOCATION_NOTE	DSC_REPLY

4.2.96.7 Button Descriptions

Button No	Button	Description
11	Add	Add a new location note

4.2.96.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	Location Sent To	Field	1	Location Sent To is required.	Select a value for the Location from the [Search] panel.
6	Note	Field	1	Note is required.	Enter text for the note description.
7	Reviewer Sent To	Field	1	Reviewer Sent to is required.	Select a User ID from the [Search] panel.
8	Date Replied	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter the date in MM/DD/CCYY format.

4.2.97 PANEL: EOB

4.2.97.1 Description

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

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select EOB link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select EOB link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select EOB link from the displayed panel].

4.2.97.2 Panel Name

EOB

4.2.97.3 EOB Layout

EOB

Top Nav ? A

View ◉ All ○ Current ○ Historical

Detail Number	EOB Code	EOB Description	Financial Payer	Benefit Plan	Status	Origin	Hipaa Adj Reason Code	Remark Code	Adjustment Amount	Adjusted Units
0	0379	PAID BY MEDICAID	DEF	FCEK2	Historical	System Generated	42	MA125	$0.00	0.000
1	0061	PAID IN FULL BY MEDICAID.	DEF	FCEK2	Historical	System Generated	42	MA125	$0.00	0.000

Select row above to update.

Detail Number
EOB Code
EOB Description
Financial Payer
Benefit Plan
Status Current
Origin System Generated
HIPAA Adj Reason Code
Adj Reason Description
Remark Code
Remark Description
Adjustment Amount
Adjusted Units

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the EOB button located in the navigation / maintenance panel.

This panel displays the EOB codes applicable to the claim. In the Data Correction page, this panel allows codes to be added or deleted.

4.2.97.4 Extra Features

This panel has no extra features.

4.2.97.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The detail number to which the EOB message is attached	Field	Number	4	T_CLM_EOB_XREF	NUM_DTL
2	HIPAA Adjustment Reason	The HIPAA reason for the adjustment	Field	Drop Down List Box	0	T_CDE_HIPAA_ADJRSN	CDE_ADJ_RSN
3	EOB Code	Code number attached to an EOB message	Field	Character	4	T_EOB	CDE_EOB
4	Remark Code	The code for the remarks	Field	Drop Down List Box	0	T_CDE_HIPAA_REMRKS	CDE_REMARK
5	EOB Description	First line of text description for EOB code	Field	Character	79	T_EOB	DSC_EOB
6	Adjustment Amount	The dollar amount adjusted on the detail. Format 9999999.99	Field	Number	9	T_CLM_EOB_XREF	AMT_ADJUSTED
7	Financial Payer	A value that identifies a unique payer within interChange	Field	Drop Down List Box	0	T_CLM_EOB_XREF	SAK_FIN_PAYER
8	Adjusted Units	The quantity adjusted on the detail. Format 9999999.999	Field	Number	10	T_CLM_EOB_XREF	QTY_ADJUSTED
9	Benefit Plan	Identifies the medical assistance program that is supported in the system	Field	Drop Down List Box	0	T_CLM_EOB_XREF	SAK_PUB_HLTH

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
10	Origin	Indicates who generated the EOB code and message	Field	Character	6	T_CLM_EOB_XREF	CDE_STATUS1
11	Status	Indicates whether the EOB is current or history	Field	Character	7	T_CLM_EOB_XREF	CDE_STAT_ERROR

4.2.97.6 Button Descriptions

Button No	Button	Description
12	Delete	Deletes a record
13	Add	Adds a new record

4.2.97.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
7	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer of select one from the [Search] panel.
9	Benefit Plan	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select one from the [Search] panel.

4.2.98 PANEL: MCO Data

4.2.98.1 Description

The MCO Data panel displays Managed Care Organization (MCO) data related to encounter claims.

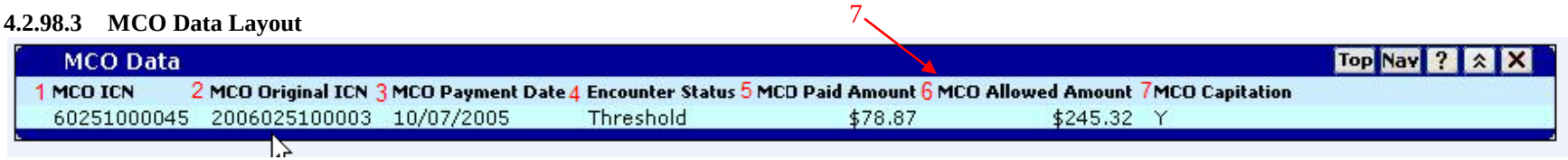
Navigation Path: [Claims -Information] - [Enter an ICN for an Encounter Claim] - [Select MCO Data link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select an Encounter Claim claim] - [Select MCO Data link from the displayed panel].

4.2.98.2 Panel Name

MCO Data (Defect 3680 under review. MCO ID currently has no correct IDs populated in drop down box in encounter page to allow this panel to populate).

4.2.98.3 MCO Data Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the MCO Data button located in the navigation / maintenance panel.

4.2.98.4 Extra Features

This panel has no extra features.

4.2.98.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	MCO ICN	Internal Control Number of the MCO claim.(when qlf_reference_id ='D9' and num_dtl = 0).	Field	Number	13	T_CLM_REF	CDE_REF_ID

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
2	MCO Original ICN	Original MCO Internal Control Number for voids and adjustments. (when qlf_reference_id ='F8' and num_dtl = 0).	Field	Number	13	T_CLM_REF	CDE_REF_ID
3	MCO Payment Date	Date the MCO paid encounter claim.	Field	Date (MM/DD/CCYY)	8	T_XXXX_OTH_PYR_HDR	DTE_CLM_ADJUDICATION
4	Encounter Status	Code which indicates the status of the encounter in the system as a result of interChange editing. The values will be T - Threshold, I - Informational or P - paid.	Field	Character	1	T_PD_XXXX_HDR OR T_DENY_XXXX_HDR	CDE_ENC_STATUS
5	MCO Paid Amount	MCO Paid Amount (when qlf_amount='D' and num_dtl = 0).	Field	Number	9	T_CLM_AMT	AMT_MONETARY
6	MCO Allowed Amount	Medicaid allowed amount, the result of re-pricing the encounter claim.(when qlf_amount='B6' and num_dtl = 0).	Field	Number	9	T_CLM_AMT	AMT_MONETARY
7	MCO Capitation	Capitation Indicator.	Field	Character	1	T_CLM_CN1	CDE_CONTRACT_TYPE

4.2.98.6 Field Edits

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

4.2.99 PANEL: MCO Detail Information

4.2.99.1 Description

The MCO Detail Information panel shows the detail MCO paid date(s) of the service(s) submitted on the encounter.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Display TCN link from the displayed panel];

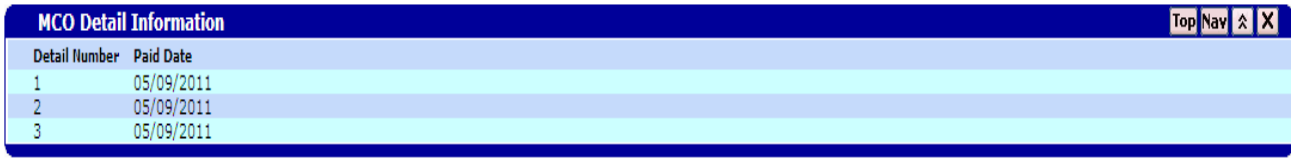
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Display TCN link from the displayed panel;

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Display TCN link from the displayed panel].

4.2.99.2 Panel Name

MCO Detail Information

4.2.99.3 MCO Detail Information Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the MCO Detail Information button located in the navigation / maintenance panel.

This panel displays the detail MCO paid date of the service(s) submitted on the encounter.

4.2.99.4 Extra Features

This panel has no extra features.

4.2.99.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The detail number associated to the MCO Paid Date	Field	Number	4	T_CLM_OTH_PYR_DTL	NUM_DTL
2	Paid Date	The detail MCO paid date of the service(s) submitted on the encounter	Field	Date (MM/DD/CCYY)	8	T_CLM_OTH_PYR_DTL	DTE_SERVICE_ADJUD

4.2.99.6 Field Edits

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

4.2.100 PANEL: Related History

4.2.100.1 Description

The Related History panel lists other claims that are related to the current claim. The panel is not updateable and is shared by all claim types. Use this panel to validate medical policy audits, duplicate payment audits, umbrella audits, limitation audits, and bundling and unbundling audits.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Related History link from the displayed panel];

OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Related History link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Related History link from the displayed panel].

4.2.100.2 Panel Name

Related History

4.2.100.3 Related History Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Related History button located in the navigation / maintenance panel.

This panel lists other claims associated to the applicable claim.

4.2.100.4 Extra Features

This panel has no extra features.

4.2.100.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Related ICN	Internal control number which uniquely identifies a claim	Field	Character	13	T_HIST_DIRECTORY	NUM_ICN_FL
2	Related Detail	Related detail information to the history claim displayed	Field	Number	3	T_HIST_DIRECTORY	NUM_DTL_RELATED
3	Error Code	Code used to indicate an error was discovered on a claim during processing in the base system	Field	Number	4	T_ERROR_DISP	CDE_ESC
4	Financial Payer	The description used to identify the financial payer for the related ICN	Field	Character	30	T_FINANCIAL_PAYER	CDE_FIN_PAYER
5	Benefit Plan	The medical assistance program associated with the related ICN	Field	Character	5	T_PUB_HLTH_PGM	SAK_PUB_HLTH

4.2.100.6 Field Edits

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

4.2.101 PANEL: CAS Inquiry

4.2.101.1 Description

The CAS Inquiry panel displays the Claim Level Adjustment Segments (CAS) information applicable to the claim or encounter.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select CAS Inquiry link from the displayed panel];

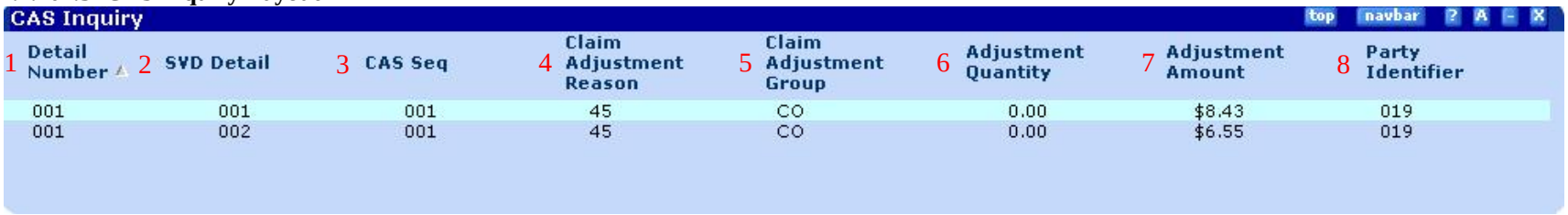
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select CAS Inquiry link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select CAS Inquiry link from the displayed panel].

4.2.101.2 Panel Name

CAS Inquiry

4.2.101.3 CAS Inquiry Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the CAS Inquiry button located in the navigation / maintenance panel.

This panel displays category, reason code and other applicable adjustment information of an adjusted claim.

4.2.101.4 Extra Features

This panel has no extra features.

4.2.101.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The number of the detail on the claim record	Field	Number	4	T_CLM_CAS	NUM_DTL
2	SVD Detail	This is the sequence number of the SVD segment with a claim detail. Up to 25 SVD segments may be related to a detail	Field	Number	4	T_CLM_CAS	NUM_DTL_SVD
3	CAS Seq	This identifies the iteration number for the CAS segment. A maximum of 99 CAS segments are allowed for a claim detail. For the claim header, the maximum is five	Field	Number	4	T_CLM_CAS	NUM_CAS_SEQ
4	Claim Adjustment Reason	This code identifies the detailed reason the adjustment was made	Field	Character	5	T_CLM_CAS	CDE_CLM_ADJ_REASON
5	Claim Adjustment Group	This code identifies the general category of a payment adjustment	Field	Character	2	T_CLM_CAS	CDE_CLM_ADJ_GROUP
6	Adjustment Quantity	Number of units of service being adjusted. Format 999999.99	Field	Number	8	T_CLM_CAS	QTY_ADJUSTMENT
7	Adjustment Amount	Monetary amount of the adjustment. Format $9999999.99	Field	Number	9	T_CLM_CAS	AMT_ADJUSTMENT
8	Party Identifier	Unique identifier for a payer	Field	Character	80	T_PARTY_IDENTIFIER	CDE_PARTY_ID

4.2.101.6 Field Edits

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

4.2.102 PANEL: Decision Rules

4.2.102.1 Description

The Decision Rules Panel displays rules written to the T_CLM_RU_MATCHED table.

Navigation Path: [Claims - Search] - [Enter Criteria] - [Select a Claim] - [Decision Rules]

Table: T_CLM_RU_MATCHED

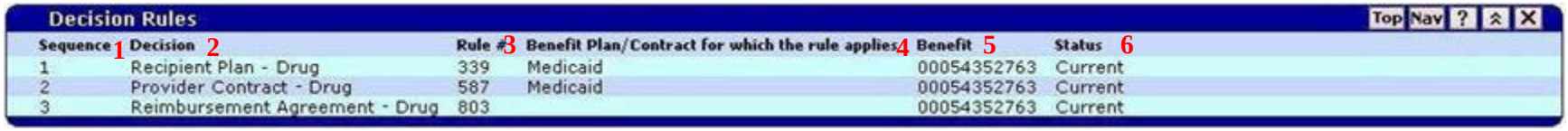
4.2.102.2 Technical Name

Clm.ClaimRulesPanel.ascx

4.2.102.3 Panel Name

Decision Rules

4.2.102.4 Decision Rules Layout



Decision Rules

Sequence 1	Decision 2	Rule # 3	Benefit Plan/Contract for which the rule applies 4	Benefit 5	Status 6
1	Recipient Plan - Drug	339	Medicaid	00054352763	Current
2	Provider Contract - Drug	587	Medicaid	00054352763	Current
3	Reimbursement Agreement - Drug	803		00054352763	Current

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Decision Rules button located in the navigation / maintenance panel.

4.2.102.5 Extra Features

This panel has no extra features.

4.2.102.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Sequence	The order in which the rule was applied for the claim detail.	Field	Number	4	N/A	T_CLM_RU_MATCHED
2	Decision	A short identifier for the decision. Examples, BP (Member Benefit Plan - Procedure), BD (Member Benefit Plan - Diagnosis).	Field	Character	4	N/A	T_CLM_RU_MATCHED
3	Rule #	Primary-Key for this table	Field	Number	9	N/A	T_CLM_RU_MATCHED
4	Benefit Plan/Contract for which the rule applies	Benefit Plan/Contract for which the rule applies	Field	Character	0	N/A	
5	Benefit	System assigned key used to uniquely identify a benefit (procedure, diagnosis, etc).	Field	Character	0	N/A	
6	Status	Code used to indicate if a rule on the claim is a current rule ('C') - a rule that was used in the the most recent processing of the claim, or an historical rule ('H') - a rule that was previously used when the claim previously processed..	Field	Character	0	N/A	T_CLM_RU_MATCHED

4.2.102.7 Field Edits

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

4.2.103 PANEL: Error

4.2.103.1 Description

Access the Claim Errors panel from the paid, denied, or suspended claim panels. This panel displays the header and/or detail errors applicable to the claim being viewed.

Field edits and the Add / Delete buttons are for Data Correction only.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Error link from the displayed panel];

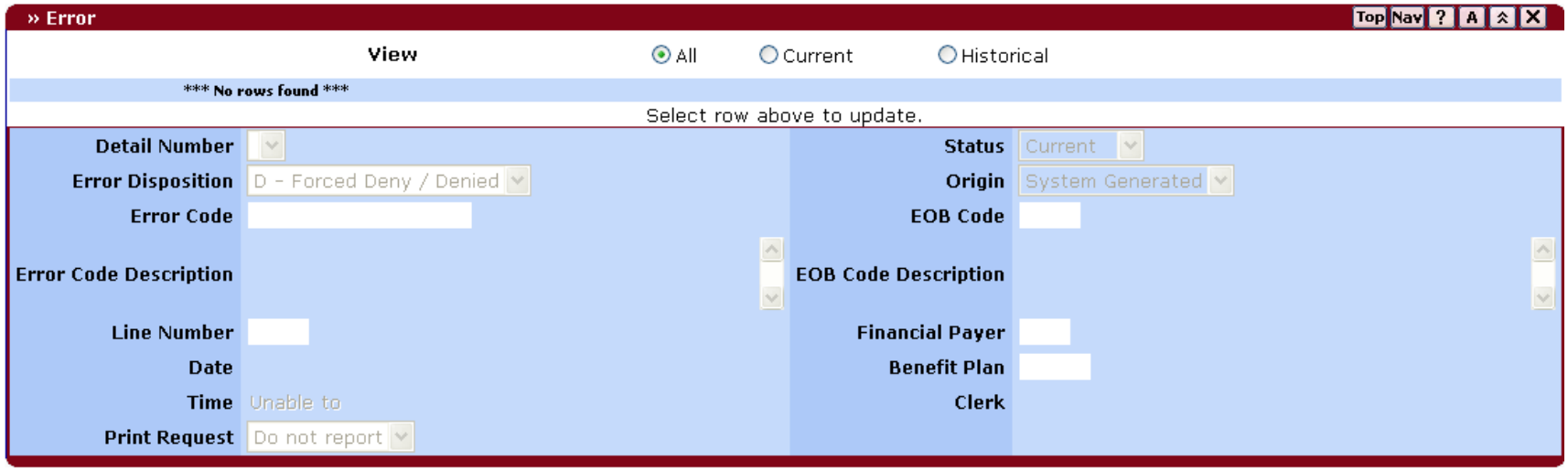
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Error link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Error link from the displayed panel].

4.2.103.2 Panel Name

Error

4.2.103.3 Error Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Error button located in the navigation / maintenance panel.

This panel displays the Error codes applicable to the claim.

4.2.103.4 Extra Features

This panel has no extra features.

4.2.103.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Number	The number of the header or detail that contains an edit or an audit failure	Field	Number	4	T_CLAIM_ERROR	NUM_DTL
2	Error Disposition	Code that represents the action that is taken on a claim at disposition time: pay(P), deny(D), suspend(S), force override(F), reject(J), or batch suspend(B)	Field	Drop Down List Box	0	T_CLAIM_ERROR	CDE_DISP_STATUS
3	Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit	Field	Number	4	T_ERROR_DISP	CDE_ESC
4	EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it	Field	Number	4	T_EOB	CDE_EOB

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Date	Date of the error code	Field	Date (MM/DD/CCYY)	8	T_CLAIM_ERROR	DTE_GENERIC
6	Time	Time of the error code. Format HH:MM:SS	Field	Number	6	T_CLAIM_ERROR	TME_STAMP
7	Print Request	The valid values are: Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report	Field	Drop Down List Box	1	T_CLAIM_ERROR	IND_RPT
8	Status	Indicates whether the Errors are current or history	Field	Drop Down List Box	7	T_CLAIM_ERROR	CDE_STAT_ERROR
9	Origin	Indicates who generated the error code and message	Field	Drop Down List Box	6	T_CLAIM_ERROR	CDE_STATUS1
10	Error Code Description	Description of the error	Field	Character	50	T_ERROR_DISP	DSC_ERROR_STAT
11	EOB Code Description	Description of the EOB	Field	Character	79	T_EOB	DSC_EOB
12	Financial Payer	A value that identifies a unique payer within interChange	Field	Character	4	T_CLAIM_ERROR	SAK_FIN_PAYER
13	Benefit Plan	Identifies the medical assistance program that is supported in the system. Use the [Search] panel to select a valid plan	Field	Check Box	5	T_PUB_HLTH_PGM	CDE_PGM_HEALTH

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
14	Clerk	Number used to identify the user who last updated the error record	Field	Character	8	T_CLAIM_ERROR	ID_CLERK

4.2.103.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	Error Code	Field	1	Invalid Error Code.	Enter a valid Error Code or select a valid code from the [Search] panel.
3	Error Code	Field	2	Error Code XXXX cannot be overridden.	The Error Code entered is a critical error or it cannot be overridden. The Error Disposition cannot be 'F - Force'.
3	Error Code	Field	3	Error Code XXXX cannot have the Error Disposition set to 'Deny'.	The Error Code entered has an Allow Deny Indicator set to 'No'; therefore the Error Disposition cannot be set to Deny.
4	EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
12	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer or select one from the [Search] panel.
13	Benefit Plan	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select a valid Benefit Plan from the [Search] panel.

4.2.104 PANEL: Member Coinsurance

4.2.104.1 Description

Allows the user to examine the Coinsurance accumulation for a member.

Navigation Path: [Claims - Search] - [Enter Criteria] - [Select Member Coinsurance]

Table :T_CLM_COINS_X

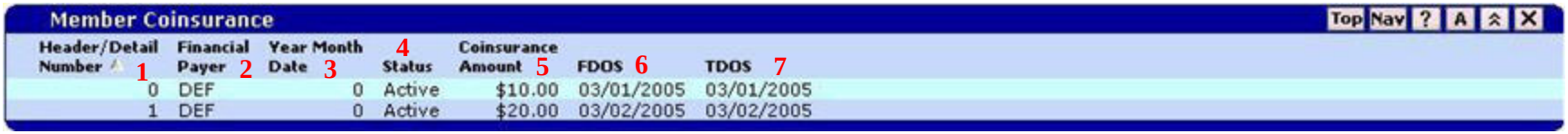
4.2.104.2 Technical Name

Clm.ClaimMemberCoinsuranceHdrPanel.ascx

4.2.104.3 Panel Name

Claim Member Coinsurance

4.2.104.4 Claim Member Coinsurance Layout



Member Coinsurance

Top Nav ? A

Header/Detail Number 1	Financial Payer 2	Year Month Date 3	4 Status	Coinsurance Amount 5	FDOS 6	TDOS 7
0	DEF	0	Active	$10.00	03/01/2005	03/01/2005
1	DEF	0	Active	$20.00	03/02/2005	03/02/2005

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Member Coinsurance button located in the navigation / maintenance panel.

4.2.104.5 Extra Features

This panel has no extra features.

4.2.104.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Header/Detail Number	The number of the detail on the claim record.A zero represents the header	Field	Number	4	T_CLM_COINS_X	NUM_DTL
2	Financial Payer	The system-assigned value that identifies a unique payer within interChange.	Field	Number	9	T_CLM_COINS_X	SAK_FIN_PAYER
3	Year Month Date	This is the year and month of the date of service of the claim that used coinsurance	Field	Number	9	T_CLM_COINS_X	DTE_YEAR_MTH
4	Status	Indicates if the record/row is active or inactive. The row becomes inactive only after an adjustment to the claim is released. Only use active ('A') to accumulate coinsurance. Values are: 'A' - Active; 'I' - Inactive	Field	Character	1	T_CLM_COINS_X	CDE_STATUS1
5	Coinsurance Amount	The coinsurance amount paid by the member for services rendered	Field	Number	9	T_CLM_COINS_X	AMT_COINSURANCE
6	FDOS	The beginning date of service for the claim	Field	Number	8	T_CLM_COINS_X	DTE_FIRST_SVC
7	TDOS	The last date of service for the claim.	Field	Number	8	T_CLM_COINS_X	DTE_LAST_SVC

4.2.104.7 Field Edits

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

4.2.105 PANEL: Submitted Data - Dental

4.2.105.1 Description

The Dental Submitted Data panel displays the submitted information applicable to a dental claim.

Navigation Path: [Claims -Information] - [Enter an ICN for a Dental claim] - [Select Submitted Data link from the displayed panel];

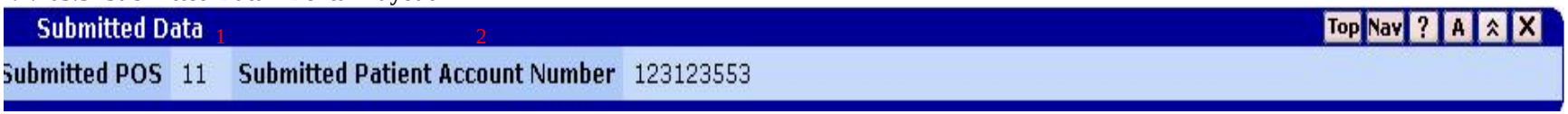
OR - [Claims -Search] - [Enter Criteria] - [Select a Dental claim] - [Select Submitted Data link from the displayed panel];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a Dental claim from the list] - [Select Submitted Data link from the displayed panel]

4.2.105.2 Panel Name

Submitted Data

4.2.105.3 Submitted Data - Dental Layout



To access this panel:

STEP 1. Access the Dental Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Submitted Data button located in the navigation / maintenance panel.

This panel displays place of service and patient account number to the applicable claim.

4.2.105.4 Extra Features

This panel has no extra features.

4.2.105.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Submitted POS	The place of service code representing the location where the dental treatment was rendered	Field	Character	2	T_DENTAL_HDR_KEYS	CDE_POS_SUB
2	Submitted Patient Account Number	Submitted Identification for a member, assigned by a provider and used in their system	Field	Character	38	T_DENTAL_HDR_KEYS	NUM_PAT_ACCT_SUB

4.2.105.6 Field Edits

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

4.2.106 PANEL: Dental Claim Detail

4.2.106.1 Description

Use the Dental Claim Detail panel to view the data entered on the detail portion of a Dental claim. When this panel is displayed in Data Correction mode, use the Add or Delete buttons to add or remove details.

Navigation Path: [Claims -Information] - [Enter an ICN for a Dental claim];

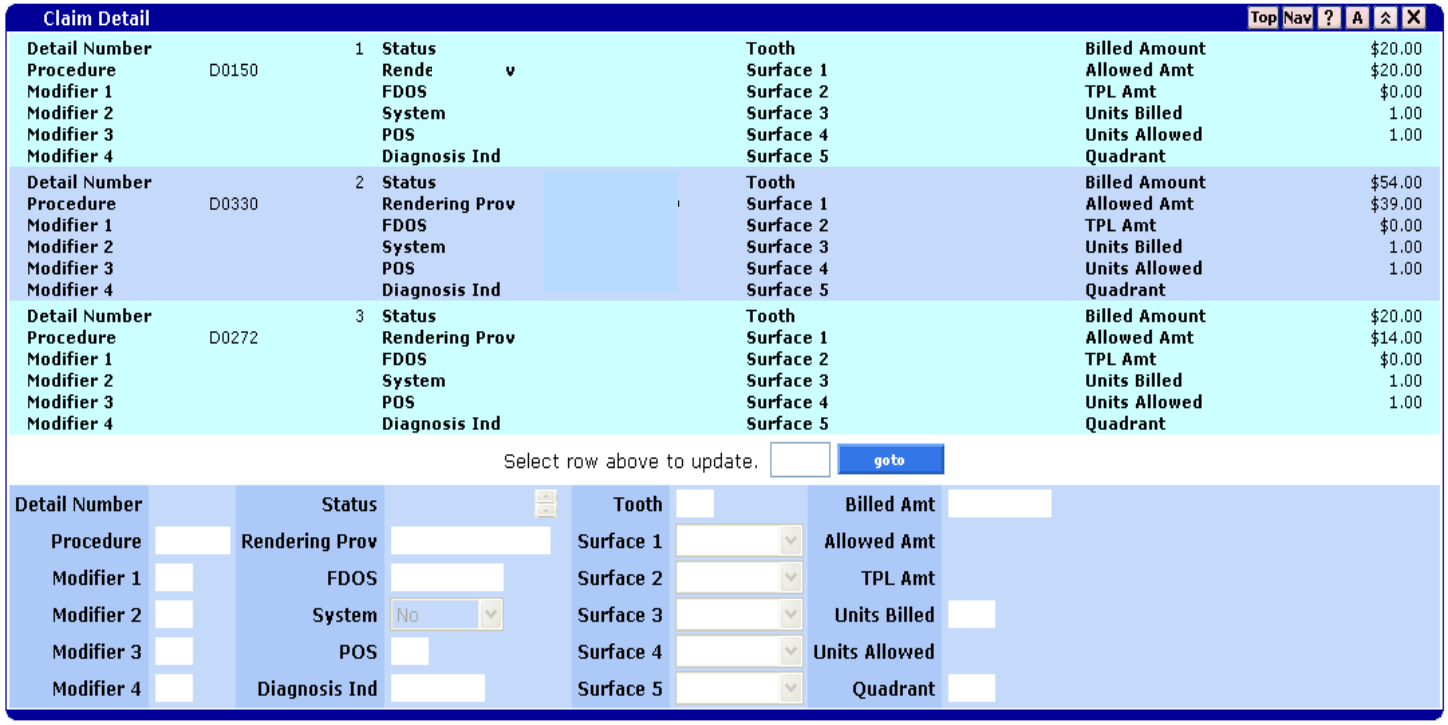
OR - [Claims -Search] - [Enter Criteria] - [Select a Dental claim];

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a Dental claim from the list].

4.2.106.2 Panel Name

Claim Detail

4.2.106.3 Dental Claim Detail Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. The Dental Claim Detail will display.

This panel displays the detail lines of a dental claim. In Data Correction page, this panel allows detail lines to be updated, added or deleted.

4.2.106.4 Extra Features

This panel has no extra features.

4.2.106.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Procedure	Code used to identify a Dental procedure	Field	Character	6	SEE NARRATIVE SECTION	SAK_PROCEDURE
2	Modifier 1	Code used to identify the modifiers connected to the procedure code	Field	Character	2	SEE NARRATIVE SECTION	CDE_MODIFIER
3	Modifier 2	Code used to identify the modifiers connected to the procedure code	Field	Character	2	SEE NARRATIVE SECTION	CDE_MODIFIER
4	Modifier 3	Code used to identify the modifiers connected to the procedure code	Field	Character	2	SEE NARRATIVE SECTION	CDE_MODIFIER
5	Modifier 4	Code used to identify the modifiers connected to the procedure code	Field	Character	2	SEE NARRATIVE SECTION	CDE_MODIFIER
6	Status	This field displays the status of the claim	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	CDE_CLM_STATUS

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
7	Rend Prov ID/LOC	The identifier and service location for the performing provider	Field	Character	10	SEE NARRATIVE SECTION	CDE_SVC_LOC_PERF
8	FDOS	Date of first service on the claim	Field	Date (MM/DD/CCYY)	8	SEE NARRATIVE SECTION	DTE_FIRST_SVC
9	System	Indicates whether detail was added by system during claim's processing. Valid values Y - yes or N - no. generated	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	IND_SYS_GENERATE
10	POS	Code which indicates the location where service was rendered	Field	Character	2	SEE NARRATIVE SECTION	CDE_PLACE_OF_SERVICE
11	Diagnosis Ind	Indicates which diagnosis (or diagnoses) for which services were provided. Valid values are 1, 2, 3, 4, 5, 6, 7, and 8. One detail can be associated with a minimum of one diagnosis in the header or maximum of eight diagnoses in the header for non-transportation claims only	Field	Number	8	SEE NARRATIVE SECTION	CDE_DIAG_TREAT_IND
12	Tooth	The tooth number that identifies the tooth the provider rendered services on. An alpha indicates temporary teeth and numeric indicates permanent teeth	Field	Character	2	SEE NARRATIVE SECTION	CDE_TOOTH_NBR

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
13	Surface 1	Code which indicates the tooth surface of a particular tooth	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	CDE_TOOTH_NBR
14	Surface 2	Code which indicates the tooth surface of a particular tooth	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	CDE_TOOTH_NBR
15	Surface 3	Code which indicates the tooth surface of a particular tooth	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	CDE_TOOTH_NBR
16	Surface 4	Code which indicates the tooth surface of a particular tooth	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	CDE_TOOTH_NBR
17	Surface 5	Code which indicates the tooth surface of a particular tooth	Field	Drop Down List Box	0	SEE NARRATIVE SECTION	CDE_TOOTH_NBR
18	Quadrant	The quadrant of the mouth that the procedure on the claim is related to	Field	Character	2	SEE NARRATIVE SECTION	CDE_QUADRANT
19	Billed Amt	Total billed amount. Format 999999.99	Field	Number	8	SEE NARRATIVE SECTION	AMT_BILLED
20	Allowed Amt	Amount allowed by the specific program (Medicaid, 590, and so on.) for the procedure. Format 9999999.99	Field	Number	9	SEE NARRATIVE SECTION	AMT_ALWD
21	TPL Amt	Amount paid by third party for services, at the claim header level. Format 999999.99	Field	Number	9	SEE NARRATIVE SECTION	AMT_DETAIL_TPL
22	Copay Amt	This is the amount of copay that is subtracted from the allowed amount. Format 99999.99	Field	Number	7	SEE NARRATIVE SECTION	AMT_COPAY

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
23	Units Billed	The number of units billed by the provider	Field	Number	6	SEE NARRATIVE SECTION	QTY_BILLED
24	Units Allowed	The number of units allowed to the provider	Field	Number	6	SEE NARRATIVE SECTION	QTY_ALLOWED
25	Detail Number	The number of the detail on a claim record	Field	Number	4	SEE NARRATIVE SECTION	NUM_DTL
26	goto	Allows the user to view a specific detail	Button	N/A	0	N/A	N/A

4.2.106.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Procedure	Field	1	Invalid Procedure code.	Enter a valid Procedure code or select a value from the [Search] field.
2	Modifier 1	Field	1	Invalid Modifier 1 code.	Enter a valid Modifier 1 code or select a value from the search [Search] panel.
3	Modifier 2	Field	1	Invalid Modifier 2 Code.	Enter a valid Modifier 2 Code or select a value from the [Search] Panel.
4	Modifier 3	Field	1	Invalid Modifier 3 Code.	Enter a valid Modifier 3 Code or select a value from the [Search] panel.
5	Modifier 4	Field	1	Invalid Modifier 4 Code.	Enter a valid Modifier 4 Code or select a value from the [Search] Panel.
7	Rend Prov ID/LOC	Field	1	Invalid Rendering Provider.	Enter a valid Rendering Provider ID or select a value from the [Search] panel.

Field No	Field	Field Type	Error Code	Error Message	To Correct
7	Rend Prov ID/LOC	Field	2	Rendering Provider ID and Service Location are required.	Enter a valid Rendering Provider ID/LOC or select a value from the [Search] panel.
8	FDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
10	POS	Field	1	Invalid Place of Service.	Enter a valid Place of Service or select a value from the [Search] panel.
11	Diagnosis Ind	Field	1	Enter a valid value.	Diagnosis Indicator must be numeric.
11	Diagnosis Ind	Field	102	Diagnosis indicator must be less than number of diagnosis on the claim.	Verify value and re-enter.
12	Tooth	Field	1	Invalid Tooth.	Enter a valid Tooth or select a value from the [Search] field.
13	Surface 1	Field	1	Invalid Tooth Surface 1 code.	Enter a Valid Tooth Surface 1 code or select a value from the list.
14	Surface 2	Field	1	Invalid Tooth Surface 2 code.	Enter a valid Tooth Surface 2 code or enter a value from the list.
15	Surface 3	Field	1	Invalid Tooth Surface 3 code.	Enter a valid Tooth Surface code or enter a value from the list.
16	Surface 4	Field	1	Invalid tooth surface 4 code.	Enter a valid Tooth Surface 4 code or enter a value from the list.
17	Surface 5	Field	1	Invalid Tooth Surface 5 code.	Enter a valid Tooth Surface 5 code or select a value from the list.
18	Quadrant	Field	1	Invalid Tooth Quadrant.	Enter a valid Tooth Quadrant or select a value from the [Search] panel.

4.2.107 PANEL: Dental Claim Detail Navigation

4.2.107.1 Description

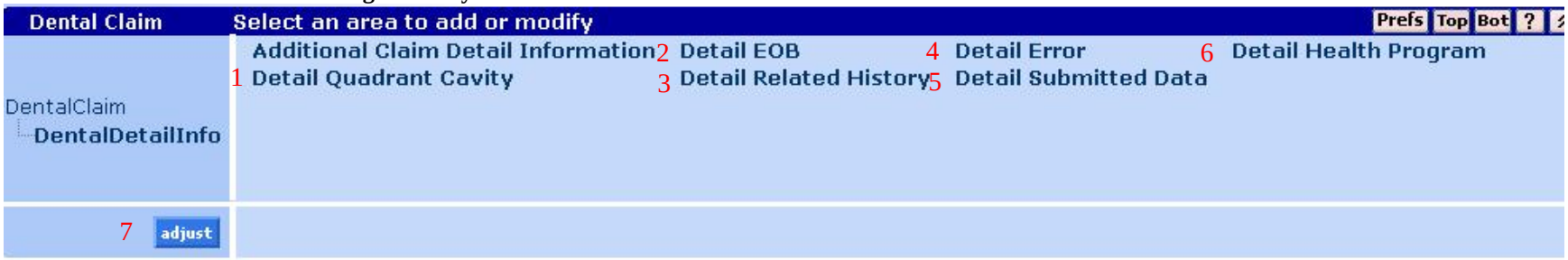
The Dental Claim Detail Navigation panel provides access to the various panels through which Dental Claims detail information can be viewed.

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

4.2.107.2 Panel Name

Dental Claim Detail Navigation

4.2.107.3 Dental Claim Detail Navigation Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. The Dental Claim Maintenance panel will display.

STEP 5. Click the Detail Information button located to the left of the maintenance panel.

The links for the Detail Information will display to the right of the maintenance panel.

4.2.107.4 Extra Features

This panel has no extra features.

4.2.107.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Detail Quadrant Cavity	Link to "Detail Quadrant Cavity" panel	Hyperlink	N/A	0	N/A	N/A
2	Detail EOB	Link to "Detail EOB" panel	Hyperlink	N/A	0	N/A	N/A
3	Detail Related History	Link to "Detail Related History" panel	Hyperlink	N/A	0	N/A	N/A
4	Detail Error	Link to "Detail Error" panel	Hyperlink	N/A	0	N/A	N/A
5	Detail Submitted Data	Link to "Detail Submitted Data" panel	Hyperlink	N/A	0	N/A	N/A
6	Detail Health Program	Link to "Detail Health Program" panel	Hyperlink	N/A	0	N/A	N/A
7	Adjust	This button displays for claims in a Paid status. Clicking the Adjust button opens up the Adjustment Request Panel. When the initial request information is entered, the ICN of the displayed claim appears in the Original ICN field and a new ICN number appears in the Adjustment ICN field	Button	N/A	0	N/A	N/A

4.2.107.6 Field Edits

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

4.2.108 PANEL: Additional Claim Information

4.2.108.1 Description

Allows the user to examine additional information submmited on the claim including the information that is used to determine the correct service location to assign to a claim.

Navigation Path: [Claims - Search] - [Enter Criteria] - [Select a Claim] - [Select Additional Claim Information]

Tables: T_CLM_ENTITY, T_PARTY_IDENTIFIER, T_CLM_NAME_N1, T_CLM_ADR_N3_N4

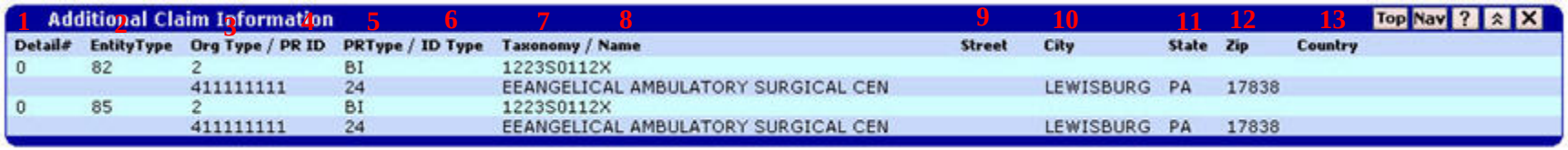
4.2.108.2 Technical Name

Clm.AdditionalClaimInformationPanel.ascx

4.2.108.3 Panel Name

Additional Claim Information

4.2.108.4 Additional Claim Information Layout



Detail#	EntityType	Org Type / PR ID	PRType / ID Type	Taxonomy / Name	Street	City	State	Zip	Country
0	82	2	BI	1223S0112X					
		411111111	24	EEANGELICAL AMBULATORY SURGICAL CEN		LEWISBURG	PA	17838	
0	85	2	BI	1223S0112X					
		411111111	24	EEANGELICAL AMBULATORY SURGICAL CEN		LEWISBURG	PA	17838	

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Additional Claim Information button located in the navigation / maintenance panel.

4.2.108.5 Extra Features

This panel has no extra features.

4.2.108.6 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Detail Number	The number of the detail on the claim record.	4	Number	T_CLM_ENTITY	NUM_DTL
2	Entity Type	Indicates the type of the Party Entity.	3	Character	T_CLM_ENTITY	QLF_ENTITY_TYPE
3	Org Type	Indicates whether the entity is a person or a non-person.	2	Character	T_CLM_ENTITY	QLF_TYPE_ORG
4	PR ID	The unique identifier for the entity type specified by the qualifier.	80	Character	T_PARTY_IDENTIFIER	CDE_PARTY_ID
5	PR Type	The type of practice for a provider.	3	Character	T_CLM_ENTITY	CDE_PROVIDER_TYPE
6	ID Type	Indicates the identification code qualifier.	2	Character	T_PARTY_IDENTIFIER	QLF_ID_TYPE
7	Taxonomy	The Referring Provider Taxonomy or Provider Specialty.	30	Character	T_CLM_ENTITY	CDE_PROV_TAXONOMY
8	Name	The last, first, middle & suffix name of the Member/Provider or the name of the Organization.	65	Character	T_CLM_NAME_N1	NAM_LAST, NAM_FIRST, NAM_MIDDLE
9	Street	The address of the Member/Provider.	55	Character	T_CLM_ADR_N3_N4	ADR_STREET_1, ADR_STREET_2
10	City	The city associated with the address for the Recipient/Provider.	30	Character	T_CLM_ADR_N3_N4	ADR_CITY
11	State	The state associated with the address for the Recipient/Provider.	2	Character	T_CLM_ADR_N3_N4	ADR_STATE
12	Zip	The zip code associated with the address for the Recipient/Provider.	15	Character	T_CLM_ADR_N3_N4	ADR_ZIP_CODE

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
13	Country	The country associated with the address for the Recipient/Provider.	3	Character	T_CLM_ADR_N3_N4	ADR_COUNTRY

4.2.108.7 Field Edits

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

4.2.109 PANEL: Detail Quadrant Cavity

4.2.109.1 Description

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

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

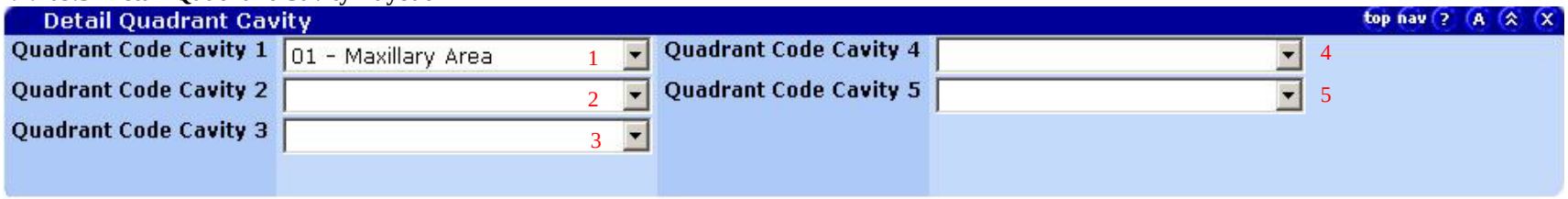
Navigation Path: [Claims -Information] - [Enter a Dental ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a Dental claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a Dental claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail Quadrant Cavity]

Table: T_DENTAL_DTL_KEYS

4.2.109.2 Panel Name

Detail Quadrant Cavity

4.2.109.3 Detail Quadrant Cavity Layout



To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click the row of a dental claim to select.

STEP 2. Click the appropriate row of the Claim Detail panel to highlight the line detail.

STEP 3. Click the Dental Detail Info button located above the Save and Cancel buttons.

STEP 4. Click the Detail Quadrant Cavity button located next to the Detail Related History button.

This panel displays the oral cavity codes applicable to the highlighted detail line. In Data Correction page, this panel allows data to be updated.

4.2.109.4 Extra Features

This panel has no extra features.

4.2.109.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Quadrant Code Cavity 1	First code identifying the area of the oral cavity in which service was rendered	Field	Drop Down List Box	0	T_DENTAL_DTL_KEYS	CDE_CAVITY_DESIG_1
2	Quadrant Code Cavity 2	Second code identifying the area of the oral cavity in which service was rendered	Field	Drop Down List Box	0	T_DENTAL_DTL_KEYS	CDE_CAVITY_DESIG_2
3	Quadrant Code Cavity 3	Third code identifying the area of the oral cavity in which service was rendered	Field	Drop Down List Box	0	T_DENTAL_DTL_KEYS	CDE_CAVITY_DESIG_3
4	Quadrant Code Cavity 4	Fourth code identifying the area of the oral cavity in which service was rendered	Field	Drop Down List Box	0	T_DENTAL_DTL_KEYS	CDE_CAVITY_DESIG_4
5	Quadrant Code Cavity 5	Fifth code identifying the area of the oral cavity in which service was rendered	Field	Drop Down List Box	0	T_DENTAL_DTL_KEYS	CDE_CAVITY_DESIG_5

4.2.109.6 Field Edits

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

4.2.110 PANEL: Detail Related History

4.2.110.1 Description

The Detail Related History panel can be accessed from the paid, denied, or suspended claim windows. This window displays the related hstory applicable to the claim detail being viewed.

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

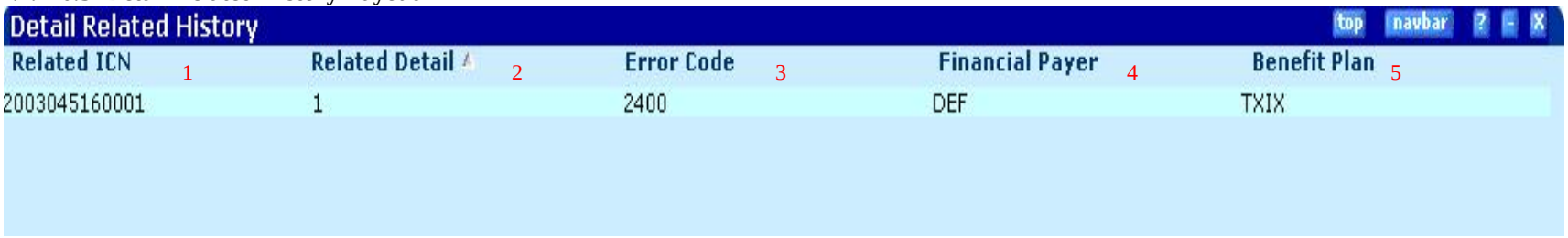
Navigation Path: [Claims -Information] - [Enter an ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail Related History]

Table: T_SUSP_RLHX

4.2.110.2 Panel Name

Detail Related History

4.2.110.3 Detail Related History Layout



To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click on Claim detail line to highlight it.

STEP 2. Click on Detail Information button located above the Save and Cancel buttons or Adjust button.

STEP 3. Click on Detail Related History button.

This panel displays other claims associated with the claim as applicable to the detail line of the claim.

4.2.110.4 Extra Features

This panel has no extra features.

4.2.110.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Related ICN	Internal Control Number of the related claim	Field	Character	13	T_SUSP_RLHX	SAK_RELATED_HX
2	Related Detail	Related detail number on the history claim displayed	Field	Number	4	T_SUSP_RLHX	NUM_DTL_RELATED
3	Error Code	Code used to indicate an error was discovered on a claim during processing in the base system	Field	Number	4	T_SUSP_RLHX	SAK_ESC
4	Financial Payer	The description used to identify the financial payer for the related ICN	Field	Character	30	T_SUSP_RLHX	SAK_FIN_PAYER
5	Benefit Plan	The medical assistance program associated with the related ICN	Field	Character	5	T_SUSP_RLHX	SAK_PUB_HLTH

4.2.110.6 Field Edits

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

4.2.111 PANEL: Detail EOB

4.2.111.1 Description

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

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

The All, Current, Historical radiobutton on the panel allows the user to select which EOB's to view based on the EOB Status. The EOB on the claim is a current EOB ('C'), one that failed in the current cycle, or a historical EOB ('H'), one that previously failed.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail EOB]

Table: T_CLM_EOB_XREF, T_CDE_HIPAA_ADJRSN, T_CDE_HIPAA_REMRKS

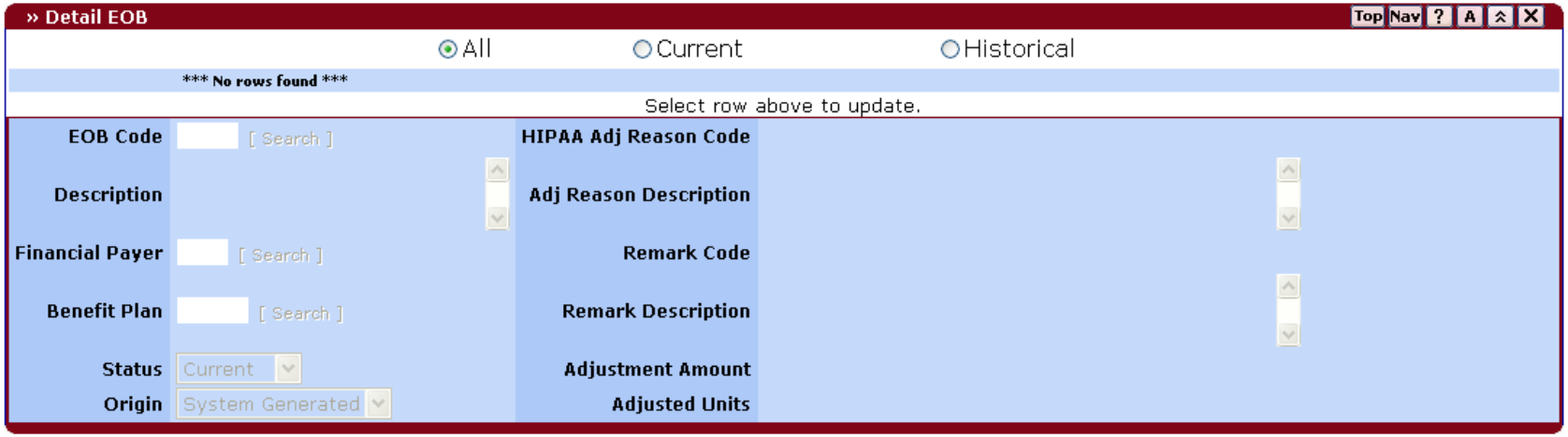
4.2.111.2 Technical name

Clm.ClaimEobPanel.ascx

4.2.111.3 Panel Name

Detail EOB

4.2.111.4 Detail EOB Layout



Copyright 2005 Electronic Data Systems Corporation. All rights reserved.

To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click a row to select.

STEP 2. Click on Claim detail line to highlight it.

STEP 3. Click on Detail Information button located above the Save and Cancel buttons or Adjust button.

STEP 4. Click on Detail EOB button located next to the Detail Error button.

This panel displays EOB code information as applicable to the detail line of the claim. In Data Correction page, this panel allows records to be updated, added or deleted.

4.2.111.5 Extra Features

This panel has no extra features.

4.2.111.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it	Field	Number	4	T_EOB	CDE_EOB
2	Description	First line of text description for EOB code	Field	Character	79	T_EOB	DSC_EOB
3	Financial Payer	A value that identifies a unique payer within interChange	Field	Drop Down List Box	0	T_CLM_EOB_XREF	SAK_FIN_PAYER
4	Benefit Plan	Identifies the medical assistance program that is supported in the system	Field	Drop Down List Box	0	T_CLM_EOB_XREF	SAK_PUB_HLTH
5	Status	Code used to indicate whether the EOB on the claim is a current EOB ('C'), one that failed in the current cycle, or a historical EOB ('H'), one that previously failed	Field	Drop Down List Box	0	T_CLM_EOB_XREF	CDE_STAT_ERROR
6	HIPAA Adjustment Reason	This is the managed care eligibility reason codes for HIPAA	Field	Character	2	T_CDE_HIPAA_ADJ RSN	CDE_ADJ_RSN
7	Remark Code	HIPAA Remarks code	Field	Character	5	T_CDE_HIPAA_RE MRKS	CDE_REMARK
8	Adjustment Amount	The dollar amount adjusted on the detail. Format 9999999.99 “NOT USED IN KY”	Field	Number	9	T_CLM_EOB_XREF	AMT_ADJUSTED

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
9	Adjusted Units	The quantity adjusted on the detail. Format 9999999.999 “NOT USED IN KY”	Field	Number	10	T_CLM_EOB_XREF	QTY_ADJUSTED
10	Origin	Indicates who generated the EOB code and message	Field	Character	6	T_CLM_EOB_XREF	CDE_STATUS1

4.2.111.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
3	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer of select one from the [Search] panel.
4	Benefit Plan	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select one from the [Search] panel.

4.2.112 PANEL: Detail Error

4.2.112.1 Description

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

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

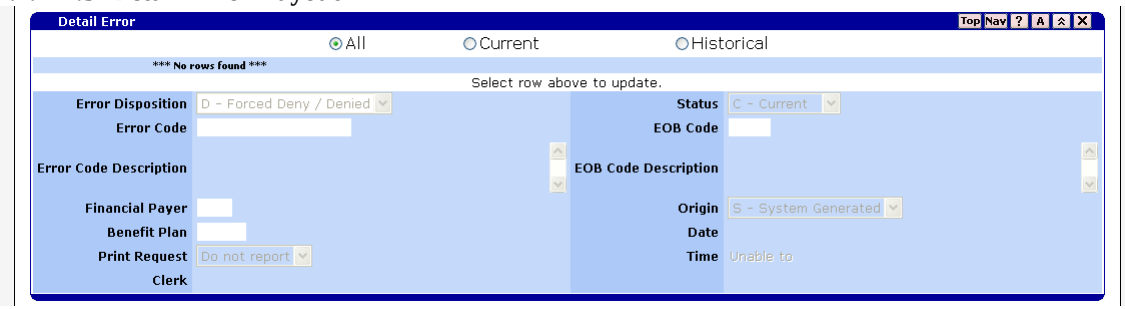
Navigation Path: [Claims -Information] - [Enter an ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail Error]

Tables: T_CLAIM_ERROR, T_ERROR_DISP, T_EOB

4.2.112.2 Panel Name

Detail Error

4.2.112.3 Detail Error Layout



To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click a row to select.

STEP 2. Click on Claim detail line to highlight it.

STEP 3. Click on DetailInformation button located above the Save and Cancel buttons or Adjust button.

STEP 4. Click on Detail Error button located next to the Detail EOB button.

This panel displays Error code information as applicable to the detail line of the claim. In Data Correction page, this panel allows records to be updated, added or deleted.

4.2.112.4 Extra Features

This panel has no extra features.

4.2.112.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Error Disposition	Disposition of the error	Field	Drop Down List Box	0	T_ERROR_DISP	DSC_ERROR_STAT
2	Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit	Field	Character	4	T_ERROR_DISP	CDE_ESC
3	EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it	Field	Number	4	T_EOB	CDE_EOB
4	Financial Payer	A value that identifies a unique payer within interChange	Field	Character	4	T_CLAIM_ERROR	SAK_FIN_PAYER
5	Benefit Plan	Identifies the medical assistance program that is supported in the system. Use the [Search] panel to select a valid plan	Field	Character	5	T_CLAIM_ERROR	SAK_PUB_HLTH
6	Print Request	The valid values for this indicator are Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report	Field	Drop Down List Box	0	T_CLAIM_ERROR	IND_RPT

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
7	Clerk	Number used to identify the user who last updated the error record	Field	Character	8	T_CLAIM_ERROR	ID_CLERK
8	Status	Indicates if the EOB is current or history	Field	Character	7	T_CLAIM_ERROR	CDE_DISP_STATUS
9	Error Description	Description of the error	Field	Character	50	T_ERROR_DISP	DSC_ERROR_STAT
10	EOB Description	Text description for the EOB code	Field	Character	79	T_EOB	DSC_EOB
11	Origin	Indicates how the EOB Code and message were generated: valid values are 'S - System Generated' or 'U - User Assigned'	Field	Drop Down List Box	0	T_CLAIM_ERROR	CDE_STATUS1
12	Date	Date of the Error code	Field	Date (MM/DD/CCYY)	0	T_CLAIM_ERROR	DTE_GENERIC
13	Time	Time of the error code	Field	Number	8	T_CLAIM_ERROR	TME_STAMP

4.2.112.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Error Code	Field	1	Invalid error code.	Enter a valid Error Code or select a valid code from the [Search] panel.
2	Error Code	Field	2	Error Code XXXX cannot be overridden.	The Error Code entered is a critical error or it cannot be overridden. The Error Disposition cannot be 'F - Force'.
2	Error Code	Field	3	Error Code XXXX cannot have the Error Disposition set to 'Deny'.	The Error Code entered has an Allow Deny Indicator set to 'No'; therefore the Error Disposition cannot be set to Deny.
3	EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
4	Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer or select one from the [Search] panel.
5	Benefit Plan	Field	1	Invalid Benefit plan.	Enter a valid Benefit Plan or select a valid Benefit Plan from the [Search] panel.

4.2.113 PANEL: Detail Submitted Data - Dental

4.2.113.1 Description

The Detail Submitted Data panel displays the Dental submitted information applicable to the claim at the detail level.

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

Navigation Path: [Claims -Information] - [Enter a Dental ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a Dental claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a Dental claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail Submitted Data]

Table: T_DENTAL_DTL_KEYS

4.2.113.2 Panel Name

Detail Submitted Data

4.2.113.3 Detail Submitted Data - Dental Layout

To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Click the row of a dental claim to select.

STEP 3. Click on Claim detail line to highlight it.

STEP 4. Click on Detail Information button located above the Save and Cancel buttons or Adjust button.

STEP 5. Click on Detail Submitted Data button.

This panel displays procedure code and/or modifiers that are replaced with the new code and/or modifier as applicable to the detail line of the claim.

4.2.113.4 Extra Features

This panel has no extra features.

4.2.113.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Ref Dtl Line	A sequence number that points to the original detail	Field	Number	4	T_DENTAL_DTL_KEYS	NUM_DTL
2	Proc Replaced	Original/Submitted Procedure Code for HIPAA 837D	Field	Character	6	T_DENTAL_DTL_KEYS	CDE_PROC_SUB
3	Sub Units Billed	Original/Submitted Units Billed for HIPAA 837D. Format 9999.99	Field	Number	6	T_DENTAL_DTL_KEYS	QTY_BILLED_SUB
4	Original Modifier 1	Original/Submitted Procedure Modifier 1 for HIPAA 837D	Field	Character	2	T_DENTAL_DTL_KEYS	CDE_PROC_MOD1_SUB
5	Original Modifier 2	Original/Submitted Procedure Modifier 2 for HIPAA 837D	Field	Character	2	T_DENTAL_DTL_KEYS	CDE_PROC_MOD2_SUB
6	Original Modifier 3	Original/Submitted Procedure Modifier 3 for HIPAA 837D	Field	Character	2	T_DENTAL_DTL_KEYS	CDE_PROC_MOD3_SUB
7	Original Modifier 4	Original/Submitted Procedure Modifier 4 for HIPAA 837D	Field	Character	2	T_DENTAL_DTL_KEYS	CDE_PROC_MOD4_SUB

4.2.113.6 Field Edits

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

4.2.114 PANEL: Detail Health Program

4.2.114.1 Description

The Detail Health Program panel can be accessed from the paid, denied, or suspended claim windows. This window displays the health program applicable to the claim detail being viewed.

In order to view information on this panel, you must first select one detail record on the Claim Detail panel. You may page forward to find the detail you want to select, or you may enter the detail number in the 'go to' field.

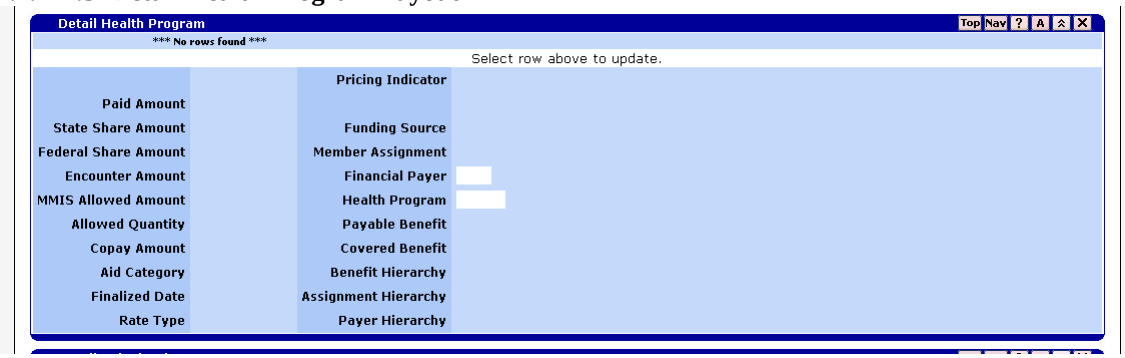
Navigation Path: [Claims -Information] - [Enter an ICN] - [Click Search] - OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - THEN - [Click on a detail record in the Claim Detail panel] - [Click on the Detail Information nav bar item link on the Navigation Panel] - [Detail Health Program]

Tables: T_CLM_PGM_XREF, T_CDE_AID, T_FINANCIAL_PAYER, T_PUB_HLTH_PGM

4.2.114.2 Panel Name

Detail Health Program

4.2.114.3 Detail Health Program Layout



To access this panel:

Access the Claim Information page using the instructions listed for the page.

STEP 1. Click on Claim detail line to highlight it.

STEP 2. Click on Detail Information button located above the Save and Cancel buttons or Adjust button.

STEP 3. Click on Detail Health Program button.

This panel displays member coverage information as applicable to the detail line of the claim. In Data Correction page, this panel allows records to be updated but only the Allowed Amount and Financial Payer fields.

4.2.114.4 Extra Features

This panel has no extra features.

4.2.114.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Paid Amount	This is the amount that is applied toward the check amount. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_PAID
2	State Share Amount	This is the amount of state share for this payment. The state share amount plus the amount Paid = Reimbursement amount. Format 99999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_STATE_SHARE
3	Federal Share Amount	This is the amount of federal share for this payment	Field	Number	10	T_CLM_PGM_XREF	AMT_FEDERAL_SHARE
4	Encounter Amount	Contains the amount for encounter services on the claim detail indicated by the detail number on table. Format 9999999.99	Field	Number	10	T_CLM_PGM_XREF	AMT_ENCOUNTER
5	Allowed Amount	Allowed Amount that is paid. Format 9999999.99	Field	Number	9	T_CLM_PGM_XREF	AMT_ALWD
6	Allowed Quantity	Number of units of service that are paid under a financial payer/benefit plan. Format 9999.99	Field	Number	6	T_CLM_PGM_XREF	QTY_ALLOWED
7	Copay Amount	Amount paid by member for services rendered. Format 99999.99	Field	Number	7	T_CLM_PGM_XREF	AMT_CO_PAY
8	Aid Category	Aid Category for Medicaid coverage	Field	Number	9	T_CDE_AID	CDE_AID_CATEGORY

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
9	Finalized Date	Date that financial finalizes the claim for this payer	Field	Date (MM/DD/CCYY)	8	T_CLM_PGM_XREF	DTE_FINAL
10	Rate Type	Code used to identify the rate type to use in determining provider reimbursement	Field	Character	3	T_CLM_PGM_XREF	CDE_RATE_TYPE
11	Pricing Indicator	Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced	Field	Character	1	T_CLM_PGM_XREF	IND_PRICING
12	Managed Care Indicator	Manage care indicator identifies claims and other transactions as to how they affect the manage care program	Field	Drop Down List Box	1	T_CLM_PGM_XREF	IND_MC
13	Fund Source	Indicates the budget category that the funds used to pay this claim/detail came from	Field	Number	9	T_FIN_FUND_CODE	T_FIN_FUND_CODE
14	Member Assignment	A group of covered services (benefits) where the member is assigned to a provider or provider organization in order to receive covered services (benefits)	Field	Number	9	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
15	Financial Payer	The system-assigned value that identifies a unique payer within interChange	Field	Number	9	T_FINANCIAL_PAYER	CDE_FIN_PAYER
16	Health Program	Identifies the medical assistance program that is supported in the system	Field	Character	5	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
17	Payable Benefit	Unique system-assigned that identifies each row on this table	Field	Number	9	T_CLM_PGM_XREF	SAK_PAYABLE_BNFT

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
18	Covered Benefit	System-assigned key used to identify a unique row for a benefit covered by a member plan	Field	Number	9	T_CLM_PGM_XREF	SAK_COVERED_BNFT
19	Benefit Hierarchy	Specifies the order in which to process multiple Benefit Plans for a member	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD
20	Assignment Hierarchy	An assignment hierarchy is an ordered set of assignment plans for which a member/beneficiary 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	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD_ASSIGNMENT
21	Payer Hierarchy	Payer Hierarchy identifies 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	Field	Number	9	T_CLM_PGM_XREF	SAK_THREAD_PAYER

4.2.114.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
5	Allowed Amount	Field	1	Enter a valid value.	Enter only a numeric value in the Allowed Amount field.
15	Financial Payer	Field	1	Enter a valid value.	Enter a valid Financial Payer or select a valid value from the [Search] panel.
16	Health Program	Field	1	Invalid Benefit Plan.	Enter a valid Benefit plan or select a value from the [Search] panel.

4.2.115 PANEL: Pharmacy Claim

4.2.115.1 Description:

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

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

There are different tables used depending on the status of the claim. The tables used are the following: T_PD_PHRM_HDR, T_DENY_PHRM_HDR, T_SUSP_PHRM_HDR, T_RE_BASE, T_PR_PROV, T_PHRM_HDR_KEYS

4.2.115.2 Technical Name

Clm.PharmacyClaimPanel.ascx

4.2.115.3 Panel Name:

Pharmacy Claim

4.2.115.4 Pharmacy Claim Panel Layout

To access this panel:

STEP 1. Access the Claims Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

This panel displays all the non-detail line claim information submitted on the claim.

4.2.115.5 Extra Features

This panel has no extra features.

4.2.115.6 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	ICN	Internal control number which uniquely identifies a claim.	13	Character	SEE NARRATIVE SECTION	NUM_ICN
2	Claim Type	Indicates the type of claim.	0	Drop Down List Box	SEE NARRATIVE SECTION	CDE_CLM_TYPE
3	Status	Identifies the status of the claim in the system.	0	Drop Down List Box	SEE NARRATIVE SECTION	CDE_CLM_STATUS
4	Member ID	A system-assigned number which uniquely identifies a member.	12	Character	T_PHRM_HDR_KEYS	ID_MEDICAID
5	RX Date	Date the drug prescription (Rx) was either filled or written, whatever is sent from PBA.	8	Date (MM/DD/CCYY)	SEE NARRATIVE SECTION	DTE_PRESCRIBE
6	Details	The number of detail service lines on the claim.	9	Number	SEE NARRATIVE SECTION	NUM_DTL_TOTAL

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
7	Last Name	The last name of the member associated with the Member ID number. If there is no association between the last name and the Member ID number the first three characters of the last name that was keyed will be displayed	15	Character	T_PHRM_HDR_KEYS	CLM_LST_NAM_RECIP
8	Disp Date	Date pharmacy dispensed the drug to the member.	8	Date (MM/DD/CCYY)	SEE NARRATIVE SECTION	DTE_DISPENSE
9	Billed	Amount of money requested for payment by a provider for services rendered. Format 999999.99	8	Number	SEE NARRATIVE SECTION	AMT_BILLED
10	First Name	The first name of the member associated with the Member ID number.	15	Character	T_PHRM_HDR_KEYS	CLM_RECIP_FST_NAM
11	Date Billed	The date on which a claim was submitted for processing.	8	Date (MM/DD/CCYY)	SEE NARRATIVE SECTION	DTE_BILLED
12	Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, and so on.). Format 999999.99	8	Number	SEE NARRATIVE SECTION	AMT_NET_BILLED
13	DOB	Member's date of birth.	8	Date (MM/DD/CCYY)	T_RE_BASE	DTE_BIRTH
14	Provider Number	The provider identification number and location that uniquely identifies the provider of services.	10	Character	T_PR_PROV	ID_PROVIDER/CDE_SERVICE_LOC
15	Spenddown	Amount of money that member is responsible for paying for services rendered. Format 9999999.99	9	Number	SEE NARRATIVE SECTION	AMT_PATNT_LIAB

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
16	Claim Diagnosis	Indicates the diagnosis codes applicable to the claim.	7	Character	T_DIAGNOSIS	CDE_DIAG
17	Rendering Provider	ID and sevice location of the provider rendering the service.	10	Character	T_PHRM_HDR_KEYS	ID_PROV_RENDERING
18	Reimbursed	Total amount the provider receives minus any State Share Amount (if applicable). Format 99999999.99	10	Number	T_PD_PHARM_HDR	AMT_TOT_REIMB
19	Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.	12	Character	T_EDI_INTERCHANGE	CDE_SENDER_ID
20	Prescribing Provider	Number of provider who prescribed the drugs to the member. This does not have to be an enrolled provider.	10	Character	T_PR_PROV	ID_PROV_PRESCRB
21	Paid	Amount paid on claim. Amount Paid will be the allowed amount minus spend down, coinsurance, deductible, patient liability, dispensing fees, tpl, etc. as applicable depending on services. This value is computed by adding up all the AMT_PAID values for the related details. Format 999999.99.	8	Number	T_CLM_PGM_XREF	AMT_PAID
22	RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.	12	Number	T_FIN_REMIT_TXN_XREF	SAK_REMIT
23	Original Prescription	Original prescription number	10	Character	T_MPHX_PHRM_DTL	ID_PROV_PERSCRB
24	TPL	Amount paid by third party for services. Format 999999.99	8	Number	SEE NARRATIVE SECTION	TPL_AMT

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
25	Signature	Indicates whether the claim was signed by the provider or representative	0	Drop Down List Box	SEE NARRATIVE SECTION	IND_PROV_SIGN
26	Prescription Nbr.	Number assigned by a pharmacy to identify the drug dispensed to a member	7	Character	SEE NARRATIVE SECTION	NUM_PRSCRIP
27	TPL Recovered Amt	The casualty case recovery amount populated from the Settlement window. Format 9999999.99	9	Number	T_PD_PHARM_HDR	AMT_TPL_RECOVERY
28	Emergency	Indicates whether this is an emergency supply.	0	Drop Down List Box	SEE NARRATIVE SECTION	IND_EMERGENCY
29	Brand Required	Indicates the reason, if any, that a brand name drug was dispensed.	1	Character	SEE NARRATIVE SECTION	IND_BRAND_MED_NEC
30	Copay	Amount paid by member for services rendered.	7	Number	SEE NARRATIVE SECTION	AMT_CO_PAY
31	Nursihg Home	Indicates whether the member is in a nursing home.	0	Drop Down List Box	SEE NARRATIVE SECTION	IND_NURSE_HOME
32	Days Supply	Number of days a prescribed drug should last a member.	9	Number	SEE NARRATIVE SECTION	NUM_DAY_SUPPLY
33	Dispensing Fee	Amount of dispensing fee, if paid. Format 99999.99	7	Number	SEE NARRATIVE SECTION	AMT_NDC_PROFEE

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
34	Pregnancy	Pregnancy Indicator.	1	Character	SEE NARRATIVE SECTION	IND_PREGNANCY
35	Refill Quantity	Number of refills on the prescription billed.	2	Character	SEE NARRATIVE SECTION	QTY_REFILL
36	DUR Outcome	The response of the pharmacist to the DUR message.	2	Character	SEE NARRATIVE SECTION	CDE_DUR_OUTCOME
37	DUR Intervention	The response of the pharmacist to the DUR message.	2	Character	SEE NARRATIVE SECTION	CDE_DUR_INTRVNTN
38	Batch Num	The unique number of the batch the encounter claim came from	7-10	Character	T_CLM_BATCH_XREF	SAK_BATCH

4.2.115.7 Field Edits

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

4.2.116 PANEL: Pharmacy Claim Navigation

4.2.116.1 Description:

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

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

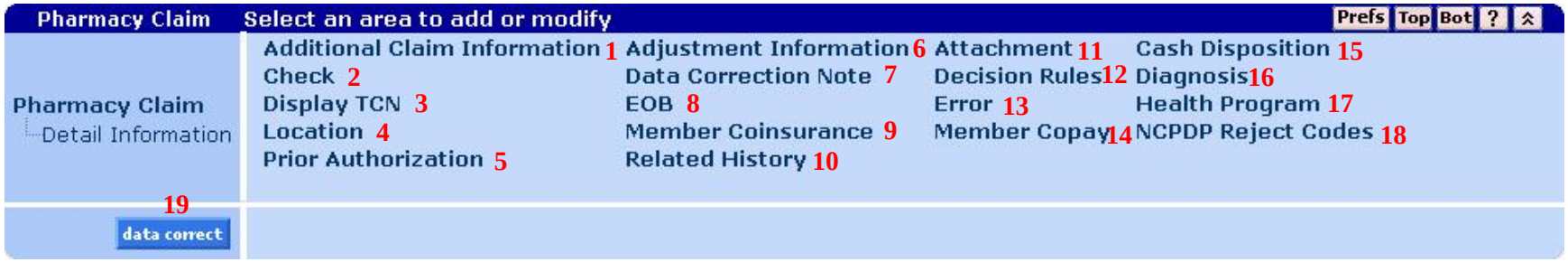
4.2.116.2 Technical Name

Clm.PharmacyClaimPage.ascx - NavGroup

4.2.116.3 Panel Name:

Pharmacy Claim Navigation

4.2.116.4 Pharmacy Claim Navigation Panel Layout



To access this panel:

STEP 1. Click a row to select a claim from search results.

When a claim record is selected, the navigation panel will open below the information panel.

4.2.116.5 Extra Features

This panel has no extra features.

4.2.116.6 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Additional Claim Information	Link to "Additional Claim Information" panel	0	N/A	N/A	N/A
2	Check	Link to "Check " panel.	0	N/A	N/A	N/A
3	Display TCN	Link to "Display TCN" panel.	0	N/A	N/A	N/A
4	Location	Link to "Location" panel.	0	N/A	N/A	N/A
5	Prior Authorization	Link to "Service/Prior Authorization" panel.	0	N/A	N/A	N/A
6	Adjustment Information	Link to "Adjustment Information " panel.	0	N/A	N/A	N/A
7	Data Correction Note	Link to "data Correction Note" panel.	0	N/A	N/A	N/A
8	EOB	Link to "EOB" panel.	0	N/A	N/A	N/A
9	Member Coinsurance	Link to "Member Coinsurance"	0	N/A	N/A	N/A
10	Related History	Link to "Related History" panel.	0	N/A	N/A	N/A
11	Attachment	Link to "Attachment" panel.	0	N/A	N/A	N/A
12	Decision Rules	Link to "Decision Rules" panel	0	N/A	N/A	N/A
13	Error	Link to "Error" panel.	0	N/A	N/A	N/A
14	Member Copay	Link to "Member Copay"	0	N/A	N/A	N/A
15	Cash Disposition	Link to "Cash Disposition" panel.	0	N/A	N/A	N/A
16	Diagnosis	Link to "Diagnosis " panel.	0	N/A	N/A	N/A
17	Health Program	Link to "Health Program" panel.	0	N/A	N/A	N/A
18	NCPDP Reject Codes	Link to "NCPDP Reject Codes" panel.	0	N/A	N/A	N/A

4.2.116.7 Button Descriptions

Button No	Button	Description
19	Data Correct	The Data Correct button will appear if this is a Suspended claim being viewed on the Claim Information Page.

4.2.116.8 Field Edits

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

4.2.117 PANEL: Encounter Data

4.2.117.1 Description

The Encounter Data panel displays the name of the Encounter Batch File on which the encounter was received.

Navigation Path: [Claims -Information] - [Enter an ICN] - [Select Display TCN link from the displayed panel];

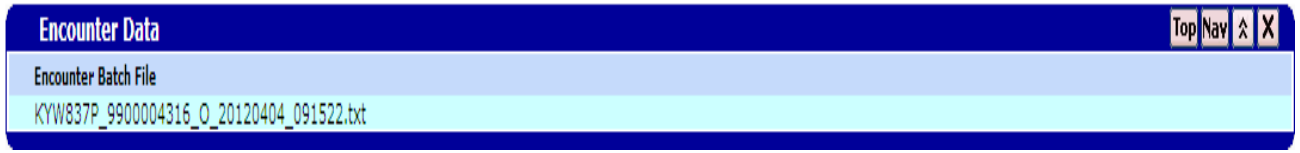
OR - [Claims -Search] - [Enter Criteria] - [Select a claim] - [Select Display TCN link from the displayed panel;

OR - [Claims - Data Correction] - [Enter Clerk ID, search then select a claim from the list] - [Select Display TCN link from the displayed panel].

4.2.117.2 Panel Name

Encounter Data

4.2.117.3 Encounter Data Layout



To access this panel:

STEP 1. Access the Claim Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the Encounter Data button located in the navigation / maintenance panel.

This panel displays the name of the Encounter Batch File on which the encounter was received.

4.2.117.4 Extra Features

This panel has no extra features.

4.2.117.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Encounter Batch File	The name of the Encounter Batch File on which the encounter was received	Field	Character	40	T_FILE_TRACK	NAME_FILE

4.2.117.6 Field Edits

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

4.2.118 PANEL: NCPDP Reject Codes

4.2.118.1 Description:

The NCPDP Reject Codes panel displays the National Council for Prescription Drug Programs (NCPDP) Reject codes and message applicable to a pharmacy claim.

Navigation Path: [Claims -Information] - [Enter an ICN for a Pharmacy claim] - [Select NCPDP Reject Codes link from the displayed panel] - OR - [Claims -Search] - [Enter Criteria] - [Select a Pharmacy claim] - [Select NCPDP Reject Codes link from the displayed panel]

Tables: T_CLM_NCPDP_MSG, T_NCPDP_RESPONSE

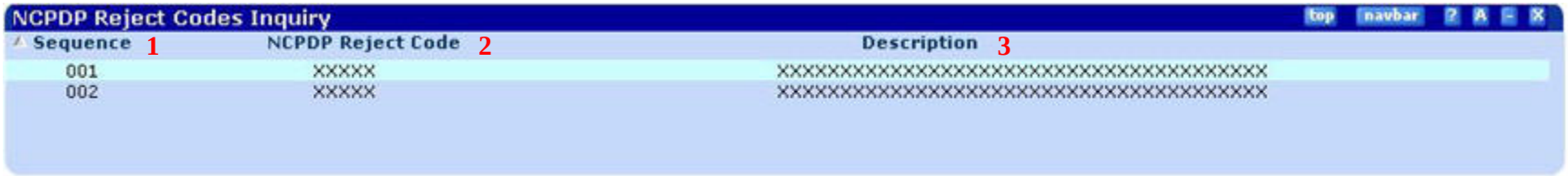
4.2.118.2 Technical Name

Clm.NCPDP Reject Codes (Design)

4.2.118.3 Panel Name:

NCPDP Reject Codes

4.2.118.4 NCPDP Reject Codes Panel Layout



To access this panel:

STEP 1. Access the Claims Information page using the instructions listed for the page.

STEP 2. Enter ICN number (13 digit number).

STEP 3. Click the Search button.

STEP 4. Click the NCPDP Reject Codes button located next to the EOB button.

This panel displays the NCPDP Reject Codes applicable to the claim.

4.2.118.5 Extra Features

This panel has no extra features.

4.2.118.6 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Sequence	This identifies the iteration number for the NCPDP Reject Codes. There can be up to 10 reject codes per transaction.	4	Number	T_CLM_NCPDP_MSG	SEQ
2	NCPDP Reject Code	This identifies the reason for which the pharmacy claims was denied.	4	Character	T_CLM_NCPDP_MSG	CDE_MSG
3	Description	Message explaining the NCPDP Reject Code.	50	Character	T_NCPDP_RESPONSE	DSC_50

4.2.118.7 Field Edits

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

4.3 PAGE: Claims Adjustment Search Page

The Claims Adjustments Search Page contains panels that are used to search for and view adjustments requests.

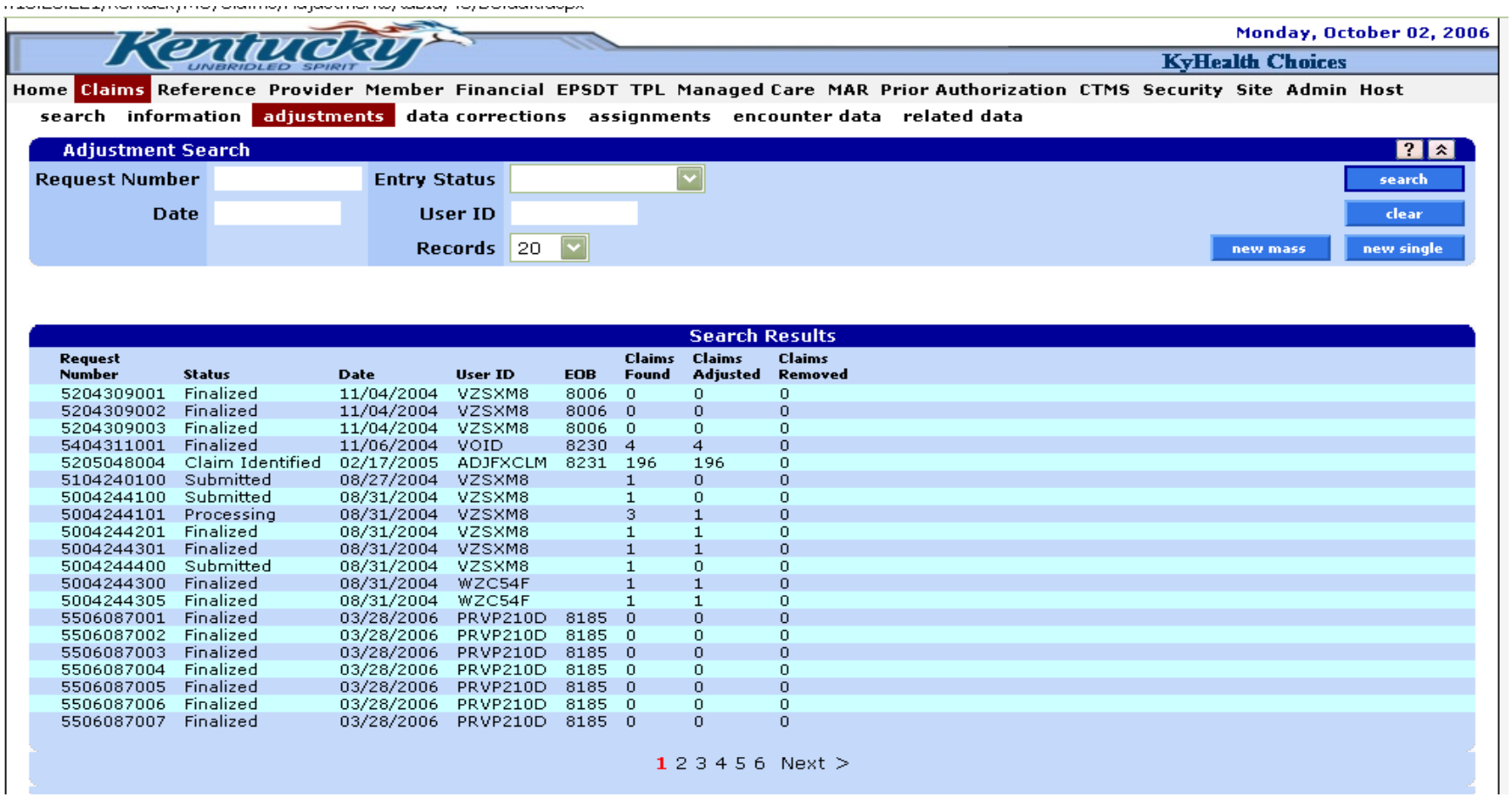
4.3.1 Technical Name

Clm.AdjustmentSearchPage.ascx

4.3.2 Web Page Name

Claims Adjustment Search Page

4.3.3 Claims Adjustment Search Page Layout



To access this page:

STEP1. Click on Claims located in the subsystem header listing under the Commonwealth logo Kentucky Unbridled Spirit.

STEP 2. Click on Adjustments located under the subsystem header listing or click on Adjustments from the drop down listing that appears when the cursor touches the Claims button in the subsystem header listing.

4.3.4 PANEL: Adjustment Search

Use the Adjustment Search panel to search for claim adjustments.
Navigation Path: [Claims - Adjustments]

4.3.4.1 Panel Name

Adjustment Search

4.3.4.2 Adjustment Search Layout

To access this panel:

Access the Claims Adjustment page using the instructions listed for the page.

STEP 1. Select category from the Entry Status drop down box.

STEP 2. Click the Search button.

4.3.4.3 Extra Features

This panel has no extra features.

4.3.4.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Request Number	The request number to be associated with the adjustments for this batch. Format is RRYYDDDBBB; RR region, YYDDD Julian year and day, BBB batch number	Field	Number	10	T_ADJ_MASS_RQST	NUM_MASS_RQST
2	Date	The date of the adjustment request	Field	Date (MM/DD/CCYY)	8	T_ADJ_MASS_RQST	NUM_COUNT

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
3	Entry Status	The status of the claim when adjustment request was made	Field	Drop Down List Box	20	T_EOB	CDE_EOB
4	User ID	ID of the user who made the request	Field	Character	8	T_ADJ_MASS_CLAIM	CASH_CTL_NO
5	Records	The number of records to be displayed	Field	Drop Down List Box	3	T_ADJ_MASS_CLAIM	NUM_ICN

4.3.4.5 Button Descriptions

Button No	Button	Description
6	Search	Returns the information for the entered search criteria
7	Clear	Clears data in the search fields
8	New Mass	Creates a new mass adjustment
9	New Single	Creates a new single adjustment

4.3.4.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Date	Field	1	Invalid Date. Format MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.

4.3.5 PANEL: Adjustment Search Results

The Adjustment Search Results panel displays the Claims Adjustment Search records returned by the search criteria.
Navigation Path: [Claims - Adjustments] - [Click Search]

4.3.5.1 Panel Name

Adjustment Search Results

4.3.5.2 Adjustment Search Results Layout

Search Results

1 Request Number	2 Status	3 Date	4 User ID	5 EOB	6 Claims Found	7 Claims Adjusted	8 Claims Removed
5004240001	Claim Identified	08/27/2004	HZGZ6S		2	0	0
5004243100	Claim Identified	08/30/2004	VZSXM8		1	0	0
5004243200	Claim Identified	08/30/2004	VZSXM8		1	0	0
5104243200	Submitted	08/30/2004	VZSXM8		1	0	0
5604243002	Claim Identified	08/30/2004	VZSXM8		1	0	0
5704243001	Submitted	08/30/2004	VZSXM8		1	0	0
5004243008	Claim Identified	08/30/2004	VZSXM8		1	0	0
5104243009	Submitted	08/30/2004	VZSXM8		1	0	0
5004243088	Claim Identified	08/30/2004	VZSXM8		1	0	0
5004243009	Claim Identified	08/30/2004	VZSXM8		1	0	0

1 2 3 4 5 6 7 8 9 10 ... Next ≥

To access this panel:

Access the Claims Adjustment page using the instructions listed for the page.

STEP 1. In the Adjustment Search panel (first box), select category from the Entry Status drop down box. Click the Search button.

STEP 2. Click on a row from the listing to select a claim adjustment.

4.3.5.3 Extra Features

This panel has no extra features.

4.3.5.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Request Number	The request number to be associated with the adjustments for this batch. Format is RRYYDDDBBB; RR region, YYDDD Julian year and day, BBB batch number	Field	Numeric	10	T_ADJ_MASS_RQST	NUM_MASS_RQST
2	Status	Status of the adjustment request	Field	Character	10	T_ADJ_MASS_RQST	CDE_STATUS1
3	Date	Adjustment request entry date	Field	Date (MM/DD/CCYY)	8	T_ADJ_MASS_RQST	DTE_REQUEST
4	User ID	Clerk who entered the adjustment request	Field	Character	8	T_ADJ_MASS_RQST	ID_CLERK
5	EOB	Explanation of Benefits code, reason for the adjustment	Field	Character	4	T_EOB	CDE_EOB
6	Claims Found	Total number of claims retrieved in this adjustment request	Field	Numeric	9	T_ADJ_MASS_RQST	NUM_COUNT
7	Claims Adjusted	Total number of claims adjusted in this adjustment request	Field	Numeric	9	T_ADJ_MASS_RQST	NUM_COUNT_ADJ
8	Claims Removed	Total number of claims removed from this adjustment request	Field	Numeric	9	T_ADJ_MASS_RQST	NUM_COUNT_DEL

4.3.5.5 Field Edits

Field	Field Type	Error Code	Error Message	To Correct

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

4.4 PAGE: Claims Adjustment Information Page

Use the Adjustment Information Page to access panels to display or create adjustment requests.

4.4.1 Technical Name

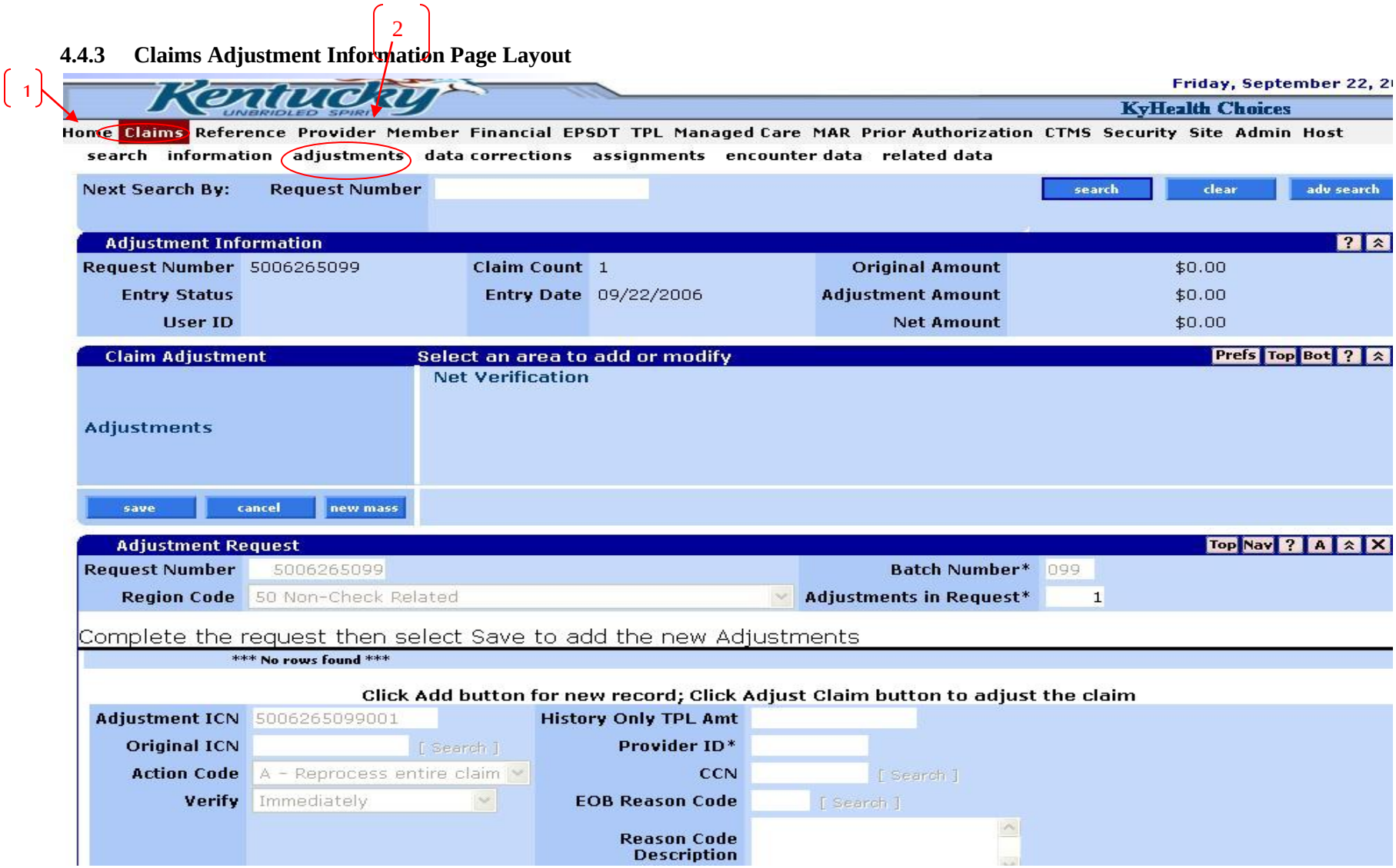
Clm.AdjustmentInformationPage.ascx

4.4.2 Web Page Name

Adjustment Information Page

For readability, this panel layout displays on the next page.

4.4.3 Claims Adjustment Information Page Layout



4.4.4 PANEL: Adjustment Mini-Search

The Adjustment Mini-Search panel permits new searches from both the Adjustment Information and the Mass Adjustment Information panels without having to return to the Adjustment Search panel.
Navigation Path: [Claims - Adjustments] - [Click Search] - [select an adjustment request]

4.4.4.1 Panel Name

Adjustment Mini Search

4.4.4.2 Adjustment Mini-Search Layout

To access this panel:

Access the Claims Adjustment page using the instructions listed for the page or use this panel after each adjustment is done in order not to go to the full Search page.

STEP 1. Enter the ten digit Request Number.

STEP 2. Click the Search button.

4.4.4.3 Extra Features

This panel has no extra features.

4.4.4.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Request Number	A unique number that identifies the mass adjustment request. Format: RRYYJJJBBB (RR - Region, YYJJJ - Julian date, BBB - Batch number). It is user-typed for manually entered adjustment requests, and system-assigned for system generated adjustments	Field	Number	10	T_ADJ_MASS_RQST	NUM_MASS_RQST
2	Search	Returns the information for the entered Request Number	Button	N/A	0	N/A	N/A

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
3	Clear	Clears the previous Adjustment Request Number from the search field	Button	N/A	0	N/A	N/A
4	Adv Search	Returns the full Adjustment Search panel	Button	N/A	0	N/A	N/A

4.4.4.5 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Request Number	Field	1	Enter a valid value.	Enter a numeric value in the Request Number field.
1	Request Number	Field	2	Record cannot be found for Request Number.	The number entered is not a valid Request Number. Enter an existing Request Number.

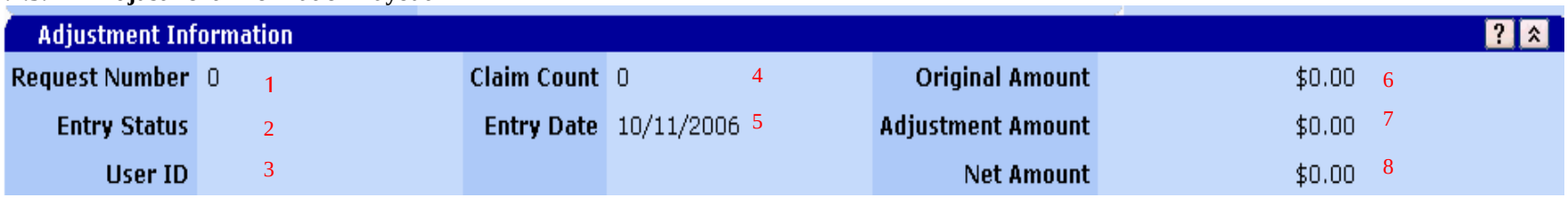
4.4.5 PANEL: Adjustment Information

The Adjustment Information panel displays information for a selected adjustment record.
Navigation Path: [Claims - Adjustments] - [select an adjustment request for a single claim]

4.4.5.1 Panel Name

Adjustment Information

4.4.5.2 Adjustment Information Layout



To access this panel:

STEP 1. Access the Claims Adjustment page using the instructions listed for the page.

STEP 2. Click the New Single button.

This panel displays information after the adjustment request panel located at the bottom is filled.

4.4.5.3 Extra Features

This panel has no extra features.

4.4.5.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Request Number	A 10 byte unique number that identifies the mass adjustment request. Format: RRYYJJJBBB. It is user-typed for manually entered adjustment requests, and system-assigned for system generated adjustments	Field	Number	10	T_ADJ_MASS_RQST	NUM_MASS_RQST
2	Entry Status	Indicates whether adjustment request is 'S' - submitted, 'I' - Claims Identified, 'P' -	Field	Character	20	T_ADJ_MASS_RQST	CDE_STATUS1

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
		Processing, 'D' - Deleted, 'V' - Verified, or 'F' - Finalized					
3	User ID	Indicates a specific user of the system and can be used to identify who entered or last updated the Adjustment Request	Field	Character	8	T_ADJ_MASS_RQST	ID_CLERK
4	Claim Count	The number of claims found for the adjustment request	Field	Number	9	T_ADJ_MASS_RQST	NUM_COUNT
5	Entry Date	Adjustment request entry date	Field	Date (MM/DD/CCYY)	8	T_ADJ_MASS_RQST	DTE_REQUEST
6	Original Amount	The original amount of the claim	Field	Number	10	N/A	N/A
7	Adjustment Amount	The adjusted amount of the claim	Field	Number	10	N/A	N/A
8	Net Amount	The amount by which the Original Amount was adjusted. This field is calculated by subtracting the Adjustment Amount from the Original Amount	Field	Number	10	N/A	N/A

4.4.5.5 Field Edits

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

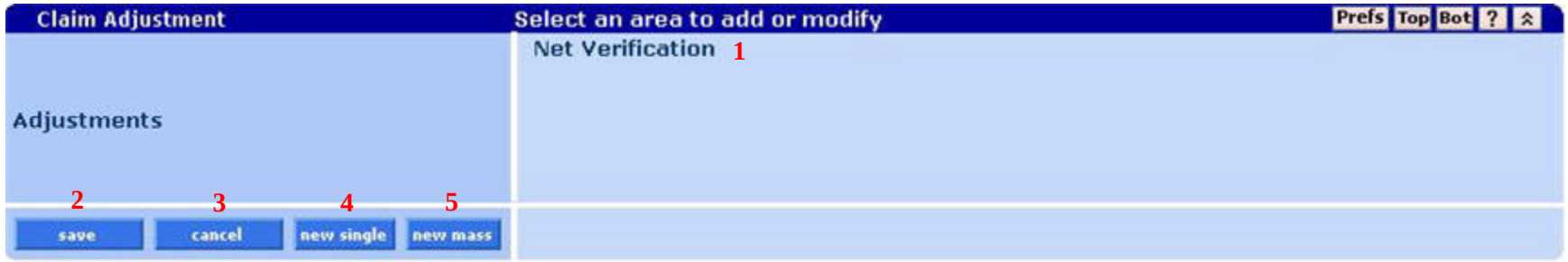
4.4.6 PANEL: Claim Adjustment Navigation

Use the Claim Adjustment Navigation panel to navigate to the Net Verification panel.
Navigation Path: [Claims -Adjustments] - [Enter Criteria] - [Click Search] - [Select a request]

4.4.6.1 Panel Name

Claim Adjustment Navigation

4.4.6.2 Claim Adjustment Navigation Layout



To access this panel:

Access the Claims Adjustment page using the instructions listed for the page.

STEP 1. In the Adjustment Search panel (first box), select category from the Entry Status drop down box. Click the Search button.

STEP 2. Click on a row from the listing to select a specific claim adjustment.Panel is the second box down. This panel displays the Net Verification button [1] which brings up a panel to verify or update changes made to an adjustment

The Save button [2] on this panel saves any changes made to an adjustment on any panels.

The Cancel button [3] on this panel cancels any changes made in any panel to an adjustment.

The New Mass button [4] creates a new mass adjustment record.

4.4.6.3 Extra Features

This panel has no extra features.

4.4.6.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Net Verification	Link to the Net Verification panel which verifies and updates the financial changes made to adjusted claims	Hyperlink	N/A	0	N/A	N/A

4.4.6.5 Button Descriptions

Button No	Button	Description
2	Save	Saves any changes made to panels on this page
3	Cancel	Cancels any changes made to panels on this page
4	New Single	Creates a new single.
5	New Mass	Creates a new mass adjustment

4.4.6.6 Field Edits

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

4.4.7 PANEL: Adjustment Request

Use the Adjustment Request panel to enter or update single adjustment requests.

Navigation Path: [Claims - Adjustments] - [Select an adjustment request]

4.4.7.1 Panel Name

Adjustment Request

4.4.7.2 Adjustment Request Layout

To access this panel:

Access the Claims Adjustment page using the instructions listed for the page.

STEP 1. In the Adjustment Search panel (first box), select category from the Entry Status drop down box. Click the Search button.

STEP 2. Click on a row from the listing to select a claim adjustment or click on New Single or New Mass button to create a new record.

STEP 3. Enter amt of claims to be adjusted and a batch number (6). Click the Save button. This brings up a new area to fill.

STEP 4. Click the Search button next to Original ICN field (8). This brings up a pop-up window listing of claims.

STEP 5. Click a row on the listing to select claim. This populates the Original ICN field and also populates a dollar amount in the History Only TPL Amount field. Enter a nine digit provider ID in the Provider ID field (10).

STEP 6. Click the Search button next to the EOB field (11). This brings up a pop-up window listing EOB codes.

STEP 7. When required fields are filled, click Adj Claim button to save adjustment. (12)

This panel allows a new record to be created for an existing adjustment.

4.4.7.3 Extra Features

This panel has no extra features.

4.4.7.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Request Number	A 10 byte unique number that identifies the mass adjustment request. Format: RRYYJJJBBB. (RR - Region, YYJJJ - Julian date, BBB - Batch number). It is user-typed for manually entered adjustment requests, and system-assigned for system generated adjustments	Field	Character	10	T_ADJ_MASS_RQST	NUM_MASS_RQST
2	Region Code	The Adjustment Request category	Field	Drop Down List Box	25	T_ADJ_MASS_RQST	NUM_MASS_RQST
3	Batch Number	The batch number of the record that was subject to the Adjustment Request	Field	Character	3	T_ADJ_MASS_RQST	NUM_MASS_RQST
4	Adjustments in Request	The number of adjustments contained in the Adjustment Request	Field	Character	3	T_ADJ_MASS_RQST	NUM_COUNT

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Adjustment ICN	This field is calculated based on the value of the Request Number and the Sequence number if the record is being added. If this is an existing request, the Adjustment ICN is obtained from one of the following tables, depending on Claim Type: T_ADJ_UB92_XREF, T_ADJ_PHRM_XREF, T_ADJ_PHYS_XREF or T_ADJ_DENT_XREF	Field	Character	13	SEE FIELD DESCRIPTION	NUM_ICN
6	Original ICN	The original ICN of the claim being adjusted	Field	Character	13	T_ADJ_MASS_CLAIM	NUM_ICN
7	CCN	Cash Control Number used to assign cash to the adjustment	Field	Character	13	T_ADJ_MASS_RQST	CASH_CTL_NO
8	EOB Reason Code	EOB code that identifies the reason for the adjustment	Field	Numeric	4	T_EOB	CDE_EOB
9	Reason Code Description	The description for the EOB Reason Code	Field	Character	30	T_ADJ_MASS_CLAIM	SAK_EOB
10	History Only TPL Amt	Field to add or change Third Party Liability amount for an adjusted claim	Field	Number	10	T_ADJ_MASS_CLAIM	AMT_PAID
11	Action Code	The action that claims engine needs to take on this adjustment: A or blank - reprocess the whole claim; P - reprocess specific details; H - update history only do not edit, audit, or re-price	Field	Drop Down List Box	30	T_ADJ_MASS_CLAIM	CDE_ADJ_ACTION

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
12	Verify	Force Adjustment to suspend indicator. Values: A -suspend after CE (Claims Engine) processing, B -suspend before CE processing, space - ignore suspense and mark claim available for CE processing	Field	Drop Down List Box	20	T_ADJ_MASS_RQST	IND_SUSPEND
13	Provider ID	The provider identification number that uniquely identifies the pay to provider	Field	Character	9	T_ADJ_MASS_CLAIM	SAK_PROV

4.4.7.5 Button Descriptions

Button No	Button	Description
14	Add	Add a new record
15	Adj Claim	Adjusts the selected Claim

4.4.7.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Request Number	Field	1	The request number must be in the format of RRYYDDDBBB.	Enter information for the request before clicking the Save button.
3	Batch Number	Field	1	Batch Number is required.	Enter a numeric Batch Number between 001-999.
4	Adjustments in Request	Field	1	Adjustment in Request can not be zero.	Enter a numeric value greater then zero.
5	Adjustment ICN	Field	1	Adjustment ICN cannot be found.	Adjustment ICN is not valid.
6	Original ICN	Field	1	Cannot adjust a non-Paid claim.	Only paid claims can be adjusted.
10	History Only TPL Amt	Field	1	Enter a valid value.	Enter a numeric value in the History Only TPL Amt field.

Field No	Field	Field Type	Error Code	Error Message	To Correct
11	Action Code	Field	1	Action code is required.	For single adjustments, Action Code is required.

4.4.8 PANEL: Net Verification

The Net Verification panel permits the user to verify and update the financial changes made to adjusted claims. The following rules apply to changing the Adjustment Status of the claim:

- The New Claim Status must not be in a Paid or Denied status;
- The user cannot change the Adjustment Status if the current adjusted status is Finalized, Processed, Deleted;
- The user can change the Adjustment Status to Release only if the current adjusted status is Suspended or Delete; and,
- The user can change the Adjustment Status to Delete if the current adjusted status is Suspended or Release.

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

Tables: T_ADJ_MASS_CLAIM, T_HIST_DIRECTORY

4.4.8.1 Technical Name

Clm.AdjustmentNetVerificationPanel.ascx

4.4.8.2 Panel Name

Net Verification

4.4.8.3 Net Verification Layout

To access this panel:

Access the Claims Adjustment page using the instructions listed for the page.

STEP 1. In the Adjustment Search panel (first box), select category from the Entry Status drop down box. Click the Search button.

STEP 2. Click on a row from the listing to select a claim adjustment.

STEP 3. Click the Net Verification button.

This panel displays financial information pertaining to the adjustment. It allows this panel to be updated only if the adjustment is not in a paid or denied status.

4.4.8.4 Extra Features

This panel has no extra features.

4.4.8.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Action Code	The action code determining how the adjustment is processed in batch. Values: 'A' - reprocess entire claim, 'P' - only reprocess claim details, 'H' - history only, do not edit, audit, or re-price	Field	Character	5	T_ADJ_MASS_CLAIM	CDE_ADJ_ACTION
2	Original ICN [List]	Field to add or change original Internal Control Number of an adjusted claim	Field	Character	13	T_ADJ_MASS_CLAIM	NUM_ICN
3	Adjustment ICN [List]	Field to add or change new Internal Control Number of an adjusted claim	Field	Character	13	T_HIST_DIRECTORY	NUM_ICN_FL
4	Original Amount	The original amount of the claim. This is a calculated value obtained by adding the Paid Amount and the State Share amount from the original Claim (from the T_CLM_PGM_XREF table). Format 99999999.99	Field	Number	9	N/A	N/A
5	Adjustment Amount	The adjusted amount of the claim. This is a calculated value obtained by adding the Paid Amount and the State Share amount from the adjusted claim (from the T_CLM_PGM_XREF table). Format 99999999.99	Field	Number	9	N/A	N/A

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
6	Net Amount	The amount by which the Original Amount was adjusted. This is a calculated value determined by subtracting the Adjustment Amount from the Original Amount. Format 99999999.99	Field	Number	9	N/A	N/A
7	Adjusted Status	Indicates the status of the claim being adjusted	Field	Character	10	T_ADJ_MASS_CLAIM	CDE_STATUS1
8	New Claim Status	The status of the adjusted claim	Field	Character	10	T_HIST_DIRECTORY	CDE_CLM_STATUS
9	CCN	Cash or check receipt control number used in dispositioning the adjustment with the cash received	Field	Character	11	T_ADJ_MASS_CLAIM	CASH_CTRL_NO
10	EOB	Explanation of Benefits Code, reason for the adjustment	Field	Number	4	T_EOB	CDE_EOB
11	Original ICN [Detail]	Field to add or change original Internal Control Number of an adjusted claim	Field	Character	13	T_ADJ_MASS_CLAIM	NUM_ICN
12	Adjustment Status	Field to add or update the status of a claim being adjusted	Field	Drop Down List Box	10	T_ADJ_MASS_CLAIM	CDE_STATUS1
13	Adjustment ICN [Detail]	Field to add or change new Internal Control Number of an adjusted claim	Field	Character	13	T_HIST_DIRECTORY	NUM_ICN_FL

4.4.8.6 Button Descriptions

Button No	Button	Description
14	Resubmit All	Sets the Adjustment Status field to R for all records. Clicking a second time blanks out the adjustment status field

Button No	Button	Description
15	Delete All	Sets the Adjustment Status field to D for all records. Clicking a second time blanks out the adjustment status field
16	Data Correct	Opens up the Corrections panel for the selected claim

4.4.8.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
7	Adjusted Status	Field	1	Cannot change the Status.	The status cannot be changed based on the value of the current status.
16	Data Correct	Button	1	You must select either delete or release to update.	Ensure the Action Code contains a value.

4.5 PAGE: Claims Mass Adjustment Information Page

4.5.1 Description

Use the Claims Mass Adjustment Information Page for access to panels to view or create mass adjustments.

4.5.2 Technical Name

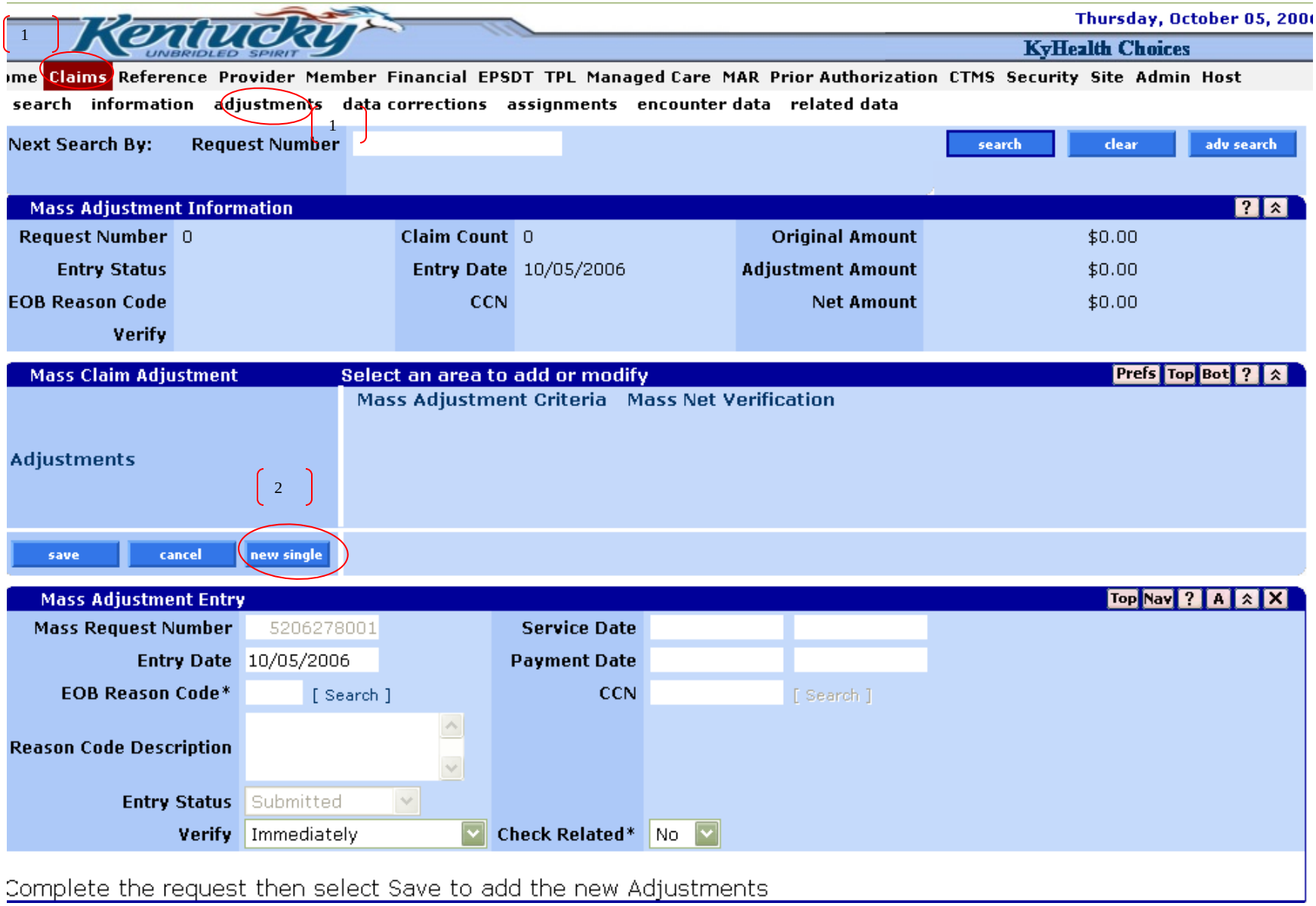
Prov.ClaimsMassAdjustmentInformationPage.ascx

4.5.3 Web Page Name:

Mass Adjustment Page

For readability the layout displays on the next page.

4.5.4 Claims Mass Adjustment Information Page Layout



To access this page:

STEP 1. Click on Claims located in the subsystem header listing under the Commonwealth logo “Kentucky Unbridled Spirit”.

STEP 2. Click on Adjustments (1) located under the subsystem header listing or click on Adjustments from the drop down listing that appears when the cursor touches the Claims button in the subsystem header listing.

STEP 3. Click on the New Mass (2) button in the Adjustment Search panel at the top of the page.

4.5.5 PANEL: Mass Adjustment Information

4.5.5.1 Description

The Mass Adjustment Information panel displays information for a selected mass adjustment record.

Navigation Path: [Claims - Adjustments] - [Select a mass adjustment request]

4.5.5.2 Panel Name

Mass Adjustment Information

4.5.5.3 Mass Adjustment Information Layout

To access this panel:

Access the Claims Mass Adjustment Information page using the instructions listed for the page.

4.5.5.4 Extra Features

This panel has no extra features.

4.5.5.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Request Number	Adjustment request number	Field	Number	10	T_ADJ_MASS_CLAIM	NUM_MASS_RQST
2	Entry Status	Status of the adjustment request	Field	Character	10	T_ADJ_MASS_CLAIM	CDE_STATUS1
3	EOB Reason Code	Explanation of Benefit reason for the adjustment	Field	Number	4	T_EOB	CDE_EOB

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
4	Verify	Force Adjustment to suspend indicator. Values: A -suspend after CE (Claims Engine) processing, B -suspend before CE processing, space - ignore suspense and mark claim available for CE processing	Field	Character	20	T_ADJ_MASS_RQST	IND_SUSPEND
5	Claim Count	The sequence number of the selected claim in the search list	Field	Character	6	T_ADJ_MASS_RQST	NUM_COUNT
6	Entry Date	Adjustment request entry date	Field	Date (MM/DD/CCYY)	8	T_ADJ_MASS_RQST	DTE_REQUEST
7	CCN	Cash or check receipt control number used in dispositioning the adjustment with the cash received	Field	Character	11	T_ADJ_MASS_RQST	CASH_CTL_NO
8	Original Amount	The original amount of the claim. This is a calculated value obtained by adding the Paid Amount and the State Share amount from the original Claim (from the T_CLM_PGM_XREF table). Format 99999999.99	Field	Character	10	N/A	N/A

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
9	Adjustment Amount	The adjusted amount of the claim. This is a calculated value obtained by adding the Paid Amount and the State Share amount from the adjusted claim (from the T_CLM_PGM_XREF table). Format 99999999.99	Field	Character	10	N/A	N/A
10	Net Amount	The amount by which the Original Amount was adjusted. This is a calculated value determined by subtracting the Adjustment Amount from the Original Amount. Format 99999999.99	Field	Character	10	N/A	N/A

4.5.5.6 Field Edits

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

4.5.6 PANEL: Mass Claims Adjustment Navigation

4.5.6.1 Description

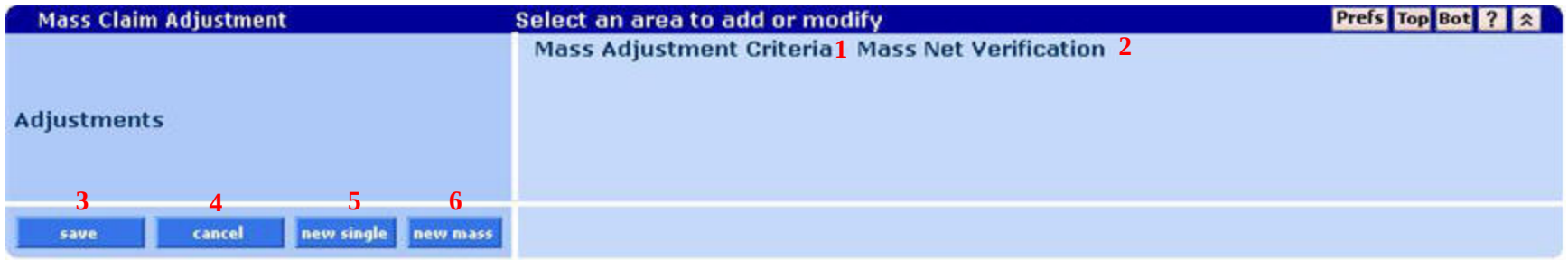
The Mass Claims Adjustment Navigation panel displays links to the Mass Net Verification panel and the Mass Adjustment Criteria panel.

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

4.5.6.2 Panel Name

Mass Claim Adjustment

4.5.6.3 Mass Claims Adjustment Navigation Layout



To access this panel:

STEP 1. Access the Claims Mass Adjustment Information page using the instructions listed for the page.

The Save button on this panel saves any changes made to an adjustment on any panel.

The Cancel button on this panel cancels any changes made to an adjustment in any panel.

The New Single button on this opens a panel to create a single new adjustment.

STEP 2. Click the Mass Adjustment Criteria button to go to the panel that allows different information to be submitted as criteria to locate claims for adjustment.

STEP 3. Click the Mass Net Verification button to go to the panel that allows verification and update changes to a mass adjustment.

4.5.6.4 Extra Features

This panel has no extra features.

4.5.6.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Mass Adjustment Criteria	Activates the Mass Adjustment Criteria search, display, and update panel	Hyperlink	N/A	0	N/A	N/A
2	Mass NetVerification	Activates the Net Verification display and update panel	Hyperlink	N/A	0	N/A	N/A

4.5.6.6 Button Descriptions

Button No	Button	Description
3	Save	Causes the record to be saved to the database
4	Cancel	This button does not save any changes and close the panel
5	New Single	Starts a new single adjustment
6	New Mass	Creates a new mass adjustment.

4.5.6.7 Field Edits

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

4.5.7 PANEL: Mass Adjustment Entry

4.5.7.1 Description

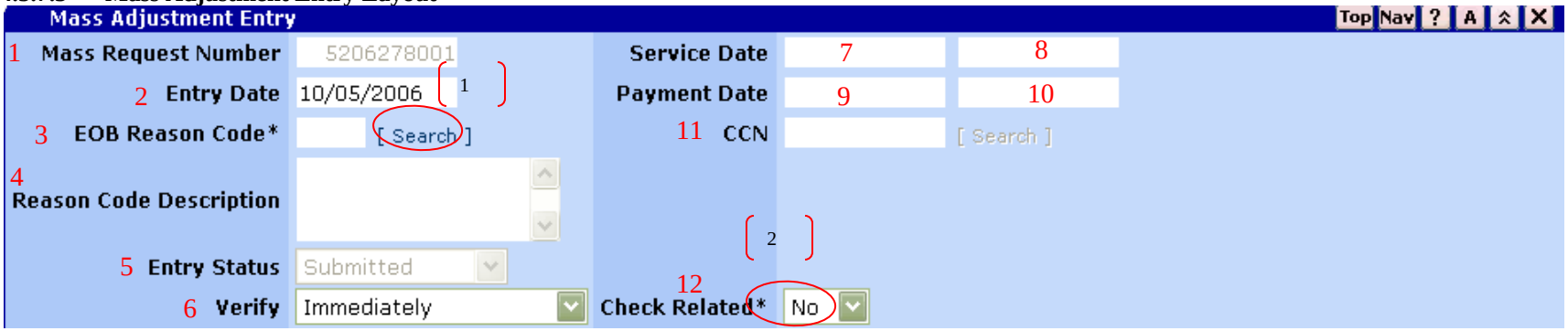
The adjustment analyst uses the Mass Adjustment Entry panel to enter a mass adjustment request.

Navigation Path: [Claims - Adjustments] - [Click New Mass button]

4.5.7.2 Panel Name

Mass Adjustment Entry

4.5.7.3 Mass Adjustment Entry Layout



To access this panel:

STEP 1. Access the Claims Mass Adjustment Information page using the instructions listed for the page.

STEP 2. Scroll to the third panel down (just below the save and cancel buttons). This panel allows a new mass adjustment to be entered.

STEP 3. Click the Search button (1) next to the EOB Reason Code field to bring up the pop-up window listing.

STEP 4. Click a row to select.

STEP 5. Select from the Check Related drop down box. (2)

STEP 6. Edit fields applicable to mass adjustment. NOTE:The Mass Request Number field is not updatable and populates with the next available number.

STEP 7. Click the Save button.

4.5.7.4 Extra Features

This panel has no extra features.

4.5.7.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Mass Request Number	The system-assigned number for a Mass Adjustment Request	Field	Number	14	TBD	TBD
2	Entry Date	Indicates the date the request was entered, system-assigned	Field	Date (MM/DD/CCYY)	8	TBD	TBD
3	EOB Reason Code	The Explanation of Benefits Reason identifies the reason for the request. The type of EOB also controls the processing action for editing and auditing purposes. Valid values: 8032 thru 8038, inclusive	Field	Character	4	TBD	TBD
4	Reason Code Description	Explanation of the EOB Reason Code	Field	Character	50	TBD	TBD
5	Entry Status	Indicates the status of the request, system determined	Field	Drop Down List Box	20	TBD	TBD
6	Verify	Indicates the mass adjustment should suspend for review, the adjustment processes through the Claims Engine and suspends for review at the end of processing. A - suspend after running through the claims engine, B - suspend before running through the claims engine	Field	Drop Down List Box	1	TBD	TBD
7	Service Date (From)	Indicates the from service date as stated on the claim	Field	Date (MM/DD/CCYY)	8	TBD	TBD
8	Service Date (To)	Indicates the to service date as stated on the claim	Field	Date (MM/DD/CCYY)	8	TBD	TBD

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
9	Payment Date (From)	Indicates the from payment date of the claim	Field	Date (MM/DD/CCYY)	8	TBD	TBD
10	Payment Date (To)	Indicates the to payment date of the claim	Field	Date (MM/DD/CCYY)	8	TBD	TBD
11	CCN	The cash or check control number used to describe the receipt of cash	Field	Character	11	TBD	TBD
12	Check Related	Indicates whether the system-assigned key is cash receipts	Field	Drop Down List Box	0	TBD	TBD

4.5.7.6 Field Edits

Field No.	Field	Field Type	Error Code	Error Message	To Correct
1	Mass Request Number	Field	1	The request number must be in the format of RRYYDDDBBB.	Enter data into the panel before clicking the Save button.
2	Mass Request Number	Field	2	The request must have one of the following: 1) List of members; 2) List of provider IDs and service locations; 3) List of Error Codes; 4) List of Procedure Code and Modifiers; 5) List of NDC Codes; 6) Revenue Codes (UB92 Only).	Enter required Mass Adjustment Criteria information.
3	EOB Reason Code	Field	1	EOB Reason Code not found.	Enter an existing EOB reason or select a code from the [Search] panel.
4	EOB Reason Code	Field	2	Adj Reason Code must be 8232 - 8238.	Enter a reason code between 8232 - 8238.
5	EOB Reason Code	Field	3	Adj Reason Code is required.	Enter an existing EOB reason or select one from the [Search] panel.

Field No.	Field	Field Type	Error Code	Error Message	To Correct
6	Service Date (From)	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a date in MM/DD/CCYY format.
7	Service Date (To)	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter an ending Service Date in the format: MM/DD/CCYY.
8	Service Date (To)	Field	2	ServiceDate must be less than or equal to ServiceToDate.	Enter an ending Service Date which is greater than or equal to the starting Service Date.
9	Service Date (To)	Field	3	The service date cannot be greater than today's date.	Enter a date less than or equal to today's date.
10	Payment Date (From)	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
11	Payment Date (From)	Field	2	The payment date cannot be greater than today's date.	Enter a valid date that is not greater than today's date.
12	Payment Date (To)	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter an ending Payment Date in MM/DD/CCYY format.
13	Payment Date (To)	Field	2	Payment From Date must be less than or equal to Payment To Date.	Enter a Payment From date that is equal to or less then the Payment To date.
14	CCN	Field	1	CCN number not found.	Enter a valid CCN number or select a valid number from the [Search] panel.
15	CCN	Field	2	CCN is required.	If the mass adjustment is check related, then the CCN number must be entered.
16	CCN	Field	3	CCN is not allowed on non-check related adjustment.	User can only enter a CCN if the Check Related = Yes.

Field No.	Field	Field Type	Error Code	Error Message	To Correct
17	CCN	Field	4	CCN balance is not greater than zero.	Balance for CCN must be greater than zero.
18	CCN	Field	5	Cash related adjustments must have a Paid Amount greater than zero.	Ensure the Paid Amount is greater than zero.

4.5.8 PANEL: Mass Adjustment Criteria

4.5.8.1 Description

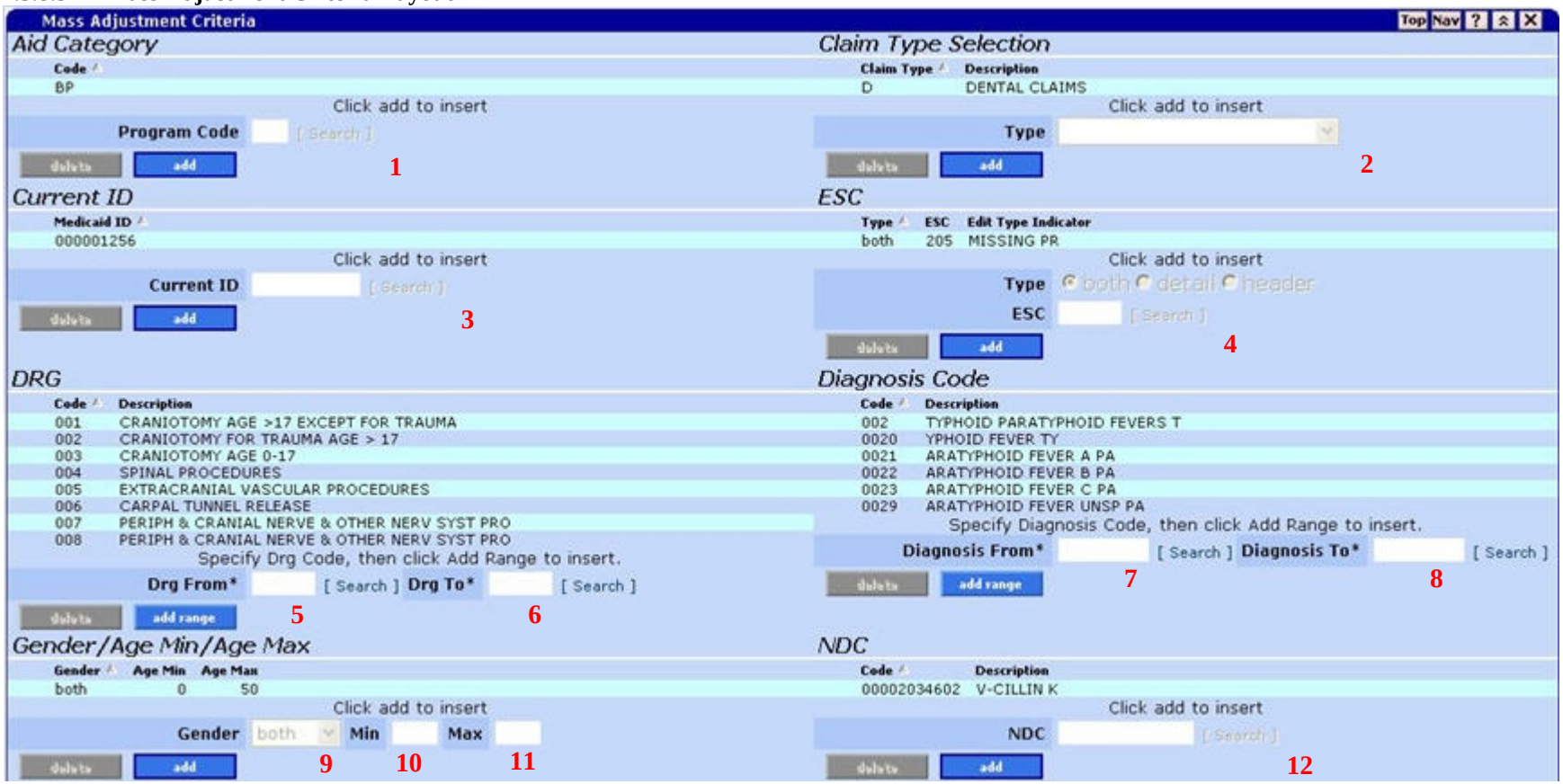
Use the combined Mass Adjustment Criteria panel to add and delete Mass Adjustment criteria.

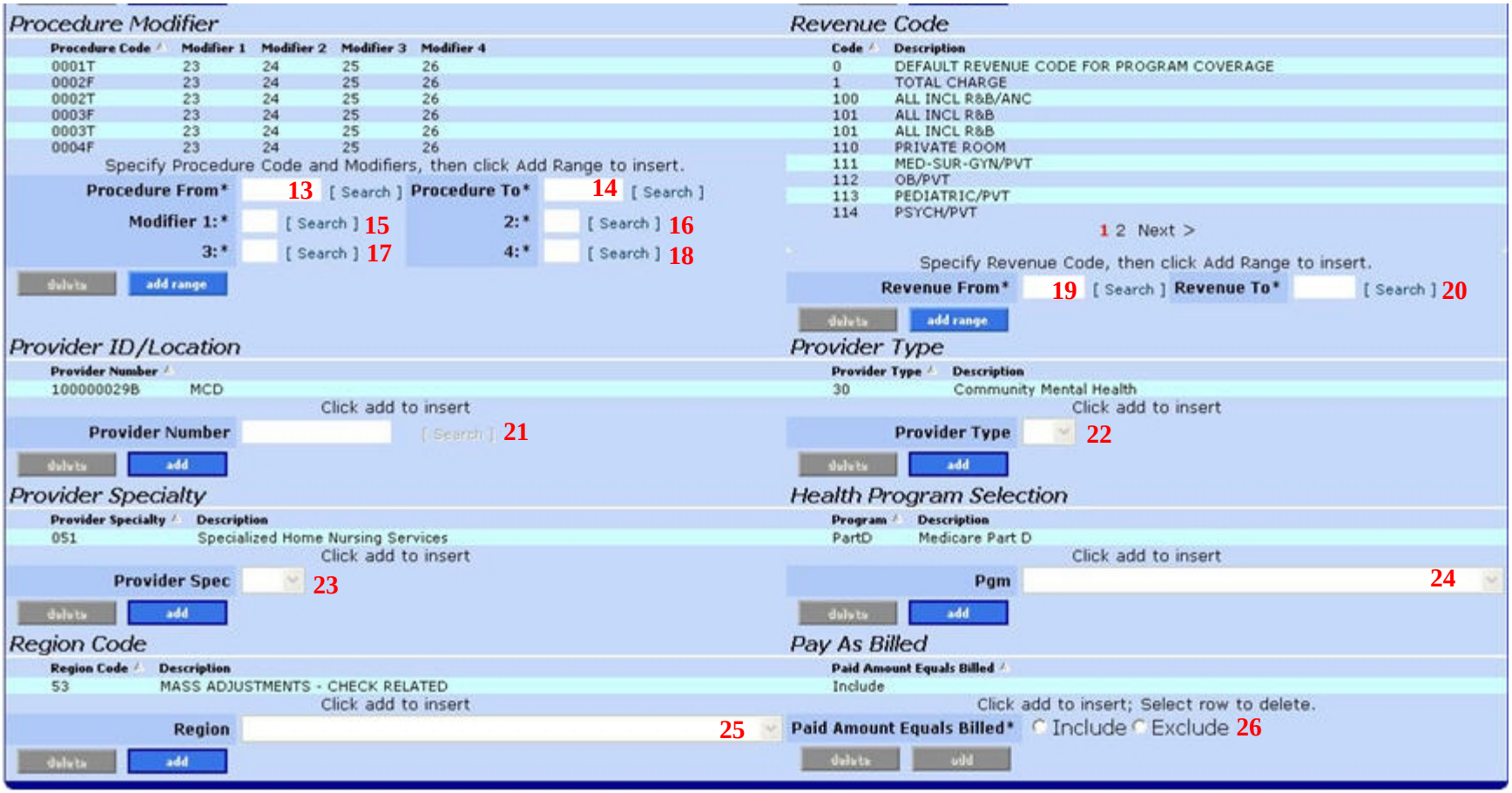
Navigation Path: [Claims - Adjustments] - [select a mass adjustment request] - [Mass Adjustment Criteria]

4.5.8.2 Panel Name

Mass Adjustment Criteria

4.5.8.3 Mass Adjustment Criteria Layout





To access this panel:

STEP 1. Access the Claims Mass Adjustment Information page using the instructions listed for the page.

STEP 2. Click the Mass Adjustment Criteria button.

This panel displays several field categories to select to create the applicable criteria to locate claims for mass adjustment.

STEP 3. Click the Add button (1) on the field to activate it.

STEP 4. Click the Search button (2) on the field to bring up the pop-up window listing.

STEP 5. Click a row to select or select from the drop down box of the field.

STEP 6. Click the Save button when all applicable fields are entered.

4.5.8.4 Extra Features

This panel has no extra features.

4.5.8.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Aid Category Program Code	The aid category entered as criteria	Field	Number	9	T_ADJMS_AID_CAT	SAK_CDE_AID
2	Claim Type Selection Type	Claim type chosen as criteria	Field	Drop Down List Box	1	T_ADJMS_CT	CDE_CLM_TYPE
3	Current ID	Displays the member ID used for criteria	Field	Character	12	T_RE_BASE	ID_MEDICAID
4	ESC	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit	Field	Number	4	T_ADJMS_ERROR	CDE
5	Drg From	Diagnosis Related Group From field. DRG is a code identifying the classification of diagnoses in which patients demonstrate similar resource consumption and length of stay patterns	Field	Character	4	T_DRG	CDE_DRG
6	Drg To	Diagnosis Related Group To field used as range criteria	Field	Character	4	T_DRG	CDE_DRG

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
7	Diagnosis From	Diagnosis From code used as criteria. Diagnosis code specifies the condition requiring medical attention	Field	Character	7	T_ADJMS_DIAG	SAK_DIAG
8	Diagnosis To	Diagnosis To used as range criteria	Field	Character	7	T_ADJMS_DAIG	SAK_DIAG
9	Gender	The sex/gender of the member	Field	Drop Down List Box	1	T_ADJMS_AGE_SEX	CDE_SEX
10	Min	The low age of the member age range	Field	Number	3	T_ADJMS_AGE_SEX	AGE_LOW
11	Max	The high age of the member age range	Field	Number	3	T_ADJMS_AGE_SEX	AGE_HIGH
12	NDC	National Drug Code(s)	Field	Character	11	T_ADJMS_DRUG	CDE_NDC
13	Procedure From	Field used to enter the From code which indicates service provided as criteria	Field	Character	6	T_ADJMS_SERV	SAK_PROCEDURE
14	Procedure To	Field used to enter the To code used as range criteria	Field	Character	6	T_ADJMS_SERV	SAK_PROCEDURE
15	Modifier 1	First modifier to be used as criteria	Field	Character	2	T_ADJMS_MODIF	CDE_PROC_MOD
16	Modifier 2	Second modifier to be used as criteria	Field	Character	2	T_ADJMS_MODIF	CDE_MODIFIER_2
17	Modifier 3	Third modifier to be used as criteria	Field	Character	2	T_ADJMS_MODIF	CDE_MODIFIER_3

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
18	Modifier 4	Fourth modifier to be used as criteria	Field	Character	2	T_ADJMS_MODIF	CDE_MODIFIER_4
19	Revenue From	The From value for Revenue criteria. This identifies a specific accommodation or ancillary service. Revenue codes are determined by CMS	Field	Number	4	T_ADJMS_REVENUE	CDE_REVENUE
20	Revenue To	The To value for Revenue Code range criteria	Field	Number	4	T_ADJMS_REVENUE	CDE_REVENUE
21	Provider Number	Provider number(s) chosen as criteria	Field	Character	10	T_ADJMS_PROV, T_ADJMS_PRSVC	ID_PROVIDER, CDE_SERVICE_LOC
22	Provider Type	Code used to identify the type of the provider	Field	Drop Down List Box	2	T_ADJMS_PROVTYP	CDE_PROV_TYPE
23	Provider Specialty	Code used to identify the specialty of the provider	Field	Drop Down List Box	3	T_ADJMS_PRSPEC	CDE_PROV_SPEC
24	Health Program Selection - Pgm	Medical Assistance Programs chosen from the list at the bottom of the panel	Field	Drop Down List Box	5	T_ADJMS_MEDAST	CDE_PGM_HEALTH
25	Region Code	Region codes chosen from the list at the bottom of the window	Field	Drop Down List Box	2	T_ADJMS_REGION	CDE_REGION
26	Pay As Billed – Paid Amount Equals Billed	Radio Button used to include or exclude claims where Paid Amount equals Billed Amount	Field	Radio Button	0		

4.5.8.6 Button Descriptions

Button	Description
Delete	Clicking on the Delete button deletes the content.
Add	Click the Add button to insert.
Add Range	Click the Add Range button to insert.

4.5.8.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Aid Category	Field	1	Enter a valid value.	Enter a numeric Aid category or select a code from the [Search] panel.
1	Aid Category	Field	2	Invalid Aid Category Code.	Enter a valid Category Code or select a code from the [Search] panel.
3	Current ID	Field	1	Invalid Current ID.	Enter a valid Current ID or select a code from the [Search] panel.
4	ESC	Field	1	Enter a valid value.	Enter a valid code or select a code from the [Search] panel.
4	ESC	Field	2	Invalid ESC Code.	Enter a valid ESC code or select a code from the [Search] panel.
5	DRG From	Field	1	Enter a valid value.	Enter a numeric Drug Code or select a code from the [Search] panel.
5	DRG From	Field	2	Invalid Drg Code.	Enter a valid Drg Code or select a code from the [Search] panel.
7	Diagnosis From	Field	1	Enter a valid value.	Enter a numeric Diagnosis or select a code from the [Search] panel.

Field No	Field	Field Type	Error Code	Error Message	To Correct
7	Diagnosis From	Field	2	Invalid Diagnosis Code.	Enter a valid Diagnosis code or select a code from the [Search] panel.
10	Min	Field	1	Enter a Valid Value.	Enter a numeric value.
11	Max	Field	1	Enter a Valid value.	Enter a numeric value.
11	Max	Field	100	The high age range must be greater than the low age range.	Verify age values and re-enter.
12	NDC	Field	1	Invalid NDC Code.	Enter a valid NDC Code or select a code from the [Search] panel.
13	Procedure From	Field	1	Invalid Procedure code.	Enter a valid Procedure Code or select a code from the [Search] panel.
15	Modifier 1	Field	1	Modifiers MUST BE entered in order, starting with 1.	Enter the modifiers in the correct order.
15	Modifier 1	Field	2	Invalid Modifier 1 Code.	Enter a valid Modifier Code or select a code from the [Search] panel.
16	Modifier 2	Field	1	Invalid Modifier 2 code.	Enter a valid Modifier Code or select a code from the [Search] panel.
17	Modifier 3	Field	1	Invalid Modifier 3 Code.	Enter a valid Modifier Code or select a code from the [Search] panel.
18	Modifier 4	Field	1	Invalid Modifier 4 Code.	Enter a valid Modifier Code or select a code from the [Search] panel.
19	Revenue From	Field	1	Invalid Revenue Code	Enter a valid Revenue code or select a code from the [Search] panel.

Field No	Field	Field Type	Error Code	Error Message	To Correct
19	Revenue From	Field	2	Enter a valid value	Enter a numeric Revenue Code or select a code from the [Search] panel.
21	Provider ID / Loc	Field	1	Both a provider ID & a Location Code are needed.	Enter a valid Provider ID & Location or select a code from the [Search] panel.
21	Provider ID / Loc	Field	2	There is no Provider in the system with that ID & Location Code.	Enter a valid Provider ID & Location or select a code from the [Search] panel.

4.5.9 PANEL: Mass Net Verification

4.5.9.1 Description

Use the Mass NetVerification panel to verify and update the financial changes made to mass adjustment claims. The following rules apply to changing the status of the claim:

- The claim must be not Paid or not Denied;
- The user cannot change the status if the current status is Finalized, Processed, Deleted;
- The user can change the status to Release only if the current status is Suspended or Delete; and,
- The user can change the status to Delete if the current status is Suspended or Release.

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

4.5.9.2 Panel Name

Mass Net Verification

For readability the layout displays on the next page.

4.5.9.3 Mass Net Verification Layout

Mass Net Verification

Top Nav ? A

	1 Action Code	2 Original ICN	3 Adjustment ICN	4 Original Amount	5 Adjusted Amount	6 Net Amount	7 Adjusted Status	8 New Claim Status	9 CCN	10 EOB
	All	2205095600001	5205121001018	$7.11	$0.00	$7.11	Release	PAID		8000
	All	2005101050125	5205121001019	$0.00	$100.00	($100.00)	Release	PAID		8000
	All	2005105250069	5205121001020	$172.50	$37.50	$135.00	Release	PAID		8000
	All	2005094600375	5205121001015	$0.00	$10.00	($10.00)	Release	PAID		8000
	All	2005094150067	5205121001016	$0.00	$633.43	($633.43)	Release	PAID		8000
	All	2005094100107	5205121001017	$0.00	$0.00	$0.00	Release	PAID		8000
	All	2205108050003	5205121001021	$22.00	$97.00	($75.00)	Release	PAID		8000
	All	2005109050040	5205121001025	$30.00	$30.00	$0.00	Release	PAID		8000
	All	2005109250040	5205121001026	$184.80	$0.00	$184.80	Release	DENIED		8000
	All	2005111050072	5205121001027	$30.00	$30.00	$0.00	Release	PAID		8000
Totals:				$24,159.83	$43,469.72	($19,309.89)				

1 2 3 Next >

Original ICN

Adjustment ICN

Adjustment Status

11 resubmit all | 13 resubmit selected | 14 delete all | 15 delete selected | 16 data correct

To access this panel:

Access the Claims Mass Adjustment Information page using the instructions listed for the page. Click the Mass Net Verifcation button. This panel allows the information selected from the listing to be updated.

STEP 1. Click the Resubmit All button to resubmit the entire listing.

STEP 2. Click the Delete All button to delete the entire listing.

STEP 3. Click the Resubmit Selected button after clicking the applicable check boxes in the listing.

STEP 4. Click the Delete Selected button after clicking the applicable check boxes in the listing.

STEP 5. Click the Data Correct button if only verifying the information listed.

4.5.9.4 Extra Features

This panel has no extra features.

4.5.9.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Action Code	The action code determining how the adjustment is processed in batch. Values: 'A' - reprocess entire claim, 'P' - only reprocess claim details, 'H' - history only, do not edit, audit, or re-price	Field	Character	5	T_ADJ_MASS_CLAIM	CDE_ADJ_ACTION
2	Original ICN	Field to add or change original Internal Control Number of an adjusted claim	Field	Character	13	T_CLM_PGM_XREF	NUM_ICN
3	Adjusted ICN	Field to add or change new Internal Control Number of an adjusted claim	Field	Character	13	T_HIST_DIRECTORY	NUM_ICN_FL
4	Adjustment Amount	The adjusted amount of the claim. This is a calculated value obtained by adding the Paid Amount and the State Share amount from the adjusted claim (from the T_CLM_PGM_XREF table). Format 99999999.99	Field	Number	9	N/A	N/A
4	Original Amount	The original amount of the claim. This is a calculated value obtained by adding the Paid Amount and the State Share amount from the original Claim (from the T_CLM_PGM_XREF table). Format 99999999.99	Field	Number	9	N/A	N/A

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Net Amount	The amount by which the Original Amount was adjusted. This is a calculated value determined by subtracting the Adjustment Amount from the Original Amount. Format 99999999.99	Field	Number	9	N/A	N/A
6	Adjusted Status	Indicates the status of the claim which is being adjusted	Field	Character	10	T_ADJ_MASS_RQST	CDE_STATUS1
7	Adjustment Status	Field to add or update the status of a claim being adjusted	Combo Box	Character	10	T_ADJ_MASS_RQST	CDE_STATUS1
8	New Claim Status	The status of the adjusted claim	Field	Character	10	T_HIST_DIRECTORY	CDE_CLM_STATUS
9	CCN	Cash or check receipt control number used in dispositioning the adjustment with the cash received	Field	Character	11	T_ADJ_MASS_RQST	CASH_CTL_NO
10	EOB	Indicates the Explanation of Benefits code entered for the claim	Field	Number	4	T_EOB	CDE_EOB

4.5.9.6 Button Descriptions

Button No	Button	Description
11	Resubmit All	Sets the Adjustment Status field to R for all records. Clicking a second time blanks out the adjustment status field
12	Resubmit Selected	The user may select the checkboxes to the left of the claims and click this button to set the Adjustment Status field to R for the selected claims.
13	Delete All	Sets the Adjustment Status field to D for all records. Clicking a second time blanks out the adjustment status field
14	Delete Selected	The user may select the checkboxes to the left of the claims and click this button to delete the selected claims
15	Data Correct	Opens up the Corrections panel for the selected claim

4.5.9.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
6	Adjusted Status	Field	1	Cannot change Status.	The status cannot be changed based on the value of the current status.
15	Data Correct	Button	1	You must select either delete or release to update.	Ensure the Action Code contains a value before attempting to data correct.

4.6 PAGE: Claims Data Correction Page

4.6.1 Description

The Claims Data Correction Page provides access to suspended claim header and detail information. A navigation panel displays, which contains links to related claim information. Use the panels on this page to update or resubmit Claims information.

4.6.2 Technical Name

Clm.DataCorrectionPage.ascx

4.6.3 Web Page Name:

Claims Data Correction Page

For readability the layout displays on the next page.

4.6.4 Claims Data Correction Page Layout

Wednesday, October 04, 2006

KyHealth Choices

ome Claims Reference Provider Member Financial EPSDT TPL Managed Care MAR Prior Authorization CTMS Security Site Admin Host

search information adjustments data corrections assignments encounter data related data

Claims Suspense List

User ID WZW7NZ Status ○ All ◉ Suspended ○ Quality Control

search

Select a row below to Data Correct.

ICN	Claim Type	Status
2003147300012	PHARMACY CLAIMS	SUSPENDED
2003226600004	HCFA 1500 CLAIMS	SUSPENDED
2003259600143	HCFA 1500 CLAIMS	SUSPENDED
2003259600145	HCFA 1500 CLAIMS	SUSPENDED
2005150050053	DENTAL CLAIMS	SUSPENDED
2006272100003	INPATIENT CLAIMS	SUSPENDED
2006272100004	INPATIENT CLAIMS	SUSPENDED
2006272100005	INPATIENT CLAIMS	SUSPENDED
2006272100008	INPATIENT CLAIMS	SUSPENDED
2006276100001	INPATIENT CLAIMS	SUSPENDED

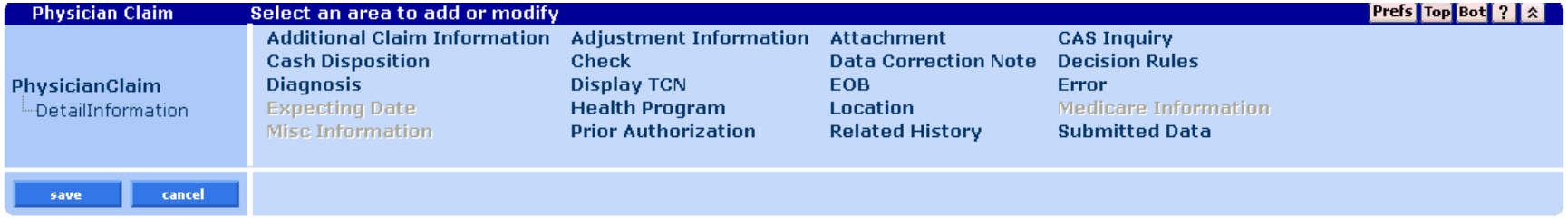
Claim Count: 12

1 2 Next >

Physician Claim

Top Nav ? A

ICN	2003226600004	Claim Type	HCFA 1500 CLAIMS	Status	Suspend
Prev ICN		FDOS*	08/03/2003	Details	1
Member ID	000002412 [Search]	TDOS*	08/03/2003	Billed	$31.00
Last Name	PAUL	Date Billed*	08/14/2003	Net Billed	$31.00
First Name	FRANK	Date Paid		Spenddown	$0.00
DOB	12/07/1957	Provider Number	100000199A MCD [Search]	Reimbursed	$0.00
Claim Diagnosis	1 - V3000	Referring Provider 1	[Search]	Paid	$0.00
Submitter ID		Referring Provider 2	[Search]	TPL	$0.00
RA Number		Hospital FDOS		Total TPL	$0.00
Signature	No	Hospital TDOS		TPL Recovered Amt	$0.00
Accident	No	Attachment	No	Copay Amount	$0.00
Accident Date		Certification Nbr.		Total Patient Liability	$0.00
PAN	Patient Acct:89	MRN			



To access this page:

STEP 1. Click on Claims located in the subsystem header listing under the Commonwealth logo “Kentucky Unbridled Spirit”. (1)

STEP 2. Click on Data Corrections located under the subsystem header listing or click on Data Corrections from the drop down listing that appears when the cursor touches the Claims button in the subsystem header listing. (2)

4.6.5 PANEL: Claims Suspense List

4.6.5.1 Description

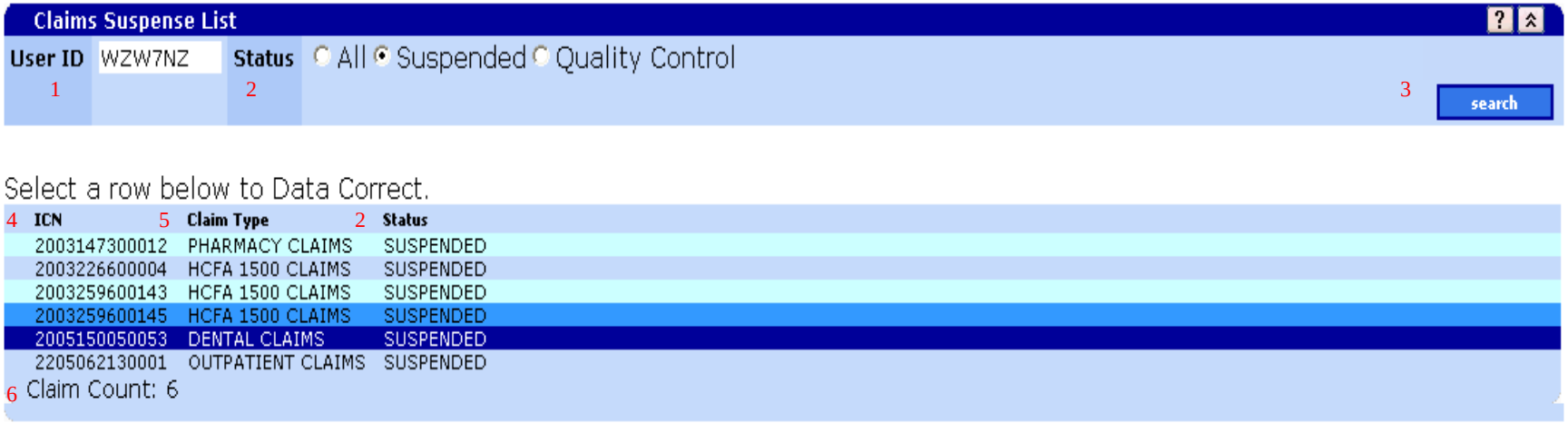
The Claim Suspense panel lists all claims that are in a suspended or resubmit status. It only lists suspended claims for a given clerk, the clerk being the user who is currently logged onto the application. A user can make data corrections to a claim by selecting it from this listing.

Navigation Path: [Claims - Data Correction]

4.6.5.2 Panel Name

Claims Suspense List

4.6.5.3 Claims Suspense List Layout



To access this panel:

Access the Data Correction page using the instructions listed for the page. This panel displays the claims that are available to be corrected.

4.6.5.4 Extra Features

This panel has no extra features.

4.6.5.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	User ID	The ID of the user to whom the claims have been assigned	Field	Character	8	T_DCOR_SCHEDULE	ID_CLERK
2	Status	The status of the claim within the system	Field	Character	9	T_HIST_DIRECTORY	CDE_CLM_STATUS
3	Search	Performs a query on the database and returns the data for the entered search criteria	Button	N/A	0	N/A	N/A
4	ICN	Internal control number (ICN) which uniquely identifies a claim	Field	Character	13	T_HIST_DIRECTORY	NUM_ICN_FL
5	Claim Type	Description of the type of claim	Field	Character	50	T_DCOR_SCHEDULE	CDE_CLM_TYPE
6	Claim Count	Number of claims displayed on the suspense list	Field	Number	9	N/A	N/A

4.6.5.6 Field Edits

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

4.6.6 PANEL: Physician Claim Correction

4.6.6.1 Description

Access the Physician Data Correction panel by selecting suspended Physician claims from the Claim Suspense Listing panel. Change the data in any of the following fields to complete Claim corrections:

- Last Name,
- First Name,
- Hospital FDOS,
- Hospital TDOS,
- FDOS,
- TDOS,
- Ref Prov 1 / Loc,
- Ref Prov 2 / Loc,
- Signature,
- Certification Number (Certification Nbr.),
- Attachment,
- Patient Acct Number (PAN),
- Medical Rec Number (MRN),
- Date Billed,
- TPL,
- Net Billed,
- Accident; and,
- Accident Date.

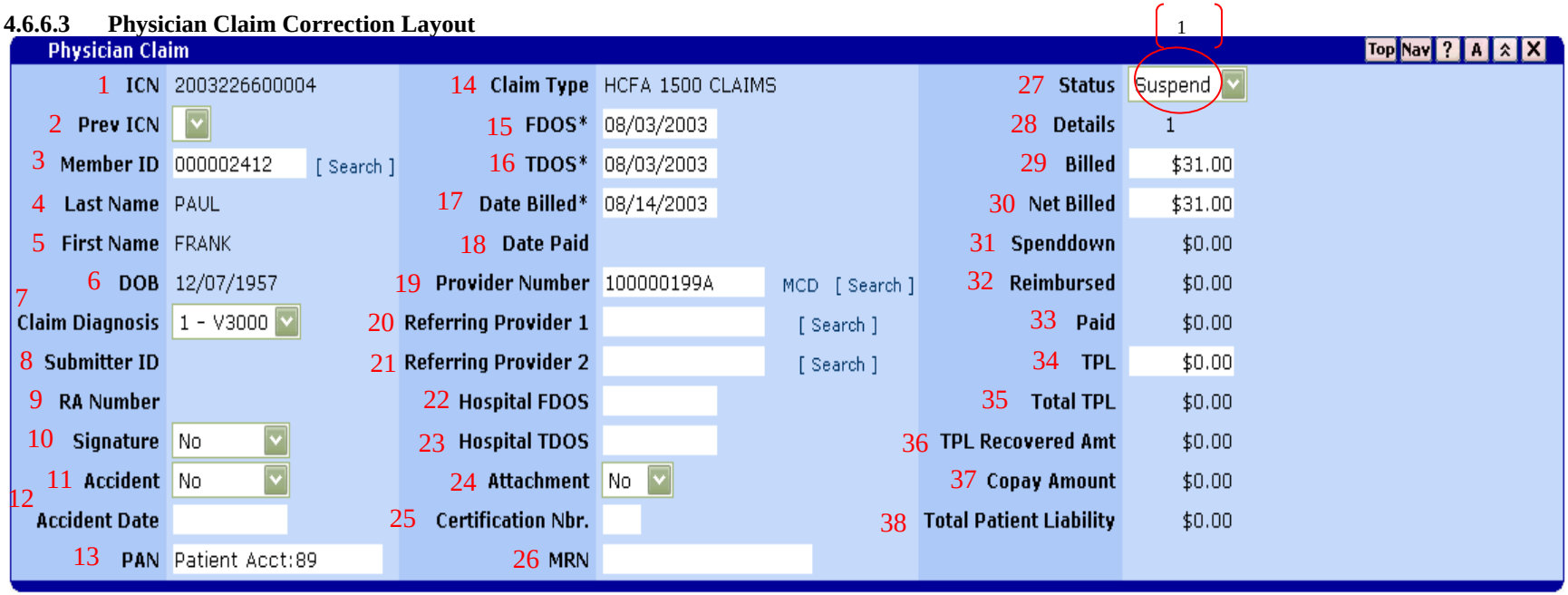
After data correction is completed, the user can resubmit the claim. Claim resubmission sends the claim through the claims processing cycle, subjecting it again to the edits and audits. The claim enters the processing cycle as soon as it is resubmitted.

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

4.6.6.2 Panel Name

Physician Claim

4.6.6.3 Physician Claim Correction Layout



To access this panel:

STEP 1. Access the Data Correction page using the instructions listed for the page.

STEP 2. Click on the row of a physician claim to select.

This panel displays the updatable non-detail fields on the claim which can include member ID, date of service, billed amount, TPL amount, provider ID and so on. NOTE: Member and Provider IDs cannot be changed on a previously adjusted claim.

STEP 3. Edit the fields.

STEP 4. Select resubmit on the Status (1) drop down box last to resubmit claim.

4.6.6.4 Extra Features

This panel has no extra features.

4.6.6.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	ICN	Internal control number which uniquely identifies a claim	Field	Character	13	T_SUSP_PHYS_HDR	NUM_ICN
2	Prev ICN	This field allows the user to select any of the claim's prior Internal Control Number and obtain information on them	Field	Drop Down List Box	0	T_PD_PHYS_HDR	NUM_ICN
3	Member ID	A system-assigned number which uniquely identifies a member	Field	Character	12	T_PHYS_HDR_KEY	ID_MEDICAID
4	Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number, the first three characters of the last name that were typed are displayed	Field	Character	15	T_PHYS_HDR_KEY	CLM_LST_NAM_RECIP
5	First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number, the first character of the first name that was typed is displayed	Field	Character	15	T_PHYS_HDR_KEY	CLM_RECIP_FST_NAM
6	DOB	Member date of birth	Field	Date (MM/DD/CCYY)	8	T_PHYS_HDR_KEY	DTE_SUBSCRIBER_DOB

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
7	Diagnosis	Code used to identify the primary or other diagnoses	Field	Drop Down List Box	0	T_SUSP_PHYS_HDR	CDE_DIAG_TREAT_IND
8	Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.	Field	Character	12	T_SUSP_PHYS_HDR	ID_SUBMITTER
9	RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles. This field does not populate for suspended claims	Field	Number	12	N/A	N/A
10	Signature	Indicates whether the claim was signed by the provider or representative	Field	Drop Down List Box	0	T_SUSP_PHYS_HDR	IND_PROV_SIGN
11	Accident	Indicates whether the service was provided as a result of an accident	Field	Drop Down List Box	0	T_SUSP_PHYS_HDR	IND_ACCIDENT
12	Accident Dt	Date of accident	Field	Date (MM/DD/CCYY)	8	T_SUSP_PHYS_HDR	DTE_ACCIDENT
13	PAN	Patient's unique identification number assigned by the provider to track the patient's financial records	Field	Character	38	T_SUSP_PHYS_HDR	NUM_PAT_ACCT
14	Attachment	Indicates whether an attachment is present	Field	DropDownListBox	0	T_SUSP_PHYS_HDR	IND_ATTACHMENT

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
14	Claim Type	Indicates the type of claim	Field	Character	50	T_SUSP_PHYS_HDR	CDE_CLM_TYPE
15	FDOS	Beginning date of service on the claim	Field	Date (MM/DD/CCYY)	8	T_SUSP_PHYS_HDR	DTE_FIRST_SVC
16	TDOS	Ending date of service on the claim	Field	Date (MM/DD/CCYY)	8	T_SUSP_PHYS_HDR	DTE_LAST_SVC
17	Date Billed	Date on which claim was submitted for processing	Field	Date (MM/DD/CCYY)	8	T_SUSP_PHYS_HDR	DTE_BILLED
18	Date Paid	Date on which the claim was paid. This does not populate for suspended claims	Field	Date (MM/DD/CCYY)	8	N/A	N/A
19	Prov ID/ Loc	The pay to provider identification number and location that uniquely identifies the provider of services	Field	Character	10	T_PHYS_HDR_KEY	ID_PROVIDER, CDE_SERVICE_LOC
20	Referring Provider 1 ID/Loc	The license number of the referring physician other than the attending physician	Field	Character	10	T_PHYS_HDR_KEY/T_DENY_PHYS_HDR	ID_PROV_REFER, CDE_SVC_LOC_REF_1
21	Referring Provider 2 ID/Loc	The license number of the second referring physician other than the attending physician. P> The unique provider. Number of the provider who referred the patient for this service. Value is ID_PROV_REFERRING_2, CDE_SVC_LOC_REF_2	Field	Character	10	T_PHYS_HDR_KEY/T_SUSP_PHYS_HDR	SEE DESCRIPTION

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
22	Hospital FDOS	First date hospitalized	Field	Date (MM/DD/CCYY)	8	T_SUSP_PHYS_HDR	DTE_FROM_HOSP
23	Hospital TDOS	Last date hospitalized	Field	Date (MM/DD/CCYY)	8	T_SUSP_PHYS_HDR	DTE_TO_HOSP
25	Certification Nbr.	Code used to identify the certification of the member	Field	Character	2	T_SUSP_PHYS_HDR	CDE_CERTIFICATE
26	MRN	Code representing the Medical Record Number	Field	Character	30	T_SUSP_PHYS_HDR	NUM_PAT_ACCT
27	Status	This field displays the status of the claim	Field	Drop Down List Box	0	T_SUSP_PHYS_HDR	CDE_CLM_STATUS
28	Details	The number of detail service lines on the claim	Field	Number	4	T_SUSP_PHYS_HDR	NUM_DTL_TOTAL
29	Billed	Amount requested by the provider for services rendered. Format 999999.99	Field	Number	8	T_SUSP_PHYS_HDR	AMT_BILLED
30	Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, and so on). Format 999999.99	Field	Number	8	T_SUSP_PHYS_HDR	AMT_NET_BILLED
31	Spenddown	Amount of money that the member is responsible for paying for services. Format 9999999.99	Field	Number	9	T_SUSP_PHYS_HDR	AMT_PATNT_LIAB

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
32	Reimbursed	Total amount the provider receives. Format 9999999.99. This field does not populate for suspended claims	Field	Number	9	N/A	N/A
33	Paid	Amount paid on claim. This value is computed by adding up all the AMT_PAID values for the related details. Format 999999.99	Field	Number	8	T_CLM_PGM_XREF	AMT_PAID
34	TPL	Amount paid by third party for services at the claim header level. Format 999999.99	Field	Number	8	T_SUSP_PHYS_HDR	TPL_AMT
35	Total TPL	The sum of the TPL amounts at the header and detail levels. Format 999999.99	Field	Number	8	N/A	N/A
36	TPL Recovered Amt	The recovery amount populated from the settlement panel. Format 9999999.99. This field does not populate for suspended claims	Field	Number	9	N/A	N/A
37	Copay	The sum of all the detail co-pay amounts applicable to the claim. Format 99999.99	Field	Number	7	T_SUSP_PHYS_HDR	AMT_CO_PAY
38	Patient Liability	The amount of patient liability applied to this claim	Field	Number	12	T_SUSP_PHYS_HDR	AMT_PD_PAT_UB92

4.6.6.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	Member ID	Field	1	Member ID is Required.	Enter a valid value or select an ID from the [Search].
3	Member ID	Field	2	Member ID is invalid.	Enter a valid value.
12	Accident Dt	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter valid date in MM/DD/CCYY format.
12	Accident Dt	Field	2	Date cannot be greater than Today's Date.	Enter valid date.
13	PAN	Field	1	Patient Account Number must be Alphanumeric.	Verify entry and re-enter. There must not be any spaces or special characters in the PAN.
15	FDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify date and format and re-enter.
15	FDOS	Field	2	FDOS can not be greater than today's date.	Enter a value in the FDOS that is equal to or less then the TDOS.
15	FDOS	Field	3	First Service Date is required.	Enter a valid in the FDOS field.
15	FDOS	Field	4	FDOS must be less than or equal to TDOS.	Enter a value in the FDOS that is equal to or less then the TDOS.
16	TDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date.
16	TDOS	Field	2	TDOS can not be greater than today's date.	Verify date and re-enter.
17	Date Billed	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify format and re-enter.
17	Date Billed	Field	2	TDOS must be less than or equal to Billed Date.	The Billed Date must be greater than or equal to the FDOS and the TDOS.

Field No	Field	Field Type	Error Code	Error Message	To Correct
19	Billing Prov ID/ Loc	Field	1	Invalid Billing Provider.	Enter a valid Billing Provider or select a value from the [Search] panel.
19	Billing Prov ID/ Loc	Field	2	Provider ID and service location are required.	Enter a valid Billing Provider and Location.
19	Billing Prov ID/ Loc	Field	3	A valid Billing Provider is required.	Enter a valid Billing Provider and Location.
20	Referring Provider 1 ID/Loc	Field	1	Ref Prov 1 / Loc is invalid.	Enter a valid Ref Prov 1 / Loc or select an ID from the [Search] panel.
20	Referring Provider 1 ID/Loc	Field	2	Referring Provider 1 ID and service location are required.	If a Ref Prov 1 is entered, a location must also be entered.
21	Referring Provider 2 ID/Loc	Field	1	Ref Prov 1 / Loc is invalid.	Enter a valid Ref Prov 1 / Loc or select an ID from the [Search] panel.
21	Referring Provider 2 ID/Loc	Field	2	Referring Provider 1 ID and service location are required.	If Ref Prov 2 is entered, a Loc must also be entered.
22	Hospital FDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify date and format and re-enter.
22	Hospital FDOS	Field	2	From Hospital Date of service can not be greater than today's date.	Verify date and re-enter.
23	Hospital TDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify date and format and re-enter.
23	Hospital TDOS	Field	2	TDOS must be less than or equal to Billed Date.	Verify date and format and re-enter.
23	Hospital TDOS	Field	3	To Hospital Date can not be greater than today's date.	Verify date and format and re-enter.

Field No	Field	Field Type	Error Code	Error Message	To Correct
28	Details	Field	101	Exceed maximum number of details.	The maximum number of details has been exceeded.
29	Billed	Field	1	Enter a Valid Value.	Enter a numeric value.
30	Net Billed	Field	1	Net billed amount must be less or equal to billed amount.	Enter a value in the Net Billed amount field that is less then the Billed amount.
30	Net Billed	Field	2	Enter a valid value.	Enter a numeric value.
30	Net Billed	Field	102	Net billed amount must be less or equal to billed amount.	Enter a valid Net Billed amount that is less than or equal to the Billed Amt.
34	TPL	Field	1	Enter a Valid Value	Enter a numeric value.

4.6.7 PANEL: UB92 Claim Correction

4.6.7.1 Description

Access the UB92 Data Correction panel by selecting suspended Inpatient claims from the Claim Suspense Listing panel. Change the data in any of the following fields to complete UB92 Claim corrections:

- Type of Bill,
- Claim Status,
- Member ID,
- Last Name,
- First Name,
- Provider ID,
- Facility ID,
- FDOS,
- TDOS,
- Attend Prov,
- Cvd (Covered) Days,
- Ncvd (Non-covered) Days,
- Admit Date,
- Other Provider1,
- Other Provider2,
- Date Billed,
- Admit Time,
- Admit Type,
- Admit Source,
- Patient Status,

- Medical Rec Number (MRN),
- Signature,
- Certification Nbr.,
- Total days; and,
- Patient Acct Number (PAN).

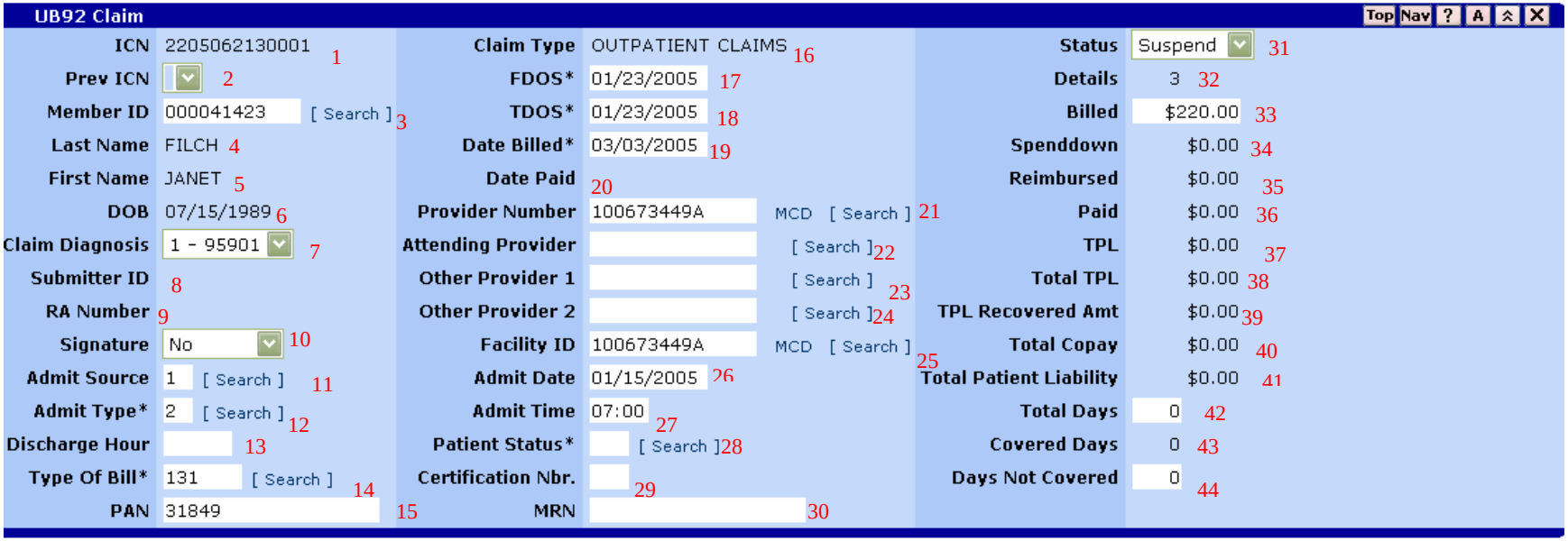
After data correction is complete, the examiner can resubmit the claim. Claim resubmission sends the claim through the claims processing cycle, subjecting it again to the edits and audits. The claim enters the processing cycle as soon as it is resubmitted. When an adjustment claim is data corrected no updates to the provider and member ID fields are allowed.

Navigation Path: [Claims - Data Correction] - [Enter Clerk ID, search then select a UB92 claim from the list]

4.6.7.2 Panel Name

UB92 Claim

4.6.7.3 UB92 Claim Correction Layout



To access this panel:

Access the Data Correction page using the instructions listed for the page.

STEP 1. Click on the row of a UB92 claim to select.

This panel displays the updatable non-detail fields on the claim which can include member ID, date of service, billed amount, TPL amount, provider ID and so on. NOTE: Member and Provider IDs cannot be changed on a previously adjusted claim.

STEP 2. Edit the fields.

STEP 3. Select resubmit on the Status drop down box last to resubmit claim.

4.6.7.4 Extra Features

This panel has no extra features.

4.6.7.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	ICN	Internal control number which uniquely identifies a claim	Field	Character	13	T_SUSP_UB92_HDR	NUM_ICN
2	Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them	Field	Drop Down List Box	0	T_SUSP_UB92_HDR	NUM_ICN
3	Member ID	An assigned number which uniquely identifies a member	Field	Character	12	T_UB92_HDR_EXT_KEY	ID_MEDICAID
4	Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number, the first three characters of the last name that were typed are displayed	Field	Character	15	T_UB92_HDR_EXT_KEY	CLM_LST_NAM_RECIP

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number, the first character of the first name that was typed is displayed	Field	Character	15	T_UB92_HDR_EXT_KEY	CLM_RECIP_FST_NAM
6	DOB	Member date of birth	Field	Date (MM/DD/CCYY)	8	T_UB92_HDR_EXT_KEY	DTE_SUBSCRIBER_DOB
7	Diagnosis	Code used to identify the primary or other diagnoses	Field	Drop Down List Box	0	T_UB91_HDR_DIAG_X	CDE_DIAG
8	Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.	Field	Character	12	T_EDI_INTERCHANGE	CDE_SENDER_ID
9	RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles	Field	Number	12	T_FIN_REMIT_TXN_XREF	SAK_REMIT
10	Signature	Indicates whether the claim was signed by the provider or representative	Field	Drop Down List Box	0	T_SUSP_UB92_HDR	IND_PROV_SIGN
11	Admit Source	Indicates the source of admission	Field	Character	1	T_SUSP_UB92_HDR	CDE_ADMIT_SOURCE
12	Admit Type	Code indicating the type of admission	Field	Character	1	T_SUSP_UB92_HDR	CDE_ADMIT_TYPE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
13	Discharge Hour	Time that the member is released from the hospital or facility	Field	Number	8	T_SUSP_UB92_HDR	CDE_TME_DISCHARGE
14	Type Of Bill	A code indicating the specific type of bill	Field	Character	3	T_SUSP_UB92_HDR	CDE_TYPE_OF_BILL
15	PAN	Patient's unique identification number assigned by the provider to track the patient's financial records	Field	Character	38	T_SUSP_UB92_HDR	NUM_PAT_ACCT
16	Claim Type	Indicates the type of claim	Field	Character	1	T_SUSP_UB92_HDR	CDE_CLM_TYPE
17	FDOS	Beginning date of service on the claim	Field	Date (MM/DD/CCYY)	8	T_SUSP_UB92_HDR	DTE_FIRST_SVC
18	TDOS	Ending date of service on the claim	Field	Date (MM/DD/CCYY)	8	T_SUSP_UB92_HDR	DTE_LAST_SVC
19	Date Billed	Date on which claim was submitted for processing	Field	Date (MM/DD/CCYY)	8	T_SUSP_UB92_HDR	DTE_BILLED
20	Date Paid	Date on which the claim was paid. This field is not populated on suspended claims	Field	Date (MM/DD/CCYY)	8	N/A	N/A
21	Provider Number	The provider identification number and location that uniquely identifies the provider of services. P> Suffix added to the provider number: CDE_SVC_LOC_OTHER_2	Field	Character	10	T_SUSP_UB92_HDR	ID_PROV_ATTEND

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
22	Attending Prov	Attending physician's prescribing number	Field	Character	10	T_SUSP_UB92_HDR	ID_PROV_ATTEND
23	Other Provider 1	The license number of the physician other than the attending physician	Field	Character	10	T_SUSP_UB92_HDR	ID_PROV_OTHER
24	Other Provider 2	The license number of the physician other than the attending physician	Field	Character	10	T_SUSP_UB92_HDR	ID_PROV_OTHER_2
25	Facility ID	Identification number assigned to the facility provider	Field	Character	11	T_UB92_HDR_EXT_KEY	ID_PR_FACILITY
26	Admit Date	The date the patient was admitted to the facility for care	Field	Date (MM/DD/CCYY)	8	T_SUSP_UB92_HDR	DTE_ADMISSION
27	Admit Time	The time that the member was admitted to the facility for care	Field	Character	4	T_SUSP_UB92_HDR	CDE_ADMIT_HOUR
28	Patient Status	Codes indicating the patient's status as of the ending service date of the period covered on the claim	Field	Character	2	T_SUSP_UB92_HDR	CDE_PATIENT_STATUS
29	Certification Nbr.	Code used to identify the certification of the member	Field	Character	2	T_SUSP_UB92_HDR	CDE_CERTIFICATE
30	MRN	Code representing the Medical Record Number	Field	Character	20	T_SUSP_UB92_HDR	CDE_MED_REC_NUM
31	Status	Identifies the status of the claim within the system	Field	Drop Down List Box	0	T_SUSP_UB92_HDR	CDE_CLM_STATUS
32	Details	The number of detail service lines on the claim	Field	Number	9	T_SUSP_UB92_HDR	NUM_DTL_TOTAL

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
33	Billed	Amount requested by the provider for services rendered. Format 999999.99	Field	Number	8	T_SUSP_UB92_HDR	AMT_BILLED
34	Spenddown	Amount allowed to the provider. Format 9999999.99	Field	Number	9	T_SUSP_UB92_HDR	AMT_PATNT_LIAB
35	Reimbursed	Total amount the provider receives. Format 99999999.99. This field is not populated for suspended claims	Field	Number	9	N/A	N/A
36	Paid	Amount paid on claim. Format 999999.99. This field is not populated on suspended claims	Field	Number	8	N/A	N/A
37	TPL	Amount paid by third party for services, at the claim header level. Format 999999.99	Field	Number	8	T_SUSP_UB92_HDR	TPL_AMT
38	Total TPL	The sum of the TPL amounts at the header and detail levels. Format 999999.99	Field	Number	8	N/A	N/A
39	TPL Recovered Amt	The recovery amount populated from the settlement panel. Format 9999999.99	Field	Number	9	T_TPL_AR_DISPS	AMT
40	Total Copay	The sum of all the detail co-pay amounts applicable to the claim. Format 99999.99	Field	Number	7	N/A	N/A
41	Patient Liability	The amount of patient liability applied to this claim	Field	Number	12	T_SUSP_UB92_HDR	TBD - CO in progress

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
42	Total Days	The total number of days that were billed on the claim.	Field	Number	4	T_SUSP_UB92_HDR	NUM_DAYS_COVD
43	Covered Days	Number of days covered by the primary payer	Field	Number	4	T_SUSP_UB92_HDR	NUM_DAYS_COVD - NUM_DAYS_NCOVD
44	Days Not Covered	The number of days that were not covered	Field	Number	4	T_SUSP_UB92_HDR	NUM_DAYS_N_COVD

4.6.7.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	Member ID	Field	1	Invalid Member ID.	Enter a Valid Member ID or select a value from the [Search] panel.
11	Admit Source	Field	1	Invalid Admit Source.	Enter a valid Source or select a value from the [Search] panel.
12	Admit Type	Field	1	Invalid Admit Type.	Enter a valid Admit Type or select a value from the [Search] field.
14	Type Of Bill	Field	1	Invalid Type of Bill.	Enter a valid Type of Bill or select a value from the [Search] panel.
17	FDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
17	FDOS	Field	102	First date of service must be prior to or equal to the last date of service.	Verify dates and re-enter.
18	TDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
19	Date Billed	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.

Field No	Field	Field Type	Error Code	Error Message	To Correct
21	Provider Number	Field	1	Invalid Billing Provider.	Enter a valid Provider or select a value from the [Search] panel.
21	Provider Number	Field	2	Provider ID and Service Location are required.	Enter a valid Provider ID/Service Location or select a value from the [Search] Panel.
24	Other Provider2	Field	1	Invalid other Provider 2.	Enter a valid Provider 2 ID / Loc or select a value from the [Search] panel.
24	Other Provider2	Field	2	Other Provider 2 ID and service location are required.	Enter a valid Provider 2 ID / Loc or select a value from the [Search] panel.
25	Facility ID	Field	1	Invalid Facility Provider.	Enter a valid Facility Provider or select a value from the [Search] panel.
25	Facility ID	Field	2	Facility Provider ID and service location are required.	Enter a valid Facility Provider ID/Service Location or select a value from the [Search] panel.
25	Facility ID	Field	3	Facility Provider is required.	Enter a valid Facility Provider or select a value from the [Search] panel.
27	Admit Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
28	Patient Status	Field	1	Invalid Patient Status.	Enter a valid Patient Status or select a value from the [Search] panel.
32	Details	Field	101	Exceed maximum number of details.	The maximum number of details exceeds 999.
33	Billed	Field	1	Enter a valid value.	Billed amount must be numeric.
42	Total Days	Field	1	Enter a valid value.	Total Days must be numeric.
43	Covered Days	Field	1	Enter a valid value.	Covered Days must be numeric.

Field No	Field	Field Type	Error Code	Error Message	To Correct
44	Days Not Covered	Field	1	Enter a valid value.	Non-Covered days must be numeric.

4.6.8 PANEL: Dental Claim Correction

4.6.8.1 Description

Access the Dental Data Correction panel by selecting suspended dental claims from the Claim Suspense Listing panel. Dental Claim corrections are accomplished by changing the data in any of the following fields:

- Accident,
- Member ID,
- Date Billed,
- Emergency,
- FDOS (First Date of Service),
- First Name,
- Net Billed,
- Other Plan,
- POS (Place of Service),
- Provider ID,
- Signature,
- TDOS (To Date of Service),
- TPL (Third Party Liability); and,
- Status (Resubmit).

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

When an adjustment claim is data corrected no updates to the provider and member ID fields are allowed.

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

4.6.8.2 Panel Name

Dental Claim

4.6.8.3 Dental Claim Correction Layout

Dental Claim Top Nav ? A

1	ICN	2005196050077	13	Claim Type	DENTAL CLAIMS	24	Status* Suspend
2	Prev ICN		14	FDOS*	05/10/2004	25	Details 1
3	Member ID*	000039888 [Search]	15	TDOS*	05/10/2004	26	Billed $15.00
4	Last Name	WAIDE	16	Date Billed*	05/11/2004	27	Net Billed $15.00
5	First Name	RICK	17	Date Paid		28	Spenddown $0.00
6	DOB	03/01/1977	18	Provider Number	100220769A MCD [Search]	29	Reimbursed $0.00
7	Claim Diagnosis		19	Rendering Provider	100170019A MCD [Search]	30	Paid $0.00
8	Submitter ID		20	POS	11 [Search]	31	TPL $0.00
9	RA Number		21	EPSDT	No	32	Total TPL $0.00
10	Signature	No	22	Other Plan	No	33	TPL Recovered Amt $0.00
11	Accident	No	23	Emergency	No	34	Total Copay $0.00
12	PAN						

To access this panel:

Access the Data Correction page using the instructions listed for the page.

STEP 1. Click on the row of a dental claim to select.

This panel displays the updatable non-detail fields on the claim which can include member ID, date of service, billed amount, TPL amount, provider ID and so on. NOTE: Member and Provider IDs cannot be changed on a previously adjusted claim.

STEP 2. Edit the fields.

STEP 3. Select resubmit on the Status drop down box last to resubmit claim.

4.6.8.4 Extra Features

This panel has no extra features.

4.6.8.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	ICN	Internal control number which uniquely identifies a claim	Field	Character	13	T_SUSP_DENTAL_HDR	NUM_ICN
2	Prev ICN	This field allows the user to select any of the other previous ICNs for the claim and view that information	Field	Drop Down List Box	0	T_SUSP_DENTAL_HDR	NUM_ICN
3	Member ID	A system-assigned number which uniquely identifies a member	Field	Character	12	T_DENTAL_HDR_KEYS	ID_MEDICAID
4	Last Name	The last name of the member associated with the Member ID number. If there is no association between the last name and the Member ID number, the first three characters of the last name that were typed are displayed	Field	Character	15	T_DENTAL_HDR_KEYS	CLM_LST_NAM_RECIP
5	First Name	The first name of the member associated with the Member ID number. If there is no association between the first name and the RID number, the first character of the first name that was typed is displayed	Field	Character	15	T_DENTAL_HDR_KEYS	CLM_RECIP_FST_NAM
6	DOB	Member date of birth	Field	Date (MM/DD/CCYY)	8	T_DENTAL_HDR_KEYS	DTE_SUBSCRIBER_DOB
7	Diagnosis	A code for the condition requiring medical attention	Field	Drop Down List Box	0	T_DIAGNOSIS	CDE_DIAG

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
8	Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.	Field	Character	12	T_SUSP_DENTAL_ HDR	ID_SUBMITTER
9	RA Number	For paid claims, this is the Remittance Advice number which uniquely identifies remittance advice sent to providers during payment cycles. For suspended claims, this field is not populated	Field	Number	12	N/A	N/A
10	Signature	Indicates whether the claim was signed by the provider or representative	Field	Drop Down List Box	0	T_SUSP_DENTAL_ HDR	IND_PROV_SIGN
11	Accident	Indicates whether the service was provided as a result of an accident	Field	Drop Down List Box	0	T_SUSP_DENTAL_ HDR	IND_ACCIDENT
12	PAN	Identification for a member assigned by a provider. (Patient Account Number)	Field	Character	38	T_SUSP_DENTAL_ HDR	NUM_PAT_ACCT
13	Claim Type	Indicates the type of claim	Field	Character	50	T_SUSP_DENTAL_ HDR	CDE_CLM_TYPE
14	FDOS	Date of first service on the claim	Field	Date (MM/DD/CCYY)	8	T_SUSP_DENTAL_ HDR	DTE_FIRST_SVC
15	TDOS	Date of last service on the claim	Field	Date (MM/DD/CCYY)	8	T_SUSP_DENTAL_ HDR	DTE_LAST_SVC
16	Date Billed	Date on which claim was submitted for processing	Field	Date (MM/DD/CCYY)	8	T_SUSP_DENTAL_ HDR	DTE_BILLED

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
17	Date Paid	For Paid Claims, this is the date on which the claim was paid. For suspended claims this field is not populated	Field	Date (MM/DD/CCYY)	8	N/A	N/A
18	Provider Number	The provider identification number and location that uniquely identifies the provider of services	Field	Character	10	T_DENTAL_HDR_KEYS	ID_PROVIDER
19	Rend Provider Number	The rendering provider identification number and location that uniquely identifies the provider of services	Field	Character	10	T_SUSP_DENTAL_HDR	CDE_SVC_LOC_REF_1
20	POS	Location where service was rendered	Field	Character	2	T_SUSP_DENTAL_HDR	CDE_POS
21	EPSDT	Indicates whether claim is EPSDT	Field	Drop Down List Box	0	T_SUSP_DENTAL_HDR	CDE_EPSDT_FP
22	Other Plan	Indicates if another form of insurance was used	Field	Drop Down List Box	0	T_SUSP_DENTAL_HDR	IND_ANOTHER_PLAN
23	Emergency	Indicates whether service was provided as a result of an emergency situation	Field	Drop Down List Box	0	T_SUSP_DENTAL_HDR	IND_EMERGENCY
24	Status	This field displays the status of the claim	Field	Drop Down List Box	6	T_SUSP_DENTAL_HDR	CDE_CLM_STATUS
25	Details	Indicates the number of detail service lines on the claim	Field	Number	9	T_SUSP_DENTAL_HDR	NUM_DTL_TOTAL

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
26	Billed	Amount of money requested for payment by a provider for services rendered. Format 999999.99	Field	Number	8	T_SUSP_DENTAL_HDR	AMT_BILLED
27	Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, and so on). Format 999999.99	Field	Number	8	T_SUSP_DENTAL_HDR	AMT_NET_BILLED
28	Spenddown	Amount of money that the member is responsible for paying for services. Format 9999999.99	Field	Number	9	T_SUSP_DENTAL_HDR	AMT_PATNT_LIAB
29	Reimbursed	Total amount the provider receives. Format 9999999.99. This value is not displayed for Suspended claims	Field	Number	9	N/A	N/A
30	Paid	Amount paid on claim. This value is computed by adding up all the AMT_PAID values on the related details. Format 999999.99. This field is not displayed for Suspended claims	Field	Number	9	N/A	N/A
31	TPL	Amount paid by third party for services. Format 999999.99	Field	Number	8	T_SUSP_DENTAL_HDR	TPL_AMT
32	Total TPL	The total Claim TPL amount equals the sum of the Header and Detail amounts. Format 999999.99	Field	Number	8	N/A	N/A
33	TPL Recovered Amt	The recovery amount populated from the settlement panel. Format 9999999.99	Field	Number	9	T_TPL_AR_CLM_XREF	AMT

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
34	Total Copay	This is the sum of the copay amounts from the claim detail records. Format 9999999.99	Field	Number	9	T_SUSP_DENTAL_ DTL	AMT_CO_PAY

4.6.8.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	Member ID	Field	1	Invalid Member ID.	Enter a valid member ID or select a value from the [Search] panel.
14	FDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
14	FDOS	Field	2	First date of service must be less than or equal to the last date of service.	Verify dates and re-enter.
15	TDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
16	Date Billed	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
18	Provider Number	Field	1	Invalid Billing Provider.	Enter a valid Provider or select a value from the [Search] panel.
18	Provider Number	Field	2	Provider ID and service location are required.	Enter a Valid ID and service location or select a value from the [Search] panel.
19	Rendering Provider	Field	1	Invalid Rendering Provider.	Enter a valid Rendering provider or select a value from the [Search] panel.
19	Rendering Provider	Field	2	Rendering ID and service location are required.	Enter a valid Provider ID or select a value from the [Search] panel.
20	POS	Field	1	Invalid Place of Service.	Enter a valid Place of Service or select a value from the [Search] panel.

Field No	Field	Field Type	Error Code	Error Message	To Correct
25	Details	Field	101	Exceed maximum number of details.	The maximum number of details has been exceeded for this claims type.
26	Billed	Field	1	Enter a valid value.	Billed Amount must be numeric.
27	Net Billed	Field	1	Enter a valid value.	Net billed Amount must be numeric.
31	TPL	Field	1	Enter a valid Value.	TPL Amount must be numeric.

4.7 PAGE: Claims Assignment Page

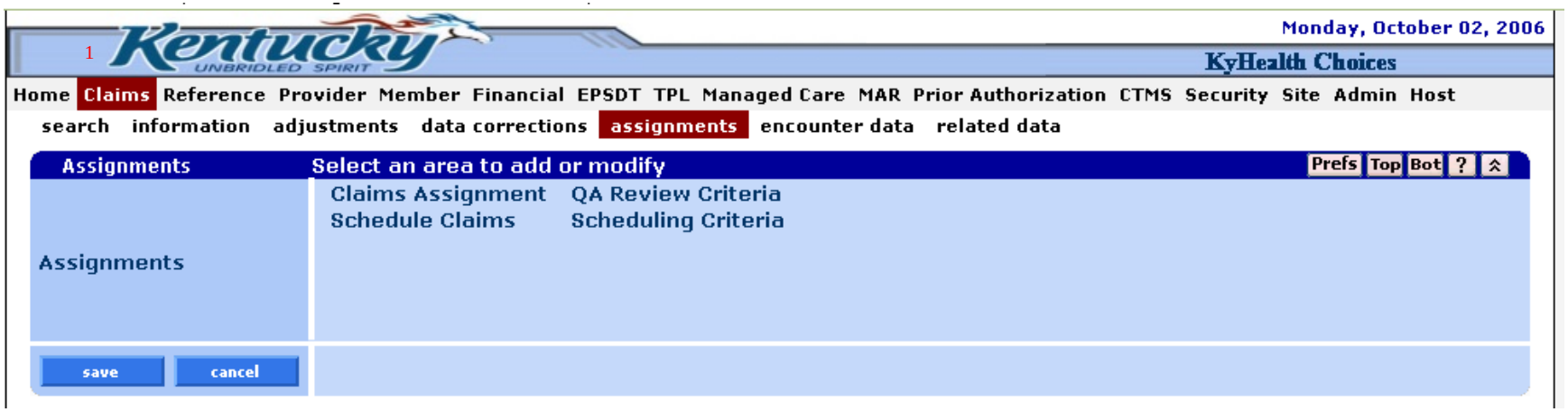
4.7.1 Description

The Claims Assignment Page contains panels to assign claims to data correction analysts.

4.7.2 Web Page Name:

Claims Assignment Page

4.7.3 Claims Assignment Page Layout



To access this page:

STEP 1. Click on Claims located in the subsystem header listing under the Commonwealth logo “Kentucky Unbridled Spirit”.

STEP 2. Click on Assignments located under the subsystem header listing or click on Assignments from the drop down listing that appears when the cursor touches the Claims button in the subsystem header listing.

4.7.4 PANEL: Assignments Navigation

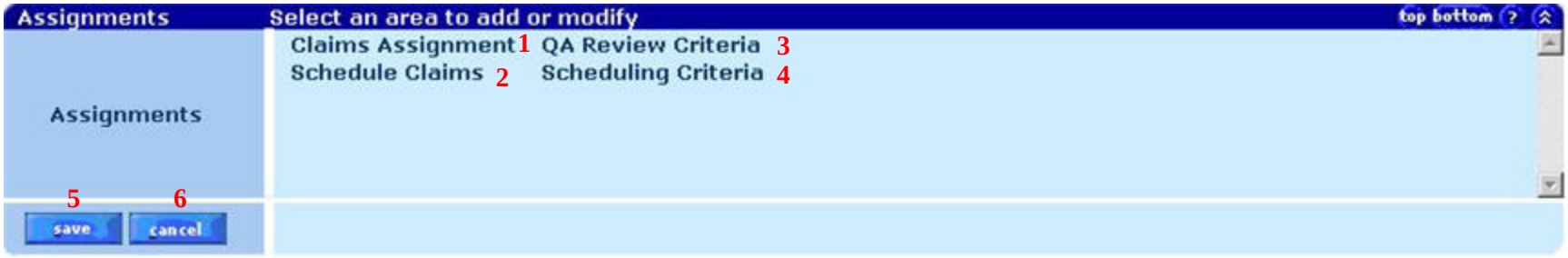
The Assignments Navigation panel contains links to the panels for the Claims Assignment area.

Navigation Path: [Claims - Assignments]

4.7.4.1 Panel Name

Assignments Navigation

4.7.4.2 Assignments Navigation Layout



To access this panel:

Access the Claims Assignment page using the instructions listed for the page.

The Claims Assignment button brings up that panel which lists claims assigned by claim type and status.

The QA Review Criteria button brings up that panel which lists claims assigned by claim type, user ID, and percentage or claims to review.

The Schedule Claims button brings up that panel which lists the claims scheduled to user IDs.

The Scheduling Criteria button brings up that panel which lists the user IDs by claim type.

The Save button on this panel saves any changes made to a change on any panels.

The Cancel button on this panel cancels any changes made in any panel to a change.

4.7.4.3 Extra Features

This panel has no extra features.

4.7.4.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Claims Assignment	A link to "Claims Assignment" Panel	Hyperlink	N/A	0	N/A	N/A
2	Schedule Claims	A link to "Schedule Claims" Panel	Hyperlink	N/A	0	N/A	N/A
3	QA Review Criteria	A link to "QA Review Criteria" Panel	Hyperlink	N/A	0	N/A	N/A
4	Scheduling Criteria	A link to "Scheduling Criteria" Panel	Hyperlink	N/A	0	N/A	N/A

4.7.4.5 Button Descriptions

Button No	Button	Description
5	Save	Saves any changes made to panels on this page
6	Cancel	Cancels any changes made to panels on this page

4.7.4.6 Field Edits

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

4.7.5 PANEL: Claims Assignment

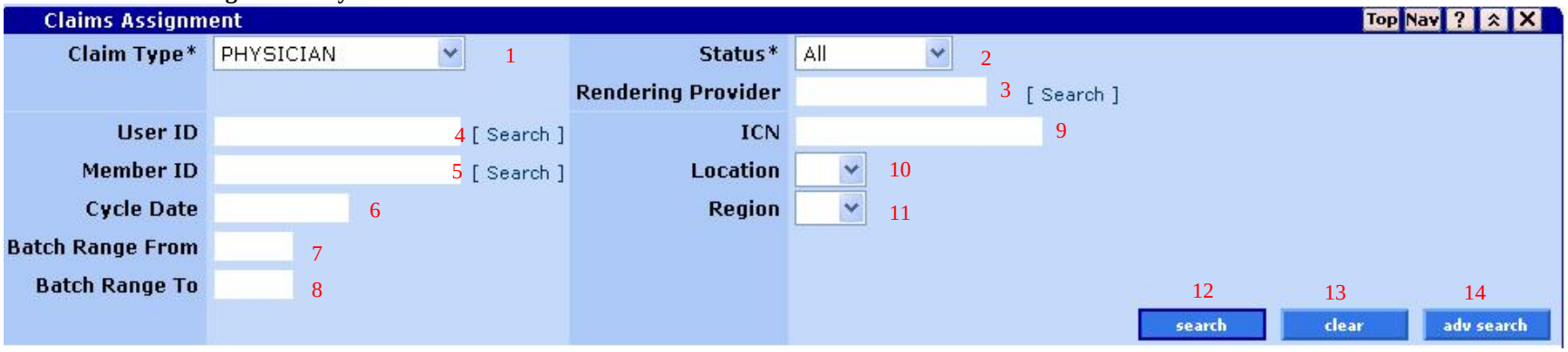
The Claim Assignment panel allows the manager or lead to reassign claims to a user by changing the User ID associated with a claim. To view a list of claims that can be reassigned, Claim Type and Claim Status must be entered. Additional search criteria can be viewed by clicking the Adv Search button. Click the Search button to display the list of claims. To select all claims, click the checkbox at the top of the panel to the left of the ICN column heading. Individual claims may be selected by clicking the checkbox to the right of each ICN. To reassign claims to a specific User ID, enter the User ID and click the Update button.

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

4.7.5.1 Panel Name

Claims Assignment

4.7.5.2 Claims Assignment Layout



To access this panel:

Access the Claims Assignment page using the instructions listed for the page.

STEP 1. Click the Claims Assignment button located next to the QA Review Criteria button and above the Schedule Claims button.

STEP 2. Select a category from the Claim Type drop down box (1).

STEP 3. Select a category from the Status drop down box (2).

STEP 4. Click the Search button (12).

This panel displays a listing of claims assigned by claim type and status. It allows claims to be reassigned to a different User ID when the check box for the row is selected.

4.7.5.3 Extra Features

This panel has no extra features.

4.7.5.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Claim Type	Indicates the claim type assigned to the user	Field	Drop Down List Box	0	T_DCOR_SCHEDULE	CDE_CLM_TYPE
2	Status	Displays the claims selected by the user depending on the status selected	Field	Drop Down List Box	0	T_HIST_DIRECTORY	CDE_CLM_STATUS
3	Rendering Provider ID	Allows the manager to limit the selection of claims to the individual provider number from the claims.	Field	Character	9	T_PR_PROV	ID_PROVIDER
4	User ID	Indicates the User ID assigned to the claims	Field	Character	8	T_DCOR_SCHEDULE	ID_CLERK
5	Member ID	Allows the manager to limit the selection to a specific Member ID number	Field	Character	12	T_DCOR_SCHEDULE	SAK_RECIP
6	Cycle Date	Allows the manager to limit the selection to a specific cycle date	Field	Date (MM/DD/CCYY)	8	T_CLAIM_LOCAT	DTE_CLM_LOCAT
7	Batch Range From	Batch Range From value that allows the manager to limit the selection of claims to a specific batch range	Field	Character	3	T_DCOR_SCHEDULE	NUM_BATCH_FROM

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
8	Batch Range To	Batch Range To value that allows the manager to limit the selection of claims to a specific batch range	Field	Character	3	T_DCOR_SCHEDULE	NUM_BATCH_TO
9	ICN	Internal control number that uniquely identifies a claim	Field	Character	13	T_CLAIM_LOCAT	NUM_ICN
10	Location	Allows the manager to limit the selection of claims to a specific location	Field	Drop Down List Box	0	T_CLAIM_LOCAT	CDE_LOCATION
11	Region	Allows the manager to limit the selection of claims to a specific region	Field	Drop Down List Box	0	T_DCOR_SCHEDULE	CDE_CLM_REGION
12	Search	Performs a query on the database and returns the data for the entered search criteria	Button	N/A	0	N/A	N/A
13	Clear	Clears the previous search criteria from the search fields	Button	N/A	0	N/A	N/A
14	Adv Search	Advanced Search Button, opens a panel with additional search criteria fields	Button	N/A	0	N/A	N/A

4.7.5.5 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Claim Type	Field	1	Must select a Claim Type and Status.	Select a value for claim type.
2	Status	Field	1	Must select a Claim Type and Status	Select a valid Status from the drop down box.

Field No	Field	Field Type	Error Code	Error Message	To Correct
6	Cycle Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify format and re-enter.
7	Batch Range From	Field	1	Batch Entry must be numeric.	Enter a numeric value.
7	Batch Range From	Field	2	Batch To must be less than or equal to Batch From.	Enter a value which is less than or equal to Batch Range To.
8	Batch Range To	Field	1	Batch Entry must be numeric.	Enter a numeric value.
8	Batch Range To	Field	2	Batch To must be less than or equal to Batch From.	Enter a value which is greater than or equal to Batch Range From.
9	ICN	Field	1	ICN must be numeric.	Enter a numeric value.

4.7.6 PANEL: Schedule Claims

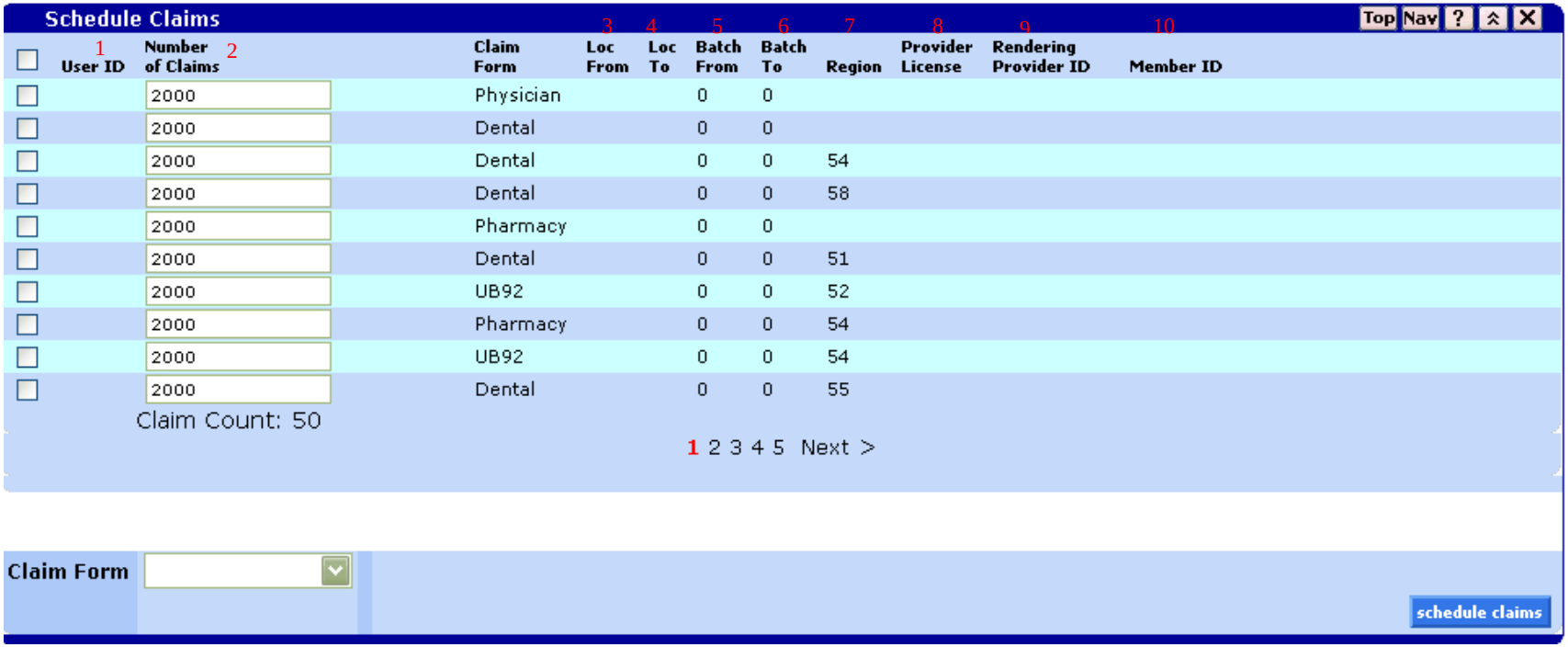
The manager or lead uses the Schedule Claims panel to distribute claims for the users on a daily basis. Claims can be assigned by claim type, or all claim types can be assigned at once.

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

4.7.6.1 Panel Name

Schedule Claims

4.7.6.2 Schedule Claims Layout



To access this panel:

Access the Claims Assignment page using the instructions listed for the page.

STEP 1. Click the Schedule Claims button located next to the Scheduling Criteria button and below the Claims Assignment button.

STEP 2. Click a check box to select a row or select claim type from the Claim Form drop down box.

STEP 3. Click the Schedule Claims button.

This panel distributes the selected claims to users on a daily basis. It allows claims to be assigned by claim type or by all claim types.

4.7.6.3 Extra Features

This panel has no extra features.

4.7.6.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	User ID	Indicates the user the claims are assigned to	Field	Character	8	T_DCOR_SCHEDULE	ID_CLERK
2	Number of Claims	This is the total number of claims found for the User	Field	Number	5	N/A	N/A
3	Location From	The beginning location of the claims assigned to the user	Field	Character	2	T_DCOR_SCHEDULE	CDE_LOC_FROM
4	Location To	The ending location of the claims assigned to the user	Field	Character	2	T_DCOR_SCHEDULE	CDE_LOC_TO
5	Batch From	The beginning batch number used to identify the grouping of the claims	Field	Number	3	T_DCOR_SCHEDULE	NUM_BATCH_FROM
6	Batch To	The ending batch number used to identify the grouping of the claims	Field	Number	3	T_DCOR_SCHEDULE	NUM_BATCH_TO

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
7	Region	The beginning region code of the claims assigned to the user	Field	Character	2	T_DCOR_SCHEDULE	CDE_CLM_REGION
8	Provider License	License number of the provider of services	Field	Character	10	T_DCOR_SCHEDULE	CDE_PROV_ATT_ID
9	Rendering Provider ID	The provider identification number that uniquely identifies the rendering provider	Field	Character	9	T_PR_PROV	ID_PROVIDER
10	Member ID	A system-assigned number which uniquely identifies a member. Claims for a specific Member ID may be assigned to a selected user	Field	Character	12	T_RE_BASE	ID_MEDICAID

4.7.6.5 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
8	Provider License	Field	106	Only UB92 Claims are allowed to have provider license specification.	If this is not a UB92 claim, a Provider License must not be entered.
9	Rendering Provider ID	Field	105	Only HCFA and Dental Claims are allowed to have provider specification.	If this is not a HCFA or Dental claim, Rendering Provider must not be entered.

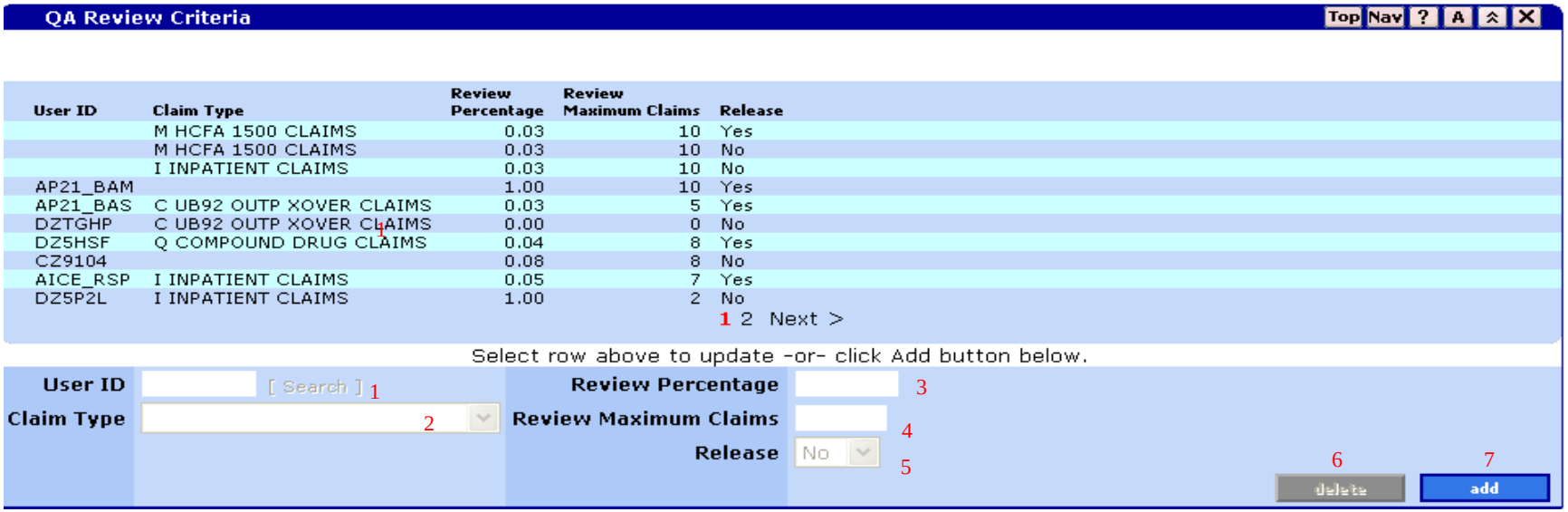
4.7.7 PANEL: QA Review Criteria

The manager or lead uses the QA Review Criteria panel to set the number of claims for each user for quality review. These claims can be set by claim type. The percent and maximum number of claims needed for review can also be set.
Navigation Path: [Claims - Assignments] - [QA Review Criteria]

4.7.7.1 Panel Name

QA Review Criteria

4.7.7.2 QA Review Criteria Layout



To access this panel:

Access the Claims Assignment page using the instructions listed for the page.

STEP 1. Click the QA Review Criteria button located next to the Claims Assignment button and above the Scheduling Criteria button.

STEP 2. Select a row from the listing or click the Add button to create a new record.

This panel displays a listing of claims assigned by claim type, user ID and percentage of claims to review. It allows the user ID percentage of claims and maximum amount of claims to be changed when the row is selected.

4.7.7.3 Extra Features

This panel has no extra features.

4.7.7.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	User ID	Indicates the User ID that has assigned claims	Field	N/A	0	T_DCOR_QLTY_CTL	ID_CLERK
2	Claim Type	Indicates the type of claim assigned to the user for review	Field	Drop Down List Box	0	T_DCOR_QLTY_CTL	CDE_CLM_TYPE
3	Review Percentage	The percent of the user's claims per day to be quality checked	Field	Number	3	T_DCOR_QLTY_CTL	NUM_DCOR_PCT
4	Review Maximum Claims	Maximum number of claims needed from the percentage to be checked for quality	Field	Number	5	T_DCOR_QLTY_CTL	QTY_DCOR_MAX
5	Release	Indicates if the claims assigned to the user are to be released at the end of the day or held until reviewed by the manager or lead	Field	Drop Down List Box	0	T_DCOR_QLTY_CTL	IND_DCOR_RELEASE
6	Delete	Deletes a record	Button	N/A	0	N/A	N/A
7	Add	Adds a new record	Button	N/A	0	N/A	N/A

4.7.7.5 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	User ID	Field	1	A valid Clerk ID is required.	Select a User ID from the [Search] panel.
2	Claim Type	Field	1	A valid Claim Type is required.	Select a value from the drop down box.
3	Review Percentage	Field	1	Enter a valid value between 01 and 99.99.	Enter a numeric value.

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	Review Percentage	Field	2	Enter a valid value between 01 and 99.99.	Enter a value between .01 and 99.99.
4	Review Maximum Claims	Field	1	Enter a valid value between 01 and 99.99.	Enter a numeric value.
4	Review Maximum Claims	Field	2	Enter a valid value between 01 and 99.99.	Enter a value between 1 - 99999.
5	Release	Field	1	Enter yes or no.	Select a value from the drop down box.

4.7.8 PANEL: Scheduling Criteria

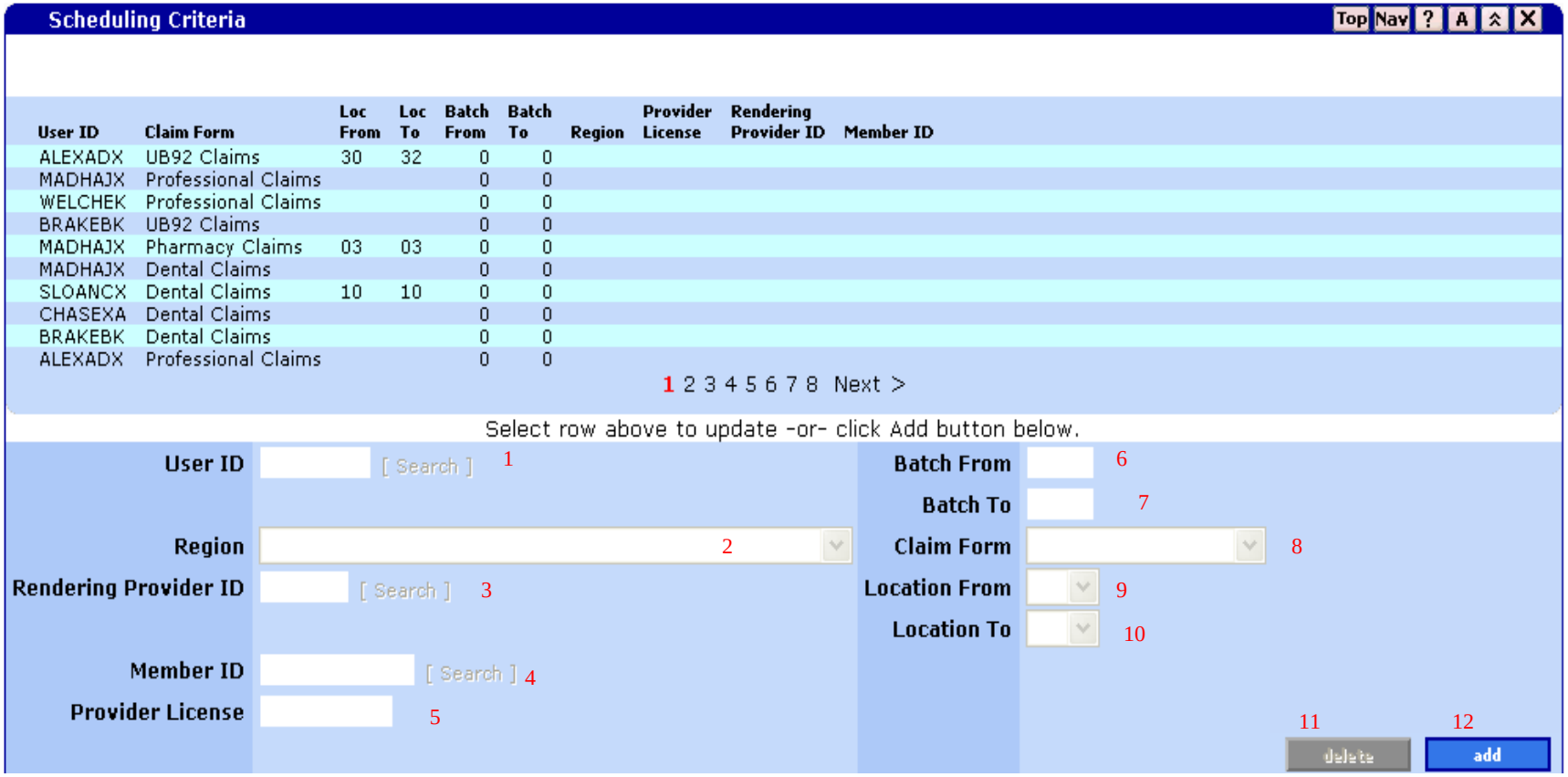
The manager or lead uses the Scheduling Criteria panel to distribute claims for the users on a daily basis. Required criteria fields are User and Claim Type. Optional fields are Location Range, Batch Range, Region, Rendering Provider, and Member ID. Claims can be assigned by claim type, or all claim types can be assigned at once.

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

4.7.8.1 Panel Name

Scheduling

4.7.8.2 Scheduling Criteria Layout



To access this panel:

Access the Claims Assignment page using the instructions listed for the page.

STEP 1. Click the Scheduling Criteria button located next to the Schedule Claims button and below the QA Review Criteria button.

STEP 2. Click the Add button to create a new record.

This panel displays a listing of user IDs assigned by claim type, location, and batch range. It allows claims to be assigned to a user ID using the criteria listed in the required fields.

4.7.8.3 Extra Features

This panel has no extra features.

4.7.8.4 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	User ID	Indicates the user the claims are assigned to. Select a valid User ID from the [Search] panel	Field	N/A	0	T_DCOR_SCHEDULE	ID_CLERK
2	Region	The beginning region code of the claims assigned to the user	Field	Drop Down List Box	0	T_DCOR_SCHEDULE	CDE_CLM_REGION
3	Rendering Provider ID	The provider identification number that uniquely identifies the provider and provider's service location. Select a valid Provider ID from the [Search] panel	Field	N/A	0	T_PR_PROV	ID_PROVIDER
4	Member ID	A system-assigned number which uniquely identifies a member. Claims for a specific Member ID may be assigned to a selected user. Select a valid Member ID from the [Search] panel	Field	N/A	11	T_RE_BASE	ID_MEDICAID

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Provider License	License number of the provider of services	Field	Character	10	T_DCOR_SCHEDULE	CDE_PROV_ATT_ID
6	Batch From	The beginning batch number used to identify the grouping of the claims	Field	Number	3	T_DCOR_SCHEDULE	NUM_BATCH_FROM
7	Batch To	The ending batch number used to identify the grouping of the claims	Field	Number	3	T_DCOR_SCHEDULE	NUM_BATCH_TO
8	Claim Form	Indicates the type of claim assigned to the user for review	Field	Drop Down List Box	0	T_DCOR_SCHEDULE	CDE_CLM_TYPE
9	Location From	The beginning location of the claims assigned to the user	Field	Drop Down List Box	0	T_DCOR_SCHEDULE	CDE_L0C_FROM
10	Location To	The ending location of the claims assigned to the user	Field	Drop Down List Box	0	T_DCOR_SCHEDULE	CDE_LOC_TO
11	Delete	Deletes a Record	Button	N/A	0	N/A	N/A
12	Add	Adds a new record	Button	N/A	0	N/A	N/A

4.7.8.5 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
6	Batch From	Field	1	Enter a valid value.	Only numeric values are accepted in this field.
6	Batch From	Field	2	From Batch Number must be less than or equal to 999.	Enter a value between 001-999.
6	Batch From	Field	102	Must enter valid from and to batch numbers.	If a From value is entered, a To value must also be entered.
6	Batch From	Field	103	From batch number must be less than or equal to batch number.	Enter a To date that is equal to or greater than the From value.

Field No	Field	Field Type	Error Code	Error Message	To Correct
7	Batch To	Field	1	Enter a valid value.	Only numeric values are accepted in this field.
7	Batch To	Field	2	To Batch Number must be less than or equal to 999.	Enter a value between 001 - 999.
7	Batch To	Field	102	Must enter valid from and to batch numbers.	If a To value is entered, a From value must also be entered.
8	Claim Form	Field	100	Claim Form Type must be M, D, U, or P.	Select a valid Claim Form Type.
9	Location From	Field	101	Must enter valid from and to claim locations.	If a From location is entered, a To location must also be entered.
9	Location From	Field	104	From claim location must be less than or equal to claim location.	Enter a Location From code which is not greater than the Location To code.
10	Location To	Field	101	Must enter valid from and to claim locations.	If a To value is entered, a valid From value must also be entered.
10	Location To	Field	104	From claim location must be less than or equal to claim location.	The Location To must be greater than or equal to the Location From.
5	Provider License	Field	106	Only UB92 Claims are allowed to have provider license specification.	If the claim type is not UB92, then a license number cannot be entered.
3	Rendering Provider ID	Field	105	Only HCFA and Dental Claims are allowed to have provider specification.	Do not enter provider criteria for pharmacy claims. Pharmacy claims do not have rendering providers.

4.8 PAGE: Claims Encounter Page

4.8.1 Description

The Claims Encounter Page contains the Encounter Navigation Panel. From here, access two main search panels, the EDI Batch Status and the Encounter Batch Summary. Both search panels may be opened and results can be viewed on the same page. Managed Care Organization is available as a part of the search criteria for both search panels allowing users to easily distinguish encounter batches submitted by different managed care entities.

When a row is selected on the Encounter Batch Summary search results panel, click on links to the Encounter Errors panel and the Encounter Claim Related panel. The error data displayed in the Encounter Errors panel relates to the selected row on the Encounter Batch Summary. The data in the Encounter Claim Related panel is associated with the error code selected on the Encounter Errors panel. As a different row is selected on either the Encounter Batch Summary panel or the Encounter Errors panel, the data in the panels below automatically updates to reflect the selected batch file or error.

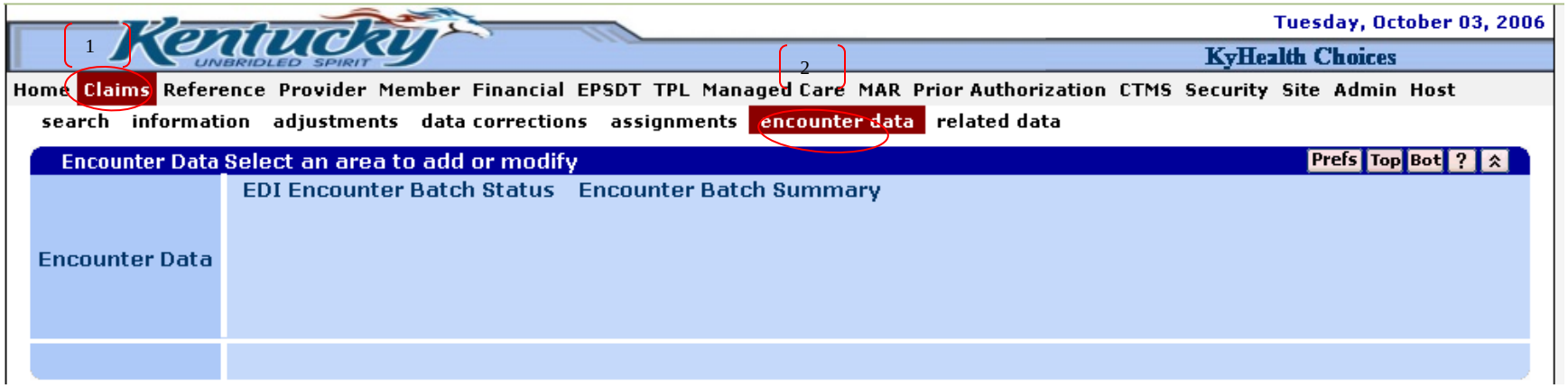
4.8.2 Technical Name

Clm.EncounterDataPage.ascx

4.8.3 Web Page Name:

Encounter Data

4.8.4 Claims Encounter Page Layout



To access this page:

STEP 1. Click on Claims located in the subsystem header listing under the Commonwealth logo “Kentucky Unbridled Spirit”.

STEP 2. Click on Encounter Data located under the subsystem header listing or click on Encounter Data from the drop down listing that appears when the cursor touches the Claims button in the subsystem header listing.

4.8.5 PANEL: Encounter Data Navigation

4.8.5.1 Description

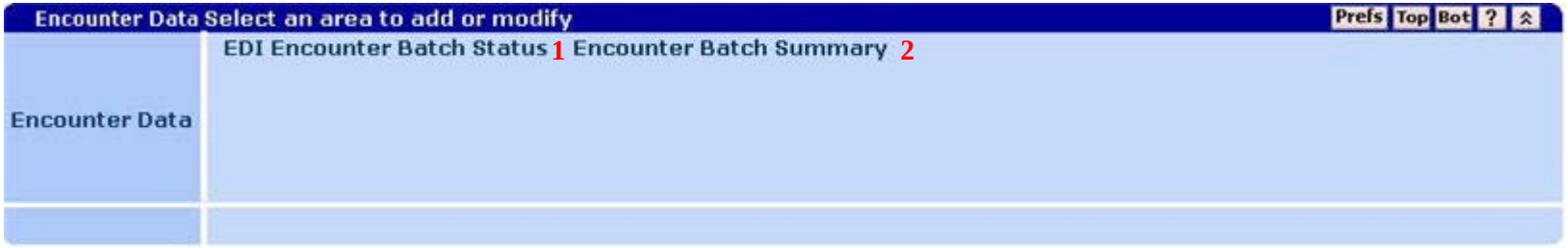
The Claims Encounter Page contains the Encounter Navigation Panel. From here, access two main search panels, the EDI Batch Status and the Encounter Batch Summary. Both search panels may be opened and results can be viewed on the same page. Managed Care Organization is available as a part of the search criteria for both search panels allowing users to easily distinguish encounter batches submitted by different managed care entities.

When a row is selected on the Encounter Batch Summary search results panel, click on links to the Encounter Errors panel and the Encounter Claim Related panel. The error data displayed in the Encounter Errors panel relates to the selected row on the Encounter Batch Summary. The data in the Encounter Claim Related panel is associated with the error code selected on the Encounter Errors panel. As a different row is selected on either the Encounter Batch Summary panel or the Encounter Errors panel, the data in the panels below automatically updates to reflect the selected batch file or error.

4.8.5.2 Panel Name

Encounter Data Navigation

4.8.5.3 Encounter Data Navigation Layout



To access this panel:

STEP 1. Access the Encounter Data page using the instructions listed for the page.

STEP 2. Click the EDI Encounter Batch Status button to go to that panel which searches for managed care claims by received dates.

STEP 3. Click the Encounter Batch Summary to go to that panel which searches for managed care claims by received dates or by paid dates.

4.8.5.4 Extra Features

This panel has no extra features.

4.8.5.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	EDI Encounter Batch Status	A link to "EDI Encounter Batch Status" Panel	Hyperlink	N/A	0	N/A	N/A
2	Encounter Batch Summary	A link to "Encounter Batch Summary" Panel	Hyperlink	N/A	0	N/A	N/A

4.8.5.6 Field Edits

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

4.8.6 PANEL: EDI Encounter Batch Status Search

4.8.6.1 Description

The EDI Encounter Batch Status searches for EDI batch files by MCO and Received Dates. Users can select Current, Historical or All records by clicking on the appropriate radio button.

Navigation Path: [Claims - Encounter Data] - [click on EDI Encounter Batch Status]

4.8.6.2 Technical Name

Clm.EDIBatchSearchPanel.ascx

4.8.6.3 Panel Name

EDI Encounter Batch Status

4.8.6.4 EDI Encounter Batch Status Search Layout

4.8.6.5 Extra Features

This panel has no extra features.

4.8.6.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	MCO ID	The Managed Care Organization that sent a batch file to the system	Field	Drop Down List Box	0	T_TP	ID_PROVIDER,NAME
2	Received Date From	The from date used to search for batch files received	Field	Date (MM/DD/CCYY)	8	T_FILE_TRACK	DTE_CREATED
3	Received Date To	The end date used to search for batch files received	Field	Date (MM/DD/CCYY)	8	T_FILE_TRACK	DTE_CREATED

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
4	Records	This is the number of records that are displayed per page. This value is either set by the user or it defaults to 20	Field	Drop Down List Box	0	N/A	N/A
5	Search	Performs a query on the database and returns the data for the entered search criteria	Button	N/A	0	N/A	N/A
6	Clear	Clears the previous search criteria from the search fields	Button	N/A	0	N/A	N/A

4.8.6.7 Field Edits

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

4.8.7 PANEL: EDI Encounter Batch Status Search Results

4.8.7.1 Description

The EDI Encounter Batch Status search results display EDI batch files by MCO and Received Dates.

Navigation Path: [Claims - Encounter Data] - [click on EDI Encounter Batch Status] - [Enter criteria, click on Search]

4.8.7.2 Technical Name

Clm.EDIBatchSearchPanel.ascx - Search Results

4.8.7.3 Panel Name

EDI Search Results

4.8.7.4 EDI Encounter Batch Status Search Results Layout

Search Results

1 Received Date	2 Received Time	3 Batch Status	4 Batch File	5 Origin
09/10/2005	01:25:30	Released to Process Complete	i83700204091301.txt	DCE9070A
09/10/2005	01:15:15	Released to Process Complete	i83700204091349.txt	DCE9070A
09/10/2005	12:33:33	Non-Compliant	i83778665091301.txt	DCE9070C
09/10/2005	10:22:30	Released to Process Complete	i83700204091112.txt	DCE9070A
09/11/2005	02:25:22	Released to Process Complete	i83700204023301.txt	DCE9070B
09/11/2005	03:25:30	Loaded	i83700204091405.txt	DCE9070A
09/11/2005	03:52:30	Released to Process Complete	i83700204091555.txt	DCE9070A
09/11/2005	20:25:05	Released to Process Complete	i83700204091999.txt	DCE9070C
09/11/2005	08:25:12	Released to Process Complete	i83700204091330.txt	DCE9070B
09/12/2005	02:25:11	Loaded	i83700204091653.txt	DCE9070A
09/12/2005	10:25:30	Non-Compliant	i8370020409113.txt	DCE9070A
09/12/2005	10:23:23	Released to Process Complete	i83700204045601.txt	DCE9070A
09/12/2005	09:25:22	Released to Process Complete	i83700200098301.txt	DCE9070A

Prev > 1 2 > 3 4 > ... Next

4.8.7.5 Extra Features

This panel has no extra features.

4.8.7.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Received Date	The date the EDI batch file was received by the system	Field	Date (MM/DD/CCYY)	8	T_FILE_TRACK	DTE_CREATED
2	Received Time	The time the EDI batch file was received by the system. NOTE: This field may be combined with the Received Date field	Field	Number	6	T_FILE_TRACK	DTE_CREATED
3	Batch Status	The status of the batch file received.	Field	Character	30	T_CDE_FILE_STATUS	DSC_FILE_STATUS
4	Batch File	The name of the EDI batch file received by the system	Field	Character	255	T_FILE_TRACK	NAM_FILE
5	Origin	The ID of the last update user or process	Field	Character	8	T_FILE_TRACK	NAM_ORGN_SERVER

4.8.7.7 Field Edits

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

4.8.8 PANEL: Encounter Batch Summary Search

4.8.8.1 Description

Use the Encounter Batch Summary Search panel to search for batch files by MCO and Received Dates or Pay Cycle Dates. Click the appropriate radio button to select Accepted, Rejected, In Process, or All records.

Navigation Path: [Claims - Encounter Data] - [click on Encounter Batch Summary]

4.8.8.2 Technical Name

Clm.EncounterBatchSearchPanel.ascx

4.8.8.3 Panel Name

Encounter Batch Search

4.8.8.4 Encounter Batch Summary Search Layout

4.8.8.5 Extra Features

This panel has no extra features.

4.8.8.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	MCO ID	The ID of the Managed Care Organization	Field	Drop Down List Box	0	T_PR_PROV	ID_PROVIDER
2	All, Accepted, In-Process, Rejected	Radio buttons indicating the selection of record types to be displayed	Field	Radio Button	0	T_ENC_BATCH_PROCESS	CDE_BATCH_STATUS

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
3	Received Dates (from)	The beginning received date range	Field	Date (MM/DD/CCYY)	8	T_FILE_TRACK	DTE_CREATED
4	Received Dates (to)	The ending received date range	Field	Date (MM/DD/CCYY)	8	T_FILE_TRACK	DTE_CREATED
5	Pay Cycle Dates (from)	The beginning pay cycle date range	Field	Date (MM/DD/CCYY)	8	T_ENC_BATCH_PROCESS	DTE_PAY_CYCLE
6	Pay Cycle Dates (to)	The ending received date range	Field	Date (MM/DD/CCYY)	8	T_ENC_BATCH_PROCESS	DTE_PAY_CYCLE
7	Records	This is the number of records that are displayed per page. This value is either set by the user or it defaults to 20	Field	Drop Down List Box	0	N/A	N/A
8	Search	Performs a query on the database and returns the data for the entered search criteria	Button	N/A	0	N/A	N/A
9	Clear	Clears the previous search criteria from the search fields	Button	N/A	0	N/A	N/A

4.8.8.7 Field Edits

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

4.8.9 PANEL: Encounter Batch Summary Search Results

4.8.9.1 Description

The Encounter Batch Summary Search Results display batch files for a Managed Care Organization by Received Dates or Pay Cycle Dates.

Navigation Path: [Claims - Encounter Data] - [click on Encounter Batch Summary] - [Enter search criteria and click Search]

4.8.9.2 Technical Name

Clm.EncounterBatchSearchPanel.ascx - Search Results

4.8.9.3 Panel Name

Encounter Batch Results

For readability, this panel layout is displayed in two separate sections beginning on the next page. The actual layout is a single, wide horizontal panel.

NOTE: When in the program use the scroll bar from left to right to view all the columns on the panel.

4.8.9.4 Encounter Batch Summary Search Results Layout

1 Received Date	2 Pay Cycle Date	Batch File 3	Threshold Count 4	Percent Errors 5	Informational Count 6	Total Encounter Count 7
06/23/2002	02/22/2006	/export/customer/dsok/mod/data/upld/x12/F.60.1000000002.txn	99,999,999	100%	99,999,999	99,999,999
03/27/2006	03/27/2006	/export/customer/dsok/mod/data/upld/x12/F.72.1000000002.txn	99,999,999	100%	99,999,999	99,999,999
06/23/2002	03/27/2006	/export/customer/dsok/mod/data/upld/x12/F.74.1000000002.txn	99,999,999	100%	99,999,999	99,999,999
06/23/2002	03/27/2006	/export/customer/dsok/mod/data/upld/x12/F.76.1000000002.txn	99,999,999	100%	99,999,999	99,999,999
06/23/2002	03/27/2006	/export/customer/dsok/mod/data/upld/x12/F.77.1000000002.txn	99,999,999	100%	99,999,999	99,999,999
06/23/2002	03/27/2006	/export/customer/dsok/mod/data/upld/x12/F.75.1000000002.txn	99,999,999	100%	99,999,999	99,999,999
03/27/2006	03/27/2006	/export/customer/dsok/mod/data/upld/x12/F.73.1000000002.txn	99,999,999	100%	99,999,999	99,999,999
06/23/2002	03/27/2006	/export/customer/dsok/mod/data/upld/x12/F.68.1000000002.txn	99,999,999	100%	99,999,999	99,999,999
06/23/2002	03/27/2006	/export/customer/dsok/mod/data/upld/x12/F.69.1000000002.txn	99,999,999	100%	99,999,999	99,999,999
06/23/2002	02/22/2006	/export/customer/dsok/mod/data/upld/x12/F.61.1000000002.txn	33,333,333	33%	66,666,666	99,999,999

Encounter Count 8	Encounter Bad Count 9	Billed Amount 10	Paid Amount 11	Batch Status 12	Bad Status 13	Origin 14	Action Date 15	Action Time 16	Sak Batch 17
99,999,999	99,999,999	$9,999,999.99	$9,999,999.99	Accepted	Yes	WZW7NZ	02/22/2006	05:02:21	60
99,999,999	99,999,999	$9,999,999.99	$9,999,999.99	Accepted	Yes	WZW7NZ	03/27/2006	11:03:13	72
99,999,999	99,999,999	$9,999,999.99	$9,999,999.99	Accepted	Yes	WZW7NZ	03/27/2006	11:03:37	74
99,999,999	99,999,999	$9,999,999.99	$9,999,999.99	Accepted	Yes	WZW7NZ	03/27/2006	11:03:00	76
99,999,999	99,999,999	$9,999,999.99	$9,999,999.99	Accepted	Yes	WZW7NZ	03/27/2006	11:03:08	77
99,999,999	99,999,999	$9,999,999.99	$9,999,999.99	Accepted	Yes	WZW7NZ	03/27/2006	11:03:48	75
99,999,999	99,999,999	$9,999,999.99	$9,999,999.99	Accepted	Yes	WZW7NZ	03/27/2006	11:03:27	73
99,999,999	99,999,999	$9,999,999.99	$9,999,999.99	Accepted	No	WZW7NZ	03/27/2006	09:03:23	68
99,999,999	99,999,999	$9,999,999.99	$9,999,999.99	Rejected	No	WZW7NZ	03/27/2006	09:03:36	69
99,999,999	2,979,422	$9,999,999.99	$9,999,999.99	Processing	Yes	WZW7NZ	02/22/2006	05:02:12	61

4.8.9.5 Extra Features

This panel has no extra features.

4.8.9.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Received Date	Date that the batch file was received by the system	Field	Date (MM/DD/CCYY)	8	T_FILE_TRACK	DTE_CREATED
2	Pay Cycle Date	Date that the batch file was processed in pay cycle	Field	Date (MM/DD/CCYY)	8	T_ENC_BATCH_PROCESS	DTE_PAY_CYCLE
3	Batch File	Name of the batch file received from a Managed Care Organization	Field	Character	255	T_FILE_TRACK	NAM_FILE
4	Threshold Count	The count of threshold errors in the batch	Field	Number	9	T_ENC_BATCH_PROCESS	CNT_TRESHOLD
5	Percent Errors	The percent of errors in the batch file. This is a calculated field based on the number of claims not processed. Format 999.99%	Field	Number	5	N/A	CALCULATED

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
6	Informational Count	The count of informational errors in the batch	Field	Number	9	T_ENC_BATCH_PROCESS	CNT_INFORMATIONAL
7	Total Encounter Count	The total count of new day claims	Field	Number	9	T_ENC_BATCH_PROCESS	ORIG_CLAIM_TOT
8	Encounter Count	The number of new day claims processed	Field	Number	9	T_ENC_BATCH_PROCESS	ORIG_CLM_CNT
9	Encounter Bad Count	The number of claims not processed due to internal errors	Field	Number	9	T_ENC_BATCH_PROCESS	BAD_CLM_CNT
10	Billed Amount	The total amount billed for the batch. Format $99999999999.99	Field	Number	13	T_ENC_BATCH_PROCESS	AMT_BILLED
11	Paid Amount	The total amount paid for the batch. Format $99999999999.99	Field	Number	13	T_ENC_BATCH_PROCESS	AMT_PAID
12	Batch Status	The status of the batch	Field	Character	1	T_ENC_BATCH_PROCESS	CDE_BATCH_STATUS
13	Bad Status	Indicator updated when bad claims have been manually resolved. This field is informational only.	Field	Character	1	T_ENC_BATCH_PROCESS	IND_BAD_STATUS
14	Origin	The ID of the last update user or process	Field	Character	8	T_ENC_BATCH_PROCESS	ID_UPDATE
15	Action Date	Date and Time of last update. NOTE: check if date and time can be displayed as one field	Field	Date (MM/DD/CCYY)	8	T_ENC_BATCH_PROCESS	DTE_UPDATE
16	Action Time	Time of the last update. Format HH:MM:SS.	Field	Number	6	T_ENC_BATCH_PROCESS	DTE_UPDATE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
17	SAK Batch	System Assigned Key that identifies the batch processed.	Field	Number	9	T_ENC_BATCH_PROCESS	SAK_BATCH

4.8.9.7 Field Edits

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

4.8.10 PANEL: Encounter Errors

4.8.10.1 Description

The Encounter Errors panel displays errors for a batch file selected on the Encounter Batch Summary search results. Open this panel by clicking on the menu item. Or it can also automatically open. This can be determined by user preferences.

Navigation Path: [Claims - Encounter Data] - [click on Encounter Batch Summary] - [Enter search criteria and click Search] - [Select a row on the Encounter Batch Summary search results] - [Click Encounter Errors]

4.8.10.2 Technical Name

Clm.EncounterBatchSearchPanel.ascx (EncounterErrors)

4.8.10.3 Panel Name

Encounter Errors

4.8.10.4 Encounter Errors Layout

Encounter Errors

1 View ◉ All ○ Threshold Errors ○ Informational Errors

2 Error Code	3 Error Code Disposition	4 Error Count	5 Percent of Total	6 Error Description
2502	Informational	293	3.45%	MCO/BHO ID Missing or Invalid
624	Informational	2	0.02%	Recip Date of Death if Before the Last Date of Service
2507	Informational	1	0.010%	This Patient Has Two Coverage Types
705	Threshold	22,093	35.45%	MCO/BHO Total Payment Amount Invalid
2022	Threshold	21,368	34.29%	Recipient Not Enrolled with MCO on Date of Service
1025	Threshold	14,998	24.07%	Billing Provider Ineligible to Bill Claims
1005	Threshold	2,221	3.55%	Recipient Covered by Medicare B (No Attachment)
5001	Threshold	2,159	3.46%	Exact Duplicate
4036	Threshold	2,068	3.32%	MCO/BHO Total Payment Amount Invalid
2077	Threshold	1	0.01%	Recipient Partially Eligible for DOS - No Attachment
Totals :		99,999	99,999%	

4.8.10.5 Extra Features

This panel has no extra features.

4.8.10.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	All, Threshold, Informational	Radio Button control that allows the user to modify the view of rows by the Error Code Disposition value	Field	Radio Button	0	N/A	N/A
2	Error Code	Error code of a number of records in the batch file	Field	Character	4	T_ERROR_DISP	CDE_ESC
3	Error Code Disposition	Specifies if the error is a Threshold error or an Informational error	Field	Character	13	T_BATCH_ERR_SUM	CDE_DISP_STATUS
4	Error Count	Number of claims setting the error	Field	Number	9	T_BATCH_ERR_SUM	CNT_ERROR
5	Percent of Total	Percent of errors in the total number of records in the batch file. This is a calculated field based on the total number of errors in a batch file and the total number of claims in the file. Format 999.99%	Field	Number	5	N/A	CALCULATED
6	Error Description	Description of the error code	Field	Character	50	T_ERROR_DISP	DSC_ERROR_STAT

4.8.10.7 Field Edits

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

4.8.12 PANEL: Encounter Resubmission Tracking Search

4.8.12.1 Description

Use the Encounter Resubmission Tracking panel to search for batch file records on the Encounter Resubmission Tracking Table by MCO and Received Dates or by Batch ID/File Name.

Navigation Path: [Claims - Encounter Data] - [click on Encounter Resubmission Tracking]

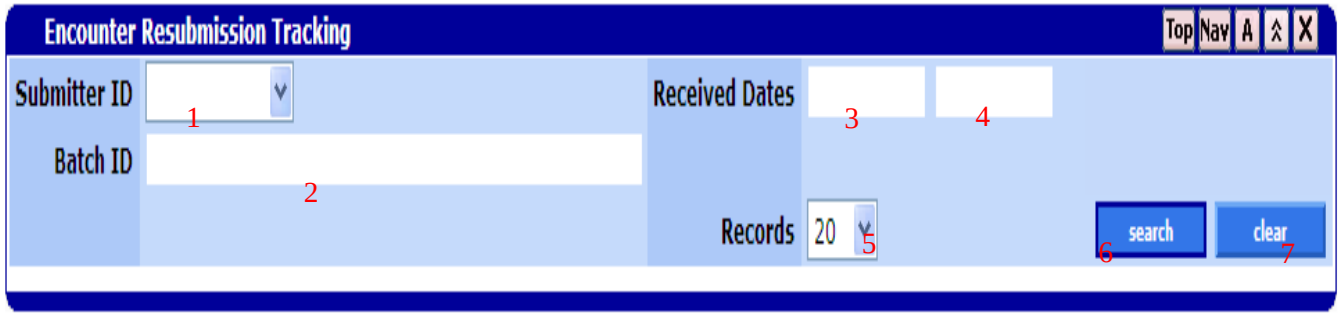
4.8.12.2 Technical Name

Clm.EncounterResubmissionPanel.ascx.

4.8.12.3 Panel Name

Encounter Resubmission Tracking

4.8.12.4 Encounter Resubmission Tracking Layout



8 9

4.8.12.5 Extra Features

This panel has no extra features.

4.8.12.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Submitter ID	The ID of the Managed Care Organization	Field	Drop Down List Box	15	T_DOCUMENT_TRACK	ID_SND
2	Batch ID	The name of the encounter file/batch	Field	Character	255	T_FILE_TRACK	NAM_FILE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
3	Received Dates (from)	The beginning received date range the user is requesting	Field	Date (MM/DD/CCYY)	8	N/A	N/A
4	Received Dates (to)	The ending received date range the user is requesting	Field	Date (MM/DD/CCYY)	8	N/A	N/A
5	Records	This is the number of records that are displayed per page. This value is either set by the user or it defaults to 20	Field	Drop Down List Box	0	N/A	N/A
6	Search	Performs a query on the database and returns the data for the entered search criteria	Button	N/A	0	N/A	N/A
7	Clear	Clears the previous search criteria from the search fields	Button	N/A	0	N/A	N/A

4.8.12.7 Field Edits

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

4.8.13 PANEL: Encounter Resubmission Tracking Search Results

4.8.13.1 Description

The Encounter Resubmission Tracking panel displays records on the Encounter Resubmission Tracking Table.

Navigation Path: [Claims - Encounter Data] - [click on Encounter Resubmission Tracking] - [Enter search criteria and click Search]

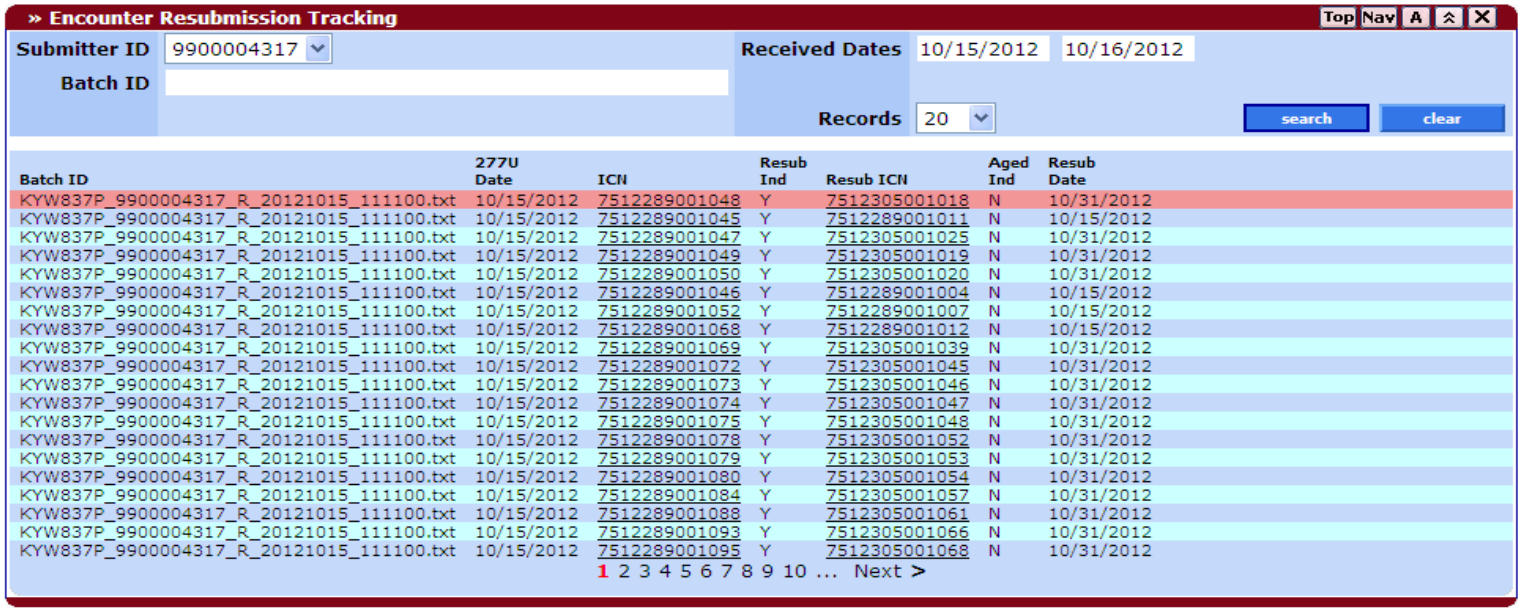
4.8.13.2 Technical Name

Clm.EncounterResubmissionPanel.ascx

4.8.13.3 Panel Name

Encounter Resubmission Tracking

4.8.13.4 Encounter Batch Summary Search Results Layout



Batch ID	277U Date	ICN	Resub Ind	Resub ICN	Aged Ind	Resub Date
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001048	Y	7512305001018	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001045	Y	7512289001011	N	10/15/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001047	Y	7512305001025	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001049	Y	7512305001019	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001050	Y	7512305001020	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001046	Y	7512289001004	N	10/15/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001052	Y	7512289001007	N	10/15/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001068	Y	7512289001012	N	10/15/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001069	Y	7512305001039	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001072	Y	7512305001045	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001073	Y	7512305001046	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001074	Y	7512305001047	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001075	Y	7512305001048	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001078	Y	7512305001052	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001079	Y	7512305001053	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001080	Y	7512305001054	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001084	Y	7512305001057	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001088	Y	7512305001061	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001093	Y	7512305001066	N	10/31/2012
KYW837P_9900004317_R_20121015_111100.txt	10/15/2012	7512289001095	Y	7512305001068	N	10/31/2012

4.8.13.5 Extra Features

This panel allows the user to sort (ascending or descending) the data for each of the fields displayed. It also allows the user to click on the ICN or the Resubmitted ICN and navigate to the Claims History Panel for that ICN.

4.8.13.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Batch ID	The name of the encounter file/batch	Field	Character	255	T_FILE_TRACK	NAM_FILE
2	277U Date	Date that the 2774U was generated for this batch	Field	Date (MM/DD/CCYY)	8	T_ENC_RESUB _TRACK	DTE_277U_SENT
3	ICN	Internal Control Number of the encounter being displayed	Field	Numeric	13	T_ENC_RESUB _TRACK	NUM_ICN
4	Resub Ind	Indicator reflecting whether the thresholded encounter has been resubmitted	Field	Character	1	T_ENC_RESUB _TRACK	IND_ENC_RESUB
5	Resub ICN	Internal Control Number of the resubmitted encounter	Field	Number	13	T_ENC_RESUB _TRACK	NUM_ICN_RESUB
6	Aged Ind	The count of informational errors in the batch	Field	Character	1	T_ENC_RESUB _TRACK	IND_RESUB_LIMIT
7	Resub Date	Date the encounter was resubmitted	Field	Date (MM/DD/CCYY)	8	T_ENC_RESUB _TRACK	DTE_RESUB

4.8.13.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Submitter ID	Field	1	Please enter Received dates when entering submitter ID.	Enter Received Dates

4.8.14 PANEL: Encounter Claims Related Data

4.8.14.1 Description

The Encounter Claims Related Data panel displays the ICN's for a particular error on a batch file. This panel can be opened by clicking on the menu item, or it can automatically open. This can be determined by user preferences.

Navigation Path: [Claims - Encounter Data] - [click on Encounter Batch Summary] - [Enter search criteria and click Search] - [Select a row on the Encounter Batch Summary search results] - [Click Encounter Errors] - [Select a row on Encounter Errors] - [Click Encounter Claims Related Data]

Tables: T_HIST_DIRECTORY, T_CLM_REF, T_CLM_SUM_ERR_X (This table points to the claims on T_HIST_DIRECTORY)

4.8.14.2 Technical Name

Clm.EncounterBatchSearchPanel.ascx (EncounterClaims)

4.8.14.3 Panel Name

Encounter Claims Related Data

4.8.14.4 Encounter Claims Related Data Layout

Encounter Claims Related Data

ICN 1	MCO ICN 2	Member ID 3	Status 4	Claim Type 5	FDOS 6	TDOS 7	Paid Date 8	Amount Billed 9
2003149130004	2205088600007	000001864	PAID	COMPOUND DRUG CLAIMS	01/26/2003	01/26/2003	02/24/2005	$15.00
2003149300010	2003282600004	000001932	DENIED	PHARMACY CLAIMS	01/26/2003	01/26/2003	02/24/2005	$15.00

4.8.14.5 Extra Features

This panel has no extra features.

4.8.14.6 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	ICN	Internal Control Number.	13	Character	T_HIST_DIRECTORY	NUM_ICN_FL
2	MCO ICN	The ICN assigned by the Managed Care Organization.	13	Character	T_CLM_REF	CDE_REF_ID
3	Member ID	Member ID associated with the ICN.	11	Character	T_RE_BASE	ID_MEDICAID
4	Status	Status of the claim.	10	Character	T_HIST_DIRECTORY	CDE_CLM_STATUS

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
5	Claim Type	Type of claim.	30	Character	T_HIST_DIRECTORY	CDE_CLAIM_TYPE
6	FDOS	From date of service on the claim header.	8	Date (MM/DD/CCYY)	T_HIST_DIRECTORY	DTE_FIRST_SVC
7	TDOS	To date of service on the claim header.	8	Date (MM/DD/CCYY)	T_HIST_DIRECTORY	DTE_TO_DATE
8	Paid Date	Paid date on the claim header.	8	Date (MM/DD/CCYY)	T_HIST_DIRECTORY	DATE_PAID
9	Amount Billed	Amount billed for the claim. Format $9999999.99.	9	Number	T_HIST_DIRECTORY	AMT_BILLED

4.8.14.7 Field Edits

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

4.9 PAGE: Claims Related Data Page

4.9.1 4.9.1 Description

The Claims Related Data Page contains a navigation panel to view claims related data. The Denied Claim Resubmit panel, Edit Recycle panel and Encounter Threshold panels are available on the navigation panel.

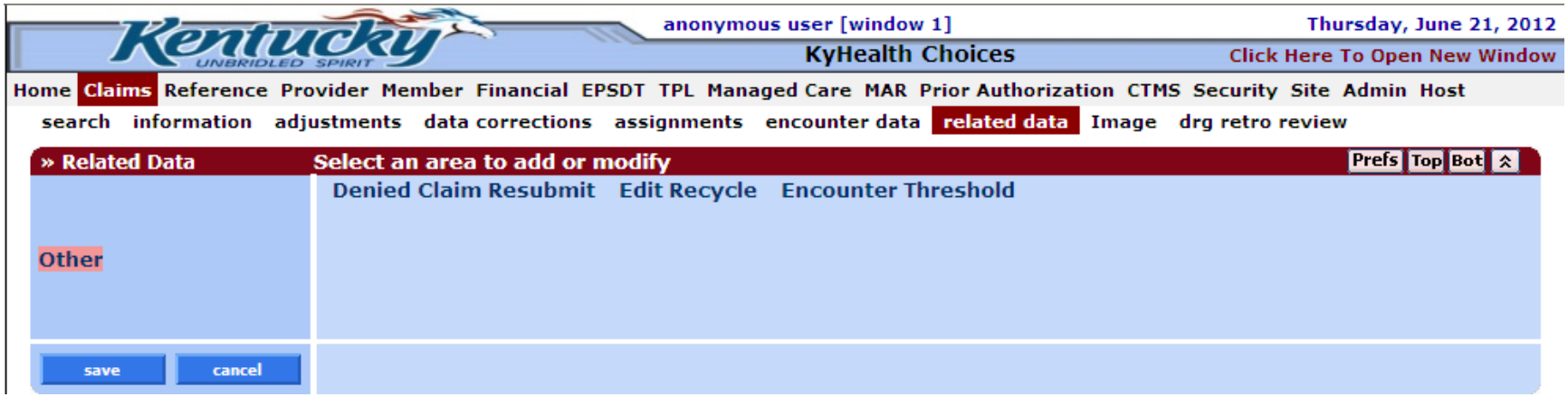
4.9.2 4.9.2 Technical Name

Clm.RelatedDataPage.ascx

4.9.3 4.9.3 Web Page Name:

Related Data Page

4.9.4 4.9.4 Claims Related Data Page Layout



To access this page:

STEP 1. Click on Claims located in the subsystem header listing under the Commonwealth logo —Kentucky Unbridled Spirit||.

STEP 2. Click on Related Data located under the subsystem header listing or click on Related Data from the drop down listing that appears when the cursor touches the Claims button in the subsystem header listing.

4.9.5 PANEL: Related Data –Other

4.9.5.1 4.9.5.1 Description

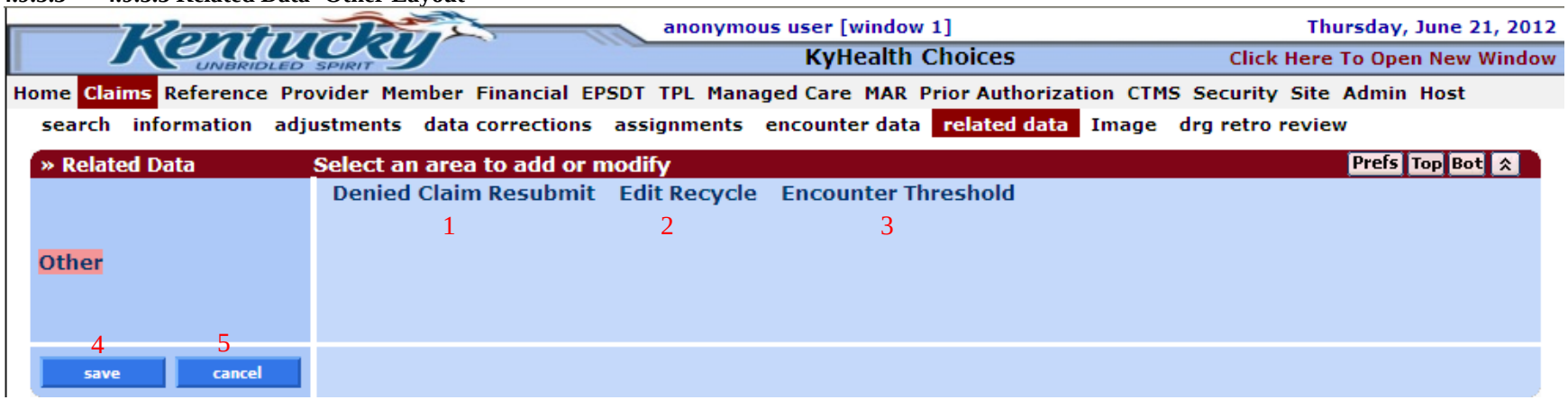
The Claims Related Data panel contains a link to the Denied Claim Resubmit, Edit Recycle and Encounter Threshold panels.

Navigation Path: [Claims - Related Data]

4.9.5.2 4.9.5.2 Panel Name

Related Data

4.9.5.3 4.9.5.3 Related Data -Other Layout



To access this panel:

STEP 1. Access the Claims Related Data page using the instructions listed for the page.

The Save button saves changes made to panels in the page.

The Cancel button cancels changes made to panels in the page.

STEP 2. Click the Edit Recycle button to go to the panel which allows edits/audits to be added or removed from the daily recycle criteria. Click the Denied Claim Resubmit button to add denied ICN's to be reprocessed as Region 80s. Click the Encounter Threshold to search Encounter data.

4.9.5.4 4.9.5.4 Extra Features

This panel has no extra features.

4.9.5.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Denied Claim Resubmit	A link to "Denied Claim Resubmit' Panel	Hyperlink	N/A	0	N/A	N/A
2	Edit Recycle	A link to "Edit Recycle" Panel	Hyperlink	N/A	0	N/A	N/A
3	Encounter Threshold	A link to "Encounter Threshold" Panel	Hyperlink	N/A	0	N/A	N/A
4	Save	Saves changes made to the panels on this page	Button	N/A	0	N/A	N/A
5	Cancel	Cancels any changes made to the panels on this page	Button	N/A	0	N/A	N/A

4.9.5.6 Field Edits

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
4	Save	Saves the ICN to be Reprocessed as a Region 80	Button		0	N/A	N/A
Valid ICN is Required Entered ICN is already in Queue Claim cannot be resubmitted due to void status							

4.9.6 PANEL: Edit Recycle

4.9.6.1 Description

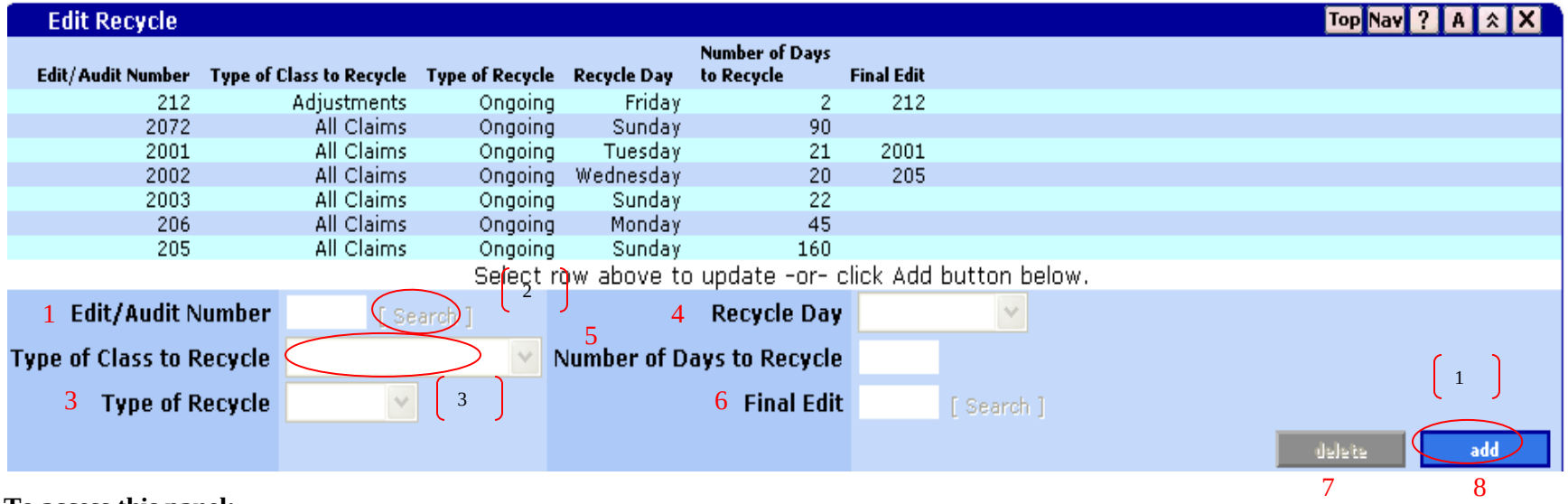
The Claims Edit Recycle panel enables select users to add and remove edits from the daily recycle parameter file.

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

4.9.6.2 Panel Name

Edit Recycle

4.9.6.3 Edit Recycle Layout



To access this panel:

STEP 1. Access the Claims Related Data page using the instructions listed for the page. Click the Edit Recycle button.

This panel allows edits/audits to be added or removed from the daily recycle criteria.

STEP 2. Click a row to select or click the Add button. (1)

STEP 3. Click the Search button (2) next to the Edit/Audit Number field to bring up the pop-up window listing.

STEP 4. Click a row to select. Select from the Type of Class to Recycle drop down box. (3) Edit applicable fields. Click the Save button.

4.9.6.4 Extra Features

This panel has no extra features.

4.9.6.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Edit/Audit Number	The number of the edit or audit to be recycled	Field	Number	4	T_EDIT_RECYCLE	SAK_ESC
2	Type of Class to Recycle	The types of claims to recycle. This can be adjustments, all claims, all but adjustments, and so on	Field	Drop Down List Box	0	T_EDIT_RECYCLE	IND_TYPE_CLMS
3	Type of Recycle	Indicates if this is a regular recycle request or an on-going request that eventually denies with a different edit number	Field	Drop Down List Box	0	T_EDIT_RECYCLE	CDE_RECYCLE_TYPE
4	Recycle Day	The day of the week that an edit is recycled	Field	Drop Down List Box	0	T_EDIT_RECYCLE	NUM_RECYCLE_DAY
5	Number of Days to Recycle	The number of days that a claim recycles for the edit before it denies with the denial edit indicated	Field	Number	4	T_EDIT_RECYCLE	NUM_DAYS
6	Final Edit	The number of the edit that denies the claim once the number of days to recycle has been exceeded	Field	Number	4	T_EDIT_RECYCLE	SAK_FINAL_ESC
7	Delete	Deletes a record	Button	N/A	0	N/A	N/A
8	Add	Adds a new Record	Button	N/A	0	N/A	N/A

4.9.6.6 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Edit/Audit Number	Field	1	A valid Edit/Audit Number is required.	Enter a valid value or select a value from the [Search] panel.

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

4.9.7 PANEL: Encounter Threshold

4.9.7.1 Description

The Claims Encounter Threshold Panel 's information will be used during encounter processing to determine if the batch is rejected or accepted.

Navigation Path: [Claims - Related Data] - [Encounter Threshold]

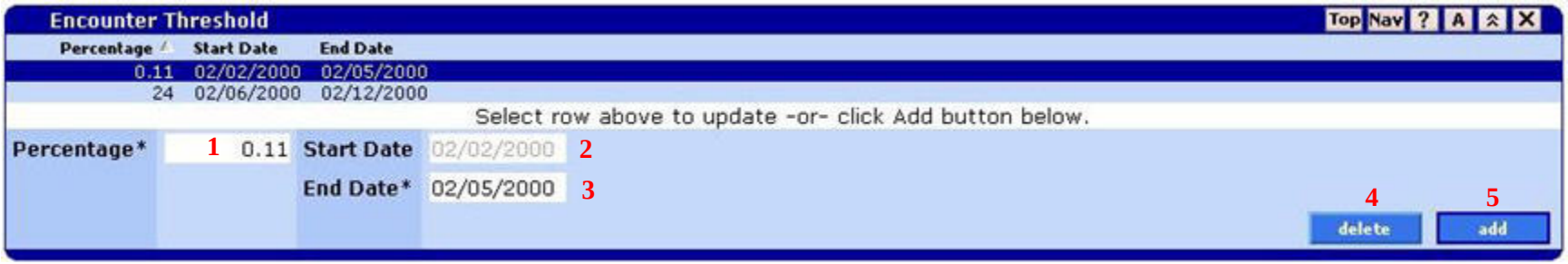
4.9.7.2 Technical Name:

Clm.ClmEncThresholdPanel.ascx

4.9.7.3 Panel Name:

Encounter Threshold

4.9.7.4 Encounter Threshold Layout



To access this panel:

STEP 1. Access the Claims Related Data page using the instructions listed for the page. Click the Encounter Threshold link.

This panel allows the encounter threshold to be changed.

STEP 2. Click a row to select or click the Add button. (1)

STEP 3. Enter information.

STEP 4. Click the Save button.

4.9.7.5 Extra Features

This panel has no extra features.

4.9.7.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Percentage	Percentage factor that will be used during the encounter processing. The min. value is 0.00, Max is 100.00		N/A	0	T_ENC_ERR_THRESHLD	PCT_THRESHOLD
2	Start Date	Start date for the associated Percentage.		Date (MM/DD/CCYY)	8	T_ENC_ERR_THRESHLD	DTE_EFFECTIVE
3	End Date	End date for the associated Percentage.		Date (MM/DD/CCYY)	8	T_ENC_ERR_THRESHLD	DTE_END

4.9.7.7 Button Descriptions

Button No	Button	Description
4	Delete	Delete an existing record.
5	Add	Add a new record.

4.9.7.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Percentage	Field	1	Threshold Percentage is Required	Verify entry and re-enter a correct Percent
1	Percentage	Field	2	Threshold Percentage must be greater than or equal to zero	Verify entry and re-enter a correct Percent
1	Percentage	Field	3	Threshold Percentage must be less than or equal to 100.00	Verify entry and re-enter a correct Percent
2	Start Date	Field	1	Effective date must less then or equal End date	Verify entry and re-enter a correct Date
2	Start Date	Field	2	Effective date and End date span must not overlap other entries	Verify entry and re-enter a correct Date span.
2	Start Date	Field	3	Invalid date (MMDDCCYY)!	Verify entry and re-enter a correct Date

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	End Date	Field	1	End date must less then or equal Effective date	Verify entry and re-enter a correct Date
3	End Date	Field	2	Effective date and End date span must not overlap other entries	Verify entry and re-enter a correct Date span.
3	End Date	Field	3	Invalid date (MMDDCCYY)!	Verify entry and re-enter a correct Date

4.9.8 PANEL: Denied Claim Resubmit

4.9.8.1 Description

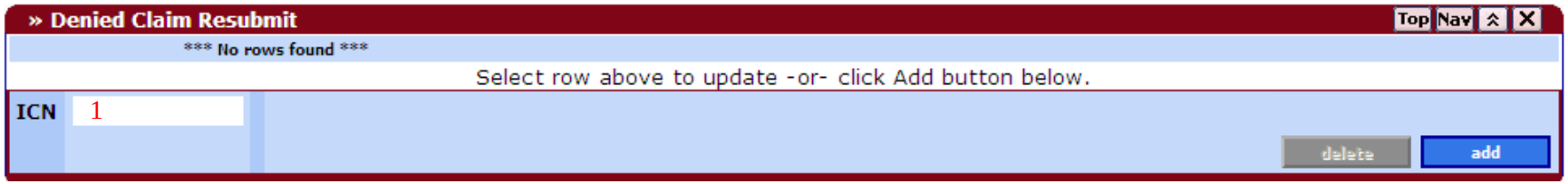
The Denied Claim Resubmit panel enables select users to add denied claims to be reprocessed as Region 80.

Navigation Path: [Claims -Related Data] - [Denied Claim Resubmit]

4.9.8.2 Panel Name

Denied Claim Resubmit

4.9.8.3 Denied Claim Resubmit Layout



To access this panel:

STEP 1. Access the Claims Related Data page using the instructions listed for the page. Click the Denied Claim Resubmit link.

This panel allows the ICN's to be entered.

STEP 2. Click a row to select or click the Add button. (1)

STEP 3. Enter information.

STEP 4. Click the Save button.

4.9.8.4 Extra Features

This panel has no extra features.

4.9.8.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	Description
1	ICN	Enter ICN to be Reprocessed	Field	13 digit ICN	13	t_adj_resub	sak_claim

4.9.8.6 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
ICN	Field	101	Valid ICN Required	Enter a valid ICN to resubmit.
ICN	Field	102	Entered ICN is already in Queue	Enter a valid ICN .
ICN	Field	103	Claim cannot be resubmitted due to void status.	Enter a valid ICN to resubmit.

5 Reports

This manual contains a sample page for each report for this system with a short description. Please refer to the Report Distribution Master for designee's to determine the frequency of the report. Please use the following: (this character is represented at the end of each report name)

A = ANNUAL

D = DAILY

M = MONTHLY

Q = QUARTERLY

R = ON REQUEST

W = WEEKLY

O = ON REQUEST

The following section provides a description and sample layout for each Report associated to the Claims 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.

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

This report lists the online updates that have been made to the credit/adjustment data entry.

5.1.1.1 Technical Name

CLM-0010-D

5.1.1.2 Sort Order

1

5.1.1.3 Distribution

OnBase

Janet Schell

5.1.1.4 Online Adjustment Daily Report Layout

```
Report  : CLM-0010-D                          COMMONWEALTH OF KENTUCKY                          Run Date: 01/24/2008
Process : CLMJD10D                      MEDICAID MANAGEMENT INFORMATION SYSTEM                  Run Time:   19:00:22
Location: CLM0010D                          ON-LINE DAILY ADJUSTMENT REPORT                         Page:          3
                                                      01/24/2008
-------------------------------------------------------------------------------------------------------------------------

ICN            ICN TO CREDIT   ADJUSTMENT      PROVIDER ID          MEMBER ID       BEGIN DATE    END DATE      REASON   CLERK ID
                REQUEST NUMBER                                                                       CODE
-------------------------------------------------------------------------------------------------------------------------
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX
 XXXXXXXXXXXX  XXXXXXXXXXXX   XXXXXXXXXX      MCD XXXXXXXX         XXXXXXXXXX      XX/XX/XXXX    XX/XX/XXXX    XXXX     XXXXXX

                                        *** END OF REPORT ***
```

5.1.1.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
ADJUSTMENT REQUEST NUMBER	A 10 byte unique number that identifies the mass adjustment request . Format: RRYYJJJBBB. It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.	10	Character	T_ADJ_MASS_CLAIM	NUM_MASS_RQST
BEGIN DATE	The first date of service.	10	Date (MM/DD/CCYY)	T_ADJ_MASS_CLAIM	DTE_FIRST_SVC
CLERK ID	The identification number of the online clerk.	9	Character	T_ADJ_CLAIMTYPE_XREF	ID_CLERK
END DATE	The last date of service.	10	Date (MM/DD/CCYY)	T_ADJ_MASS_CLAIM	DTE_LAST_SVC
ICN	The unique internal control number for a Medicaid claim.	14	Character	T_CLAIM_LOCAT	NUM_ICN
ICN TO CREDIT	The internal control number to be credited/adjusted.	13	Character	T_ADJ_MASS_CLAIM	NUM_ICN
MEMBER ID	The unique member identification number for the member receiving the services.	14	Character	T_RE_BASE	ID_MEDICAID
PROVIDER ID	The provider number and the service location for the provider.	10	Character	T_PR_PROV+T_ADJ_MASS_CLAIM	ID_PROVIDER+CDE_SERVICE _LOC
REASON CODE	The code identifying the primary reason for the credit or adjustment.	5	Character	T_EOB	CDE_EOB

5.1.1.6 Associated Programs

Program	Description

Program	Description
clm0010d	Online Adjustment Daily Report
copy2routedir	Copy Reports to Router

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

This report lists the number of errors each clerk ID has worked in the Suspense Table.

5.1.2.1 Technical Name

CLM-0011-D

5.1.2.2 Sort Order

Clerk ID

5.1.2.3 Distribution

OnBase

Charlene Howard

5.1.2.4 Clerk ID Recycle Claims Report Layout

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


          CLERK ID        DENIED        FORCED        MANUALLY PRICED      OTHER        CLAIMS
          XXXXXXXX        999,999       999,999               999,999      999,999      999,999
          XXXXXXXX        999,999       999,999               999,999      999,999      999,999
          XXXXXXXX        999,999       999,999               999,999      999,999      999,999
          XXXXXXXX        999,999       999,999               999,999      999,999      999,999

          TOTALS          999,999       999,999               999,999      999,999      999,999

                                       ***   END OF REPORT   ***
                                      ***   NO DATA THIS RUN   ***
```

5.1.2.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIMS	The total number of claim records processed for clerk.	7	Number	T_CLERK	SAK_CLAIM

Field	Description	Length	Data Type	DB Table	DB Attributes
CLERK ID	The identification number of the clerk who has been assigned to work this claim.	8	Character	T_CLERK	ID_CLERK
DENIED	The total number of denied edits for clerk.	7	Number	T_DENIED_EDITS	EDIT_COUNT
FORCED	The total number of forced errors for clerk.	7	Number	T_FORCED_EDITS	EDIT_COUNT
MANUALLY PRICED	The total number of manually priced edits for clerk.	7	Number	T_MANUAL_PRICE D_EDITS D_EDITS	EDIT_COUNT
OTHER	The total number of other records processed for clerk.	7	Number	T_OTHER_EDITS	EDIT_COUNT
TOTALS (Claims)	The total number of claim records processed.	7	Number	N/A	CALCULATED FIELD
TOTALS (Manually Priced)	The total number of manually priced edits.	7	Number	N/A	CALCULATED FIELD
TOTALS(Denied)	The total number of denied edits.	7	Number	N/A	CALCULATED FIELD
TOTALS(Forced)	The total number of forced edits.	7	Number	N/A	CALCULATED FIELD
TOTALS (Other)	The total number of other records processed.	7	Number	N/A	CALCULATED FIELD

5.1.2.6 Associated Programs

Program	Description
clm0011d	Clerk ID Recycle Claims Report
copy2routedir	Copy Reports to Router

5.1.3 CLM-0012-D -- EOB Listing

This report lists each Explanation of Benefits (EOB) code and its description.

5.1.3.1 Technical Name

CLM-0012-D

5.1.3.2 Sort Order

EOB Code

5.1.3.3 Distribution

OnBase

5.1.3.4 EOB Listing Layout

```
Report   : CLM-0012-D                    COMMONWEALTH OF KENTUCKY                          Run Date:  MM/DD/CCYY
Process  : CLMJD012                 MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: CLM0012D                            EOB LISTING                                      Page:       9999
                                              MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------
        E O B              DESCRIPTION
        CODE
-------------------------------------------------------------------------------------------------------------------

        9999               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

        9999               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

        9999               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

        9999               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

        9999               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

        9999               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                        *** END OF REPORT ***
                                      *** NO DATA THIS RUN ***
```

5.1.3.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
DESCRIPTION (LINE 1)	The EOB description (first line).	79	Character	T_EOB	DSC_EOB
DESCRIPTION (LINE 2)	The EOB description (second line).	79	Character	T_EOB	DSC_EOB2
EOB	The explanation of benefit code.	4	Number	T_EOB	CDE_EOB

5.1.3.6 Associated Programs

Program	Description
clm0012d	EOB Listing
copy2routedir	Copy Reports to Router

5.1.4 CLM-0015-D -- ClaimCheck Potential History to Adjust

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

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

5.1.4.1 Technical Name

CLM-0015-D

5.1.4.2 Sort Order

ICN

First Date of Service

5.1.4.3 Distribution

OnBase

5.1.4.4 ClaimCheck Potential History to Adjust Layout

```
REPORT:   CLM-0015-D                          COMMONWEALTH OF KENTUCKY                          RUN DATE: MM/DD/CCYY
PROCESS:  CLMJD015                                REPORTING SYSTEM                               RUN TIME: HH:MM:SS
LOCATION: CLM0015D                        CLAIMCHECK POTENTIAL HISTORY TO ADJUST                 PAGE: 99,999
                                                     MM/DD/CCYY

HIST/CURR   ICN            PROVIDER+LOC      DATE     PROC      MODIFIERS    REPL                                  ALLOWED
                                            OF SVC    CODE     M1 M2 M3 M4   PROC   UNITS    CLAIMCHECK ERROR(S)     AMOUNT

ORIGINAL MEMBER ID:     999999999999                CLAIMCHECK CLAIM NUMBER:            9999999999999

HISTORY CLAIM LINES POTENTIALLY AFFECTED

  X         XXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999   9,999.999.99
  X         XXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999   9,999.999.99
  X         XXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999   9,999.999.99
  X         XXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999   9,999.999.99
  X         XXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999   9,999.999.99

OTHER CURRENT AND HISTORY CLAIM LINES

  X         XXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999   9,999.999.99
  X         XXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999   9,999.999.99
  X         XXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999   9,999.999.99
  X         XXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999   9,999.999.99

  X         XXXXXXXXXXXXX  XXXXXXXXX      MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999   9,999.999.99

                                          ***   END OF REPORT   ***

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

5.1.4.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
ALLOWED AMOUNT	The amount allowed.	10	Character	T_CC_HIST_ADJUST	AMT_ALWD

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIMCHECK CLAIM NUMBER	The internal control number of the current claim.	13	Character	T_CC_HIST_ADJUST	ID_MEDICAID
CLAIMCHECK ERROR(S)	The ClaimCheck error number(s).	4	Number	T_CC_HIST_ADJUST	CDE_ESC1 (2,3,4,5)
DATE OF SVC	The date of service.	10	Date (MM/DD/CCYY)	T_CC_HIST_ADJUST	DTE_FIRST_SVC
HIST/CURR	The code indicating if the detail comes from history or the current claim.	1	Character	T_CC_HIST_ADJUST	IND_HIST_CURR
ICN	The internal control number.	13	Character	T_CC_HIST_ADJUST	NUM_ICN
MODIFIERS M1	The first procedure code modifier.	2	Character	T_CC_HIST_ADJUST	CDE_PROC_MOD1
MODIFIERS M2	The second procedure code modifier.	2	Character	T_CC_HIST_ADJUST	CDE_PROC_MOD2
MODIFIERS M3	The third procedure code modifier.	2	Character	T_CC_HIST_ADJUST	CDE_PROC_MOD3
MODIFIERS M4	The fourth procedure code modifier.	2	Character	T_CC_HIST_ADJUST	CDE_PROC_MOD4
ORIGINAL MEMBER ID	The original member identification number..	12	Character	T_CC_HIST_ADJUST	ID_MEDICAID
PROC CODE	The procedure code that was on the original claim.	6	Character	T_CC_HIST_ADJUST	CDE_PROC
PROVIDER ID	The provider number	12	Character	T_CC_HIST_ADJUST	ID_PROVIDER
PROVIDER ID TYPE	The provider type	3	Character	T_CC_HIST_ADJUST	ID_PROVIDER

Field	Description	Length	Data Type	DB Table	DB Attributes
REPL PROC	The procedure code that should be added or bundled on the claim. This field can be blank or the same as the original procedure code.	6	Character	T_CC_HIST_ADJUST	CDE_PROC_REPL
UNITS	The number of units billed.	3	Number	T_CC_HIST_ADJUST	QTY_BILLED

5.1.4.6 Associated Programs

Program	Description
clm0015d	Claim Check Potential History To Adjust
copy2routedir	Copy Reports to Router

5.1.5 CLM-0016-D -- Claims Processing Daily Summary

This report lists summary information by claim type for a claim adjudication cycle. For CMS 1500 an additional break out by provider type is listed.

5.1.5.1 Technical Name

CLM-0016-D

5.1.5.2 Sort Order

Claim Location

5.1.5.3 Distribution

OnBase

R001 Jay Hackett

Ro21 Janet Schell

For readability, the report layout displays across several pages.

5.1.5.4 Claims Processing Daily Summary Layout

```
Report  : CLM-0016-D                          COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process : CLMJD018                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLM0018D                           CLAIMS PROCESSING DAILY SUMMARY                                Page:       9999
                                                     MM/DD/CCYY

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

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

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

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

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

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

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

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

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

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

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

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

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


-------------------------------------------------------------------------------------------------------------------------------------
Report  : CLM-0016-D                              COMMONWEALTH OF KENTUCKY                                   Run Date: MM/DD/CCYY
Process : CLMJD018                          MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLM0018D                              CLAIMS PROCESSING DAILY SUMMARY                                  Page:       9999
                                                         MM/DD/CCYY

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

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

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

GRAND TOTAL FOR ALL PROVIDER TYPES PER 1500 CLAIM FORMS:

     99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99


                                        *** END OF REPORT ***
                                      *** NO DATA THIS RUN ***
```

5.1.5.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
APPROVED FOR DENIAL-%	The percentage of claims that have be denied of a specific claim type	4	Character	N/A	CALCULATED FIELD
APPROVED FOR DENIAL-AVG CHG	The average charge of submitted claim of specific type that have been denied. Average of the field selected based on: 1. Claim type M - Select AMT_BILLED From T_DENY_PHYS_HDR 2. Claim type D - Select AMT_BILLED From T_DENY_DNTL_HDR 3. Claim type P - Select AMT_BILLED From T_DENY_PHARM_HDR 4. Claim type U - Select AMT_BILLED_92 From T_DENY_UB92_HDR 5. Provider type M - Select AMT_BILLED From T_DENY_PHYS_HDR	10	Character	SEE DESCRIPTION	AMT_BILLED / AMT_BILLED_UB92
APPROVED FOR DENIAL-NUMBER	The number of claims that have been denied of a specific claim type. Field Count(SAK_CLAIM) selected from table based on the type 1. Claim type M - T_DENY_PHYS_HDR 2. Claim type D - T_DENY_DNTL_HDR 3. Claim type P - T_DENY_PHARM_HDR 4. Claim type U - T_DENY_UB92_HDR 5. Provider type M - T_DENY_PHYS_HDR	7	Character	SEE DESCRIPTION	SAK_CLAIM

Field	Description	Length	Data Type	DB Table	DB Attributes
APPROVED FOR DENIAL-TOTAL AMT	The total charge of submitted claims of a specific type that have been denied. Sum of the field selected based on: 1. Claim type M - Select AMT_BILLED From T_DENY_PHYS_HDR 2. Claim type D - Select AMT_BILLED From T_DENY_DNTL_HDR 3. Claim type P - Select AMT_BILLED From T_DENY_PHARM_HDR 4. Claim type U - Select AMT_BILLED_92 From T_DENY_UB92_HDR 5. Provider type M - Select AMT_BILLED From T_DENY_PHYS_HDR	11	Character	SEE DESCRIPTION	AMT_BILLED / AMT_BILLED_UB92
APPROVED FOR PAYMENT-%	The percentage of claims approved for payment of a specific type	4	Character	N/A	CALCULATED FIELD
APPROVED FOR PAYMENT-AVG PMT	The average payment amount approved for a specific claim type. Average of the field selected based on: 1. Claim type M - Select AMT_TOT_REIMB From T_PD_PHYS_HDR 2. Claim type D - Select AMT_PAID From T_PD_DNTL_HDR 3. Claim type P - Select AMT_TOT_REIMB From T_PD_PHARM_HDR 4. Claim type U - Select AMT_PAID From T_PD_UB92_HDR 5. Provider type M - Select AMT_TOT_REIMB From T_PD_PHYS_HDR	10	Character	SEE DESCRIPTION	AMT_BILLED / AMT_TOT_REIMB

Field	Description	Length	Data Type	DB Table	DB Attributes
APPROVED FOR PAYMENT-NUMBER	The number of claims approved for payment of a specific claim/provider type. FieldCount(SAK_CLAIM) selected from table based on the type 1. Claim type M - T_PD_PHYS_HDR 2. Claim type D - T_PD_DNTL_HDR 3. Claim type P - T_PD_PHARM_HDR 4. Claim type U - T_PD_UB92_HDR 5. Provider type M - T_PD_PHYS_HDR	5	Character	SEE DESCRIPTION	SAK_CLAIM
APPROVED FOR PAYMENT-PAYMENT AMT	The total amount approved for payment of a specific claim type. Sum of the field selected based on: 1. Claim type M - Select AMT_TOT_REIMB From T_PD_PHYS_HDR 2. Claim type D - Select AMT_PAID From T_PD_DNTL_HDR 3. Claim type P - Select AMT_TOT_REIMB From T_PD_PHARM_HDR 4. Claim type U - Select AMT_PAID From T_PD_UB92_HDR 5. Provider type M - Select AMT_TOT_REIMB From T_PD_PHYS_HDR	11	Character	SEE DESCRIPTION	AMT_BILLED / AMT_TOT_REIMB
CLAIM TYPE	The 'English' name of claim type. Code that specifies the type of claim record.	11	Character	T_CLAIM_LOCAT	CDE_CLAIM_TYPE
GRAND TOTAL FOR ALL CLAIM TYPES	The grand total for all columns.	84	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
GRAND TOTAL FOR ALL PROVIDER TYPES PER 1500 CLAIM FORMS	The grand total for all columns.	84	Character	N/A	CALCULATED FIELD
PROV TYPE	The type of practice for a provider. Field CDE_PROV_TYPE from the database tables: 1. T_PD_PHYS_HDR 2. T_DENY_PHYS_HDR 3. T_SUSP_PHYS_HDR	2	Character	SEE DESCRIPTION	CDE_PROV_TYPE
SUSPENDED NUMBER	The total number of suspended claims of a specific type. Field Count(SAK_CLAIM) selected from table based on the type 1. Claim type M - T_SUSP_PHYS_HDR 2. Claim type D - T_SUSP_DNTL_HDR 3. Claim type P - T_SUSP_PHARM_HDR 4. Claim type U - T_SUSP_UB92_HDR 5. Provider type M - T_SUSP_PHYS_HDR	5	Character	SEE DESCRIPTION	SAK_CLAIM
SUSPENDED-%	The percentage of claims suspended of a specific claim type	4	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
SUSPENDED-AVG CHG	The average charge for suspended claims of a specific claim/provider type. Average of the field selected based on: 1. Claim type M - Select AMT_BILLED From T_SUSP_PHYS_HDR 2. Claim type D - Select AMT_BILLED From T_SUSP_DNTL_HDR 3. Claim type P - Select AMT_BILLED From T_SUSP_PHARM_HDR 4. Claim type U - Select AMT_BILLED_92 From T_SUSP_UB92_HDR 5. Provider type M - Select AMT_BILLED From T_SUSP_PHYS_HDR	7	Character	SEE DESCRIPTION	AMT_BILLED / AMT_BILLED_UB92
SUSPENDED-TOTAL CHG	The total charge for suspended claims of a specific claim/provider type. Sum of the field selected based on: 1. Claim type M - Select AMT_BILLED From T_SUSP_PHYS_HDR 2. Claim type D - Select AMT_BILLED From T_SUSP_DNTL_HDR 3. Claim type P - Select AMT_BILLED From T_SUSP_PHARM_HDR 4.Claim type U - Select AMT_BILLED_92 From T_SUSP_UB92_HDR 5. Provider type M - Select AMT_BILLED From T_SUSP_PHYS_HDR	11	Character	SEE DESCRIPTION	AMT_BILLED / AMT_BILLED_UB92
TOTAL PROCESSED-AVG CHG	The average charge for processed claims of a specific claim/provider type.	9	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
TOTAL PROCESSED-NUMBER	The total claims processed of a specified claim/provider type.	6	Character	N/A	CALCULATED FIELD
TOTAL PROCESSED-TOTAL CHG	The total charge for processed claims of a specific claim/provider type.	11	Character	N/A	CALCULATED FIELD

5.1.5.6 Associated Programs

Program	Description
clm0018d	Claims Processing Daily Summary
copy2routedir	Copy Reports to Router

5.1.6 CLM-0017-D -- Original Claims Processing Daily Summary

This report lists summary information by claim type for original claims for a claim adjudication cycle. For CMS 1500, an additional break out by provider type is listed.

5.1.6.1 Technical Name

CLM-0017-D

5.1.6.2 Sort Order

Claim Location

5.1.6.3 Distribution

OnBase

Rhonda Poston

Jay Hackett

5.1.6.4 Original Claims Processing Daily Summary Layout

```
Report  : CLM-0017-D                          COMMONWEALTH OF KENTUCKY                          Run Date:MM/DD/CCYY
Process : CLMJD018                     MEDICAID MANAGEMENT INFORMATION SYSTEM                   Run Time:  HH:MM:SS
Location: CLM0018D                    ORIGINAL CLAIMS PROCESSING DAILY SUMMARY                  Page    :      9999
                                                   MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------
CLAIM  *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *---------SUSPENDED----*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %   TOTAL CHG   AVG CHG   NUMBER % TOTAL CHG AVG CHG
-------------------------------------------------------------------------------------------------------------------------
MEDICAL
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
DENTAL
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
DRUG
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
COMPOUND
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
HOME HEALTH
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
LTC
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
XOVER A
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
XOVER B
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
XOVER C
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
INPATIENT
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
OUTPATIENT
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
GRAND TOTAL FOR ALL CLAIM TYPES:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99
```

```
-----------------------------------------------------------------------------------------------------------------------------------
Report  : CLM-0017-D                                COMMONWEALTH OF KENTUCKY                                  Run Date:MM/DD/CCYY
Process : CLMJD018                            MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:HH:MM:SS
Location: CLM0018D                           ORIGINAL CLAIMS PROCESSING DAILY SUMMARY                         Page:9999
                                                          MM/DD/CCYY

-----------------------------------------------------------------------------------------------------------------------------------
PROV   *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *-------SUSPENDED------*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %   TOTAL CHG   AVG CHG   NUMBER % TOTAL CHG AVG CHG
-----------------------------------------------------------------------------------------------------------------------------------
PROV TYPE:  XX
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
PROV TYPE:  XX
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
PROV TYPE:  XX
   999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999
GRAND TOTAL FOR ALL PROVIDER TYPES PER 1500 CLAIM FORMS:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99

                                          * * * END OF REPORT * * *
                                         * * * NO DATA THIS RUN * * *
```

5.1.6.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
APPROVED FOR DENIAL-%	The percentage of claims that have be denied for a specific claim/provider type.	4	Character	N/A	CALCULATED FIELD
APPROVED FOR DENIAL-AVG CHG	The average charge of submitted claims of specific claim/provider type that have been denied. Average of the field selected based on: 1. Claim type M - Select AMT_BILLED From T_DENY_PHYS_HDR 2. Claim type D - Select AMT_BILLED From T_DENY_DNTL_HDR 3. Claim type P - Select AMT_BILLED From T_DENY_PHARM_HDR 4. Claim Type U - Select AMT_BILLED_92 From T_DENY_UB92_HDR 5. Provider type M - Select AMT_BILLED From T_DENY_PHYS_HDR	10	Character	SEE DESCRIPTION	AMT_BILLED / AMT_BILLED_UB92
APPROVED FOR DENIAL-NUMBER	The number of claims that been denied for a specific claim/provider type. Field Count(SAK_CLAIM) selected from table based on the type. 1. Claim type M - T_DENY_PHYS_HDR 2. Claim type D - T_DENY_DNTL_HDR 3. Claim type P - T_DENY_PHARM_HDR 4. Claim type U - T_DENY_UB92_HDR 5. Provider type M - T_DENY_PHYS_HDR	5	Character	SEE DESCRIPTION	SAK_CLAIM

Field	Description	Length	Data Type	DB Table	DB Attributes
APPROVED FOR DENIAL-TOTAL CHG	The total charge of submitted claims for a specific claim/provider type. Sum of the field selected based on: 1. Claim type M - Select AMT_BILLED From T_DENY_PHYS_HDR 2. Claim type D - Select AMT_BILLED From T_DENY_DNTL_HDR 3. Claim type P - Select AMT_BILLED From T_DENY_PHARM_HDR 4. Claim type U - Select AMT_BILLED_92 From T_DENY_UB92_HDR 5. Provider type M - Select AMT_BILLED From T_DENY_PHYS_HDR	11	Character	SEE DESCRIPTION	AMT_BILLED / AMT_BILLED_UB92
APPROVED FOR PAYMENT-%	The percentage of claims approved for payment of a specific claim/provider type.	4	Character	N/A	CALCULATED FIELD
APPROVED FOR PAYMENT-AVG PMT	The average payment amount approved for a specific claim/provider type. Average of the field selected based on: 1. Claim type M - Select AMT_TOT_REIMB From T_PD_PHYS_HDR 2. Claim type D - Select AMT_PAID From T_PD_DNTL_HDR 3. Claim type P - Select AMT_TOT_REIMB From T_PD_PHARM_HDR 4. Claim type U - Select AMT_PAID From T_PD_UB92_HDR 5. Provider type M - Select AMT_TOT_REIMB From T_PD_PHYS_HDR	10	Character	SEE DESCRIPTION	AMT_ BILLED / AMT_TOT_REIMB

Field	Description	Length	Data Type	DB Table	DB Attributes
APPROVED FOR PAYMENT-NUMBER	The number of claims approved for payment of a specific claim/provider type. FieldCount(SAK_CLAIM) selected from table based on the type 1. Claim type M - T_PD_PHYS_HDR 2. Claim type D - T_PD_DNTL_HDR 3. Claim type P - T_PD_PHARM_HDR 4. Claim type U - T_PD_UB92_HDR 5. Provider type M - T_PD_PHYS_HDR	5	Character	SEE DESCRIPTION	SAK_CLAIM
APPROVED FOR PAYMENT-PAYMENT AMT	The total amount approved for payment of a specific claim/provider type. Sum of the field selected based on: 1. Claim type M - Select AMT_TOT_REIMB From T_PD_PHYS_HDR 2. Claim type D - Select AMT_PAID From T_PD_DNTL_HDR 3. Claim type P - Select AMT_TOT_REIMB From T_PD_PHARM_HDR 4. Claim type U - Select AMT_PAID from T_PD_UB92_HDR 5. Provider type M - Select AMT_TOT_REIMB From T_PD_PHYS_HDR	11	Character	SEE DESCRIPTION	AMT_BILLED / AMT_TOT_REIMB
CLAIM TYPE	The 'English' name of claim type. Code that specifies the type of claim record.	11	Character	T_CLAIM_LOCAT	CDE_CLM_TYPE
GRAND TOTAL FOR ALL CLAIM TYPES	The grand total for all columns.	84	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
GRAND TOTAL FOR ALL PROVIDER TYPES PER 1500 CLAIM FORMS	The grand total for all columns.	84	Character	N/A	CALCULATED FIELD
PROV TYPE	The type of practice for a provider. Field cde_prov_type from the database tables: 1. T_PD_PHYS_HDR 2. T_DENY_PHYS_HDR 3. T_SUSP_PHYS_HDR	2	Character	SEE DESCRIPTION	CDE_PROV_TYPE
SUSPENDED NUMBER	The total number of suspended claims of a specific claim/provider type. Field Count(SAK_CLAIM) selected from table based on the type 1. Claim type M - T_SUSP_PHYS_HDR 2. Claim type D - T_SUSP_DNTL_HDR 3. Claim type P - T_SUSP_PHARM_HDR 4. Claim type U - T_SUSP_UB92_HDR 5. Provider type M - T_SUSP_PHYS_HDR	5	Character	SEE DESCRIPTION	SAK_CLAIM
SUSPENDED-%	The percentage of claims suspended of a specific claim/provider type.	4	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
SUSPENDED-AVG CHG	The average charge for suspended claims of a specific claim/provider type. Average of the field selected based on: 1. Claim type M - Select AMT_BILLED From T_SUSP_PHYS_HDR 2. Claim type D - Select AMT_BILLED From T_SUSP_DNTL_HDR 3. Claim type P - Select AMT_BILLED From T_SUSP_PHARM_HDR 4. Claim type U - Select AMT_BILLED_92 From T_SUSP_UB92_HDR 5. Provider type M - Select AMT_BILLED From T_SUSP_PHYS_HDR	7	Character	SEE DESCRIPTION	AMT_BILLED / /AMT_BILLED_UB92
SUSPENDED-TOTAL CHG	The total charge for suspended claims of a specific claim/provider type. Sum of the field selected based on: 1. Claim type M - Select AMT_BILLED From T_SUSP_PHYS_HDR 2. Claim type D - Select AMT_BILLED From T_SUSP_DNTL_HDR 3. Claim type P - Select AMT_BILLED From T_SUSP_PHARM_HDR 4. Claim type U - Select AMT_BILLED_92 From T_SUSP_UB92_HDR 5. Provider type M - Select AMT_BILLED From T_SUSP_PHYS_HDR	11	Character	SEE DESCRIPTION	AMT_BILLED / AMT_BILLED_UB92
TOTAL PROCESSED-AVG CHG	The average charge for processed claims of a specific claim/provider type.	9	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
TOTAL PROCESSED-NUMBER	The total claims processed of a specified claim/provider type	6	Character	N/A	CALCULATED FIELD
TOTAL PROCESSED-TOTAL CHG	The total charge for processed claims of a specific claim/provider type.	11	Character	N/A	CALCULATED FIELD

5.1.6.6 Associated Programs

Program	Description
clm0018d	Claims Processing Daily Summary
copy2routedir	Copy Reports to Router

5.1.7 CLM-0018-D -- Adjustment Credit Claims Processing Daily Summary

This report lists summary information by claim type for adjustments and credits for a claim adjudication cycle.

5.1.7.1 Technical Name

CLM-0018-D

5.1.7.2 Sort Order

Claim Location

5.1.7.3 Distribution

OnBase

Rhonda Poston

Jay Hackett

For readability, the report layout displays across several pages.

5.1.7.4 Adjustment Credit Claims Processing Daily Summary Layout

```
Report  : CLM-0018-D                          COMMONWEALTH OF KENTUCKY                                   Run Date: MM/DD/CCYY
Process : CLMJD018                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLM0018D                  ADJUSTMENT/CREDIT CLAIMS PROCESSING DAILY SUMMARY                        Page:       9999
                                                   MM/DD/CCYY

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

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

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

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

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

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

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

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

XOVER B
```

```
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

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

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

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

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


-------------------------------------------------------------------------------------------------------------------------------------
Report  : CLM-0018-D                          COMMONWEALTH OF KENTUCKY                                    Run Date: MM/DD/CCYY
Process : CLMJD018                       MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLM0018D             ADJ/CREDIT CLAIM PROCESSING DAILY SUMMARY BY MEDICAL PROVIDER                   Page:       9999
                                         DATE RANGE:  MM/DD/CCYY  -  MM/DD/CCYY


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

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


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

                                        *** END OF REPORT ***
                                       *** NO DATA THIS RUN ***
```

5.1.7.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
APPROVED FOR DENIAL-%	The percentage of claims that have be denied of a specific claim/provider type.	4	Character	N/A	CALCULATED FIELD
APPROVED FOR DENIAL-AVG PMT	The average charge of submitted claim of specific type that have been denied	10	Character	N/A	CALCULATED FIELD
APPROVED FOR DENIAL-NUMBER	The number of claims that have been denied of a specific claim/provider type. Field Count(SAK_CLAIM) selected from table based on the type. 1. Claim type M - T_DENY_PHYS_HDR 2. Claim type D - T_DENY_DNTL_HDR 3. Claim type P - T_DENY_PHARM_HDR 4. Claim type U - T_DENY_UB92_HDR 5. Provider type M - T_DENY_PHYS_HDR	5	Character	SEE DESCRIPTION	SAK_CLAIM
APPROVED FOR DENIAL-PAYMENT AMT	The total charge of submitted claims of a specific type that have been denied	11	Character	N/A	CALCULATED FIELD
APPROVED FOR PAYMENT-%	The percentage of claims approved for payment of a specific claim/provider type.	4	Character	N/A	CALCULATED FIELD
APPROVED FOR PAYMENT-AVG PMT	The average payment amount approved for a specific claim/provider type. Average of the field selected based on: 1. Claim type M - Select AMT_TOT_REIMB From	10	Character	SEE DESCRIPTION	AMT_BILLED / AMT_TOT_REIMB

Field	Description	Length	Data Type	DB Table	DB Attributes
	T_PD_PHYS_HDR 2. Claim type D - Select AMT_PAID From T_PD_DNTL_HDR 3. Claim type P - Select AMT_TOT_REIMB From T_PD_PHARM_HDR 4. Claim type U - Select AMT_PAID From T_PD_UB92_HDR 5. Provider type M - Select AMT_TOT_REIMB From T_PD_PHYS_HDR				
APPROVED FOR PAYMENT-NUMBER	The number of claims approved for payment of a specific claim/provider type. FieldCount(SAK_CLAIM) selected from table base on the type 1. Claim type M - T_PD_PHYS_HDR 2. Claim type D - T_PD_DNTL_HDR 3. Claim type P - T_PD_PHARM_HDR 4. Claim type U - T_PD_UB92_HDR 5. Provider type M - T_PD_PHYS_HDR	5	Character	SEE DESCRIPTION	SAK_CLAIM
APPROVED FOR PAYMENT-PAYMENT AMT	The total amount approved for payment of a specific claim/provider type. Sum of the field selected based on: 1. Claim type M - Select AMT_TOT_REIMB From T_PD_PHYS_HDR 2. Claim type D - Select AMT_PAID From T_PD_DNTL_HDR 3. Claim type P - Select AMT_TOT_REIMB From	11	Character	SEE DESCRIPTION	AMT_BILLED / AMT_TOT_REIMB

Field	Description	Length	Data Type	DB Table	DB Attributes
	T_PD_PHARM_HDR 4. Claim type U - Select AMT_PAID From T_PD_UB92_HDR 5. Provider type M - Select AMT_TOT_REIMB From T_PD_PHYS_HDR				
CLAIM TYPE	The 'English' name of claim type. Code that specifies the type of claim record.	11	Character	T_CLAIM_LOCAT	CDE_CLM_TYPE
GRAND TOTAL FOR ALL CLAIM TYPES	The grand total for all columns.	84	Character	N/A	CALCULATED FIELD
GRAND TOTAL FOR ALL PROVIDER TYPES PER 1500 CLAIM FORMS	The grand total for all columns.	84	Character	N/A	CALCULATED FIELD
PROV TYPE	The type of practice for a provider. Field CDE_PROV_TYPE from the database tables: 1. T_PD_PHYS_HDR 2. T_DENY_PHYS_HDR 3. T_SUSP_PHYS_HDR	2	Character	SEE DESCRIPTION	CDE_PROV_TYPE
SUSPENDED NUMBER	Total number of suspended claims of a specific type. Field Count(SAK_CLAIM) selected from table based on the type. 1. Claim type M - T_SUSP_PHYS_HDR 2. Claim type D - T_SUSP_DNTL_HDR	5	Character	SEE DESCRIPTION	SAK_CLAIM

Field	Description	Length	Data Type	DB Table	DB Attributes
	3. Claim type P - T_SUSP_PHARM_HDR 4. Claim type U - T_SUSP_UB92_HDR 5. Provider type M - T_SUSP_PHYS_HDR				
SUSPENDED-%	The percentage of claims suspended of a specific claim/provider type	4	Character	N/A	CALCULATED FIELD
SUSPENDED-AVG CHG	The average charge for suspended claims of a specific claim/provider type. Average of the field selected based on: 1. Claim type M - Select AMT_BILLED From T_SUSP_PHYS_HDR 2. Claim type D - Select AMT_BILLED From T_SUSP_DNTL_HDR 3. Claim type P - Select AMT_BILLED From T_SUSP_PHARM_HDR 4. Claim type U - Select AMT_BILLED_92 From T_SUSP_UB92_HDR 5. Provider type M - Select AMT_BILLED From T_SUSP_PHYS_HDR	7	Character	SEE DESCRIPTION	AMT_BILLED / AMT_BILLED_UB92
SUSPENDED-TOTAL CHG	The total charge for suspended claims of a specific claim/provider type. Sum of the field selected based on: 1. Claim type M - Select AMT_BILLED From T_SUSP_PHYS_HDR 2. Claim type D - Select AMT_BILLED From T_SUSP_DNTL_HDR	11	Character	SEE DESCRIPTION	AMT_BILLED / AMT_BILLED_UB92

Field	Description	Length	Data Type	DB Table	DB Attributes
	3. Claim type P - Select AMT_BILLED From T_SUSP_PHARM_HDR 4. Claim type U - Select AMT_BILLED_92 From T_SUSP_UB92_HDR 5. Provider type M - Select AMT_BILLED From T_SUSP_PHYS_HDR				
TOTAL PROCESSED-AVG CHG	The average charge for processed claims of a specific claim/provider type.	9	Character	N/A	CALCULATED FIELD
TOTAL PROCESSED-NUMBER	The total claims processed of a specified claim/provider type.	6	Character	N/A	CALCULATED FIELD
TOTAL PROCESSED-TOTAL CHG	The total charge for processed claims of a specific claim/provider type.	11	Character	N/A	CALCULATED FIELD

5.1.7.6 Associated Programs

Program	Description
clm0018d	Claims Processing Daily Summary
copy2routedir	Copy Reports to Router

5.1.8 CLM-0020-D -- Aged Detail Suspense Report

This report is a detail listing by claim type of claims that have been in the suspense file longer than 30 days.

5.1.8.1 Technical Name

CLM-0020-D

5.1.8.2 Sort Order

Claim Type

Claim Age

Claim ICN

5.1.8.3 Distribution

OnBase

Rhonda Poston

Jimmie Estill

5.1.8.4 Aged Detail Suspense Report Layout

```
Report   : CLM-0020-D                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/YYYY
Process  : CLMJD020                 MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: CLM0020D                      AGED DETAIL SUSPENSE REPORT                            Page:       9999
                                              MM/DD/CCYY

THE FOLLOWING CLAIMS IN THE SYSTEM AT LEAST 999 DAYS                                  CLAIM TYPE: DENTAL CLAIMS

ICN              MEMBER ID        PROVIDER+LOC   LOCATION      ERROR CODE                                    CLAIM-AGE
                                                 CODE                                                          (DAYS)
XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXX        99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX      999
XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXX        99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX      999
XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXX        99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX      999
XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXX        99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX      999
XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXX        99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX      999

                                            *** END OF REPORT ***

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

5.1.8.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIM TYPE	The code that specifies the type of claim record.	50	Character	T_CLAIM_TYPE	CDE_CLM_TYP
CLAIM-AGE (DAYS)	The age of the claim - number of days. CLAIM AGE = SYSDATE - DTE_CLM_LOCAT	3	Number	T_CLAIM_LOCAT	SYSDATE - DTE_CLM_LOCAT
ERROR CODE	The error codes the claim failed. Note: There can be multiple occurrences of errors in this field.	4	Character	T_ERROR_DISP	CDE_ESC
ICN	The unique internal control number for a Medicaid claim.	13	Character	T_CLAIM_LOCAT	NUM_ICN
LOCATION CODE	The suspense location of the claim.	2	Character	T_CLAIM_LOCAT	CDE_LOCATION
MEMBER ID	The member identification number. The unique identification for the member receiving the services.	12	Character	T_RE_BASE	ID_MEDICAID
NUM DAYS IN SYSTEM	The minimum number of days that the claims have been in the system. The default is 30 days. CLAIM AGE >= 30	3	Number	N/A	CALCULATED FIELD
PROVIDER ID	The provider number for the requesting and servicing provider and the service location for the provider.	10	Character	T_PR_PROV	ID_PROVIDER + CDE_SERVICE_LOC

Field	Description	Length	Data Type	DB Table	DB Attributes
PROVIDER ID TYPE	This is the Provder ID Type. (NPI-National Provider ID MCD-Medicaid Provider Number BSE-Base Provider ID)	3	Character	T_PR_IDENTIFIER	CDE_PROV_ID

5.1.8.6 Associated Programs

Program	Description
clm0020d	Aged Detail Suspense Report
copy2routedir	Copy Reports to Router

5.1.9 CLM-0021-D -- Suspense File Analysis by Error Code

The daily Suspense File Analysis by Error Code report provides a count by error code of claims that were suspended during the previous daily claims cycle. This report also provides the cumulative total by error code.

5.1.9.1 Technical Name

CLM-0021-D

5.1.9.2 Sort Order

Exception Code

Claim Type

5.1.9.3 Distribution

OnBase

Rhonda Poston

Jay Hackett

Janet Schell

5.1.9.4 Suspense File Analysis by Error Code Layout

```
Report   : CLM-0021-D                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process  : CLMJD021                 MEDICAID MANAGEMENT INFORMATION SYSTEM           Run Time:   HH:MI:SS
Location: CLM0021D                   SUSPENSE FILE ANALYSIS BY ERROR CODE                Page:       9999
                                                 MM/DD/CCYY

CLAIM TYPE                    ERROR  ERROR DESCRIPTION                                SUSPEND     CURRENT        TOTAL
                              CODE                                                    LOCATION    OCCURRENCES    OCCURRENCES
-------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXXXXXXXXXXXXX    XXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      xx       9,999,999      9,999,999
XXXXXXXXXXXXXXXXXXXXXXXXXX    XXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      xx       9,999,999      9,999,999
XXXXXXXXXXXXXXXXXXXXXXXXXX    XXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      xx       9,999,999      9,999,999
XXXXXXXXXXXXXXXXXXXXXXXXXX    XXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      xx       9,999,999      9,999,999
XXXXXXXXXXXXXXXXXXXXXXXXXX    XXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      xx       9,999,999      9,999,999

                                        ******   GRAND TOTAL BY ERROR CODE   ******             99,999,999     99,999,999
                                                  *** END OF REPORT ***
                                               *** NO DATA THIS REPORT ***
```

5.1.9.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIM TYPE	The 'English' name of claim type. Code that specifies the type of claim record.	22	Character	DSC_CLM_TYP	T_CLAIM_TYPE
CURRENT OCCURRENCES	The number of current occurrences in suspense file.	9	Character	N/A	CALCULATED FIELD
ERROR CODE	The code of the error.	4	Number	CDE_ESC	T_ERROR_DISP
ERROR DESCRIPTION	The description of each error.	50	Character	DSC_ERROR_STAT	T_ERROR_DISP
GRAND TOTAL BY ERROR CODE(CURRENT OCCURRENCES)	The grand total by error code for current occurrences.	12	Character	N/A	CALCULATED FIELD
GRAND TOTAL BY ERROR CODE(TOTAL OCCURENCES)	The grand total by error code for total occurrences.	12	Number	N/A	CALCULATED FIELD
SUSPEND LOCATION	The code location for suspended claims.	2	Character	CDE_LOCATION	T_CLAIM_LOCAT
TOTAL OCCURRENCES	The total occurrences of each error code.	9	Character	N/A	CALCULATED FIELD

5.1.9.6 Associated Programs

Program	Description
clm0021d	Suspense File Analysis By Error Code
copy2routedir	Copy Reports to Router

5.1.10 CLM-0022-D -- Combined Claim Error

The Pending Claims Unit uses this report to correct suspended claims.

5.1.10.1 Technical Name

CLM-0022-D

5.1.10.2 Sort Order

ICN

5.1.10.3 Distribution

OnBase

5.1.10.4 Combined Claim Error Layout

```
Report  :  CLM-0022-D                          COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/YYCC
Process :  CLMJD422                      MEDICAID MANAGEMENT INFORMATION SYSTEMS                 Run Time:   HH:MM:SS
Location:  CLMP422                                COMBINED CLAIM ERROR                              Page:       9999
                                                     MM/DD/CCYY


LOC XX
ICN XXXXXXXXXXXXX     MEMBER NAME  XXXXXXXXXXXXXXX XXXXXXXXXXXXX X  MEMBER ID XXXXXXXXXXXX   SEX X
PROVIDER NO 9999999999   PAY TO PROV NO    9999999999 ORIGINAL ICN XXXXXXXXXXXXX
DIAGNOSIS:  FIRST XXXXXXX  SECOND XXXXXXX   THIRD XXXXXXX   FOURTH XXXXXXX   FIFTH XXXXXXX
ADMISSION DATE 04/28/2002   NO. COVERED DAYS  000   ADMIT HOUR XX

                                 STATEMENT COVER PERIOD - FROM XX/XX/XXXX TO XX/XX/XXXX

  SPAN OCC CODE  99         TYPE OF ADMISSION     XX        SURG PROC CODE (1) XXX  DATE 99/99/9999   TOTAL CHARGE        $ 999999.99
  SPAN OCC FROM  99/99/9999 SOURCE OF ADMISSION   XX        SURG PROC CODE (2) XXX  DATE 99/99/9999   NONCOVERED CHARGES  $ 999999.99
  SPAN OCC THRU  99/99/9999 PATIENT STATUS        XX        SURG PROC CODE (3) XXX  DATE 99/99/9999   THIRD PARTY PAYMENT $ 999999.99
                            PRIMARY PRESC NO.  XXXXXXXXXXXX SURG PROC CODE (4) XXX  DATE 99/99/9999   CLAIM SPENDDOWN     $ 999999.99
                            PRIMARY SURG NO.   XXXXXXXXXXXX SURG PROC CODE (5) XXX  DATE 99/99/9999   NET CHARGE          $ 999999.99
  SEC SPAN CODE  99         SECONDARY SURG NO. XXXXXXXXXXXX SURG PROC CODE (6) XXX  DATE 99/99/9999   PAT LIAB            $ 999999.99
  SEC SPAN FROM  99/99/9999
  SEC SPAN THRU  99/99/9999
***ERROR***   - XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                        STATUS  X   CLERK XXXXX

-----------------------------------------------------  STATEMENT OF SERVICES  -----------------------------------------------------
LINE        DATE                   REV PROCEDURE         DIAGNOSIS-REL     FM    E    FND    UNITS  PREG SUBMIT  ALLOWED PRICING
NO    FIRST      LAST    LOCATION CODE CODE/MD/MD/MD/MD   1  2  3  4      CODE CODE  CODE     SVC   IND  CHARGE  CHARGE  INDICATOR
999 99/99/9999 99/99/9999   X     XXXX XXXXXX/XX/XX/XX/XX X  X  X  X       X     X          99.999   X   999.99  999.99      X

-----------------------------------------------------    RELATED HISTORY      -----------------------------------------------------
LINE   EOB     HIST                PROVIDER    PROCEDURE             DIAG      DATES OF SERVICE        UNITS     ALLOWED
 NO    CODE    IND   ICN           NUMBER      CODE/MD/MD/MD/MD      CODE      FROM        THRU        SVC       CHARGE
999      9      X  9999999999999  999999999   XXXXXX/XX/XX/XX/XX   XXXXXXX 99/99/9999  99/99/9999     9.999     999.99

                                                 *** END OF DATA ***
                                              *** NO DATA THIS RUN ***
```

5.1.10.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
ADMISSION DATE	The date of admission. Admission Date is selected based on the following criteria: If the date processing is about 1. Dental Services DTE_ADMISSION is selected from table T_SUSP_DENTAL_HDR. 2. Drug Services DTE_ADMISSION is selected from table T_SUSP_PHRM_HDR 3. Medical/Professional Services DTE_ADMISSION is selected from table T_SUSP_PHYS_HDR 4. UB92 DTE_ADMISSION is selected from table T_SUSP_UB92_HDR	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	DTE_ADMISSION
ADMIT HOUR	The hour and minute during which the patient was admitted for inpatient or outpatient care.	2	Character	T_SUSP_UB02_HDR	CDE_ADMIT_HOUR

Field	Description	Length	Data Type	DB Table	DB Attributes
ALLOWED CHARGE	The charge allowed on the claim. Charge allowed on claim is selected based on the following criteria: If the Unit is about 1. Suspended Dental History AMT_ALWD is selected from table T_SUSP_DNTL_DTL 2. Paid Dental History AMT_ALWD is selected from table T_PD_DNTL_DTL 3. Suspended UB92 History QTY_UNITS_BILLED is selected from table T_SUSP_UB92_HDR 4. Paid Physician History AMT_ALWD is selected from table T_PD_PHYS_DTL 5. Paid Drug History AMT_ALWD is selected from table T_PD_PHARM_DTL 6. Paid UB92 history AMT_ALWD is selected from table T_PD_UB92_DTL.	11	Character	SEE DESCRIPTION	AMT_ALWD
CLAIM SPENDDOWN	The claim spenddown amount is the amount the member has to pay before Medicaid takes over.	9	Character	T_RE_SPEND_LIAB	AMT_SPENDDOWN
CLERK	The on-line clerk identification number.	8	Character	T_CLAIM_ERROR	ID_CLERK

Field	Description	Length	Data Type	DB Table	DB Attributes
DATE FIRST	The first date of service. First date of service is selected based on the followings: If the error processing is about 1. Dental Services DTE_FIRST_SVC is selected from table T_SUSP_DENTAL_HDR. 2. Drug Services DTE_FIRST_SVC is selected from table T_SUSP_PHRM_HDR 3. Medical/Professional Services DTE_FIRST_SVC is selected from table T_SUSP_PHYS_HDR 4. Inpatient, Outpatient, and so on services DTE_FIRST_SVC is selected from table T_SUSP_UB92_HDR	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	DTE_FIRST_SVC
DATE LAST	The last date of service. Last date of service is selected based on the followings: If the error processing is about 1. Dental Services DTE_LAST_SVC is selected from table T_SUSP_DENTAL_HDR. 2. Drug Services DTE_LAST_SVC is selected from table T_SUSP_PHRM_HDR 3. Medical/Professional Services DTE_LAST_SVC is selected from table T_SUSP_PHYS_HDR 4. Inpatient, Outpatient, and so on services DTE_LAST_SVC is selected from table T_SUSP_UB92_HDR	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	DTE_LAST_SVC

Field	Description	Length	Data Type	DB Table	DB Attributes
DATE OF SURG PROC CODE (1 - 6)	The date associated with the surgery procedure code.	10	Date (MM/DD/CCYY)	T_UB92_HDR_ICD9CM	DTE_ICD_9_CM_PROC
DATES OF SERVICE FROM	The beginning date of service.	10	Date (MM/DD/CCYY)	T_HIST_DIRECTORY	DTE_FIRST_SVC
DATES OF SERVICE THRU	The ending date of service.	10	Date (MM/DD/CCYY)	T_HIST_DIRECTORY	DTE_TO_DATE
DIAG CODE	The diagnosis code.	7	Character	T_CLM_DIAG_XREF	CDE_DIAG
DIAGNOSIS-REL (1-4)	The diagnosis indicator.	1	Character	N/A	CALCULATED FIELD
DIAGNOSIS: FIFTH	The diagnosis code ICD-9 (fifth).	7	Number	CDE_DIAG, CDE_DIAG_SEQ	FIFTH_CDE_DIAG
DIAGNOSIS: FIRST	The diagnosis code ICD-9 (first).	7	Number	T_UB92_HDR_DIAG_X	FIRST_CDE_DIAG
DIAGNOSIS: FOURTH	The diagnosis code ICD-9 (fourth).	7	Number	T_UB92_HDR_DIAG_X	FOURTH_CDE_DIAG
DIAGNOSIS: SECOND	The diagnosis code ICD-9 (second).	7	Number	T_UB92_HDR_DIAG_X	SECOND_CDE_DIAG
DIAGNOSIS: THIRD	The diagnosis code ICD-9 (third).	7	Number	T_UB92_HDR_DIAG_X	THIRD_CDE_DIAG
E CODE	The emergency code indicator.	1	Character	T_SUSP_PHYS_DTL	IND_EMERGENCY
EOB CODE	The explanation of benefits code.	4	Number	N/A	CALCULATED FIELD
ERROR	The error code number.	4	Character	T_ERROR_DISP	CDE_ESC
FM CODE	The family planning code.	1	Character	T_SUSP_PHYS_DTL	CDE_EPSDT_FP

Field	Description	Length	Data Type	DB Table	DB Attributes
FND CODE	The fund code indicator.	1	Character	T_FIN_FUND_CODE, T_CLM_PGM_XREF	CDE_FUND_CODE
HIST IND	The history indicator for the claim detail.	1	Character	T_CLAIM_ERROR	CDE_STAT_ERROR
ICN	The unique internal control number for a Medicaid claim. Selected from tables T_SUSP_DENTAL_HDR, T_SUSP_PHRM_HDR, T_SUSP_PHYS_HDR, T_SUSP_UP92_HDR	13	Character	SEE DESCRIPTION	NUM_ICN
LINE NO	The line number on form.	3	Number	T_SUSP_UB92_DTL	NUM_DTL
LOC	The type of location in which a claim can be placed during processing in the MMIS.	2	Character	T_CLAIM_LOCAT	CDE_LOCATION
LOCATION	The location of the claim. Location of the claim is selected based on the following: If the error processing is about 1. Dental Services CDE_LOCATION is selected from table T_SUSP_DENTAL_HDR. 2. Drug Services CDE_LOCATION is selected from table T_SUSP_PHRM_HDR 3. Medical/Professional Services CDE_LOCATION is selected from table T_SUSP_PHYS_HDR 4. Inpatient, Outpatient, and so on Services CDE_LOCATION is selected from table T_SUSP_UB92_HDR	2	Character	SEE DESCRIPTION	CDE_LOCATION

Field	Description	Length	Data Type	DB Table	DB Attributes
MEMBER ID	The member identification number. The unique identification for the member receiving the services.	12	Character	T_SUSP_UB92_HDR	ID_MEDICAID
MEMBER NAME	The name of the member on claim. Name of Member on claim is the concatenation of NAM_LAST, NAM_FIRST, NAM_MID_INIT.	39	Character	T_RE_BASE	SEE DESCRIPTION
NET CHARGE	The net billed amount. Net billed amount is selected based on the following criteria: If the Net Charge is about 1. Dental Services AMT_NET_BILLED is selected from table T_SUSP_DENTAL_HDR. 2. Drug Services AMT_NET_BILLED is selected from table T_SUSP_PHRM_HDR 3. Medical/Professional Services AMT_NET_BILLED is selected from table T_SUSP_PHYS_HDR	14	Character	SEE DESCRIPTION	AMT_NET_BILLED
NO. COVERED DAYS	The total number of covered days.	2	Number	T_SUSP_UB92_HDR	NUM_DAYS_COVD
NONCOVERED CHARGES	The non-covered charges.	9	Number	T_UB92_DTL_EXT_KEY	AMT_NON_COVERED
ORIGINAL ICN	The ICN of original claim.	13	Number	AIM00.T_CLAIM_LOCAT	ORIG_NUM_ICN

Field	Description	Length	Data Type	DB Table	DB Attributes
PAT LIAB.	The member file Pat liable amount for LTC (Long Term Care) or PCS. Member file Patient liability amount for LTC or PCS is selected based on the followings: If the liability Amount is about 1.Dental Services AMT_PATNT_LIAB is selected from table T_SUSP_DENTAL_HDR. 2.Drug Services AMT_PATNT_LIAB is selected from table T_SUSP_PHRM_HDR 3.Medical/Professional Services AMT_PATNT_LIAB is selected from table T_SUSP_PHYS_HDR. 4.Inpatient, Outpatient, and so on Services AMT_PATNT_LIAB is selected from table T_SUSP_UB92_HDR	9	Character	SEE DESCRIPTION	AMT_PATNT_LIAB
PATIENT STATUS	The code which indicates the status of the member.	1	Number	T_SUSP_UB92_HDR	CDE_PATIENT_STATUS

Field	Description	Length	Data Type	DB Table	DB Attributes
PAY TO PROV NO	The provider number to pay. Provider number to pay is the concatenation of ID_PROVIDER and CDE_SERVICE_LOC, which is selected based on the followings: If the error processing is about 1. Dental Services CDE_SERVICE_LOC is selected from table T_SUSP_DENTAL_HDR. 2. Drug Services CDE_SERVICE_LOC is selected from table T_SUSP_PHRM_HDR 3. Medical/Professional Services CDE_SERVICE_LOC is selected from table T_SUSP_PHYS_HDR 4.Inpatient, Outpatient, and so on Services _SERVICE_LOC is selected from table T_SUSP_UB92_HDR	10	Character	SEE DESCRIPTION	ID_PROVIDER, CDE_SERVICE_LOC
PREG IND	The pregnancy indicator.	1	Character	T_SUSP_PHYS_DTL	IND_PREGNANCY

Field	Description	Length	Data Type	DB Table	DB Attributes
PRICING INDICATOR	The type of pricing. Indicates the type of pricing.Field ind_pricing is selected based on the following criteria: If the indicator is about 1.Dental Services IND_PRICING is selected from table T_SUSP_DENTAL_DTL. 2.Medical/Professional Services IND_PRICING is selected from table T_SUSP_PHYS_DTL 3. UB92 IND_PRICING is selected from table T_SUSP_UB92_DTL	1	Character	SEE DESCRIPTION	IND_PRICING
PRIMARY PRESC NO.	The primary prescriber number.	18	Number	T_SUSP_PHRM_HDR	ID_PROV_PRESCRB
PRIMARY SURG NO.	The primary surgeon number.	18	Number	T_SUSP_UB92_HDR	ID_PROV_OTHER
PROCEDURE: CODE	The code that identifies the service performed for a member.	6	Character	T_PROC	CDE_PROC
PROCEDURE: MD (1-4)	The procedure code modifiers(1-4).	2	Character	T_SUSP_PHYS_DTL	CDE_PROC_MOD
PROVIDER ID (Claim Header)	The provider number on the prior authorization update transaction (3+15).	18	Character	T_SUSP_UB92_HDR	ID_PROV_
PROVIDER ID (Related History)	The provider number based on the service type (3+15).	18	Character	SEE DESCRIPTION	SEE DESCRIPTION

Field	Description	Length	Data Type	DB Table	DB Attributes
REV CODE	The revenue code. Revenue code is selected based on the followings: If the error processing is about 1. Dental Services CDE_REVENUE is selected from table T_SUSP_DENTAL_HDR. 2. Drug Services CDE_REVENUE is selected from table T_SUSP_PHRM_HDR 3. Medical/Professional Services CDE_REVENUE is selected from table T_SUSP_PHYS_HDR 4. Inpatient, Outpatient, and so on Services CDE_REVENUE is selected from table T_SUSP_UB92_HDR	5	Number	SEE DESCRIPTION	CDE_REVENUE
SEC SPAN CODE	The second span code.	2	Number	T_UB92_HDR_OCC	CDE_OCCURENCE
SEC SPAN FROM	The second span from date.	10	Date (MM/DD/CCYY)	T_UB92_HDR_OCC	SEC_SPAN_FROM
SEC SPAN THRU	The second span thru date.	10	Date (MM/DD/CCYY)	T_UB92_HDR_OCC	SEC_SPAN_THRU
SECONDARY SURG NO.	The secondary surgeon number.	7	Number	T_SUSP_UB92_HDR	ID_PROV_OTHER_2
SEX	The sex code.	1	Character	T_RE_BASE	CDE_SEX
SOURCE OF ADMISSION	The admission source code.	2	Number	T_SUSP_UB92_HDR	CDE_ADMIT_SOURCE
SPAN OCC CODE	The occurrence code span.	2	Number	T_UB92_HDR_OCC	CDE_OCCURENCE

Field	Description	Length	Data Type	DB Table	DB Attributes
SPAN OCC FROM	The occurrence code span from date.	10	Date (MM/DD/CCYY)	T_UB92_HDR_OCC	DTE_OCCURENCE
SPAN OCC THRU	The occurrence code span thru date.	10	Date (MM/DD/CCYY)	T_UB92_HDR_OCC	DTE_OCC_TO
STATEMENT COVER PERIOD FROM	The 'period from' covered in the statement. Period from covered in the statement is selected based on the followings: If the error processing is about 1. Dental Services DTE_FIRST_SVC is selected from table T_SUSP_DENTAL_HDR. 2. Drug Services DTE_FIRST_SVC is selected from table T_SUSP_PHRM_HDR 3. Medical/Professional services DTE_FIRST_SVC is selected from table T_SUSP_PHYS_HDR 4. Inpatient, Outpatient, and so on Services DTE_FIRST_SVC is selected from table T_SUSP_UB92_HDR	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	DTE_FIRST_SVC

Field	Description	Length	Data Type	DB Table	DB Attributes
STATEMENT COVER PERIOD TO	The 'period to' covered in the statement. Period to covered in the statement is selected based on the followings: If the error processing is about 1. Dental Services DTE_LAST_SVC is selected from table T_SUSP_DENTAL_HDR. 2. Drug Services DTE_LAST_SVC is selected from table T_SUSP_PHRM_HDR 3. Medical/Professional Services DTE_LAST_SVC is selected from table T_SUSP_PHYS_HDR 4. Inpatient, Outpatient, and so on Services DTE_LAST_SVC is selected from table T_SUSP_UB92_HDR	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	DTE_LAST_SVC
STATUS	The error status.	1	Number	T_CLAIM_ERROR	CDE_STATUS1
SUBMIT CHARGE	The submitted charge Submitted charge is selected based on the following criteria: If the amount is about 1. Dental Services AMT_BILLED is selected from table T_SUSP_DENTAL_DTL. 2. Drug Services AMT_BILLED is selected from table T_SUSP_PHRM_DTL 3. Medical/Professional Services AMT_BILLED is selected from table T_SUSP_PHYS_DTL 4. UB92 AMT_BILLED is selected from table T_SUSP_UB92_DTL	11	Character	SEE DESCRIPTION	AMT_BILLED

Field	Description	Length	Data Type	DB Table	DB Attributes
SURG PROC CODE (1- 6)	The surgical procedure code.	4	Number	T_UB92_HDR_ICD9CM	CDE_PROC_ICD9
THIRD PARTY PAYMENT	The third party payment. Third party payment is selected based on the following criteria: If the payment is about 1. Dental Services TPL_AMT is selected from table T_SUSP_DENTAL_HDR. 2. Drug Services TPL_AMT is selected from table T_SUSP_PHRM_HDR 3. Medical/Professional Services TPL_AMT is selected from table T_SUSP_PHYS_HDR	9	Number	SEE DESCRIPTION	TPL_AMT
TOTAL CHARGE	The total service charge. Total service charge is selected based on the following criteria: If the charge is about 1. Dental Services AMT_BILLED is selected from table T_SUSP_DENTAL_HDR. 2. Drug Services AMT_BILLED is selected from table T_SUSP_PHRM_HDR 3. Medical/Professional Services AMT_BILLED is selected from table T_SUSP_PHYS_HDR 4. Inpatient, Outpatient, and so on Services AMT_BILLED is selected from table T_SUSP_UB92_HDR	14	Character	SEE DESCRIPTION	AMT_BILLED

Field	Description	Length	Data Type	DB Table	DB Attributes
TYPE OF ADMISSION	The admission type code.	1	Number	T_SUSP_UB92_HDR	CDE_ADMIT_TYPE
UNITS SVC	The units of service. Unit of service is selected based on the following criteria: If the Unit is about 1. Dental Services QTY_UNITS_BILLED is selected from table T_SUSP_DENTAL_HDR. 2. Drug Services QTY_UNITS_BILLED is selected from table T_SUSP_PHRM_HDR 3. Medical/Professional Services QTY_UNITS_BILLED is selected from table T_SUSP_PHYS_HDR 4. UB92 QTY_UNITS_BILLED is selected from table T_SUSP_UB92_HDR	9	Character	SEE DESCRIPTION	QTY_UNITS_BILLED

5.1.10.6 Associated Programs

Program	Description
clmp422	Combined Claim Error
copy2routedir	Copy Reports to Router

5.1.11 CLM-0023-D -- Claims Error Report

The Claims Resolution Unit uses this report as an inventory of claims to be resolved. Detailed Error Reports by claim type are used by clerks to resolve claims.

5.1.11.1 Technical Name

CLM-0023-D

5.1.11.2 Sort Order

Location

ICN

5.1.11.3 Distribution

OnBase

Jay Hackett

Rhonda Poston

5.1.11.4 Claims Error Report Layout

```
Report   : CLM-0023-D                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process  : CLMJD023                 MEDICAID MANAGEMENT INFORMATION SYSTEM           Run Time:   HH:MM:SS
Location: CLM0023D                        CLAIMS ERROR REPORT                           Page:      99999
                                              MM/DD/CCYY
```

ICN	MEMBER ID	LOC	PROVIDER +LOC	PROV SPEC	PROV TYPE	DATES OF SERVICE FIRST	LAST	NET CLAIM CHARGE	PAYMENT AMOUNT	ERROR CODE	CLAIM DISP PD SUSP DENY	ERROR FORCED
XXXXXXXXXXXXX	XXXXXXXXXXXX	XX	XXXXXXXXX	XXX	XX	MM/DD/CCYY	MM/DD/CCYY	$999,999.00	$999,999.00	XXXX	XXXXXXXXXXXX	X
XXXXXXXXXXXXX	XXXXXXXXXXXX	XX	XXXXXXXXX	XXX	XX	MM/DD/CCYY	MM/DD/CCYY	$999,999.00	$999,999.00	XXXX	XXXXXXXXXXXX	X
XXXXXXXXXXXXX	XXXXXXXXXXXX	XX	XXXXXXXXX	XXX	XX	MM/DD/CCYY	MM/DD/CCYY	$999,999.00	$999,999.00	XXXX	XXXXXXXXXXXX	X
XXXXXXXXXXXXX	XXXXXXXXXXXX	XX	XXXXXXXXX	XXX	XX	MM/DD/CCYY	MM/DD/CCYY	$999,999.00	$999,999.00	XXXX	XXXXXXXXXXXX	X
XXXXXXXXXXXXX	XXXXXXXXXXXX	XX	XXXXXXXXX	XXX	XX	MM/DD/CCYY	MM/DD/CCYY	$999,999.00	$999,999.00	XXXX	XXXXXXXXXXXX	X

```
                    *** END OF REPORT **
                 *** NO DATA THIS RUN ***
```

5.1.11.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIM DISP PD SUSP DENY	The status of the claim.	1	Character	N/A	CALCULATED FIELD
DATES OF SERVICE FIRST	The first date of service on the claim. This field is select on a Union of T_DENY_DNTL_HDR,T_DENY_PHRM_HDR, T_DENY_PHYS_HDR,T_DENY_UB92_HDR, T_PD_DNTL_HDR, T_PD_PHARM_HDR,T_PD_PHYS_HDR, T_PD_UB92_HDR, T_SUSP_DNTL_HDR,T_SUSP_PHARM_HDR, T_SUSP_PHYS_HDR,T_SUSP_UB92_HDR, T_PD_UB92_DTL, T_DENY_UB92_DTL,T_SUSP_UB92_DTL, T_RE_BASE, T_ERROR_DISP,T_CLAIM_ERROR, T_TEMP_PRINTTYPEL (Temporary Table) tables.	10	Date (MM/DD/CCYY)	SEE DESCRIPTION.	DTE_FIRST_SVC

Field	Description	Length	Data Type	DB Table	DB Attributes
DATES OF SERVICE LAST	The last date of service on the claim. This field is select on a Union of T_DENY_DNTL_HDR,T_DENY_PHRM_HDR, T_DENY_PHYS_HDR,T_DENY_UB92_HDR, T_PD_DNTL_HDR, T_PD_PHARM_HDR,T_PD_PHYS_HDR, T_PD_UB92_HDR, T_SUSP_DNTL_HDR,T_SUSP_PHARM_HDR, T_SUSP_PHYS_HDR,T_SUSP_UB92_HDR, T_PD_UB92_DTL, T_DENY_UB92_DTL,T_SUSP_UB92_DTL, T_RE_BASE, T_ERROR_DISP,T_CLAIM_ERROR, T_TEMP_PRINTTYPEL (Temporary Table) tables.	10	Date (MM/DD/CCYY)	SEE DESCRIPTION.	DTE_LAST_SVC
ERROR CODE	The code to uniquely identify an error condition. This field is select on a Union of T_DENY_DNTL_HDR,T_DENY_PHRM_HDR, T_DENY_PHYS_HDR,T_DENY_UB92_HDR, T_PD_DNTL_HDR, T_PD_PHARM_HDR,T_PD_PHYS_HDR, T_PD_UB92_HDR, T_SUSP_DNTL_HDR,T_SUSP_PHARM_HDR, T_SUSP_PHYS_HDR,T_SUSP_UB92_HDR, T_PD_UB92_DTL, T_DENY_UB92_DTL,T_SUSP_UB92_DTL, T_RE_BASE, T_ERROR_DISP,T_CLAIM_ERROR, T_TEMP_PRINTTYPEL (Temporary Table) tables.	4	Number	SEE DESCRIPTION.	CDE_ESC

Field	Description	Length	Data Type	DB Table	DB Attributes
ERROR FORCED	The indicator designating if error was forced through the system	1	Character	N/A	CALCULATED FIELD
ICN	The internal control number used to uniquely identify a claim. This field is select on a Union of T_DENY_DNTL_HDR,T_DENY_PHRM_HDR, T_DENY_PHYS_HDR, T_DENY_UB92_HDR, T_PD_DNTL_HDR, T_PD_PHARM_HDR,T_PD_PHYS_HDR, T_PD_UB92_HDR, T_SUSP_DNTL_HDR,T_SUSP_PHARM_HDR, T_SUSP_PHYS_HDR,T_SUSP_UB92_HDR, T_PD_UB92_DTL, T_DENY_UB92_DTL,T_SUSP_UB92_DTL, T_RE_BASE, T_ERROR_DISP,T_CLAIM_ERROR, T_TEMP_PRINTTYPEL (Temporary Table) tables.	13	Character	SEE DESCRIPTION.	NUM_ICN

Field	Description	Length	Data Type	DB Table	DB Attributes
LOC	The current location of the claim. This field is select on a Union of T_DENY_DNTL_HDR,T_DENY_PHRM_HDR, T_DENY_PHYS_HDR,T_DENY_UB92_HDR, T_PD_DNTL_HDR, T_PD_PHARM_HDR, T_PD_PHYS_HDR, T_PD_UB92_HDR, T_SUSP_DNTL_HDR, T_SUSP_PHARM_HDR, T_SUSP_PHYS_HDR, T_SUSP_UB92_HDR, T_PD_UB92_DTL, T_DENY_UB92_DTL, T_SUSP_UB92_DTL, T_RE_BASE, T_ERROR_DISP, T_CLAIM_ERROR, T_TEMP_PRINTTYPEL (Temporary Table) tables.	2	Character	SEE DESCRIPTION.	CDE_LOCATION
MEMBER ID	The member identification number. This contains the unique identification for the member receiving the services. This field is select on a Union of T_DENY_DNTL_HDR,T_DENY_PHRM_HDR, T_DENY_PHYS_HDR, T_DENY_UB92_HDR, T_PD_DNTL_HDR, T_PD_PHARM_HDR,T_PD_PHYS_HDR, T_PD_UB92_HDR, T_SUSP_DNTL_HDR,T_SUSP_PHARM_HDR, T_SUSP_PHYS_HDR,T_SUSP_UB92_HDR, T_PD_UB92_DTL, T_DENY_UB92_DTL,T_SUSP_UB92_DTL, T_RE_BASE, T_ERROR_DISP,T_CLAIM_ERROR, T_TEMP_PRINTTYPEL (Temporary Table) tables.	12	Character	SEE DESCRIPTION.	ID_MEDICAID

Field	Description	Length	Data Type	DB Table	DB Attributes
NET CLAIM CHARGE	The net claim charge after spenddown, tpl, payments applied, etc. This field is select on a Union of T_DENY_DNTL_HDR, T_DENY_PHRM_HDR, T_DENY_PHYS_HDR, T_DENY_UB92_HDR, T_PD_DNTL_HDR, T_PD_PHARM_HDR, T_PD_PHYS_HDR, T_PD_UB92_HDR, T_SUSP_DNTL_HDR, T_SUSP_PHARM_HDR, T_SUSP_PHYS_HDR, T_SUSP_UB92_HDR, T_PD_UB92_DTL, T_DENY_UB92_DTL, T_SUSP_UB92_DTL, T_RE_BASE, T_ERROR_DISP, T_CLAIM_ERROR, T_TEMP_PRINTTYPEL (Temporary Table) tables.	9	Character	SEE DESCRIPTION.	AMT_NET_BILLED,AMT_PAID
PAYMENT AMOUNT	The amount reimbursed to provider. This field is select on a Union of T_DENY_DNTL_HDR, T_DENY_PHRM_HDR, T_DENY_PHYS_HDR, T_DENY_UB92_HDR, T_PD_DNTL_HDR, T_PD_PHARM_HDR, T_PD_PHYS_HDR, T_PD_UB92_HDR, T_SUSP_DNTL_HDR, T_SUSP_PHARM_HDR, T_SUSP_PHYS_HDR, T_SUSP_UB92_HDR, T_PD_UB92_DTL, T_DENY_UB92_DTL, T_SUSP_UB92_DTL, T_RE_BASE, T_ERROR_DISP, T_CLAIM_ERROR, T_TEMP_PRINTTYPEL (Temporary Table) tables.	9	Character	SEE DESCRIPTION.	AMT_PAID

Field	Description	Length	Data Type	DB Table	DB Attributes
PROV SPEC	The provider specialty. This field is select on a Union of T_DENY_DNTL_HDR, T_DENY_PHRM_HDR, T_DENY_PHYS_HDR, T_DENY_UB92_HDR, T_PD_DNTL_HDR, T_PD_PHARM_HDR, T_PD_PHYS_HDR, T_PD_UB92_HDR, T_SUSP_DNTL_HDR, T_SUSP_PHARM_HDR, T_SUSP_PHYS_HDR, T_SUSP_UB92_HDR, T_PD_UB92_DTL, T_DENY_UB92_DTL, T_SUSP_UB92_DTL, T_RE_BASE, T_ERROR_DISP, T_CLAIM_ERROR, T_TEMP_PRINTTYPEL (Temporary Table) tables.	3	Character	SEE DESCRIPTION.	CDE_PROV_SPEC
PROV TYPE	The type of practice for a provider. This field is select on a Union of T_DENY_DNTL_HDR,T_DENY_PHRM_HDR, T_DENY_PHYS_HDR,T_DENY_UB92_HDR, T_PD_DNTL_HDR, T_PD_PHARM_HDR,T_PD_PHYS_HDR, T_PD_UB92_HDR, T_SUSP_DNTL_HDR,T_SUSP_PHARM_HDR, T_SUSP_PHYS_HDR,T_SUSP_UB92_HDR, T_PD_UB92_DTL, T_DENY_UB92_DTL,T_SUSP_UB92_DTL, T_RE_BASE, T_ERROR_DISP,T_CLAIM_ERROR, T_TEMP_PRINTTYPEL (Temporary Table) tables.	2	Character	SEE DESCRIPTION.	CDE_PROV_TYPE

5.1.11.6 Associated Programs

Program	Description

Program	Description
clm0023d	Claims Error Report
copy2routedir	Copy Reports to Router

5.1.12 CLM-0024-D -- Daily Error Summary By Claim Type

This daily report shows how many times each error occurred by claim type. The report provides information on the preceding five cycles.

5.1.12.1 Technical Name

CLM-0024-D

5.1.12.2 Sort Order

Grouped by Claim Type, Sorted by Error Code

5.1.12.3 Distribution

OnBase

Jay Hackett

Rhonda Poston

5.1.12.4 Daily Error Summary By Claim Type Layout

```
Report  : CLM-0024-D                          COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process : CLMJDER2                         MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: CLMPER01                            DAILY ERROR SUMMARY BY CLAIM TYPE                            Page:        999
                                                      MM/DD/CCYY

CLAIM TYPE:  xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
ERROR                                                  MM/DD/CCYY      MM/DD/CCYY      MM/DD/CCYY      MM/DD/CCYY      MM/DD/CCYY
CODE     ERROR DESCRIPTION                             OCC.   RECS     OCC.   RECS     OCC.   RECS     OCC.   RECS     OCC.   RECS
XXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999
XXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999
XXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999
XXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999
XXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999

TOTALS BY CLAIM TYPE:
                                                       9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999

GRAND TOTAL:
                                                      99,999 99,999   99,999 99,999   99,999 99,999   99,999 99,999   99,999 99,999

                                                 **** END OF REPORT ****
                                                *** NO DATA THIS RUN ***
```

5.1.12.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIM TYPE	The claim type description that specifies the type of claim record. This is the tag1 field from the clmStat_st structure. These values are initialized in the program.	49	Character	N/A	N/A
CYCLE 1 (DATE)	The run date for cycle 1.	10	Date (MM/DD/CCYY)	N/A	CALCULATED FIELD
CYCLE 1 OCC.	The number of occurrences of error codes for cycle 1.	4	Character	N/A	CALCULATED FIELD
CYCLE 1 RECS	The number of error records for cycle 1.	4	Character	N/A	CALCULATED FIELD
CYCLE 2 (DATE)	The run date for cycle 2.	10	Date (MM/DD/CCYY)	N/A	CALCULATED FIELD
CYCLE 2 OCC.	The number of occurrences of error codes for cycle 2	4	Character	N/A	CALCULATED FIELD
CYCLE 2 RECS	The number of error records or error codes for cycle 2.	4	Character	N/A	CALCULATED FIELD
CYCLE 3 (DATE)	The run date for cycle 3.	10	Date (MM/DD/CCYY)	N/A	CALCULATED FIELD
CYCLE 3 OCC.	The number of occurrences of error codes for cycle 3.	4	Character	N/A	CALCULATED FIELD
CYCLE 3 RECS	The number of error records or error codes for cycle	4	Character	N/A	CALCULATED

Field	Description	Length	Data Type	DB Table	DB Attributes
	3.				FIELD
CYCLE 4 (DATE)	The run date for cycle 4.	10	Date (MM/DD/CCYY)	N/A	CALCULATED FIELD
CYCLE 4 OCC.	The number of occurrences of error codes for cycle 4.	4	Character	N/A	CALCULATED FIELD
CYCLE 4 RECS	The number of error records or error codes for cycle 4.	4	Character	N/A	CALCULATED FIELD
CYCLE 5 (DATE)	The run date for cycle 5.	10	Date (MM/DD/CCYY)	N/A	CALCULATED FIELD
CYCLE 5 OCC.	The number of occurrences of error codes for cycle 5.	4	Character	N/A	CALCULATED FIELD
CYCLE 5 RECS	The number of error records or error codes for cycle 5.	4	Character	N/A	CALCULATED FIELD
ERROR CODE	The error code on the claim. This is the CDE_ESC field from the extrInpRec structure associated with the clm01029.srt input file.	3	Number	N/A	N/A
ERROR DESCRIPTION	The error code description on the claim. This is the DSC_ERROR_STAT field from the extrInpRec structure associated with the clm01029.srt input file.	50	Character	N/A	N/A
GRAND TOTALS	Total Number of Records for all Claim Types on this	6	Character	N/A	CALCULATED

Field	Description	Length	Data Type	DB Table	DB Attributes
(CYCLE 1 OCC)	Cycle Date for all Error codes.				FIELD
GRAND TOTALS (CYCLE 1 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	CALCULATED FIELD
GRAND TOTALS (CYCLE 2 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	CALCULATED FIELD
GRAND TOTALS (CYCLE 2 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	CALCULATED FIELD
GRAND TOTALS (CYCLE 3 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	CALCULATED FIELD
GRAND TOTALS (CYCLE 3 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	CALCULATED FIELD
GRAND TOTALS (CYCLE 4 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	CALCULATED FIELD
GRAND TOTALS (CYCLE 4 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	CALCULATED FIELD
GRAND TOTALS (CYCLE 5 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	CALCULATED FIELD
GRAND TOTALS (CYCLE 5 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	CALCULATED FIELD
TOTAL BY CLAIM TYPE (CYCLE 1 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
TOTAL BY CLAIM TYPE (CYCLE 1 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Errorn codes.	5	Character	N/A	CALCULATED FIELD
TOTAL BY CLAIM TYPE (CYCLE 2 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	CALCULATED FIELD
TOTAL BY CLAIM TYPE (CYCLE 2 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Errorn codes.	5	Character	N/A	CALCULATED FIELD
TOTAL BY CLAIM TYPE (CYCLE 3 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	CALCULATED FIELD
TOTAL BY CLAIM TYPE (CYCLE 3 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Errorn codes.	5	Character	N/A	CALCULATED FIELD
TOTAL BY CLAIM TYPE (CYCLE 4 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	CALCULATED FIELD
TOTAL BY CLAIM TYPE (CYCLE 4 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Errorn codes.	5	Character	N/A	CALCULATED FIELD
TOTAL BY CLAIM TYPE (CYCLE 5 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	CALCULATED FIELD
TOTAL BY CLAIM TYPE (CYCLE 5 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Errorn codes.	5	Character	N/A	CALCULATED FIELD

5.1.12.6 Associated Programs

Program	Description
clmper01	Daily Error Summary By Claim Type
copy2routedir	Copy Reports to Router

5.1.13 CLM-0025-D -- Services to be Clerically Denied Report

This report lists the claims that had services denied by a clerk. It enables supervisory personnel to identify those clerks who appear to resolve an inordinate number of suspended claims by denying error codes.

5.1.13.1 Technical Name

CLM-0025-D

5.1.13.2 Sort Order

ICN

Detail Number

5.1.13.3 Distribution

OnBase

5.1.13.4 Services to be Clerically Denied Report Layout

```
Report  : CLM-0025-D                          COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process : CLMJD25D                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLM0025D                      SERVICES TO BE CLERICALLY DENIED REPORT                             Page:       9999
                                                   MM/DD/CCYY


ICN          DETAIL    MEMBER ID      PROVIDER+       PROVIDER  PROVIDER     DATES OF SERVICE      NET  BILLED    DENIED  CLERK ID
             NUMBER                   LOC             TYPE      SPECIALTY  FIRST       LAST         AMT            ERRORS
XXXXXXXXXXXX   XXX    XXXXXXXXXXXX   XXXXXXXXXX      XX          XXX      MM/DD/CCYY  MM/DD/CCYY  $999,999.99    XXXX    XXXXXXX
XXXXXXXXXXXX   XXX    XXXXXXXXXXXX   XXXXXXXXXX      XX          XXX      MM/DD/CCYY  MM/DD/CCYY  $999,999.99    XXXX    XXXXXXX
XXXXXXXXXXXX   XXX    XXXXXXXXXXXX   XXXXXXXXXX      XX          XXX      MM/DD/CCYY  MM/DD/CCYY  $999,999.99    XXXX    XXXXXXX
XXXXXXXXXXXX   XXX    XXXXXXXXXXXX   XXXXXXXXXX      XX          XXX      MM/DD/CCYY  MM/DD/CCYY  $999,999.99    XXXX    XXXXXXX
XXXXXXXXXXXX   XXX    XXXXXXXXXXXX   XXXXXXXXXX      XX          XXX      MM/DD/CCYY  MM/DD/CCYY  $999,999.99    XXXX    XXXXXXX


*****CLERK ID RECAP*****
CLERK ID     CLAIM COUNT

XXXXXXXX       XXXXXXX

                                        *** END OF REPORT ***
                                      *** NO DATA THIS RUN ***
```

5.1.13.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLERK ID	The clerk identification number. The identification number of the clerk who has been assigned to work this claim.	9	Character	T_CLAIM_ERROR	ID_CLERK
CLERK ID RECAP - CLAIM COUNT	The claim count per clerk.	12	Character	T_CLAIM_ERROR	ID_CLERK
CLERK ID RECAP - CLERK ID	The clerk identification number.	9	Character	T_CLAIM_ERROR	ID_CLERK
DATE OF SERVICE FIRST	The first date of service on the claim. Is the result of UNION (T_PD_PHYS_HDR, T_SUS_PHYS_HDR, T_DENY_PHYS_HDR,T_PD_DNTL_HDR, T_SUS_DENTAL_HDR,T_DENY_DNTL_HDR, T_PD_PHARM_HDR,T_SUSP_PHRM_HDR,T_DENY_PHRM_HDR, T_PD_UB92_HDR,T_SUSP_UB92_HDR, T_DENY_UB92_HDR). Table in DB:T_PD_PHYS_HDR, T_SUS_PHYS_HDR,T_DENY_PHYS_HDR, T_PD_DNTL_HDR, T_SUS_DENTAL_HDR,T_DENY_DNTL_HDR, T_PD_PHARM_HDR,T_SUS_PHRM_HDR,T_DENY_PHRM_HDR, T_PD_UB92_HDR,T_SUSP_UB92_HDR, T_DENY_UB92_HDR Field in DB: DTE_FIRST_SVC,DTE_DISPENSE, DTE_PRESCRIBE	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	SEE DESCRIPTION

Field	Description	Length	Data Type	DB Table	DB Attributes
DATE OF SERVICE LAST	The last date of service on the claim. Is the result of UNION (T_PD_PHYS_HDR, T_SUS_PHYS_HDR, T_DENY_PHYS_HDR,T_PD_DNTL_HDR, T_SUS_DENTAL_HDR,T_DENY_DNTL_HDR, T_PD_PHARM_HDR,T_SUSP_PHRM_HDR,T_DENY_PHRM_HDR, T_PD_UB92_HDR,T_SUSP_UB92_HDR, T_DENY_UB92_HDR). Table in DB:T_PD_PHYS_HDR, T_SUS_PHYS_HDR,T_DENY_PHYS_HDR, T_PD_DNTL_HDR, T_SUS_DENTAL_HDR,T_DENY_DNTL_HDR, T_PD_PHARM_HDR,T_SUS_PHRM_HDR,T_DENY_PHRM_HDR, T_PD_UB92_HDR,T_SUSP_UB92_HDR, T_DENY_UB92_HDR Field in DB: DTE_FIRST_SVC,DTE_DISPENSE, DTE_PRESCRIBE	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	SEE DESCRIPTION
DENIED ERRORS	The denied errors on claim.	5	Character	T_ERROR_DISP	CDE_ESC
DETAIL NUMBER	The detail that was clerically denied.	5	Character	T_CLAIM_ERROR	NUM_DTL

Field	Description	Length	Data Type	DB Table	DB Attributes
ICN	The unique internal control number for a Medicaid claim. Is the result of UNION(T_PD_PHYS_HDR,T_SUS_PHYS_HDR, T_DENY_PHYS_HDR,T_PD_DNTL_HDR,T_SUSP_DENTAL_HDR,T_DENY_DNTL_HDR, T_PD_PHARM_HDR,T_SUSP_PHRM_HDR,T_DENY_PHRM_HDR, T_PD_UB92_HDR,T_SUSP_UB92_HDR,T_DENY_UB92_HDR). Table in DB:T_PD_PHYS_HDR, T_SUS_PHYS_HDR,T_DENY_PHYS_HDR, T_PD_DNTL_HDR, T_SUS_DENTAL_HDR,T_DENY_DNTL_HDR, T_PD_PHARM_HDR,T_SUS_PHRM_HDR, T_DENY_PHRM_HDR, T_PD_UB92_HDR,T_SUSP_UB92_HDR, T_DENY_UB92_HDR.	14	Character	SEE DESCRIPTION	NUM_ICN
MEMBER ID	The member identification number. This contains the unique identification for the member receiving the services.	13	Character	T_RE_BASE	ID_MEDICAID
NET BILLED AMT	The net billed amount. Is the UNION of (T_PD_PHYS_HDR, T_SUS_PHYS_HDR,T_DENY_PHYS_HDR, T_PD_DNTL_HDR,T_SUSP_DENTAL_HDR,T_DENY_DNTL_HDR, T_PD_PHARM_HDR, T_SUSP_PHRM_HDR, T_DENY_PHRM_HDR, T_PD_UB92_HDR, {Difference AMT_BILLED_UB92 - SUM(AMT_PD_PAT_UB92 + SUM(SUM_TPL)]}, T_SUSP_UB92_HDR, T_DENY_UB92_HDR) Field in DB: AMT_NET_BILLED,	11	Character	SEE DESCRIPTION	SEE DESCRIPTION

Field	Description	Length	Data Type	DB Table	DB Attributes
	AMT_BILLED_UB92, AMT_PD_PAT_UB92, AMT_DETAIL_TPL Table in DB: T_PD_PHYS_HDR, T_SUS_PHYS_HDR, T_DENY_PHYS_HDR, T_PD_DNTL_HDR, T_SUSP_DENTAL_HDR, T_DENY_DNTL_HDR, T_PD_PHARM_HDR, T_SUSP_PHRM_HDR, T_DENY_PHRM_HDR, T_PD_UB92_DNTL, T_SUSP_UB92_DTL, T_DENY_UB92_DTL, T_PD_UB92_HDR, T_SUSP_UB92_HDR,T_DENY_UB92_HDR				
PROVIDER + LOC	The provider number and the service location for the provider.	11	Character	T_PR_PROV + T_PR_TYPE	ID_PROVIDER + CDE_SERVICE_LOC
PROVIDER SPECIALTY	The specialty code for the provider.	4	Character	T_PR_TYPE	CDE_PROV_SPEC_PRIM
PROVIDER TYPE	The type of practice for a provider.	3	Character	T_PR_TYPE	CDE_PROV_TYPE

5.1.13.6 Associated Programs

Program	Description
clm0025d	Services To Be Clerically Denied Report
copy2routedir	Copy Reports to Router

5.1.14 CLM-0026-D -- Claims Paid Due To Force Report

This report lists those claims that have errors that were clerically forced or overridden. It enables supervisory personnel to identify those clerks who appear to resolve an inordinate number of suspended claims by forcing error codes.

5.1.14.1 Technical Name

CLM-0026-D

5.1.14.2 Sort Order

ICN

Detail Number

5.1.14.3 Distribution

OnBase

Janet Schell

5.1.14.4 Claims Paid Due To Force Report Layout

```
Report  : CLM-0026-D                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process : CLMJD26D                MEDICAID MANAGEMENT INFORMATION SYSTEM            Run Time:   HH:MM:SS
Location: CLM0026D                 CLAIMS TO BE PAID DUE TO FORCE REPORT                Page:        999
                                              MM/DD/CCYY


ICN            DETAIL MEMBER ID      PROVIDER+     PROV    PROV   DATES OF SERVICE        NET BILLED        PAYMENT       FORCED      CLERK ID
               NUMBER                LOC           TYPE    SPEC   FIRST       LAST        AMT               AMOUNT        ERRORS
XXXXXXXXXXXX   XXX    XXXXXXXXXXXX   XXXXXXXXXX    XX      XXX    MM/DD/CCYY  MM/DD/CCYY  $999,999.99       $9,999,999.99  XXXX        XXXXXXXX
XXXXXXXXXXXX   XXX    XXXXXXXXXXXX   XXXXXXXXXX    XX      XXX    MM/DD/CCYY  MM/DD/CCYY  $999,999.99       $9,999,999.99  XXXX        XXXXXXXX
XXXXXXXXXXXX   XXX    XXXXXXXXXXXX   XXXXXXXXXX    XX      XXX    MM/DD/CCYY  MM/DD/CCYY  $999,999.99       $9,999,999.99  XXXX        XXXXXXXX
XXXXXXXXXXXX   XXX    XXXXXXXXXXXX   XXXXXXXXXX    XX      XXX    MM/DD/CCYY  MM/DD/CCYY  $999,999.99       $9,999,999.99  XXXX        XXXXXXXX
XXXXXXXXXXXX   XXX    XXXXXXXXXXXX   XXXXXXXXXX    XX      XXX    MM/DD/CCYY  MM/DD/CCYY  $999,999.99       $9,999,999.99  XXXX        XXXXXXXX


*****CLERK ID RECAP*****
CLERK ID     CLAIM COUNT

XXXXXXXX       XXXXXXX
                                          *** END OF REPORT ****
                                         *** NO DATA THIS RUN ***
```

5.1.14.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLERK ID	The clerk identification number. The identification number of the clerk who has been assigned to work this claim.	8	Character	T_CLAIM_ERROR	ID_CLERK
CLERK ID RECAP - CLAIM COUNT	The claim count per clerk.	7	Character	T_CLAIM_ERROR	SAK_CLAIM,NUM_DTL, SAK_ESC
CLERK ID RECAP - CLERK ID	The clerk identification number.	8	Character	T_CLAIM_ERROR	ID_CLERK
DATE OF SERVICE FIRST	The first date of service on the claim. Is the result of UNION SET (T_PD_PHYS_HDR, T_PD_DNTL_HDR, T_PD_PHARM_HDR,T_PD_UB92_HDR) Field in DB:T_PD_PHYS_HDR, T_PD_DNTL_HDR,T_PD_PHARM_HDR, T_PD_UB92_HDR	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	DTE_FIRST_SVC, DTE_PRESCRIBE
DATE OF SERVICE LAST	The last date of service on the claim. Is the result of UNION SET (T_PD_PHYS_HDR, T_PD_DNTL_HDR, T_PD_PHARM_HDR,T_PD_UB92_HDR) Field in DB:T_PD_PHYS_HDR, T_PD_DNTL_HDR,T_PD_PHARM_HDR, T_PD_UB92_HDR	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	DTE_LAST_SVC, DTE_PRESCRIBE
DETAIL NUMBER	The detail that was clerically denied.	5	Character	T_CLAIM_ERROR	NUM_DTL

Field	Description	Length	Data Type	DB Table	DB Attributes
FORCED ERRORS	The total number of forced errors.	4	Character	T_ERROR_DISP	CDE_ESC
ICN	ICN = Internal Control Number (ICN) is the result of UNION(T_PD_PHYS_HDR, T_PD_DNTL_HDR, T_PD_PHARM_HDR, T_PD_UB92_HDR). Table in DB:T_PD_PHYS_HDR, T_PD_DNTL_HDR,T_PD_PHARM_HDR, T_PD_UB92_HDR	14	Character	SEE DESCRIPTION	NUM_ICN
MEMBER ID	The member identification number. This contains the unique identification for the member receiving the services.	13	Character	T_RE_BASE	ID_MEDICAID
NET BILLED AMT	The claim charge. Is the UNION SET (T_PD_PHYS_HDR, T_PD_DNTL_HDR,T_PD_PHARM_HDR, {Difference [AMT_BILLED_UB92 - SUM(AMT_PD_PAT_UB92 + SUM_TPL)]} Field in DB: AMT_NET_BILLED, AMT_BILLED_UB92,AMT_PD_PAT_UB92, SAK_CLAIM,AMT_DETAIL_TPL). Table in DB:(T_PD_PHYS_HDR, T_PD_DNTL_HDR,T_PD_PHARM_HDR, T_PD_UB92_HDR,T_PD_UB92_DTL). SUM_TPL is the SUM(AMT_DETAIL_TPL) from T_PD_UB92_DTL table Group By SAK_CLAIM.	11	Character	SEE DESCRIPTION	SEE DESCRIPTION

Field	Description	Length	Data Type	DB Table	DB Attributes
PAYMENT AMOUNT	The amount due to the provider. Field in DB:AMT_TOT_REIMB, AMT_PAID,AMT_REIMBURSEMENT. Table in DB:T_PD_PHYS_HDR, T_PD_DNTL_HDR,T_PD_PHARM_HDR, T_PD_UB92_HDR.	13	Character	SEE DESCRIPTION	SEE DESCRIPTION
PROV SPEC	The specialty code for the provider.	4	Character	T_PR_TYPE	CDE_PROV_SPEC_PRIM
PROV TYPE	The type of practice for a provider.	3	Character	T_PR_TYPE	CDE_PROV_TYPE
PROVIDER + LOC	The provider number and the service location for the provider.	11	Character	T_PR_PROV + T_PR_TYPE	ID_PROVIDER + CDE_SERVICE_LOC

5.1.14.6 Associated Programs

Program	Description
clm0026d	Claims Paid Due To Force Report
copy2routedir	Copy Reports to Router

5.1.15 CLM-0027-D -- Transaction Register

This report identifies every claim processed in a daily claim adjudication cycle. Each claim is identified by Internal Control Number (ICN), Member ID Number, Provider Number, Transaction Code, Dates of Service, and Payment Amount. Additionally, this report displays any error codes posted to the claim throughout the daily claim adjudication cycle.

5.1.15.1 Technical Name

CLM-0027-D

5.1.15.2 Sort Order

ICN

5.1.15.3 Distribution

OnBase

Jay Hackett

Rhonda Poston

5.1.15.4 Transaction Register Layout

```
Report  : CLM-0027-D                          COMMONWEALTH OF KENTUCKY                                Run Date: MM/DD/CCYY
Process : CLMJD027                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLM0027D                              TRANSACTION REGISTER                                      Page:          1
                                                     MM/DD/CCYY

ICN            MEMBER        PROVIDER+LOC  FROM          TO            REIMBURSEMENT AMT   ERRORS
-------------------------------------------------------------------------------------------------------------------------------

XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXXX      XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX
XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXXX      XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX
XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXXX      XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX
XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXXX      XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX
XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXXX      XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX
                                                  *** END OF REPORT ***
                                                *** NO DATA THIS RUN ***
```

5.1.15.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
ERRORS	The error codes the claim failed. This field is a select from union of T_CLAIM_LOCAT,T_CLAIM_ERROR, T_ERROR_DISP, T_RE_BASE, T_PR_PROV, T_PD_PHYS_HDR, T_DENY_PHYS_HDR, T_PD_DNTL_HDR,T_DENY_DNTL_HDR, T_PD_UB92_HDR, T_DENY_UB92_HDR,T_PD_PHARM_HDR, T_DENY_PHRM_HDR, T_SUSP_PHYS_HDR, T_SUSP_DENTAL_HDR, T_SUSP_PHRM_HDR,T_SUSP_UB92_HDR tables.	4	Character	SEE DESCRIPTION	CDE_ESC
FROM	The first date of service on the claim. This field is a select from union of T_CLAIM_LOCAT,T_CLAIM_ERROR, T_ERROR_DISP, T_RE_BASE, T_PR_PROV, T_PD_PHYS_HDR, T_DENY_PHYS_HDR, T_PD_DNTL_HDR,T_DENY_DNTL_HDR, T_PD_UB92_HDR, T_DENY_UB92_HDR,T_PD_PHARM_HDR, T_DENY_PHRM_HDR, T_SUSP_PHYS_HDR, T_SUSP_DENTAL_HDR, T_SUSP_PHRM_HDR,T_SUSP_UB92_HDR tables.	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	DTE_FIRST_SVC
ICN	The internal control number.This represents the unique internal control number for a Medicaid claim. This field is a select from union of T_CLAIM_LOCAT,T_CLAIM_ERROR,	13	Character	SEE DESCRIPTION	NUM_ICN

Field	Description	Length	Data Type	DB Table	DB Attributes
	T_ERROR_DISP, T_RE_BASE, T_PR_PROV, T_PD_PHYS_HDR, T_DENY_PHYS_HDR, T_PD_DNTL_HDR,T_DENY_DNTL_HDR, T_PD_UB92_HDR, T_DENY_UB92_HDR,T_PD_PHARM_HDR, T_DENY_PHRM_HDR, T_SUSP_PHYS_HDR, T_SUSP_DENTAL_HDR, T_SUSP_PHRM_HDR,T_SUSP_UB92_HDR tables.				
MEMBER ID	The member identification number.This contains the unique identification for the member receiving the services. This field is a select from union of T_CLAIM_LOCAT,T_CLAIM_ERROR, T_ERROR_DISP, T_RE_BASE, T_PR_PROV, T_PD_PHYS_HDR, T_DENY_PHYS_HDR, T_PD_DNTL_HDR,T_DENY_DNTL_HDR, T_PD_UB92_HDR, T_DENY_UB92_HDR,T_PD_PHARM_HDR, T_DENY_PHRM_HDR, T_SUSP_PHYS_HDR, T_SUSP_DENTAL_HDR, T_SUSP_PHRM_HDR,T_SUSP_UB92_HDR tables.	12	Character	SEE DESCRIPTION	ID_MEDICAID
PROVIDER ID	The provider number and the service location for the provider. This field is a select from union of T_CLAIM_LOCAT,T_CLAIM_ERROR, T_ERROR_DISP, T_RE_BASE, T_PR_PROV, T_PD_PHYS_HDR, T_DENY_PHYS_HDR, T_PD_DNTL_HDR,T_DENY_DNTL_HDR,	15	Character	SEE DESCRIPTION	ID_PROVIDER CDE_SERVICE_LOC ATION

Field	Description	Length	Data Type	DB Table	DB Attributes
	T_PD_UB92_HDR, T_DENY_UB92_HDR,T_PD_PHARM_HDR, T_DENY_PHRM_HDR, T_SUSP_PHYS_HDR, T_SUSP_DENTAL_HDR, T_SUSP_PHRM_HDR,T_SUSP_UB92_HDR tables.				
PROVIDER ID TYPE	This is the Provider ID Type. This field is a select from table T_PR_IDENTIFIER	3	Character	SEE DESCRIPTION	CDE_PROV_ID_TYPE
REIMBURSED AMT	The reimbursement amount. This field is a select from union of T_CLAIM_LOCAT,T_CLAIM_ERROR, T_ERROR_DISP, T_RE_BASE, T_PR_PROV, T_PD_PHYS_HDR, T_DENY_PHYS_HDR, T_PD_DNTL_HDR,T_DENY_DNTL_HDR, T_PD_UB92_HDR, T_DENY_UB92_HDR,T_PD_PHARM_HDR, T_DENY_PHRM_HDR, T_SUSP_PHYS_HDR, T_SUSP_DENTAL_HDR, T_SUSP_PHRM_HDR,T_SUSP_UB92_HDR tables.	13	Character	SEE DESCRIPTION	AMT_TOT_REIMB
TO	The last date of service on the claim. This field is a select from union of T_CLAIM_LOCAT,T_CLAIM_ERROR, T_ERROR_DISP, T_RE_BASE, T_PR_PROV, T_PD_PHYS_HDR, T_DENY_PHYS_HDR, T_PD_DNTL_HDR,T_DENY_DNTL_HDR, T_PD_UB92_HDR, T_DENY_UB92_HDR,T_PD_PHARM_HDR,	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	DTE_LAST

Field	Description	Length	Data Type	DB Table	DB Attributes
	T_DENY_PHRM_HDR, T_SUSP_PHYS_HDR, T_SUSP_DENTAL_HDR, T_SUSP_PHRM_HDR,T_SUSP_UB92_HDR tables.				

5.1.15.6 Associated Programs

Program	Description
clm0027d	Transaction Register
copy2routedir	Copy Reports to Router

5.1.16 CLM-0031-M -- Suspense File Analysis by Claim Type 2

This report provides counts and amounts of claims suspended during the current and previous fiscal year periods. The counts/amounts are reported by claim type. For professional claims, counts/amounts are also reported by provider type.

5.1.16.1 Technical Name

CLM-0031-M

5.1.16.2 Sort Order

Claim Type

Provider Type

5.1.16.3 Distribution

OnBase

Jay Hackett

Rhonda Poston

For readability, the report layout displays across several pages.

5.1.16.4 Suspense File Analysis by Claim Type 2 Layout

```
Report  : CLM-0031-M                          COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : CLMJM031                         MEDICAID MANAGEMENT INFORMATION SYSTEM               Run Time:   HH:MM:SS
Location: CLM0031M                          SUSPENSE FILE ANALYSIS BY CLAIM TYPE                    Page:       9999
                                                 MM/DD/CCYY  -  MM/DD/CCYY
```

CLAIM TYPE	FY 2002 NUMBER	FY 2002 DOLLAR VALUE	PREVIOUS FY 2001 NUMBER	PREVIOUS FY 2001 DOLLAR VALUE
XXXXXXXXXX	99,999	999,999,999.99	99,999	999,999,999.99
XXXXXXXXXX	99,999	999,999,999.99	99,999	999,999,999.99
XXXXXXXXXX	99,999	999,999,999.99	99,999	999,999,999.99
XXXXXXXXXX	99,999	999,999,999.99	99,999	999,999,999.99
XXXXXXXXXX	99,999	999,999,999.99	99,999	999,999,999.99
XXXXXXXXXX	99,999	999,999,999.99	99,999	999,999,999.99
XXXXXXXXXX	99,999	999,999,999.99	99,999	999,999,999.99
XXXXXXXXXX	99,999	999,999,999.99	99,999	999,999,999.99
XXXXXXXXXX	99,999	999,999,999.99	99,999	999,999,999.99
XXXXXXXXXX	99,999	999,999,999.99	99,999	999,999,999.99
XXXXXXXXXX	99,999	999,999,999.99	99,999	999,999,999.99
TOTAL	99,999	999,999,999.99	99,999	999,999,999.99

```
Report  : CLM-0031-M                          COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : CLMJM031                       MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: CLM0031M                     SUSPENSE FILE ANALYSIS BY MEDICAL PROVIDER                   Page:        999
                                              MM/DD/CCYY  -  MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------
 PROV                        FY   2002                                PREVIOUS FY   2001
 TYPE                NUMBER      DOLLAR VALUE                      NUMBER      DOLLAR VALUE
-------------------------------------------------------------------------------------------------------------------------
PROV TYPE:  XX       99,999    999,999,999.99                      99,999    999,999,999.99

PROV TYPE:  XX       99,999    999,999,999.99                      99,999    999,999,999.99
PROV TYPE:  XX       99,999    999,999,999.99                      99,999    999,999,999.99
PROV TYPE:  XX       99,999    999,999,999.99                      99,999    999,999,999.99
PROV TYPE:  XX       99,999    999,999,999.99                      99,999    999,999,999.99
PROV TYPE:  XX       99,999    999,999,999.99                      99,999    999,999,999.99

PROV TYPE:  XX       99,999    999,999,999.99                      99,999    999,999,999.99
PROV TYPE:  XX       99,999    999,999,999.99                      99,999    999,999,999.99

PROV TYPE:  XX       99,999    999,999,999.99                      99,999    999,999,999.99
PROV TYPE:  XX       99,999    999,999,999.99                      99,999    999,999,999.99

  TOTAL              99,999    999,999,999.99                      99,999    999,999,999.99

                                          *** END OF REPORT ***
                                       *** NO DATA THIS RUN ***
```

5.1.16.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIM TYPE	The code that specifies the type of claim record.	10	Character	T_MR_PROV_SUSP	CDE_CLM_TYPE
FY CCYY DOLLAR VALUE (by Claim Type)	Total of reimbursement amount for this claim type.	14	Character	T_MR_PROV_SUSP	AMT_BILLED
FY CCYY DOLLAR VALUE (by Provider Type)	Total of reimbursement amount for this provider type.	14	Character	T_MR_PROV_SUSP	AMT_BILLED
FY CCYY NUMBER (by Provider Type)	Count of claims of this provider type.	7	Character	T_MR_PROV_SUSP	CDE_CLM_TYPE

Field	Description	Length	Data Type	DB Table	DB Attributes
FY CCYY NUMBER (by Claim type)	The count of claims.(FY:Fiscal Year, CCYY:Year Format)	7	Character	T_MR_PROV_SUSP	CDE_CLM_TYPE
PREVIOUS FY CCYY DOLLAR VALUE (by Claim Type)	Total of reimbursement amount for this claim type for the previous fiscal year.	14	Character	T_MR_PROV_SUSP	AMT_BILLED
PREVIOUS FY CCYY DOLLAR VALUE (by Provider Type)	Total of reimbursement amount for this provider type for the previous fiscal year.	14	Character	T_MR_PROV_SUSP	AMT_BILLED
PREVIOUS FY CCYY NUMBER (By Claim Type)	Count of claims of this type for the previous fiscal year.	7	Character	T_MR_PROV_SUSP	CDE_CLM_TYPE
PREVIOUS FY CCYY NUMBER (by Provider Type)	Count of claims of this type for the previous fiscal year.	7	Character	T_MR_PROV_SUSP	CDE_PROV_TYPE
PREVIOUS FY CCYY TOTAL NUMBER (By Claim Type)	Count of all claims for the previous fiscal year	7	Character	T_MR_PROV_SUSP	CDE_CLM_TYPE
PREVIOUS FY CCYY TOTAL DOLLAR VALUE (by Claim Type)	Total of reimbursement amount for the previous fiscal year.	14	Character	T_MR_PROV_SUSP	AMT_BILLED
PROV TYPE	Claim type that a provider is licensed for.	2	Character	T_MR_PROV_SUSP	CDE_PROV_TYPE
TOTAL FY CCYY DOLLAR VALUE (by Claim Type)	Total of each dollar value subheading.	14	Character	T_MR_PROV_SUSP	AMT_BILLED

Field	Description	Length	Data Type	DB Table	DB Attributes
TOTAL FY CCYY DOLLAR VALUE (Provider Type)	Total of reimbursement amount.	14	Character	T_MR_PROV_SUSP	AMT_BILLED
TOTAL NUMBER (by Claim Type)	Count of all claims.	7	Character	T_MR_PROV_SUSP	CDE_CLM_TYPE
TOTAL PREVIOUS FY CCYY DOLLAR VALUE (by Provider Type)	Total of reimbursement amount for the previous fiscal year.	14	Character	T_MR_PROV_SUSP	AMT_BILLED
TOTAL PREVIOUS FY CCYY NUMBER (by Provider Type)	Count of all claims for the previous fiscal year.	7	Character	T_MR_PROV_SUSP	CDE_PROV_TYPE

5.1.16.6 Associated Programs

Program	Description
clm0031m	Suspense File Analysis By Claim Type
copy2routedir	Copy Reports to Router

5.1.17 CLM-0046-M -- Potential Schedule 2 Narcotic Drug Abuse

This report summarizes prescribing information relating to narcotic drugs.

5.1.17.1 Technical Name

CLM-0046-M

5.1.17.2 Sort Order

Member ID

5.1.17.3 Distribution

OnBase

For readability, the report layout displays on the next page.

5.1.17.4 Potential Schedule 2 Narcotic Drug Abuse Layout

```
Report  : CLM-0046-M                                   COMMONWEALTH OF KENTUCKY                                   Run Date: MM/DD/CCYY
Process : CLMJM046                                  MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:     HH:MM:SS
Location: CLMP046M                                 POTENTIAL SCHEDULE 2 NARCOTIC DRUG ABUSE                       Page:            99999
                                                          MEMBER NUMBER ORDER
                                                      MM/DD/CCYY  -  MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------------------
MEMBERID      MEMBER NAME                                    PRESC
  PROV+LOC     PROVIDER NAME                                 -NUM-     ICN           DT SERV    DRUG CODE   DRUG NAME                      SUP   QTY
-------------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999

XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999

XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999

XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999
  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99   99099.999

                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```

5.1.17.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
DRUG CODE	The code for drug prescribed.	10	Character	T_DRUG	CDE_NDC
DRUG NAME	The name of drug prescribed.	29	Character	T_DRUG	DSC_NDC
DT SERV	The first date of service.	10	Date (MM/DD/CCYY)	T_DENY_PHRM_HDR	DTE_DISPENSE
ICN	The internal control number.	13	Character	T_DENY_PHRM_HDR	NUM_ICN
MEMBER ID	The member identification number.	12	Character	T_RE_BASE	ID_MEDICAID
MEMBER NAME	The name of member.	28	Character	T_RE_BASE	NAM_LAST, NAM_FIRST
PRESC NUM	The prescriber number.	7	Character	T_DENY_PHRM_HDR	NUM_PRSCRIP
PROV + LOC	The provider identification number and location code.	9	Character	T_PR_PROV,T_DENY_PHRM_HDR	ID_PROVIDER, CDE_SERVICE_LOC
PROVIDER NAME	The provider name on file who wrote the prescription.	50	Character	T_DENY_PHRM_HDR	PROV_BILLING
QTY	The quantity dispensed.	9	Character	T_PD_PHARM_DTL	QTY_DISPENSE
SUP	The days supplied.	2	Number	T_DENY_PHRM_HDR	NUM_DAY_SUPPLY

5.1.17.6 Associated Programs

Program	Description
clmp046m	Potential Narcotic Drug Abuse Report
copy2routedir	Copy Reports to Router

5.1.18 CLM-0050-M -- Retro Active Rate Adjustment Report

This report lists the Retro Active Rate Adjustments by member.

5.1.18.1 Technical Name

CLM-0050-M

5.1.18.2 Sort Order

Member ID

5.1.18.3 Distribution

OnBase

For readability, the layout displays on the next page.

5.1.18.4 Retro Active Rate Adjustment Report Layout

```
Report  : CLM-0050-M                          COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : CLMJM050                       MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: CLM0050M                         RETROACTIVE RATE ADJUSTMENT REPORT                       Page:      99999
                                                MM/DD/CCYY - MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------
MEMBER ID      MEMBER NAME
   ADJ
   SPEND-                                                                  FIRST      LAST                          SPEND-
   DOWN   PAY-TO                SERVING                              DTL DATE OF    DATE OF      REIMBURSED       DOWN
   REASON PROVIDER ID           PROVIDER ID          ICN             NUM SERVICE    SERVICE      AMOUNT           AMOUNT
-------------------------------------------------------------------------------------------------------------------------

XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXX   XXX XXXXXXXXXXXXXXX  XXX XXXXXXXXXXXXXXX  XXXXXXXXXXXXX   9999 MM/DD/YYYY MM/DD/YYYY   999,999.99   999,999.99
   XXXX   XXX XXXXXXXXXXXXXXX  XXX XXXXXXXXXXXXXXX  XXXXXXXXXXXXX   9999 MM/DD/YYYY MM/DD/YYYY   999,999.99   999,999.99
   XXXX   XXX XXXXXXXXXXXXXXX  XXX XXXXXXXXXXXXXXX  XXXXXXXXXXXXX   9999 MM/DD/YYYY MM/DD/YYYY   999,999.99   999,999.99
   XXXX   XXX XXXXXXXXXXXXXXX  XXX XXXXXXXXXXXXXXX  XXXXXXXXXXXXX   9999 MM/DD/YYYY MM/DD/YYYY   999,999.99   999,999.99

XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXX   XXX XXXXXXXXXXXXXXX  XXX XXXXXXXXXXXXXXX  XXXXXXXXXXXXX   9999 MM/DD/YYYY MM/DD/YYYY   999,999.99   999,999.99

XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXX   XXX XXXXXXXXXXXXXXX  XXX XXXXXXXXXXXXXXX  XXXXXXXXXXXXX   9999 MM/DD/YYYY MM/DD/YYYY   999,999.99   999,999.99
   XXXX   XXX XXXXXXXXXXXXXXX  XXX XXXXXXXXXXXXXXX  XXXXXXXXXXXXX   9999 MM/DD/YYYY MM/DD/YYYY   999,999.99   999,999.99
   XXXX   XXX XXXXXXXXXXXXXXX  XXX XXXXXXXXXXXXXXX  XXXXXXXXXXXXX   9999 MM/DD/YYYY MM/DD/YYYY   999,999.99   999,999.99

XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXX   XXX XXXXXXXXXXXXXXX  XXX XXXXXXXXXXXXXXX  XXXXXXXXXXXXX   9999 MM/DD/YYYY MM/DD/YYYY   999,999.99   999,999.99

XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXX   XXX XXXXXXXXXXXXXXX  XXX XXXXXXXXXXXXXXX  XXXXXXXXXXXXX   9999 MM/DD/YYYY MM/DD/YYYY   999,999.99   999,999.99

XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXX   XXX XXXXXXXXXXXXXXX  XXX XXXXXXXXXXXXXXX  XXXXXXXXXXXXX   9999 MM/DD/YYYY MM/DD/YYYY   999,999.99   999,999.99

                                   *** END OF REPORT ***
                                  *** NO DATA THIS RUN ***
```

5.1.18.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
ADJ SPEND-DOWN REASON	The code which identifies the reason for the adjustment.	4	Character	T_EOB	CDE_EOB
FIRST DATE OF SERVICE	The beginning date of service. Is selected from the database table based on the following criteria: If it is. 1. Paid Physician - Select DTE_FIRST_SVC From T_PD_PHYS_HDR 2. Paid Pharmacy - Select DTE_FIRST_SVC FromT_PD_PHARM_HDR 3. Paid Dental - Select DTE_FIRST_SVC From T_PD_DNTL_HDR 4. Paid UB92 - Select DTE_FIRST_SVC From T_PD_UB92_HDR	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	DTE_FIRST_SVC
ICN	Internal control number which uniquely identifies a claim. Field NUM_ICN is selected from the database table based on the following criteria: If it is 1. Paid Physician - Select NUM_ICN From T_PD_PHYS_HDR 2. Paid Pharmacy - Select NUM_ICN From T_PD_PHARM_HDR 3. Paid Dental - Select NUM_ICN From T_PD_DNTL_HDR 4. Paid UB92 - Select NUM_ICN From T_PD_UB92_HDR	13	Character	SEE DESCRIPTION	NUM_ICN
LAST DATE	The ending date of service.	10	Date	SEE DESCRIPTION	DTE_LAST_SVC

Field	Description	Length	Data Type	DB Table	DB Attributes
OF SERVICE	Is selected from the database table based on the following criteria: If it is. 1. Paid Physician - Select DTE_LAST_SVC From T_PD_PHYS_HDR 2. Paid Pharmacy - Select DTE_LAST_SVC FromT_PD_PHARM_HDR 3. Paid Dental - Select DTE_LAST_SVC From T_PD_DNTL_HDR 4. Paid UB92 - Select DTE_LAST_SVC From T_PD_UB92_HDR		(MM/DD/CCYY)		
MEMBER ID	The member identification number which uniquely identifies a member.	12	Character	T_RE_BASE	ID_MEDICAID
MEMBER NAME	The name of member. Consists of Last Name with trailing blanks removed, comma, space, First Name with trailing spaces removed, space, Middle Initial	39	Character	T_RE_BASE	NAM_LAST, NAM_FIRST,NAM_MID_INIT
PAY-TO PROVIDER ID	The provider identification number which uniquely identifies the provider. Tables: T_PR_PROV and the criteria below. Fields:ID_PROVIDER, CDE_SERVICE_LOC. Field CDE_SERVICE_LOC is selected from the database table based on the following criteria: If it is. 1. Paid Physician - Select CDE_SERVICE_LOC From T_PD_PHYS_HDR 2. Paid Pharmacy - Select CDE_SERVICE_LOC From T_PD_PHARM_HDR 3. Paid Dental - Select CDE_SERVICE_LOC	15	Character	SEE DESCRIPTION	SEE DESCRIPTION

Field	Description	Length	Data Type	DB Table	DB Attributes
	From T_PD_DNTL_HDR 4. Paid UB92 - Select CDE_SERVICE_LOC From T_PD_UB92_HDR				
REIMBURSED AMOUNT	The amount paid to provider. Is selected from the database table based on the following criteria: If it is. 1. Paid Physician - Select AMT_TOT_REIMB From T_PD_PHYS_HDR 2. Paid Pharmacy - Select AMT_TOT_REIMB From T_PD_PHARM_HDR 3. Paid Dental - Select AMT_TOT_REIMB From T_PD_DNTL_HDR 4. Paid UB92 - Select AMT_TOT_REIMB From T_PD_UB92_HDR	11	Character	SEE DESCRIPTION	AMT_TOT_REIMB
SERVICING PROVIDER ID TYPE	This is the Provider ID Type.	3	Character	T_PR_IDENTIFIER	CDE_PROV_ID_TYPE
SERVING PROVIDER ID	The service performing provider identification number. Fields: ID_PROVIDER,CDE_SERVICE_LOV Field CDE_SERVICE_LOC is selected from the database table based on the following criteria: If it is. 1. Paid Physician - Select CDE_SERVICE_LOC From T_PD_PHYS_HDR 2. Paid Pharmacy - Select CDE_SERVICE_LOC From T_PD_PHARM_HDR 3. Paid Dental - Select CDE_SERVICE_LOC	15	Character	SEE DESCRIPTION	SEE DESCRIPTION

Field	Description	Length	Data Type	DB Table	DB Attributes
	From T_PD_DNTL_HDR 4. Paid UB92 - Select CDE_SERVICE_LOC From T_PD_UB92_HDR				
SPEND-DOWN AMOUNT	The amount the member has to pay before Medicaid takes over.	9	Character	T_CLM_PATLIAB_X	AMT_PD_PAT_UB92

5.1.18.6 Associated Programs

Program	Description
clm0050m	Retro Active Rate Adjustment Report
copy2routedir	Copy Reports to Router

5.1.19 CLM-0051-D -- Aged Detail Adjustment Report

This report displays the list of claims in suspense for more than 30 days (31 days or longer) sorted by claim type.

5.1.19.1 Technical Name

CLM-0051-D

5.1.19.2 Sort Order

Claim Type

Claim Age (Days)

ICN

Edits

5.1.19.3 Distribution

OnBase

5.1.19.4 Aged Detail Adjustment Report Layout

```
Report  : CLM-0051-D                    COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/YYYY
Process : CLMJD051                  MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: CLM0051D                      AGED DETAIL ADJUSTMENT REPORT                                 Page:       9999
                                              MM/DD/CCYY

THE FOLLOWING CLAIMS IN THE SYSTEM AT LEAST 999 DAYS                                   CLAIM TYPE: DENTAL CLAIMS

ICN                MEMBER ID        PROVIDER+LOC      LOCATION   ERRORS                                          CLAIM-AGE
                                                                                                                  (DAYS)
XXXXXXXXXXXX     XXXXXXXXXXX      XXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX      999
XXXXXXXXXXXX     XXXXXXXXXXX      XXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX      999
XXXXXXXXXXXX     XXXXXXXXXXX      XXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX      999
XXXXXXXXXXXX     XXXXXXXXXXX      XXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX      999
XXXXXXXXXXXX     XXXXXXXXXXX      XXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX      999

                                        *** END OF REPORT ***
                                      *** NO DATA THIS RUN ***
```

5.1.19.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIM AGE(DAYS)	The number of days that an adjustment has been in process.	3	Number	SUSP_CLAIM	CLAIM_AGE
CLAIM TYPE	The claim type description that specifies the type of claim record.	60	Character	SUSP_CLAIM	DSC_CLM_TYP
ERRORS	The error codes the claim failed. Note: There can be multiple occurrences of errors in this field.	50	Character	SUSP_CLAIM	CDE_ESC
ICN	The internal control number.	13	Character	SUSP_CLAIM	NUM_ICN
LOCATION	The code which identifies the suspense location.	2	Number	SUSP_CLAIM	CDE_LOCATION
MEMBER ID	The member identification number. The unique identification for the member receiving the services.	12	Character	SUSP_CLAIM	ID_MEDICAID
NUM DAYS IN SYSTEM	The minimum number of days that the claims have been in the system.	3	Number	SUSP_CLAIM	CALCULATED FIELD
PROVIDER ID	The provider number for the requesting and servicing provider and the service location for the provider.	15	Character	SUSP_CLAIM	ID_PROVIDER + CDE_SERVICE_LOC
PROVIDER ID TYPE	This is the Provider ID Type	3	Character	T_PR_IDENTIFIER	CDE_PROV_ID_TYPE

5.1.19.6 Associated Programs

Program	Description
clm0051d	Aged Detail Adjustment Report
copy2routedir	Copy Reports to Router

5.1.20 CLM-0054-D -- Error Recycle Parameters

This report lists each suspense transaction input to the system. It also displays the error that will be posted when the recycle limit has been exceeded.

5.1.20.1 Technical Name

CLM-0054-D

5.1.20.2 Sort Order

Edit/Audit Number

Claim Type

5.1.20.3 Distribution

OnBase

5.1.20.4 Error Recycle Parameters Layout

```
Report  : CLM-0054-D                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : CLMJD054                 MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: CLM0054D                        ERROR RECYCLE PARAMETERS                            Page:       9999
                                               MM/DD/CCYY

  ERROR            TYPE OF CLAIMS        TYPE OF              RECYCLE            # OF DAYS            FINAL
  CODE              TO RECYCLE           RECYCLE                DAY             TO RECYCLE           ERROR

   9999             XXXXXXXXXX          XXXXXXXXXX            XXXXXXXXX            999               9999
   9999             XXXXXXXXXX          XXXXXXXXXX            XXXXXXXXX            999               9999
   9999             XXXXXXXXXX          XXXXXXXXXX            XXXXXXXXX            999               9999
   9999             XXXXXXXXXX          XXXXXXXXXX            XXXXXXXXX            999               9999
   9999             XXXXXXXXXX          XXXXXXXXXX            XXXXXXXXX            999               9999
   9999             XXXXXXXXXX          XXXXXXXXXX            XXXXXXXXX            999               9999
   9999             XXXXXXXXXX          XXXXXXXXXX            XXXXXXXXX            999               9999
   9999             XXXXXXXXXX          XXXXXXXXXX            XXXXXXXXX            999               9999
   9999             XXXXXXXXXX          XXXXXXXXXX            XXXXXXXXX            999               9999
   9999             XXXXXXXXXX          XXXXXXXXXX            XXXXXXXXX            999               9999

                                   *** END OF REPORT ***
                                 *** NO DATA THIS RUN ***
```

5.1.20.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
# OF DAYS TO RECYCLE	The number of days for the recycle process.	3	Number	T_EDIT_RECYCLE	NUM_DAYS
ERROR CODE	The code used to identifies error.	4	Number	T_ERROR_DISP	CDE_ESC
FINAL ERROR	The final error code.	4	Number	T_ERROR_DISP	CDE_ESC
RECYCLE DAY	The day the claim is recycled.	9	Character	T_EDIT_RECYCLE	NUM_RECYCLE_DAY
TYPE OF CLAIMS TO RECYCLE	The claim type needed to resubmit (ALL CLAIMS / ADJUSTMENTS / ALL BUT ADJUSTMENTS / INVALID).	21	Character	T_EDIT_RECYCLE	IND_TYPE_CLMS
TYPE OF RECYCLE	The type of resubmission (ONGOING / REGULAR / INVALID).	8	Character	T_EDIT_RECYCLE	CDE_RECYCLE_TYPE

5.1.20.6 Associated Programs

Program	Description
clm0054d	Error Recycle Parameters
copy2routedir	Copy Reports to Router

5.1.21 CLM-0055-D -- Daily Error Summary By Claim Type Original Claims

This report shows how many times each error occurred by claim type for the last 5 cycles. (Original Claims)

5.1.21.1 Technical Name

CLM-0055-D

5.1.21.2 Sort Order

Grouped by Claim Type, Sorted by Error Code

5.1.21.3 Distribution

OnBase

5.1.21.4 Daily Error Summary By Claim Type Original Claims Layout

```
Report  : CLM-0055-D                          COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process : CLMJDER2                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLMPER01                  DAILY ERROR SUMMARY BY CLAIM TYPE ORIGINAL CLAIMS                   Page:            999
                                                   MM/DD/CCYY
Claim
Type: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

ERROR                                                   MM/DD/CCYY       MM/DD/CCYY       MM/DD/CCYY       MM/DD/CCYY       MM/DD/CCYY
CODE ERROR DESCRIPTION                                 OCC.    CLAIMS   OCC      CLAIMS   OCC.     CLAIMS   OCC.     RECS     CLAIMS   RECS

XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999

TOTALS BY CLAIM TYPE                                               9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999

GRAND TOTALS                                                      99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999

                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```

```
Report  : CLM-0055-D                          COMMONWEALTH OF KENTUCKY                                   Run Date: MM/DD/CCYY
Process : CLMJDER2                         MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: CLMPER01                      DAILY ERROR SUMMARY BY CLAIM TYPE ORIGINAL CLAIMS                Page:            999
                                                          MM/DD/CCYY
Claim
Type: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

ERROR                                                   MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY
CODE ERROR DESCRIPTION                                OCC.       RECS   OCC.       RECS   OCC.       RECS   OCC.       RECS   OCC.       RECS

XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999

TOTALS BY CLAIM TYPE                                  9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999

GRAND TOTALS                                         99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999


                                                 *** END OF REPORT ***
                                               *** NO DATA THIS RUN ***
```

5.1.21.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIM TYPE	The claim type description that specifies the type of claim record. This is the tag1 field from the clmStat_st structure. These values are initialized in the program.	49	Character	N/A	N/A
CYCLE 1 (DATE)	The run date for cycle 1.	10	Date (MM/DD/CCYY)	N/A	Calculated Field
CYCLE 1 OCC.	The number of occurrences of error codes for cycle 1.	4	Character	N/A	Calculated Field
CYCLE 1 RECS	The number of error records for cycle 1.	4	Character	N/A	Calculated Field
CYCLE 2 (DATE)	The run date for cycle 2.	10	Date (MM/DD/CCYY)	N/A	Calculated Field
CYCLE 2 OCC.	The number of occurrences of error codes for cycle 2.	4	Character	N/A	Calculated Field

Field	Description	Length	Data Type	DB Table	DB Attributes
CYCLE 2 RECS	The number of error records or error codes for cycle 2.	4	Character	N/A	Calculated Field
CYCLE 3 (DATE)	The run date for cycle 3.	10	Date (MM/DD/CCYY)	N/A	Calculated Field
CYCLE 3 OCC.	The number of occurrences of error codes for cycle 3.	4	Character	N/A	Calculated Field
CYCLE 3 RECS	The number of error records or error codes for cycle 3.	4	Character	N/A	Calculated Field
CYCLE 4 (DATE)	The run date for cycle 4.	10	Date (MM/DD/CCYY)	N/A	Calculated Field
CYCLE 4 OCC.	The number of occurrences of error codes for cycle 4.	4	Character	N/A	Calculated Field
CYCLE 4 RECS	The number of error records or error codes for cycle 4.	4	Character	N/A	Calculated Field
CYCLE 5 (DATE)	The run date for cycle 5.	10	Date (MM/DD/CCYY)	N/A	Calculated Field
CYCLE 5 OCC.	The number of occurrences of error codes for cycle 5.	4	Character	N/A	Calculated Field
CYCLE 5 RECS	The number of error records or error codes for cycle 5.	4	Character	N/A	Calculated Field
ERROR CODE	The error code on the claim. This is the CDE_ESC field from the extrInpRec structure associated with the clm01029.srt input file.	3	Number	N/A	N/A
ERROR DESCRIPTION	The error code description on the claim. This is the DSC_ERROR_STAT field from the extrInpRec structure associated with the clm01029.srt input file.	50	Character	N/A	N/A
GRAND TOTAL (CYCLE 1 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 1 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field

Field	Description	Length	Data Type	DB Table	DB Attributes
GRAND TOTAL (CYCLE 2 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 2 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 3 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 3 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 4 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 4 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 5 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 5 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 1 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 1 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Error codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 2 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	Calculated Field

Field	Description	Length	Data Type	DB Table	DB Attributes
TOTAL BY CLAIM TYPE (CYCLE 2 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Error codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 3 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 3 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Error codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 4 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 4 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Error codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 5 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 5 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Error codes.	5	Character	N/A	Calculated Field

5.1.21.6 Associated Programs

Program	Description
clmper01	Daily Error Summary By Claim Type
copy2routedir	Copy Reports to Router

5.1.22 CLM-0056-D -- Daily Error Summary By Claim Type Adjustments

This report shows how many times each error occurred by claim type for the last 5 cycles. (Adjustments)

5.1.22.1 Technical Name

CLM-0056-D

5.1.22.2 Sort Order

Claim Type - Error Code

5.1.22.3 Distribution

OnBase

5.1.22.4 Daily Error Summary By Claim Type Adjustments Layout

```
Report  : CLM-0055-D                          COMMONWEALTH OF KENTUCKY                                    Run Date: MM/DD/CCYY
Process : CLMJDER2                       MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLMPER01                   DAILY ERROR SUMMARY BY CLAIM TYPE ORIGINAL CLAIMS                    Page:            999
                                                      MM/DD/CCYY
Claim
Type: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

ERROR                                                   MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY
CODE ERROR DESCRIPTION                                OCC.       RECS   OCC.       RECS   OCC.       RECS   OCC.       RECS   OCC.       RECS

XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999

TOTALS BY CLAIM TYPE                                      9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999

GRAND TOTALS                                             99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999


                                                  *** END OF REPORT ***
                                                *** NO DATA THIS RUN ***
```

5.1.22.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIM TYPE	The claim type description that specifies the type of claim record. This is the tag1 field from the clmStat_st structure. These values are initialized in the program.	49	Character	N/A	N/A
CYCLE 1 (DATE)	The run date for cycle 1.	10	Date (MM/DD/CCYY)	N/A	Calculated Field
CYCLE 1 OCC.	The number of occurrences of error codes for cycle 1.	4	Character	N/A	Calculated Field
CYCLE 1 RECS	The number of error records for cycle 1.	4	Character	N/A	Calculated Field
CYCLE 2 (DATE)	The run date for cycle 2.	10	Date (MM/DD/CCYY)	N/A	Calculated Field
CYCLE 2 OCC.	The number of occurrences of error codes for cycle 2.	4	Character	N/A	Calculated Field
CYCLE 2 RECS	The number of error records or error codes for cycle 2.	4	Character	N/A	Calculated Field
CYCLE 3 (DATE)	The run date for cycle 3.	10	Date (MM/DD/CCYY)	N/A	Calculated Field
CYCLE 3 OCC.	The number of occurrences of error codes for cycle 3.	4	Character	N/A	Calculated Field
CYCLE 3 RECS	The number of error records or error codes for cycle 3.	4	Character	N/A	Calculated Field
CYCLE 4 (DATE)	The run date for cycle 4.	10	Date (MM/DD/CCYY)	N/A	Calculated Field
CYCLE 4 OCC.	The number of occurrences of error codes for cycle 4.	4	Character	N/A	Calculated Field
CYCLE 4 RECS	The number of error records or error codes for cycle 4.	4	Character	N/A	Calculated Field
CYCLE 5 (DATE)	The run date for cycle 5.	10	Date (MM/DD/CCYY)	N/A	Calculated Field

Field	Description	Length	Data Type	DB Table	DB Attributes
CYCLE 5 OCC.	The number of occurrences of error codes for cycle 5.	4	Character	N/A	Calculated Field
CYCLE 5 RECS	The number of error records or error codes for cycle 5.	4	Character	N/A	Calculated Field
ERROR CODE	The error code on the claim. This is the CDE_ESC field from the extrInpRec structure associated with the clm01029.srt input file.	3	Number	N/A	N/A
ERROR DESCRIPTION	The error code description on the claim. This is the DSC_ERROR_STAT field from the extrInpRec structure associated with the clm01029.srt input file.	50	Character	N/A	N/A
GRAND TOTAL (CYCLE 1 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 1 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 2 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 2 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 3 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 3 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 4 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 4 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field

Field	Description	Length	Data Type	DB Table	DB Attributes
GRAND TOTAL (CYCLE 5 OCC)	Total Number of Records for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
GRAND TOTAL (CYCLE 5 RECS)	Total Number of Unique combinations for all Claim Types on this Cycle Date for all Error codes.	6	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 1 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 1 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Error codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 2 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 2 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Error codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 3 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 3 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Error codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 4 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Errors codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 4 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Error codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 5 OCC)	Total Number of Records for a particular Claim Type on this Cycle Date for all Error codes.	5	Character	N/A	Calculated Field
TOTAL BY CLAIM TYPE (CYCLE 5 RECS)	Total Number of Unique combinations for a particular Claim Type on this Cycle Date for all Error codes.	5	Character	N/A	Calculated Field

5.1.22.6 Associated Programs

Program	Description
clmper01	Daily Error Summary By Claim Type
copy2routedir	Copy Reports to Router

5.1.23 CLM-0058-Q -- ClaimCheck Error Report

This is a savings report that indicates savings generated from clinical products errors, excluding denied claims that are to be rebilled. This report is generated quarterly.

5.1.23.1 Technical Name

CLM-0058-Q

5.1.23.2 Sort Order

Error Code

5.1.23.3 Distribution

OnBase

For readability, the report layout displays on the next page.

5.1.23.4 ClaimCheck Error Report Layout

```
Report  : CLM-0058-Q                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : CLMJQ058                  MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS
Location: CLM0058Q                          CLAIMCHECK ERROR REPORT                           Page:        999
                                          MM/DD/CCYY  -  MM/DD/CCYY
```

ERROR DESCRIPTION	ERROR CODE	TOTAL DTLS	BILLED AMT	ALLOWED AMT
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	999,999	$99,999.99	$99,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	999,999	$99,999.99	$99,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	999,999	$99,999.99	$99,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	999,999	$99,999.99	$99,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	999,999	$99,999.99	$99,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	999,999	$99,999.99	$99,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	999,999	$99,999.99	$99,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	999,999	$99,999.99	$99,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	999,999	$99,999.99	$99,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	999,999	$99,999.99	$99,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	999,999	$99,999.99	$99,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	999,999	$99,999.99	$99,999.99

TOTALS

```
NUMBER OF CLAIMCHECK ERRORS:                                  999,999,999

TOTAL NUMBER OF CLAIM DETAILS PROCESSED:                      999,999,999
TOTAL NUMBER OF CLAIM DETAILS DENIED:                         999,999,999

TOTAL NUMBER OF CC ERRORS POSTED:                             999,999,999
TOTAL NUMBER OF CLAIM DETAILS EDITED WITH CC ERRORS:          999,999,999

TOTAL DOLLARS SAVED BY BILLED AMOUNT:                     $999,999,999.99
TOTAL DOLLARS SAVED BY ALLOWED AMOUNT:                    $999,999,999.99
```

*** END OF REPORT ***

*** NO DATA THIS RUN ***

5.1.23.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
ALLOWED AMT	The sum of allowed amount savings for denied claim procedures with specific error code. This is the old allowed amount, or allowed replace amount for rebundled, less the current allowed amount for detail.	10	Character	N/A	CALCULATED FIELD
BILLED AMT	The sum of billed amount savings for claim procedures with specific error code. This is the old billing amount, or billing replace amount for rebundled, less the current billed amount for detail.	10	Character	N/A	CALCULATED FIELD
ERROR CODE	The ClaimCheck savings error.	5	Number	T_ERROR_DISP	CDE_ESC
ERROR DESCRIPTION	The descriptions of the ClaimCheck Savings error.	49	Character	T_ERROR_DISP	DSC_ERROR_STAT
NUMBER OF CLAIMCHECK ERRORS	The count of the number of ClaimCheck errors included on the report that are considered savings.	11	Character	N/A	CALCULATED FIELD
TOTAL DOLLARS SAVED BY ALLOWED AMOUNT	The total Dollars saved by billed amount. The sum of report body billed amount column.	15	Character	N/A	CALCULATED FIELD
TOTAL DOLLARS SAVED BY BILLED AMOUNT	The total Dollars saved by allowed amount. The sum of report body allowed amount column.	15	Character	N/A	CALCULATED FIELD
TOTAL DTLS	The number details that have the claim check error posted to it.	7	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
TOTAL NUMBER OF CC ERRORS POSTED	The total number of claim check savings errors posted. Sum of total details from report body.	11	Character	N/A	CALCULATED FIELD
TOTAL NUMBER OF CLAIM DETAILS DENIED	The total number of claim details denied by ClaimCheck during the specified time period.	11	Character	N/A	CALCULATED FIELD
TOTAL NUMBER OF CLAIM DETAILS EDITED WITH CC ERRORS	The total number of distinct claim details edited with GMIS and having a savings error.	11	Character	N/A	CALCULATED FIELD
TOTAL NUMBER OF CLAIM DETAILS PROCESSED	The total number of claim details processed by ClaimCheck during the specified time period.	11	Character	N/A	CALCULATED FIELD

5.1.23.6 Associated Programs

Program	Description
clm0058q	ClaimCheck Error
copy2routedir	Copy Reports to Router

5.1.24 CLM-0060-D -- Suspense File Analysis By Claim Type 3

This report lists the number and dollar value totals of the various claim types that are currently in the suspense file. It also includes the same totals for claims that are 1 to 30 days old, 31 to 60 days old, 61 to 90 days old and over 90 days old, as well as totals for each of the above.

5.1.24.1 Technical Name

CLM-0060-D

5.1.24.2 Sort Order

N/A – Totals Only

5.1.24.3 Distribution

OnBase

For readability, the report layout displays on the next page.

5.1.24.4 Suspense File Analysis By Claim Type 3 Layout

```
Report  : CLM-0060-D                          COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : CLMJD060                       MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: CLM0060D                        SUSPENSE FILE ANALYSIS BY CLAIM TYPE                      Page:        999
                                                   MM/DD/CCYY
```

CLAIM TYPE	*-------CURRENT--------* NUMBER	DOLLAR VALUE	*-----01 TO 30 DAYS----* NUMBER	DOLLAR VALUE	*----31 TO 60 DAYS-----* NUMBER	DOLLAR VALUE	*-----61 TO 90 DAYS----* NUMBER	DOLLAR VALUE	*-----OVER 90 DAYS-----* NUMBER	DOLLAR VALUE	AVG DAY
MEDICAL	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	999
DENTAL	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	999
DRUG	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	999
COMPOUND	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	999
HOME HEALTH	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	999
LTC	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	999
XOVER A	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	999
XOVER B	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	999
XOVER C	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	999
INPATIENT	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	999
OUTPATIENT	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	999
TOTAL	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	99,999,999	$999,999.99	999

*** END OF REPORT ***
*** NO DATA THIS RUN ***

5.1.24.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
01 TO 30 DAYS DOLLAR VALUE	The total value of claim type in suspense 1 to 30 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR.2. AMT_BILLED in the table T_SUSP_DENTAL_HDR.3. AMT_BILLED in the table T_SUSP_PHRM_HDR.4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	15	Character	SEE DESCRIPTION	SEE DESCRIPTION
01 TO 30 DAYS DOLLAR VALUE TOTAL	The total value of claims in suspense 1 to 30 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	15	Character	SEE DESCRIPTION	SEE DESCRIPTION
01 TO 30 DAYS NUMBER	The number of claims in suspense 1 to 30 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR.2. AMT_BILLED in the table T_SUSP_DENTAL_HDR. 3. AMT_BILLED in the table T_SUSP_PHRM_HDR.4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	10	Character	SEE DESCRIPTION	SEE DESCRIPTION

Field	Description	Length	Data Type	DB Table	DB Attributes
01 TO 30 DAYS NUMBER TOTAL	The total number of claims in suspense 1 to 30 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	10	Character	SEE DESCRIPTION	SEE DESCRIPTION
31 TO 60 DAYS DOLLAR VALUE	The total value of claim type in suspense 31 to 60 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	15	Character	SEE DESCRIPTION	SEE DESCRIPTION
31 TO 60 DAYS DOLLAR VALUE TOTAL	The total value of claims in suspense 31 to 60 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	15	Character	SEE DESCRIPTION	SEE DESCRIPTION

Field	Description	Length	Data Type	DB Table	DB Attributes
31 TO 60 DAYS NUMBER	The number of claims in suspense 31 to 60 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR.2. AMT_BILLED in the table T_SUSP_DENTAL_HDR.3. AMT_BILLED in the table T_SUSP_PHRM_HDR.4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	10	Character	SEE DESCRIPTION	SEE DESCRIPTION
31 TO 60 DAYS NUMBER TOTAL	The total number of claims in suspense 31 to 60 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	10	Character	SEE DESCRIPTION	SEE DESCRIPTION
61 TO 90 DAYS DOLLAR VALUE	The total value of claim type in suspense 61 to 90 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	15	Character	SEE DESCRIPTION	SEE DESCRIPTION

Field	Description	Length	Data Type	DB Table	DB Attributes
61 TO 90 DAYS DOLLAR VALUE TOTAL	The total value of claims in suspense 61 to 90 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	15	Character	SEE DESCRIPTION	SEE DESCRIPTION
61 TO 90 DAYS NUMBER	The number of claims in suspense 61 to 90 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	10	Character	SEE DESCRIPTION	SEE DESCRIPTION
61 TO 90 DAYS NUMBER TOTAL	The total number of claims in suspense 61 to 90 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	10	Character	SEE DESCRIPTION	SEE DESCRIPTION
AVG DAY	The average claims per day. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	3	Number	SEE DESCRIPTION	SEE DESCRIPTION

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIM TYPE	The claim type description that specifies the type of claim record.	12	Character	N/A	N/A
CURRENT DOLLAR VALUE	The total value of claim type in current day. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR.2. AMT_BILLED in the table T_SUSP_DENTAL_HDR.3. AMT_BILLED in the table T_SUSP_PHRM_HDR. 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	15	Character	SEE DESCRIPTION	SEE DESCRIPTION
CURRENT DOLLAR VALUE TOTAL	The total value of claims on current day. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	15	Character	SEE DESCRIPTION	SEE DESCRIPTION
CURRENT NUMBER	The number of claim type in current day. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR. 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR.3. AMT_BILLED in the table T_SUSP_PHRM_HDR.4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	10	Character	SEE DESCRIPTION	SEE DESCRIPTION

Field	Description	Length	Data Type	DB Table	DB Attributes
CURRENT NUMBER TOTAL	The total number of claims on current day. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	10	Character	SEE DESCRIPTION	SEE DESCRIPTION
OVER 90 DAYS DOLLAR VALUE	The total value of claim type over 90 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	15	Character	SEE DESCRIPTION	SEE DESCRIPTION
OVER 90 DAYS DOLLAR VALUE TOTAL	The total value of claims over 90 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	15	Character	SEE DESCRIPTION	SEE DESCRIPTION
OVER 90 DAYS NUMBER	The number of claims over 90 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	10	Character	SEE DESCRIPTION	SEE DESCRIPTION

Field	Description	Length	Data Type	DB Table	DB Attributes
OVER 90 DAYS NUMBER TOTAL	The total number of claims over 90 days. Data is collected from the following fields: 1. AMT_BILLED in the table T_SUSP_PHYS_HDR 2. AMT_BILLED in the table T_SUSP_DENTAL_HDR 3. AMT_BILLED in the table T_SUSP_PHRM_HDR 4. AMT_BILLED_UB92 in the table T_SUSP_UB92_HDR	10	Character	SEE DESCRIPTION	SEE DESCRIPTION

5.1.24.6 Associated Programs

Program	Description
clm0060d	Suspense File Analysis by Claim Type
copy2routedir	Copy Reports to Router

5.1.25 CLM-0064-W -- Suspended Claims by Claim Type - Region

This weekly report provides the number of suspended claims by region and claim type.

5.1.25.1 Technical Name

CLM-0064-W

5.1.25.2 Sort Order

Claim Region

5.1.25.3 Distribution

OnBase

5.1.25.4 Suspended Claims by Claim Type - Region Layout

```
Report:   CLM-0064-W                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process:  CLMJW064                 MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: CLMPW064                 SUSPENDED CLAIMS BY CLAIM TYPE / REGION                    Page:       9999
                                          MM/DD/CCYY  -  MM/DD/CCYY


                              *-----------------------------------Claim Type Heading One and Two  --------------------------------*
REGION-REGION DESCRIPTION     A-UB   B-1500  C-UB OP  D-DENTAL  H-HOME  I-INPAT  L-LTC  M-1500  O-OUTPAT  P-RX   Q-CMPND  TOTALS  %
                              XOVER  XOVER   XOVER                                                         POS      RX

99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%

TOTAL                        99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  999,999
TOTAL PERCENTAGE              99.9%   99.9%   99.9%     99.9%    99.9%    99.9%   99.9%  99.9%   99.9%    99.9%   99.9%
                                              *** END OF REPORT ***
                                             *** NO DATA THIS RUN ***
```

5.1.25.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
TOTAL PERCENTAGE	The total percentage of all claim type per region.	6	Character	N/A	CALCULATED FIELD
CLAIM TYPE HEADING ONE	The 'English' name of claim type. The claim type description that specifies the type of claim record - heading line one.	25	Character	N/A	N/A

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIM TYPE HEADING TWO	The 'English' name of claim type. The claim type description that specifies the type of claim record - heading line two.	25	Character	N/A	N/A
REGION	The two byte code which represents the claim media and claim type.	2	Number	T_REGION	NUM_REGION
REGION DESCRIPTION	The region description.	25	Character	T_REGION	DESC_REGION
TOTAL	The total of claims per claim type for all regions.	6	Character	N/A	CALCULATED FIELD
TOTAL PERCENTAGE	The percentage of claims per claim type for all regions.	5	Character	N/A	CALCULATED FIELD
TOTALS	The total count of all claim types per region.	6	Character	N/A	CALCULATED FIELD

5.1.25.6 Associated Programs

Program	Description
clmpw064	Suspended Claims by Claim Type / Region
sort	Sort
copy2routedir	Copy Reports to Router

5.1.26 CLM-0065-D -- Aged Suspended Claims By Location Report

This reports lists the totals for aged claims that are 1 to 30 days old, 31 to 60 days old, 61 to 90 days old, and over 90 days old. It also lists the totals for each location, each aged claims period for all the locations, and the grand total.

5.1.26.1 Technical Name

CLM-0065-D

5.1.26.2 Sort Order

Claim Location

ICN

5.1.26.3 Distribution

OnBase

Rhonda Poston

5.1.26.4 Aged Suspended Claims By Location Report Layout

```
Report  : CLM-0065-D                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process : CLMJD065                MEDICAID MANAGEMENT INFORMATION SYSTEM            Run Time:   HH:MM:SS
Location: CLM0065D               AGED SUSPENDED CLAIMS BY LOCATION REPORT               Page:          1
                                              MM/DD/CCYY
```

Location Code	Current to 30 days	Aged > 30 days	Aged > 60 days	Aged > 90 days	Total of all Aged
99	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
99	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
99	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
99	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
99	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
99	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
99	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
99	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
TOTAL	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999

```
*** END OF REPORT ***
*** NO DATA THIS RUN ***
```

5.1.26.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Aged > 30 Days	The total number claims that have been suspended 31 to 60 days.	10	Character	N/A	CALCULATED FIELD
Aged > 60 Days	The total number of claims that have been suspended 61 to 90 days.	10	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Aged > 90 days	The total number of claims that have been suspended 91 days or greater.	10	Character	N/A	CALCULATED FIELD
Current to 30 Days	The total number of claims that have been suspended for 1 to 30 days.	10	Character	N/A	CALCULATED FIELD
Location Code	The location code.	2	Character	T_CLAIM_LOCAT	CDE_LOCATION
Total	The total of each subheading.	10	Character	N/A	CALCULATED FIELD
Total of all Aged	The total number of claims that are aged.	10	Character	N/A	CALCULATED FIELD

5.1.26.6 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
clm0065d	Aged Suspended Claims By Location Report

5.1.27 CLM-0130-D -- Claims Submission Statistics - Daily

This report provides a daily summary of claim counts sent to the claims engine by submission type (NCPDP, WEB DDE, ASC x12). It reports at the summary level, and at the submitter level.

5.1.27.1 Technical Name

CLM-0130-D

5.1.27.2 Sort Order

Batch Code

Claim Type

Claim Status

Batch Sender

Claim Type

Claim Status

5.1.27.3 Distribution

OnBase

For readability, the report layout displays across several pages.

5.1.27.4 Claims Submission Statistics – Daily Layout

```
Report   : CLM-0130-D                    COMMONWEALTH OF KENTUCKY                    Run Date:  MM/DD/CCYY
Process  : CLMJD130                 MEDICAID MANAGEMENT INFORMATION SYSTEM           Run Time:    HH:MM:SS
Location: CLM0130                    CLAIMS SUBMISSION STATISTICS - DAILY                Page:        9999
                                              MM/DD/CCYY
```

Submission Type	Claim Type	Accepted Claims	Suspended Claims	Paid Claims	Denied Claims
NCPDP		**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
WEB DDE		**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
ASC X12		**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
System Total		**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**

Sender: Submitter 1 Submission Type: NCPDP

Claim Type	Accepted Claims	Suspended Claims	Paid Claims	Denied Claims
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
Total	**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**

Sender: Submitter 2 Submission Type: WEB DDE

Claim Type	Accepted Claims	Suspended Claims	Paid Claims	Denied Claims
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
Total	**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**

Sender: Submitter 3 Submission Type: ASC X12

Claim Type	Accepted Claims	Suspended Claims	Paid Claims	Denied Claims
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
Total	**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**

*** END OF REPORT ***
*** NO DATA THIS RUN ***

5.1.27.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Accepted Transactions	Total count of claims submitted by indicated submission type and sent to the claims engine. This total should equal the count of suspended, paid, and denied claims in this report.	11	Character	CALCULATED FIELD	CALCULATED FIELD
Accepted Transactions (By Submitter Code, Submission Type)	Total count of claims submitted by indicated submission type and Submitter Code, and sent to the claims engine. This total should equal the count of suspended, paid, and denied claims in this report.	11	Character	CALCULATED FIELD	CALCULATED FIELD
Accepted Transactions (Submission Type)	Total count of claims submitted. By Submission Type.	11	Character	CALCULATED FIELD	CALCULATED FIELD
Claim Type	The claim type description that specifies the type of claim record.	25	Character	CALCULATED FIELD	CALCULATED FIELD
Claim Type (Submission Type)	Claim Type.	15	Character	CALCULATED FIELD	CALCULATED FIELD
Claims Denied	Total count of claims submitted by indicated submission type, sent to the claims engine, and denied by the claims engine.	11	Character	CALCULATED FIELD	CALCULATED FIELD
Claims Denied (Submission Type)	The total count of claims submitted and denied by the claims engine.	11	Character	CALCULATED FIELD	CALCULATED FIELD
Claims Denied(By Submitter Code, Submission Type)	Total count of claims submitted by indicated submission type and submitter code, sent to the claims engine, and denied by the claims engine	11	Character	CALCULATED FIELD	CALCULATED FIELD
Claims Not Processed	Total count of non-adjudicated claims	11	Character	CALCULATED FIELD	CALCULATED FIELD
Claims Paid	Total count of claims submitted by indicated submission type, sent to the claims engine, and paid by the claims engine.	11	Character	CALCULATED FIELD	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Claims Paid (Submission Type)	The total count of claims submitted and paid by the claims engine.	11	Character	CALCULATED FIELD	CALCULATED FIELD
Claims Paid(By Submitter Code, Submission Type)	Total count of claims submitted by indicated submission type and submitter code, sent to the claims engine, and paid by the claims engine	11	Character	CALCULATED FIELD	CALCULATED FIELD
Claims Suspended	Total count of claims submitted by indicated submission type, sent to the claims engine, and suspended by the claims engine.	11	Character	CALCULATED FIELD	CALCULATED FIELD
Claims Suspended (Submission Type)	The total count of claims submitted and suspended by the claims engine.	11	Character	CALCULATED FIELD	CALCULATED FIELD
Claims Suspended (By Submitter Code, Submission Type)	Total count of claims submitted by indicated submission type, sent to the claims engine, and suspended by the claims engine	11	Character	CALCULATED FIELD	CALCULATED FIELD
Claims Void	Total count of claims submitted by indicated submission type, sent to the claims engine, and void by the claims engine.	11	Character	CALCULATED FIELD	CALCULATED FIELD
Claims Void (Submission Type)	The total count of claims submitted and void by the claims engine.	11	Character	CALCULATED FIELD	CALCULATED FIELD
Claims Void(By Submitter Code, Submission Type)	Total count of claims submitted by indicated submission type and submitter code, sent to the claims engine, and voided by the claims engine	11	Character	CALCULATED FIELD	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Filename	Filename is composed of: MEDIA:- is the media type (web, disk, tape, cdrom, ftp,TCP/IP) SAK_UPLOAD:- is a 9-digit number that uniquely identifies this batch TPID:- is a 10-digit ID that identifies the submitting entity TXN is the transaction type (837P, 837I, 837D, 270, 276, NCPDP, etc. -- claims would only be the 837x and NCPDP types)	255	Character	T_BATCH	CALCULATED FIELD
Submission Type	The origination of transmission (NCPDP, WEB DDE, ASC X12, RRI).	15	Character	T_BATCH,T_TRANSACTION	CALCULATED FIELD
Submitter	The submitter Code for the claim	50	Character	T_BATCH	SENDER
System Totals (Accepted Transactions)	Total of Accepted Transactions for all Submissions Type.	11	Character	CALCULATED FIELD	CALCULATED FIELD
System Totals (Claims Denied)	Total of Claims Denied for all Submissions Type.	11	Character	CALCULATED FIELD	CALCULATED FIELD
System Totals (Claims Paid)	Total of Claims Paid for all Submissions Type.	11	Character	CALCULATED FIELD	CALCULATED FIELD
System Totals (Claims Suspended)	Total of Claims Suspended for all Submissions Type.	11	Character	CALCULATED FIELD	CALCULATED FIELD
System Totals (Claims Void)	Total of Claims Void for all Submissions Type.	11	Character	CALCULATED FIELD	CALCULATED FIELD
System Totals (Total Claim Type)	Total of Total Claim Type for all Submissions Type.	11	Character	CALCULATED FIELD	CALCULATED FIELD
Total Claim Type	Total per line of each claim type.	11	Character	CALCULATED FIELD	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Total Claim Type (Submission Type)	Total per line of each claim type by Submission Type.	11	Character	CALCULATED FIELD	CALCULATED FIELD
Total(Accepted Transactions (By Submitter Code, Submission Type)	Total count of claims submitted. By Submission Type and Submitter Code	11	Character	CALCULATED FIELD	CALCULATED FIELD
Total(Claims Denied(By Submitter Code, Submission Type))	Total count of claims submitted and denied by the claims engine. By Submission Type and Submitter Code	11	Character	CALCULATED FIELD	CALCULATED FIELD
Total(Claims Paid(By Submitter Code, Submission Type)	Total count of claims submitted and paid by the claims engine. By Submission Type and Submitter Code	11	Character	CALCULATED FIELD	CALCULATED FIELD
Total(Claims Suspended (By Submitter Code, Submission Type))	Total count of claims submitted and Suspended by the claims engine. By Submission Type and Submitter Code	11	Character	CALCULATED FIELD	CALCULATED FIELD
Total(Claims Void(By Submitter Code, Submission Type)	Total count of claims submitted and void by the claims engine. By Submission Type and Submitter Code	11	Character	CALCULATED FIELD	CALCULATED FIELD
Total(Total_Claim_Type(By Submitter, By Submission code))	Total per line of each claim type by Submission Type for Submitter Code	11	Character	CALCULATED FIELD	CALCULATED FIELD
Total_Claim_Type(By Submitter, By Submission code)	Total per line of each claim type	11	Character	CALCULATED FIELD	

5.1.27.6 Associated Programs

Program	Description

Program	Description
clm0130	Claims Submission Statistics
copy2routedir	Copy Reports to Router

5.1.28 CLM-0130-M -- Claims Submission Statistics - Monthly

This report provides a monthly summary of claim counts sent to the claims engine by submission type (NCPDP, WEB DDE, ASC x12). It reports at the summary level, and at the submitter level.

5.1.28.1 Technical Name

CLM-0130-M

5.1.28.2 Sort Order

Batch Code

Claim Type

Claim Status

Batch Sender

Claim Type

Claim Status

5.1.28.3 Distribution

OnBase

For readability, the report layout displays across several pages.

5.1.28.4 Claims Submission Statistics - Monthly Layout

```
Report  : CLM-0130-M                    COMMONWEALTH OF KENTUCKY                    Run Date:  MM/DD/CCYY
Process : CLMJM130                 MEDICAID MANAGEMENT INFORMATION SYSTEM           Run Time:    HH:MM:SS
Location: CLM0130                   CLAIMS SUBMISSION STATISTICS - MONTHLY               Page:        9999
                                          MM/DD/CCYY  -  MM/DD/CCYY
```

Submission Type	Claim Type	Accepted Claims	Claims Suspended	Claims Paid	Claims Denied
NCPDP		**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
WEB DDE		**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
ASC X12		**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
System Total		**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**

Sender: Submitter 1 Submission Type: NCPDP

Claim Type	Accepted Claims	Claims Suspended	Claims Paid	Claims Denied
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
Total	**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**

Sender: Submitter 2 Submission Type: WEB DDE

Claim Type	Accepted Claims	Claims Suspended	Claims Paid	Claims Denied
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
Total	**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**

Sender: Submitter 3 Submission Type: ASC X12

Claim Type	Accepted Claims	Claims Suspended	Claims Paid	Claims Denied
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
Total	**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**

*** END OF REPORT ***
*** NO DATA THIS RUN ***

5.1.28.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Accepted Claims	Total count of claims submitted by indicated submission type and sent to the claims engine. This total should equal the count of suspended, paid, and denied claims in this report.	11	Character	N/A	CALCULATED FIELD
Accepted Claims (Submission Type)	Total count of claims submitted. By Submission Type.	11	Character	N/A	CALCULATED FIELD
Accepted Transactions (By Submitter Code, Submission Type)	Total count of claims submitted by indicated submission type and Submitter Code, and sent to the claims engine. This total should equal the count of suspended, paid, and denied claims in this report.	11	Character	N/A	CALCULATED FIELD
Claim Type	MMIS Claim Type.	11	Character	T_CLAIM_TYPE	DSC_CLM_TYP
Claim Type (Submission Type)	Claim Type.	15	Character	DSC_CLM_TYP	T_CLAIM_TYPE
Claims Denied	Total count of claims submitted by indicated submission type, sent to the claims engine, and denied by the claims engine.	11	Character	N/A	CALCULATED FIELD
Claims Denied (Submission Type)	Total count of claims submitted and denied by the claims engine. By Submission Type.	11	Character	N/A	CALCULATED FIELD
Claims Denied(By Submitter Code, Submission Type)	Total count of claims submitted by indicated submission type and submitter code, sent to the claims engine, and denied by the claims engine	11	Character	N/A	CALCULATED FIELD
Claims Not Processed	Total count of non-adjudicated claims	11	Character	N/A	CALCULATED FIELD
Claims Paid	Total count of claims submitted by indicated submission type, sent to the claims engine, and paid by the claims engine.	11	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Claims Paid (Submission Type)	Total count of claims submitted and paid by the claims engine. By Submission Type.	11	Character	N/A	CALCULATED FIELD
Claims Paid(By Submitter Code, Submission Type)	Total count of claims submitted by indicated submission type and submitter code, sent to the claims engine, and paid by the claims engine	11	Character	N/A	CALCULATED FIELD
Claims Suspended	Total count of claims submitted by indicated submission type, sent to the claims engine, and suspended by the claims engine.	11	Character	N/A	CALCULATED FIELD
Claims Suspended (By Submitter Code, Submission Type)	Total count of claims submitted by indicated submission type and Submitter Code, sent to the claims engine, and suspended by the claims engine	11	Character	N/A	CALCULATED FIELD
Claims Suspended (Submission Type)	Total count of claims submitted and Suspended by the claims engine. By Submission Type.	11	Character	N/A	CALCULATED FIELD
Filename	Filename is composed of: MEDIA:- is the media type (web, disk, tape, cdrom, ftp,TCP/IP) SAK_UPLOAD:- is a 9-digit number that uniquely identifies this batch TPID:- is a 10-digit ID that identifies the submitting entity TXN is the transaction type (837P, 837I, 837D, 270, 276, NCPDP, etc. -- claims would only be the 837x and NCPDP types)	255	Character	T_BATCH	FILENAME
Submission Type	The origination of transmission (NCPDP, WEB DDE, ASC X12 and RRI).	15	Character	T_BATCH	CDE_SUBMIT
Submitter Code	The submitter Code for the claim	50	Character	T_BATCH	SENDER

Field	Description	Length	Data Type	DB Table	DB Attributes
System Totals (Accepted Claims)	Total of Accepted Transactions for all Submissions Type.	11	Character	N/A	CALCULATED FIELD
System Totals (Claims Denied)	Total of Claims Denied for all Submissions Type.	11	Character	N/A	CALCULATED FIELD
System Totals (Claims Paid)	Total of Claims Paid for all Submissions Type.	11	Character	N/A	CALCULATED FIELD
System Totals (Claims Suspended)	Total of Claims Suspended for all Submissions Type.	11	Character	N/A	CALCULATED FIELD
Totals(Submission Type and Submitter Code(Accepted Claims)	Total of Accepted Claims per Submission Type and Submitter code	11	Character	N/A	CALCULATED FIELD
Totals(Submission Type(Claims Denied)	Total of Claims Denied per Submission Type and Submitter Code	11	Character	CALCULATED FIELD	N/A
Totals(Submission Type(Claims Paid)	Total of Claims Paid per Submission Type and Submitter Code	11	Character	CALCULATED FIELD	N/A
Totals(Submission Type(Claims Suspended)	Total of Claims Suspended per Submission Type and Submitter Code	11	Character	CALCULATED FIELD	N/A

5.1.28.6 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
clm0130	Claims Submission Statistics

5.1.29 CLM-0130-W -- Claims Submission Statistics - Weekly

This report provides a weekly summary of claim counts sent to the claims engine by submission type (NCPDP, WEB DDE, ASC x12). It reports at the summary level, and at the submitter level.

5.1.29.1 Technical Name

CLM-0130-W

5.1.29.2 Sort Order

Batch Code

Claim Type

Claim Status

Batch Sender

Claim Type

Claim Status

5.1.29.3 Distribution

OnBase

For readability, the report layout displays across several pages.

5.1.29.4 Claims Submission Statistics - Weekly Layout

```
Report  : CLM-0130-W                    COMMONWEALTH OF KENTUCKY                    Run Date:  MM/DD/CCYY
Process : CLMJW130                MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time:    HH:MM:SS
Location: CLM0130                 CLAIMS SUBMISSION STATISTICS - WEEKLY               Page:        9999
                                        MM/DD/CCYY  -  MM/DD/CCYY
```

Submission Type	Claim Type	Accepted Claims	Claims Suspended	Claims Paid	Claims Denied
NCPDP		**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
WEB DDE		**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
ASC X12		**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
	xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
System Total		**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**

Sender: Submitter 1 Submission Type: NCPDP

Claim Type	Accepted Claims	Claims Suspended	Claims Paid	Claims Denied
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
Total	**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**

Sender: Submitter 2 Submission Type: WEB DDE

Claim Type	Accepted Claims	Claims Suspended	Claims Paid	Claims Denied
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
Total	**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**

Sender: Submitter 3 Submission Type: ASC X12

Claim Type	Accepted Claims	Claims Suspended	Claims Paid	Claims Denied
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
xxxxxxxx	999,999,999	999,999,999	999,999,999	999,999,999
Total	**999,999,999**	**999,999,999**	**999,999,999**	**999,999,999**

*** END OF REPORT ***

*** NO DATA THIS RUN ***

5.1.29.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Accepted Claims	Total count of claims submitted by indicated submission type and sent to the claims engine. This total should equal the count of suspended, paid, and denied claims in this report.	11	Character	N/A	CALCULATED FIELD
Accepted Claims (Submission Type)	Total count of claims submitted. By Submission Type.	11	Character	N/A	CALCULATED FIELD
Accepted Transactions (By Submitter Code, Submission Type)	Total count of claims submitted by indicated submission type and Submitter Code, and sent to the claims engine. This total should equal the count of suspended, paid, and denied claims in this report.	11	Character	N/A	CALCULATED FIELD
Claim Type	MMIS Claim Type.	11	Character	T_CLAIM_TYPE	DSC_CLM_TYP
Claim Type (Submission Type)	Claim Type.	15	Character	DSC_CLM_TYP	T_CLAIM_TYPE
Claims Denied	Total count of claims submitted by indicated submission type, sent to the claims engine, and denied by the claims engine.	11	Character	N/A	CALCULATED FIELD
Claims Denied (Submission Type)	Total count of claims submitted and denied by the claims engine. By Submission Type.	11	Character	N/A	CALCULATED FIELD
Claims Denied(By Submitter Code, Submission Type)	Total count of claims submitted by indicated submission type and submitter code, sent to the claims engine, and denied by the claims engine	11	Character	N/A	CALCULATED FIELD
Claims Not Processed	Total count of non-adjudicated claims	11	Character	N/A	CALCULATED FIELD
Claims Paid	Total count of claims submitted by indicated submission type, sent to the claims engine, and paid by the claims engine.	11	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Claims Paid (Submission Type)	Total count of claims submitted and paid by the claims engine. By Submission Type.	11	Character	N/A	CALCULATED FIELD
Claims Paid(By Submitter Code, Submission Type)	Total count of claims submitted by indicated submission type and submitter code, sent to the claims engine, and paid by the claims engine	11	Character	N/A	CALCULATED FIELD
Claims Suspended	Total count of claims submitted by indicated submission type, sent to the claims engine, and suspended by the claims engine.	11	Character	N/A	CALCULATED FIELD
Claims Suspended (By Submitter Code, Submission Type)	Total count of claims submitted by indicated submission type and Submitter Code, sent to the claims engine, and suspended by the claims engine	11	Character	N/A	CALCULATED FIELD
Claims Suspended (Submission Type)	Total count of claims submitted and Suspended by the claims engine. By Submission Type.	11	Character	N/A	CALCULATED FIELD
Filename	Filename is composed of: MEDIA:- is the media type (web, disk, tape, cdrom, ftp,TCP/IP) SAK_UPLOAD:- is a 9-digit number that uniquely identifies this batch TPID:- is a 10-digit ID that identifies the submitting entity TXN is the transaction type (837P, 837I, 837D, 270, 276, NCPDP, etc. -- claims would only be the 837x and NCPDP types)	255	Character	T_BATCH	FILENAME
Submission Type	The origination of transmission (NCPDP, WEB DDE, ASC X12 and RRI).	15	Character	T_BATCH	CDE_SUBMIT
Submitter Code	The submitter Code for the claim	50	Character	T_BATCH	SENDER

Field	Description	Length	Data Type	DB Table	DB Attributes
System Totals (Accepted Claims)	Total of Accepted Transactions for all Submissions Type.	11	Character	N/A	CALCULATED FIELD
System Totals (Claims Denied)	Total of Claims Denied for all Submissions Type.	11	Character	N/A	CALCULATED FIELD
System Totals (Claims Paid)	Total of Claims Paid for all Submissions Type.	11	Character	N/A	CALCULATED FIELD
System Totals (Claims Suspended)	Total of Claims Suspended for all Submissions Type.	11	Character	N/A	CALCULATED FIELD
Totals(Submission Type and Submitter Code(Accepted Claims)	Total of Accepted Claims per Submission Type and Submitter code	11	Character	N/A	CALCULATED FIELD
Totals(Submission Type(Claims Denied)	Total of Claims Denied per Submission Type and Submitter Code	11	Character	CALCULATED FIELD	
Totals(Submission Type(Claims Paid)	Total of Claims Paid per Submission Type and Submitter Code	11	Character	CALCULATED FIELD	
Totals(Submission Type(Claims Suspended)	Total of Claims Suspended per Submission Type and Submitter Code	11	Character	CALCULATED FIELD	

5.1.29.6 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
clm0130	Claims Submission Statistics

5.1.30 CLM-0132-D -- Encounters Submission Statistics - Daily

This report provides a daily Encounters Submission Statistics summary of claim counts sent to the claims engine by submission type (NCPDP, ASC x12).

5.1.30.1 Technical Name

CLM-0132-D

5.1.30.2 Sort Order

The first section of the report:
Batch Code

Claim Type

Claim Status

The second section of the report:
Pharmacy Submitter

5.1.30.3 Distribution

OnBase

For readability, the report layout displays across several pages.

5.1.30.4 Encounters Submission Statistics - Daily Layout

```
Report:   CLM-0132-D                    COMMONWEALTH OF KENTUCKY                    Run Date:  MM/DD/CCYY
Process:  CLMJD132                  MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time:    HH:MM SS
Location: CLM0132                 ENCOUNTERS SUBMISSION STATISTICS - DAILY              Page:       99999
                                              MM/DD/CCYY
```

Submission Type	Claim Type	Encounters Paid	Encounters Denied	Encounters Threshold	Encounters Informational	Encounters Void	Total Claim Type
837	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
Total		xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
NCPDP	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
Total		xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
System Totals		xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx

```
    Submitter 1          Submission Type: 837

Claim Type               Encounters      Encounters      Encounters      Encounters      Encounters      Total
                         Paid            Denied          Threshold       Informational   Void            Claim Type

xxxxxxxxxxxxxxx          xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx
xxxxxxxxxxxxxxx          xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx
xxxxxxxxxxxxxxx          xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx

Totals                   xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx

    Submitter 2          Submission Type: NCPDP

Claim Type               Encounters      Encounters      Encounters      Encounters      Encounters      Total
                         Paid            Denied          Threshold       Informational   Void            Claim Type

xxxxxxxxxxxxxxx          xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx
xxxxxxxxxxxxxxx          xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx
xxxxxxxxxxxxxxx          xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx

Totals                   xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx     xxx,xxx,xxx

                                  *** END OF REPORT ***
                                ***NO DATA THIS REPORT ***
```

5.1.30.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Claim Type (By Submission Type)	The claim type description that specifies the type of claim record.	15	Character	T_CLAIM_TYPE	DSC_CLM_TYPE
Claim Type (By Submitter and Submission Type)	The claim type description that specifies the type of claim record.	15	Character	T_CLAIM_TYPE	DSC_CLM_TYPE
Encounters Denied (By Submitter and Submission Type)	The total count of encounters submitted and denied by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Encounters Denied (By Submission Type)	The total count of encounters submitted by indicated submission type, sent to the claims engine, and denied by the claims engine.	11	Character	N/A	CALCULATED FIELD
Encounters Informational (By Submission Type)	The error disposition for encounters claims. (I) - Informational.	11	Character	N/A	CALCULATED FIELD
Encounters Informational (By Submitter and Submission Type)	The total count of encounters submitted and informational by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Encounters Paid (By Submitter and Submission Type).	The total count of encounters submitted and processed by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Encounters Paid (By Submission Type)	The total count of encounters submitted by indicated submission type, sent to the claims engine, and processed by the claims engine.	11	Character	N/A	CALCULATED FIELD
Encounters Threshold (By Submission Type)	The error disposition for encounters claims. (T) - Threshold.	11	Character	N/A	CALCULATED FIELD
Encounters Threshold (By Submitter and Submission Type)	The total count of encounters submitted and Threshold by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Encounters Void (By Submission Type)	The total count of encounters submitted by indicated submission type, sent to the claims engine, and void by the claims engine.	11	Character	N/A	CALCULATED FIELD
Encounters Void (By Submitter and Submission Type)	The total count of encounters submitted and void by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Submission Type (By Submission Type)	The origination of transmission. This field can have the following values: NCPDP (National Council for Prescription Drug Programs), ASC X12.	15	Character	T_BATCH	CDE_SUBMIT
Submission Type (By Submitter and Submission Type)	The origination of transmission. This field can have the following values: NCPDP (National Council for Prescription Drug Programs), ASC X12.	15	Character	N/A	CALCULATED FIELD
Submitter (By Submitter and Submission Type)	The Submitter ID on electronic claims or encounters.	16	Character	T_BATCH	CDE_SUBMIT
System Totals - Total Claim Type	The total of Claim type for all submission Types.	11	Character	N/A	CALCULATED FIELD
System Totals - Encounters Denied	The total of Encounters Denied for all Submission Types.	11	Character	N/A	CALCULATED FIELD
System Totals - Encounters Informational	The total of Encounters Informational for all Submission Types.	11	Character	N/A	CALCULATED FIELD
System Totals - Encounters Paid	The total of Encounters Paid for all Submission Types.	11	Character	N/A	CALCULATED FIELD
System Totals - Encounters Threshold	The total of Encounters Threshold for all Submission Types.	11	Character	N/A	CALCULATED FIELD
System Totals - Encounters Void	The total of Encounters Void for all Submission Types.	11	Character	N/A	CALCULATED FIELD
Total -Encounters Denied	The total of Encounters Denied for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total -Encounters Informational	The total of Encounters Informational for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total -Encounters Paid	The total of Encounters Paid for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Total -Encounters Threshold	The total of Encounters Threshold for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total -Encounters Void	The total of Encounters Void for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total -Total Claim Type	The total of Total Encounter Type for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total Claim Type	The total per line of each encounter type for the indicated submission type.	11	Character	N/A	CALCULATED FIELD
Total Claim Type (By Submitter and Submission Type)	The total per line of each encounter type for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Totals -Encounters Denied (By Submitter and Submission Type)	The total of Encounters Denied for the Submitter and Submission Type combination.	11	Character	N/A	CALCULATED FIELD
Totals -Encounters Informational (By Submitter and Submission Type)	The totals -Encounters Informational -By Submitter / Submission Type	11	Character	N/A	CALCULATED FIELD
Totals -Encounters Paid (By Submitter and Submission Type)	The total of Encounters Paid for the Submitter and Submission Type combination.	11	Character	N/A	CALCULATED FIELD
Totals -Encounters Void (By Submitter and Submission Type)	The total of Encounters Void for the Submitter and Submission Type combination.	11	Character	N/A	CALCULATED FIELD
Totals -Encounters threshold (By Submitter and Submission Type)	The total of Encounters Threshold for the Submitter and Submission Type combination.	11	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Totals -Total Claim Type (By Submitter and Submission Type)	The total of Encounter for the submitter and submission Type combination.	11	Character	N/A	CALCULATED FIELD

5.1.30.6 Associated Programs

Program	Description
clm0132	Encounters Submission Statistics
copy2routedir	Copy Reports to Router

5.1.31 CLM-0132-M -- Encounters Submission Statistics - Monthly

This report provides a Monthly Encounters Submission Statistics summary of claim counts sent to the claims engine by submission type (NCPDP, ASC x12).

5.1.31.1 Technical Name

CLM-0132-M

5.1.31.2 Sort Order

The first section of the report:
Batch Code

Claim Type

Claim Status

The second section of the report:
Pharmacy Submitter

5.1.31.3 Distribution

OnBase

For readability, the report layout displays across several pages.

5.1.31.4 Encounters Submission Statistics - Monthly Layout

```
Report:   CLM-0132-M                    COMMONWEALTH OF KENTUCKY                    Run Date:  MM/DD/CCYY
Process:  CLMJM132                MEDICAID MANAGEMENT INFORMATION SYSTEM            Run Time:    HH:MM SS
Location: CLM0132                ENCOUNTERS SUBMISSION STATISTICS - MONTHLY         Page:          99999
                                        MM/DD/CCYY  -  MM/DD/CCYY
```

Submission Type	Claim Type	Encounters Paid	Encounters Denied	Encounters Threshold	Encounters Informational	Encounters Void	Total Claim Type
837	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
Total		xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
NCPDP	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
Total		xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
System Totals		xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx

```
    Submitter 1          Submission Type: 837

Claim Type               Encounters     Encounters     Encounters     Encounters     Encounters     Total
                         Paid           Denied         Threshold      Informational  Void           Claim Type

xxxxxxxxxxxxxx           xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx
xxxxxxxxxxxxxx           xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx
xxxxxxxxxxxxxx           xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx

Totals                   xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx

    Submitter 2          Submission Type: NCPDP

Claim Type               Encounters     Encounters     Encounters     Encounters     Encounters     Total
                         Paid           Denied         Threshold      Informational  Void           Claim Type

xxxxxxxxxxxxxx           xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx
xxxxxxxxxxxxxx           xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx
xxxxxxxxxxxxxx           xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx

Totals                   xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx

                                  *** END OF REPORT ***
                                ***NO DATA THIS REPORT ***
```

5.1.31.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Claim Type	The 'English' name of claim type. The claim type description that specifies the type of claim record.	15	Character	T_CLAIM_TYPE	DSC_CLM_TYPE
Claim Type -By Submitter / Submission Type.	The 'English' name of claim type. The claim type description that specifies the type of claim record.	15	Character	T_CLAIM_TYPE	DSC_CLM_TYPE

Field	Description	Length	Data Type	DB Table	DB Attributes
Encounters Denied -By Submitter / Submission Type.	The total count of encounters submitted and denied by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Encounters Denied.	The total count of encounters submitted by indicated submission type, sent to the claims engine, and denied by the claims engine.	11	Character	N/A	CALCULATED FIELD
Encounters Informational	The error disposition for encounters claims. (I) - Informational.	11	Character	N/A	CALCULATED FIELD
Encounters Informational -By Submitter / Submission Type	The total count of encounters submitted and informational by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Encounters Paid -By Submitter / Submission Type.	The total count of encounters submitted and processed by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Encounters Paid.	The total count of encounters submitted by indicated submission type, sent to the claims engine, and processed by the claims engine.	11	Character	N/A	CALCULATED FIELD
Encounters Threshold	The error disposition for encounters claims. (T) - Threshold.	11	Character	N/A	CALCULATED FIELD
Encounters Threshold - By Submitter / Submission Type	The total count of encounters submitted and Threshold by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Encounters Void	The total count of encounters submitted by indicated submission type, sent to the claims engine, and void by the claims engine.	11	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Encounters Void -By Submitter / Submission Type	The total count of encounters submitted and void by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Submission Type	The origination of transmission. This field can have the following values:NCPDP (National Council for Prescription Drug Programs) ,ASC X12.	15	Character	T_BATCH	CDE_SUBMIT
Submission Type -By Submitter / Submission Type	The origination of transmission. This field can have the following values:NCPDP (National Council for Prescription Drug Programs),ASC X12.	15	Character	N/A	CALCULATED FIELD
Submitter -By Submitter / Submission Type	The Submitter ID on electronic claims or encounters.	16	Character	T_BATCH	CDE_SUBMIT
System Totals - Total Claim Type	The total of Claim type for all submission Types.	11	Character	N/A	CALCULATED FIELD
System Totals - Encounters Denied	The total of Encounters Denied for all Submission Types.	11	Character	N/A	CALCULATED FIELD
System Totals - Encounters Informational	The total of Encounters Informational for all Submission Types.	11	Character	N/A	CALCULATED FIELD
System Totals - Encounters Paid	The total of Encounters Paid for all Submission Types.	11	Character	N/A	CALCULATED FIELD
System Totals - Encounters Threshold	The total of Encounters Threshold for all Submission Types.	11	Character	N/A	CALCULATED FIELD
System Totals - Encounters Void	The total of Encounters Void for all Submission Types.	11	Character	N/A	CALCULATED FIELD
Total -Encounters Denied	The total of Encounters Denied for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Total -Encounters Informational	The total of Encounters Informational for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total -Encounters Paid	The total of Encounters Paid for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total -Encounters Threshold	The total of Encounters Threshold for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total -Encounters Void	The total of Encounters Void for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total -Total Claim Type	The total of Total Encounter Type for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total Claim Type	The total per line of each encounter type for the indicated submission type.	11	Character	N/A	CALCULATED FIELD
Total Claim Type -By Submitter / Submission Type	The total per line of each encounter type for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Totals -Encounters Denied -By Submitter / Submission Type	The total of Encounters Denied for the Submitter and Submission Type combination.	11	Character	N/A	CALCULATED FIELD
Totals -Encounters Informational -By Submitter / Submission Type	The totals -Encounters Informational -By Submitter / Submission Type	11	Character	N/A	CALCULATED FIELD
Totals -Encounters Paid -By Submitter / Submission Type	The total of Encounters Paid for the Submitter and Submission Type combination.	11	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Totals -Encounters Void - By Submitter / Submission Type	The total of Encounters Void for the Submitter and Submission Type combination.	11	Character	N/A	CALCULATED FIELD
Totals -Encounters threshold -By Submitter / Submission Type	The total of Encounters Threshold for the Submitter and Submission Type combination.	11	Character	N/A	CALCULATED FIELD
Totals -Total Claim Type - By Submitter/ Submission Type	The total of Encounter for the submitter and submission Type combination.	11	Character	N/A	CALCULATED FIELD

5.1.31.6 Associated Programs

Program	Description
clm0132	Encounters Submission Statistics
copy2routedir	Copy Reports to Router

5.1.32 CLM-0132-O -- Encounters Submission Statistics - On Request

This report provides On Request Encounters Submission Statistics summary of claim counts sent to the claims engine by submission type (NCPDP, ASC x12).

5.1.32.1 Technical Name

CLM-0132-O

5.1.32.2 Sort Order

The first section of the report:
Batch Code

Claim Type

Claim Status

The second section of the report:
Pharmacy Submitter

5.1.32.3 Distribution

OnBase

For readability, the report layout displays across several pages.

5.1.32.4 Encounters Submission Statistics - On Request Layout

```
Report:   CLM-0132-0                          COMMONWEALTH OF KENTUCKY                          Run Date:  MM/DD/CCYY
Process:  CLMJ0132                       MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:    HH:MM SS
Location: CLM0132                     ENCOUNTERS SUBMISSION STATISTICS - ON REQUEST             Page:           99999
                                                MM/DD/CCYY  -  MM/DD/CCYY
```

Submission Type	Claim Type	Encounters Paid	Encounters Denied	Encounters Threshold	Encounters Informational	Encounters Void	Total Claim Type
837	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
Total		xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
NCPDP	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
	xxxxxxxxxxxxxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
Total		xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx
System Totals		xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx	xxx,xxx,xxx

```
    Submitter 1          Submission Type: 837

Claim Type               Encounters     Encounters     Encounters     Encounters     Encounters     Total
                         Paid           Denied         Threshold      Informational  Void           Claim Type

xxxxxxxxxxxxxxx          xxx,xxx,xxx     xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx
xxxxxxxxxxxxxxx          xxx,xxx,xxx     xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx
xxxxxxxxxxxxxxx          xxx,xxx,xxx     xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx

Totals                   xxx,xxx,xxx     xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx

    Submitter 2          Submission Type: NCPDP

Claim Type               Encounters     Encounters     Encounters     Encounters     Encounters     Total
                         Paid           Denied         Threshold      Informational  Void           Claim Type

xxxxxxxxxxxxxxx          xxx,xxx,xxx     xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx
xxxxxxxxxxxxxxx          xxx,xxx,xxx     xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx
xxxxxxxxxxxxxxx          xxx,xxx,xxx     xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx

Totals                   xxx,xxx,xxx     xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx    xxx,xxx,xxx

                                  *** END OF REPORT ***
                                ***NO DATA THIS REPORT ***
```

5.1.32.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Claim Type	The 'English' name of claim type. The claim type description that specifies the type of claim record.	15	Character	T_CLAIM_TYPE	DSC_CLM_TYPE
Claim Type -By Submitter / Submission Type.	The 'English' name of claim type. The claim type description that specifies the type of claim record.	15	Character	T_CLAIM_TYPE	DSC_CLM_TYPE

Field	Description	Length	Data Type	DB Table	DB Attributes
Encounters Denied -By Submitter / Submission Type.	The total count of encounters submitted and denied by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Encounters Denied.	The total count of encounters submitted by indicated submission type, sent to the claims engine, and denied by the claims engine.	11	Character	N/A	CALCULATED FIELD
Encounters Informational	The error disposition for encounters claims. (I) - Informational	11	Character	N/A	CALCULATED FIELD
Encounters Informational -By Submitter / Submission Type	The total count of encounters submitted and informational by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Encounters Paid -By Submitter / Submission Type.	The total count of encounters submitted and paid by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Encounters Paid.	The total count of encounters submitted by indicated submission type, sent to the claims engine, and paid by the claims engine.	11	Character	N/A	CALCULATED FIELD
Encounters Threshold	The error disposition for encounters claims. (T) - Threshold.	11	Character	N/A	CALCULATED FIELD
Encounters Threshold -By Submitter / Submission Type	The total count of encounters submitted and Threshold by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Encounters Void	The total count of encounters submitted by indicated submission type, sent to the claims engine, and void by the claims engine.	11	Character	N/A	CALCULATED FIELD
Encounters Void -By Submitter / Submission Type	The total count of encounters submitted and void by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Submission Type	The origination of transmission. This field can have the following values:NCPDP (National Council for Prescription Drug Programs) ,ASC X12.	15	Character	T_BATCH	CDE_SUBMIT
Submission Type -By Submitter / Submission Type	The origination of transmission. This field can have the following values:NCPDP (National Council for Prescription Drug Programs),ASC X12.	15	Character	N/A	CONCANTENATED FIELD
Submitter -By Submitter / Submission Type	The Submitter ID on electronic claims or encounters.	16	Character	T_BATCH	CDE_SUBMIT
System Totals - Total Claim Type	The total of Claim type for all submission Types.	11	Character	N/A	CALCULATED FIELD
System Totals -Encounters Denied	The total of Encounters Denied for all Submission Types.	11	Character	N/A	CALCULATED FIELD
System Totals -Encounters Informational	The total of Encounters Informational for all Submission Types.	11	Character	N/A	CALCULATED FIELD
System Totals -Encounters Paid	The total of Encounters Paid for all Submission Types.	11	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
System Totals -Encounters Threshold	The total of Encounters Threshold for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
System Totals -Encounters Void	The total of Encounters Void for all Submission Types.	11	Character	N/A	CALCULATED FIELD
Total -Encounters Denied	The total of Encounters Denied for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total -Encounters Informational	The total of Encounters Informational for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total -Encounters Paid	The total of Encounters Paid for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total -Encounters Threshold	The total of Encounters Threshold for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total -Encounters Void	The total of Encounters Void for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total -Total Claim Type	The total of Total Encounter Type for all Encounters Types for the current Submission Type.	11	Character	N/A	CALCULATED FIELD
Total Claim Type	The total per line of each encounter type for the indicated submission type.	11	Character	N/A	CALCULATED FIELD
Total Claim Type -By Submitter / Submission Type	The total per line of each encounter type for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
Totals -Encounters Denied - By Submitter / Submission Type	The total of Encounters Denied for the Submitter and Submission Type combination.	11	Character	N/A	CALCULATED FIELD
Totals -Encounters Informational -By Submitter / Submission Type	The total count of encounters submitted and informational by the claims engine, for the Submitter, Submission Type and Encounter Type combination.	11	Character	N/A	CALCULATED FIELD
Totals -Encounters Paid -By Submitter / Submission Type	The total of Encounters Paid for the Submitter and Submission Type combination.	11	Character	N/A	CALCULATED FIELD
Totals -Encounters Void -By Submitter / Submission Type	The total of Encounters Void for the Submitter and Submission Type combination.	11	Character	N/A	CALCULATED FIELD
Totals -Encounters threshold - By Submitter / Submission Type	The total of Encounters Threshold for the Submitter and Submission Type combination.	11	Character	N/A	CALCULATED FIELD
Totals -Total Claim Type - By Submitter/ Submission Type	The total of Encounter for the submitter and submission Type combination.	11	Character	N/A	CALCULATED

5.1.32.6 Associated Programs

Program	Description
clm0132	Encounters Submission Statistics
copy2routedir	Copy Reports to Router

5.1.33 CLM-0800-S – Child Medical Conference Semi-Annual Report

This report is generated every 6 months indicating the billed amount, paid amount, number of units for procedure codes 96040, 99366 & 99367, and the number of unduplicated children for which the procedures were billed.

5.1.33.1 Technical Name

CLM-0800-S

5.1.33.2 Sort Order

Procedure Code

5.1.33.3 Distribution

OnBase

5.1.33.4 Child Medical Conference Semi-Annual Report Layout

```
Report  : CLM-0800-S                          COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/YYYY
Process : CLMJS800                          MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MM:SS
Location: CLMP800S                        CHILD MEDICAL CONFERENCE SEMI-ANNUAL REPORT                       Page:       9999
                                          REPORTING PERIOD : MM/DD/CCYY TO MM/DD/CCYY

PROCEDURE CODE        BILLED AMOUNT           PAID AMOUNT           UNITS        UNDUPLICATED MEMBERS
-------------------------------------------------------------------------------------------------------

96040                 99,999,999.99         99,999,999.99         999,999              9,999,999

99366                 99,999,999.99         99,999,999.99         999,999              9,999,999

99367                 99,999,999.99         99,999,999.99         999,999              9,999,999


GRAND TOTAL FOR ALL PROCEDURE CODES:
                     999,999,999.99        999,999,999.99       9,999,999             99,999,999


                                          *** END OF REPORT ***
                                         *** NO DATA THIS RUN ***
```

DMS Approved: 05/12/2009

5.1.33.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
BILLED AMOUNT	Amount billed by the providers.	13	Number (Decimal)	T_PD_PHYS_DTL	AMT_BILLED
PAID AMOUNT	Amount paid to the providers.	13	Number (Decimal)	T_PD_PHYS_DTL	AMT_PAID
PROCEDURE CODE	Procedure codes followed by Child Evaluation Providers. The codes are 96040, 99366, 99367.	6	Character	T_PROC	CDE_PROC
UNDUPLICATED MEMBERS	No. of members billed for a specific procedure code and each member is counted on only once.	9	Number (Integer)		
UNITS	Quantity billed on the claim.	7	Number (Integer)	T_PD_PHYS_DTL	QTY_BILLED

5.1.33.6 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
clmp800s	Procedure Report

DMS Approved: 05/12/2009

5.1.34 CLM-5000-D -- Top Ten Claims Approved For Payment

This report lists the ten claims with the highest reimbursement amounts approved for payment for each claim type for the adjudication cycle.

5.1.34.1 Technical Name

CLM-5000-D

5.1.34.2 Sort Order

Grouped by Claim Type

5.1.34.3 Distribution

OnBase

Jay Hackett

For readability, the report layout displays across several pages.

5.1.34.4 Top Ten Claims Approved For Payment Layout

```
REPORT  :  CLM-5000-D                    COMMONWEALTH OF KENTUCKY                          RUN DATE: MM/DD/YY
PROCESS :  CLMJD500                 MEDICAID MANAGEMENT INFORMATION SYSTEM                 RUN TIME: HH:MM:SS
LOCATION:  CLM5000D                   TOP 10 CLAIMS APPROVED FOR PAYMENT                       PAGE:     9999
                                              MM/DD/CCYY
```

CLAIM TYPE	ICN	PROVIDER +LOC	COS	MEMBER ID	DATES OF SERVICE FIRST	DATES OF SERVICE LAST	TOTAL CHARGE	PAYMENT AMOUNT
DENTAL CLAIMS	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
INPATIENT CLAIMS	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99
	XXXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	99999999.99	99999999.99

```
PHARMACY CLAIMS          XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99

OUTPATIENT CLAIMS        XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99
                         XXXXXXXXXXX     XXXXXXXXXXX  XX   XXXXXXXXX MM/DD/CCYY MM/DD/CCYY  99999999.99   99999999.99

                                          *** END OF REPORT ***
                                       *** NO DATA THIS RUN ***
```

5.1.34.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIM TYPE	The 'English' name of the claim type code that specifies the type of claim record.	11	Character	T_CLAIM_TYPE	DSC_CLM_TYPE
DATES OF SERVICE- FIRST	The first day of service of the claim.	10	Date (MM/DD/CCYY)	T_PD_[DNTL|PHARM|PHYS|UB92]_HDR	DTE_FIRST_SVC|DTE_PRESCRIBE
DATES OF SERVICE- LAST	The last day of service of the claim.	10	Date (MM/DD/CCYY)	T_PD_[DNTL|PHARM|PHYS|UB92]_HDR	DTE_LAST_SVC|DTE_PRESCRIBE
ICN	The internal control number.	13	Character	T_PD_[DNTL|PHARM|PHYS|UB92]_HDR	NUM_ICN

Field	Description	Length	Data Type	DB Table	DB Attributes
MEMBER ID	The Medicaid identification number for the member.	11	Character	T_RE_BASE	ID_MEDICAID
PAYMENT AMOUNT	The reimbursement amount.	15	Number	T_PD_[DNTL|PHARM|PHYS|UB92]_HDR	AMT_PAID|AMT_TOT_REIMB(phys)
PROVIDER ID	The pay-to provider number. The provider number for the requesting and servicing provider..	15	Character	T_PR_IDENTIFIER + HDR	ID_PROVIDER||SAK_PROV_LOC
PROVIDER ID TYPE	This is the Provder ID Type. (NPI-National Provider ID MCD-Medicaid Provider Number BSE-Base Provider ID)	3	Character	T_PR_IDENTIFIER	CDE_PROV_ID_TYPE
TOTAL CHARGE	The total charge.	15	Number	T_PD_[DNTL|PHARM|PHYS|UB92]_HDR	AMT_BILLED|AMT_BILLED_UB92

5.1.34.6 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
clm5000d	Top Ten Claims Approved For Payment

5.1.35 CLM-8600-W -- Pended Claims Aging

This report provides a total of pended claim documents by claim type and number of days in which they have been in a pending claim status. The submitted charge for each date range and a cumulative submitted charge also are shown on this report.

5.1.35.1 Technical Name

CLM-8600-W

5.1.35.2 Sort Order

N/A

5.1.35.3 Distribution

OnBase

5.1.35.4 Pended Claims Aging Layout

```
Report  : CLM-8600-W                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/YYYY
Process : CLMJW860                  MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time:   HH:MI:SS
Location: CLM8600W                      PENDED CLAIMS AGING REPORT                  Page:          9999
                                              MM/DD/CCYY

     CLAIM TYPE: XXXXXXXXXXXXXX

                   ---- FOR NON-ADJUSTMENTS  ---      ------ FOR ADJUSTMENTS ------      --------- CUMULATIVE --------
   DAYS            PENDING          SUBM. CHARGE      PENDING          SUBM. CHARGE      PENDING          SUBM. CHARGE
                   DOCUMENTS                          DOCUMENTS                          DOCUMENTS
   0 -  30           9,999          999,999.99            9                 9.99           9,999          9,999,999.99
  31 -  60             999          999,999.99            9                 9.99           9,999          9,999,999.99
  61 -  90             999          999,999.99            9                 9.99           9,999          9,999,999.99
  91 - 120             999           99,999.99            9                 9.99           9,999          9,999,999.99
 121 - 150               9            9,999.99            9                 9.99           9,999          9,999,999.99
  > 210               999           99,999.99            9                 9.99           9,999          9,999,999.99

     CLAIM TYPE: XXXXXXXXXXXXXX

                   ---- FOR NON-ADJUSTMENTS  ---      ------ FOR ADJUSTMENTS ------      --------- CUMULATIVE --------
   DAYS            PENDING          SUBM. CHARGE      PENDING          SUBM. CHARGE      PENDING          SUBM. CHARGE
                   DOCUMENTS                          DOCUMENTS                          DOCUMENTS
   0 -  30           9,999        9,999,999.99            9                 9.99           9,999          9,999,999.99
  31 -  60           9,999          999,999.99            9                 9.99           9,999          9,999,999.99
  61 -  90             999           99,999.99            9                 9.99           9,999          9,999,999.99
  91 - 120              99           99,999.99            9                 9.99           9,999          9,999,999.99
 121 - 150               9            9,999.99            9                 9.99           9,999          9,999,999.99
 151 - 180               9              999.99            9                 9.99           9,999          9,999,999.99
 181 - 210               9              999.99            9                 9.99           9,999          9,999,999.99
  > 210               999           99,999.99            9                 9.99           9,999          9,999,999.99

                                   ***   END OF REPORT   ***
                                ***   NO DATA THIS RUN   ***
```

5.1.35.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIM TYPE	The description of the claim type is printed after the value of the claim input form indicator. Claim type of 'all' is produced at the end of the report for all of the listed claim types (using the same ranges).	50	Character	T_CLAIM_TYPE	DSC_CLM_TYPE
CUMULATIVE	The tally of claim documents and dollars for claims and adjustments falling into the ranges listed cumulatively from the first to the last range - Heading.	28	Number (Integer)	N/A	CALCULATED FIELD
CUMULATIVE - PENDING DOCUMENTS	The tally of the number of claims and adjustment documents with a suspended claim status on the Suspended Claims File for the specific range of days of file.	6	Number (Integer)	N/A	CALCULATED FIELD
CUMULATIVE - SUBM. CHARGE	The tally of the total claim charge amounts in the claims and adjustments which were tallied for the specific range of days. This represents dollar amounts requested (total claim charges).	12	Number (Decimal)	N/A	CALCULATED FIELD
DAYS	The number of days ranges which are printed represent the number of days difference between date entered and the most current suspense date for claims in that claim type. The number of days ranges are incremented by 30 with a range dependent on the oldest suspended claim.	9	Number (Integer)	N/A	CALCULATED FIELD
FOR ADJUSTMENTS	The tally of claims and dollars for adjustment claims - Heading.	28	Number (Integer)	N/A	CALCULATED FIELD
FOR ADJUSTMENTS - PENDING DOCUMENTS	The tally of the number of adjustments with a suspended status on the suspended claims file for the specific range of days.	5	Number (Integer)	N/A	CALCULATED FIELD

Field	Description	Length	Data Type	DB Table	DB Attributes
FOR ADJUSTMENTS - SUBM CHARGE	The tally of the total claim charge amounts in the adjustments which were tallied for the specific range of days.	10	Number (Decimal)	N/A	CALCULATED FIELD
FOR NON-ADJUSTMENT	The tally of claims and dollars for non-adjustment claims - Heading.	28	Number (Integer)	N/A	CALCULATED FIELD
FOR NON-ADJUSTMENT - PENDING DOCUMENTS	The tally of the number of claim documents with a suspended claim status on the Suspended Claims File for the specific range of days.	5	Number (Integer)	N/A	CALCULATED FIELD
FOR NON-ADJUSTMENT - SUBM. CHARGE	The tally of the total claim charge amounts in the claims which were tallied for the specific range of days. This represents dollar amounts requested (total claim charges).	10	Number (Decimal)	N/A	CALCULATED FIELD

5.1.35.6 Associated Programs

Program	Description
clm8600w	Pended Claims Aging Report
copy2routedir	Copy Reports to Router

5.1.36 CLM-9914-Q -- Abortions Procedure Report

This report displays and summarizes claims with abortion procedures for the quarter.

5.1.36.1 Technical Name

CLM-9914-Q

5.1.36.2 Sort Order

ICN

5.1.36.3 Distribution

OnBase

5.1.36.4 Abortions Procedure Report Layout

```
REPORT  : CLM-9914-Q                    COMMONWEALTH OF KENTUCKY                          RUN DATE: MM/DD/YY
PROCESS : CLMJQ9914                 MEDICAID MANAGEMENT INFORMATION SYSTEM                RUN TIME: HH:MM:SS
LOCATION: CLM9914Q                      ABORTIONS PROCEDURE REPORT                            PAGE:        1
                                        MM/DD/CCYY  -  MM/DD/CCYY
```

MEMBER NAME	MEMBER DOB	MEMBER ID	PROVIDER + LOC	ICN	FDOS	LDOS	PAID AMT	CLAIM TYPE
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CCYY/MM/DD	999999999-9	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	999999.99	X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CCYY/MM/DD	999999999-9	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	999999.99	X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CCYY/MM/DD	999999999-9	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	999999.99	X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CCYY/MM/DD	999999999-9	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	999999.99	X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CCYY/MM/DD	999999999-9	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	999999.99	X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CCYY/MM/DD	999999999-9	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	999999.99	X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CCYY/MM/DD	999999999-9	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	999999.99	X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CCYY/MM/DD	999999999-9	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	999999.99	X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CCYY/MM/DD	999999999-9	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	999999.99	X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CCYY/MM/DD	999999999-9	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	999999.99	X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CCYY/MM/DD	999999999-9	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	999999.99	X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CCYY/MM/DD	999999999-9	XXXXXXXXXX	XXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	999999.99	X

*** END OF REPORT ***

*** NO DATA THIS RUN ***

5.1.36.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CLAIM TYPE	The claim type of the reported claim. Field in DB: CDE_CLM_TYPE Table in DB: UNION(T_PD_PHYS_HDR, T_PD_UB92_HDR).	10	Character	SEE DESCRIPTION	CDE_CLM_TYPE
FDOS	The from date of service on the claim. Field in DB: DTE_FIRST_SVC Table in DB: UNION(T_PD_PHYS_DTL, T_PD_UB92_DTL).	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	DTE_FIRST_SVC
ICN	The internal transaction control number. Field in DB: NUM_ICN Table in DB: UNION(T_PD_PHYS_HDR, T_PD_UB92_HDR).	20	Character	SEE DESCRIPTION	NUM_ICN
LDOS	The last date of service on the claim. Field in DB: DTE_LAST_SVC Table in DB: UNION(T_PD_PHYS_DTL, T_PD_UB92_DTL).	10	Date (MM/DD/CCYY)	SEE DESCRIPTION	DTE_LAST_SVC
MEMBER DOB	The member date of birth.	10	Date (CCYY/MM/DD)	T_RE_BASE	DTE_BIRTH
MEMBER ID	The member identification number.	11	Character	T_RE_BASE	ID_MEDICAID
MEMBER NAME	The member name from the claim.	30	Character	T_RE_BASE	NAM_LAST + NAM_FIRST + NAM_MID_INIT

Field	Description	Length	Data Type	DB Table	DB Attributes
PAID AMT	The claim paid amount. Field in DB: AMT_PAID Table in DB: UNION(T_PD_PHYS_DTL, T_PD_UB92_DTL).	15	Number	SEE DESCRIPTION	AMT_PAID
PROVIDER ID	The provider number for the requesting and servicing provider. Field in DB: ID_PROVIDER + CDE_SERVICE_LOC Table in DB: T_PR_PROV, UNION(T_PD_PHYS_HDR, T_PD_UB92_HDR).	15	Character	SEE DESCRIPTION	SEE DESCRIPTION
PROVIDER ID TYPE	This the Provider ID type(NPI, MID, BSE).	3	Character	T_PR_IDENTIFIER	CDE_PROV_ID_TYPE

5.1.36.6 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
clm9914q	Abortions Procedure Report

6 Letters

The Claims subsystem does not produce or send any letters.

7 Glossary of Terms

7.1 Terms and Acronyms

270/271 **Eligibility/Benefit Inquiry/Response – The Eligibility and Benefit transactions are designed so that inquiry submitters (information receivers) can determine: a) whether an information source organization (e.g., payer, employer, HMO) has a particular subscriber or dependent on file, and b) the health care eligibility and/or benefit information about that subscriber and/or dependent(s). The data available through these transaction sets is used to verify an individual's eligibility and benefits, but cannot provide a history of benefit use. The information source organization may provide information about other organizations that may have third party liability for coordination of benefits. These are x-12 transactions mandated by HIPAA regulations.**

276/277 Claim Status Request/Claim Status Response – The 276 and 277 transaction sets are intended to meet specific needs of the health care industry. The 276 is used to request the current status of a specified claim(s). The 277 transaction set can be used as the following: a) a solicited response to a health care claim status request (276), b) a notification about health care claim(s) status, including front end acknowledgments, or c) a request for additional information about a health care claim(s). The 276 is used only in conjunction with the 277 Health Care Claim Status Response. These are x-12 transactions mandated by HIPAA regulations.

277 Unsolicited Claim Status – The Unsolicited Claim Status (277) transaction set can be used to transmit an unsolicited notification about a health care claim status. This is an x-12 transaction mandated by HIPAA regulations.

820 Premium Payment – The 820 can be used by premium remitters to report premium payment remittance information, as well as premium payment to a premium receiver. The premium remitter can be: a) an employer-operated internal department or an outside agency which performs payroll processing on behalf of an employer, b) a government agency paying health care premiums, or c) an employer paying group premiums. The premium receiver can be either an insurance company, a government agency, or a health care organization. The 820 can be sent from the premium remitter to the premium receiver either directly, through a VAN, or through a financial institution using an ACH (Automated Clearing House) Network to facilitate both the remittance and dollars movement. This is an x-12 transaction mandated by HIPAA regulations.

834 Enrollment/Maintenance – The 834 is used to transfer enrollment information from the sponsor, the party that ultimately pays for the coverage, benefit, or policy to a payer, the party that pays claims and/or administers the insurance coverage, benefit, or product. This is an x-12 transaction mandated by HIPAA regulations.

835 Payment Advice – The 835 contains information about the payee, the payer, the amount, and any identifying information of the payment. In addition, the 835 can authorize a payee to have a DFI (Depository Financial Institutions) take funds from the payer's account and transfer those funds to the payee's account. This is an x-12 transaction mandated by HIPAA regulations.

837 Dental/Professional/ Institutional Claim – The Claims/Encounters (837) is intended to originate with the health care provider or the health care provider's designated agent. The 837 provides all necessary information to allow the destination payer to at least begin to adjudicate the claim. The 837 coordinates with a variety of other transactions including, but not limited to, the following: Claim Status (277), Remittance Advice (835), and Functional Acknowledgment (997). This is an x-12 transaction mandated by HIPAA regulations

997 Functional Acknowledgement – The Functional Acknowledgement is generated by the receiver of an 837 and is used to notify the sender that the acknowledged transaction has been: a) accepted, b) rejected, c) accepted with errors, or d) partially accepted. This is an x-12 transaction mandated by HIPAA regulations.

7.1.1 A

ABANDONED CALL	**A call is considered abandoned if the caller is connected to the system but hangs up before being connected with an agent or informational announcement. Also known as a lost call.**
ABR	Automatic Backup and Recovery
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT	A lump sum payment made upon the loss of life of an insured as a direct cause of an accident or upon the accidental loss of a limb or sight of an insured.
ACCOMMODATION	A hospital room with one or more beds.
ACCOMMODATION CHARGE	A Charge billed on inpatient hospital claims for bed, board, and nursing care (revenue codes 100-219).
ACCOUNTS RECEIVABLES (AR, A/R)	Money owed to the State by a provider, beneficiary, insurance company, drug manufacturer, etc.
ACCRETION	A process that occurs when a beneficiary is eligible for coverage under both Medicaid and Medicare. Medicaid pays the beneficiary's Medicare premium, thus buying into the Medicare Program.
ACG	Ambulatory Care Grouper
ACTUAL CHARGE	A Charge made by a physician or other supplier of medical services and used in the determination of reasonable Charges.
AD HOC REQUEST	A request to provide non-production support. This support may be in the form of one-time updates to production files or the creation of specific one-time or as needed output reports.
ADA	Americans with Disabilities Act

ADC	Adult Day Care
ADJUDICATE (CLAIM)	The adjudication process occurs during claims processing to determine the disposition of a claim (paid or denied). A claim passes through all the edit and audit criteria until it is determined whether all program requirements have been met and whether the claim is to be paid or denied.
ADJUSTMENT (ADJ)	A change made to a previously processed claim that is not in denied status by correcting underpayments, overpayments, or history. Adjustments also include capitation correction of a payment or credit to capitation. The provider, contractor, or State can submit adjustments.
ADJUDICATION CYCLE	This cycle refers to the daily, or daily/weekly claims processing cycles that are known as the system processing of claims to the point where a decision has been made to pay, deny, or suspend the claim.
ADJUSTED CLAIM	A previously paid claim that has undergone data modification. The need to adjust a claim may result from data entry errors, billing errors, file updates, or program logic modifications. (See Adjustment.)
ADJUSTMENT PROCESSING	A batch process that sends a file of adjustment request records to the Financial Subsystem for incorporation into the claims processing cycle.
ADJUSTMENT REASON CODES (PRIMARY AND SECONDARY)	The adjustment reason codes specify why the initial adjustment took place, whereas the secondary adjustment reason indicates the second adjustment occurrence on a claim. These codes are also known as the primary reason and the secondary adjustment reason.
ADMISSION	The first day on which a patient is furnished inpatient hospital or extended care services by a qualified provider.
ADR	Address
Advanced Registered Nurse Practitioner (ARNP)	A registered nurse with specialized training in advanced nursing skills.

AG	Attorney General
AGGREGATE	A collection of data at the summary level.
AHA	American Hospital Association
AID CATEGORY	Program category under which a member can be eligible for Medicaid.
Aid to Families with Dependent Children (AFDC)	A welfare program funded by federal and State dollars that provides cash and Medicaid benefits to families with at least one child where one or both parents are absent, deceased, or incapacitated.
AIDS	Acquired Immune-Deficiency Syndrome
ALLOWABLE AMOUNT	The maximum dollar amount assigned for a particular procedure based on various pricing mechanisms. Medicaid reimburses hospitals for certain, but not all costs. Excluded costs include non-covered services, luxury accommodations, and unnecessary and unreasonable costs.
ALLOWED AMOUNT	The amount billed for a medical service or the amount determined payable by the State, whichever is the lesser figure.
ALPHANUMERIC	The use of alphabetic letters mixed with numbers and special Characters as in name, address, city, and state.
ALS	Advanced Life Support
AMERICAN DENTAL ASSOCIATION (ADA)	The national professional association for dentists.
AMERICAN MEDICAL ASSOCIATION (AMA)	The national professional association of physicians. This organization publishes the highly utilized CPT-4 books.

AMERICAN NATIONAL STANDARDS INSTITUTE (ANSI)	In computer programming, ANSI most often denotes the standard versions of C, FORTRAN, COBOL, or other programming languages. ANSI-standard escape sequences control computer screens; whereas ANSI extended Character set used in Microsoft's Windows products includes all of the ASCII Characters.
AMERICAN STANDARD CODE FOR INFORMATION INTERCHANGE (ASCII)	The most popular coding method used by small computers for converting letters, numbers, punctuation and control codes into digital form. Once defined, ASCII Characters can be recognized and understood by other computers and by communications devices. ASCII represents Characters, numbers, punctuation marks or signals in seven on-off bits. Capital "C", for example, is 1000011, while "3" is 0110011. This compatible coding allows all PCs to talk to each other, if they use a compatible modem or null modem cable and transmit and receive at the same speed (Imaging).
ANCILLARY CHARGE	A Charge used only in institutional claims for any item except hospital and doctor fees (examples include drug, laboratory, and x-ray Charges).
AR	Accounts Receivable
ARCHIVE	A copy of data on disks, CD-ROM, magnetic tape, etc., for long-term storage and later possible access. Archived files are often compressed to save storage space (Imaging).
AS OF DATE	Based on parameters entered, the date of the cycle run.
ASC	Ambulatory Surgical Center
ASSIGNED CLAIM	A claim for which the provider of service has agreed to accept the program allowed Charge as payment in full without recourse to the patient, except for coinsurance or deductible amounts.

ASSIGNMENT When a provider accepts the maximum allowable Charge offered for a given procedure under the Medicare Program, it is said that this person accepts assignment. The provider has waived the right to bill the beneficiary for the difference between what Medicare pays and what the provider usually Charges for a fee. The term assignment is not related to the administration of the Medicaid Program except that some Medicaid agencies treat crossover claims differently depending upon whether or not the provider accepts assignment.

ATTACHMENT Attachments may accompany claims to provide additional claim-related information for which no field is specified on the corresponding claim form, or when the specified field is not adequate to submit the required information.

AUDIT Limitations applied to specific procedures, diagnoses or other data elements after editing and validation of the claim to ensure conformity and consistency of claim payment.

AUTHENTICATION A query method that ensues that both the sender and receiver of an electronic message are valid and are authorized to transmit and receive messages.

AUTO ASSIGNMENT An automated process used to make 'intelligent' Managed Care assignments for beneficiaries who do not make a selection of a Primary Medical Provider of their own accord.

AUTOMATED VOICE RESPONSE SYSTEM (AVRS) This is the machine and the application that enable users to access KY Medicaid information by using a touch-tone telephone.

AUTOMATIC RECOUPMENT Automatic recoupment occurs when an A/R with a credit balance has recoupments applied to it by adjustments or new-day claims. Money is recouped only through the payment process, which is automatic, and cannot be posted online with a refund.

7.1.2 B

BACKUP	**Duplicate copy of data placed in a separate, safe place - electronic storage, on a tape, on a disk, in a vault - to guard against total loss in the event the original data somehow become inaccessible. Generally for short-term safety. Contrast with archive, which is a filed-away record of data meant to be maintained a long time, in the event of future reference. (Imaging)**
BALANCED BUDGET ACT OF 1997 (BBA)	Federal legislation enacted in 1997 that gave beneficiaries certain rights related to Managed Care enrollment and disenrollment. Most significant changes in the Medicaid/Medicare Program since their inception. Provides for state option to use Managed Care. Provides that an MMIS must be compatible with Medicare claims processing and must, after January 1, 1999, transmit data in a format consistent with the Medicaid Statistical Information System (MSIS).
BATCH	A set of claims.
BENEFICIARY DATA EXCHANGE SYSTEM (BENDEX)	An interface system between the Commonwealth of Kentucky and Social Security Administration that provides Social Security beneficiary information. Information includes eligibility for benefits as well as Medicare Part A and Part B entitlement and eligibility information.
BENEFIT PERIOD	The period of time a health plan will pay for covered benefits.
BENEFIT PLAN	A group of covered services (benefits) that are granted to a beneficiary who is deemed eligible for the program the benefit plan represents.
BENEFITS	A schedule of health care service coverage that an eligible KY Medicaid member receives for the treatment of illness, injury, or other conditions allowed under the State Plan.
BILLED AMOUNT	The billed amount is the dollar figure submitted by a provider for medical services rendered.

BILLING PROVIDER	The provider who will receive payment (if a group/clinic number is present, it would be the "Billing Provider"
BIN	Bank Identification Number
BITMAP	Representation of Characters or graphics by individual pixels, or points of light, dark or color, arranged in row (horizontal) and column (vertical) order. Each pixel is represented by either one bit (simple black and white) or up to 32 bits (fancy high definition color). (Imaging)
BLS	Basic Life Support
BUNDLED CHARGES	Charges that are combined together or represent a flat rate such as in capitated reimbursed where there would be a specified fee for a service. In an example of a surgery procedure, the bundled Charges would include supplies, surgery Charges, anesthesia Charges, recovery, etc. In contrast, unbundled Charges would be separate Charges for each entity.
BUY-IN	Procedure whereby states pay a monthly premium to the Social Security Administration on behalf of Medicaid beneficiaries, enrolling them in Medicare Title XVIII Part A, Part B and/or Part D program.
BUY-IN DATA MAINTENANCE	Medicaid beneficiaries who are entitled to receive Medicare benefits may have Medicare premiums paid by the State. This is known as Medicare buy-in. Automated data exchanges between HP Enterprise Services and the Centers for Medicare and Medicaid Services (CMS), are conducted monthly to identify, update, resolve differences, and monitor new and ongoing Medicare buy-in cases. The State is responsible for initiating Medicare buy-in for eligible members. Because Medicare is usually primary to the State, payment of Medicare premiums, coinsurance, and deductibles costs the State less than paying the entire cost of medical care for a beneficiary. In addition, the State receives Federal Financial Participation (FFP) for premiums paid on behalf of members eligible as Qualified Medicare Beneficiaries (QMB), Qualified Disabled Working Individual (QWSI), Specified Low Income Medicare Beneficiaries (SLMB), and Cash Assistance beneficiaries (Supplemental Security Income (SSI) and cash assistance from Temporary Assistance for Families (TAF).

BYTE Common unit of computer storage. A byte is eight bits of information, one of which may be a parity bit. Generally, eight bits equals one Character. Also called 'octet'. (Imaging)

7.1.3 C

CACHE	**(Pronounced "cash") Small portion of high-speed memory used for temporary storage of frequently used data. Reduces the time it would take to access that data, since it no longer has to be retrieved from the disk. (Imaging)**
CAPITATION	A specified amount paid periodically to a health care provider for a group of specified health care services regardless of quantity rendered. A fee is paid per person. Capitation fees are paid for each enrollee, regardless of whether an enrollee actually received a service. The use of capitation separated the payment process from the claims submission process. Encounter claims are submitted for historical data, not for payment. Also known as capitation payment or rate.
CAPITATION RATE	The payment of a fixed dollar amount, per person, for the provision of a defined set of health services to a defined population for a specified period of time (e.g. one month). Capitation is a fixed revenue system that pays the same amount each month no matter how many or how few services are actually provided.
CARRIER	A carrier refers to a private insurance company.
CASE	A file opened at the DCBS office when an individual applies for government assistance.
CASE MANAGEMENT/MANAGER	Method designed to accommodate the specific health services needed by an individual through a coordinated effort to achieve the desired health outcome in a cost-effective manner.
CASE MIX INDEX	A numeric score with a specific range that identifies the relative resources used by a particular group of residents and represents the average resource consumption across a population or sample.
CASE NUMBER	The number assigned to each Medicaid case opened by DCBS.

CASH CONTROL NUMBER (CCN)	This is the unique number assigned to a Cash Receipt.
CATEGORICALLY NEEDY	Individuals certified by the state welfare agency as being low income and thus being eligible for Medicaid benefits. A person is categorically needy and may receive assistance if that person's income and resources do not exceed the categorically needy maximums and they fit into one of six categories: Age 65, Blind, Disabled, Families with dependent children (TANF), Pregnant, Incapacitated. A person must still meet various other criteria (categorical relationship, citizenship etc.) before receiving Medicaid payments from the Commonwealth of Kentucky. This applies to all cases. Individuals whose income and resources are in excess of the maximums but still cannot pay their medical expenses are considered medically needy. However, to receive aid, the client must still fall into one of the six) categories.
CATEGORY OF SERVICE (CAT OF SRVC, COS)	The type of service that a provider renders. An indication of the general classification of the procedures performed. Examples include: inpatient hospital, outpatient hospital, skilled nursing facility, hospice, prescribed drugs, physician care, dental care, transportation, family planning services, therapy services, and crossover.
CCN	Cash Control Number
CDC	Centers for Disease Control
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	The agency within the U.S. Department of Health and Human Services responsible for administering Title XIX and Title XXI of the Social Security Act. With the help of Health Resources and Services Admin, CMS also runs the Child Health Insurance program.
CENTRAL PROCESSING UNITY (CPU)	The computing part of the computer. Also called the processor, it is made up of the control unit and ALU.
CERTIFICATION	A review by the U.S. Department of Health and Human Services/CMS of an operational MMIS, in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system and the ensuing certification resulted from a favorable review.

CERTIFICATION DATE An effective date specified in a written approval notice from CMS to the State when 75 percent federal financial participation (FFP) is authorized for the administrative costs of an MMIS.

CHANGE ORDER (CO) The documentation of a modification to the transfer system. A change order is not a modification of a requirement; it is the modification of the base system to meet an existing requirement.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) A classification given to children who require special health services. The classification comes through the Title V program.

CIVILIAN HEALTH AND MEDICAL PROGRAMS OF THE UNIFORMED SERVICES (CHAMPUS) The medical benefit program for military personnel or retirees and their dependents who exercise their option to obtain civilian medical treatment. CHAMPUS can be considered as a possible source for third-party coverage.

CLAIM The form required for providers to bill their services. Each claim is formatted into three levels of information: Header, Detail, and Trailer or Footer.

CLAIM ADJUSTMENT A claim adjustment is a modification to some part of the data of a previously paid claim. All adjustments will maintain an audit trail to deny adjustments to a previously adjusted claim. A message is displayed stating that the claim has already been adjusted or denied. (See Adjusted Claim)

CLAIM HISTORY All claims processed in the MMIS are kept available in the system and are referred to as being "in history." The Kentucky MMIS adjustment process has access to 60 months of claims data plus a lifetime file.

CLAIM TYPE Claim types indicate the classification of claims by origin or type of service provided to a beneficiary. In the MMIS, this is a user-defined data element that refers to the kind of service being billed. For example, common claim types are dental, pharmacy, transportation, nursing, EPSDT, physician, inpatient, etc. Outside of the MMIS, the term often refers to the invoice type, i.e., HCFA-1500, UB-92, etc. The invoice type could be the claim type in an MMIS, but because more than one type of service can be billed on an invoice, the term "claim type" is usually defined in more detail.

CLAIMS PROCESSING ASSESSMENT SYSTEM (CPAS)	A State-administered Medicaid quality-control program that serves as a management tool for examining and evaluating the accuracy of claims processing and payments.
CLERK ID	A code assigned to personnel involved with processing records in the MMIS claims processing system.
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)	A certification process done by CMS to ensure the proficiency of medical laboratories.
COINSURANCE **(also CO-INSURANCE)**	The dollar amount or percentage of the cost of medical care that a patient pays. The coinsurance or a percentage amount that will be paid by KY Medicaid if the beneficiary is eligible for Medicaid.
COMMON BUSINESS-ORIENTED LANGUAGE (COBOL)	A third generation computer language developed by the Federal Government and adopted by computer manufacturers in the 1960s. It is the most utilized language on mainframe business computers
COMMON GATEWAY INTERFACE (CGI)	One of the most common ways to add programs or scripting languages that execute on the server to your Web-based applications.
COMMON PROCEDURAL TERMINOLOGY (CPT)	A unique structure scheme for all medical procedures approved by the American Medical Association.
COMMUNITY MENTAL HEALTH CENTER (CMHC)	A center that provides many services necessary for treatment of mental health conditions. Services include diagnostic evaluations, psychological testing, therapy (family, group, and individual), and medication checks.
COMPACT DISK (CD)	A standard medium for storage of digital data in machine-readable form, accessible with a laser-based reader. CDs are 4-3/4 in diameter. CDs are faster and more accurate than magnetic tape for data storage: Faster, because even though data is generally written on a CD contiguously within each track, the tracks themselves are directly accessible. This means the tracks can be accessed and played back in any order. More accurate, because data is recorded directly into binary code; whereas magnetic tape requires data to be translated into analog form. In addition, extraneous noise (tape hiss) associated with magnetic tape is absent from CDs.

COMPACT DISK-READ ONLY MEMORY (CD-ROM)	A data storage system using CDs as the medium. CD-ROMs hold more than 600 megabytes of data.
COMPUTER OUTPUT TO LASER DISK (COLD)	A system that provides the ability to take output from a report program that often runs on a mainframe computer and makes the information useful without the use of paper.
CONSOLIDATION OF BENEFITS IN RETIREMENT ACT (COBRA)	Cobra is a law that makes an employer let an employee remain covered under the employer's group health plan for a period of time after: the death of your spouse, losing your job, work hours reduction, or getting a divorce. The employee may have to pay both their share and the employer's share of the premium.
CONTACT TRACKING NUMBER (CTN)	A unique number assigned in CTMS.
CONTRACTOR	Successful bidder under an RFP or ITB. A person or organization from which the State contracts for products or service.
CONTRACT START DATE	The date the Contract for Services requested by an RFP becomes effective.
CONTROLLED DRUGS / SCHEDULED DRUGS	Drugs that have a high potential for abuse. These are drugs classified as narcotics. There are five schedules, with Schedule I drugs being the most dangerous.
CONVERSION FACTOR	The factor used to convert units of service; applicable to drug claims being processed in Drug Rebate.
COORDINATION OF BENEFITS (COB)	When Medicaid and other primary insurance companies coordinate their benefits to ensure that beneficiaries/providers do not receive duplicate payments for a service.
COPAY/COPAYMENT (also CO-PAY)	A Charge the beneficiary is responsible for paying on selected procedures or services. It is the patient's responsibility to pay some fixed portion of the cost of the medical service received, while the insurer pays the remainder.

CONTACT TRACKING MAINTENANCE SYSTEM (CTMS) This ancillary application provides a means of access and storage for all information associated with a customer service contact. All contact information is associated with an assigned CTN. This information includes contact type, demographic information, questions, resolutions, and contact reasons. HP Enterprise Services and DMS staff enter information for each contact through online windows. Search windows allow users to sort and access contacts based on a variety of criteria. Reports are available based on open dates, status, clerk IDs and department.

COS Category of Service

COST AVOIDANCE A claim may be denied when coverage exists and there is no indication that the carrier has been billed (cost avoided).

COST SHARING Provisions of an insurance policy requiring the covered individual to pay some portion of covered medical expenses. Premium amounts are not included in cost sharing. Deductibles (a set amount paid before payment of benefits occurs), co-payments (a fixed amount paid for each service), and coinsurance (payment of a set portion of the cost per service), are forms of cost sharing.

COVERAGE CODE A system of letters or numbers assigned to the type of coverage provided by the third party carrier policy.

CLAIM CREDIT A financial transaction that reverses a previously paid claim to zero amount. A credit is entered in the MMIS just like a claim. A provider can request a credit if he has been paid for a service he did not perform. The State agency can also request a credit. It is one type of adjustment. Also known as Credit-Only Adjustment.

CRNA Certified Registered Nurse Anesthetist

CROSSOVER CLAIM If a beneficiary is eligible for both Medicare and Medicaid, the Medicare claim is automatically sent to Medicaid after the Medicare carrier processes it. The claim, in effect, crosses over from one system to the other via tapes or disks. It is important to know that Medicaid is considered the payer of last resort. Therefore, claims must always be sent to Medicare first when a beneficiary is eligible for both programs.

CROSS WALK	A table used to relate one code to another code
CURRENT PROCEDURAL TERMINOLOGY, FOURTH EDITION (CPT-4)	Contains procedure codes that are used by medical practitioners in billing for services rendered to Medicaid beneficiaries. The book is published by the American Medical Association. The CPT codes are also included as the Level One codes in the HCPCS list of codes.
CURSOR	A highlighted mark on the screen that shows where the next Character you enter will appear.
CUSTOMARY CHARGE	A dollar amount that represents the median Charge for a given service by an individual physician or supplier.
CUSTOMER INFORMATION CONTROL SYSTEM (CICS)	An IBM software system that provides the on-line user interface to MMIS data. This is the "front" end of the mainframe-based MMIS online system. CICS was originally developed to provide transaction processing for IBM mainframes. It controls the interaction between applications and users and lets programmers develop screen displays without detailed knowledge of the terminals used. It provides terminal routing, password security, transaction logging for error recovery and activity journals for performance analysis. CICS commands are written along with and into the source code of the applications, typically COBOL.
CUTBACK	A reduction in quantity or rate.

7.1.4 D

DATA ELEMENT DICTIONARY (DED)	**Describes the fields (data elements) within a database.**
DATA ENTRY	Entering data into the computer, which includes keyboard entry, scanning and voice recognition. When transactions are entered after the fact (batch data entry), they are just stacks of source documents to the keyboard operator. Deciphering poor handwriting from a source document is a judgment call that is often error prone.
DATA WAREHOUSE	The architecture that serves as the secondary storage area for a collection of data, both at a detailed and aggregated level. The EIS/DSS Data Warehouse is a collection of ORACLE tables that contain the data extracted from flat files generated from the Kentucky MMIS on a monthly basis.
DATABASE (DB)	Data that has been organized and structured in a disciplined fashion, so that access to information of interest is as quick as possible. Database management programs form the foundation for most document storage indexing systems. (Imaging)
DATABASE ADMINISTRATOR (DBA)	The person responsible for maintaining the database system: managing data, designing database objects, database performance and data recovery and integrity at a physical level. This person is not an applications programmer.
DATABASE TABLE	A collection of similar records in a database.
DATE OF SERVICE (DOS)	The date of service on a claim; the date the beneficiary received medical service.
DC	Doctor of Chiropractic
DCBS	Department for Community Based Services

DD	Developmentally Disabled
DDE	Direct Data Entry
DDI	Design, development, and implementation.
DDS	Doctor of Dentistry
DECISION SUPPORT SYSTEM (DSS)	The Decision Support System (DSS) function provides access to the MMIS data and various external data sources. The data is stored in an Oracle RDBMS and is accessed through the Business Objects application. A computer program application that analyzes and presents business data in a form that assists users in making business decisions more easily. It is an informational ad-hoc reporting application, not an operational one. A DSS may present information graphically and may include an expert system or artificial intelligence.
DECOMPRESS	To reverse the procedure conducted by compression software, and thereby return compressed data to its original size and condition. (Imaging)
DEDUCTIBLE	The out-of-pocket expense a beneficiary must pay before other third party will begin payment for covered medical expenses, usually based on a calendar year. This amount, or a percentage thereof, is paid by Medicaid for beneficiaries also eligible for Medicaid.
DEFAULT	An automated process used to make random Managed Care assignments for beneficiaries who do not make a selection of a Primary Medical Provider of their own accord or were not assigned through auto assignment.
DEFENSE ENROLLMENT AND ELIGIBILITY REPORTING SYSTEM (DEERS)	A system that contains eligibility information on CHAMPUS, the insurance company for military dependents.

DELIMITER	A special Character used to separate fields of data. The three used in an EDI file are the segment delimiter, the element delimiter, and the sub-element delimiter.
DENIED CLAIM	Claim for services not paid by KY Medicaid, including services provided to an ineligible member, services provided by an ineligible provider, or services not billed in the correct manner.
DENY	Claim denial.
DETAIL (DTL)	A term that refers to the actual health care service provided to a member, billed on a claim form as the only service or possibly as one of several services provided. This is frequently called a line item or detail line.
DETAILED SYSTEM DESIGN (DSD)	Document created by the Fiscal Agent as a detailed guide to developing a new system or subsystem.
DIAGNOSIS CODE (DIAG, DX)	The medical classification of a disease or condition according to ICD-9-CM or HCPCS. A numeric code that identifies the patient's condition as determined by the provider of the performed service.
DIAGNOSIS-RELATED GROUP (DRG)	DRGs are the basis for one type of hospital reimbursement. A hospital specific fee is calculated for each diagnosis group for each hospital. Factors of age, sex, length of stay data, and historical costs for each hospital are taken into consideration in calculating the reimbursement amount. Usually, mental institutions and pediatric hospitals are excluded from DRG reimbursement due to the abnormal length of stay experienced by most patients.
DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS, THIRD EDITION, REVISED (DSM III)	A publication of the American Psychiatric Association establishing a coding system for mental diagnoses.

DISABILITY	A physical or mental condition that makes an insured incapable of performing one or more duties of his occupation or any occupation.
DISABILITY BENEFIT	A payment that arises because of the total and/or permanent disability of an insured; a provision added to a policy that provides for a waiver of premium in case of total and permanent disability.
DISABILITY DETERMINATION SERVICES (DDS)	A division of SRS that contracts with the Social Security Administration to determine the disability status of Social Security Disability applicants.
DISABILITY INCOME INSURANCE	A form of health insurance that provides periodic payments when the insured is unable to work as a result of illness, disease, or injury.
DISASTER RECOVERY (DR)	Facilities, plans, tests, etc. for the recovery of the MMIS from a total loss.
DISENROLLMENT	Removal of assignment or from the Managed Care program.
DISPOSITION	The actual status of a claim. The result of processing a claim is the assignment of a status or disposition. The disposition of a claim is determined by the Exception Control File.
DISPROPORTIONATE SHARE HOSPITAL (DSH)	Qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income persons.
DMS	Department for Medicaid Services
DO	Doctor of Osteopathy
DOB	Date of Birth
DOCTOR	Specifically, any person with a doctoral degree. In common usage, a synonym for physician; a person with a doctor of medicine degree.

DOCUMENT	Structured file sent to a trading partner. In ASC X12 usage, a document is synonymous with a transaction set.
DOCUMENT IMAGES	A computerized representation of a picture or graphic. (Imaging)
DOCUMENT RETRIEVAL	The ability to search for, select and display a document or its facsimile from storage. (Imaging)
DOD	Date of Death
DOING BUSINESS AS (DBA)	Refers to a type of Provider Name and Address.
DOT	Department of Transportation
DP	Data Processing
DPM	Doctor of Podiatric Medicine
DRILLDOWN	Applies additional criteria to an existing subset of data displayed on the DSS.
DROP DOWN DATAWINDOW (DDDW)	This is a tabular presentation of data that is used as a drop-down list on a window.
DRUG	Any substance or its components recognized in one of the official drug compendia for use in the diagnosis, cure, mitigation, treatment or prevention of disease, or intended to affect the structure or function of the body.
DRUG FORMULARY	A listing of drugs covered by a state Medicaid Program, which includes the drug code, description, strength and manufacturer.

DRUG REBATE SYSTEM (DR, DRS)	Federal regulations provide for drug manufacturers, with whom CMS has a formal agreement and whose drug products are covered by Medicaid, to give financial rebates to Medicaid based upon the volume of the manufacturer's products dispensed by Medicaid. The Kentucky Drug Rebate Subsystem maintains the information to carry out the federal mandates related to drug rebate processing.
DSS	Decision Support System
DUPLICATE PAYMENT	A payment to a provider for services provided to a beneficiary resulting from the processing of a duplicate or near-duplicate claim by the contractor.
DURABLE MEDICAL EQUIPMENT (DME)	Equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, such as crutches, wheelchairs, and walkers.
DX	Diagnosis Code, Diagnosis.

7.1.5 E

E&M	**Evaluation and Management**
E-DOS	Ending Date of Service
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)	As described in Title XIX of the Social Security Act.
EDIT	As applied to MMIS, an edit is a set of parameters against which a claim transaction is "edited." These edits can stop payment and/or generate reports. The verification and validation of claims data for detection of errors or potential error situations. Logic placed in the MMIS programming to cause claims that have specific errors to be placed in a suspend or deny mode due to not having successfully passed these edits.
EDP	Electronic Data Processing
EFT	Electronic Fund Transfer
ELECTRONIC BENEFITS TRANSFER (EBT)	EBT capabilities allow the State to issue food stamps and benefit checks electronically by utilizing the plastic Beneficiary ID Cards. Conforms to the ANSI Uniform Health Care ID Card Standards.
ELECTRONIC CLAIMS SUBMISSION (ECS)	See EDI.
ELECTONIC DATA INTERCHANGE (EDI)	Standard format for exchanging business data. The standard is ANSI x12, which was developed by the data interchange standards association (DISA). ANSI x12 is either closely coordinated with or is being merged with an international standard, EDIFACT. Standards for EDI include: ANSI for claims, eligibility, enrollment, EBT, and remittance. CCIT for others. NCPDP for pharmacy, HEDIS for managed care.

ELECTONIC DATA SYSTEMS (EDS) The Fiscal Agent for the Commonwealth of Kentucky.

ELECTRONIC FUNDS TRANSFER (EFT) An electronic deposit system for provider remittance amounts, and the process of authorizing a computer system to transfer funds between accounts.

ELECTRONIC MEDIA CLAIMS (EMC) Claims that are electronically transmitted to the MMIS through media such as telephone lines, diskettes, or tapes. This term is no longer used.

ELECTRONIC REMITTANCE ADVICE (ERA) Generally, RAs are submitted to the provider using the same media that the provider uses when submitting a claim. If the claim is submitted using a particular standard format, the RA is returned in the same format. See RA, NCPDP.

ELIG Eligibility

ELIGIBLE PROVIDER An institute, facility, agency, person, partnership, corporation, or association as enrolled and approved by the State that accepts, as payment in full for providing eligible services, reimbursement provisions, regulations, and schedules.

ENCOUNTER A record of a medically related service rendered to a beneficiary who is enrolled in a participating health plan (HMO) or in a PCCM plan during date of service. It includes (but is not limited to) all services for which the plan incurred any financial responsibility. Encounters are priced at the Medicaid value of a similar claim, but the reimbursement amount is zero (see STOP-LOSS). If a service is not covered under the HMO/PCCM plan, the claim will be billed by the provider as a FFS claim. Encounters are sometimes referred to as Shadow Claims as no money is paid out.

ER Emergency Room

ESC Error Status Code

EXCEPTION	The phrase "posts an exception" is commonly used when discussing claims processing to indicate there is data on the claim that fails an edit; therefore, an exception is posted to the claim.
EXCEPTION CODE	This code indicates that there is data on a claim that has caused the claim to fail an edit. An exception is then posted to the claim in question. Depending on the disposition of the edit on the Claim Edit Disposition Listing, the claim may pay, even with edits posted to it. An exception code can have different dispositions dependent upon media type.
EXPENDITURES (EXP)	The issuance of checks, disbursement of cash, or electronic transfer of funds as reported by the State.
EXPLANATION OF BENEFITS (EOB)	A notice issued to a provider that explains in detail the payment or nonpayment of a specific claim processed. Also a three-digit code that prints on the remittance advice to explain why a claim was either denied or suspended.
EXTENSIBLE MARKUP LANGUAGE (XML)	Universal format for structured documents and data on the Web.

7.1.6 F

FAIR HEARING (FH)	**A formal meeting where a Hearings Officer listens to all the facts and then makes a decision based on the law.**
FAMILY PLANNING (FP)	A medically approved treatment, counseling, drugs, supplies, or devices that are prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.
FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	Number assigned to a business entity for tax purposes. This number might be of value in identifying all the businesses owned by a corporation.
FEDERAL INSURANCE CONTRIBUTIONS ACT (FICA)	Social Security taxes deducted by the employer.
FEDERAL POVERTY LEVEL (FPL)	The poverty threshold is a statistical measure used to indicate the level of cash income needed by a family to purchase a “minimally adequate” market basket of goods and services. The threshold is adjusted for family size and updated every February for inflation. It is a nationwide standard of poverty.
FEDERAL REGISTER (FR)	The Federal Register is the official daily publication for Rules, Proposed Rules, and Notices of Federal agencies and organizations, as well as Executive Orders and other Presidential Documents.
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	A federally funded agency that provides medical services on a sliding fee schedule to the general public.
FEE FOR SERVICE (FFS)	The payment method by which KY Medicaid reimburses providers on a service-by-service basis.
FEE SCHEDULE	A listing of acceptable Charges or established allowances, normally representative of either standard or maximum Charges, for the listed medical or dental procedures.

FIELD An on-screen area used for entering specific information, such as a name or extension number, within the telephone system. A field prompt identifies the type of information that belongs in each field.

FILE MAINTENANCE The periodic updating of master files. For example, adding or deleting employees and customers, making address changes and changing product prices. It does not refer to daily transaction processing and batch processing.

FILE TRANSFER PROTOCOL/PROGRAM (FTP) A method of transferring files between heterogeneous computing platforms. Since most large scale computing systems interface between mainframes, mini, PC's, and the Internet, a method is needed to transfer data between these different platforms. (See TCP/IP)

FIREWALL Security protection for a Web site (see proxy server), LAN, and Intranet. May check incoming and outgoing messages.

FISCAL AGENT (FA) The contractor retained by the State for operation of the MMIS and for the performance of claims processing and other related Medicaid functions in KY Medicaid.

FISCAL INTERMEDIARY (FI) Similar to a fiscal agent. A corporation is designated to have complete responsibility for a government health program, including all data processing functions, program administration, professional relations, and clerical staffing for claims processing.

FISCAL YEAR (FY) Any twelve-month period for which manual accounts are retained. The fiscal year may, but need not, correspond to the calendar year. The federal Fiscal Year starts October 1 and ends September 30 of the following year. States usually operate on July 1 through June 30 of the following year.

FLAT FILE A database consisting of one table. It is a stand-alone data file that does not have any predefined linkages or pointers to locations of data in other files. This is the type of file used in a relational database; however, the term is often used to refer to a type of file that has no relational capability, which is exactly the opposite.

FOOD AND DRUG ADMINISTRATION (FEDERAL DRUG AGENCY, FDA)	A federal agency responsible for the monitoring and regulation of foods and drugs distributed in the United States.
FORMULARY	A listing of drugs and the regulations that govern payment.
FPA	Family Planning Agency
FROM DATE OF SERVICE (FDOS)	Date used in the claim.
FRAUD AND ABUSE (F&A)	Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by KMAP. This is not the same as fraud.
FTE	Full-Time Equivalent
FULL TEXT SEARCH	The ability to search text files for occurrences of certain words, digits, sentences, or patterns of Characters. Generally, a scanned document cannot be full text searched. To do that, the document would have to be retyped or scanned with an OCR to create a text file. (Imaging)
FUNCTIONAL ACKNOWLEDGEMENT	An EDI message that is sent in response to the receipt of an EDI message or packet of messages to notify the sender of the original message that it was received. It acknowledges only the receipt of the message or message packet, and does not imply agreement with or understanding of its content.

7.1.7 G

GARNISHMENT	**A court-ordered attachment, or withholding, of a provider's earnings to pay a debt.**
GATEWAY	The interconnection between public or private networks that allow the transmission of documents in X12 format across multiple networks. Also called interconnect.
GB	Gigabyte
GENERAL PRACTITIONER	A doctor of medicine who generally performs a wide range of medical services as opposed to one who specializes only in certain areas of practice.
GENERIC	A term used in reference to drugs that meet the following criteria: 1) The product is available from more than one source. 2) The Average Wholesale Price of the product is significantly lower than the non-generic. 3) The product is not under patent.
GENERIC CODE NUMBER (GCN)	The standard generic code for drugs.
GLOBAL POSITIONING SOFTWARE (GPS)	This software is incorporated into the MMIS interChange allowing default and auto assignment of beneficiaries to providers. It utilizes longitude and latitude for assignment purposes.
GRAPHICAL USER INTERFACE (GUI)	A "windows" based computer interface that allows for consistency of this application with other applications used by the operators. The device drivers associated with these GUIs optimize the painting of snippets and the rendering of fonts to take full advantage of the high-performance graphic cards installed in PCs. (Imaging)

GRAY SCALE The spectrum, or range, of shades of black an image has. Scanners and terminals gray scales are determined by the number of gray shades, or steps, they can recognize and reproduce. A scanner that can only see a gray scale of 16 will not produce as accurate an image as one that distinguishes a gray scale of 256. (Imaging)

GROUP PRACTICE A medical practice where more than one provider render and bill for services under a single provider number.

GSD General System Design

7.1.8 H

HARD DISK **A storage device that uses a magnetic recording material. Generally, hard disks are fixed inside a PC, but there are removable cartridge versions. Hard disks store anywhere from five to hundreds of megabytes. (Imaging)**

HCFA-1500 CMS-approved uniform claim form that is required for most professional providers to bill for most non-institutional services. The form is mandated for use in billing both Medicare and Medicaid programs for medically related services.

HEADER (HDR) This term refers to data on a claim that is not line item specific, but applies to the entire claim. An example of header information would be the provider's name, address and SSN.

HEALTH AND HUMAN SERVICES (HHS) The executive department of the federal government responsible for social and economic security, educational opportunity, national health and child welfare. Specifically, the department is responsible for Medicaid and Medicare Programs. Formerly DHEW.

HEALTH CARE FINANCING ADMINISTRATION (HCFA) See CMS.

HEALTH INSURANCE A contract under which a company guarantees payment for specified loss by disease or accidental bodily injury normally by covering a portion of the associated medical costs.

HEALTH INSURANCE PORTABILITY AND ACCOUTABILITY ACT OF 1996 (HIPAA) A Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191. Accountability Act of 1996.

HIPAA	Health Insurance Portability and Accountability Act of 1996
HEALTH INSURANCE PREMIUM PAYMENT SYSTEM (HIPP)	A program where Medicaid-eligible beneficiaries may receive insurance premium assistance using Medicaid funds when it is determined cost-effective to purchase group health insurance.
HEALTH MAINTENANCE ORGANIZATION (HMO)	A prepaid cost-effective health plan that provides a range of preventative and maintenance services in return for a fixed monthly premium that entitles the enrollees to a predetermined set of basic and supplemental services. A health care providing organization, which Charges a flat fee per month (Capitation) per person, enrolled. The services provided are defined by contract and generally are comprehensive. HMO enrollment is an alternative form of health care delivery that is offered to Medicaid beneficiaries.
HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS)	Used to measure a plan's performance. Utilized in Quality Assurance for Managed Care. HEDIS and HEDIS and Compliance Audit are registered trademarks of the National Committee for Quality Assurance (NCQA). NCQA encourages and promotes the use of performance measures that comprise HEDIS. HEDIS Compliance Audit is a rigorous process for evaluating the accuracy and validity of plan-reported performance results.
HEALTH PLAN EMPLOYER DATA AND INFORMATION SET STANDARD (HEDIS STANDARD)	A Federal standard for Electronic Data Interchange (EDI) for Medicaid Managed Care programs.
HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)	A uniform health care procedural coding system approved by CMS. It describes the physician and non-physician patient services covered by the Medicaid and Medicare programs. It is used primarily to report reimbursable services provided to patients. There are three types of HCPCS codes. Level 1 includes the CPT-4 codes. Level 2 includes the alphanumeric codes A through V which CMS maintains for a wide range of services from ambulance trips to hearing aids which are not addressed by the CPT-4 coding. Level 3 includes the alphanumeric codes W through Z, which are assigned for use by the state agencies.

HOME AND COMMUNITY BASED SERVICES (HCBS)	Home and Community Based services are for persons with mental retardation or other developmental disabilities are made possible through Medicaid waivers. These services are intended as an alternative to institutional services. Each waiver offers services for a specific group: Head Injury, Technology Assistance, Physical Disability, Frail and Elderly, Developmental Disabilities, and Children with Severe Emotional Disturbance.
HOME HEALTH AGENCY (HHA)	An agency that provides home health care services such as home health aide visits, LPN and RN visits, and therapy services.
HOSPICE	A program that provides an integrated program of appropriate hospital and home care for the terminally ill patient. A hospice is a public agency or private organization that provides services for terminally ill people. It is usually affiliated with a hospital. Hospice care may be home care, inpatient care, or respite care. Respite care is inpatient care provided for the beneficiary to give the family temporary relief from the strain of caring for a loved one at home.
HOSPITAL	A health care institution whose primary function is to provide inpatient services for a variety of surgical and non-surgical medical conditions. Hospitals are classified by length of stay, teaching or non-teaching, major type of services, and by control.
HOSPITAL INSURANCE PROGRAM (PART A)	The compulsory portion of Medicare that automatically enrolls all persons 65 years of age or older, entitled to railroad retirement and eligible for disability for over two years, and insured workers and their dependents requiring dialysis or kidney transplants.
HOST	Computer in which an application or database resides or to which a user is connected. Sometimes used generically as synonym for computer. (Imaging)
HYPERTEXT MARKUP LANGUAGE (HTML)	Programming language used to develop and maintain web pages on the Internet.
HYPERTEXT TRANSFER PROTOL (HTTP)	The underlying protocol used by the World Wide Web. HTTP defines how messages are formatted and transmitted, and what actions Web servers and browsers should take in response to various commands.

HYPERTEXT TRANSFER PROTOCOL SECURE (HTTPS)	Protocol to provide encrypted transmission of data between Web browsers and Web servers.

7.1.9 I

ICD-10-CM	**International Classification of Diseases, Tenth Revision**
iCE	interChange Enhanced
ICF/MR	Intermediate Care Facility/Mental Retardation
ICN	Internal Control Number.
ICON	The basis of a graphical user interface, an icon is a picture or drawing of a device or program that is activated, usually with a mouse, to access the device or run the program.
IMAGE	The computerized representation of a picture or graphic. (Imaging)
IMAGING	A method of electronically capturing a representation of a form, whether it is a claim or other piece of correspondence, to allow rapid retrieval and processing of the source document copy.
IMAGING SYSTEM	Collection of units that work together to capture and recreate images. At its simplest, it has an acquisition device (scanner, camera), an image processor and an imaging device (printer, microfilm, computer). (Imaging)
INCOME MAINTENANCE (IM)	A division within the Commission of Income Maintenance/Employment Preparation Services of SRS. The division is responsible for administration and oversight of programs relating to eligibility for Public Assistance programs, including AFDC, Medicaid, and food stamps.
INFORMATION TECHNOLOGY (IT)	A broad term referring to the entire field – computers, communications, Internet, imaging, etc.

INPATIENT (IN, INP, IP) A patient who has been admitted, at least overnight, to a health care facility. A patient who is literally in residence or in bed in the facility.

INQUIRY MODE An window mode where the user is viewing data as the result of an inquiry rather than having accessed the specific window in order to add, change or delete data from certain financial records and/or claims. Inquiry Mode allows flow between the various parts of the system but does not allow changes to the data being viewed.

INSURANCE Health insurance.

INTEGRATED TEST FACILITY (ITF) Copy of MMIS production system used for testing changes and enhancements to the MMIS.

INTENSIVE CARE UNIT (ICU) The level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.

INTERACTIVE Back-and-forth dialog between the user and a computer.

INTERMEDIARY A public or private insurance organization under contract with the government to handle claims from hospitals, skilled nursing facilities and home health agencies (Part A Medicare).

INTERMEDIATE CARE FACILITY (ICF) Any facility that provides room, board, and all routine services and supplies.

INTERMEDIATE CARE FACILITY FOR MENTAL RETARDATION (ICF/MR) Facilities that have met state licensure standards and that provide habilitation-related care and services, prescribed by a physician, in conjunction with active treatment programming for beneficiaries who are mentally retarded and who have related health and physical conditions.

INTERNAL CONTROL NUMBER (ICN) A unique 13-digit identification number assigned to every KMAP claim in order to distinguish it from all other claims received by the system. The ICN consists of: 2-byte Region, which represents claim media and claim type; a 5-byte Date of Receipt, which consists of the YY – year and JJJ – Julian; and a 6-byte Sequence number.

INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)	A classification and coding structure of diseases used by the health care community to describe patients' conditions and illness, and to facilitate the collection of statistical and historical data.
INTERNATIONAL CLASSIFICATION OF DISEASES, NINTH REVISION (ICD-9-CM)	A three-volume coding manual that contains the diagnosis codes used in coding claims, as well as the procedure codes used in billing for services performed in a hospital setting.
INTERNATIONAL STANDARDS ORGANIZATION (ISO)	An international organization, working with the United Nations that maintains the standards for all applications of technology and mechanics for global industry.
INTERNET CONTROL MESSAGE PROTOCOL (ICMP)	Extension to IP supporting packets containing error and control information. For example. The PING command uses ICMP to test an Internet connection. (See IP, TCP/IP.)
INTERNET PROTOCOL (IP)	Works like the postal system. There is no direct connection – just the packet address to send messages to, and the address for returned messages.
INTERNET SERVICE PROVIDER (ISP)	Commercial provider of Internet services; e.g., AOL, Sprynet, Flashnet, etc. To use the Internet a user must have a commercial ISP that maintains a computer system through which the user accesses the Internet.
IP	Inpatient
IP	Internet Protocol

7.1.10 J

JCAHO	**Joint Commission On The Accreditation Of Health Care Organizations**
JCODE	A five-digit procedure code that begins with the letter J.
JOB CONTROL LANGUAGE (JCL)	A language designed to express statements in a computer job that are used to identify the job or describe its requirements to an operating system.
JOINT APPLICATION DESIGN (JAD)	The process where the system user and designer meet together to define the application. Generally, requirements are reviewed, validated, and clarified.
JULIAN DATE	The representation of month and day by a consecutive number starting with January 1. For example, February 1 is Julian 032. Dates are converted into Julian dates for calculation.

7.1.11 K

KAPER	**Kentucky Application for Provider Evaluation and Re-evaluation**
KenPAC	Kentucky Patient Access and Care program.
KEY	Keys are indexed columns in tables, often used to join tables. Keys uniquely identify each record, or row, in a table. Examples would be Cust-ID or Provider Number. A word, number or phrase associated with a document to aid in its retrieval from storage. Sometimes called descriptors. There are often many keys used together to fully locate a document; together they are called an index. Also called a retrieval key. (Imaging)
KILOBYTE	One thousand bytes. To a computer, its actually 1,024. So, 16 kbytes, or 16K, is actually 16,384 bytes; 64K is 65,536 bytes, etc. (Imaging)
KMAA	Kentucky Medicaid Administrative Agent

7.1.12 L

LASER DISC	**An optical disc with the same technology as a Compact Disc, except laser discs are 12 inches in diameter. (Imaging)**
LEGACY	Term used to refer to the prior MMIS used in Kentucky
LENGTH OF STAY/SERVICE (LOS)	A designation generally correlated to the patient's diagnosis that refers to the number of days that a patient is confined to an inpatient facility.
LIFETIME RESERVE DAYS	A nonrenewable sixty-day period of additional hospital days awarded to Medicare beneficiaries.
LINE ITEM	A term used in reference to a level of detail on a claim. Line item details are services billed using a procedure code, a quantity, and a date of service for a specific fee. Claims may have multiple line items or detail lines.
LKN	Lock-In
LMB	Low-Income Medicare Beneficiary
LOC	Level of Care

LOCAL AREA NETWORK (LAN)

A communications network that serves users within a confined geographical area. It is made up of servers, workstations, a network operating system and a communications link.

Servers are high-speed machines that hold programs and data shared by all network users. The workstations, or clients, are the users' personal computers, which perform stand-alone processing and access the network servers as required.

The controlling software in a LAN is the network operating system, such as NetWare, UNIX, and Appletalk, which resides in the server. A component part of the software resides in each client and allows the application to read and write data from the server as if it were on the local machine.

The message transfer is managed by a transport protocol such IPX, SPX, and TCP/IP. The physical transmission of data is performed by the access method (Ethernet, Token Ring, etc.), which is implemented in the network adapters that plug into the machines. The actual communications path is the cable (twisted pair, coax, optical fiber) that interconnects each network adapter.

LOCAL CODES

A generic term for code values that are defined for a state or other political subdivision, or for a specific payer. This term is most commonly used to describe HCPCS Level III Codes, but also applies to state-assigned Institutional Revenue Codes, Condition Codes, Occurrence Codes, Value Codes, etc.

LOCAL OFFICE

The DCBS office in an individual county. Local county offices are grouped into a management area for administrative efficiency.

LOCK-IN

The punitive restriction of a Medicaid beneficiary to a particular provider for a period of time as determined by the State.

LONG TERM CARE (LTC)

Beneficiary care that includes room, board, and all routine services and supplies. The LTC program includes the SNF, ICF and ICF/MR services.

LPN

Licensed Practical Nurse

7.1.13 M

MAGNETIC DISK AND TAPE	**The primary computer storage media. The choice depends on accessing requirements. Disk is direct access; tape is sequential access. Locating a program or data on disk can take a fraction of a second. On tape, it can take seconds or minutes.**
MAGNETIC RESONANCE IMAGING (MRI)	A noninvasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves.
MAINFRAME	A large, powerful computer, often serving several connected terminals.
MANAGED CARE (MC)	Comprehensive health care integrating clinic/admin for cost effective care (HMO). Managed Care includes Capitated HMO, PCCM, and Fee-For-Service managed care.
MANAGED CARE ORGANIZATION (MCO)	An organization paid to provide services to a select group of beneficiaries assigned to them for a given time period.
MANAGEMENT ADMINISTRATIVE REPORTING SUBSYSTEM (MAR, MARS)	The MMIS subsystem that produces the management data required for financial, benefit, provider and beneficiary reporting.
MANUAL CHECKS	Checks written outside the automated check writing cycle.
MAPPING	The act of determining what pieces of information in the company's database should be placed into each data element of an EDI message or transaction set, or in reverse, what data elements of an EDI message or transaction set should be placed into the company's database.

MASS ADJUSTMENTS The systematic adjustment of more than one claim at the same time for the same reason. Multiple adjustments entered at one time. Mass adjustments are requested on line and they are particularly useful when it is necessary to reprocess hundreds or thousands of claims. Mass adjustment requests are submitted for a specific population of claims. In other words, claims that have something in common. They may be all of the drug claims processed after a certain date; they may be a subset of claims for a specific provider, or they may be all of the claims processed for a specific beneficiary. The criterion for claims selection is highly variable.

MB Megabyte

MEDICAID (MCD) The joint federal and state medical assistance program that is described in Title XIX of the Social Security Act, designed to provide health benefits assistance to medically needy young persons (less than 21 years of age) and to the aged (more than 65 years of age). A health insurance program for the poor which is jointly funded by the state and federal governments. Also, referred to as Title XIX of the Social Security Act. The Medicaid Program is administered by the states under the management of the Centers for Medicare and Medicaid (CMS).

Federal/State partnership of medical assistance for low income (title XIX, SS act) persons. There are 33 million people eligible. Includes ABD, low-income with children, low-income pregnant, and people with very high medical bills. In order to receive medical assistance a client must qualify into one of six categories: age 65, Blind, disabled, families with dependent children (TANF), pregnant, incapacitated (= categorically needy).

MEDICAID STATISTICAL INFORMATION SYSTEM (MSIS) Reporting required by CMS in standard formats. MSIS reports are required by each state and combined by CMS.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS, MMIS INTERCHANGE) Computer application that makes up the Medical Assistance Program system. A system composed of at least six subsystems for the general design of Title XIX systems as defined, outlined, and documented by the Department of Health and Human Services. All states with Medicaid Programs are required to have an MMIS. The MMIS processes medical claims and produces reports which track expenditures by aid category, claim type, category of service, or some other parameter.

MEDICAL NECESSITY (MN) A documented decision by a medical practitioner that a therapy, treatment, drug, item, or service prescribed or provided is essential to treat or diagnose a specific physical or psychiatric condition.

MEDICALLY NEEDY (MN) Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.

Beneficiary who has a catastrophic illness and cannot pay the incurred costs. (See "CATEGORICAL NEEDY"). Must still fall into one of the six categories.

MEDICAL REVIEW (MR) Analysis of Medicaid claims to ensure that the service was necessary and appropriate.

MEDICARE The federal medical assistance program that is described in Title XVIII of the Social Security Act for people 65 years of age or older, for persons eligible for Social Security disability payments, and for certain workers of their dependents who require kidney dialysis or transplantation. A health insurance program for individuals over 65 years of age, as well as certain disabled persons. Medicare is 100 percent federally funded. The Medicare Program is administered by the Health Care Financing Administration (HCFA). Applications for Medicare benefits are processed by the Social Security Administration. Medicare has two distinct plans: Part A is hospital insurance covering inpatient, hospice, home health, and skilled nursing facility care; and Part B is medical insurance covering physicians' services, outpatient care, diagnostic tests, durable medical equipment, and ambulance services. Refer to Title XVIII.

MEDICARE PART A Part A of Title XVIII of the Social Security amendments of 1965 that provided benefits principally for hospital and hospital-related services. The formal designation is "Hospital Insurance Benefits for the Aged".

MEDICARE PART B Part B of Title XVIII of the Social Security amendments of 1965 that provided benefits principally for physician's services. The formal designation is "Supplementary Medical Insurance Benefits for the Aged".

MEDIGAP In relation to Medicare, this private health insurance pays most of the health care service Charges not covered by Parts A or B of Medicare. These policies, which must meet federally imposed standards, are offered by many commercial health insurance companies.

MEGABYTE Approximately one million bytes. Precisely, 1,024 kilobytes or 1,048,576 bytes. (Imaging)

MENTAL RETARDATION (MR)	Significantly sub-average intellectual functioning, evidenced by an IQ rating of 70 or below on any standardized measure of intelligence, concurrently existing deficits in adaptive behavior as listed in the Other Development Disability definition.
MICROMEDIA	For the purpose of this document, micromedia refers to microfilm, microfiche, or the ability to access online those documents residing on the State's imaging database.
MSIS	Medicaid Statistical Information System
MSW	Master of Social Work
MTD	Month to Date
MULTIMEDIA	Combining more than one media for the dissemination of information, i.e., using text, audio, graphics, animation and full-motion video all together. Requires enormous amounts of bandwidth and processing power. (Imaging)

7.1.14 N

NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP)	**An ANSI-accredited council developed to review and define national standards for the billing of prescription drug services for reimbursement by private insurance as well as state and federal agencies. Some of the standard formats are included in the HIPAA mandates.** **Provides standards for data interchange and standards for processing pharmacy services in the health care industry. The NCPDP Telecommunications Standard defines the record layout for interactive prescription drug claim transactions between providers and adjudicators. Version 5 of this standard is currently in draft form.**
NATIONAL DATA CORPORATION/NATIONAL DRUG CODE (NDC)	Provider of communication software/hardware for pharmacies. (See ENVOY.) or A generally accepted system for drug identification that is the primary drug ID used. (1) A standard coding scheme of eleven digits that assigns a unique numeric code to all drugs on the market. (The first five digits indicate the drug manufacturer; the next four digits specify the particular drug and the last two digits refer to the package size.) (2) A 10-Character code assigned to all prescription drug products by the labeler/distributor of the product under FDA regulation. Each NDC is composed of three sub-codes, which can assume different configurations. The NDC codes are impractical to use for data processing applications such as sorting, searching, etc., because of the variable structure of the sub-codes. The National Drug Data File (NDDF) Code therefore is always eleven digits in length and each of its sub-codes always contains the same number of Characters (5-4-2). This is achieved by inserting a leading zero in one of the three sub-codes in the NDC.
NATIONAL PROVIDER FILE (NPF)	A national repository of provider identification data to support assignment of a national provider identifier.
NATIONAL PROVIDER IDENTIFIER (NPI)	A national system of provider identification that is used nationally by all providers starting in 1997.

NATIONAL STANDARD FORMAT (NSF)	The NSF was designed to standardize and increase the submission of electronic claims and coordination of benefits exchange. The NSF is used to electronically submit health care claims and encounter information from providers of health care services to payers. It is also used to exchange health care claims and payment information between payers with different payment responsibility.
NEMT	Non Emergency Transportation
NH	Nursing Home
NON-COVERED SERVICES (NC)	The service does not meet the requirements of a Medicaid benefit category, or the service is excluded from coverage or is not reasonable and necessary.
NON EMERGENT MEDICAL TRANSPORTATION (NEMT)	Non-commercial medical transportation provided to beneficiaries in private vehicles, including their own.
NURSE PRACTITIONER (NP)	A registered nurse who has advanced training in a specialized nursing field such as geriatrics or pediatrics.

NURSING FACILITY (NF)

Any facility that provides room, board, and all routine services and supplies. All NFs are required to be licensed by the secretary of the state Department of Health.

An institution or a distinct part of an institution which is primarily engaged in providing to residents: nursing care and related services, rehabilitation services or health related care, and services (above the level of room and board) which can be made available only in an institutional facility. The facility must have in effect a transfer agreement with one or more hospitals and must meet Medicaid participation requirements.

Any place or facility operating for not less than twenty-four (24) hours in any day and caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves, and for whom reception, accommodation, board and skilled nursing care and treatment is provided, and which place or facility is staffed to provide 24-hour-a-day, licensed, nursing personnel plus additional staff, and is maintained and equipped primarily for the accommodation of individuals who are not acutely ill and are not in need of hospital care but who require skilled nursing care.

7.1.15 O

OCC	**Occurrence Codes (Inpatient claims)**
OCCUPATIONAL THERAPY (OT)	The use of life related activities to restore and evaluate motor skills so that disabled persons may attain health, social, or economic independence.
OCR DATA RECOGNITION (OCR)	Images passed to the OCR subsystem are fed to the recognition engines one claim at a time. The recognition engines interpret each Character or mark sense field based on the form definition used. All recognized data is placed in an ASCII data file. (Imaging)
OD	Doctor of Optometry
OIG	Office of Inspector General
OMNIBUS BUDGET RECONCILIATION ACT (OBRA)	See PASARR. OBRA-90 establishes the Drug Rebate program.
OMNIBUS BUDGET AND RECONCILIATION ACT OF 1990 (OBRA-90)	Establishes the Drug Rebate program.
ONBASE	OnBase processes the print output of application programs, extracts index fields from the data, stores the index information in a relational database, and stores one or more copies of the data in the system so that the user can archive newly created and frequently accessed reports or images on high speed, disk storage volumes and automatically migrate them to other types of storage volumes as they age.

ONLINE

The use of a computer terminal to display computer data interactively.

Available for immediate use. If your data is on disk attached to your computer, the data is online. If it is on a disk in your desk drawer, it is offline.

A peripheral device (terminal, printer, etc.) that is turned on and connected to the computer is said to be online. However, a printer can be taken offline by simply pressing the ONLINE or SEL button. It is still attached and connected, but is internally cut off from receiving data from the computer. Pressing the ONLINE or SEL button will turn it back on-line.

Systems are designed as either online or batch. Online means terminals are connected to a central computer, and batch means entering batches of transactions on a second or third shift. Other terms, such as real-time and transaction processing evolved from online processing.

OPERATING SYSTEM (OS)

The master control program that runs the computer. It is the first program loaded when the computer is turned on, and its main part, called the kernel, resides in memory at all times. It may be developed by the vendor of the computer it's running in or by a third party. It is an important component of the computer system, because it sets the standards for the application programs that run in it. All programs must "talk to" the operating system. See API, JCL.

ORACLE

The Corporation that provides the ORACLE software which is the major Relational Database software for minicomputers and PCs.

OTHER INSURANCE (OI)

A term used to describe primary insurance payers. Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.

OUTPATIENT (OPT)

A patient who is receiving care at a hospital or other health facility without being admitted. Outpatient normally does not include patients receiving services from a facility that does not also give inpatient care.

OUTPATIENT CARE

Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.

OVER THE COUNTER (OTC)

A drug classification used to describe pharmaceuticals that do not require a prescription.

7.1.16 P

PA	**Physician's Assistant** **Prior Authorization**
PAID CLAIM	A claim that has been processed through the adjudication and payment cycles. In the MMIS, the term “paid” refers to a claim with a payment status of either “paid” or “denied”. A paid claim can result in the provider being reimbursed for some dollar amount or a zero paid amount.
PARAMETER	Any value passed to a program by the user or by another program in order to customize the program for a particular purpose. A parameter may be anything; for example, a file name, a coordinate, a range of values, a money amount or a code of some kind. Parameters may be required as in parameter-driven software or they may be optional. Parameters are often entered as a series of values following the program name when the program is loaded.
PASSPORT	Managed care organization which serves Medicaid members in Jefferson and surrounding counties.
PASSWORD	Confidential code used in conjunction with the User ID to gain access to a system.
PATIENT	A person receiving treatment or care from a physician or other health professional.
PATIENT LIABILITY (PAT LIAB)	A beneficiary's monetary obligation to a nursing facility that is determined by his or her income level.
PAY AND CHASE	Under certain circumstances, the claims are initially paid by the Claims processing system and then the claims must accumulate to a pre-determined threshold prior to payment by the third party insurance. In this situation, a claim is paid, despite coverage, and the carrier is billed (pay and chase).

PAYER OF LAST RESORT	The insurance program that pays after all of a patient's other insurance programs have paid for a service. Medicaid is usually the payer of last resort.
PAYMENT CYCLE	The processing of adjudicated claims to a paid or denied status. Users determine the frequency of running payment cycles. Most state agencies pay providers weekly.
PAY-TO PROVIDER	The provider who will receive payment (if a group/clinic number is present, it would be the "Pay-to Provider"
PAYOUT (PAY)	Non-claim specific payment to a provider or other entity (i.e.: insurance company).
PBA	Pharmacy Benefits Administrator
PDD	Procedure, Drug, Diagnosis
PE	Presumptive Eligibility
PEER	A person or committee in the same profession as the provider whose claim is being reviewed.
PEER REVIEW	An activity performed by a group or groups of practitioners or other providers to review the medical practices of their peers for conformance to generally accepted standards.
PEER REVIEW ORGANIZATION (PRO)	A quality assurance or peer review program that reviews Medicare, Medicaid and Maternal and Child Health program claims. Mandated by the federal government to review the necessity and appropriateness of admissions to hospitals and continued stay in hospitals. PROs have the authority to deny payment or recoup payment for services that are deemed unnecessary.
PER DIEM	A daily rate usually associated with payment to an institution such as a hospital or a skilled nursing facility assigned to institutional providers.

PERSONAL COMPUTER (PC)	Although the term "PC" is sometimes used to refer to any kind of personal computer, PC refers to computers that conform to the PC standard originally developed by IBM. PCs are used as stand-alone personal computers or as workstations and file servers in a LAN (local area network). They are predominantly used as single-user systems under DOS; however, they are occasionally used as a central computer in a multi-user environment under UNIX and other operating systems.
PERSONAL IDENTIFICATION NUMBER (PIN)	A number used to provide a password into the system for security purposes.
PF KEY	The function keys at the top of a computer keyboard which serve as commands (for example, F1, F2, F3, etc.).
PHARMACIST	A professional qualified by education and authorized by law to prepare, preserve, compound, dispense and give appropriate instruction in the use of drugs.
PHARMACY BENEFIT MANAGEMENT (PBM)	Pharmacy Benefit Management (PBM) applies managed care principles to prescription drug programs, with the goal of optimal and cost-effective drug prescribing and use. PBM functions include (1) claims processing and adjudication, (2) data management, reporting, and trending (3) formulary management and clinical review services, (4) prospective Drug Utilization Review (ProDUR), and (5) drug rebate management.
PHARMACY POINT-OF-SERVICE (RX-POS, POS)	The Pharmacy POS system enables Medicaid providers to submit electronic pharmacy claims in an on-line, real-time environment. The electronic claim submission will verify beneficiary eligibility; including other health insurance coverage, and monitor Medicaid drug policies. Claims will also be screened against beneficiary medical and prescription history within the Medicaid system. Once these processes are complete, the provider will receive an electronic response indicating payment or denial within seconds of submitting the electronic claim. Also referred to Point of Sale.
PHD	Doctorate of Philosophy.
PHYSICAL THERAPY (PT)	Rehabilitation concerned with the restoration of function and prevention of disability following disease, injury, or loss of a body part.

PHYSICIAN (PHY, PHYS)	A professional qualified by education and authorized by law to practice medicine.
PHYSICIANS DESK REFERENCE (PDR)	PDR is considered the standard prescription drug reference.
POS	Place Of Service The location at which a service was rendered, such as office, home, emergency room, etc.
POS	Point Of Sale
PLAN OF CARE	A document completed following the determination of long-term care eligibility and the individual elects home and community based services instead of nursing facility services. This document must include: the services to be provided, the frequency of each service, who will provide each service, and the cost of each service.
PM	Project Manager
PMP	Primary Medical Provider
POD	Podiatrist
POS	Place of Service
POVERTY LEVEL	The poverty threshold is a statistical measure used to indicate the level of cash income needed by a family to purchase a “minimally adequate” market basket of goods and services. The threshold is adjusted for family size and updated every February for inflation. It is a nationwide standard of poverty.
PPO	Preferred Provider Organization

PRE-CERTIFICATION (PRE-CERT)	Serves as an entry and approval process PA requests. It interfaces with the PA subsystem to provide automated update to the PA files.
PREMIUM	The periodic payment (e.g. monthly, quarterly) made to an insurance company to keep an insurance policy in force.
PRICING INDICATOR CODE (PIC)	An indicator that determines the reimbursement restrictions for drug and procedure codes.
PRIMARY CARE	Basic level of health care rendered by general practitioners.
PRIMARY CARE PROVIDER (PCP)	A professional, which could be a physician, ARNP, health department, or clinic, who manages a beneficiary's health care needs.
PRIMARY CARE SERVICES	Those services provided by a duly licensed medical practitioner who has contracted with SRS to initiate or approve specified medical services for participating Medicaid beneficiaries.
PRIMARY MEDICAL PROVIDER	An individual provider or organization assigned to a beneficiary with the responsibility of providing the majority of a beneficiary's medical services.
PRIOR AUTHORIZATION (PA)	Authorization granted by SRS staff, or its designated representative, to a provider to render specified services to a designated beneficiary. Acknowledgement, given before payment may occur, that certain specified services meet an established criterion. Acquiring permission before performing a service. Prior authorization is a condition for payment for many services reimbursed by Medicaid.
PROCEDURE (PROC)	A numeric or alphanumeric code used to describe the specific service rendered to a patient by a provider.
PROCEDURE, DRUG, AND DIAGNOSIS FILE (PDDF FILE)	A file within the Reference Subsystem that contains records on all billable codes. The file also contains information on provider restrictions, beneficiary eligibility, and service limitations.

PROCESSED CLAIM	A claim that has been adjudicated, properly paid or denied, and the remittance has been sent.
PROFESSIONAL COMPONENT (PC)	Charges associated with a physician's expert reading of and interpreting some x-ray, lab, and diagnostic procedures.
PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO)	A quality assurance or peer review program that reviews Medicare, Medicaid and Maternal and Child Health program claims.
PROJECT WORKBOOK (PWB)	HP Enterprise Services proprietary WEB application that serves as a repository of HP Enterprise Services interChange information. The Project Workbook contains administrative, application, and project information.
PROMPT	To request input from the user by displaying a message on the computer screen or by playing an audio message on the telephone.
PROTOCOL	In information technology, it is a set of rules describing the contents of an electronic communication. To communicate, both the sender and receiver must adhere to the protocol. See TCP/IP, HTTP, and FTP.
PROVIDER	An eligible institution, facility, agency, managed care organization, administrative service organization, person, partnership, corporation, or association as enrolled and approved by the State which accepts, as payment in full for providing eligible services, reimbursement provisions, regulations, and schedules.
PROVIDER CATEGORY OF SERVICE	A code that indicates on a claim the type of service given by the provider in question. This code indicates the specific categories of service a provider may bill for.
PROVIDER SPECIALITY (PS)	A code that specifies the type of service a provider renders.
PROVIDER TYPE	A general code that indicates the type of service a provider can perform.

PROXY SERVER	A firewall security for a web site. A server that acts as an intermediary between a workstation user and the Internet and is associated with the gateway server that separates the enterprise network from outside intrusion.
PSY	Psychologist
PSYCHIATRIC HOSPITAL	An institution that is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons.
PURGE	Refers to moving data from the master files to the archive files. For example, beneficiary eligibility records may be purged if there is no activity within a three-year period.

7.1.17 Q

QA	**Quality Assurance**
QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI)	A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Certain formerly disabled persons who lost Medicare benefits because of their return to work are allowed to purchase Medicare Part A coverage. The State Medicaid Program must pay the Part A premium for those individuals entitled to enroll in Part A if their income does not exceed twice the SSI limit and they are not otherwise eligible for Medicaid benefits.
QUALIFIED MEDICARE BENEFICIARY (QMB)	A State program that pays for a beneficiary's Medicare premiums, coinsurance, and deductible amounts within limits.
QUALIFIED WORKING DISABLED (QWD)	See QDWI. A special program authorized by the Social Security Administration that allows certain individuals to work and still collect their disability payments for a period of time. SRS allows these individuals to remain on Medicaid while in QWD status.
QUARTER	Calendar quarter unless otherwise specified.
QUEUE DIRECTORY	A directory on a hard drive into which batch requests to unit storage are placed. (Imaging)

7.1.18 R

RA	**Remittance Advice**
RAILROAD RETIREMENT BOARD (RRB)	A separate insurance program that covers some aged people who would otherwise be covered by Medicare.
RANDOM ACCESS	An accessing process that finds any record in a database quickly by using two logical reads; the first read being the accessing of the index pointing to that data, the second read accessing the actual record or data. This process is the opposite of sequential accessing.
RANDOM ACCESS MEMORY (RAM)	The primary memory in a computer. Memory that can be overwritten with new information. The random access part of its name comes from the fact that all information in RAM can be located -- no matter where it is -- in an equal amount of time. This means that access to and from RAM memory is extraordinarily fast. By contrast, other storage media -- like magnetic tape -- require searching for the information, and therefore take longer. (Imaging)
RD	Registered Dietitian
REALTIME SYSTEM	A computer system that responds to input signals fast enough to keep an operation moving at its required speed.
RECORD	A set of related fields used to enter and store information in the telephone system. A table is a set of records.
RECOUPMENT (REC)	Money withheld from a provider's payment due to overpayment of claims during adjudication cycles. Recoupments may be established ion line by accessing the Accounts Receivable Set Up window. They may be set up as a percentage or as a set amount to be recouped. An Accounts Receivable record is established for each recoupment type a provider might have.

REFERENCE DATA MAINTENANCE SUBSYSTEM
The Reference Data Maintenance subsystem maintains a consolidated source of reference information that is accessed by the MMIS during performance of claims and adjustment processing functions, prior authorization functions, and Third Party Liability (TPL) processing. The Reference Data Maintenance function also supports MMIS reporting functions.

REFERRING PROVIDER
Provider who gives referral (such as the KenPAC provider)

REFORMAT
To change the record layout of a file or database.

To initialize a disk over again.

REGULATION
A federal or state agency legal statement of general or specific applicability designed to implement or interpret law.

REHABILITATION THERAPIES
Services designed to improve the skills and adjustment of the head injured individual, integrating prevocational, educational, and independent living goals, in order to return, or maintain the individual at their most optimum level of functioning at the least restrictive level of care. Services include occupational therapy, physical therapy, speech-language therapy, cognitive therapy, behavioral therapies, and drug and alcohol abuse counseling.

REJECTED CLAIM
A claim that contains errors such as missing data, incorrect claim form, or missing provider signature and is returned to the responsible provider without being adjudicated.

RELATIONAL DATABASE
A database or collection of data organized into related tables comprised of rows and columns. The tables define relationships between the records.

RELATIVE VALUE SCALE
A type of fee schedule which uses unit values (multiplied times a dollar conversion factor) to price procedures, instead of using a flat fee. The methodology establishes value relationships between procedures. For example, a limited office visit might be valued at five units and an extended office visit (which is more complex) at 8 units. RVS based fee schedules have the advantage of being easier to revise because it is not necessary to change the units, only the conversion factors. These are carried as system parameters in the MMIS.

RELEASE

The release is associated with a specific version of a product being made available to the client. Also known as system release or version.

REMITTANCE ADVICE (RA)

REMITTANCE ADV

The statement mailed to a provider detailing Charges pending, paid, denied.

A document sent to providers to explain the payment status of claims. The statement mailed to the provider detailing the outcome of the claims processed in the most recent payment cycle. The claims are listed by claim type and then disposition, i.e., paid, denied, suspense, and History only. RAs are generated in the financial system in accordance with the providers' RA media type indicator. Only those providers sending the majority of their claims electronically will be allowed a choice of media. All providers will be allowed only one type of media for RAs.

REMOTE ACCESS SERVICES (RAS)

A feature built into Windows NT that enables users to log into an NT-based LAN using a modem, X.25 connection or WAN link. RAS works with several major network protocols, including TCP/IP, IPX, and Netbeui.

RENDERING PROVIDER

Provider who actual provides the service (for example, an individual physician)

REQUEST FOR PROPOSAL (RFP)

The bidding mechanism used to purchase goods and services.

RESOLUTION

Usually used in context as claims resolution, pending resolution, or suspense resolution. It refers to the process of working or correcting errors on a claim, forcing edits, updating or modifying inaccurate data such as a provider number or category of service, or any other activity necessary to complete the adjudication of the claim.

Measure of imager output capability, usually expressed in dots per inch (DPI).

Measure of halftone quality, usually expressed in lines per inch (LPI). (Imaging)

RETRIEVE

To call up data that has been stored in a computer system. When a user queries a database, the data is retrieved into the computer first and then transmitted to the screen.

RETURN TO PROVIDER (RTP)

Request for additional information from the provider in the form of a letter.

REVENUE CODES	The three-digit accounting codes used on hospital claims to designate the service which generated the income, e.g., room and board = 110, laboratory pathology = 300, and physical therapy = 420. Revenue codes are used in billing both inpatient and outpatient services. These codes are essential to the hospital cost reporting process.
RN	Registered Nurse
RN BSN	Registered Nurse with Bachelor of Science Degree in Nursing
ROUTE TABLE	A database table that specifies resources, such as agent groups or trunks, that calls can be routed to within the telephone system.
RULES BASED PROCESS	Rules Based Processing, or Table Driven System, or Parameter Based Processing are terms that refer to systems that store data element variables in user-alterable tables rather than storing them inside a fixed computer program.
RUN DATE	The date a report was generated.
RURAL HEALTH CLINIC (RHC)	A federally funded rural agency that provides medical services on a sliding fee schedule to the general public.
RVS	Relative Value Scale
RX	Prescription

7.1.19 S

SAK	**System Assigned Key**
SCALING	Process of uniformly changing the size of Characters or graphics. (Imaging)
SCAN	To convert human-readable images into bitmapped or ASCII machine-readable code. (Imaging)
SCAN RATE	Number, measured in times per second, a scanner samples an image. (Imaging)
SCANNER	A device that reads text, images and bar codes. Text and bar code scanners recognize printed fonts and bar codes and convert them into a digital code. Graphics scanners convert a printed image into a video image without recognizing the actual content of the text or pictures.
SCHOOL-BASED SERVICES	Medicaid reimbursable services provided to Medicaid eligible children in local education agencies (LEAs) by enrolled providers.
SCL	Supports for Community Living
SCU	Storage Control Unit
SKILLED NURSING FACILITY (SNF)	Any facility that provides room, board, and all routine services and supplies. A nursing home facility requiring qualified professional personnel to remain on site twenty-four hours a day.
SOBRA	Sixth Omnibus Budget Reconciliation Act
SOCIAL SECURITY ADMINISTRATION (SSA)	Branch of the Department of Health and Human Services which administers the Medicare and Medicaid Programs.

SOCIAL SECURITY INCOME (SSI) A program of income support administered by the Social Security Administration that replaces the previously stated administered programs for low-income aged, blind and disabled individuals. Federal dollars paid to aged, blind, or disabled individuals to help pay their living expenses.

SOCIAL SECURITY NUMBER (SSN) An account number issued and used by the SSA to identify an individual on whose earnings SSA benefits are being paid. It is a Social Security account number followed by a three-digit suffix designating the type of beneficiary.

SOCIAL SERVICES (SS) Services that seek to improve the quality of life for individuals and families (i.e., public assistance, medical assistance, food stamps, etc.).

SPECIALIST A physician, dentist, or other health professional who works primarily in a certain field of medicine, related to specific services, certain categories of patients or types of diseases.

SPECIALTY The specialized area of practice of a provider, such as general practice, surgery, endocrinology, pathology.

SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLMB) Medicare beneficiaries who would meet the QMB requirements, except for having income in excess of the QMB limit but less than 110 percent of the federal poverty level in 1994 and less than 120 percent of the federal poverty level in 1995. The state Medicaid Program must pay the Medicare Part B premium for these individuals.

SPENDDOWN (SPN) A type of Medicaid insurance deductible. The dollar amount of medical bills the beneficiary is responsible for taking care of before Medicaid can help the beneficiary pay his or her medical bills. Spenddown is the difference between the beneficiary's income and the Medicaid income limit. A qualifying county nurse may assign this dollar amount to a beneficiary (based on the beneficiary's income, etc.), which must be spent on medical needs prior to Medicaid benefits being available.

A process whereby an otherwise Medicaid-eligible person, but for excess income, may become eligible through obligation of the excess amount of incurred medical expenses. A requirement that certain beneficiaries, in order to be eligible for Medicaid, must spend money on their medical bills to offset their excess income. This is a requirement for the Medically Needy category of eligible beneficiaries. In cases of short-term spenddown, the spenddown amount is defined as being the amount that should be used for a beneficiary's provided services prior to Medicaid being involved.

SQL SERVER Relational DataBase Management Software which uses Structured Query Language.

SSDI Social Security Disability Income

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) A program providing medical benefits for beneficiaries under the age of 19 who are between 150 and 200 percent of poverty. Also referred to as Title XX. In Kentucky, this is referred to as K-CHIP.

STD Sexually Transmitted Diseases

STOP-LOSS Portion of a claim that exceeds the Stop-Loss cap. Provides protection for a managed care provider (as agreed to in the HCA/HMO contract) from catastrophic expenses (losses). For example, if the HMO refers a beneficiary to a specialist whose fee ends up to be greater than the Stop-Loss amount and the HCA/HMO contract provides for Stop-Loss, then the excess will be paid at a percentage factor (70% or 90%) contained on the Plan File for this Plan and Service Class. PCP/CM claims are paid at 100% when the cap is reached.

STRUCTURED QUERY LANGUAGE (SQL) The programming language used to access data in relational databases.

SUBCONTRACTOR	The entity contracting with the prime Contractor to perform services.
SUBJECT MATTER EXPERT (SME)	A person who is an expert for a particular subject matter and becomes the contact for information in that area.
SURVEILLANCE AND UTILIZATION REVIEW (SUR)	The processes and procedures by which the quality, quantity, appropriateness, cost of care, and services provided are evaluated against established standards.
SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (SURS)	A subsystem within the KMMIS that reports on benefit usage, profiles beneficiaries and providers, and reports on anomalies in payment or services.
SUSPENDED	When a claim is being processed, it is considered a "suspended" claim. The claim has neither paid nor denied.
SUSPENDED ADJUSTMENT	An adjustment that cannot pay or deny until data is corrected.
SUSPENDED CLAIM	A claim that cannot pay or deny until data is supplied or corrected. Claims which could not be processed during an initial or previous submission cycle.
SUSPENSE FILE LIST	A list containing all ICNs that should remain in cache is provided by the mainframe and transferred to the PC imaging network. (Imaging)
SYSTEM	This term refers to all of the subsystems within the MMIS collectively.
SYSTEM GENERATED	Information not input from another source (e.g., a data file, data transmission or keyed by the user). Examples are date, time, calculated numbers, etc.

7.1.20 T

T-1 CONNECTION	**A high-speed connection to the Internet. Required in organizations having a large number of employees accessing the Internet.**
TAGGED IMAGE FILE FORMAT (TIFF)	A bit map file format for describing and storing color and gray scale images. (Imaging)
TB	Tuberculosis
TCN	Transaction Control Number
TDOS	To Date of Service - Date used in the claim.
TECHNICAL COMPONENT (TC)	The technician's services used in some x-ray, lab, and diagnostic procedures.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)	Replaces AFDC rules. Must use old AFDC eligibility standards for Medicaid, so a person may be eligible for Medicaid but not TANF whereas before if a person was eligible for AFDC he/she was automatically eligible for Medicaid. A welfare program funded by federal and state dollars that provides cash and Medicaid benefits to families with at least one child where one or both parents are absent, deceased, or incapacitated.
TEXT-STRING SEARCHES	When a text-string search is performed, each page returns whether the specific text-string value was found. A page is searched for specific text string based on the columns in which that text string appears. (Imaging)
TFAL	Technical Functional Area Lead

THERAPEUTIC CLASS

Drugs are categorized according to their beneficial effects or their ingredients. First DataBank offers three different therapeutic classifications systems. Therapeutic class is used as a selection criterion to group together claims for different drugs that have the same effect, e.g., central nervous system depressants.

THIRD PARTY LIABILILTY (TPL)

A system that provides cost containment of the Medicaid program through the identification of services for which other insurance should be the primary payer. This includes, but is not limited to, private health insurance, any applicable Medicare coverage, worker's compensation, and accident-related liability insurance.

Implies that another insurance company has primary responsibility to pay for the service - not the patient or Medicaid. A term referring to a situation in which a submitted claim is the result of an accident or injury where another individual or organization may be at fault and responsible for payment, or in which an individual has health insurance resources other than Medicaid or Medicare.

TITLE I (1)

The Old Age Assistance program (OAA) that was replaced by the Supplemental Security Income program (SSI).

TITLE IV (4)

The Aid to Families with Dependent Children program (AFDC).

TITLE IV-E

Title IV-E of the Social Security Act provides federal funds for the purposes of providing maintenance cost of care for eligible children in foster care, administration of the foster care program and training of workers and foster parents. Title IV-E Adoption subsidy is also available for eligible children placed for adoption with special needs and provides support for maintenance cost of care.

TITLE X (10)

The Aid to the Blind program (AB) that was replaced by the Supplemental Security Income program (SSI).

TITLE XIV (14)

The Permanently and Totally Disabled program (PTD) that was replaced by the Supplemental Security Income Program (SSI).

TITLE XVI (16)

The Supplemental Security Income program (SSI). Grants to states for ABD—Supplemental Security Income for ABD – SS Act.

TITLE XVIII (18) ABD Health Insurance Program as part of SS Act. The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B) of the Social Security Act. See Medicare.

TITLE XIX (T19) Medicaid law as part of the Social Security Act (Medicaid). Federal law authorizing federal payments to states that have elected to provide Medicaid services to residents. See Medicaid.

TITLE XXI (T21) Child Health Insurance Program as part of SS Act. A program providing medical benefits for beneficiaries under the age of 19 who are between 150 and 200 percent of poverty. Also referred to as SCHIP. Refer to HealthWave.

TOB Type of Bill

TOC Table of Contents

TOC Type of Coverage

TOOLBAR Icons that work as short cuts to many system functions are located on the top or side of the screen within a toolbar.

TRANSACTION PROCESSING Processing transactions as they are received by the computer. Also called online or real-time systems, transaction processing means that master files are updated as soon as transactions are entered at terminals or received over communications lines.

TRANSACTION SET A block of information in EDI, making up a business transaction or part of a business transaction.

TRANSACTION SET STANDARDS The system of syntax, data elements, segments, and transaction sets (messages) with which EDI will be conducted.

TRANSLATOR A program used to convert information from flat file to EDI format or from EDI format to flat file.

TRANSMISSION CONTROL PROTOCOL/INTERNET PROTOCOL (TCP/IP)	A set of protocols developed to allow cooperating computers to share resources across a network. This methodology is used to communicate on the Internet and the Wide Area Network. Also used to transfer data between a web site (Internet or Intranet) and other computing platforms. The IP portion refers to the addressing scheme used to address the Internet Network, hence the IP address for a packet. And while the IP does not establish a direct link (just to/from address), the TCP enables two computers to have a connection and exchange streams of data. See IP, ICMP.
TREATMENT	Any type of medical care and services recognized under state law to prevent, correct or ameliorate disease or abnormalities detected by screening and diagnostic procedures.
TRUNK	A telephone line used to make and/or receive calls within the telephone system.
Txn	Transaction
TYPE OF SERVICES (TOS)	A code indicating a general category of service, such as medical, surgical, consultation, laboratory or x-ray. A broad classification of services used in conjunction with a procedure code to uniquely define a service.

7.1.21 U

UAT	**User Acceptance Testing**
UB-92	A standard claim form used to bill hospitals, home-health, and LTC services. (HCFA) Uniform Billing Form for all hospital services used by all payers (HCFA 1450) – Universal Billing form that was revised in 1992. Previously it was UB-16, then UB-82. This form is in use nationally for billing hospital-based services. In some states, it is also used for billing home health, rural health, hospice, and nursing home services.
UNIX	A computer operating system used primarily in mini computers. The IBM 390 mainframe platform provides this OS as a sub-operating system to OS 390.
UPIN	Universal Provider Identification Number
USER	A data processing system customer.
USER ID	The code unique to an individual which allows the user to sign-on to the computer system and defines the user's security status.
USUAL AND CUSTOMARY CHARGE (UCC ,U&C)	Those Charges most commonly billed for a service by each provider. The price the provider Charges his patients for a given service.
USUAL AND CUSTOMARY RATE (UCR)	A method of calculating a reasonable Charge based on profiles generated from historical billed Charges.
UTILIZATION MANAGEMENT (UM)	A unit of the fiscal agent that promotes cost-effective, quality health care through research, thorough reviews, and networks with agencies and committees.
UTILIZATION REVIEW (UR/UTLIZATION REV)	Methods and procedures related to the utilization of covered care and services necessary to safeguard against unnecessary or inappropriate use of care and services.

7.1.22 V

VACCINE FOR CHILDREN (VFC)	**A federally funded program that provides immunization serum for qualified children.**
VALUE-ADDED NETWORK (VAN)	A vendor of EDI data communications and translation services. (Switched network provider).
VDT	Video Display Terminal (Screen)
VENDOR	An institution, agency, organization, or an individual practitioner who provides health care services.
VIRTUAL PRIVATE NETWORK (VPN)	Internet software for the client desktop. This allows two users to communicate via the Internet and for security purposes, it is a closed network between the two sites. Along with this technique is "tunneling" which allows data to be sent through a private tunnel rather than over the Internet connection.
VIRTUAL STORAGE ACCESS METHOD (VSAM)	An IBM access method for storing data, widely used in IBM mainframes.

7.1.23 W

WAIVER	**A CMS-approved process that allows states to customize specific rules and regulations to their medical assistance programs to provide more cost-effective services.**
WAN	Wide Area Network. See LAN.
WARRANT	An order for payment/reimbursement. After adjudication, a claim is marked for payment or denial. For the ones marked for payment, a warrant is issued for State finance to issue a check.
WARRANT NUMBER	The actual check number issued for claims payments to providers.
WARRANT TYPE	The type of warrant that is issued to Medicaid providers, be it a value of E (electronic funds transfer) or P (paper).
WIC	Women, Infants, and Children
WINDOWS	A graphics-based windows environment from Microsoft that integrates with and interacts with DOS. It provides a desktop environment similar to the Macintosh, in which applications are displayed in re-sizable, movable windows on screen.
WITHHOLD	An amount which SRS instructs the Fiscal Agent to withhold from the monthly capitation of an HMO.
WORKERS' COMPENSATION	A type of third party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which the employer's insurance company may be obligated under the Workers' Compensation Act.
WORKSTATION	A single-user microcomputer or terminal, usually one that is dedicated to a single type of task (graphics, CAD, scientific applications, etc.). (Imaging)

7.1.24 X

X12	**An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards mandated or proposed under HIPAA are X12 standards.**
X.25	A CCITT protocol that defines a standard way of arranging data in packets to be shipped over transmission lines. (Standard for packet switched networks). See CCITT.
X.400	A CCITT mail and messaging standard.
X.500	A CCITT directory services standard.
XA	Extended Architecture
XML	Extensible Markup Language
XOVER	Cross Over
XREF	Cross-Reference

7.1.25 Y

YEARLY ENROLLMENT	**Managed Care re-enrollment opportunity that includes formal education on enrollment for all members annually after the actual county conversion.**
YTD	Year to Date

8 Appendix A – interChange Navigational Overview

8.1 System Navigation Introduction

8.1.1 Introduction

The new Kentucky Medicaid Management Information System (MMIS), currently based upon an HP Enterprise Services proprietary system called interChange, is designed according to a set of development standards. This document is designed to introduce users to standard system navigation features within interChange.

8.1.2 Screen Display Features

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

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

8.1.2.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log in to interChange.	The Home page opens.
2	In the Web browser menu bar, click View.	The View menu options appear.
3	Highlight Text Size, and then click Smaller.	The default Text Size is set to medium; however, after the user selects smaller, the system objects appear smaller.

8.2 System Wide Common Terminology and Layouts

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

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

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

- Page;
- Page Header;
- Page Footer;
- Sub Menu;
- Main Menu bar;
- Panel;
- Advanced Search;
- Mini Search panel;
- Hot Link;
- Information panel;
- Navigation panel;
- Task List panel;
- Title Bar Icons;
- Related Data; and,
- Personal Settings.

8.2.1 Home Page Layout

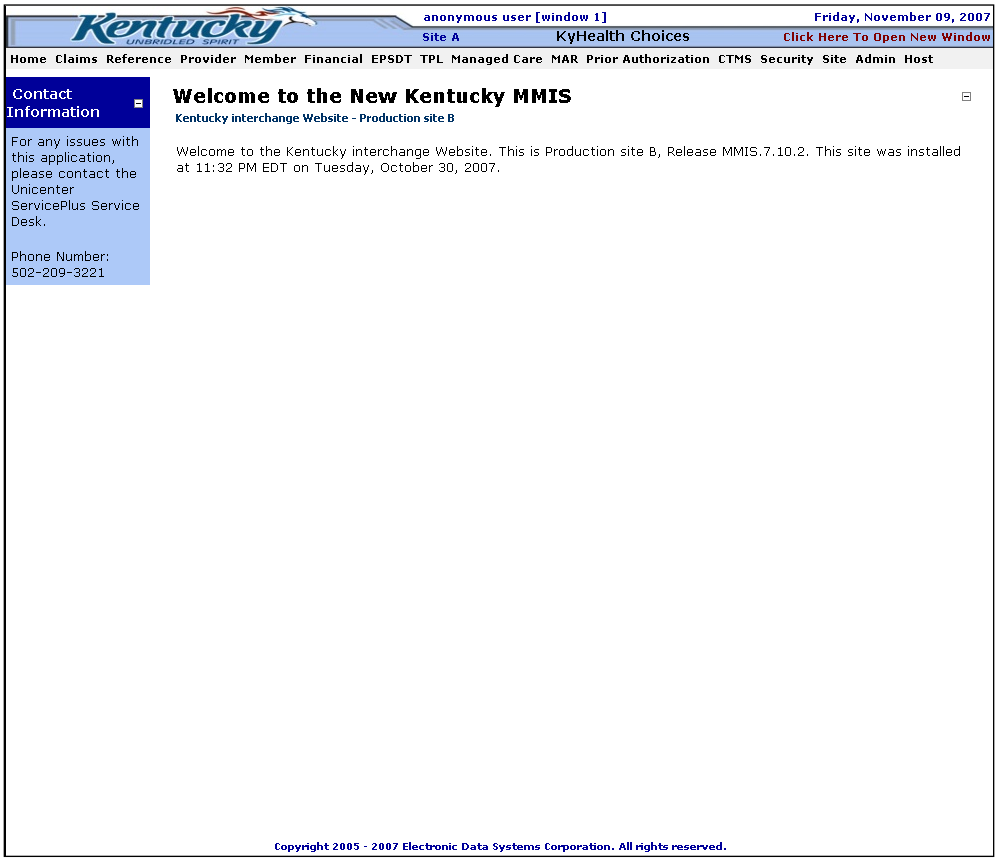


Figure 1 interChange Home Page

Menu Selection	Description
Home	Home Page, includes links to other applications
Claims	Link to Claims subsystem
Reference	Link to Reference subsystem
Provider	Link to Provider subsystem
Member	Link to Member subsystem
Financial	Link to Financial subsystem
EPSDT	Link to EPSDT subsystem
TPL	Link to TPL subsystem
Managed Care	Link to Managed Care subsystem
MAR	Link to MAR subsystem
Prior Authorization	Link to Prior Authorization subsystem
CTMS	Link to CTMS subsystem
Security	Link to Security settings
Site	Link to activate or modify personal settings

Menu Selection	Description
Admin	Link to log in as administrator and set up site settings
Host	Link to log in as host and set up host settings

8.2.2 Page Layout

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

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

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

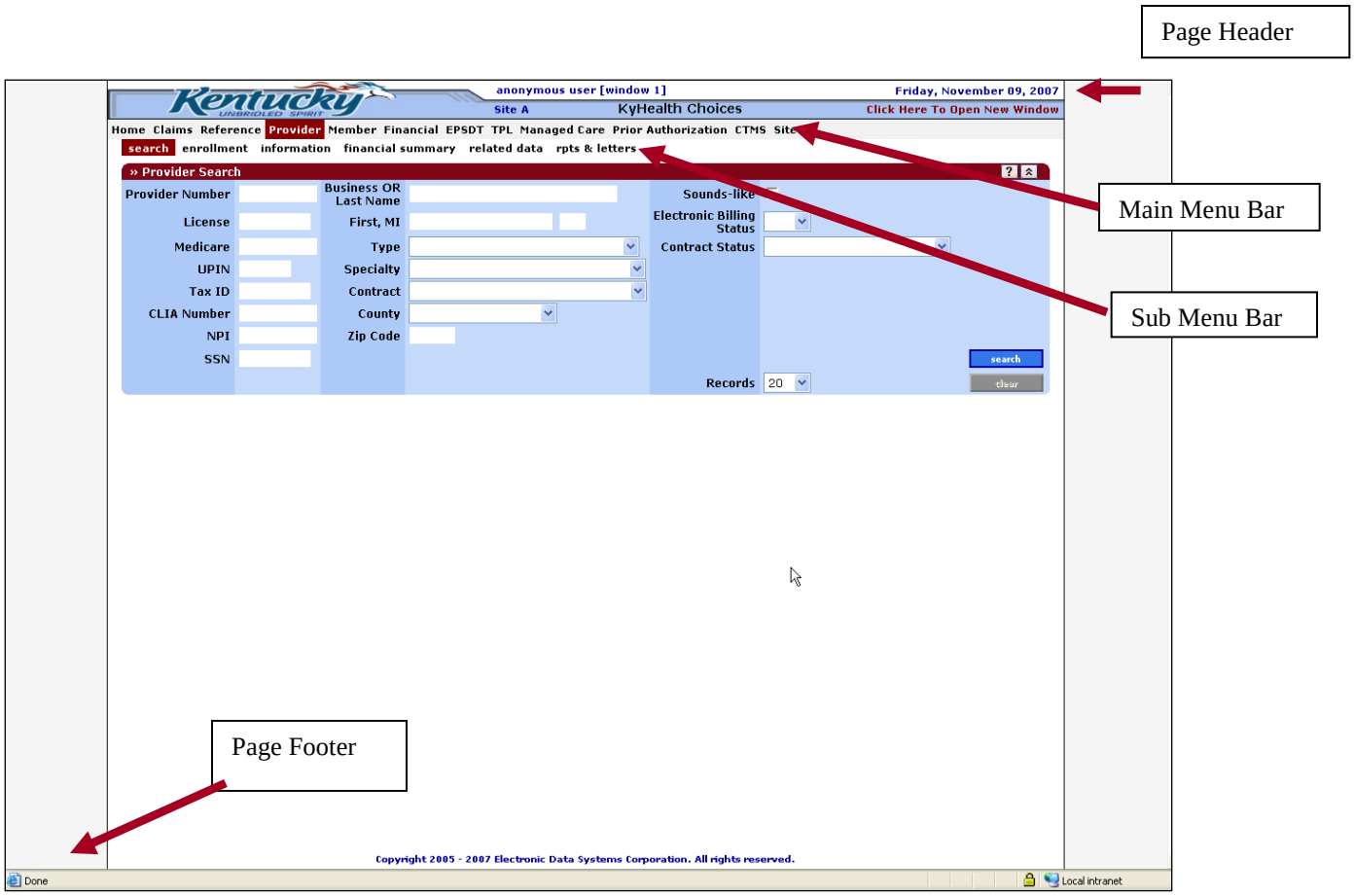


Figure 2 Provider Search Page

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

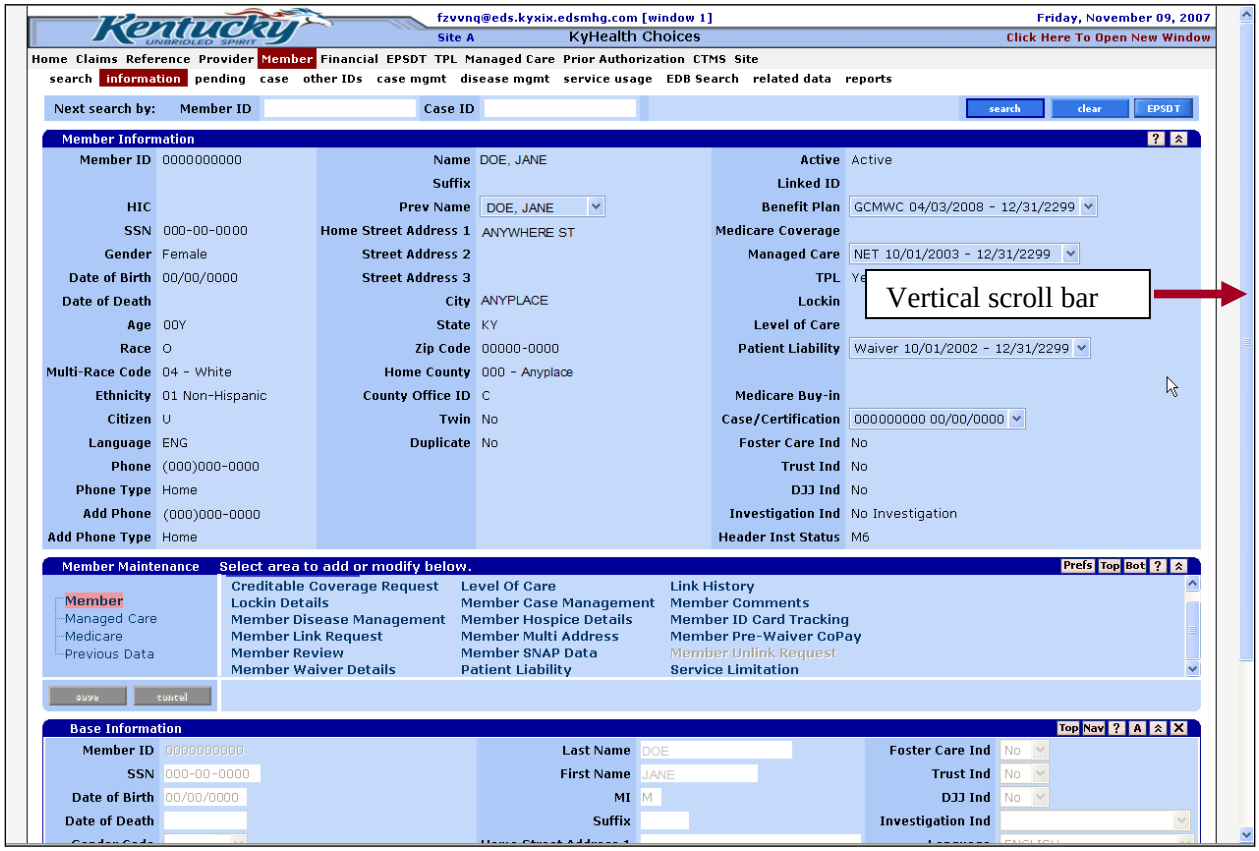


Figure 3 Member Information Page

If a user attempts to add, update, or delete information within the page, then prior to navigating away from the page, the system prompts the user with a pop-up modal window message. When the system generates the message, the detail panels are locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.

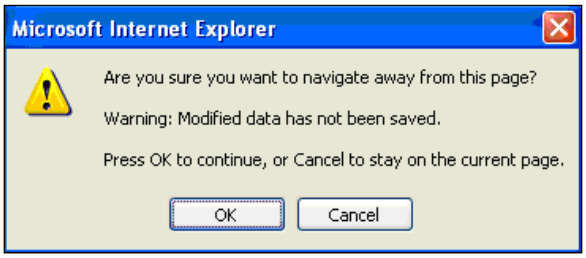


Figure 4 System Message

8.2.3 Search Options

There are several search options available within interChange.

8.2.3.1 Search Panels

The system contains more than one type of search panel: Search and Advanced Search.

Some subsystems such as the Provider Data Maintenance subsystem contain a search panel without an advanced search button included on the panel.

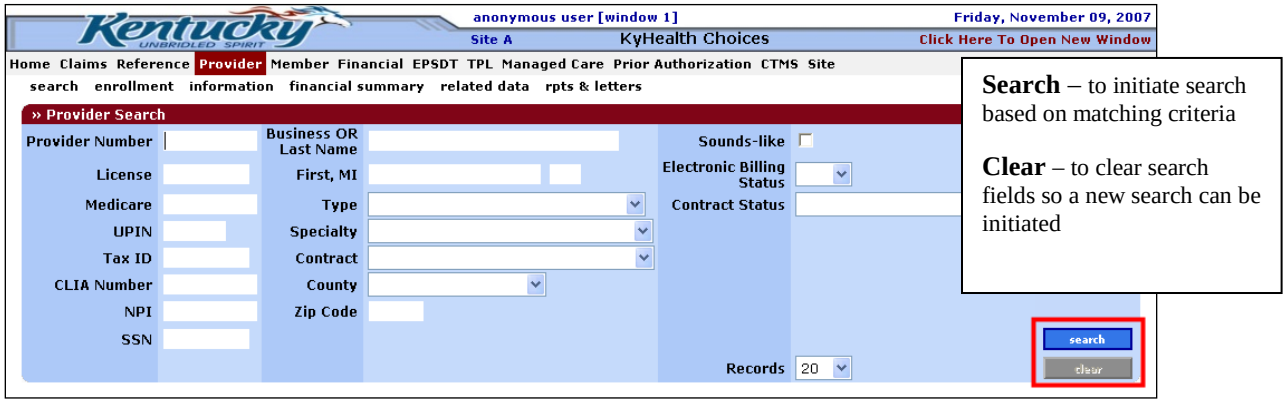


Figure 5 Provider Search Panel

Some subsystems such as the Claims subsystem contain a search panel with an advanced search button included for displaying an additional, advanced search panel.

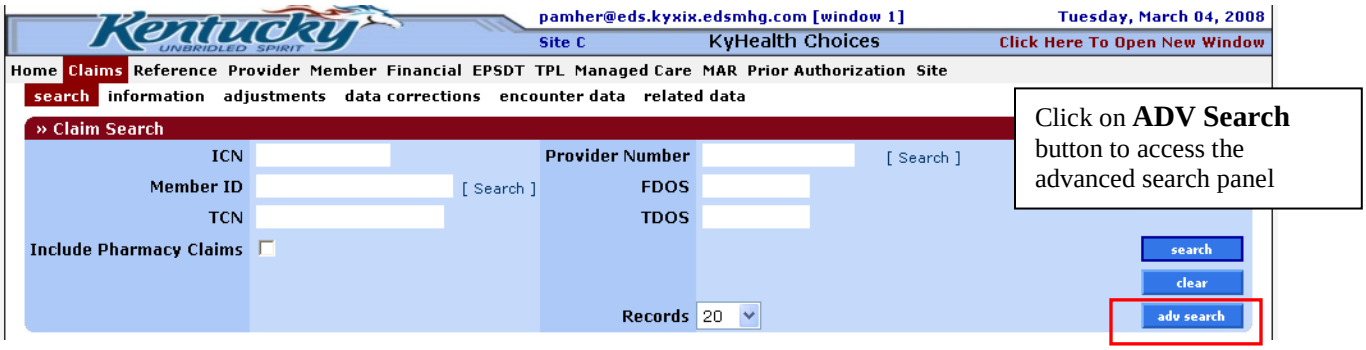
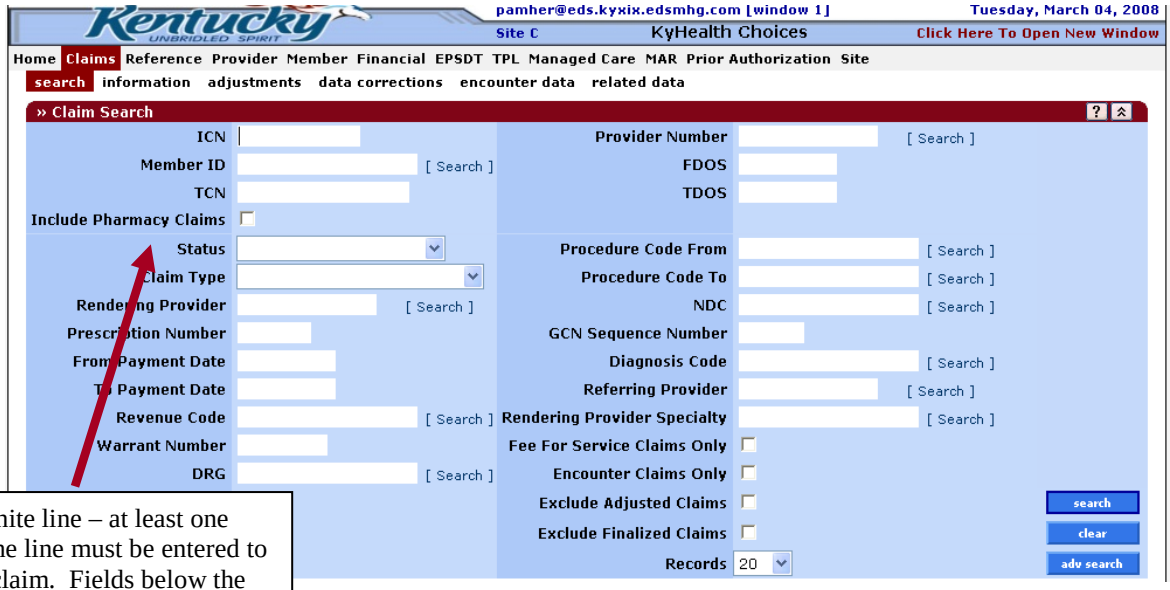
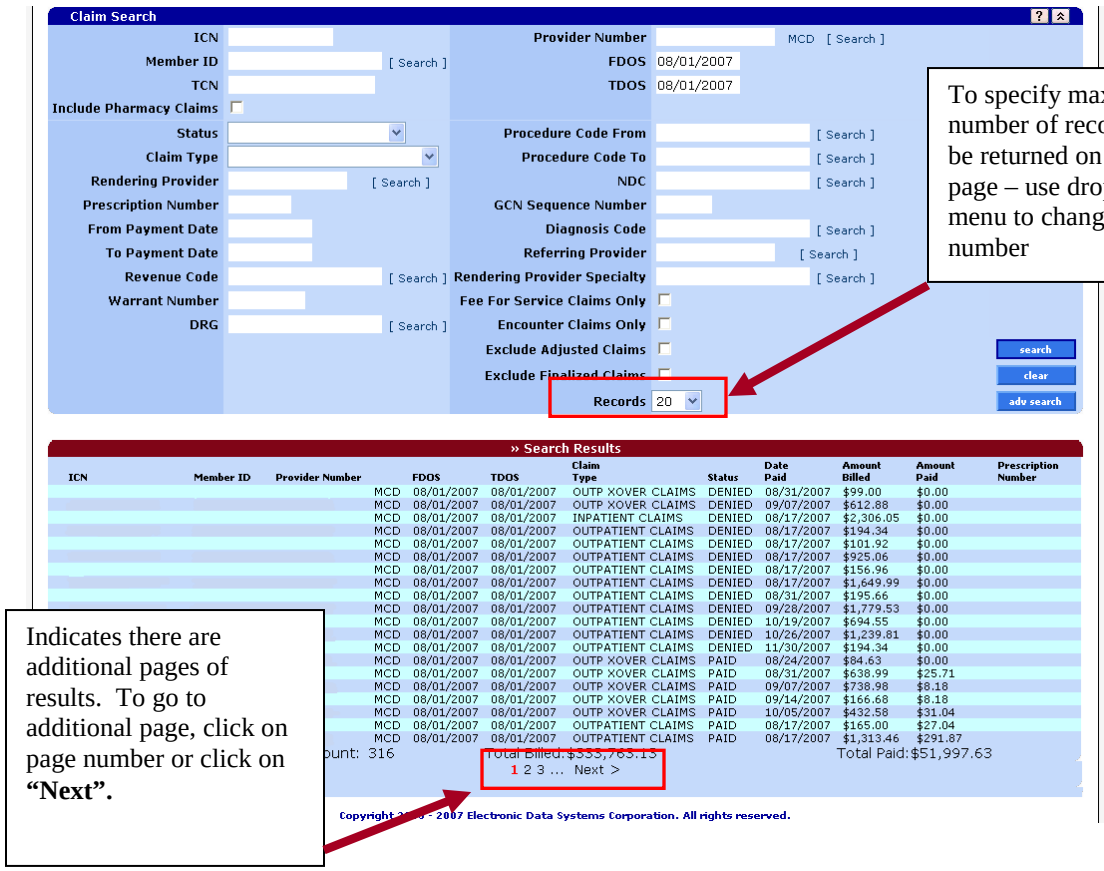


Figure 6 Claim Search Panel



Notice the white line – at least one field above the line must be entered to search for a claim. Fields below the line are optional.

Figure 7 Advanced Claim Search Panel



To specify maximum number of records to be returned on single page – use drop down menu to change number

Indicates there are additional pages of results. To go to additional page, click on page number or click on **"Next"**.

Figure 8 Claim Search Results Panel

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

In Figure 9, the search results are sorted in descending order by Member ID.

» Search Results

ICN	Member ID	Provider Number		FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid	Prescription Number
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	09/14/2007	$382.61	$177.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	08/17/2007	$1,837.25	$354.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	09/14/2007	$259.26	$177.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	$450.68	$177.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	08/31/2007	$14,116.96	$3,138.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	10/26/2007	$193.42	$164.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	$2,198.71	$813.53	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$2,198.71	$0.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	08/17/2007	$1,122.70	$264.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	11/16/2007	$1,088.02	$264.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	09/07/2007	$18,067.14	$6,501.28	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	11/30/2007	$101.92	$37.71	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$101.92	$0.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	11/30/2007	$83.24	$16.20	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$83.24	$0.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	09/28/2007	$197.19	$0.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$197.19	$0.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	11/30/2007	$197.19	$72.96	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$382.61	$0.00	
			MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	11/30/2007	$382.61	$177.00	

[Compute Totals] Claim Count: 316 Total Billed:$333,763.13 Total Paid: $51,997.63

1 2 3 ... Next >

Figure 9 Search Results Page Sorted by Member ID

8.2.3.2 Selecting a Search Result Row

If the user clicks once on a search result row, the associated information panel opens. In Figure 10, the user clicks the third row of the Claim Search Results panel and the Paid Outpatient Claim for the associated ICN displays.

» Search Results

ICN	Member ID	Provider Number		FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid	Prescription Number
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	09/14/2007	$382.61	$177.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	08/17/2007	$1,837.25	$354.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	09/14/2007	$259.26	$177.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	$450.68	$177.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	08/31/2007	$14,116.96	$3,138.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	10/26/2007	$193.42	$164.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	$2,198.71	$813.53	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$2,198.71	$0.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	08/17/2007	$1,122.70	$264.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	11/16/2007	$1,088.02	$264.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	09/07/2007	$18,067.14	$6,501.28	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	11/30/2007	$101.92	$37.71	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$101.92	$0.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	11/30/2007	$83.24	$16.20	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$83.24	$0.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	09/28/2007	$197.19	$0.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$197.19	$0.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	11/30/2007	$197.19	$72.96	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	DENIED	08/17/2007	$382.61	$0.00	
0000000000000	0000000000	00000000	MCD	08/01/2007	08/01/2007	OUTPATIENT CLAIMS	PAID	11/30/2007	$382.61	$177.00	

[Compute Totals] Claim Count: 316 Total Billed:$333,763.13 Total Paid: $51,997.63

1 2 3 ... Next >

Figure 10 Selecting a Search Result Row

8.2.3.3 Hot Links

Within certain Search panels, the user can also click hot links to see additional information. If the fields in a column are underlined, there is a hot link available. As Figure 11 demonstrates, if the user clicks the Member ID hot link, then the Member Information panel opens for that claim Internal Control Number (ICN) search result.

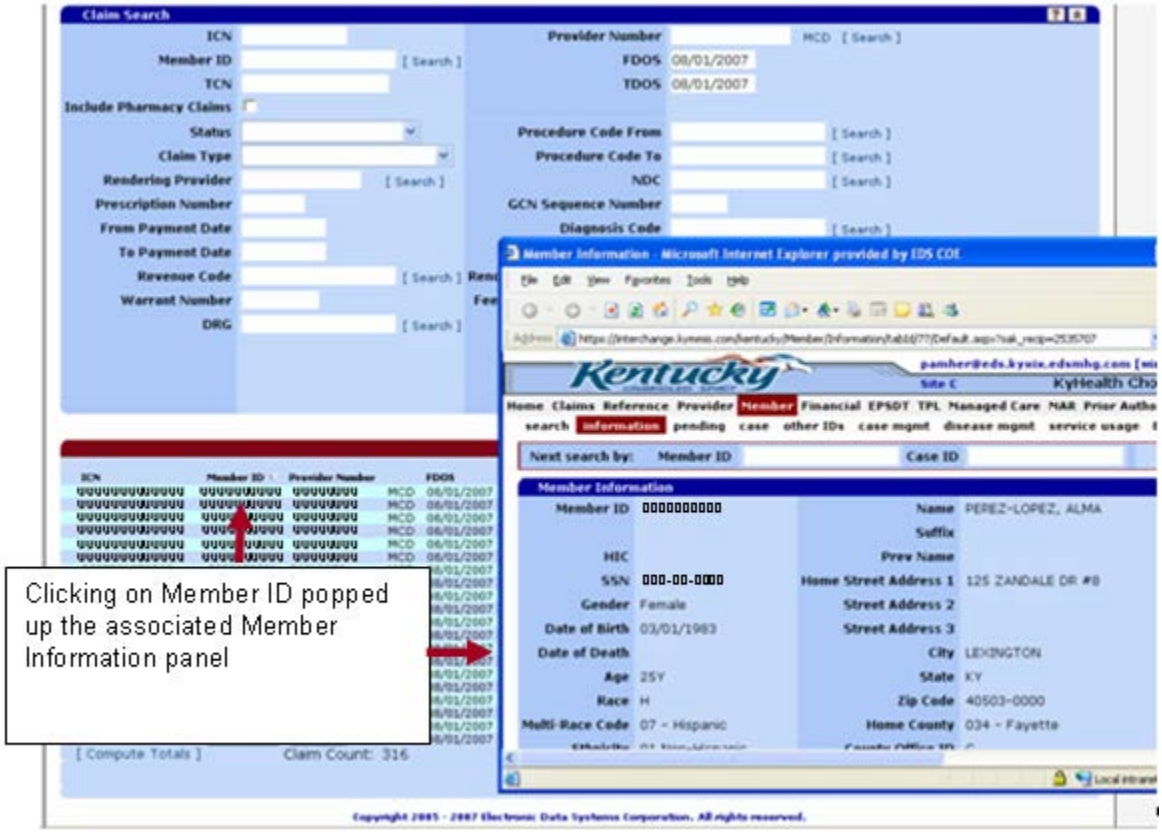


Figure 11 Member Information Pop Up

8.2.3.4 Mini Search

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

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

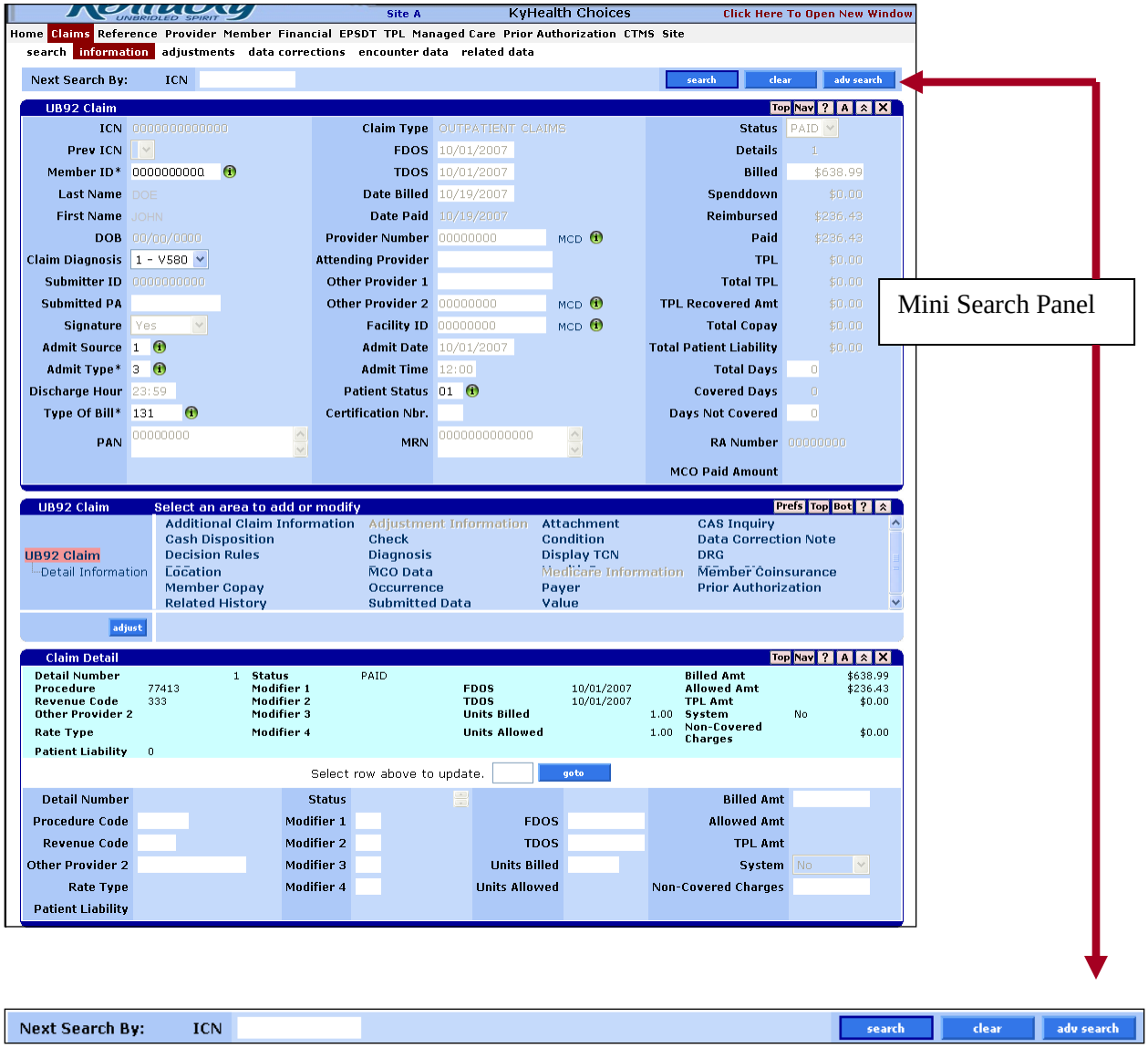


Figure 12 Claim Mini Search Panel

8.2.3.5 Pop Up Search

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

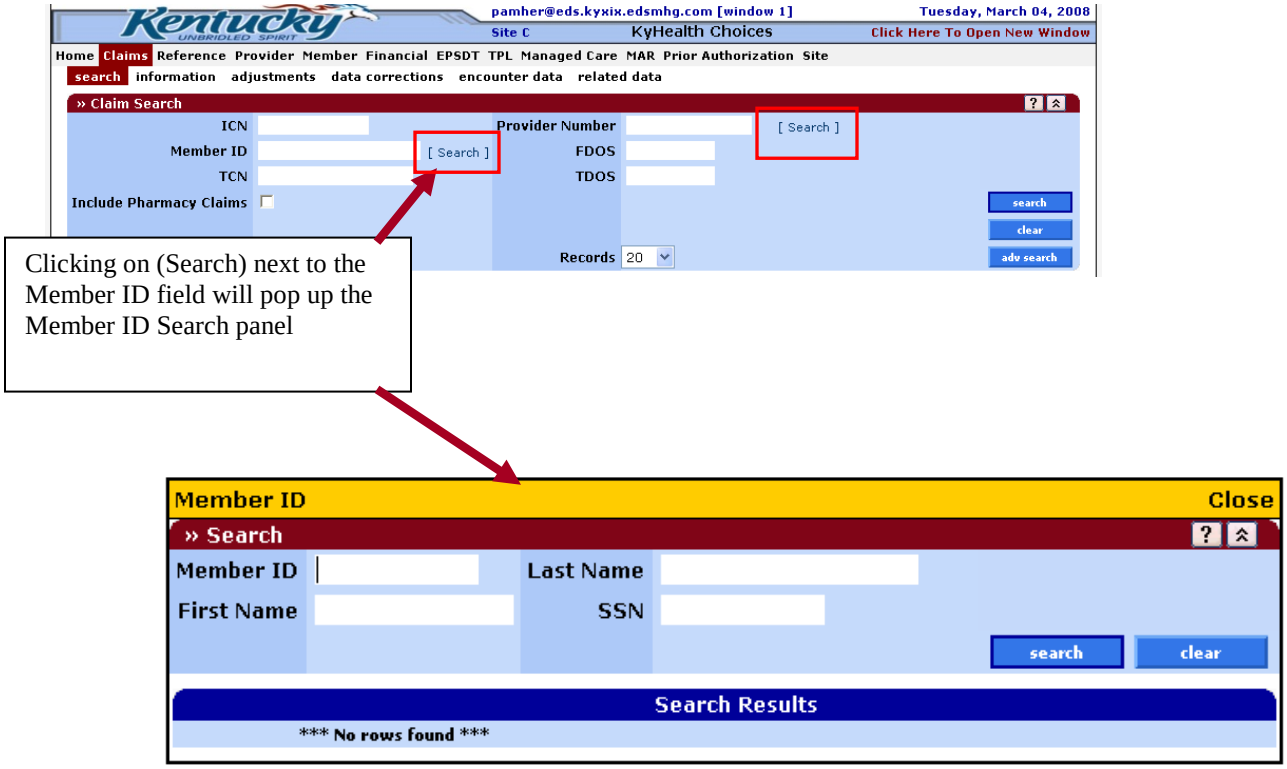


Figure 13 Claim Search Page

8.2.4 Panel Layout

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

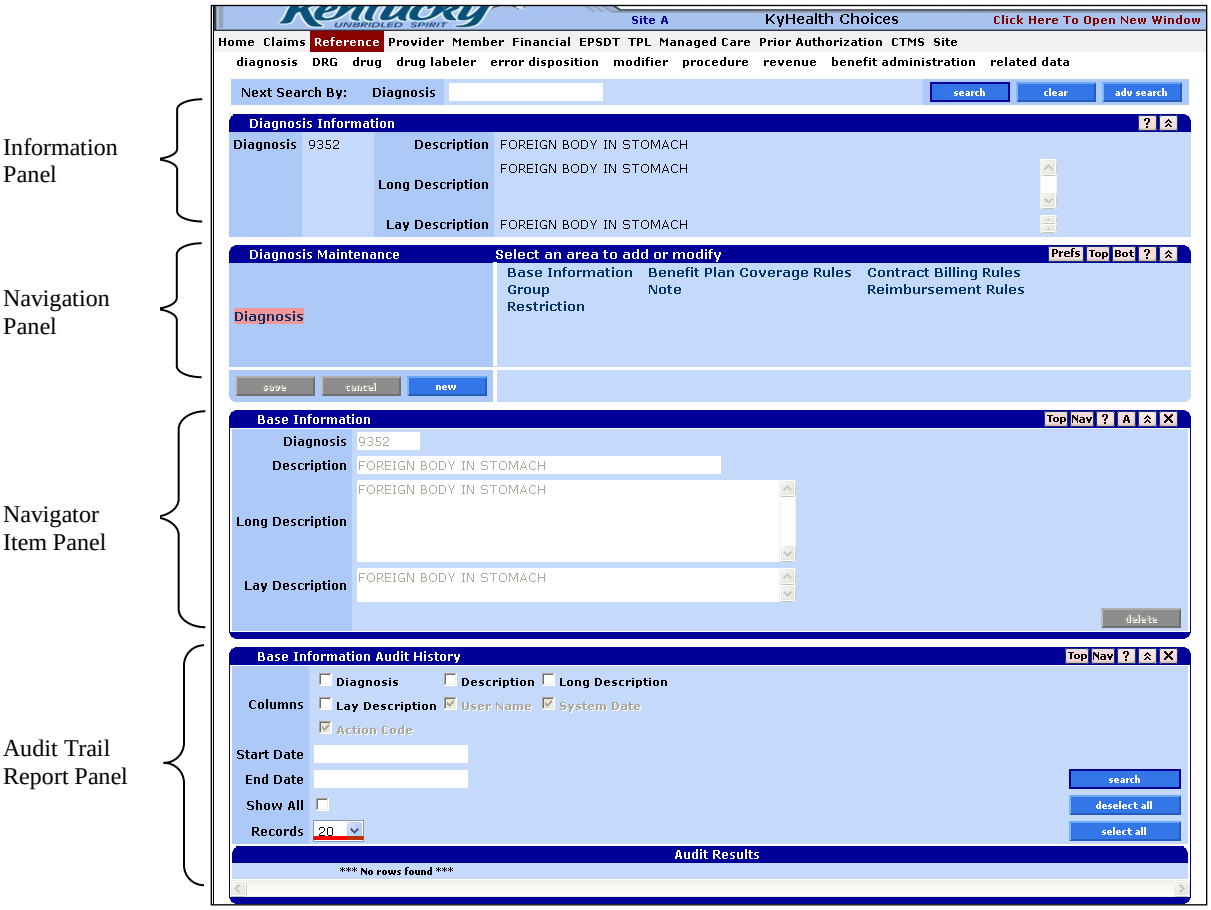
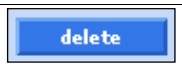


Figure 14 Diagnosis Code Base Information and Audit Panel

8.2.4.1 Panel Types and Functions

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

Button/Icon	Description
Add Button	Allows the user to insert a new data record on a panel. Click "Add" to open a record with blank fields. Fill in the applicable information. Click the "Save" button located on the Navigation panel to save the new record.
Delete Button 	Allows the user to delete a selected data record on a panel. Click on the record that needs deletion, which will highlight the record. Click on "Delete". Click the "Save" button located on the Navigation panel to save the deletion.

Button/Icon	Description
Cancel Button	Cancels all unsaved changes applied to all panels on the page. Can be found on the navigation panel.
Save Button	If a new record is added to a panel, clicking "Save" will save the new record. If changes are made to an existing record on a panel, clicking "Save" will save the changes. If validation errors occur, an error message displays in the Task List panel. Can be found on the Navigation panel.
Asterisk	Displayed next to a required field. Fields indicated with an asterisk are required to contain data.
Preferences Button	Displays a checkmark box next to each Navigator Item link. By checking the box, the link automatically opens whenever the user browses the page. To hide the boxes, click on the button a second time. Can be found only on the Navigation panel.
Top Button	Allows user to jump to the top of the page.
Bottom Button	Allows user to jump to the bottom of the page.
Help Button	Opens a window that displays the panel help page.
Maximize Button	Expands a panel to display all of its content.
Minimize Button	Collapses a panel.
Navigation Button	To jump to the Navigation panel.
Audit History Button	Opens the Audit History Panel for a specific panel.
X Button	Closes a panel.
Green Information Button	Opens information file for the associated field.

Among the panel types are the following:

- Navigation panel;
- Task List panel;
- Navigator Item Panel; and,
- Audit panel.

8.2.4.2 Navigation Panel

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

The navigation panel is used to navigate within a page, never to leave the page.

Figure 15 demonstrates Navigator Group Links (Provider and Service Location) and the associated Navigator Item links. By clicking on an Item Link (such as Comment), the associated panel opens.

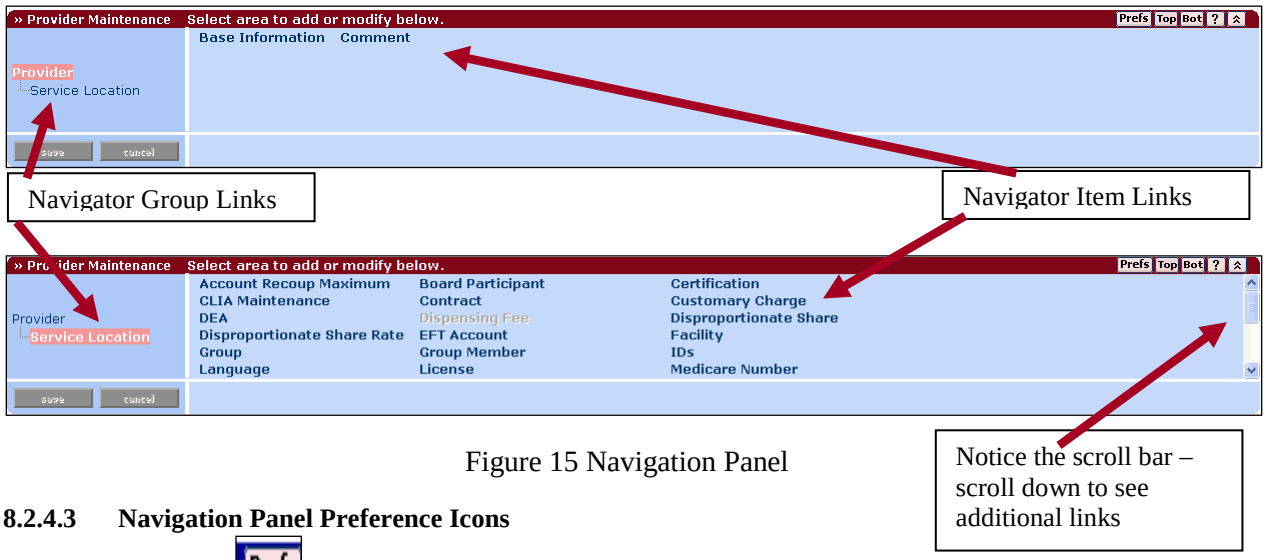


Figure 15 Navigation Panel

8.2.4.3 Navigation Panel Preference Icons

Users can click the icon in the upper right-hand area of the navigation panel title bar to pre-set which panels automatically opens each time the user accesses that particular navigation page.

When the user clicks a link in the right-hand side of the navigation panel, the associated panel displays beneath the navigation panel.

In Figure 16, the Provider Maintenance navigation panel is open. If the user checks the Certification and Customary Charge check boxes, then the associated panels automatically displays directly beneath the navigation panel each time the user accesses this page.

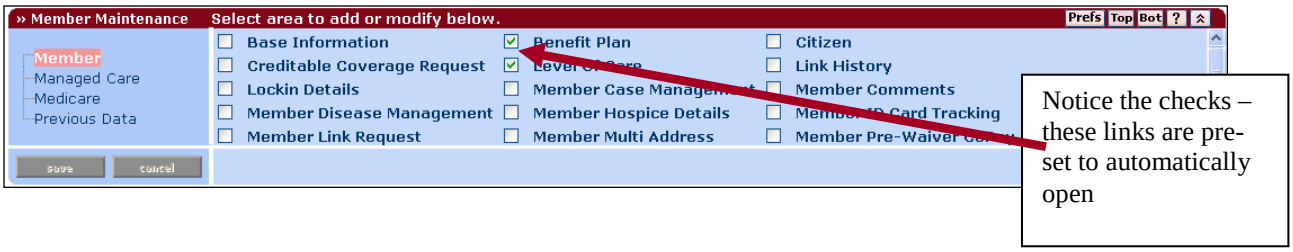


Figure 16 Preference Feature for Provider Navigation Panel

The opening of multiple panels results in the display of the panels vertically down the page.

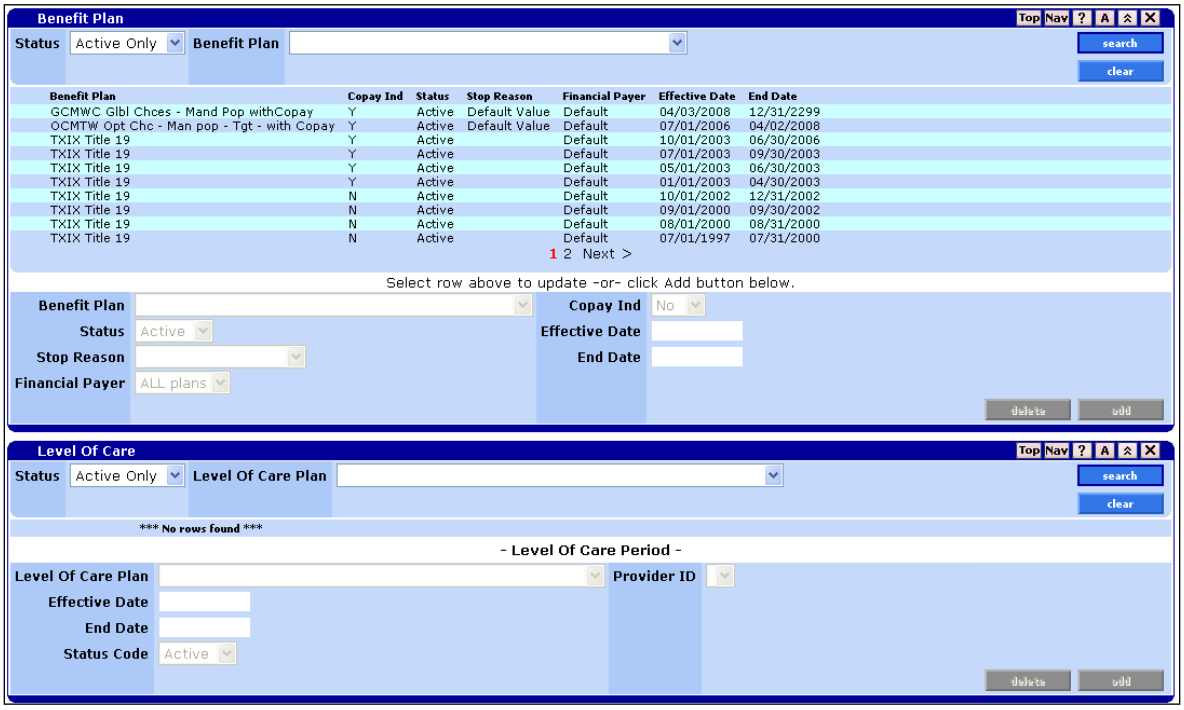


Figure 17 User Preference Panel Display

8.2.4.4 Task List Panel

Task List panels appear within navigation panels and provide messages to the user regarding whether the data was successfully saved, or if errors occurred to prevent the data from being successfully saved, or warning messages which may or may not include a radio button selection for the user to activate prior to completing the task.

Detail panels are locked open and navigation away from the page is not permitted until changes are saved or cancelled.

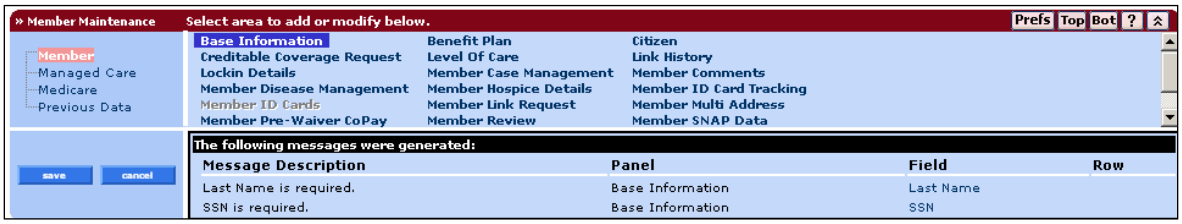


Figure 18 Task List Panel

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

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

An error message can also contain additional information which is accessed by clicking on a square node icon in the lower left side of the Task List panel.

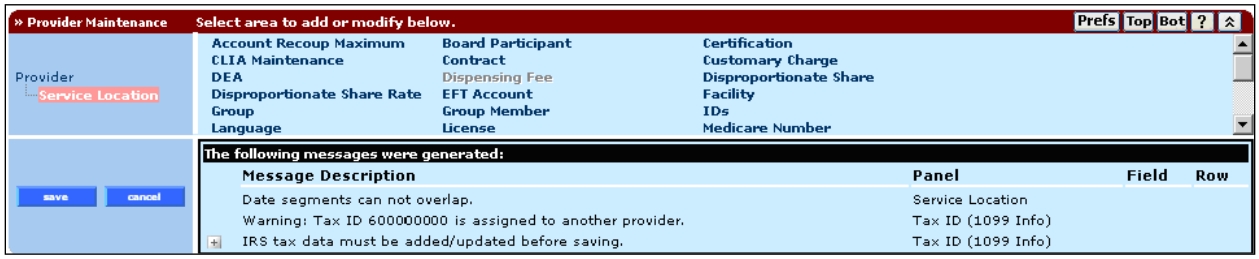


Figure 19 Warning Message

The task list can also be used to display messages that require a response. The user answers the question by completing an action within the message area, then click on the Continue link at the center bottom of the Task List panel to indicate the answer is ready for processing.

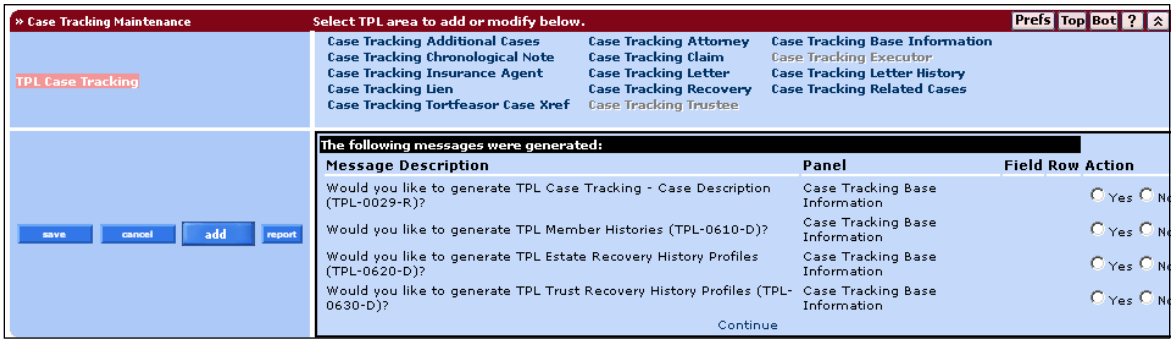


Figure 20 Response Message

The user answers the question posed by the message and then the user clicks the Continue link to indicate the answer is ready for processing.

8.2.4.5 Navigator Item Panel

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

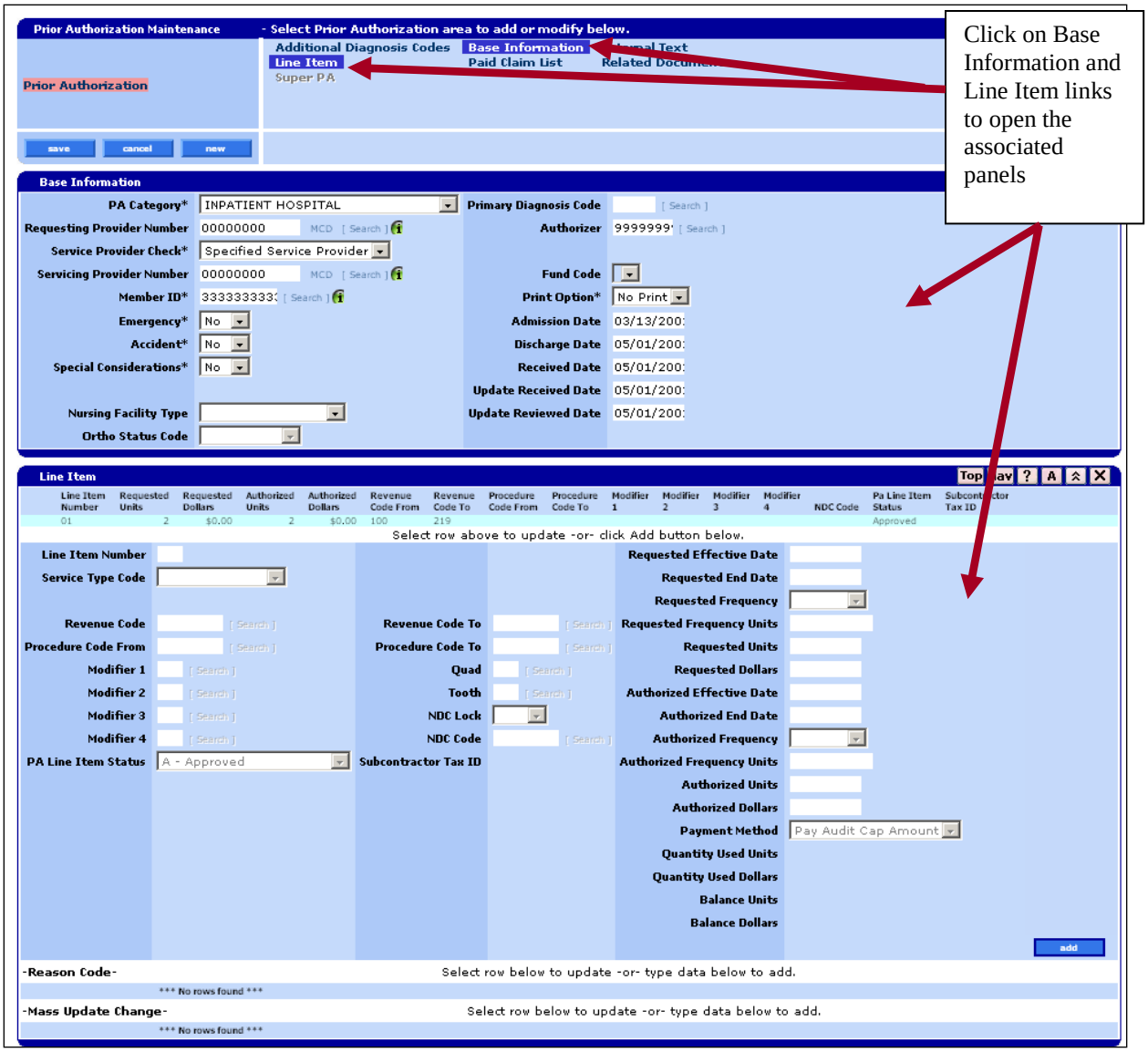


Figure 21 Base Information and Line Item Panels

By clicking on a data record, the fields below auto-populates. This allows the user to view detailed information about the data record, or, modify or delete the data record.

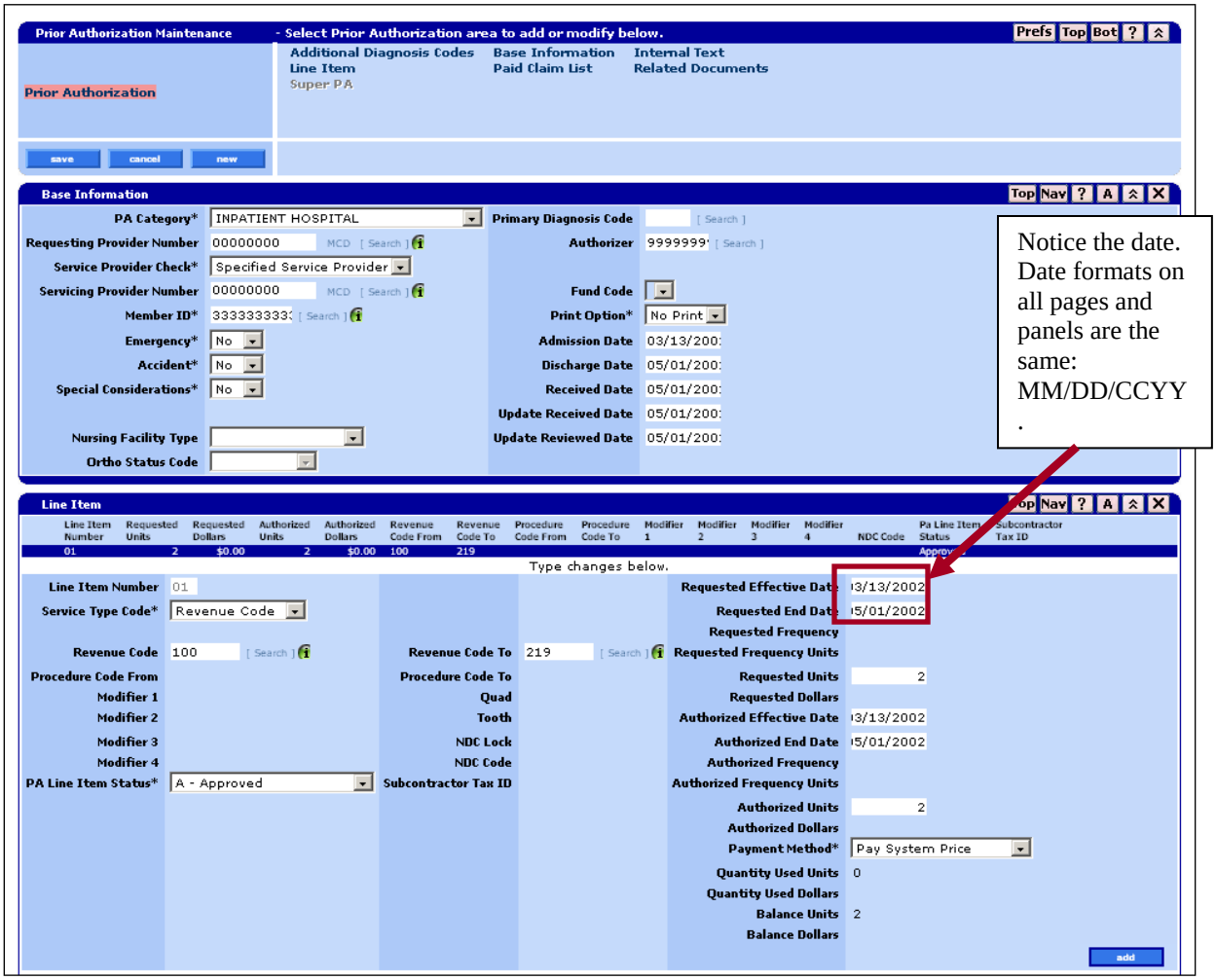


Figure 22 Row Selection in Navigator Item Panel

8.2.4.6 Audit Panel

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

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

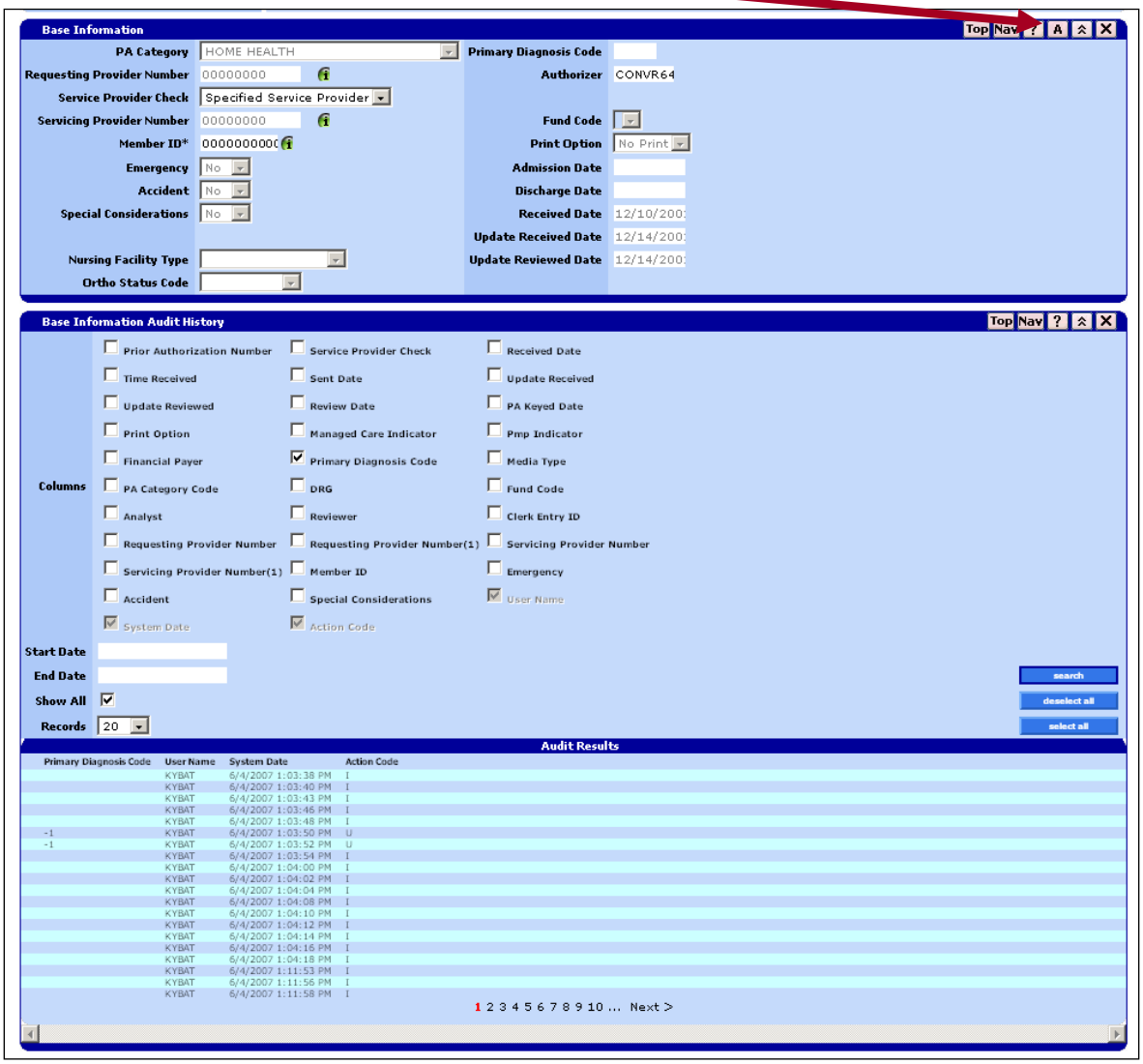


Figure 23 Audit History Panel

Field Name	Field Description
Columns	A check box for each editable field on the main panel displays. Allows the user to display select fields only.
Start Date	User can optionally limit Audit Results to matches where the system date of the change is equal to or greater than this date.

Field Name	Field Description
End Date	User can optionally limit Audit Results to matches where the system date of the change is equal to or less than this date.
Show All	If not checked, the audit result displays changes to only the single data row selected in the main panel. If checked, the audit results reports changes to all data rows contained in the list of the main panel.
Records	Number of records to display per page in the Audit Results.
Search	Displays Audit Results based on search criteria entered on the panel.
Deselect All	Removes all column checkboxes.
Select All	Checks all column checkboxes.
System Date	The date of the change.
Action Code	The type of change performed (delete, insert, update).

8.2.5 Related Data

Each subsystem, with the exception of MAR, contains Related Data. Related Data is a Sub Menu that contains codes, cross-reference tables, and other information for each associated subsystem.

8.2.5.1 Related Data Codes Page

The Related Data Codes page allows the user to access the various code tables not otherwise defined within the associated subsystem area.

The following subsystems contain a Related Data Codes page: Reference, Provider, Member, Financial, TPL, Managed Care, and Prior Authorization. Listed below are examples of "Codes" that can be found in Related Data.

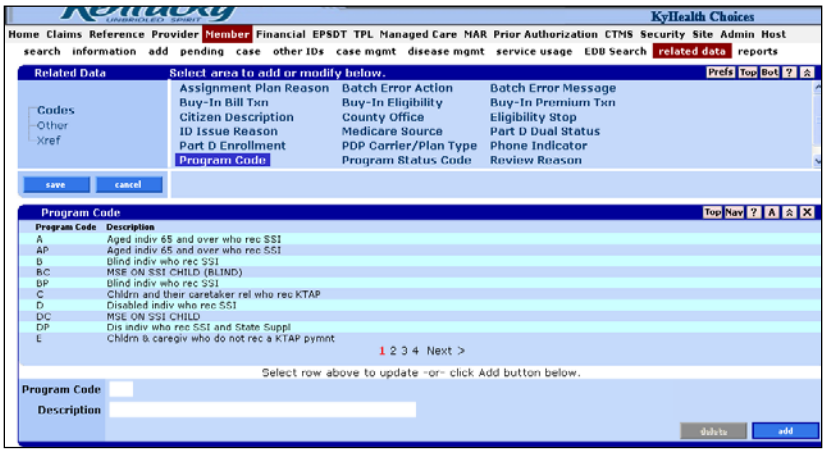


Figure 24 Program Codes (located in Member)

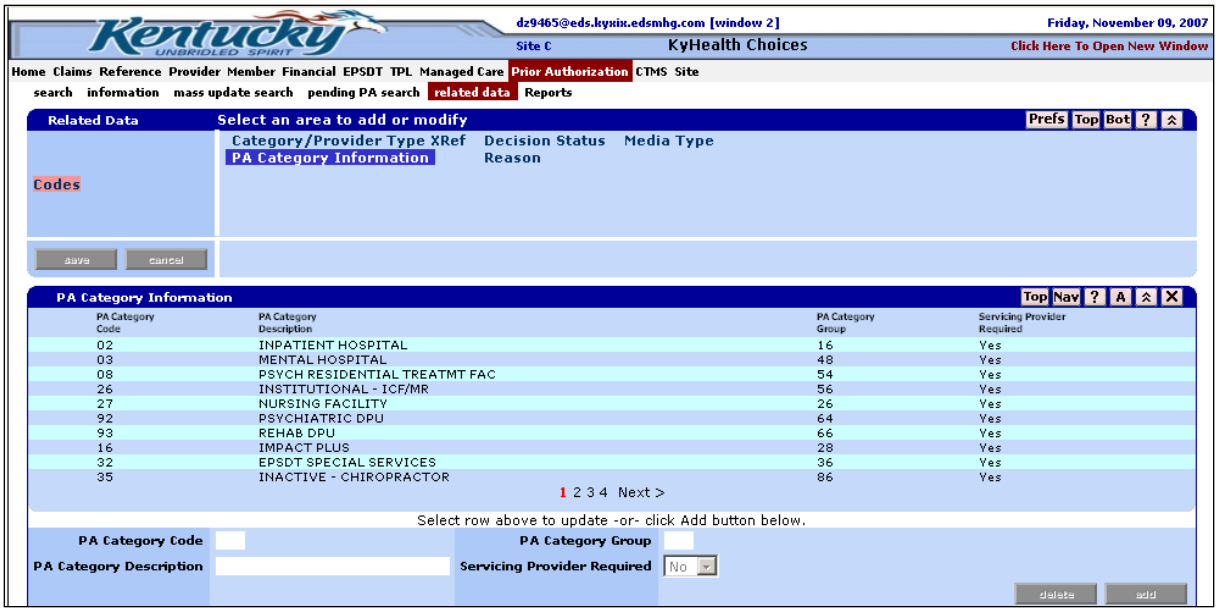


Figure 25 PA Category Information (located in Prior Authorization)

8.2.5.2 Related Data Other Page

The Related Data Other page allows the user to access the various miscellaneous data maintained within the associated subsystem area.

The following subsystems contain a Related Data Other page: Claims, Reference, Provider, Member, Financial, EPSDT, TPL, and Managed Care. Listed below are examples of “Other” panels that can be found in Related Data:

Click on "Other" to access these links.

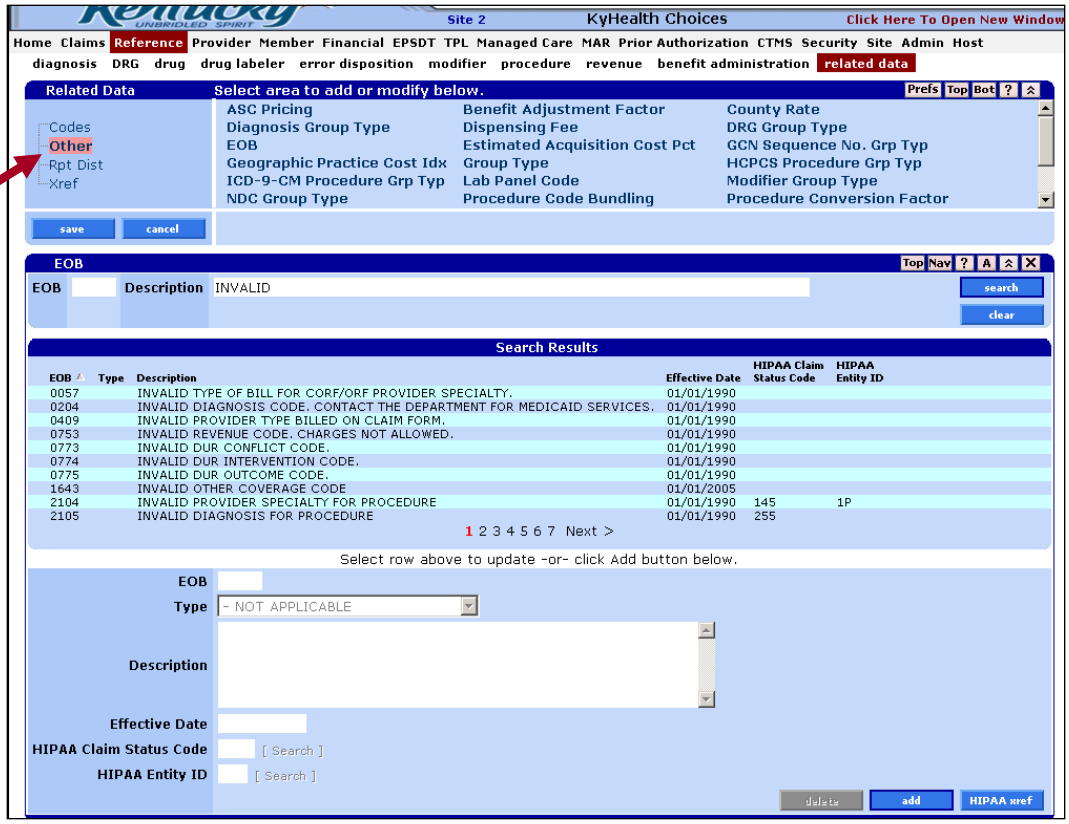


Figure 26 EOB (located in Reference)

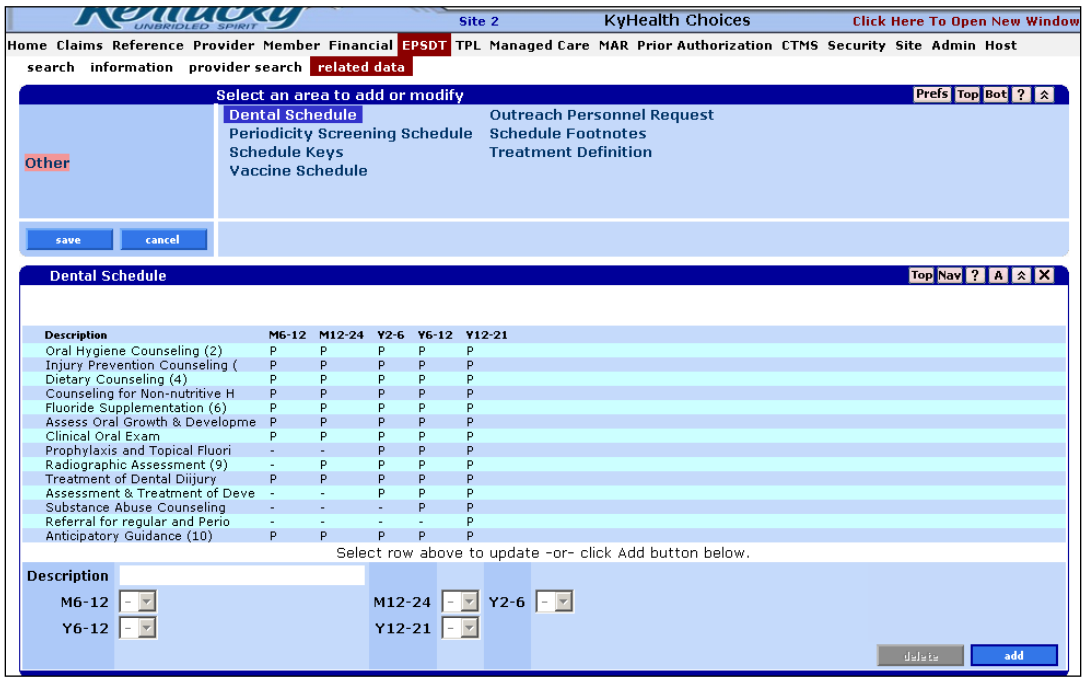


Figure 27 Dental Schedule (located in EPSDT)

8.2.5.3 Related Data Cross-Reference (Xref) Page

The Related Data Xref page allows the user to access the various cross-reference data tables maintained within the associated subsystem area.

The following subsystems contain a Related Data Xref page: Reference, Member, TPL, and Managed Care. Listed below are examples of "Xref" panels that can be found in Related Data:

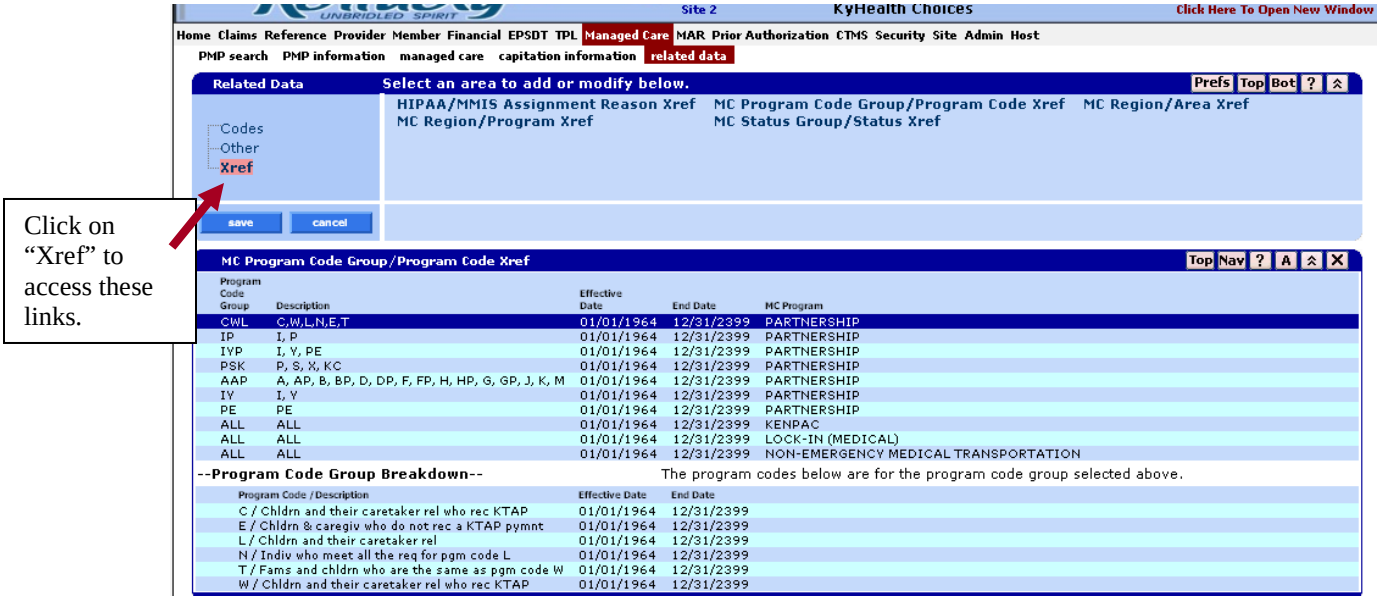


Figure 28 MC Program Code Group/Program Code Xref

(located in Managed Care)

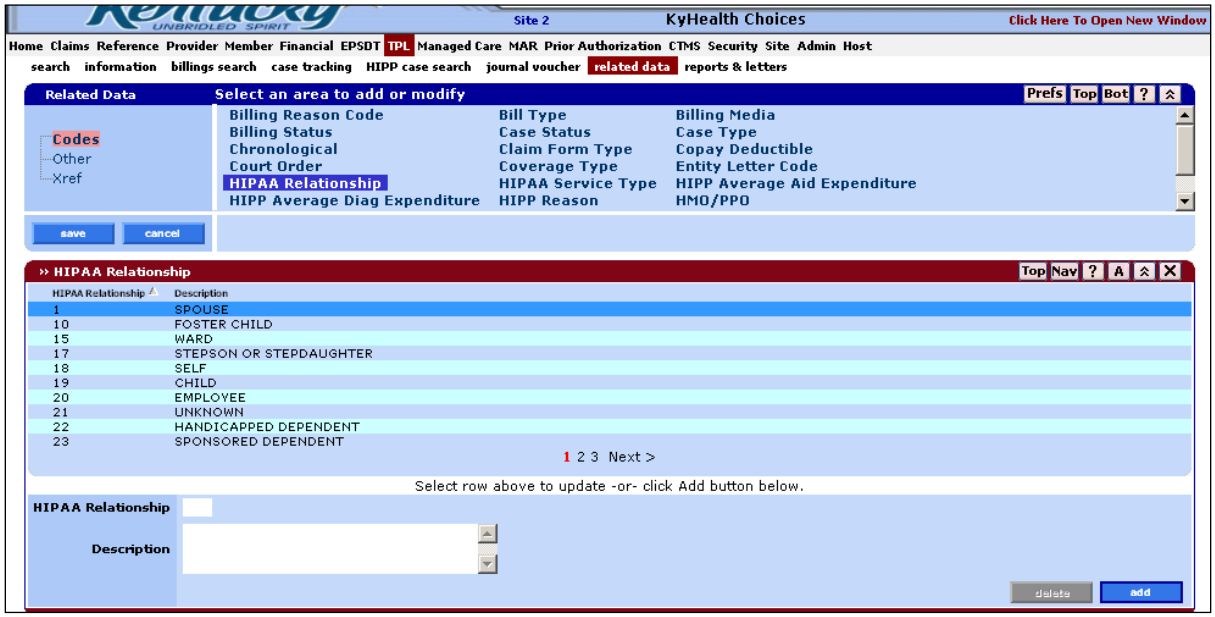


Figure 29 Local/HIPAA Relationship Code (located in TPL)

8.2.5.4 Related Data Report Distribution Page

The Reference subsystem contains a Related Data Report Distribution page. Listed below is an example of a Report Distribution panel:

Click on "Rpt Dist" to access these links.

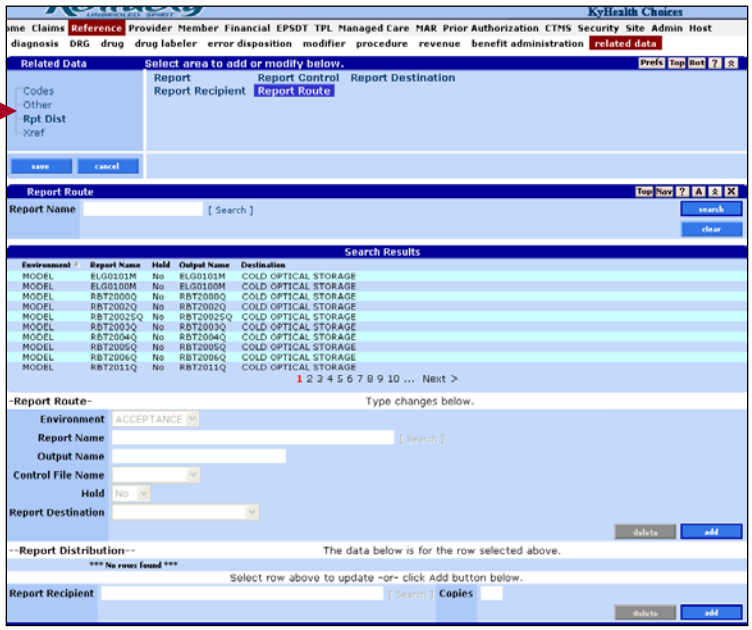


Figure 30 Report Route (located in Reference)

8.2.5.5 Related Data Payee Page

The Financial subsystem contains a Related Data Payee page. This page contains the link for one panel – EFT Account.

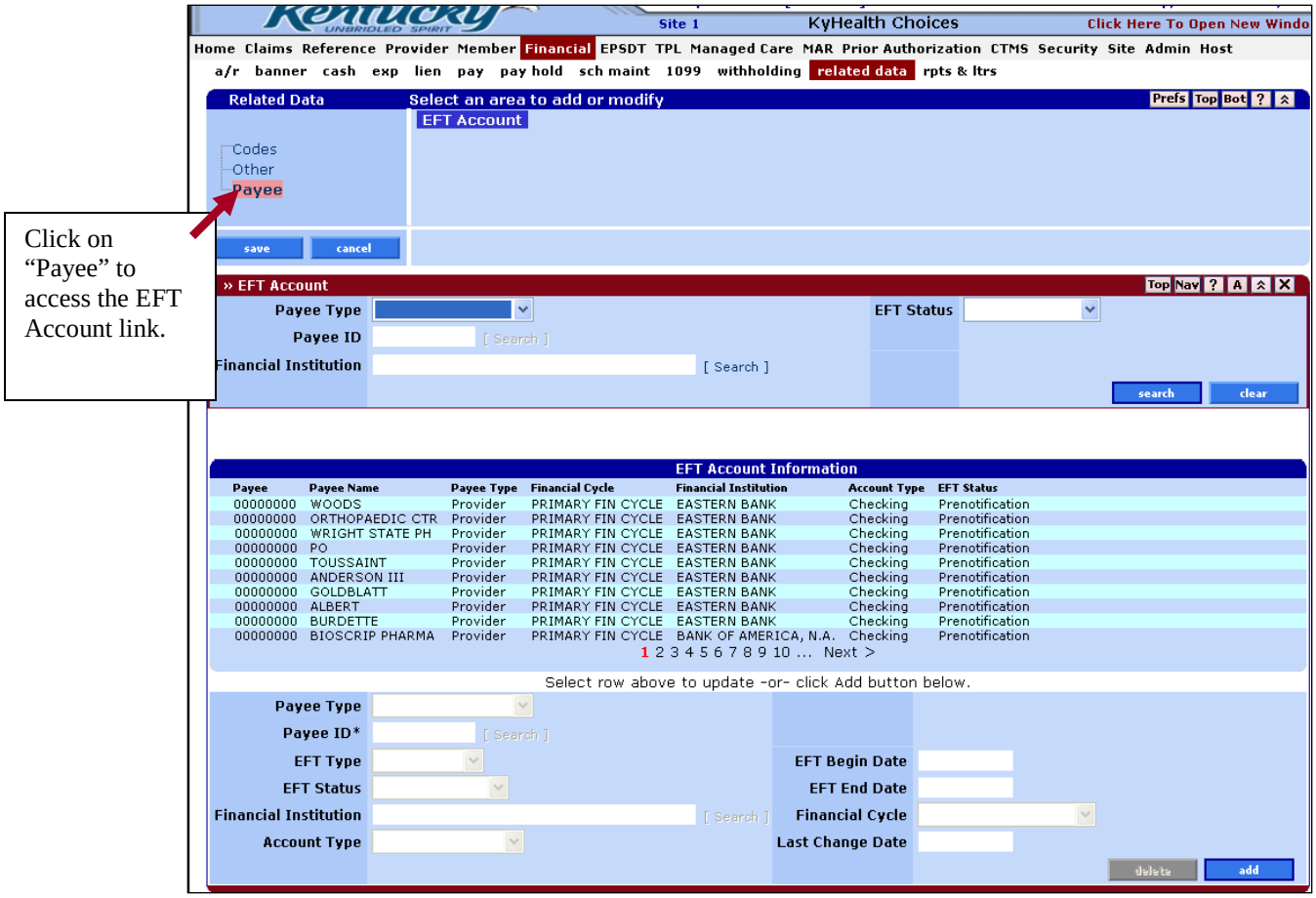
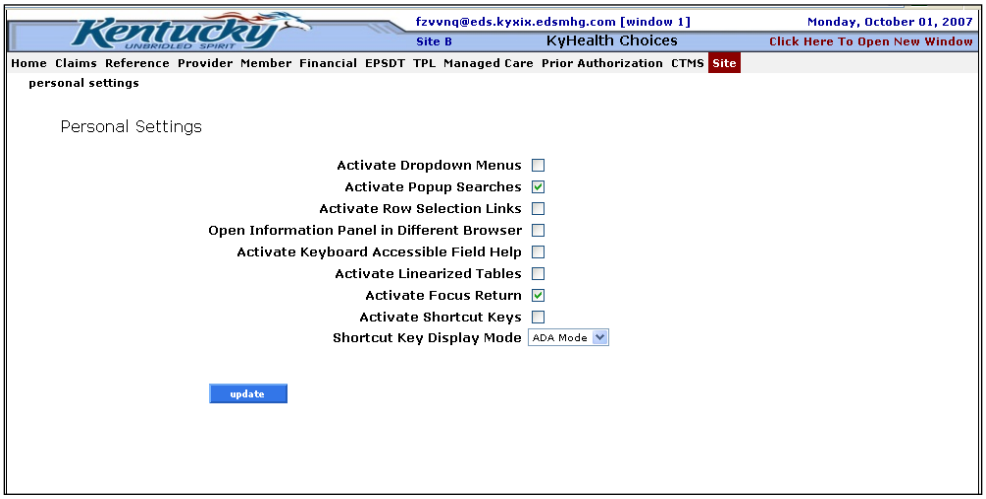


Figure 31 EFT Account (located in Financial)

8.2.6 Personal Settings

The Site subsystem allows the user to activate or modify personal settings. Click on the Site link and the following page will be displayed:



Field	Description
Activate Dropdown Menus	If enables, a drop down menu will display when scroll the mouse over the subsystem menu. If disabled, a drop down menu will not display.
Activate Popup Searches	If enabled, popup searches will be accessible by clicking the "[Search]" link next to some fields. If disabled, popup searches will not be available.
Activate Row Selection Links	If enabled, a link will be added at the beginning of each row in a list. To select a row, the user will click on the link. If disabled, there will not be a link and the user will click on the row itself to select a row.
Open Information Panel in Different Browser	If enabled, when a record is selected from search results, a different browser window will open, displaying the record selected. If disabled, a different browser window will not open. The selected record will be displayed in the same browser window as the search result panel.
Activate Keyboard Accessible Field Help	If enabled, the help feature for a field will be accessible by pressing ENTER on the keyboard. If disabled, the help feature will be accessible by clicking on the field name with the mouse.
Activate Linearized Tables	If enabled, the fields on a page and panel will be displayed in one column. If disabled, the fields on a page and panel will be displayed in two or more columns.
Activate Focus Return	If enabled, the cursor placement will be handled automatically, which will eliminate the need for the user to scroll and click on fields after a page navigation or refresh. If disabled, the cursor will not automatically return to the last field.
Activate Shortcut Keys	If activated, the system will enable shortcut keys and display shortcut key indicators on buttons and menu links. If disabled, the user will navigate the system by clicking on menu links and buttons with the mouse.
Shortcut Key Display Mode	The mode in which the shortcut key is displayed: ADA Mode or Underlined.

Field	Description
Update	Updates changes to the Personal Settings fields.
Last Update	Indicates date and time of most recent update to personal settings.

To activate a personal setting, click to insert a check mark in the associated box, and then click the "Update" button.

To disable a personal setting, click to remove the check mark in the associated box and click the "Update" button.

The following personal setting functions are demonstrated in the next sections: Popup Searches, Row Selection Links, Linearized Tables, and Shortcut Keys.

8.2.6.1 Pop Up Searches

If the user activates the pop up searches function, the [Search] link located next to certain fields will become accessible.

If the pop up search function is not enabled, the [Search] link will not be displayed, as shown in Figure 32.

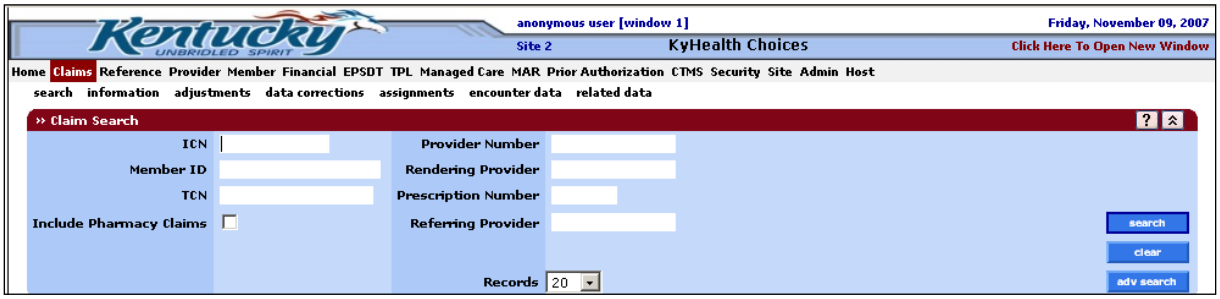


Figure 32 Claims Search Page without Pop Up Searches

To activate the pop up searches, click on the Site link, check "Activate Popup Searches", and click the "Update" button.

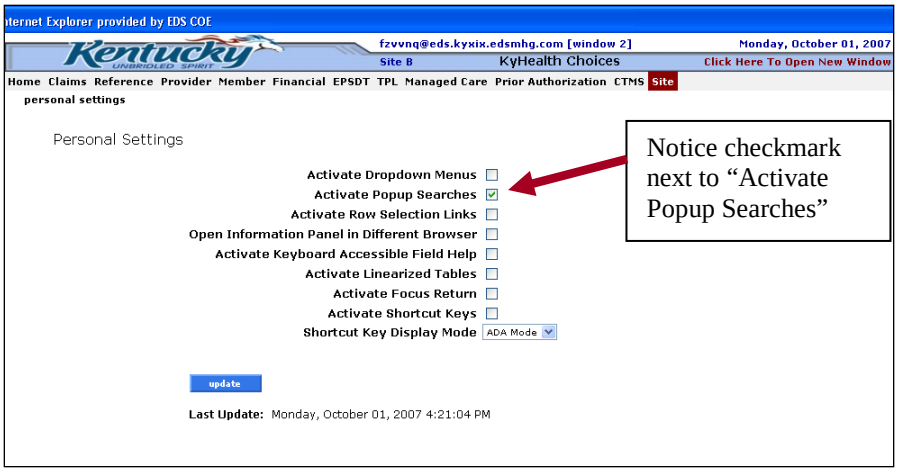


Figure 33 Personal Settings Page – Activate Popup Searches

The pop up search links are now accessible.

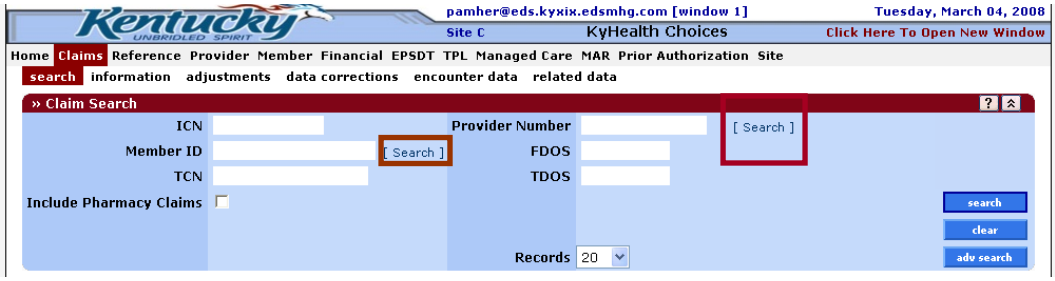


Figure 34 Claims Search Page with Pop Up Searches

8.2.6.2 Row Selection Links

The "Activate Row Selection Links" field determines how a user will select a row of records.

To activate the row selection links, click on the Site link, check "Activate Row Selection Links", and click the blue "Update" button.

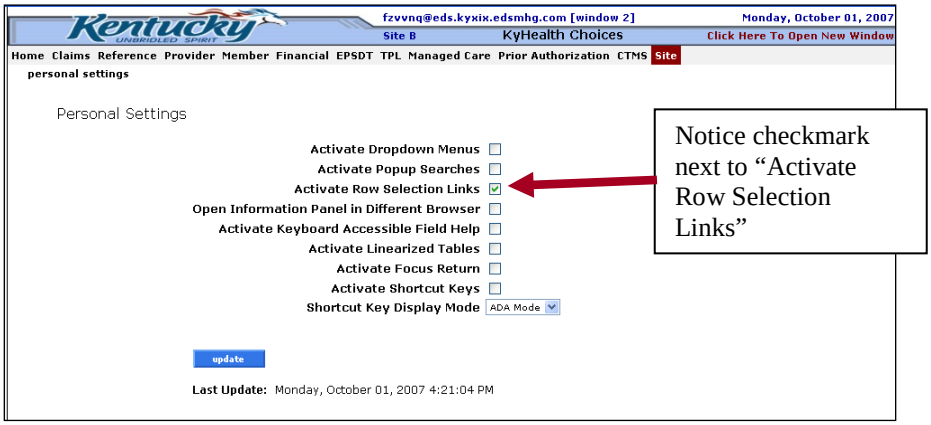


Figure 35 Personal Settings Page – Activate Row Selection Links

When activated, the user will select a row by clicking on the link next to the row.

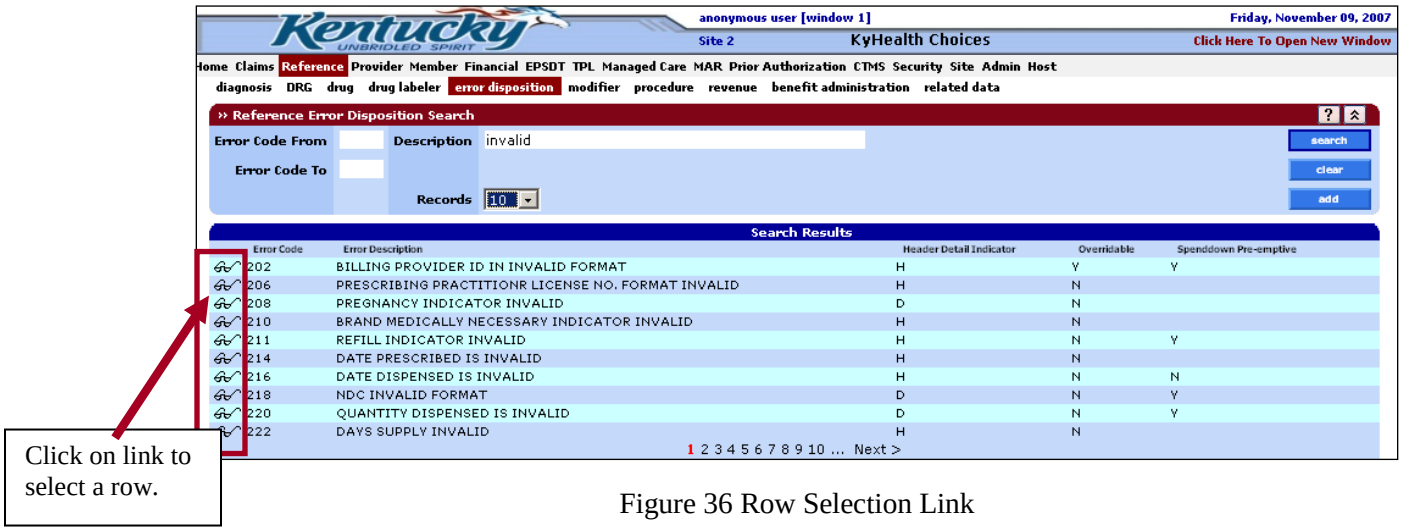


Figure 36 Row Selection Link

If the Row Selection Links is disabled, the link next to the row will not be available. The user will select a row by clicking once anywhere within the row itself (except on a Hot Link, as discussed in a previous section).

8.2.6.3 Linearized Tables

The "Activate Linearized Tables" function determines how fields are displayed on a pages and panels.

To activate the linearized table function, click on the Site link, check "Activate Linearized Tables", and click the blue "Update" button.

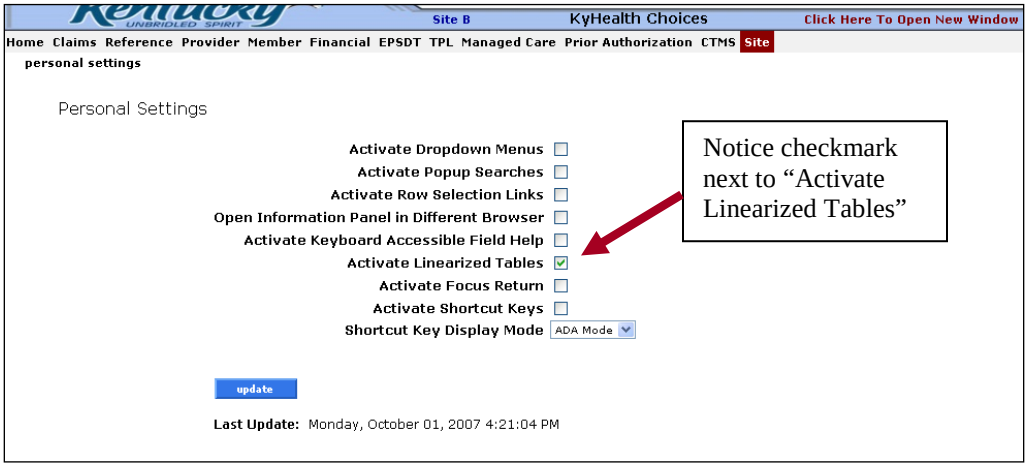


Figure 37 Personal Settings Page – Activate Linearized Tables

When activated, the linearized table function will display the fields in one column on a page and panel.

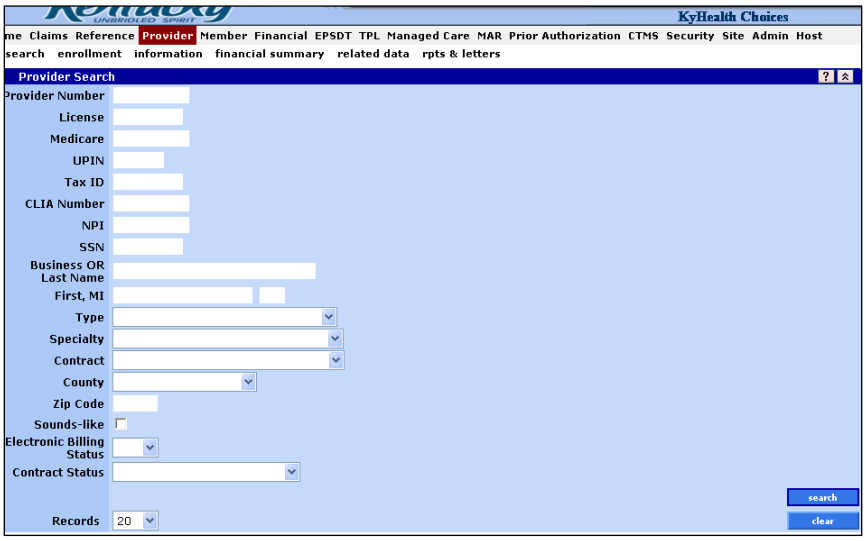


Figure 38 Provider Search Panel with a Linearized Table

If the linearized table function is disabled, the fields will be displayed in two or more columns.

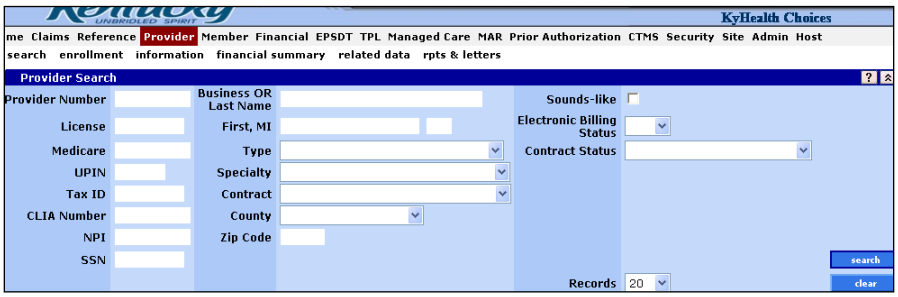


Figure 39 Provider Search Panel without a Linearized Table

8.2.6.4 Shortcut Keys

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

To active the shortcut key, click on the Site link, check “Activate Shortcut Keys”, and select the Shortcut Key Display Mode (either “Underline” or “ADA Mode”). Click the blue “Update” button.

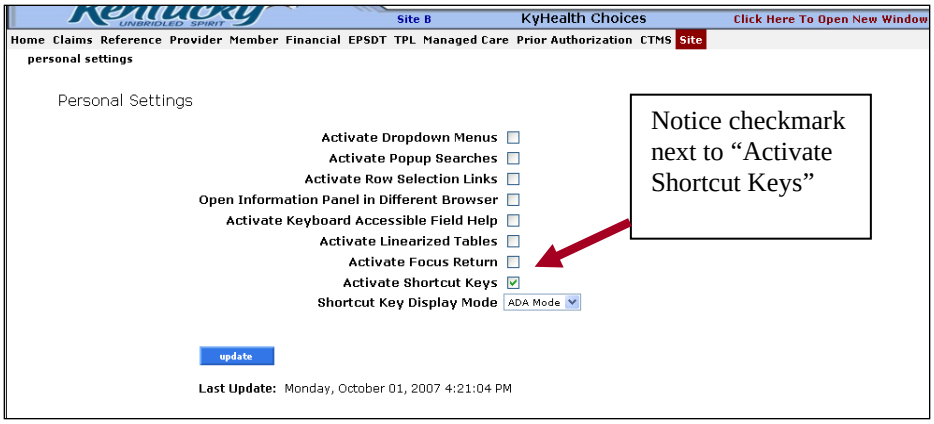


Figure 40 Personal Settings Page – Shortcut Key Activated

To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name.

If the "Underline" display mode is selected, the shortcut key will be displayed within the sub menu name. Within the name, the letter that has a horizontal bar above and below it is the shortcut key letter.

Figure 41 demonstrates how the user can use the shortcut keys to quickly navigate from the Claims Search panel to the Data Corrections panel by using the following shortcut key combination: (Ctrl + Alt + O) since the letter "O" is found within the horizontal bars on the Sub Menu adjustment link.

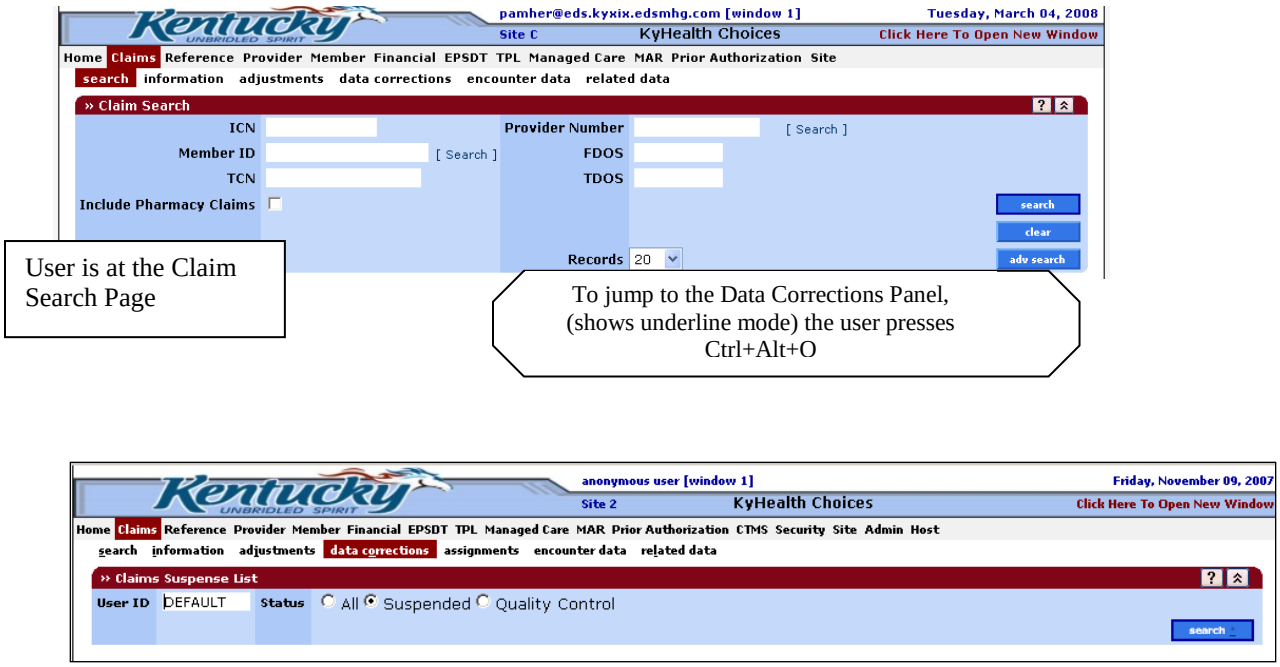


Figure 41 Shortcut Key – Jump from Search Page to Data Corrections Page

If the "ADA Mode" is selected as the display mode, the shortcut key will be displayed to the right of the sub menu name in brackets [ ].

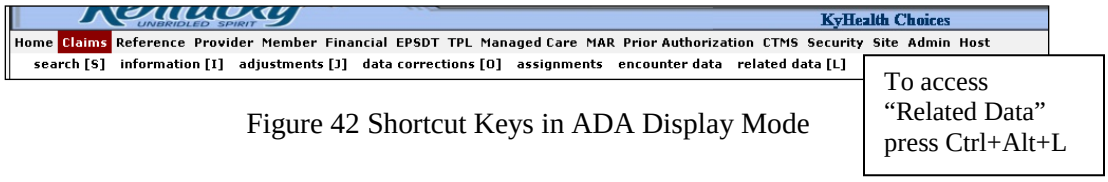


Figure 42 Shortcut Keys in ADA Display Mode

8.2.6.5 Drop Down Menus

If the user activates the drop down menu function, a drop down menu will display when the mouse is scrolled over the subsystem menus. Each submenu within the subsystem will display.

If the drop down function is not enabled, then the menu is displayed horizontally across the page

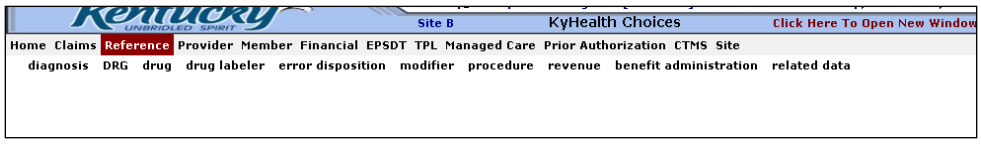


Figure 43 Subsystem Menu Without the Drop Down Menu Function

To active the shortcut key, click on the Site link, check "Activate Dropdown Menus". Click the blue "Update" button.

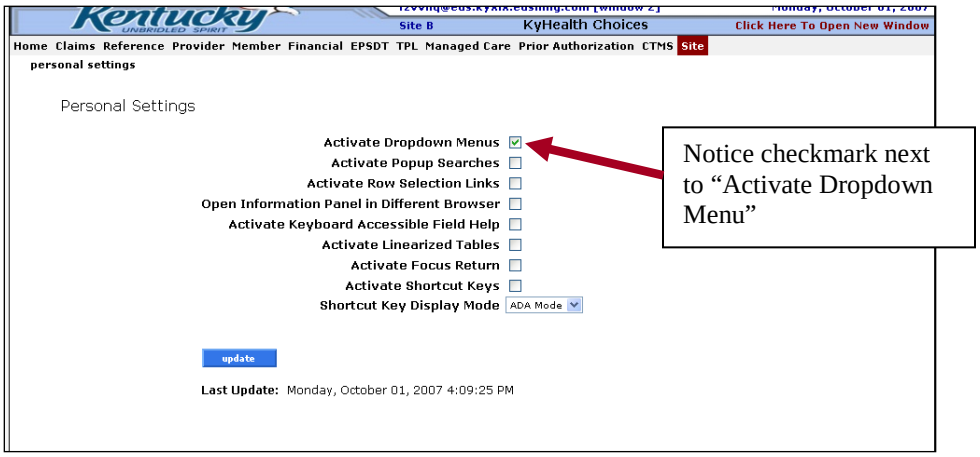


Figure 44 Personal Settings Page – Dropdown Menu Activated

If the dropdown menu is activated, the submenu will be displayed in the dropdown menu when the mouse is scrolled over the subsystem menu.

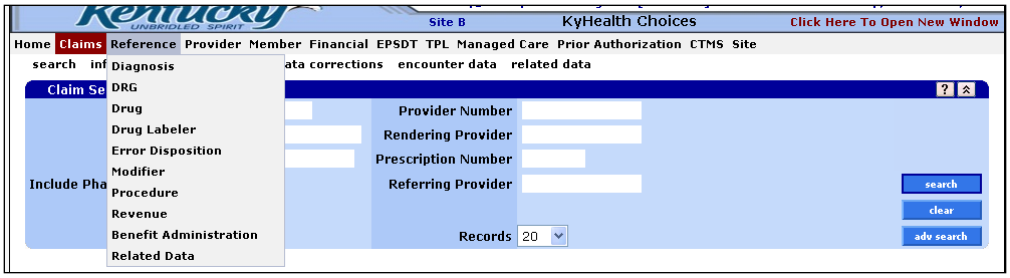


Figure 45 Dropdown Menu Displayed

8.2.6.6 Opening the Information Panel in a Different Browser Window

If the user activates the different browser window function, the user can select a search result from the search panel, and the selected record will open in a different browser window. Then the user will have two different browser windows open.

If the user does not activate this function, then only one browser window will be open. When a record is selected from the search results panel, the record will display in the same browser window as the search panel.

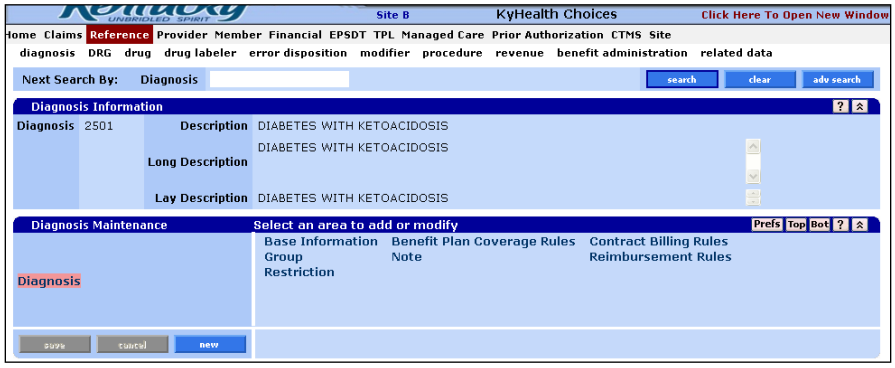


Figure 46 Diagnosis Information Panel (One Browser Window)

To active the shortcut key, click on the Site link, check “Open Information Panel in Different Window”. Click the blue “Update” button.

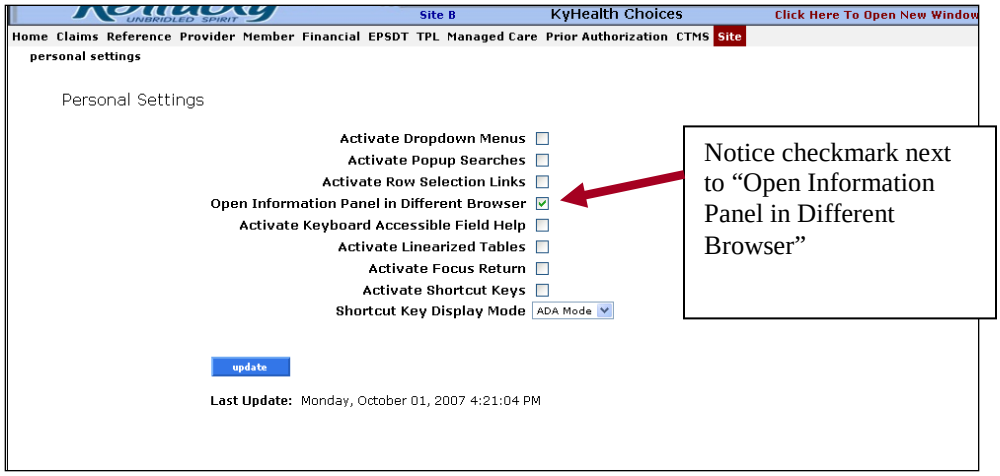


Figure 47 Personal Settings Page – Different Browser Function Activated

If the different browser function is activated, two browser windows will display. One window displayed the search results panel and the other window will display the record.

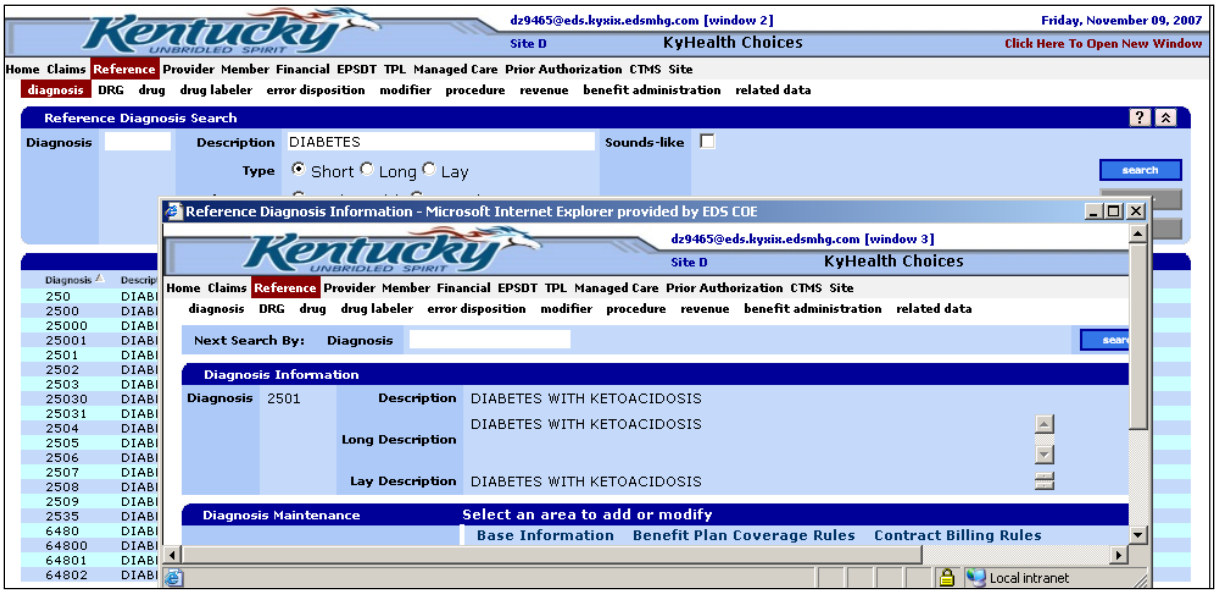


Figure 48 Two Browser Windows Displayed

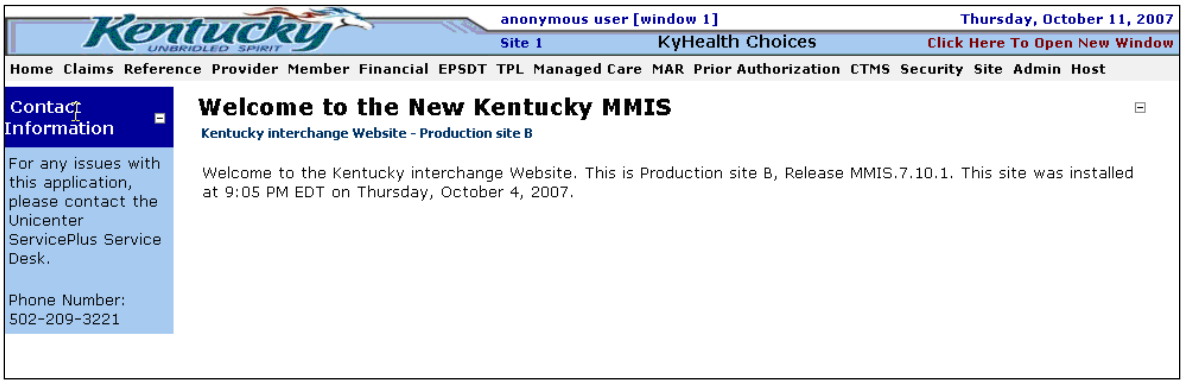
Diagnosis Search Panel and Diagnosis Information Panel

9 Appendix B – How To Search for Claims

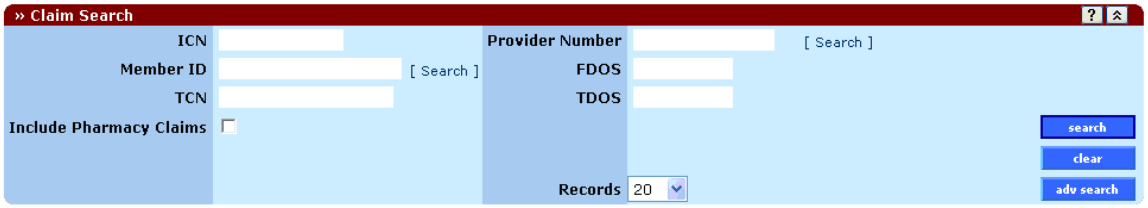
9.1 How to Search for a Claim Using an Internal Control Number

STEP 1. Access interChange.

STEP 2. Select Claims from the main menu.



STEP 3. The Claim Search panel will open.



Claim Search Panel

9.1.1 Claims/Claim Search Panel Field Descriptions

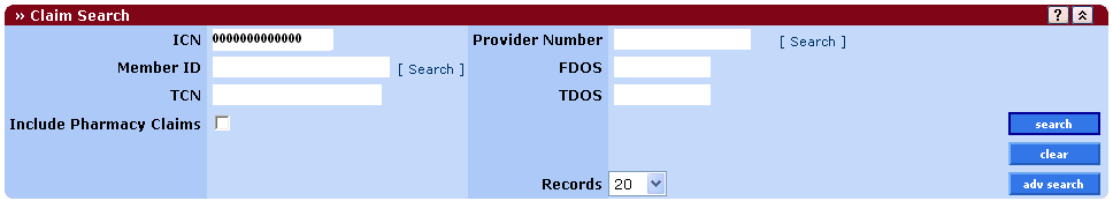
Field	Description
ICN	Internal Control Number that uniquely identifies a claim.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
TCN	Transaction Control Number assigned to all claims received in the Legacy system.
Include Pharmacy Claims	When selected, will list all claim types including pharmacy claims; when not selected, will list all claim types except pharmacy claims
Provider Number	Provider Identification Number that uniquely identifies pay to provider.
Rendering Provider ID	Provider Identification Number that uniquely identifies rendering provider.

Field	Description
Prescription Number	Number assigned by pharmacy to identify drug dispensed to member.
Referring Provider	Provider Identification Number that uniquely identifies referring provider.
Records	Maximum number of records that displays per page. Valid Values are: 5 10 20 50 100

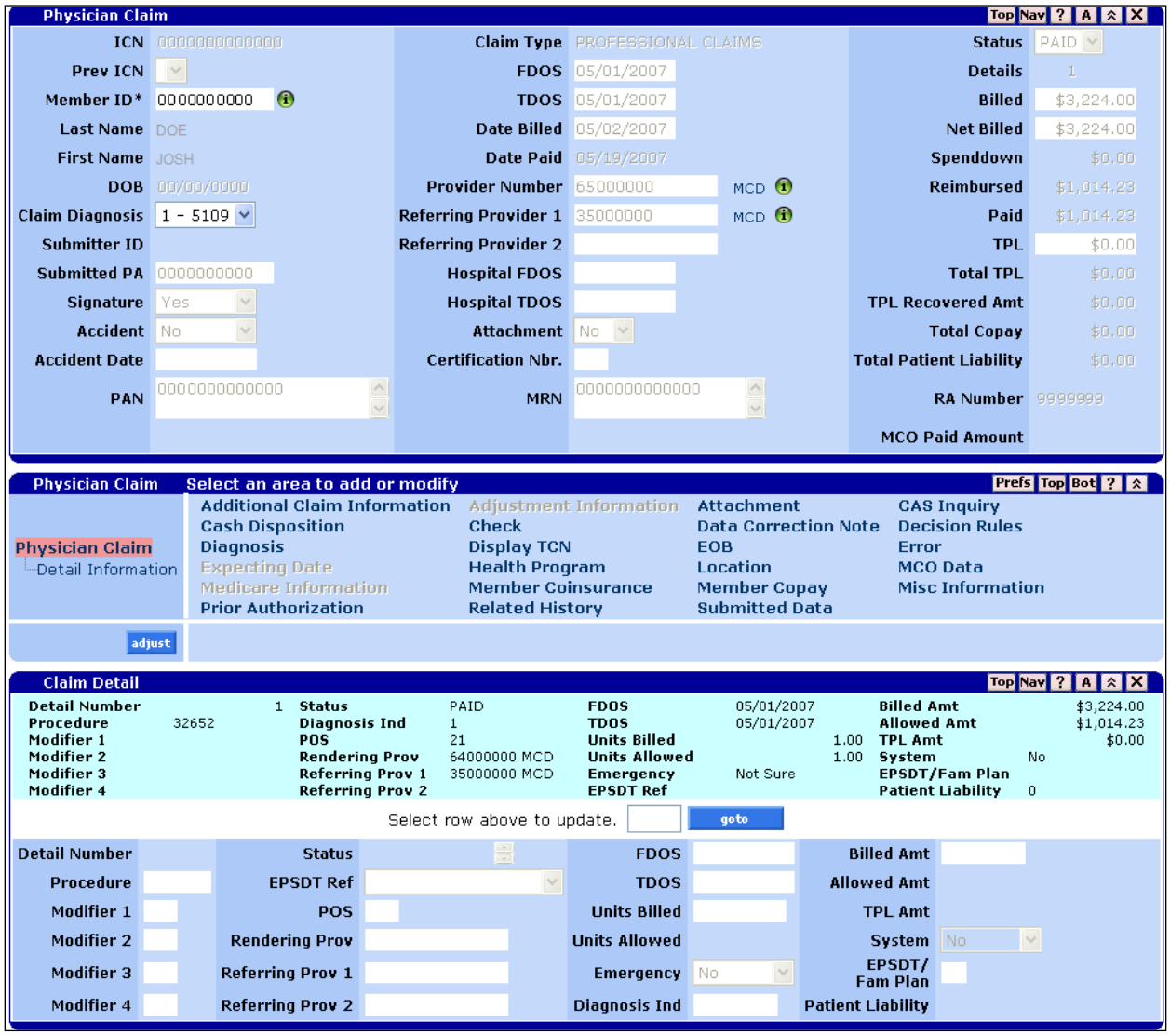
9.1.2 Claims/Claim Search Panel Button Descriptions

Button	Description
Search	Performs a query on the database and returns the data for the entered search criteria.
Clear	Clears the previous search criteria from the search fields.
Adv Search	The Advanced Search button opens a panel with additional search criteria fields.

STEP 4. Enter the Internal Control Number in the ICN field. Click the “Search” button.



STEP 5. The requested claim information page appears.



Physician Claim Information Page

9.1.3 Claims/Information/Physician Claim Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
Last Name	Last name of member.
First Name	First name of member.

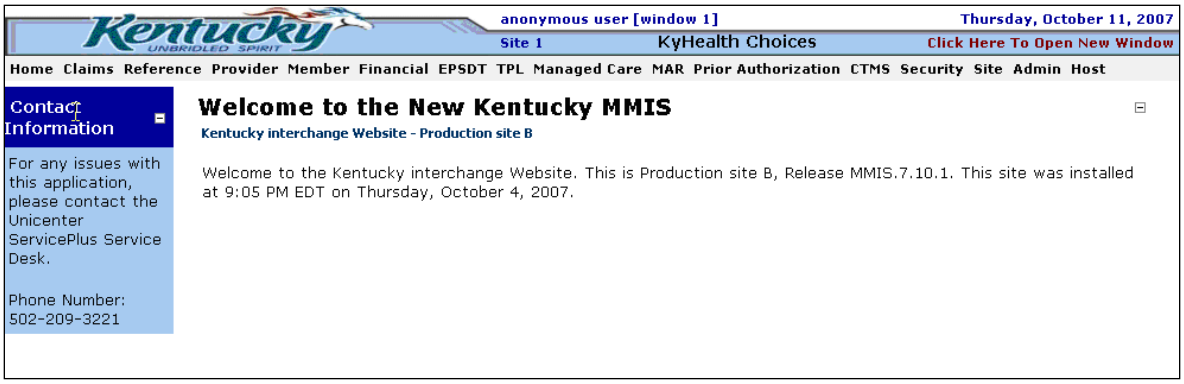
Field	Description
DOB	Date of Birth on record for member.
Claim Diagnosis	Code used to identify the primary or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates whether the service performed was as a result of an accident.
Accident Date	Date of accident.
PAN	Patient's unique identification number assigned by the provider to track the patient's financial records.
Claim Type	Indicates the type of claim.
FDOS	Beginning date of service on the claim.
TDOS	Ending date of service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The pay to provider identification number.
Referring Provider 1	The license number of the referring physician and location other than the attending physician.
Referring Provider 2	The license number of the second referring physician and location other than the attending physician.
Hospital FDOS	First date hospitalized.
Hospital TDOS	Last date hospitalized.
Attachment	Indicates whether an attachment is present.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing the Medical Record Number.
Status	The status of the claim.
Details	The number of detail service lines on the claim.
Billed	Amount requested by the provider for services rendered.
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, etc.).

Field	Description
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives.
Paid	Amount paid on claim.
TPL	Third Party Liability. The amount paid by a third party for services, at the claim header level.
Total TPL	The sum of the TPL amounts at the header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement window.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records.
Total Patient Liability	The amount of patient liability applied to this claim.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

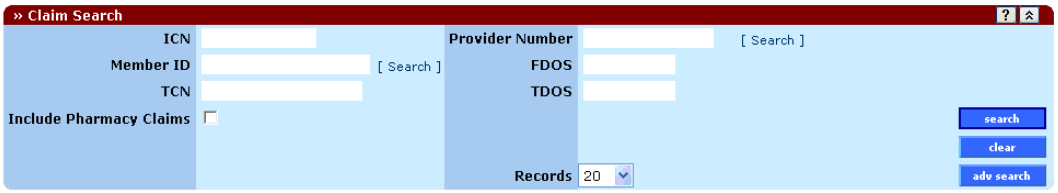
9.2 How to Search for a Claim Using a Provider Number and Member Number

STEP 1. Access interChange.

STEP 2. Select Claims from the main menu.



STEP 3. The Claim Search panel will open.



Claim Search Panel

9.2.1 Claims/Claim Search Panel Field Descriptions

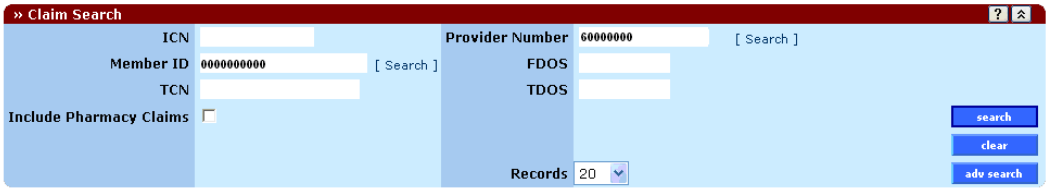
Field	Description
ICN	Internal Control Number that uniquely identifies a claim.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
TCN	Transaction Control Number assigned to all claims received in the Legacy system.
Include Pharmacy Claims	When selected, will list all claim types including pharmacy claims; when not selected, will list all claim types except pharmacy claims
Provider Number	Provider Identification Number that uniquely identifies pay to provider.
Rendering Provider ID	Provider Identification Number that uniquely identifies rendering provider.
Prescription Number	Number assigned by pharmacy to identify drug dispensed to member.
Referring Provider	Provider Identification Number that uniquely identifies referring provider.

Field	Description
Records	Maximum number of records that displays per page. Valid Values are: 5 10 20 50 100

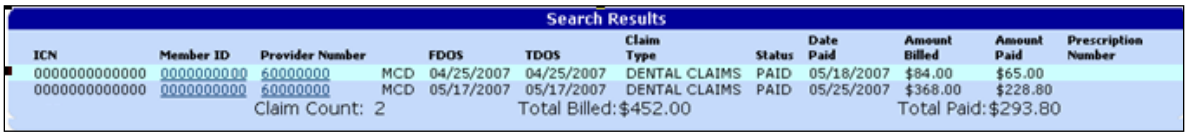
9.2.2 Claims/Claim Search Panel Button Descriptions

Button	Description
Search	Performs a query on the database and returns the data for the entered search criteria.
Clear	Clears the previous search criteria from the search fields.
Adv Search	The Advanced Search button opens a panel with additional search criteria fields.

STEP 4. Enter the member number in the Member ID field and the provider number in the Provider Number field. Click the "Search" button.



STEP 5. If a search returns multiple claims, select the specific claim by clicking the row one time.

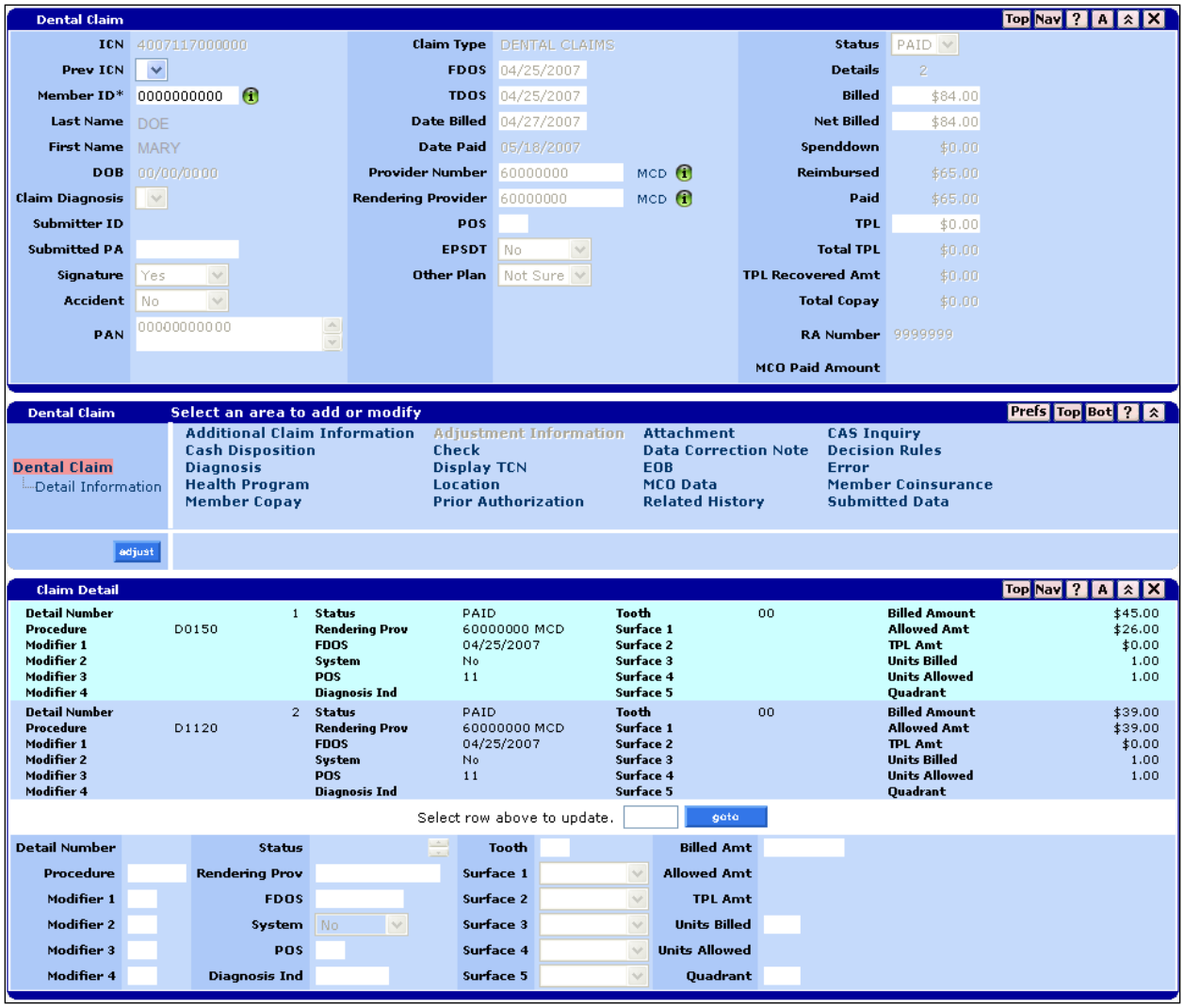


Claim Search Results Panel

9.2.3 Claims/Search Results Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim meeting the selection criteria.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
Provider Number	Provider Identification Number that uniquely identifies pay to provider.
FDOS	From Date of Service for the claim.
TDOS	To Date of Service for the claim.
Claim Type	Indicates the type of claim.
Status	Identifies status of the claim within the system.
Date Paid	Date the claim was paid.
Amount Billed	Billed amount on claim.
Amount Paid	Amount paid on claim.
Prescription Number	Number assigned by a pharmacy to identify drug dispensed to a member.

STEP 6. The requested claim information page appears.



Dental Claim Information Page

9.2.4 Claims/Information/Dental Claims Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the other previous ICNs for the claim and view that information. The MCO Original ICN for an encounter claim. Not used on claims other than encounters.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID number. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.

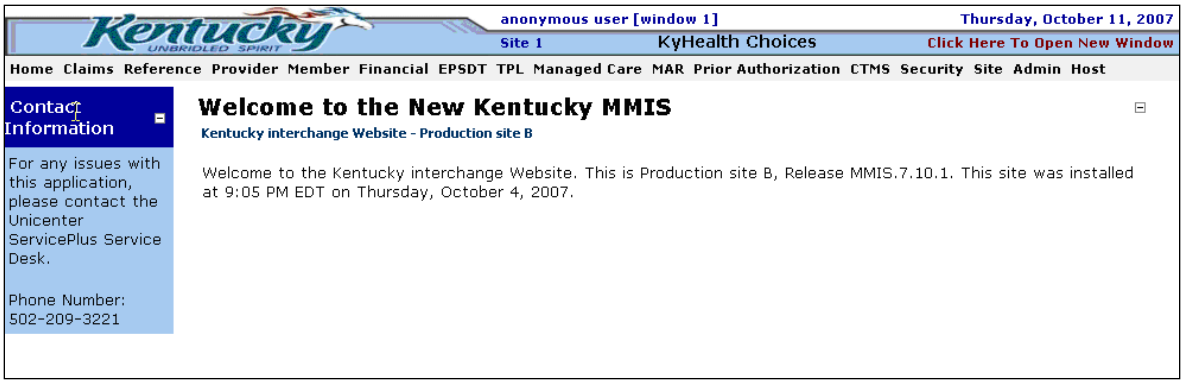
Field	Description
First Name	The first name of the member associated with the Member ID number. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	A code for the condition requiring medical attention.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates the accident reason. It draws its drop down values from the T_ACCIDENT_TYPE table.
PAN	Identification for a member assigned by a provider. (Patient Account Number)
Claim Type	Indicates the type of claim.
FDOS	First Date of Service on the claim.
TDOS	Date of last service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The provider identification number and location that uniquely identifies the provider of services.
Rendering Provider	The Rendering provider identification number and location that uniquely identifies the provider of services.
POS	Place of Service where service was rendered.
EPSDT	Indicates whether claim is EPSDT.
Other Plan	Indicates if another form of insurance was used.
Status	This field displays the status of the claim.
Details	Indicates the number of detail service lines on the claim.
Billed	Amount of money requested for payment by a provider for services rendered.
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL and so on).
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives minus any state share amount (if applicable).

Field	Description
Paid	Amount paid on claim. Amount paid will be the allowed amount minus spend down, coinsurance, deductible, patient liability, dispensing fees, TPL, etc., as applicable depending on services. This value is computed by adding up all the AMT_PAID values on the related details.
TPL	Third Party Liability. The amount paid by a third party for services.
Total TPL	Total Third Party Liability. This is the sum of the copay amounts from Health Program panel records(T_CLM_PGM_XREF table).
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement panel.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records (T_CLM_PGM_XREF table).
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

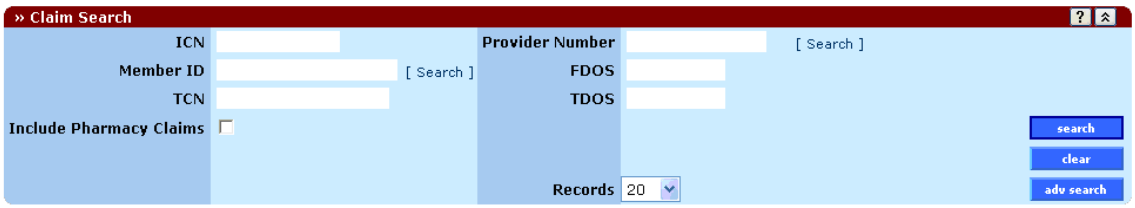
9.3 How to Search for a Claim Using Other Criteria (Advanced Search)

STEP 1. Access interChange.

STEP 2. Select Claims from the main menu.

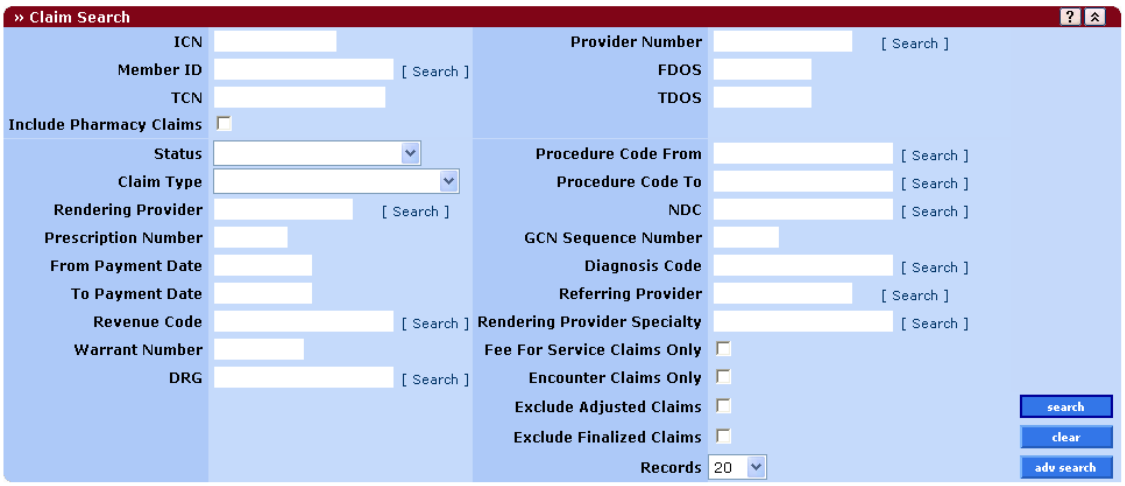


STEP 3. The Claim Search panel will open. Click the "Adv Search" button.



Claim Search Panel

STEP 4. The Search panel will expand, providing additional search options.



Advanced Search Panel

9.3.1 Claims/Advanced Search Panel Field Descriptions

Field	Description
ICN	Internal Control Number that uniquely identifies a claim.
Member ID	Member's 10-digit *KY Medicaid* ID number. Field is numeric only.
TCN	Transaction control number used to uniquely identify claims on the previous MMIS.
Include Pharmacy Claims	When selected, will list all claim types including pharmacy claims; when not selected, will list all claim types except pharmacy claims
Status	Current status of a claim.

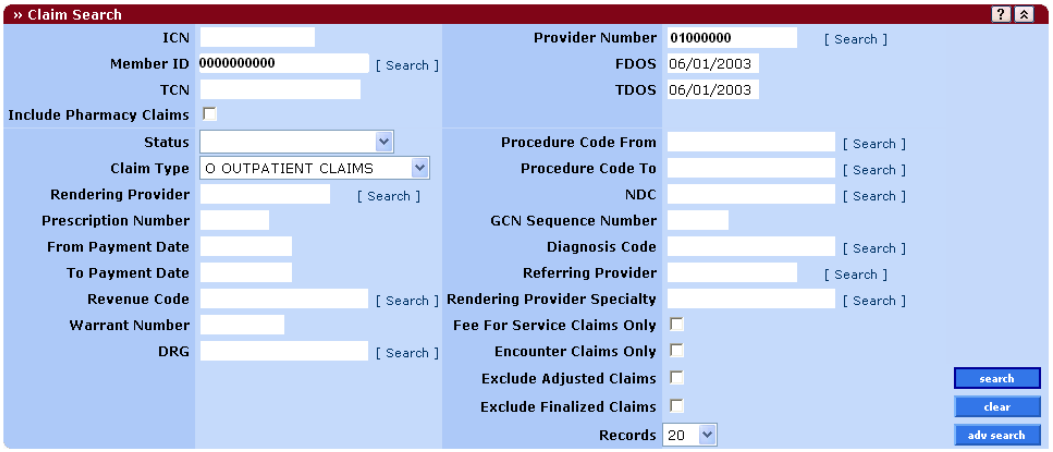
Field	Description
Claim Type	Valid Values: A- INST XOVER CLAIMS B- PROF XOVER CLAIMS C- OUTP XOVER CLAIM D- DENTAL CLAIMS I- INPATIENT CLAIMS L- LONG TERM CARE CLAIMS M- PROFESSIONAL CLAIMS O- OUTPATIENT CLAIMS P- PHARMACY CLAIMS Q- COMPOUND DRUG CLAIMS H- HOME HEALTH CLAIMS
FDOS	From Date of Service on a claim.
TDOS	To Date of Service on a claim.
From Payment Date	From Payment date.
To Payment Date	To Payment date.
Revenue Code	Revenue code search option.
Warrant Number	Warrant number search option.
DRG	Diagnosis Related Group number for UB92 claims.
Provider Number	Provider Identification Number that uniquely identifies pay to provider.
Rendering Provider	Provider Identification Number that uniquely identifies rendering provider.
Prescription Number	Number assigned by a pharmacy to identify drug dispensed to member.
Referring Provider	Provider Identification Number that uniquely identifies referring provider.
Procedure Code From	Beginning procedure code in a range selection option.
Procedure Code To	Ending procedure code in a range selection option.
NDC	National Drug Code search option.
GCN Sequence Number	Generic code number search option.
Diagnosis Code	Diagnosis code search option.

Field	Description
Rendering Provider Specialty	Rendering provider's specialty code.
Fee for Service Claims Only	List only fee for service claims.
Encounter Claim Only	List only encounter claims.
Exclude Adjusted Claims	Exclude adjusted claims.
Exclude Finalized Claims	Exclude finalized claims.
Records	Maximum number of records that displays per page. Valid Values are: 5 10 20 50 100

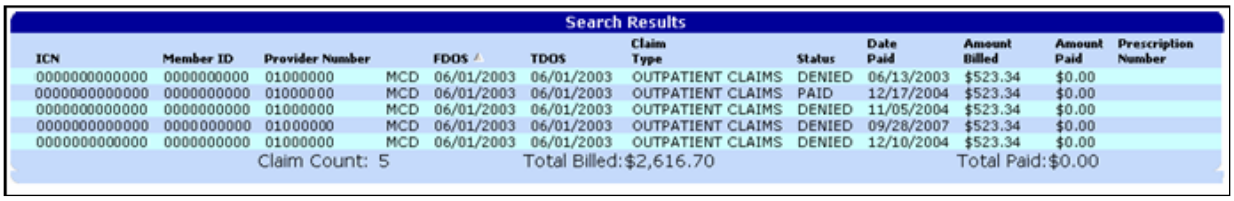
9.3.2 Claims/Advanced Search Panel Button Descriptions

Button	Description
Search	Performs a query on the database and returns the data for the entered search criteria.
Clear	Clears the previous search criteria from the search fields.
Adv Search	The Advanced Search button opens a panel with additional search criteria fields.

STEP 5. Enter the search criteria. Click the “Search” button.



STEP 6. If a search returns multiple claims, select the specific claim by clicking the row one time.

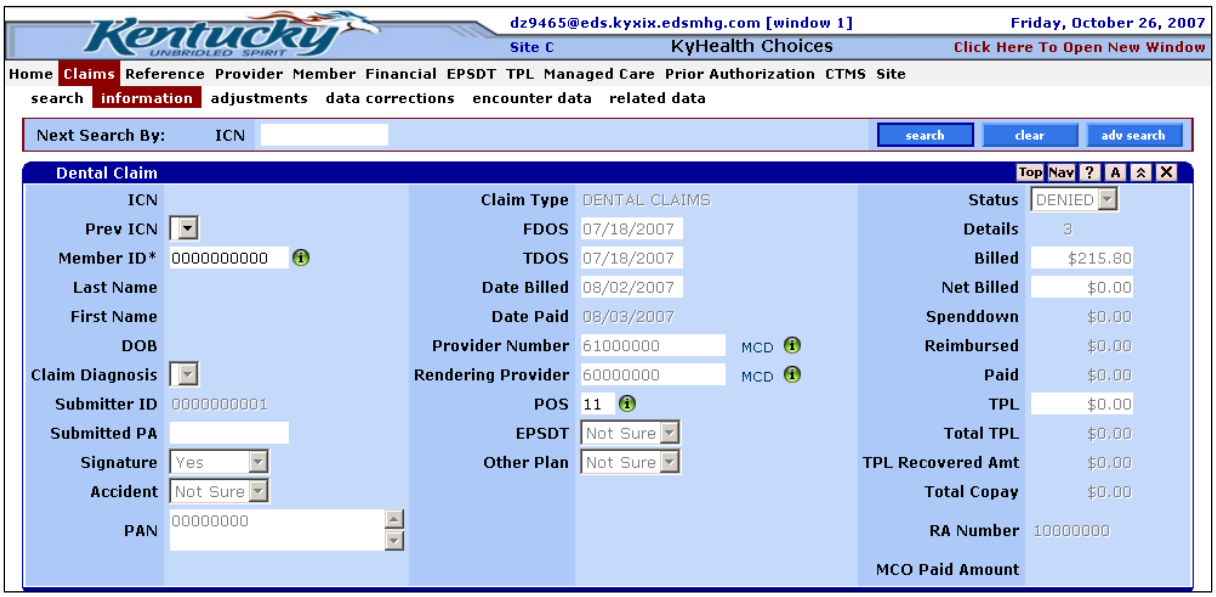


Search Results

ICN	Member ID	Provider Number		FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid	Prescription Number
0000000000000	0000000000	01000000	MCD	06/01/2003	06/01/2003	OUTPATIENT CLAIMS	DENIED	06/13/2003	$523.34	$0.00	
0000000000000	0000000000	01000000	MCD	06/01/2003	06/01/2003	OUTPATIENT CLAIMS	PAID	12/17/2004	$523.34	$0.00	
0000000000000	0000000000	01000000	MCD	06/01/2003	06/01/2003	OUTPATIENT CLAIMS	DENIED	11/05/2004	$523.34	$0.00	
0000000000000	0000000000	01000000	MCD	06/01/2003	06/01/2003	OUTPATIENT CLAIMS	DENIED	09/28/2007	$523.34	$0.00	
0000000000000	0000000000	01000000	MCD	06/01/2003	06/01/2003	OUTPATIENT CLAIMS	DENIED	12/10/2004	$523.34	$0.00	

Claim Count: 5 Total Billed:$2,616.70 Total Paid:$0.00

STEP 7. The selected claim information page appears.



UB92 Claim Information Page

9.3.3 Claims/Information/UB92 Claim Information Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit *KY Medicaid* ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.
First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.

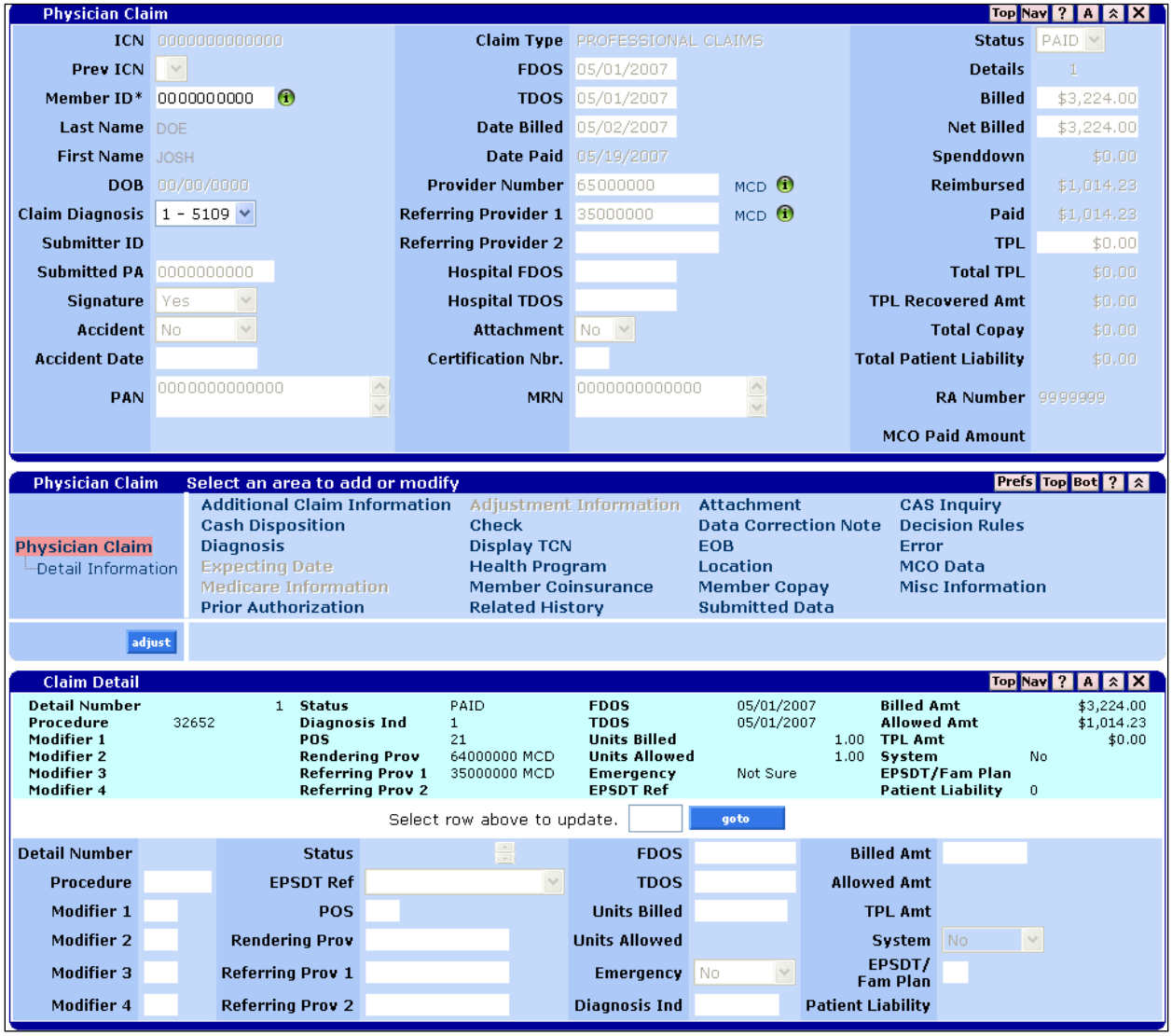
Field	Description
DOB	Member date of birth.
Claim Diagnosis	Code used to identify the primary, admitting, emergency or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim form.
Signature	Indicates where claim was signed by provider or representative.
Admit Source	Indicates source of admission.
Admit type	Code indicating type of admission.
Discharge Hour	Time member is released from hospital or facility.
Type of Bill	Code indicating specific type of bill.
PAN	Patient's unique identification number assigned by provider to track patient's financial records.
Claim Type	Indicates type of claim.
FDOS	Beginning date of service on claim.
TDOS	Ending date of service on claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which claim was adjudicated.
Provider Number	*KY Medicaid* Provider number.
Attending Provider	Attending physician's prescribing number.
Other Provider 1	License number of physician other than attending physician.
Other Provider 2	License number of physician other than attending physician.
Facility ID	Identification number assigned to facility provider and service location.
Admit Date	Date patient was admitted to facility for care.
Admit Time	Time member was admitted to facility for care.
Patient Status	Codes indicating patient's status as of ending service date of period covered on claim.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing Medical Record Number.
Status	Identifies status of claim within system.

Field	Description
Details	Number of detail service lines on claim.
Billed	Amount requested by provider for services rendered.
Spenddown	Amount of member's spend down applied to claim.
Reimbursed	Total amount provider receives.
Paid	Amount paid on claim. The amount paid is the allowed amount minus spend down, coinsurance, deductible, patient liability, dispensing fees, TPL, etc; as applicable depending on services. This value is computed by adding up all the AMT_PAID values for the related details.
TPL	Third Party Liability. The amount paid by a third party for services, at claim header level.
Total TPL	Sum of Third Party Liability amounts at header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. Casualty case recovery amount populated from Settlement window.
Total Co-pay	Sum of all detail co-pay amounts applicable to claim.
Total Patient Liability	Amount of patient liability applied to claim.
Total Days	Total number of days billed on claim.
Covered Days	Number of days covered by primary payer.
Days Not Covered	Number of days not covered.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization Paid Amount.

10 Appendix C – How To Review Claim Information

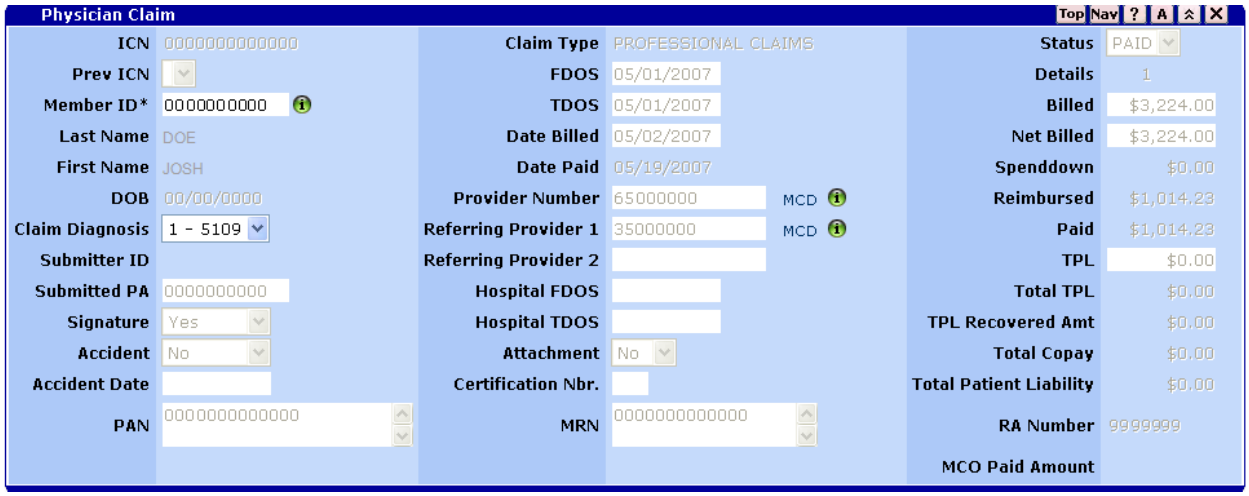
10.1 Viewing Claim Header Information

STEP 1. Access a Claim Information Page.



Physician Claim Information Page

STEP 2. The header information is listed on the first panel of the Claim Information Page.



Physician Claim Panel

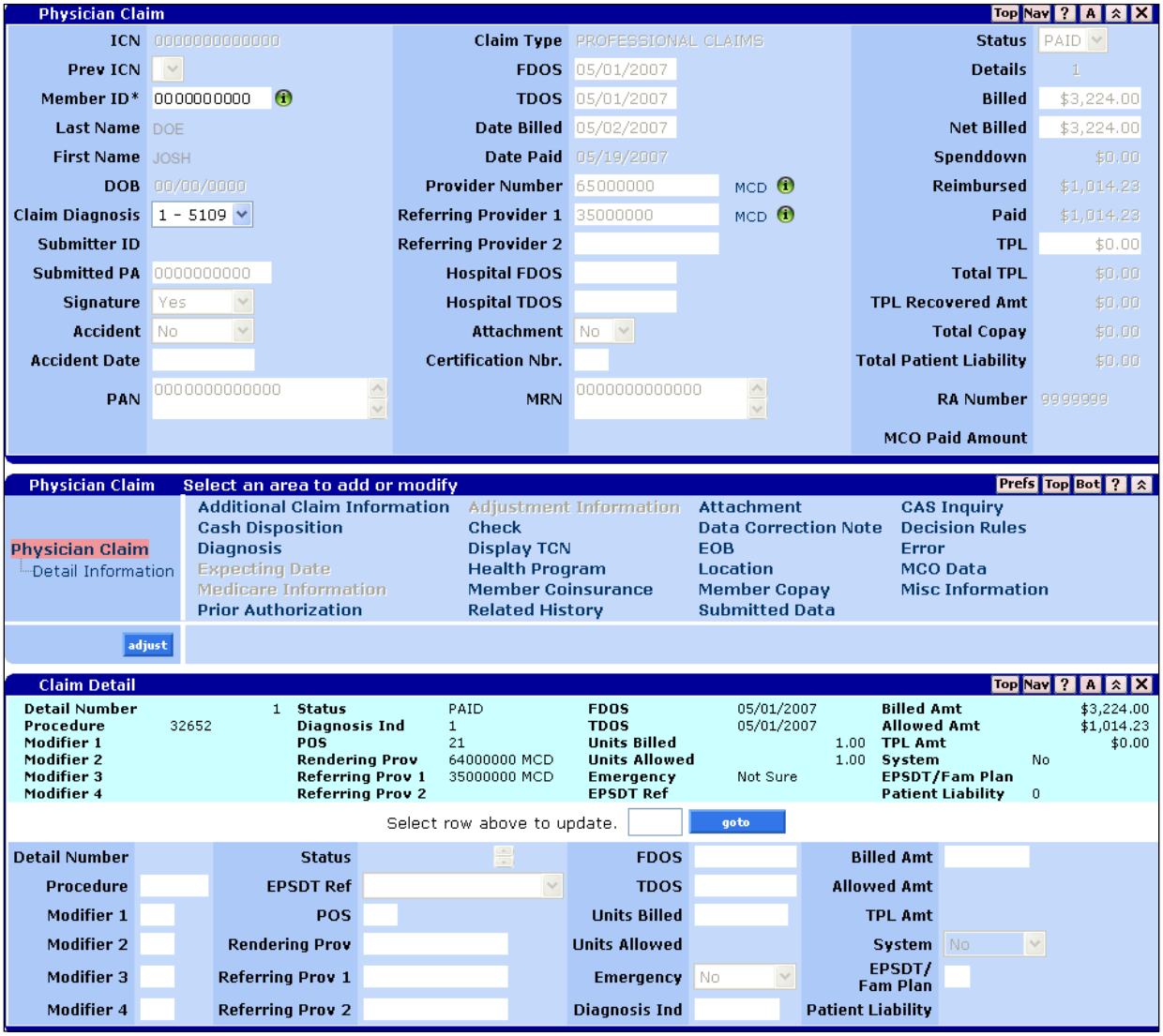
10.1.1 Claims/Information/Physician Claim Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
Last Name	Last name of member.
First Name	First name of member.
DOB	Date of Birth on record for member.
Claim Diagnosis	Code used to identify the primary or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates whether the service performed was as a result of an accident.
Accident Date	Date of accident.
PAN	Patient's unique identification number assigned by the provider to track the patient's financial records.
Claim Type	Indicates the type of claim.
FDOS	Beginning date of service on the claim.

Field	Description
TDOS	Ending date of service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The pay to provider identification number.
Referring Provider 1	The license number of the referring physician and location other than the attending physician.
Referring Provider 2	The license number of the second referring physician and location other than the attending physician.
Hospital FDOS	First date hospitalized.
Hospital TDOS	Last date hospitalized.
Attachment	Indicates whether an attachment is present.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing the Medical Record Number.
Status	The status of the claim.
Details	The number of detail service lines on the claim.
Billed	Amount requested by the provider for services rendered.
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, etc.).
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives.
Paid	Amount paid on claim.
TPL	Third Party Liability. The amount paid by a third party for services, at the claim header level.
Total TPL	The sum of the TPL amounts at the header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement window.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records.
Total Patient Liability	The amount of patient liability applied to this claim.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

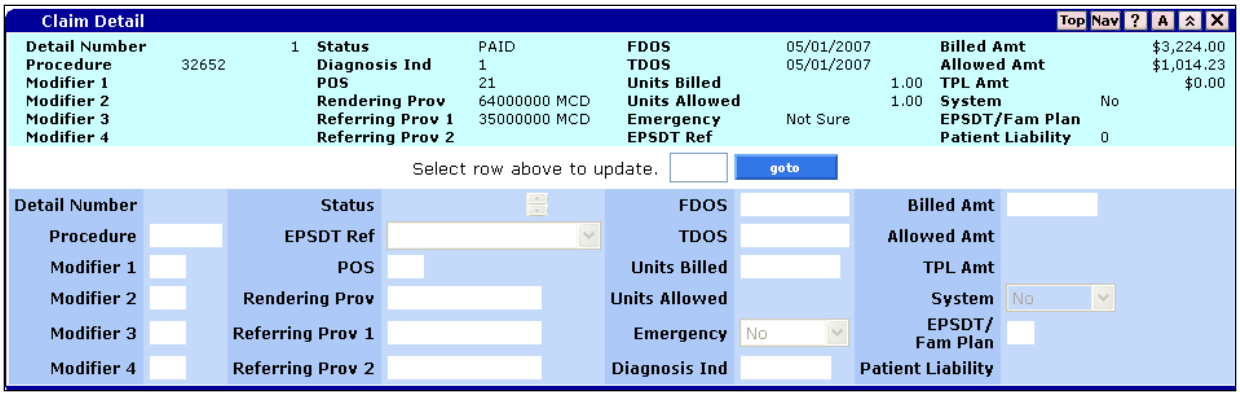
10.2 Viewing Claim Detail Information

STEP 1. Access a Claim Information Page.



Physician Claim Information Page

STEP 2. The claim detail line information is listed on the third panel of the Claim Information Page.



Physician Claim Detail Panel

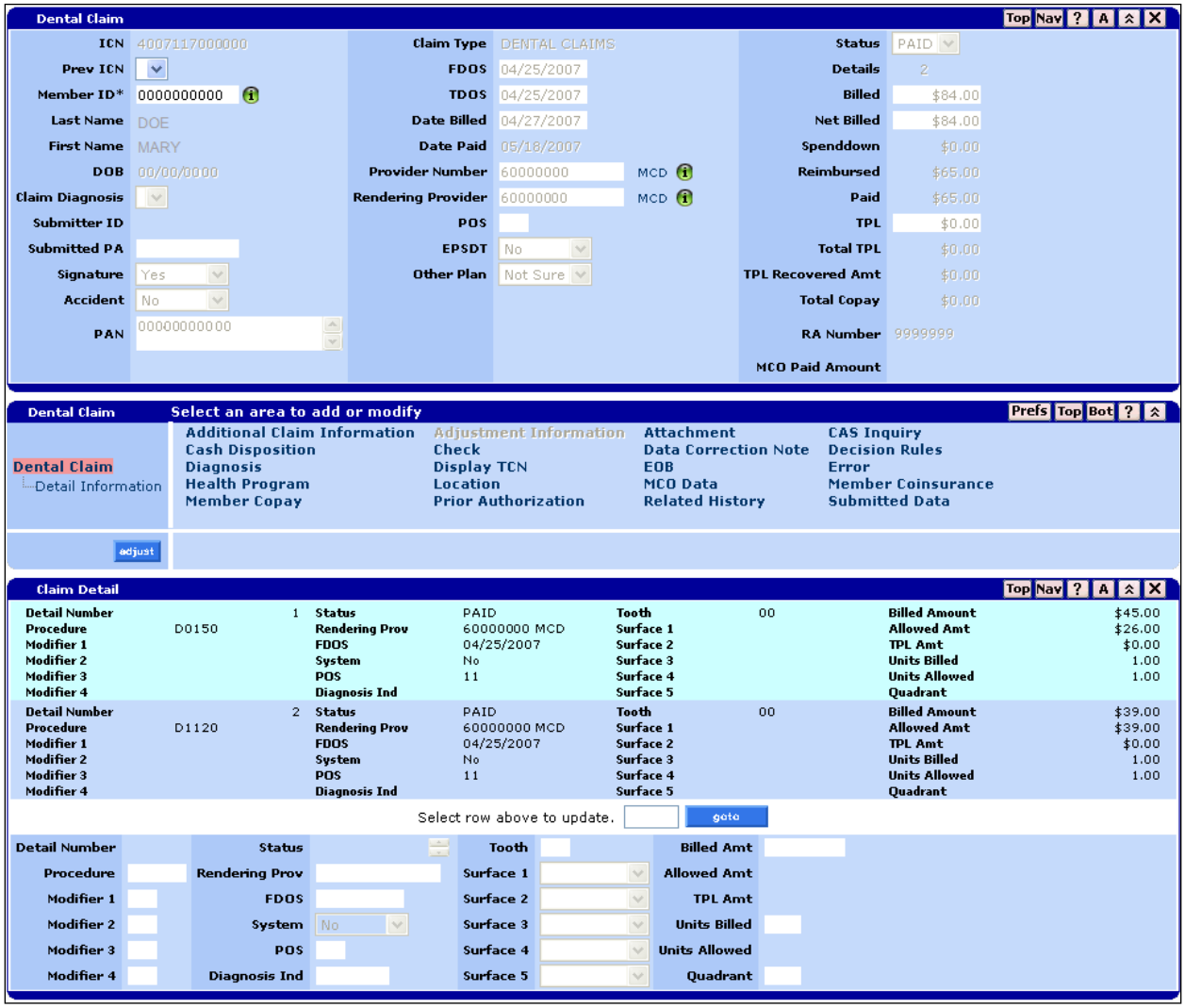
10.2.1 Claims/Information/Physician Claim/Claim Detail Panel Field Descriptions

Field	Description
Detail Number	The number of the detail on a claim record
Procedure	System-assigned key for a procedure code on a detail which indicates the service that was provided.
Modifier 1	Code used to identify the modifiers connected to the procedure code.
Modifier 2	Code used to identify the modifiers connected to the procedure code.
Modifier 3	Code used to identify the modifiers connected to the procedure code.
Modifier 4	Code used to identify the modifiers connected to the procedure code.
Status	Detail adjudication status.
Diagnosis Ind	Indicates which diagnosis (or diagnoses) for which services were provided. Valid values are 1,2,3,4 for paper claims and 1-8 for electronic claims.
POS	Place of Service where service was rendered.
Rendering Prov	The rendering provider identification number and location that uniquely identifies the provider of services.
Referring Prov 1	Provider Identification Number that uniquely identifies the referring provider and location that uniquely identifies the provider of services.

Field	Description
Referring Prov 2	Provider Identification Number that uniquely identifies the referring provider and location that uniquely identifies the provider of services.
FDOS	Date on which service was first provided
TDOS	Last service date.
Units Billed	The number of units billed by the provider.
Units Allowed	Number of units of service that will be paid for.
Emergency	Indicates whether the service was provided as result of emergency situation.
EPSDT Ref	EPSDT referral / treatment information.
Billed Amt	Amount of money requested for payment by a provider for services rendered. Format 999999.99.
Allowed Amt	Amount allowed that will be paid. Format 9999999.99.
TPL Amount	Third Party Liability Amount. The amount paid by a third party for services, at the claim header level. Format 999999.99.
System	Indicates whether detail was added by system during claim's processing.
EPSDT/Fam Plan	A code from the HCFA 1500 claim form block 24 H indicating EPSDT or Family Planning.
Patient Liability	The amount of patient liability applied to this claim.

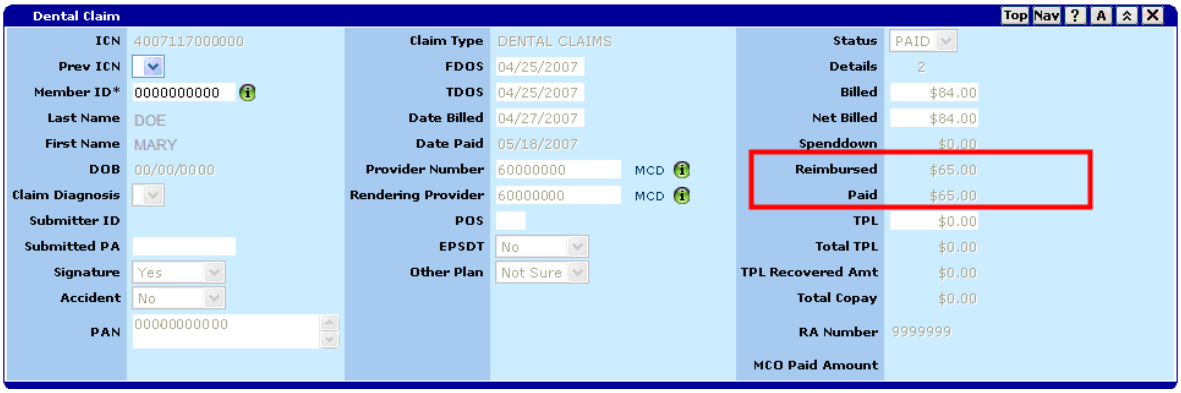
10.3 Determining a Claim Payment Amount

STEP 1. Access the Claim Information Page for a paid claim.



Dental Claim Information Page

STEP 2. The total claim payment amount is located in the third column of the top panel.



Dental Claim Panel

10.3.1 Claims/Information/Dental Claims Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the other previous ICNs for the claim and view that information. The MCO Original ICN for an encounter claim. Not used on claims other than encounters.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID number. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.
First Name	The first name of the member associated with the Member ID number. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	A code for the condition requiring medical attention.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates the accident reason. It draws its drop down values from the T_ACCIDENT_TYPE table.
PAN	Identification for a member assigned by a provider. (Patient Account Number)
Claim Type	Indicates the type of claim.
FDOS	First Date of Service on the claim.
TDOS	Date of last service on the claim.

Field	Description
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The provider identification number and location that uniquely identifies the provider of services.
Rendering Provider	The Rendering provider identification number and location that uniquely identifies the provider of services.
POS	Place of Service where service was rendered.
EPSDT	Indicates whether claim is EPSDT.
Other Plan	Indicates if another form of insurance was used.
Status	This field displays the status of the claim.
Details	Indicates the number of detail service lines on the claim.
Billed	Amount of money requested for payment by a provider for services rendered.
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL and so on).
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives minus any state share amount (if applicable).
Paid	Amount paid on claim. Amount paid will be the allowed amount minus spend down, coinsurance, deductible, patient liability, dispensing fees, TPL, etc., as applicable depending on services. This value is computed by adding up all the AMT_PAID values on the related details.
TPL	Third Party Liability. The amount paid by a third party for services.
Total TPL	Total Third Party Liability. This is the sum of the copay amounts from Health Program panel records(T_CLM_PGM_XREF table).
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement panel.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records (T_CLM_PGM_XREF table).
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

10.4 Determining a Reason for Claim Denial

STEP 1. Access a Claim Information Page for a denied claim.

UB92 Claim Information Page

10.4.1 Claims/Information/UB92 Claim Information Panel Field Descriptions

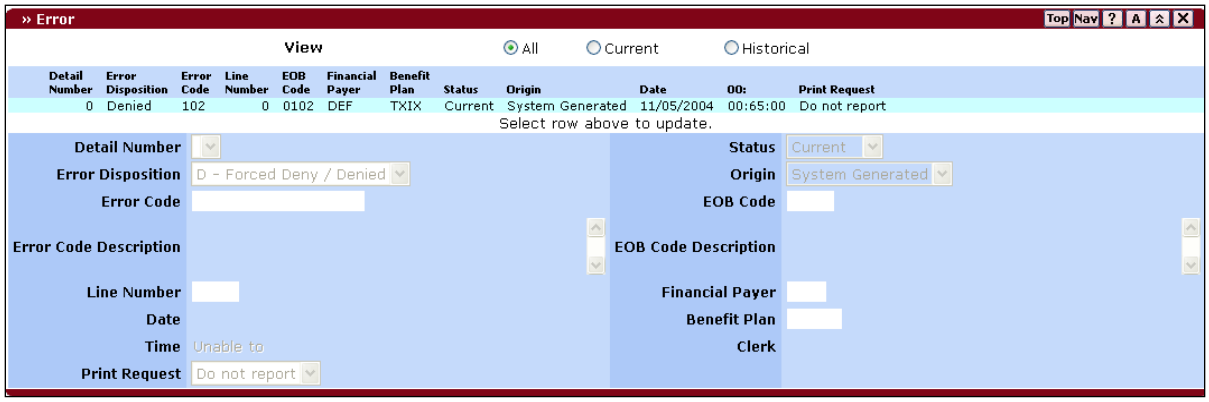
Field	Description
ICN	Internal control number which uniquely identifies a claim.

Field	Description
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit *KY Medicaid* ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.
First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	Code used to identify the primary, admitting, emergency or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim form.
Signature	Indicates whether the claim was signed by provider or representative.
Admit Source	Indicates source of admission.
Admit type	Code indicating type of admission.
Discharge Hour	Time member is released from hospital or facility.
Type of Bill	Code indicating specific type of bill.
PAN	Patient's unique identification number assigned by provider to track patient's financial records.
Claim Type	Indicates type of claim.
FDOS	Beginning date of service on claim.
TDOS	Ending date of service on claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which claim was adjudicated.
Provider Number	*KY Medicaid* Provider number.
Attending Provider	Attending physician's prescribing number.
Other Provider 1	License number of physician other than attending physician.
Other Provider 2	License number of physician other than attending physician.
Facility ID	Identification number assigned to facility provider and service location.

Field	Description
Admit Date	Date patient was admitted to facility for care.
Admit Time	Time member was admitted to facility for care.
Patient Status	Codes indicating patient's status as of ending service date of period covered on claim.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing Medical Record Number.
Status	Identifies status of claim within system.
Details	Number of detail service lines on claim.
Billed	Amount requested by provider for services rendered.
Spenddown	Amount of member's spend down applied to claim.
Reimbursed	Total amount provider receives.
Paid	Amount paid on claim. The amount paid is the allowed amount minus spend down, coinsurance, deductible, patient liability, dispensing fees, TPL, etc; as applicable depending on services. This value is computed by adding up all the AMT_PAID values for the related details.
TPL	Third Party Liability. The amount paid by a third party for services, at claim header level.
Total TPL	Sum of Third Party Liability amounts at header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. Casualty case recovery amount populated from Settlement window.
Total Co-pay	Sum of all detail co-pay amounts applicable to claim.
Total Patient Liability	Amount of patient liability applied to claim.
Total Days	Total number of days billed on claim.
Covered Days	Number of days covered by primary payer.
Days Not Covered	Number of days not covered.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. Access the Claim Maintenance Panel. Select the "Error" link.

STEP 3. This will open the Error panel, which provides information as to why a claim was denied payment.



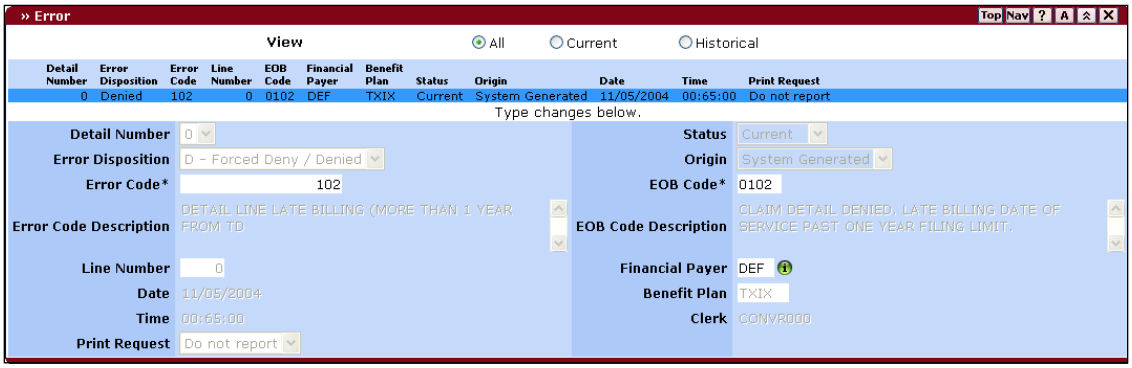
Error Panel

10.4.2 Claims/Information/UB92 Claim/ Error Panel Field Description

Field	Description
View	Select All, Current, or Historical.
Detail Number	The number of the header or detail that contains an edit or an audit failure.
Error Disposition	Disposition of the error.
Error Code	Code used to indicate error was discovered on claim during processing in base system.
Error Code Description	Brief description of error.
Line Number	Number that indicates the detail of the error disposition line item from which the error disposition was assigned.
Date	Date of Error code.
Time	Time of Error code.
Print Request	Valid values for indicator are Space - do not select claims with error to report; L - Report claims at summary level on CLM-0024-D report; W - Report claims on general paper worksheet which is CLM-0023-D report.
Status	Indicates if EOB is current or history.

Field	Description
Origin	Indicates how EOB Code and message were generated: Valid values are 'S - System Generated' or 'U - User Assigned'.
EOB Code	Number that uniquely identifies the explanation of benefits description.
EOB Code Description	Brief description of EOB.
Financial Payer	Value that identifies unique payer within interChange.
Benefit Plan	Identifies medical assistance program supported in system.
Clerk	Number used to identify user who last updated error record.

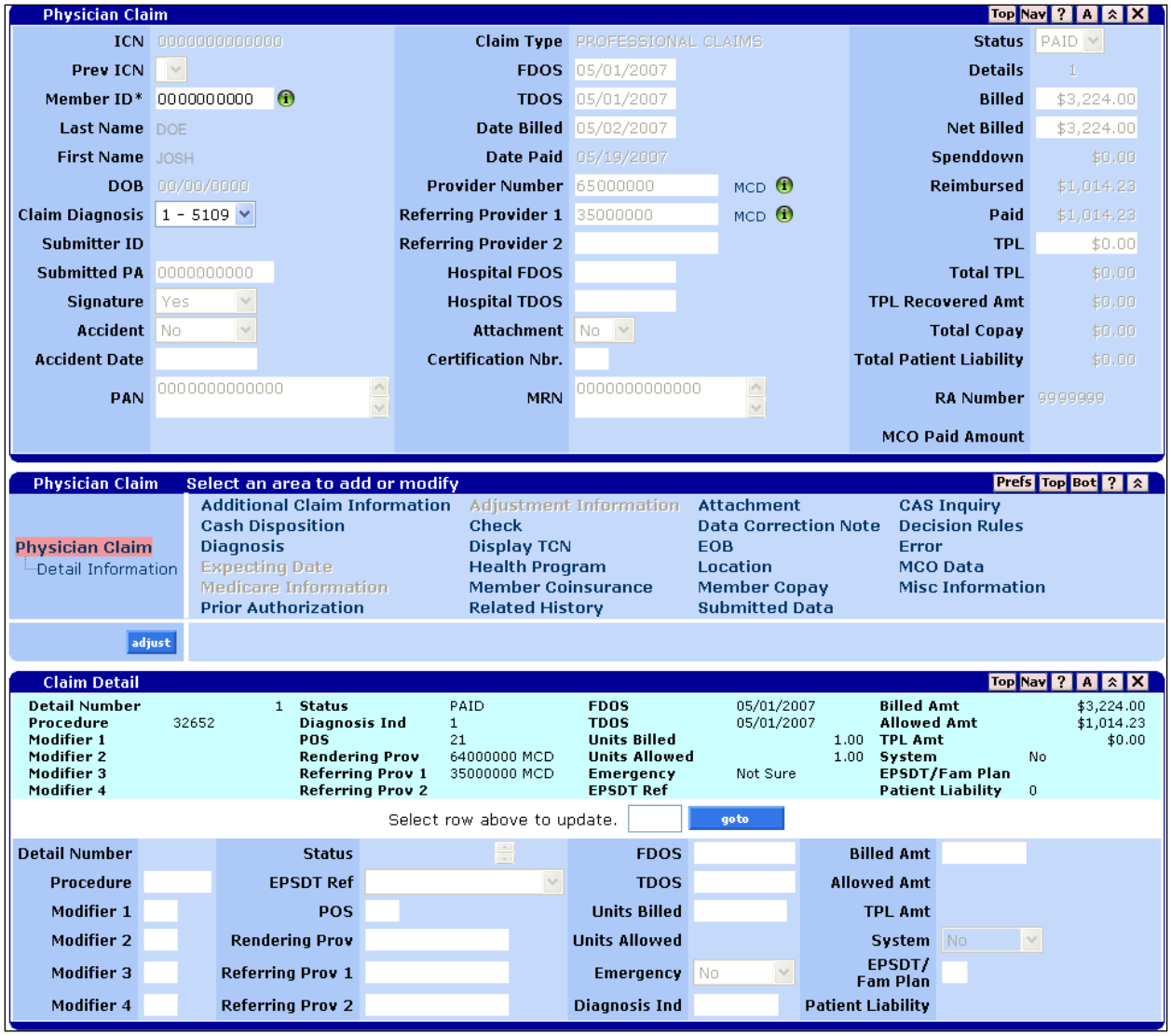
STEP 4. To view a description of the error code and the accompanying EOB code, click on the record one time. This will auto-populate the information in the fields below the record.



10.5 Viewing Additional Information on Professional Claims

10.5.1 Viewing Member Copay/Coinsurance Information on Professional Claims

STEP 1. Access a Physician Claim Information Page.



Physician Claim Information Page

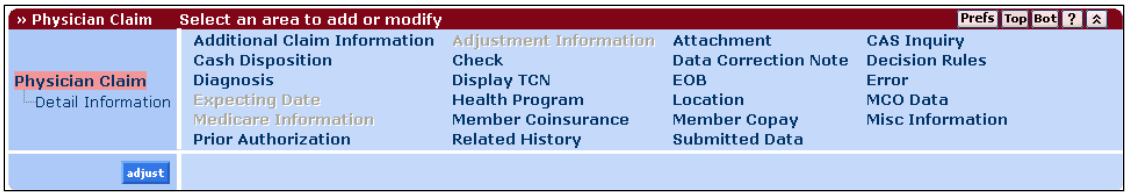
10.5.1.1 Claims/Information/Physician Claim Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
Last Name	Last name of member.
First Name	First name of member.
DOB	Date of Birth on record for member.

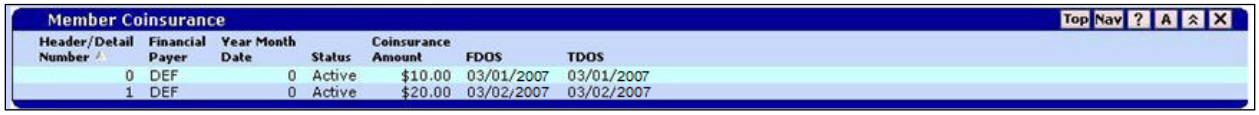
Field	Description
Claim Diagnosis	Code used to identify the primary or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates whether the service performed was as a result of an accident.
Accident Date	Date of accident.
PAN	Patient's unique identification number assigned by the provider to track the patient's financial records.
Claim Type	Indicates the type of claim.
FDOS	Beginning date of service on the claim.
TDOS	Ending date of service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The pay to provider identification number.
Referring Provider 1	The license number of the referring physician and location other than the attending physician.
Referring Provider 2	The license number of the second referring physician and location other than the attending physician.
Hospital FDOS	First date hospitalized.
Hospital TDOS	Last date hospitalized.
Attachment	Indicates whether an attachment is present.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing the Medical Record Number.
Status	The status of the claim.
Details	The number of detail service lines on the claim.
Billed	Amount requested by the provider for services rendered.
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, etc.).
Spenddown	Amount of money that the member is responsible for paying for services.

Field	Description
Reimbursed	Total amount the provider receives.
Paid	Amount paid on claim.
TPL	Third Party Liability. The amount paid by a third party for services, at the claim header level.
Total TPL	The sum of the TPL amounts at the header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement window.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records.
Total Patient Liability	The amount of patient liability applied to this claim.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. Select the Member Co-Insurance link on the Physician Claim Maintenance panel.



This will open the Member Co-Insurance panel.

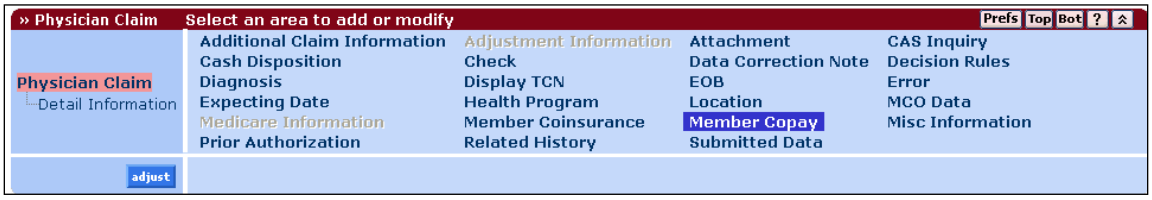


Member Co-Insurance Panel

10.5.1.2 Claims/Information/Physician Claim/Member Co-insurance Panel Field Descriptions

Field	Description
Header/Detail Number	The number of the detail on the claim record. A zero represents the header.
Financial Payer	The system-assigned value that identifies a unique payer within interChange.
Year Month Date	This is the year and month of the date of service of the claim that used coinsurance.
Status	Indicates if the record/row is active or inactive. The row becomes inactive only after an adjustment to the claim is released. Only use active ('A') to accumulate coinsurance. Values are: 'A' - Active; 'I' - Inactive
Coinsurance Amount	The coinsurance amount paid by the member for services rendered.
FDOS	The beginning date of service for the claim.
TDOS	The last date of service for the claim.

STEP 3. Select the Member Co-Pay link on the Physician Claim Maintenance panel.



This will open the Member Co-Pay panel.

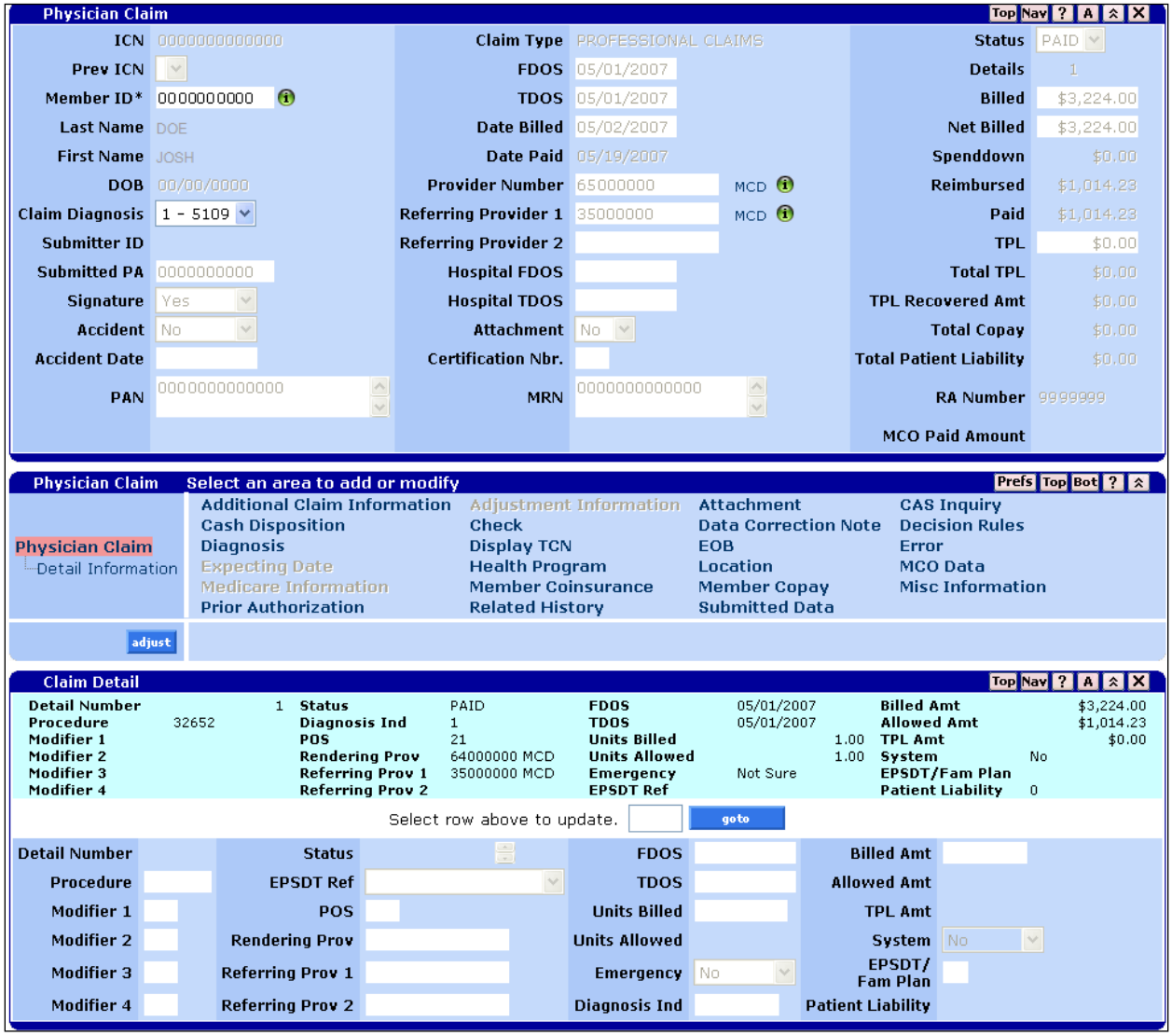
Member Co-Pay Panel

10.5.1.3 Claims/Information/Physician Claim/Member Co-pay Panel Field Descriptions

Field	Description
Header/Detail Number	The number of the detail on the claim record. A zero represents the header.
Financial Payer	The system-assigned value that identifies a unique payer within interChange.
Year Month Date	This is the year and month of the date of service of the claim that used copay.
Status	Indicates if the record/row is active or inactive. The row becomes inactive only after an adjustment to the claim is released. Only use active ('A') to accumulate coinsurance. Values are: 'A' - Active; 'I' - Inactive
Copay Value	Determines if the row has actual copay deducted from the claim or if the copay was just additive and not deducted from the claim. Values are: 'DA' - Deduct and accumulate copay 'OA' - Only accumulate copay
Copay Amount	The copay amount paid by the member for services rendered
FDOS	The beginning date of service for the claim.
TDOS	The last date of service for the claim.

10.5.2 Viewing Procedure Codes (HCPCS) on Professional Claims

STEP 1. Access a Physician Claim Information Page.



Physician Claim Information Page

10.5.2.1 Claims/Information/Physician Claim Panel Field Descriptions

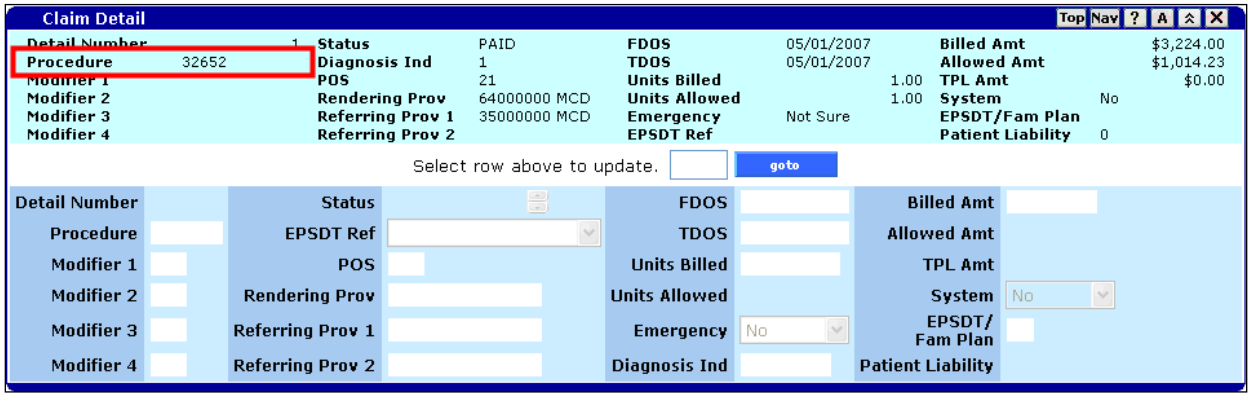
Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.

Field	Description
Last Name	Last name of member.
First Name	First name of member.
DOB	Date of Birth on record for member.
Claim Diagnosis	Code used to identify the primary or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates whether the service performed was as a result of an accident.
Accident Date	Date of accident.
PAN	Patient's unique identification number assigned by the provider to track the patient's financial records.
Claim Type	Indicates the type of claim.
FDOS	Beginning date of service on the claim.
TDOS	Ending date of service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The pay to provider identification number.
Referring Provider 1	The license number of the referring physician and location other than the attending physician.
Referring Provider 2	The license number of the second referring physician and location other than the attending physician.
Hospital FDOS	First date hospitalized.
Hospital TDOS	Last date hospitalized.
Attachment	Indicates whether an attachment is present.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing the Medical Record Number.
Status	The status of the claim.
Details	The number of detail service lines on the claim.
Billed	Amount requested by the provider for services rendered.

Field	Description
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, etc.).
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives.
Paid	Amount paid on claim.
TPL	Third Party Liability. The amount paid by a third party for services, at the claim header level.
Total TPL	The sum of the TPL amounts at the header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement window.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records.
Total Patient Liability	The amount of patient liability applied to this claim.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. The procedure code is located in the Claim Detail Panel.

NOTE: The modifier codes are also listed in the Claim Detail Panel.

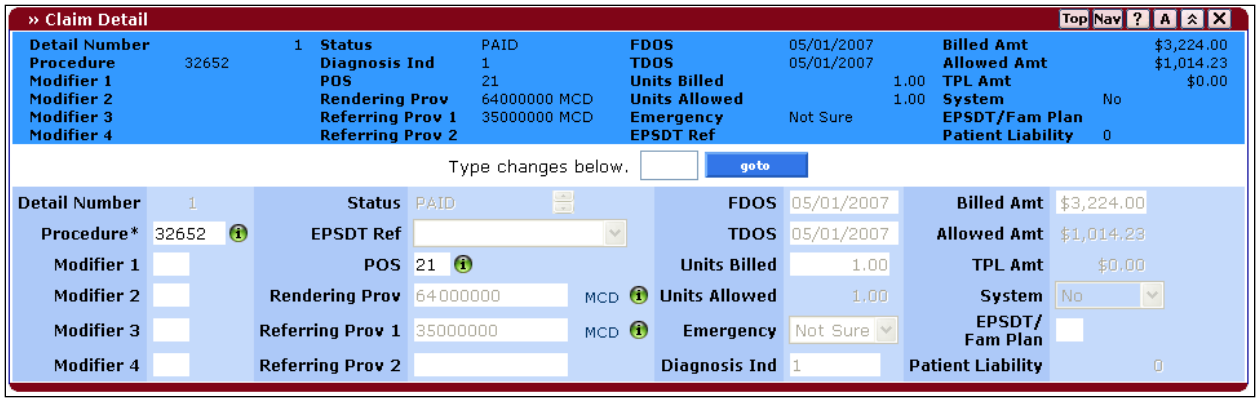


10.5.2.2 Claims/Information/Physician Claim Detail Panel Field Descriptions

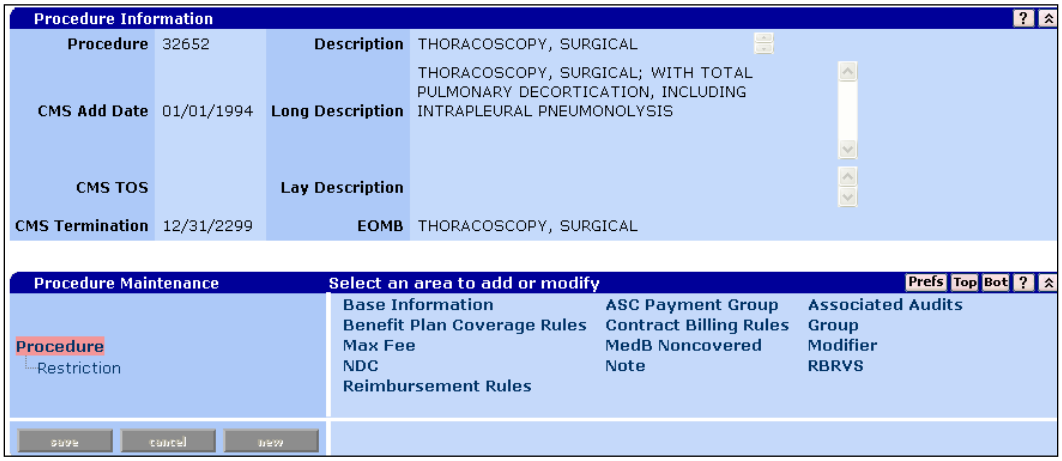
Field	Description
Detail Number	Number of detail line of claim.

Field	Description
Procedure	Procedure code billed on a particular line of a claim.
Modifier 1 - 4	First, second, third, and fourth modifier of procedure code.
Status	Detail adjudication status.
Diagnosis Ind	Indicates which diagnosis (or diagnoses) for which services were provided. Valid values are 1,2,3,4 for paper claims and 1-8 for electronic claims.
POS	Place of Service where service was rendered.
Rendering Prov	The rendering provider identification number and location that uniquely identifies the provider of services.
Referring Prov1	Provider identification number that uniquely identifies the referring provider.
Referring Prov2	Provider identification number that uniquely identifies the referring provider.
FDOS	Beginning date of service for claim detail.
TDOS	Ending date of service for claim detail.
Units Billed	Number of units billed for detail procedure.
Units Allowed	Number of units that can be billed for particular detail procedure code for given date span.
Emergency	Indicates whether service was provided as result of an emergency situation.
EPSDT Ref	EPSDT referral/treatment information.
Billed Amt	Amount billed for detail line.
Allowed Amt	Amount *KY Medicaid* would reimburse given detail line information.
TPL Amt	Third Party Liability. Amount paid by third party for services, at the claim header level.
System	Indicates whether detail was added by system during claim's processing.
EPSDT/Fam Plan	Code from HCFA 1500 claim form blocks 24 H indicating EPSDT or Family Planning.
Patient Liability	The amount of patient liability applied to this claim.

STEP 3. To view the procedure code description, click on the record one time. This will auto-populate the information in the fields below the record.

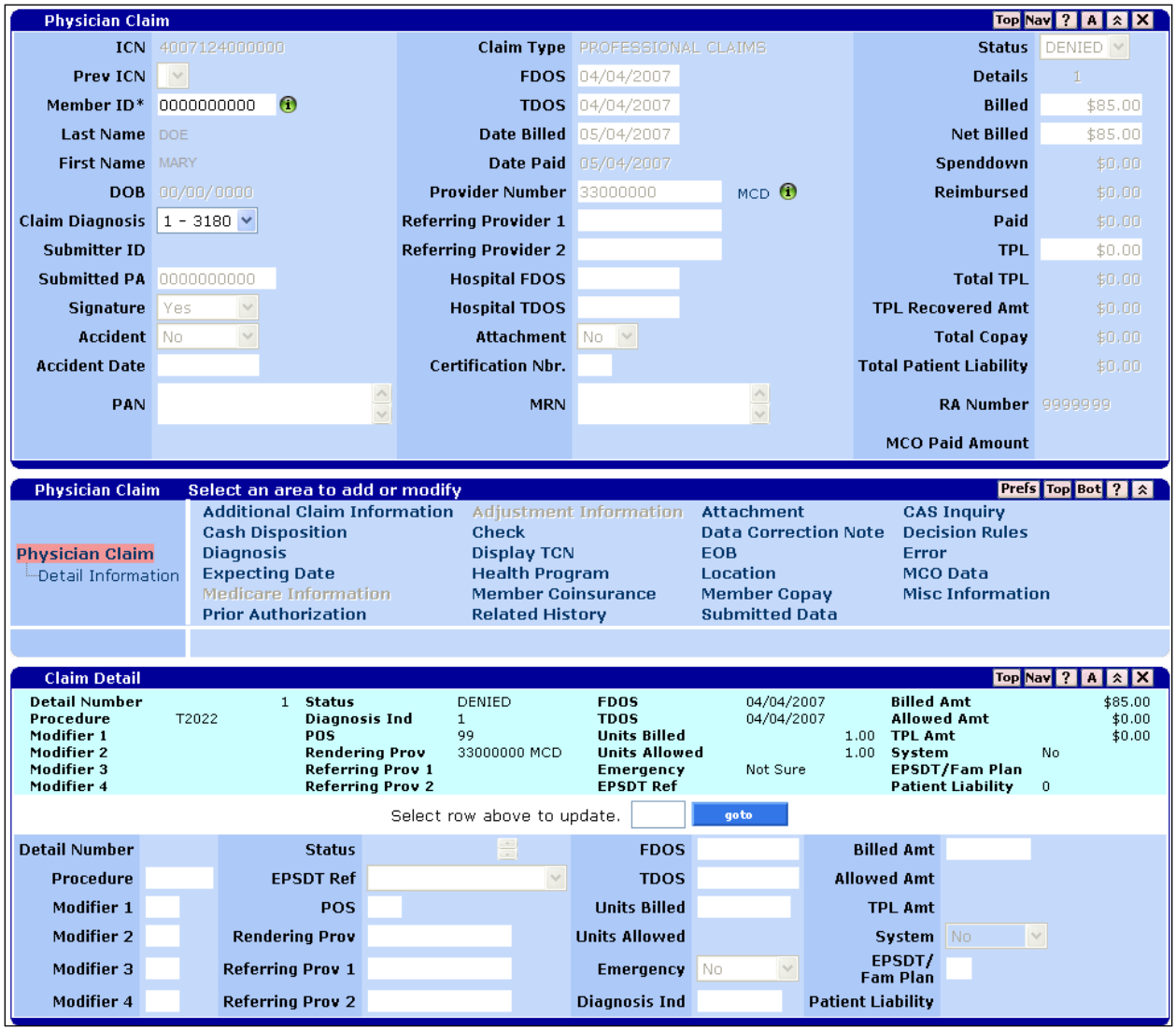


STEP 4. Click on the green "i" button located to the right of the procedure code field. A pop-up window will appear, which is a link to the procedure code information page. This page will provide a description of the procedure code.



10.5.3 Viewing Claim Related History on Professional Claims

STEP 1. Access a Physician Claim Information Page.



Physician Claim Information Page

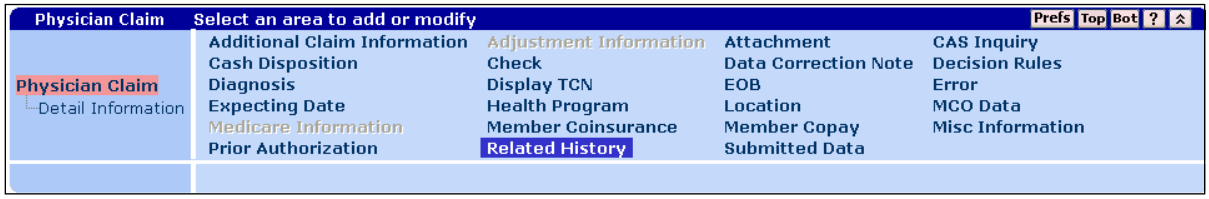
10.5.3.1 Claims/Information/Physician Claim Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.

Field	Description
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
Last Name	Last name of member.
First Name	First name of member.
DOB	Date of Birth on record for member.
Claim Diagnosis	Code used to identify the primary or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates whether the service performed was as a result of an accident.
Accident Date	Date of accident.
PAN	Patient's unique identification number assigned by the provider to track the patient's financial records.
Claim Type	Indicates the type of claim.
FDOS	Beginning date of service on the claim.
TDOS	Ending date of service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The pay to provider identification number.
Referring Provider 1	The license number of the referring physician and location other than the attending physician.
Referring Provider 2	The license number of the second referring physician and location other than the attending physician.
Hospital FDOS	First date hospitalized.
Hospital TDOS	Last date hospitalized.
Attachment	Indicates whether an attachment is present.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing the Medical Record Number.
Status	The status of the claim.
Details	The number of detail service lines on the claim.

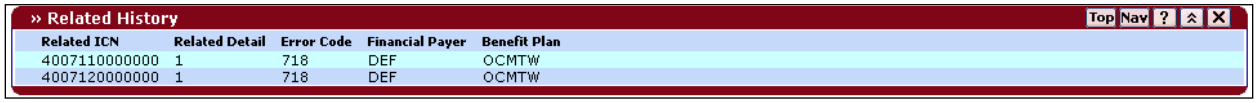
Field	Description
Billed	Amount requested by the provider for services rendered.
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, etc.).
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives.
Paid	Amount paid on claim.
TPL	Third Party Liability. The amount paid by a third party for services, at the claim header level.
Total TPL	The sum of the TPL amounts at the header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement window.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records.
Total Patient Liability	The amount of patient liability applied to this claim.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. Access the Physician Claim Maintenance Panel. Select the “Related History” link.



Physician Claim Navigation Panel

STEP 3. This will open the Related History panel.

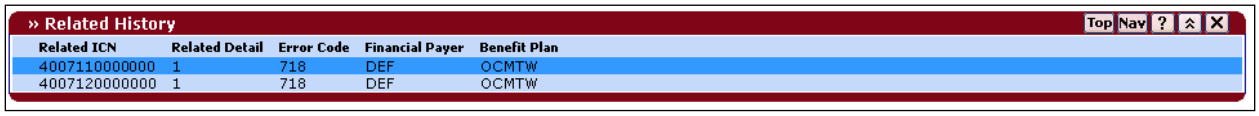


Related History Panel

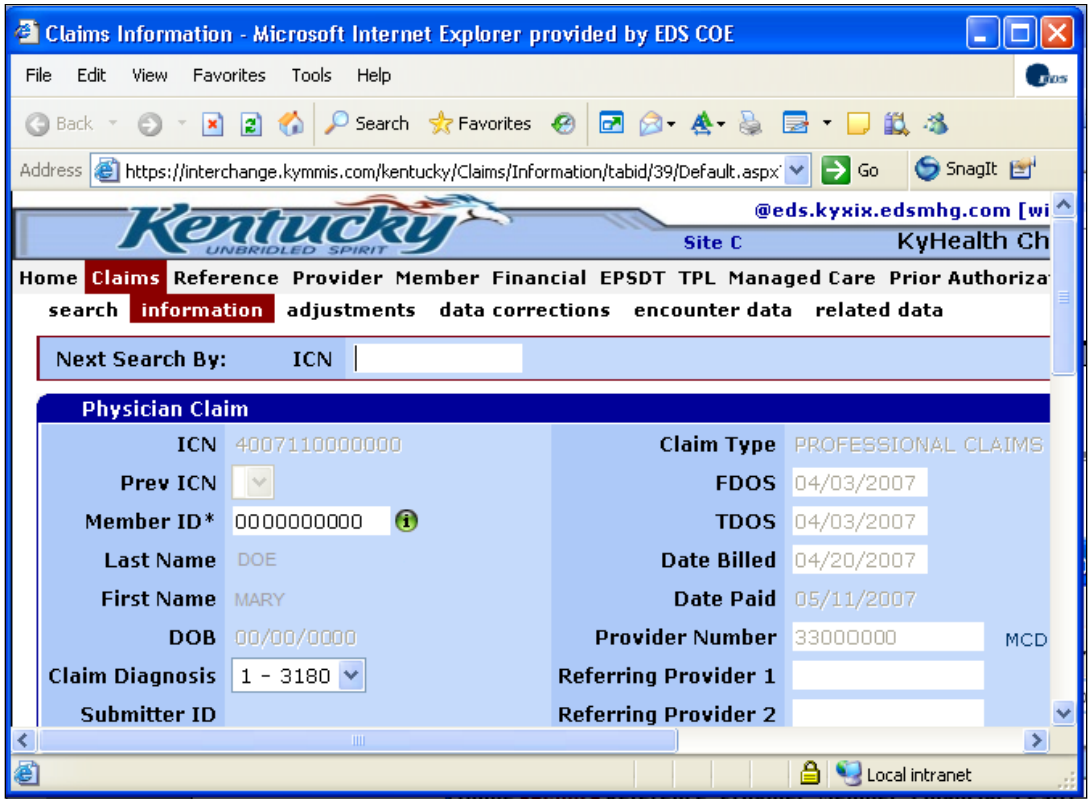
10.5.3.2 Claims/Information/Physician Claim/Related History Field Descriptions

Field	Description
Related ICN	Internal control number which uniquely identifies a claim.
Related Detail	Related detail information to the history claim displayed.
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system.
Financial Payer	The description used to identify the financial payer for the related ICN.
Benefit Plan	The medical assistance program associated with the related ICN.

STEP 4. To view the detail information for the related claim, click on the record one time.

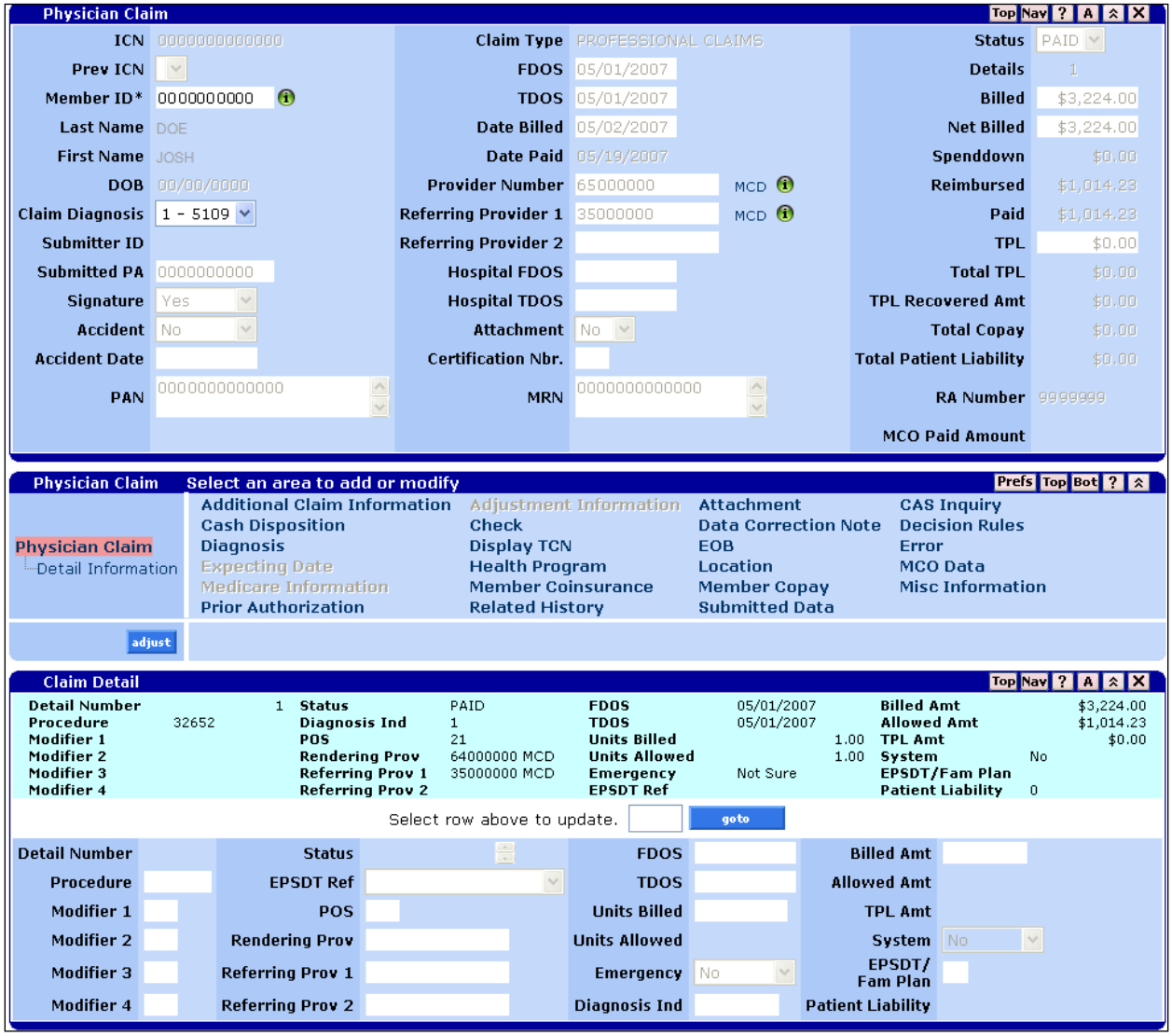


STEP 5. A pop-up window will appear, which is a link to the related Claim Information Page.



10.5.4 Viewing Diagnosis Codes on Professional Claims

STEP 1. Access a Physician Claim Information Page.



Physician Claim Information Page

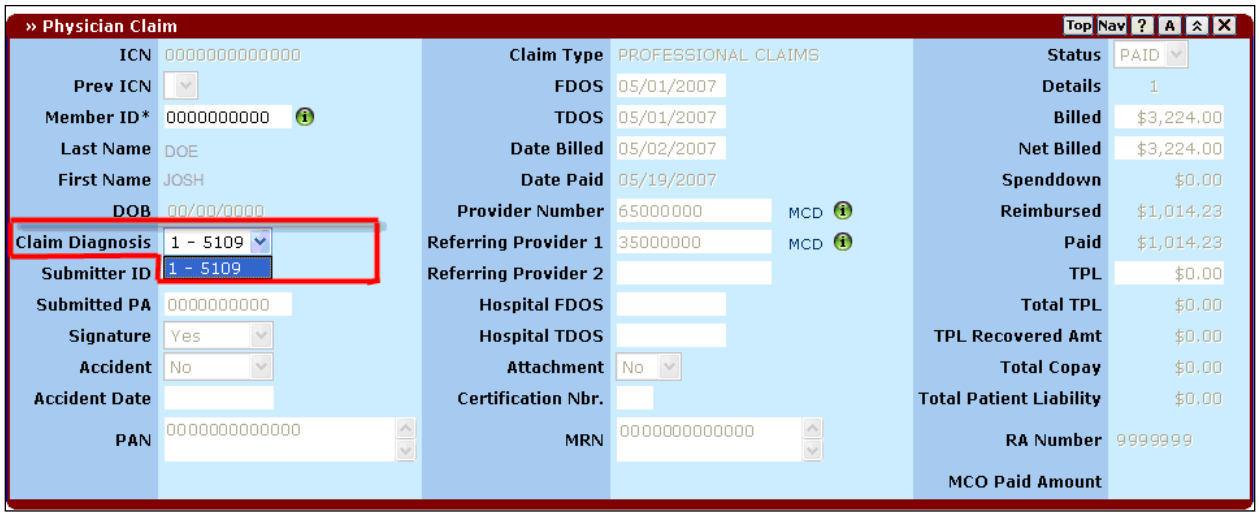
10.5.4.1 Claims/Information/Physician Claim Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.

Field	Description
Last Name	Last name of member.
First Name	First name of member.
DOB	Date of Birth on record for member.
Claim Diagnosis	Code used to identify the primary or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates whether the service performed was as a result of an accident.
Accident Date	Date of accident.
PAN	Patient's unique identification number assigned by the provider to track the patient's financial records.
Claim Type	Indicates the type of claim.
FDOS	Beginning date of service on the claim.
TDOS	Ending date of service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The pay to provider identification number.
Referring Provider 1	The license number of the referring physician and location other than the attending physician.
Referring Provider 2	The license number of the second referring physician and location other than the attending physician.
Hospital FDOS	First date hospitalized.
Hospital TDOS	Last date hospitalized.
Attachment	Indicates whether an attachment is present.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing the Medical Record Number.
Status	The status of the claim.
Details	The number of detail service lines on the claim.
Billed	Amount requested by the provider for services rendered.

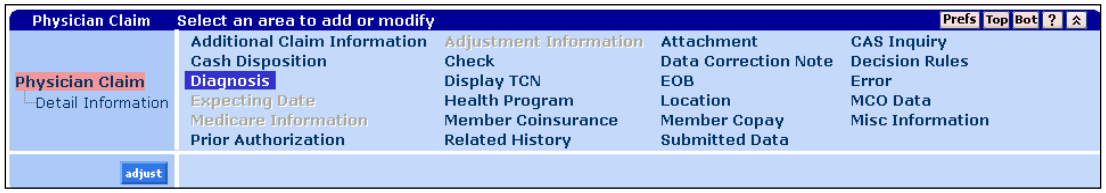
Field	Description
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, etc.).
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives.
Paid	Amount paid on claim.
TPL	Third Party Liability. The amount paid by a third party for services, at the claim header level.
Total TPL	The sum of the TPL amounts at the header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement window.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records.
Total Patient Liability	The amount of patient liability applied to this claim.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. The diagnosis code is listed in the first panel, the Physician Claim Panel. It is a drop down box that provides diagnosis codes for each claim detail line.

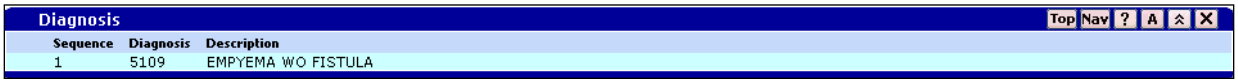


Physician Claim Panel

STEP 3. To view the diagnosis code description, access the Physician Claim Maintenance Panel, which is the second panel. Select the “Diagnosis” link.



STEP 4. The diagnosis code description is available to view.



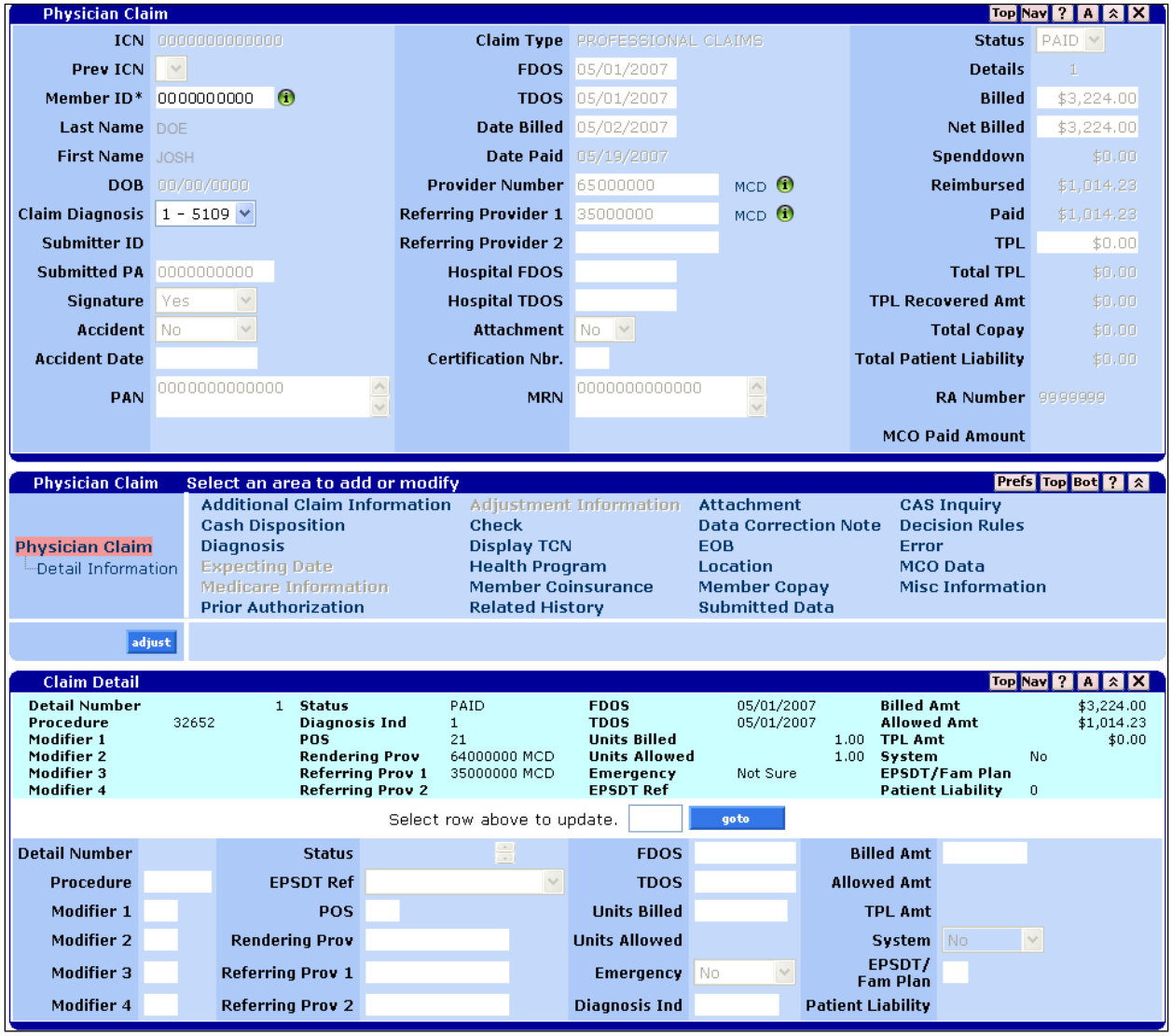
Diagnosis Panel

10.5.4.2 Claims/Information/Physician Claim/Diagnosis Panel Field Descriptions

Field	Description
Sequence	Sequence numbers for the diagnosis codes. For UB92 claims, the Admitting diagnosis have a value of 'A' in the Sequence column and Emergency diagnosis have an 'E' in the Sequence column. For all claim types, Primary diagnosis have a value of '1'. Other diagnosis codes have a value of '2' through '24'.
Diagnosis	Indicates the diagnosis codes applicable to the claim. Diagnosis code is a code for the condition requiring medical attention.
Description	Description of the diagnosis code.

10.5.5 Viewing Check Information on Professional Claims

STEP 1. Access a Physician Claim Information Page.



Physician Claim Information Page

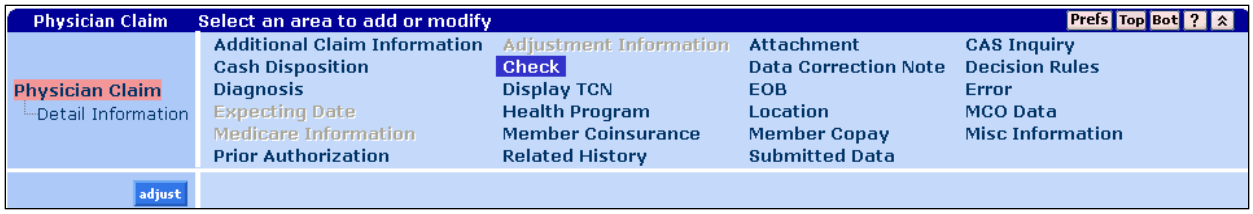
10.5.5.1 Claims/Information/Physician Claim Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.

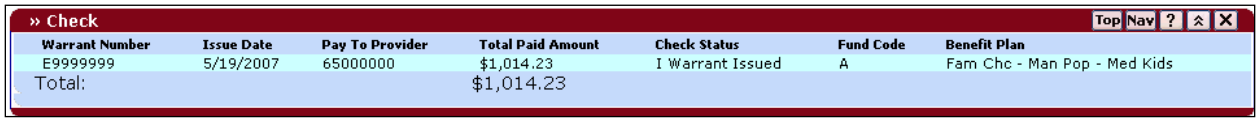
Field	Description
Last Name	Last name of member.
First Name	First name of member.
DOB	Date of Birth on record for member.
Claim Diagnosis	Code used to identify the primary or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates whether the service performed was as a result of an accident.
Accident Date	Date of accident.
PAN	Patient's unique identification number assigned by the provider to track the patient's financial records.
Claim Type	Indicates the type of claim.
FDOS	Beginning date of service on the claim.
TDOS	Ending date of service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The pay to provider identification number.
Referring Provider 1	The license number of the referring physician and location other than the attending physician.
Referring Provider 2	The license number of the second referring physician and location other than the attending physician.
Hospital FDOS	First date hospitalized.
Hospital TDOS	Last date hospitalized.
Attachment	Indicates whether an attachment is present.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing the Medical Record Number.
Status	The status of the claim.
Details	The number of detail service lines on the claim.
Billed	Amount requested by the provider for services rendered.

Field	Description
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, etc.).
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives.
Paid	Amount paid on claim.
TPL	Third Party Liability. The amount paid by a third party for services, at the claim header level.
Total TPL	The sum of the TPL amounts at the header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement window.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records.
Total Patient Liability	The amount of patient liability applied to this claim.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. Access the Physician Claim Maintenance Panel, which is the second panel. Select the "Check" link.



STEP 3. The check information is available to view.

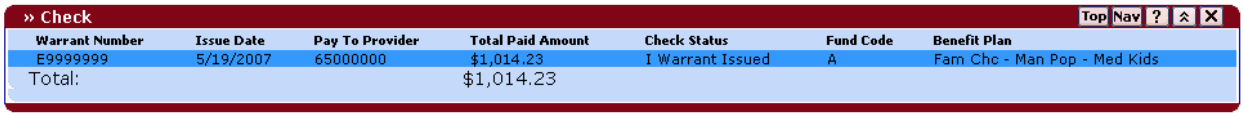


Check Panel

10.5.5.2 Claims/Information/Physician Claim/Check Panel Field Descriptions

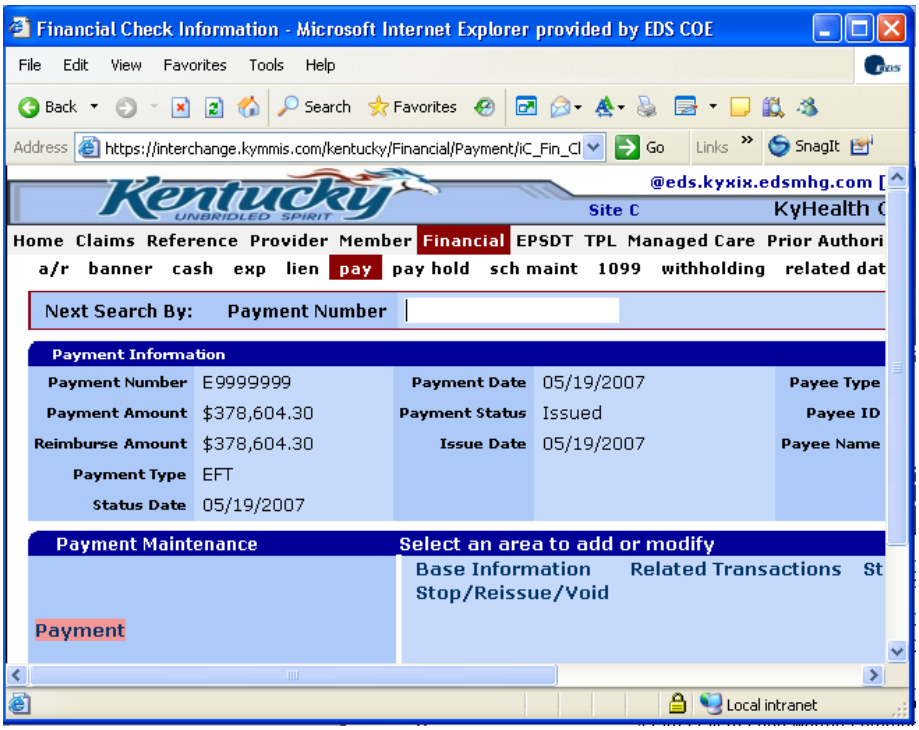
Field	Description
Warrant Number	The number of the check that the provider received, or the number of the Electronic Funds Transfer.
Issue Date	The date when the check was issued or the EFT was sent.
Pay To Provider	The Provider ID who received the check or EFT.
Total Paid Amount	The total amount that was issued to the provider.
Check Status	The status of the check. Examples are: An 'I' would indicate the check has been issued, a 'V' indicates a VOID, an 'R' indicates the check was reissued, a 'C' indicates a check has CLEARED the bank, an 'S' indicates Stopped and an 'X' for Cancelled by Statute.
Fund Code	The Fund Code assigned to the check or EFT.
Benefit Plan	The Benefit Plan associated with the check or EFT.

STEP 4. To view the detail information for the check, search for the warrant number that relates to the claim. Click on the record one time.


» Check

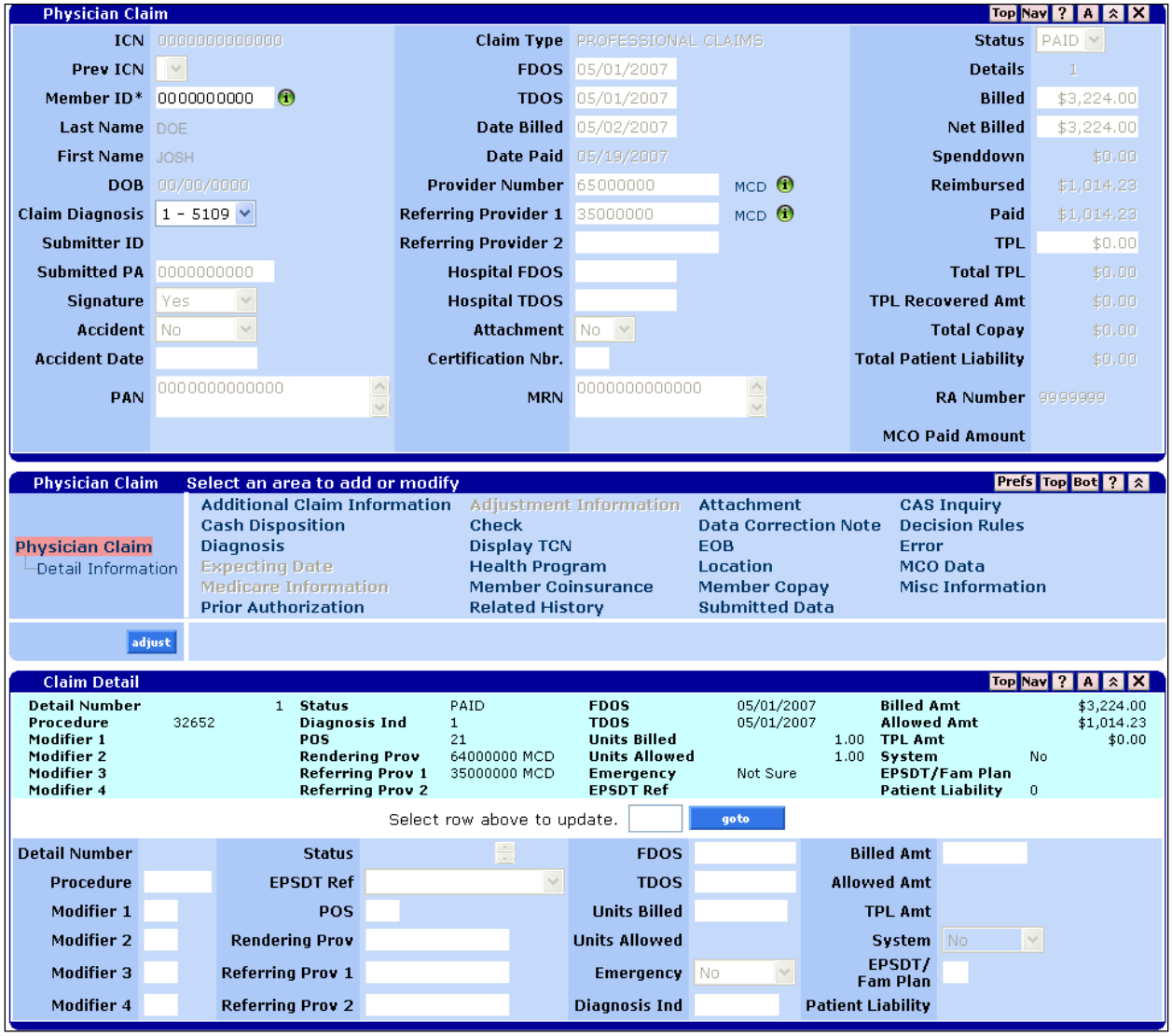
Warrant Number	Issue Date	Pay To Provider	Total Paid Amount	Check Status	Fund Code	Benefit Plan
E9999999	5/19/2007	65000000	$1,014.23	I Warrant Issued	A	Fam Chc - Man Pop - Med Kids
Total:			$1,014.23			

STEP 5. A pop-up window will appear, which is a link to the related Payment Information Page.


Financial Check Information - Microsoft Internet Explorer provided by EDS COE
File Edit View Favorites Tools Help
Back Search Favorites
Address https://interchange.kymmis.com/kentucky/Financial/Payment/iC_Fin_Cl
Go Links SnagIt
Kentucky UNBRIDLED SPIRIT
@eds.kyxix.edsmhg.com
Site C
KyHealth
Home Claims Reference Provider Member Financial EPSDT TPL Managed Care Prior Authori
a/r banner cash exp lien pay pay hold sch maint 1099 withholding related dat
Next Search By: Payment Number
Payment Information
Payment Number E9999999
Payment Amount $378,604.30
Reimburse Amount $378,604.30
Payment Type EFT
Status Date 05/19/2007
Payment Date 05/19/2007
Payment Status Issued
Issue Date 05/19/2007
Payee Type
Payee ID
Payee Name
Payment Maintenance
Select an area to add or modify
Base Information
Related Transactions
Stop/Reissue/Void
Payment
Local intranet

10.5.6 Viewing Health Program Information on Professional Claims

STEP 1. Access a Physician Claim Information Page.



Physician Claim Information Page

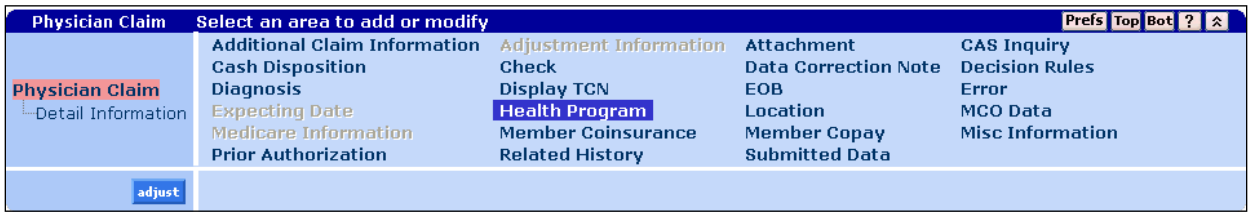
10.5.6.1 Claims/Information/Physician Claim Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.

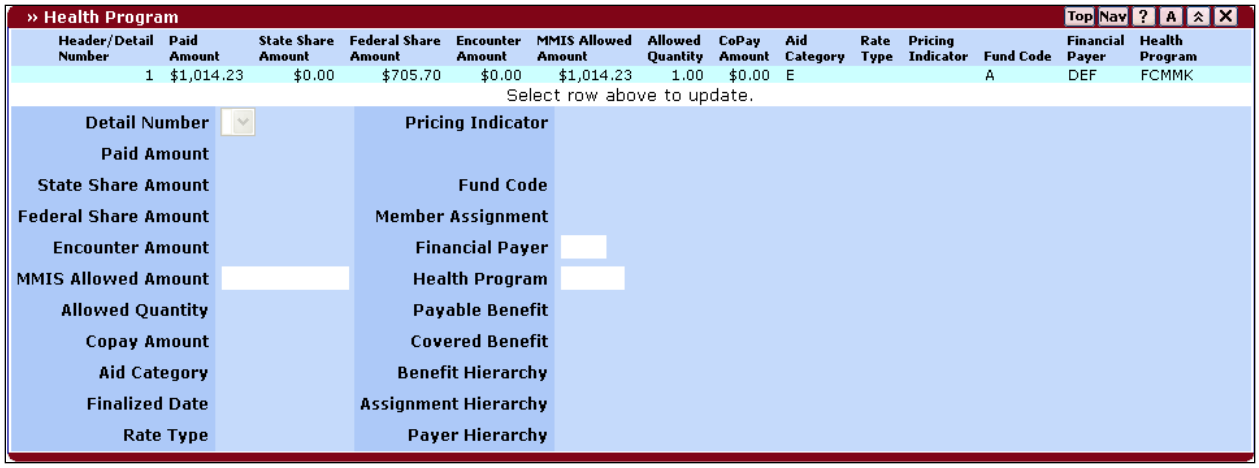
Field	Description
Last Name	Last name of member.
First Name	First name of member.
DOB	Date of Birth on record for member.
Claim Diagnosis	Code used to identify the primary or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates whether the service performed was as a result of an accident.
Accident Date	Date of accident.
PAN	Patient's unique identification number assigned by the provider to track the patient's financial records.
Claim Type	Indicates the type of claim.
FDOS	Beginning date of service on the claim.
TDOS	Ending date of service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The pay to provider identification number.
Referring Provider 1	The license number of the referring physician and location other than the attending physician.
Referring Provider 2	The license number of the second referring physician and location other than the attending physician.
Hospital FDOS	First date hospitalized.
Hospital TDOS	Last date hospitalized.
Attachment	Indicates whether an attachment is present.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing the Medical Record Number.
Status	The status of the claim.
Details	The number of detail service lines on the claim.
Billed	Amount requested by the provider for services rendered.

Field	Description
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, etc.).
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives.
Paid	Amount paid on claim.
TPL	Third Party Liability. The amount paid by a third party for services, at the claim header level.
Total TPL	The sum of the TPL amounts at the header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement window.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records.
Total Patient Liability	The amount of patient liability applied to this claim.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. Access the Physician Claim Maintenance Panel. Select the “Health Program” link.



STEP 3. The Health Program Panel is available to view.



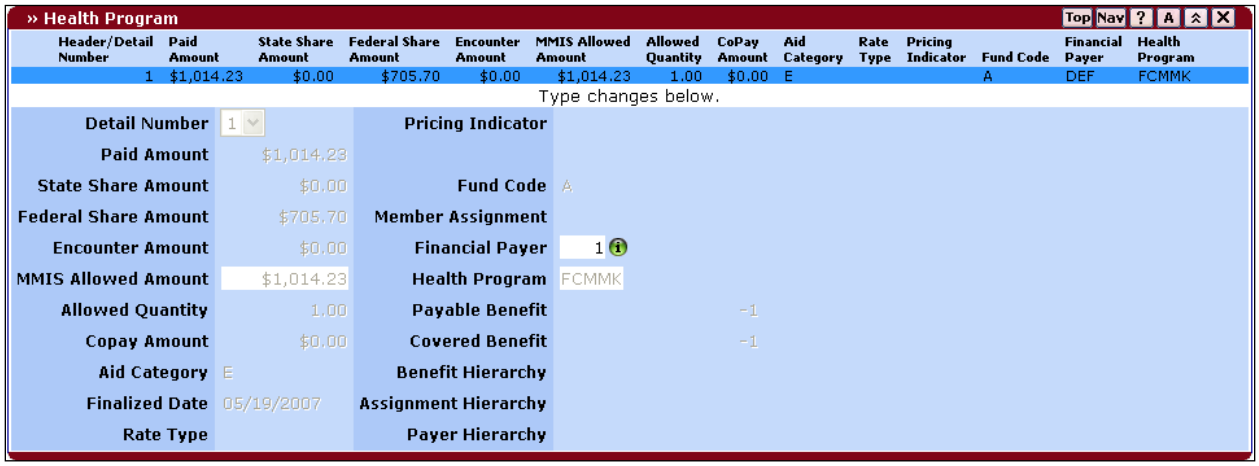
Health Program Panel

10.5.6.2 Claims/Physician Claims/Health Program Panel Field Descriptions

Field	Description
Detail Number	Indicates if the row pertains to the claim header or a claim detail line. The claim header is denoted by a zero.
Paid Amount	The amount that is applied toward the check amount.
State Share Amount	The amount that is applied toward the check amount.
Federal Share Amount	The amount of federal share for this payment.
Encounter Amount	Contains amount for encounter services on claim detail indicated by detail number on table.
MMIS Allowed Amount	Amount approved to pay for services provided.
Allowed Quantity	Number of units *KY Medicaid* would pay on given procedure code and date span.
Co-pay Amount	The amount of co-pay that is subtracted from the allowed amount.
Aid Category	Aid Category for *KY Medicaid* coverage.
Finalized Date	Date financial finalizes claim for Payer.
Rate Type	Code used to identify rate type to use in determining provider reimbursement.
Pricing Indicator	Pricing indicator which dictates method by which procedure must be priced or indicates how claim detail was priced.
Fund Code	Indicates the budget category funds used to pay claim/detail.
Member Assignment	Group of covered services (benefits) where member is assigned to provider or provider organization in order to receive covered services (benefits).

Field	Description
Financial Payer	Description of financial payer.
Health Program	Name of program from which the header/detail was processed and/or paid.
Payable Benefit	Unique system-assigned that identifies each row on this table.
Covered Benefit	System-assigned key used to identify unique row for benefit covered by member plan. Identifies row to be ignored for benefit.
Benefit Hierarchy	Assignment hierarchy is an ordered set of assignment plans which member/beneficiary may be assigned concurrently. For example, a beneficiary may be assigned to PCP and Health Community Based Services agency at overlapping periods of time.
Assignment Hierarchy	Set of assignment plans for which member/beneficiary may be assigned concurrently.
Payer Hierarchy	Payer Hierarchy identifies order of processing of financial payers, benefit plans, or assignment plans for beneficiaries who are enrolled in multiple entities.

STEP 4. To view additional details about the Health Program, click on the record one time. This will auto-populate the information in the fields below the record.



10.5.7 Viewing Medicare Information on Professional Claims

STEP 1. Access a Physician Claim Information Page for a HCFA 1500 Crossover Claim.

Physician Claim Top Nav ? A

ICN	2007000000000	Claim Type	PROF XOVER CLAIMS	Status	PAID
Prev ICN		FDOS	05/01/2007	Details	3
Member ID*	0000000000	TDOS	05/01/2007	Billed	$7,738.00
Last Name	DOE	Date Billed	06/01/2007	Net Billed	$0.00
First Name	MARY	Date Paid	07/13/2007	Spenddown	$0.00
DOB	00/00/0000	Provider Number	65000000 MCD	Reimbursed	$468.18
Claim Diagnosis	4 - 5609	Referring Provider 1		Paid	$468.18
Submitter ID	COBA	Referring Provider 2		TPL	$0.00
Submitted PA		Hospital FDOS	05/01/2007	Total TPL	$0.00
Signature	Yes	Hospital TDOS		TPL Recovered Amt	$0.00
Accident	Not Sure	Attachment	No	Total Copay	$0.00
Accident Date		Certification Nbr.		Total Patient Liability	$0.00
PAN	0000000000000	MRN	000000000000	RA Number	00000000
				MCO Paid Amount	

Physician Claim Select an area to add or modify Prefs Top Bot ? A

Physician Claim
Detail Information

Additional Claim Information	Adjustment Information	Attachment	CAS Inquiry
Cash Disposition	Check	Data Correction Note	Decision Rules
Diagnosis	Display TCN	EOB	Error
Expecting Date	Health Program	Location	MCO Data
Medicare Information	Member Coinsurance	Member Copay	Misc Information
Prior Authorization	Related History	Submitted Data	

adjust

Claim Detail Top Nav ? A

Detail Number		1	Status	PAID	FDOS	05/01/2007		Billed Amt	$3,340.00
Procedure	44144		Diagnosis Ind	1	TDOS	05/01/2007		Allowed Amt	$285.48
Modifier 1	GC		POS	21	Units Billed		1.00	TPL Amt	$0.00
Modifier 2			Rendering Prov		Units Allowed		0.00	System	No
Modifier 3			Referring Prov 1		Emergency	Not Sure		EPSDT/Fam Plan	
Modifier 4			Referring Prov 2		EPSDT Ref			Patient Liability	0
Detail Number		2	Status	PAID	FDOS	05/01/2007		Billed Amt	$2,998.00
Procedure	44120		Diagnosis Ind	4	TDOS	05/01/2007		Allowed Amt	$101.04
Modifier 1	59		POS	21	Units Billed		1.00	TPL Amt	$0.00
Modifier 2	51		Rendering Prov		Units Allowed		0.00	System	No
Modifier 3	GC		Referring Prov 1		Emergency	Not Sure		EPSDT/Fam Plan	
Modifier 4			Referring Prov 2		EPSDT Ref			Patient Liability	0
Detail Number		3	Status	PAID	FDOS	05/01/2007		Billed Amt	$1,400.00
Procedure	49002		Diagnosis Ind	1	TDOS	05/01/2007		Allowed Amt	$81.66
Modifier 1	59		POS	21	Units Billed		1.00	TPL Amt	$0.00
Modifier 2	58		Rendering Prov		Units Allowed		0.00	System	No
Modifier 3	GC		Referring Prov 1		Emergency	Not Sure		EPSDT/Fam Plan	
Modifier 4	51		Referring Prov 2		EPSDT Ref			Patient Liability	0

Select row above to update. goto

Detail Number		Status		FDOS		Billed Amt	
Procedure		EPSDT Ref		TDOS		Allowed Amt	
Modifier 1		POS		Units Billed		TPL Amt	
Modifier 2		Rendering Prov		Units Allowed		System	No
Modifier 3		Referring Prov 1		Emergency	No	EPSDT/ Fam Plan	
Modifier 4		Referring Prov 2		Diagnosis Ind		Patient Liability	

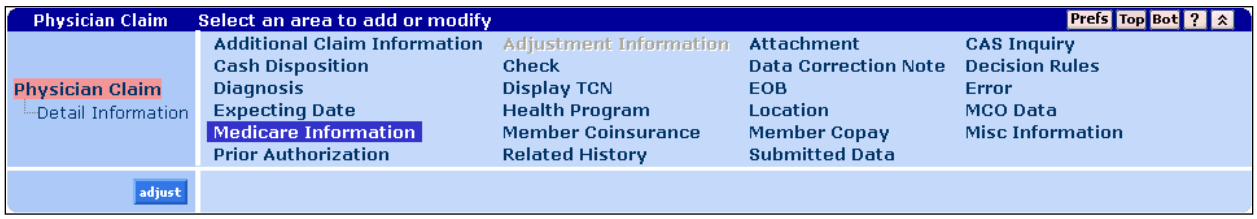
Physician Crossover Claim Information Page

10.5.7.1 Claims/Information/Physician Claim Panel Field Descriptions

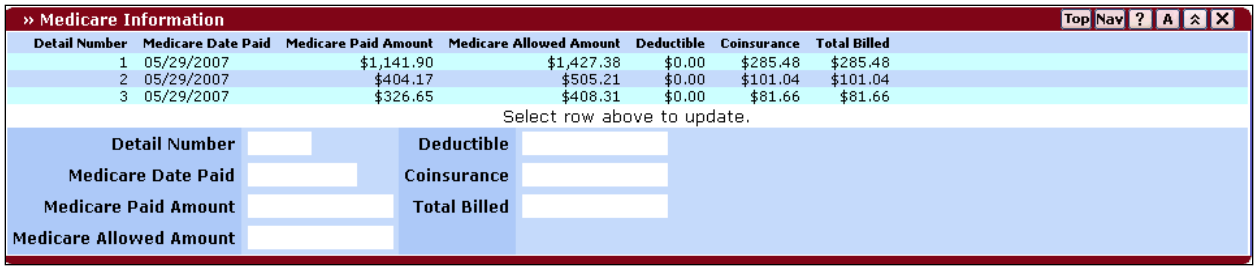
Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
Last Name	Last name of member.
First Name	First name of member.
DOB	Date of Birth on record for member.
Claim Diagnosis	Code used to identify the primary or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates whether the service performed was as a result of an accident.
Accident Date	Date of accident.
PAN	Patient's unique identification number assigned by the provider to track the patient's financial records.
Claim Type	Indicates the type of claim.
FDOS	Beginning date of service on the claim.
TDOS	Ending date of service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The pay to provider identification number.
Referring Provider 1	The license number of the referring physician and location other than the attending physician.
Referring Provider 2	The license number of the second referring physician and location other than the attending physician.
Hospital FDOS	First date hospitalized.
Hospital TDOS	Last date hospitalized.
Attachment	Indicates whether an attachment is present.
Certification Nbr.	Code used to identify the certification of the member.

Field	Description
MRN	Code representing the Medical Record Number.
Status	The status of the claim.
Details	The number of detail service lines on the claim.
Billed	Amount requested by the provider for services rendered.
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, etc.).
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives.
Paid	Amount paid on claim.
TPL	Third Party Liability. The amount paid by a third party for services, at the claim header level.
Total TPL	The sum of the TPL amounts at the header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement window.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records.
Total Patient Liability	The amount of patient liability applied to this claim.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. Access the Physician Claim Maintenance Panel. Select the “Medicare” link.



STEP 3. The Medicare Information Panel is available to view.



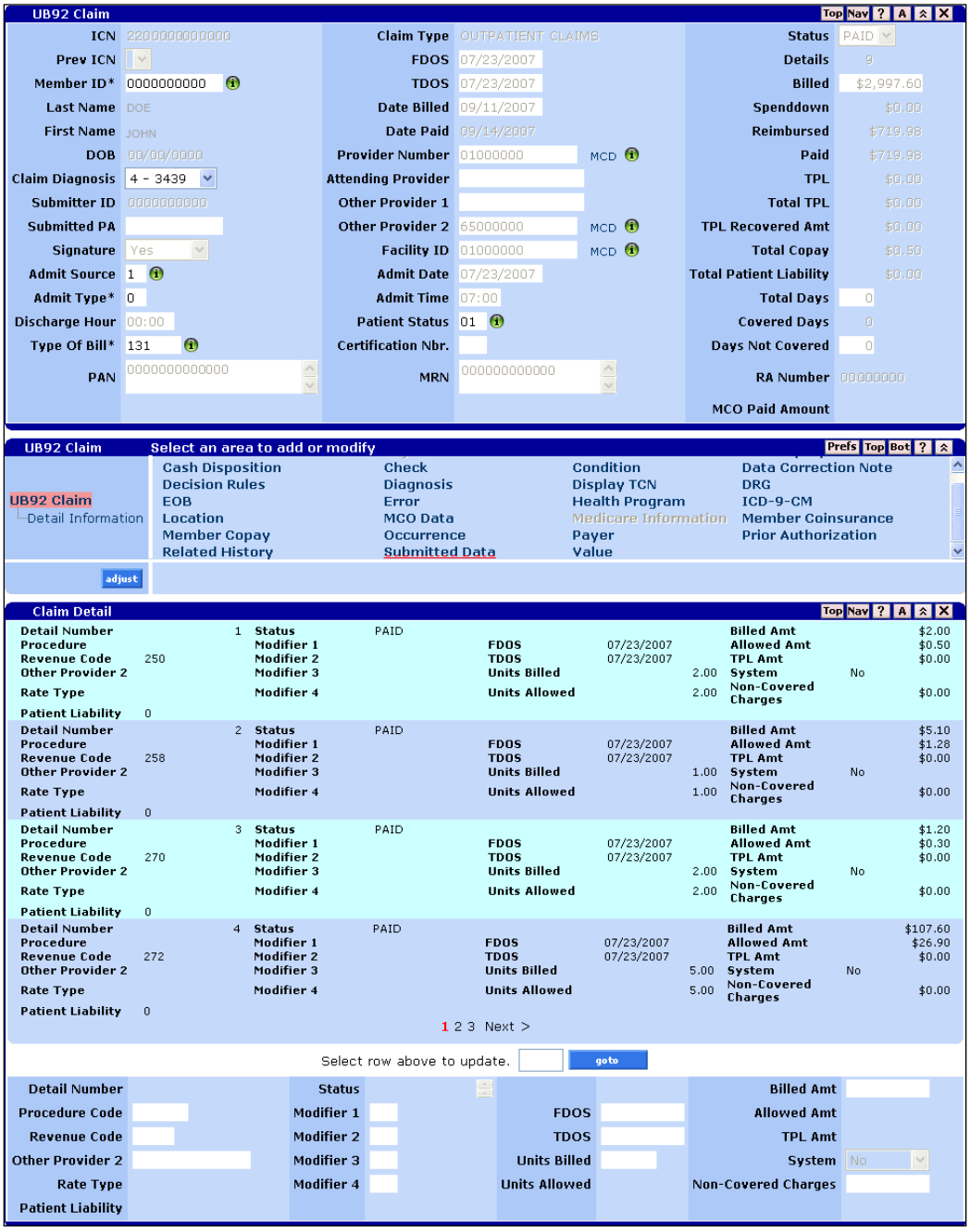
10.5.7.2 Claims/Information/Physician Claim/Medicare Information Panel Field Descriptions

Field	Description
Detail Number	The number of the detail on a claim record.
Medicare Date Paid	The date Medicare pays for the services.
Medicare Paid Amount	The dollar amount paid by Medicare for the services. Format 999999.99
Medicare Allowed Amount	The dollar amount allowed by Medicare for the services. Format 999999.99.
Deductible	The amount the member must pay before Medicare. Format 999999.99.
Coinsurance	Amount which represents the members' coinsurance payment. Format 999999.99.
Total Billed	The amount Medicare has determined that a member must pay. (sum of Coinsurance + Deductible). Format 999999.99.

10.6 Viewing Additional Information on Institutional Claims

10.6.1 Viewing Member Co-Pay / Co-Insurance Information on Institutional Claims

STEP 1. Access a UB92 Claim Information Page.



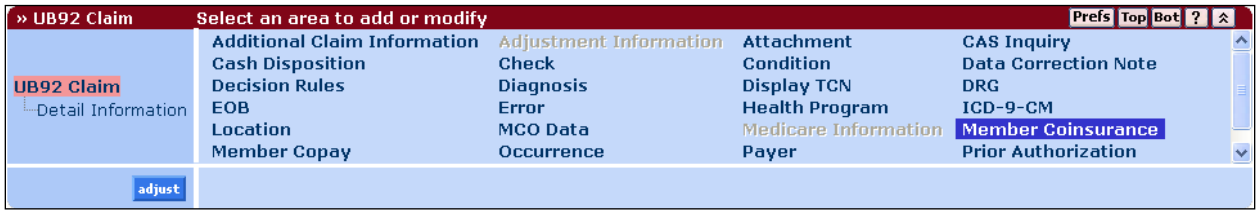
UB92 Claim Information Page

10.6.1.1 Claims/Information/UB92 Claim Information Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit *KY Medicaid* ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.
First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	Code used to identify the primary, admitting, emergency or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim form.
Signature	Indicates where claim was signed by provider or representative.
Admit Source	Indicates source of admission.
Admit type	Code indicating type of admission.
Discharge Hour	Time member is released from hospital or facility.
Type of Bill	Code indicating specific type of bill.
PAN	Patient's unique identification number assigned by provider to track patient's financial records.
Claim Type	Indicates type of claim.
FDOS	Beginning date of service on claim.
TDOS	Ending date of service on claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which claim was adjudicated.
Provider Number	*KY Medicaid* Provider number.
Attending Provider	Attending physician's prescribing number.
Other Provider 1	License number of physician other than attending physician.

Field	Description
Other Provider 2	License number of physician other than attending physician.
Facility ID	Identification number assigned to facility provider and service location.
Admit Date	Date patient was admitted to facility for care.
Admit Time	Time member was admitted to facility for care.
Patient Status	Codes indicating patient's status as of ending service date of period covered on claim.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing Medical Record Number.
Status	Identifies status of claim within system.
Details	Number of detail service lines on claim.
Billed	Amount requested by provider for services rendered.
Spenddown	Amount of member's spend down applied to claim.
Reimbursed	Total amount provider receives.
Paid	Amount paid on claim. The amount paid is the allowed amount minus spend down, coinsurance, deductible, patient liability, dispensing fees, TPL, etc; as applicable depending on services. This value is computed by adding up all the AMT_PAID values for the related details.
TPL	Third Party Liability. The amount paid by a third party for services, at claim header level.
Total TPL	Sum of Third Party Liability amounts at header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. Casualty case recovery amount populated from Settlement window.
Total Co-pay	Sum of all detail co-pay amounts applicable to claim.
Total Patient Liability	Amount of patient liability applied to claim.
Total Days	Total number of days billed on claim.
Covered Days	Number of days covered by primary payer.
Days Not Covered	Number of days not covered.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. Select the Member Co-Insurance link on the UB92 Claim Maintenance panel.



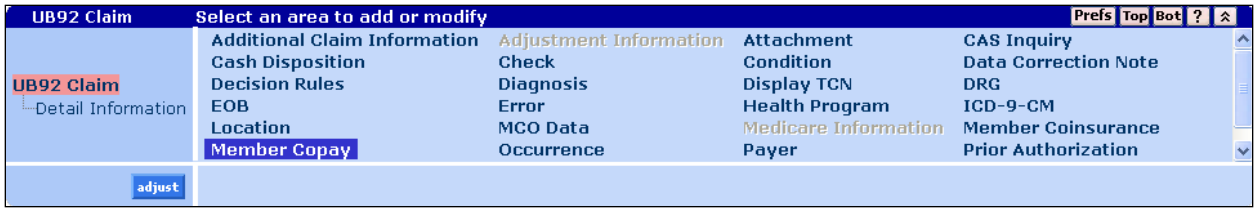
This will open the Member Co-Insurance panel.

Member Co-Insurance Panel

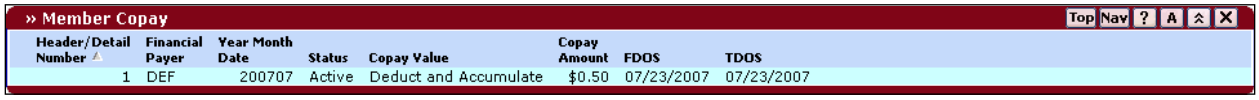
10.6.1.2 Claims/Information/UB92 Claim/Member Co-insurance Panel Field Descriptions

Field	Description
Header/Detail Number	The number of the detail on the claim record. A zero represents the header.
Financial Payer	The system-assigned value that identifies a unique payer within interChange.
Year Month Date	This is the year and month of the date of service of the claim that used coinsurance.
Status	Indicates if the record/row is active or inactive. The row becomes inactive only after an adjustment to the claim is released. Only use active ('A') to accumulate coinsurance. Values are: 'A' - Active; 'I' - Inactive
Coinsurance Amount	The coinsurance amount paid by the member for services rendered.
FDOS	The beginning date of service for the claim.
TDOS	The last date of service for the claim.

STEP 3. Select the Member Co-Pay link on the UB92 Claim Maintenance panel.



This will open the Member Co-Pay panel.



Member Co-Pay Panel

10.6.1.3 Claims/Information/Physician Claim/Member Co-pay Panel Field Descriptions

Field	Description
Header/Detail Number	The number of the detail on the claim record. A zero represents the header.
Financial Payer	The system-assigned value that identifies a unique payer within interChange.
Year Month Date	This is the year and month of the date of service of the claim that used copay.
Status	Indicates if the record/row is active or inactive. The row becomes inactive only after an adjustment to the claim is released. Only use active ('A') to accumulate coinsurance. Values are: 'A' - Active; 'I' - Inactive
Copay Value	Determines if the row has actual copay deducted from the claim or if the copay was just additive and not deducted from the claim. Values are: 'DA' - Deduct and accumulate copay 'OA' - Only accumulate copay
Copay Amount	The copay amount paid by the member for services rendered
FDOS	The beginning date of service for the claim.
TDOS	The last date of service for the claim.

10.6.2 Viewing Procedure Codes (HCPCS) on Institutional Claims

STEP 1. Access a UB92 Claim Information Page.

UB92 Claim

ICN	22000000000000	Claim Type	OUTPATIENT CLAIMS	Status	PAID
Prev ICN		FDOS	07/23/2007	Details	9
Member ID*	0000000000	TDOS	07/23/2007	Billed	$2,997.60
Last Name	DOE	Date Billed	09/11/2007	Spenddown	$0.00
First Name	JOHN	Date Paid	09/14/2007	Reimbursed	$719.98
DOB	00/00/0000	Provider Number	01000000 MCD	Paid	$719.98
Claim Diagnosis	4 - 3439	Attending Provider		TPL	$0.00
Submitter ID	0000000000	Other Provider 1		Total TPL	$0.00
Submitted PA		Other Provider 2	65000000 MCD	TPL Recovered Amt	$0.00
Signature	Yes	Facility ID	01000000 MCD	Total Copay	$0.50
Admit Source	1	Admit Date	07/23/2007	Total Patient Liability	$0.00
Admit Type*	0	Admit Time	07:00	Total Days	0
Discharge Hour	00:00	Patient Status	01	Covered Days	0
Type Of Bill*	131	Certification Nbr.		Days Not Covered	0
PAN	0000000000000	MRN	000000000000	RA Number	00000000
				MCO Paid Amount	

UB92 Claim — Select an area to add or modify

UB92 Claim
Detail Information

Cash Disposition	Check	Condition	Data Correction Note
Decision Rules	Diagnosis	Display TCN	DRG
EOB	Error	Health Program	ICD-9-CM
Location	MCO Data	Medicare Information	Member Coinsurance
Member Copay	Occurrence	Payer	Prior Authorization
Related History	Submitted Data	Value	

adjust

Claim Detail

Detail Number	Procedure	Revenue Code	Other Provider 2	Rate Type	Patient Liability	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	FDOS	TDOS	Units Billed	Units Allowed	Billed Amt	Allowed Amt	TPL Amt	System	Non-Covered Charges
1		250			0	PAID					07/23/2007	07/23/2007	2.00	2.00	$2.00	$0.50	$0.00	No	$0.00
2		258			0	PAID					07/23/2007	07/23/2007	1.00	1.00	$5.10	$1.28	$0.00	No	$0.00
3		270			0	PAID					07/23/2007	07/23/2007	2.00	2.00	$1.20	$0.30	$0.00	No	$0.00
4		272			0	PAID					07/23/2007	07/23/2007	5.00	5.00	$107.60	$26.90	$0.00	No	$0.00

1 2 3 Next >

Select row above to update. goto

Detail Number		Status			Billed Amt
Procedure Code		Modifier 1		FDOS	Allowed Amt
Revenue Code		Modifier 2		TDOS	TPL Amt
Other Provider 2		Modifier 3		Units Billed	System No
Rate Type		Modifier 4		Units Allowed	Non-Covered Charges
Patient Liability					

UB92 Claim Information Page

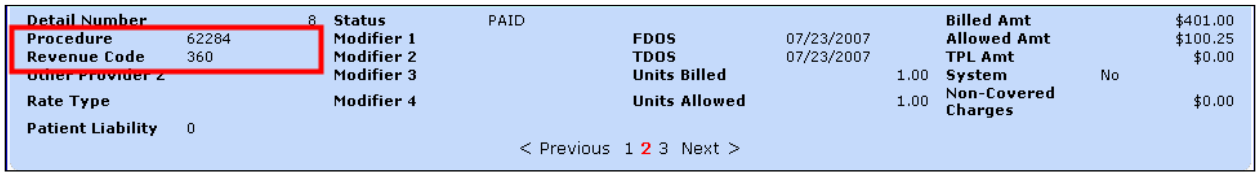
10.6.2.1 Claims/Information/UB92 Claim Information Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit *KY Medicaid* ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.
First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	Code used to identify the primary, admitting, emergency or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim form.
Signature	Indicates where claim was signed by provider or representative.
Admit Source	Indicates source of admission.
Admit type	Code indicating type of admission.
Discharge Hour	Time member is released from hospital or facility.
Type of Bill	Code indicating specific type of bill.
PAN	Patient's unique identification number assigned by provider to track patient's financial records.
Claim Type	Indicates type of claim.
FDOS	Beginning date of service on claim.
TDOS	Ending date of service on claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which claim was adjudicated.
Provider Number	*KY Medicaid* Provider number.
Attending Provider	Attending physician's prescribing number.
Other Provider 1	License number of physician other than attending physician.

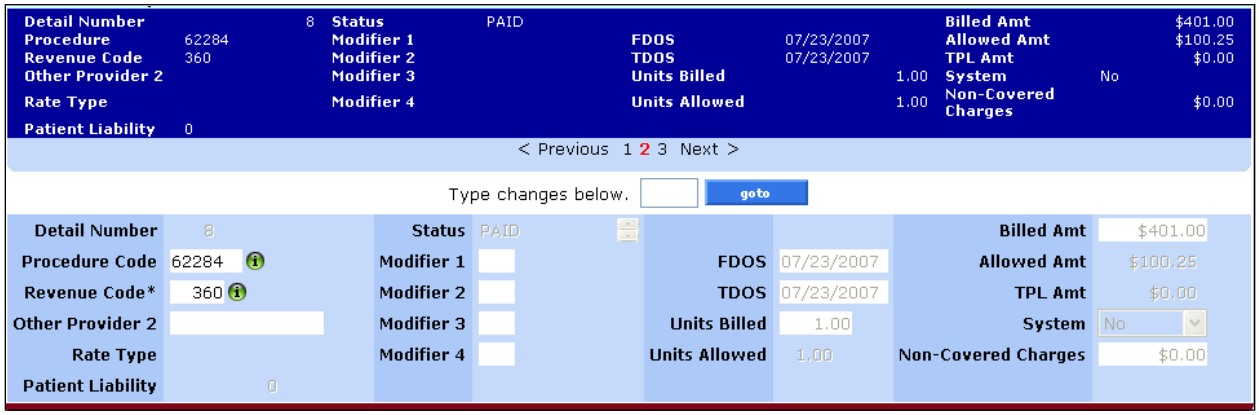
Field	Description
Other Provider 2	License number of physician other than attending physician.
Facility ID	Identification number assigned to facility provider and service location.
Admit Date	Date patient was admitted to facility for care.
Admit Time	Time member was admitted to facility for care.
Patient Status	Codes indicating patient's status as of ending service date of period covered on claim.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing Medical Record Number.
Status	Identifies status of claim within system.
Details	Number of detail service lines on claim.
Billed	Amount requested by provider for services rendered.
Spenddown	Amount of member's spend down applied to claim.
Reimbursed	Total amount provider receives.
Paid	Amount paid on claim. The amount paid is the allowed amount minus spend down, coinsurance, deductible, patient liability, dispensing fees, TPL, etc; as applicable depending on services. This value is computed by adding up all the AMT_PAID values for the related details.
TPL	Third Party Liability. The amount paid by a third party for services, at claim header level.
Total TPL	Sum of Third Party Liability amounts at header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. Casualty case recovery amount populated from Settlement window.
Total Co-pay	Sum of all detail co-pay amounts applicable to claim.
Total Patient Liability	Amount of patient liability applied to claim.
Total Days	Total number of days billed on claim.
Covered Days	Number of days covered by primary payer.
Days Not Covered	Number of days not covered.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. The procedure code is located in the Claim Detail Panel.

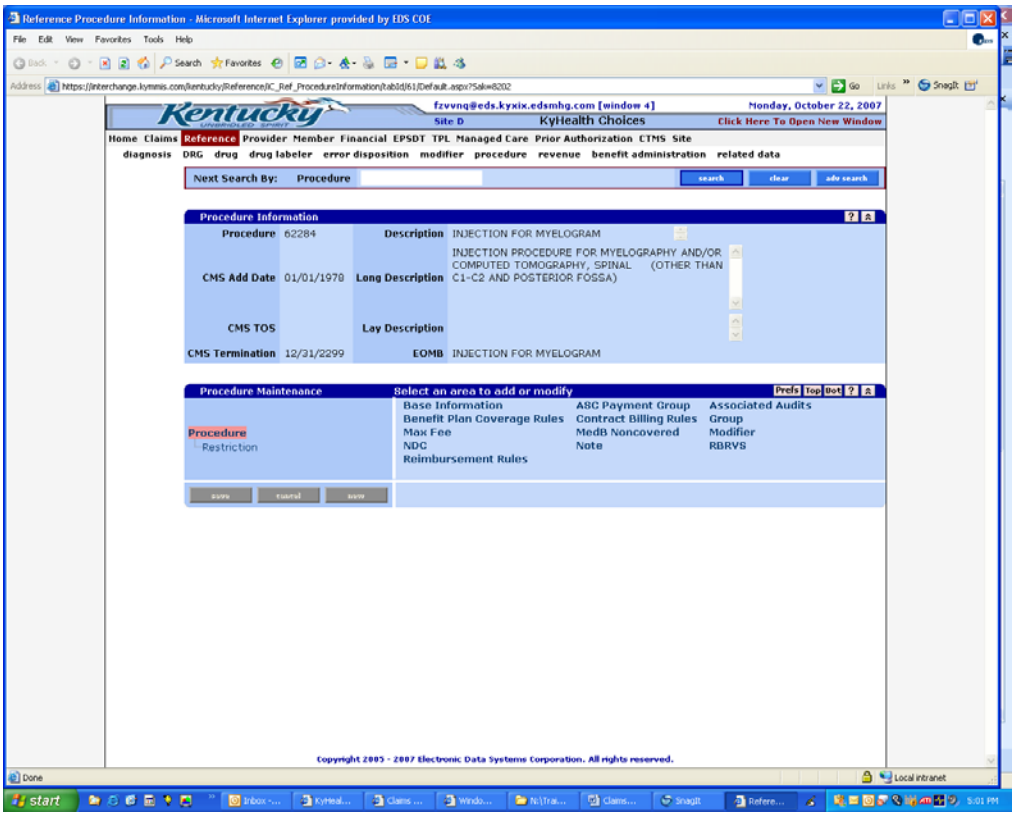
NOTE: The revenue code is also listed in the Claim Detail Panel.



STEP 3. To view the procedure code description, click on the record one time. This will auto-populate the information in the fields below the record.

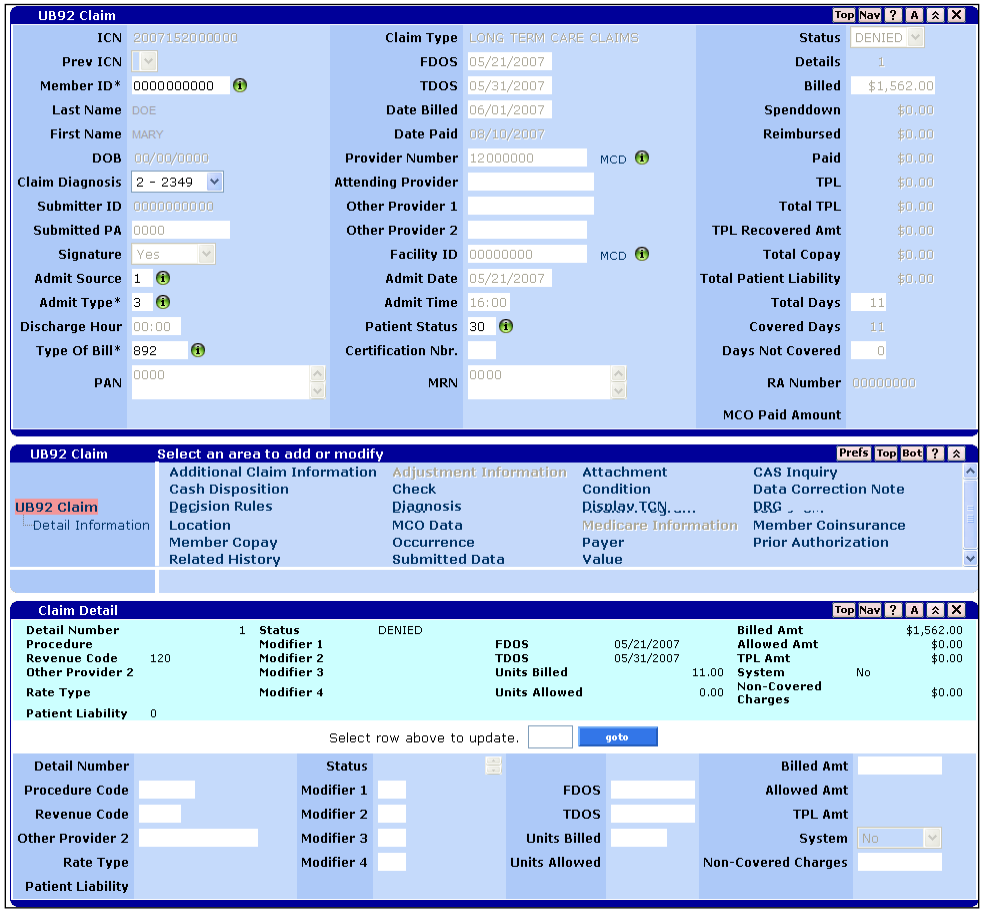


STEP 4. Click on the green "i" button . A pop-up window will appear, which is a link to the procedure code information page. This page will provide a description of the procedure code.


Reference Procedure Information - Microsoft Internet Explorer provided by EDS COE
File Edit View Favorites Tools Help
Kentucky
fzvvnq@eds.kyxix.edsmhg.com [window 4]
Monday, October 22, 2007
Site D
KyHealth Choices
Click Here To Open New Window
Home Claims Reference Provider Member Financial EPSDT TPL Managed Care Prior Authorization CTMS Site
diagnosis DRG drug drug labeler error disposition modifier procedure revenue benefit administration related data
Next Search By: Procedure
search clear adv search
Procedure Information
Procedure 62284
Description INJECTION FOR MYELOGRAM
CMS Add Date 01/01/1970
Long Description INJECTION PROCEDURE FOR MYELOGRAPHY AND/OR COMPUTED TOMOGRAPHY, SPINAL (OTHER THAN C1-C2 AND POSTERIOR FOSSA)
CMS TOS
Lay Description
CMS Termination 12/31/2299
EOMB INJECTION FOR MYELOGRAM
Procedure Maintenance
Select an area to add or modify
Prefs Top Bot
Procedure
Restriction
Base Information
Benefit Plan Coverage Rules
Max Fee
NDC
Reimbursement Rules
ASC Payment Group
Contract Billing Rules
MedB Noncovered
Note
Associated Audits
Group
Modifier
RBRVS
Copyright 2005 - 2007 Electronic Data Systems Corporation. All rights reserved.
Done
Local intranet
start

10.6.3 Viewing Claim Related History Institutional Claims

STEP 1. Access a UB92 Claim Information Page.



UB92 Claim Information Page

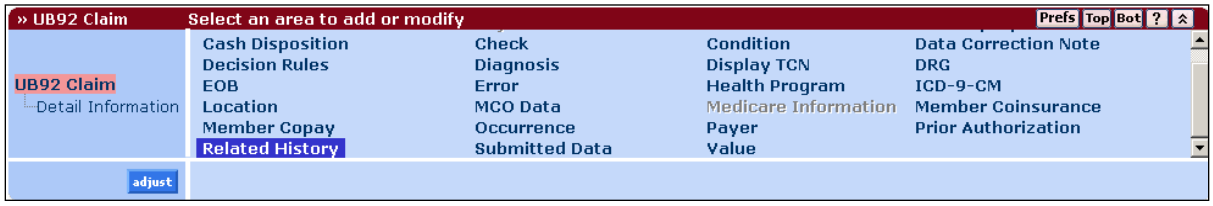
10.6.3.1 Claims/Information/UB92 Claim Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit *KY Medicaid* ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.

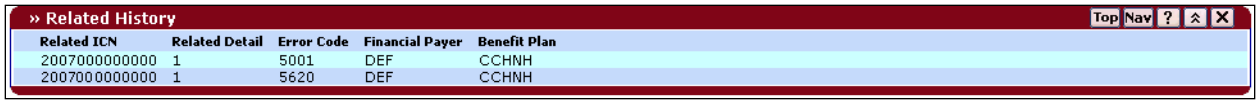
Field	Description
First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	Code used to identify the primary, admitting, emergency or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted with claim.
Signature	Indicates where claim was signed by provider or representative.
Admit Source	Indicates source of admission.
Admit type	Code indicating type of admission.
Discharge Hour	Time member is released from hospital or facility.
Type of Bill	Code indicating specific type of bill.
PAN	Patient's unique identification number assigned by provider to track patient's financial records.
Claim Type	Indicates type of claim.
FDOS	Beginning date of service on claim.
TDOS	Ending date of service on claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which claim was adjudicated.
Provider Number	*KY Medicaid* Provider number.
Attending Provider	Attending physician's prescribing number.
Other Provider 1	License number of physician other than attending physician.
Other Provider 2	License number of physician other than attending physician.
Facility ID	Identification number assigned to facility provider and service location.
Admit Date	Date patient was admitted to facility for care.
Admit Time	Time member was admitted to facility for care.
Patient Status	Codes indicating patient's status as of ending service date of period covered on claim.
Certification Nbr.	Code used to identify the certification of the member.

Field	Description
MRN	Code representing Medical Record Number.
Status	Identifies status of claim within system.
Details	Number of detail service lines on claim.
Billed	Amount requested by provider for services rendered.
Spenddown	Amount of member's spend down applied to claim.
Reimbursed	Total amount provider receives.
Paid	Amount paid on claim. Value is computed by adding up all AMT_PAID values for related details.
TPL	Third Party Liability. Amount paid by third party for services, at claim header level.
Total TPL	Sum of Third Party Liability amounts at header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. Casualty case recovery amount populated from Settlement window.
Total Co-pay	Sum of all detail co-pay amounts applicable to claim.
Total Patient Liability	Amount of patient liability applied to claim.
Total Days	Total number of days billed on claim.
Covered Days	Number of days covered by primary payer.
Days Not Covered	Number of days not covered.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. Access the UB92 Claim Maintenance Panel. Select the "Related History" link.



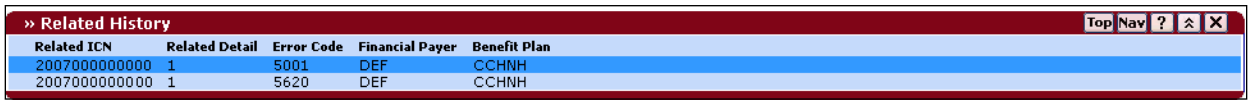
STEP 3. This will open the Related History panel.



10.6.3.2 Claims/Information/UB92 Claim/Related History Field Descriptions

Field	Description
Related ICN	Internal control number which uniquely identifies a claim.
Related Detail	Related detail information to the history claim displayed.
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system.
Financial Payer	The description used to identify the financial payer for the related ICN.
Benefit Plan	The medical assistance program associated with the related ICN.

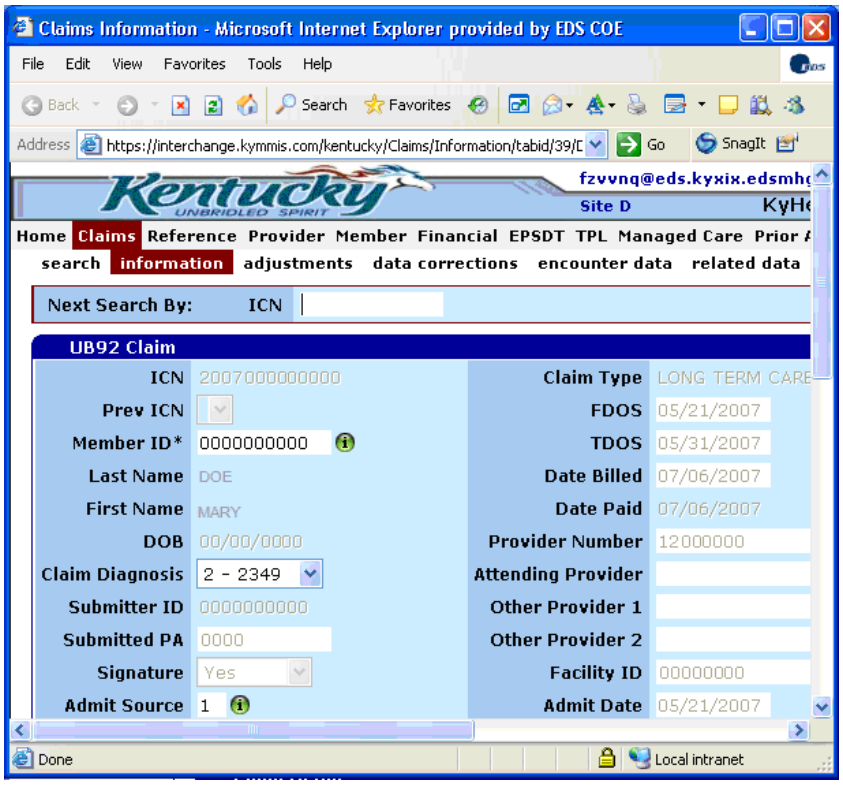
STEP 4. To view the detail information for the related claim, click on the record one time.



10.6.3.3 Claims/Information/UB92 Claim/Related History Field Descriptions

Field	Description
Related ICN	Internal control number which uniquely identifies a claim.
Related Detail	Related detail information to the history claim displayed.
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system.
Financial Payer	The description used to identify the financial payer for the related ICN.
Benefit Plan	The medical assistance program associated with the related ICN.

STEP 5. A pop-up window will appear, which is a link to the related Claim Information Page.


Claims Information - Microsoft Internet Explorer provided by EDS COE
File Edit View Favorites Tools Help
Back Search Favorites
Address https://interchange.kymmis.com/kentucky/Claims/Information/tabid/39/
Go SnagIt
Kentucky UNBRIDLED SPIRIT
Site D
Home Claims Reference Provider Member Financial EPSDT TPL Managed Care
search information adjustments data corrections encounter data related data
Next Search By: ICN
UB92 Claim
ICN 20070000000000
Prev ICN
Member ID* 0000000000
Last Name DOE
First Name MARY
DOB 00/00/0000
Claim Diagnosis 2 - 2349
Submitter ID 0000000000
Submitted PA 0000
Signature Yes
Admit Source 1
Claim Type LONG TERM CARE
FDOS 05/21/2007
TDOS 05/31/2007
Date Billed 07/06/2007
Date Paid 07/06/2007
Provider Number 12000000
Attending Provider
Other Provider 1
Other Provider 2
Facility ID 00000000
Admit Date 05/21/2007
Done
Local intranet

10.6.4 Viewing Diagnosis Codes Institutional Claims

STEP 1. Access a UB92 Claim Information Page.

UB92 Claim Information Page

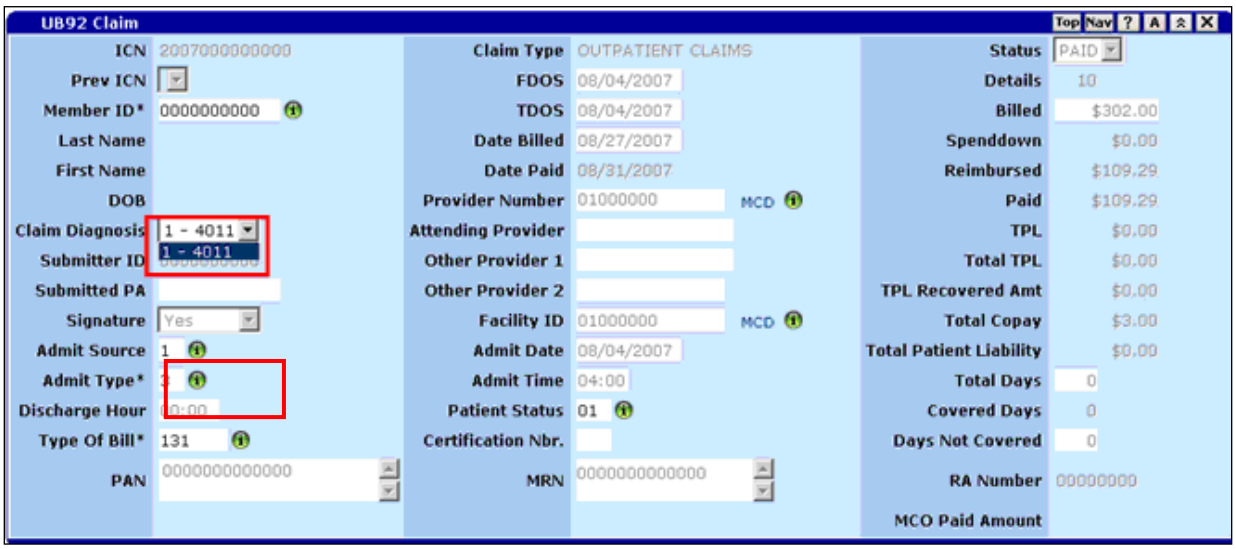
10.6.4.1 Claims/Information/UB92 Claim Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit *KY Medicaid* ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.
First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	Code used to identify the primary, admitting, emergency or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted with claim.
Signature	Indicates where claim was signed by provider or representative.
Admit Source	Indicates source of admission.
Admit type	Code indicating type of admission.
Discharge Hour	Time member is released from hospital or facility.
Type of Bill	Code indicating specific type of bill.
PAN	Patient's unique identification number assigned by provider to track patient's financial records.
Claim Type	Indicates type of claim.
FDOS	Beginning date of service on claim.
TDOS	Ending date of service on claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which claim was adjudicated.
Provider Number	*KY Medicaid* Provider number.

Field	Description
Attending Provider	Attending physician's prescribing number.
Other Provider 1	License number of physician other than attending physician.
Other Provider 2	License number of physician other than attending physician.
Facility ID	Identification number assigned to facility provider and service location.
Admit Date	Date patient was admitted to facility for care.
Admit Time	Time member was admitted to facility for care.
Patient Status	Codes indicating patient's status as of ending service date of period covered on claim.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing Medical Record Number.
Status	Identifies status of claim within system.
Details	Number of detail service lines on claim.
Billed	Amount requested by provider for services rendered.
Spenddown	Amount of member's spend down applied to claim.
Reimbursed	Total amount provider receives.
Paid	Amount paid on claim. Value is computed by adding up all AMT_PAID values for related details.
TPL	Third Party Liability. Amount paid by third party for services, at claim header level.
Total TPL	Sum of Third Party Liability amounts at header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. Casualty case recovery amount populated from Settlement window.
Total Co-pay	Sum of all detail co-pay amounts applicable to claim.
Total Patient Liability	Amount of patient liability applied to claim.
Total Days	Total number of days billed on claim.
Covered Days	Number of days covered by primary payer.
Days Not Covered	Number of days not covered.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.

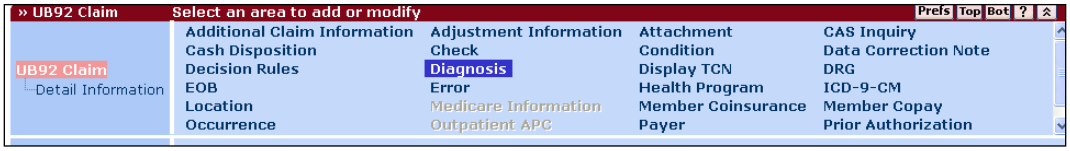
Field	Description
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. The diagnosis code is listed in the first panel, the UB92 Claim Panel. It is a drop down box that provides diagnosis codes for each claim detail line.

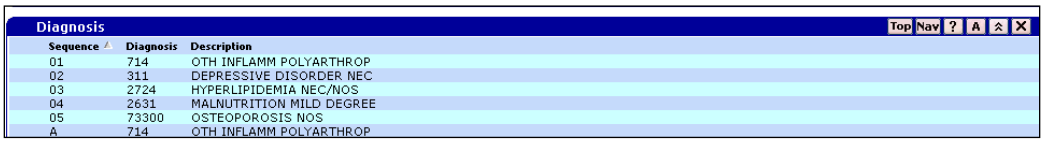


UB92 Claim Panel

STEP 3. To view the diagnosis code description, access the Physician Claim Maintenance Panel, which is the second panel. Select the "Diagnosis" link.



STEP 4. The diagnosis code description is available to view.



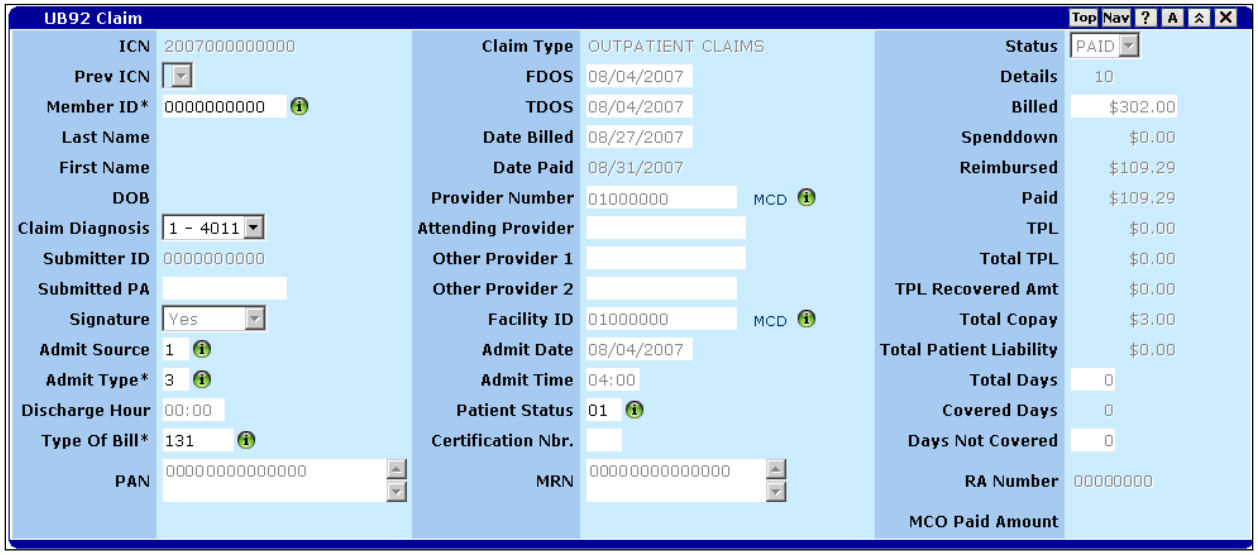
UB92 Diagnosis Panel

10.6.4.2 Claims/Information/UB92 Claim/Diagnosis Panel Field Descriptions

Field	Description
Sequence	Sequence numbers for diagnosis codes. For UB92 claims, Admitting diagnosis have value of 'A' in Sequence column and Emergency diagnosis have 'E' in Sequence column. For all claim types, Primary diagnosis have value of '1'. Or diagnosis codes have value of '2' through '24'.
Diagnosis	Indicates diagnosis codes applicable to claim. Diagnosis code is code for condition requiring medical attention.
Description	Description of diagnosis code.

10.6.5 Viewing Check Information Institutional Claims

STEP 1. Access a UB92 Claim Information Page.



UB92 Claim Information Page

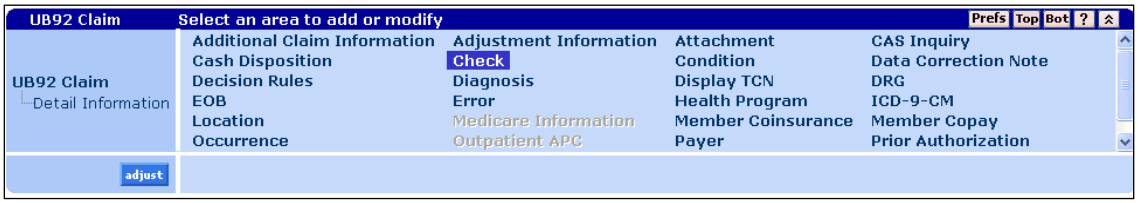
10.6.5.1 Claims/Information/UB92 Claim Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit *KY Medicaid* ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.
First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	Code used to identify the primary, admitting, emergency or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted with claim.
Signature	Indicates where claim was signed by provider or representative.

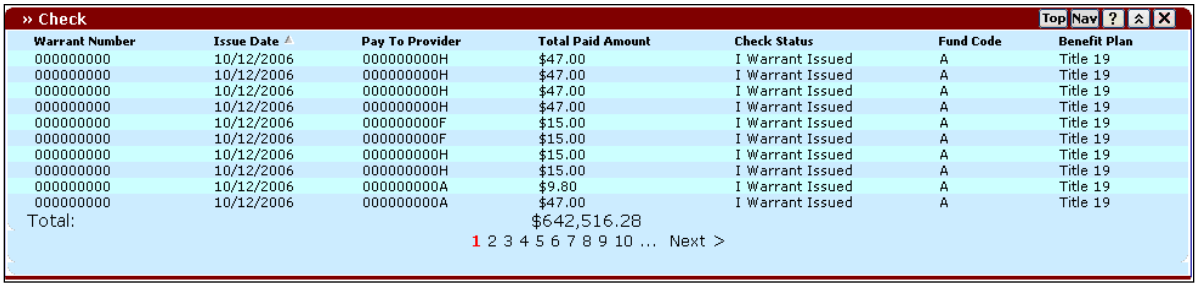
Field	Description
Admit Source	Indicates source of admission.
Admit type	Code indicating type of admission.
Discharge Hour	Time member is released from hospital or facility.
Type of Bill	Code indicating specific type of bill.
PAN	Patient's unique identification number assigned by provider to track patient's financial records.
Claim Type	Indicates type of claim.
FDOS	Beginning date of service on claim.
TDOS	Ending date of service on claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which claim was adjudicated.
Provider Number	*KY Medicaid* Provider number.
Attending Provider	Attending physician's prescribing number.
Other Provider 1	License number of physician other than attending physician.
Other Provider 2	License number of physician other than attending physician.
Facility ID	Identification number assigned to facility provider and service location.
Admit Date	Date patient was admitted to facility for care.
Admit Time	Time member was admitted to facility for care.
Patient Status	Codes indicating patient's status as of ending service date of period covered on claim.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing Medical Record Number.
Status	Identifies status of claim within system.
Details	Number of detail service lines on claim.
Billed	Amount requested by provider for services rendered.
Spenddown	Amount of member’s spend down applied to claim.
Reimbursed	Total amount provider receives.
Paid	Amount paid on claim. Value is computed by adding up all AMT_PAID values for related details.

Field	Description
TPL	Third Party Liability. Amount paid by third party for services, at claim header level.
Total TPL	Sum of Third Party Liability amounts at header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. Casualty case recovery amount populated from Settlement window.
Total Co-pay	Sum of all detail co-pay amounts applicable to claim.
Total Patient Liability	Amount of patient liability applied to claim.
Total Days	Total number of days billed on claim.
Covered Days	Number of days covered by primary payer.
Days Not Covered	Number of days not covered.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount

STEP 2. Access the UB92 Claim Maintenance Panel, which is the second panel. Select the "Check" link.



STEP 3. The check information is available to view.

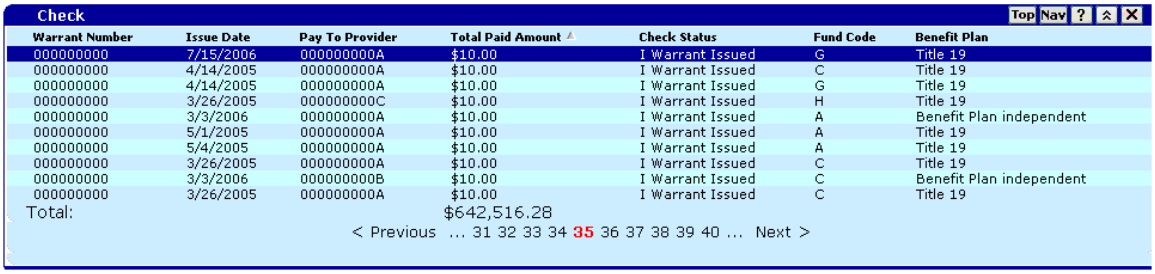


Check Panel

10.6.5.2 Claims/Information/UB92 Claim/Check Panel Field Descriptions

Field	Description
Warrant Number	The number of the check that the provider received, or the number of the Electronic Funds Transfer.
Issue Date	The date when the check was issued or the EFT was sent.
Pay To Provider	The Provider ID who received the check or EFT.
Total Paid Amount	The total amount that was issued to the provider.
Check Status	The status of the check. Examples are: An 'I' would indicate the check has been issued, a 'V' indicates a VOID, an 'R' indicates the check was reissued, a 'C' indicates a check has CLEARED the bank, an 'S' indicates Stopped and an 'X' for Cancelled by Statute.
Fund Code	The Fund Code assigned to the check or EFT.
Benefit Plan	The Benefit Plan associated with the check or EFT.

STEP 4. To view the detail information for the check, search for the warrant number that relates to the claim. Click on the record one time.

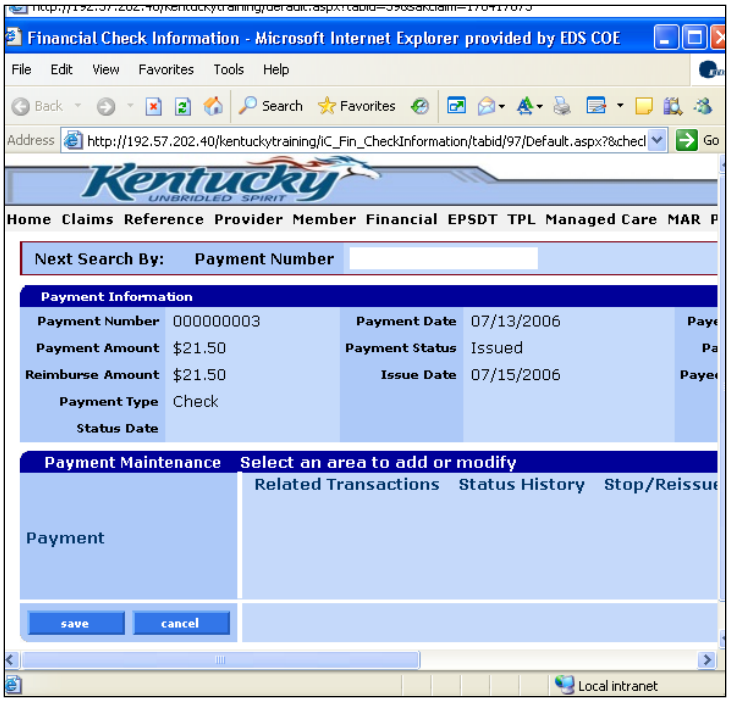


Check

Warrant Number	Issue Date	Pay To Provider	Total Paid Amount	Check Status	Fund Code	Benefit Plan
000000000	7/15/2006	000000000A	$10.00	I Warrant Issued	G	Title 19
000000000	4/14/2005	000000000A	$10.00	I Warrant Issued	C	Title 19
000000000	4/14/2005	000000000A	$10.00	I Warrant Issued	G	Title 19
000000000	3/26/2005	000000000C	$10.00	I Warrant Issued	H	Title 19
000000000	3/3/2006	000000000A	$10.00	I Warrant Issued	A	Benefit Plan independent
000000000	5/1/2005	000000000A	$10.00	I Warrant Issued	A	Title 19
000000000	5/4/2005	000000000A	$10.00	I Warrant Issued	A	Title 19
000000000	3/26/2005	000000000A	$10.00	I Warrant Issued	C	Title 19
000000000	3/3/2006	000000000B	$10.00	I Warrant Issued	C	Benefit Plan independent
000000000	3/26/2005	000000000A	$10.00	I Warrant Issued	C	Title 19
Total:			$642,516.28			

< Previous ... 31 32 33 34 35 36 37 38 39 40 ... Next >

STEP 5. A pop-up window will appear, which is a link to the related Payment Information Page.


Financial Check Information - Microsoft Internet Explorer provided by EDS COE
File Edit View Favorites Tools Help
Back Search Favorites
Address http://192.57.202.40/kentuckytraining/iC_Fin_CheckInformation/tabid/97/Default.aspx?&checl
Go
Kentucky
UNBRIDLED SPIRIT
Home Claims Reference Provider Member Financial EPSDT TPL Managed Care MAR
Next Search By: Payment Number
Payment Information
Payment Number 000000003
Payment Date 07/13/2006
Payment Amount $21.50
Payment Status Issued
Reimburse Amount $21.50
Issue Date 07/15/2006
Payment Type Check
Status Date
Payment Maintenance Select an area to add or modify
Related Transactions Status History Stop/Reissue
Payment
save cancel
Local intranet

10.6.6 Viewing Health Program Information Institutional Claims

STEP 1. Access a UB92 Claim Information Page.

UB92 Claim Top Nav ? A

ICN	2007000000000	Claim Type	OUTPATIENT CLAIMS	Status	PAID
Prev ICN		FDOS	08/04/2007	Details	10
Member ID*	0000000000	TDOS	08/04/2007	Billed	$302.00
Last Name		Date Billed	08/27/2007	Spenddown	$0.00
First Name		Date Paid	08/31/2007	Reimbursed	$109.29
DOB		Provider Number	01000000 MCD	Paid	$109.29
Claim Diagnosis	1 - 4011	Attending Provider		TPL	$0.00
Submitter ID	0000000000	Other Provider 1		Total TPL	$0.00
Submitted PA		Other Provider 2		TPL Recovered Amt	$0.00
Signature	Yes	Facility ID	01000000 MCD	Total Copay	$3.00
Admit Source	1	Admit Date	08/04/2007	Total Patient Liability	$0.00
Admit Type*	3	Admit Time	04:00	Total Days	0
Discharge Hour	00:00	Patient Status	01	Covered Days	0
Type Of Bill*	131	Certification Nbr.		Days Not Covered	0
PAN	00000000000000	MRN	00000000000000	RA Number	00000000
				MCO Paid Amount	

UB92 Claim Select an area to add or modify Prefs Top Bot ?

UB92 Claim
Detail Information

Cash Disposition	Check	Condition	Data Correction Note
Decision Rules	Diagnosis	Display TCN	DRG
EOB	Error	Health Program	ICD-9-CM
Location	MCO Data	Medicare Information	Member Coinsurance
Member Copay	Occurrence	Payer	Prior Authorization
Related History	Submitted Data	Value	

adjust

Claim Detail Top Nav ? A

Detail Number	1	Status	PAID					Billed Amt	$47.00
Procedure	80061	Modifier 1		FDOS	08/04/2007			Allowed Amt	$16.44
Revenue Code	300	Modifier 2		TDOS	08/04/2007			TPL Amt	$0.00
Other Provider 2		Modifier 3		Units Billed		1.00		System	No
Rate Type		Modifier 4		Units Allowed		1.00		Non-Covered Charges	$0.00
Patient Liability	0								
Detail Number	2	Status	PAID					Billed Amt	$51.00
Procedure	84439	Modifier 1		FDOS	08/04/2007			Allowed Amt	$13.02
Revenue Code	300	Modifier 2		TDOS	08/04/2007			TPL Amt	$0.00
Other Provider 2		Modifier 3		Units Billed		1.00		System	No
Rate Type		Modifier 4		Units Allowed		1.00		Non-Covered Charges	$0.00
Patient Liability	0								
Detail Number	3	Status	PAID					Billed Amt	$49.00
Procedure	84443	Modifier 1		FDOS	08/04/2007			Allowed Amt	$24.25
Revenue Code	300	Modifier 2		TDOS	08/04/2007			TPL Amt	$0.00
Other Provider 2		Modifier 3		Units Billed		1.00		System	No
Rate Type		Modifier 4		Units Allowed		1.00		Non-Covered Charges	$0.00
Patient Liability	0								
Detail Number	4	Status	PAID					Billed Amt	$12.00
Procedure	84550	Modifier 1		FDOS	08/04/2007			Allowed Amt	$6.52
Revenue Code	300	Modifier 2		TDOS	08/04/2007			TPL Amt	$0.00
Other Provider 2		Modifier 3		Units Billed		1.00		System	No
Rate Type		Modifier 4		Units Allowed		1.00		Non-Covered Charges	$0.00
Patient Liability	0								

1 2 3 Next >

Select row above to update. goto

Detail Number		Status			Billed Amt
Procedure Code		Modifier 1	FDOS		Allowed Amt
Revenue Code		Modifier 2	TDOS		TPL Amt
Other Provider 2		Modifier 3	Units Billed		System No
Rate Type		Modifier 4	Units Allowed		Non-Covered Charges
Patient Liability					

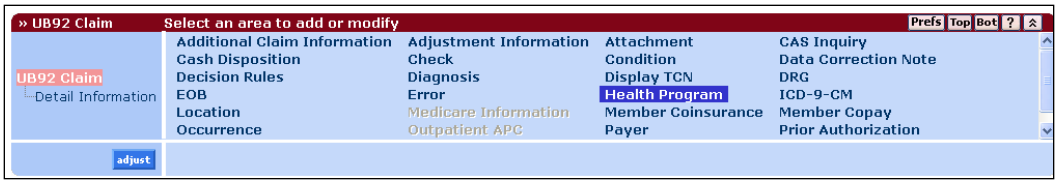
UB92 Claim Information Page

10.6.6.1 Claims/Information/UB92 Claim Panel Field Descriptions

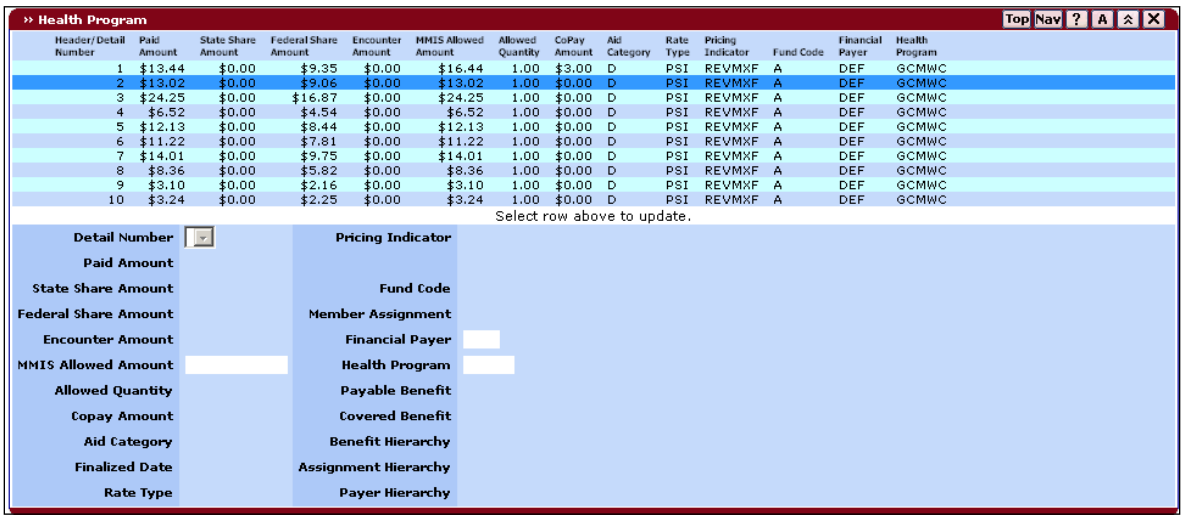
Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit *KY Medicaid* ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.
First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	Code used to identify the primary, admitting, emergency or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted with claim.
Signature	Indicates where claim was signed by provider or representative.
Admit Source	Indicates source of admission.
Admit type	Code indicating type of admission.
Discharge Hour	Time member is released from hospital or facility.
Type of Bill	Code indicating specific type of bill.
PAN	Patient's unique identification number assigned by provider to track patient's financial records.
Claim Type	Indicates type of claim.
FDOS	Beginning date of service on claim.
TDOS	Ending date of service on claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which claim was adjudicated.
Provider Number	*KY Medicaid* Provider number.
Attending Provider	Attending physician's prescribing number.
Other Provider 1	License number of physician other than attending physician.

Field	Description
Other Provider 2	License number of physician other than attending physician.
Facility ID	Identification number assigned to facility provider and service location.
Admit Date	Date patient was admitted to facility for care.
Admit Time	Time member was admitted to facility for care.
Patient Status	Codes indicating patient's status as of ending service date of period covered on claim.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing Medical Record Number.
Status	Identifies status of claim within system.
Details	Number of detail service lines on claim.
Billed	Amount requested by provider for services rendered.
Spenddown	Amount of member's spend down applied to claim.
Reimbursed	Total amount provider receives.
Paid	Amount paid on claim. Value is computed by adding up all AMT_PAID values for related details.
TPL	Third Party Liability. Amount paid by third party for services, at claim header level.
Total TPL	Sum of Third Party Liability amounts at header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. Casualty case recovery amount populated from Settlement window.
Total Co-pay	Sum of all detail co-pay amounts applicable to claim.
Total Patient Liability	Amount of patient liability applied to claim.
Total Days	Total number of days billed on claim.
Covered Days	Number of days covered by primary payer.
Days Not Covered	Number of days not covered.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount

STEP 2. Access the UB92 Claim Maintenance Panel. Select the "Health Program" link.



STEP 3. The Health Program Panel is available to view.



Header/Detail Number	Paid Amount	State Share Amount	Federal Share Amount	Encounter Amount	MMIS Allowed Amount	Allowed Quantity	CoPay Amount	Aid Category	Rate Type	Pricing Indicator	Fund Code	Financial Payer	Health Program
1	$13.44	$0.00	$9.35	$0.00	$16.44	1.00	$3.00	D	PSI	REVMXF	A	DEF	GCMWC
2	$13.02	$0.00	$9.06	$0.00	$13.02	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
3	$24.25	$0.00	$16.87	$0.00	$24.25	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
4	$6.52	$0.00	$4.54	$0.00	$6.52	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
5	$12.13	$0.00	$8.44	$0.00	$12.13	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
6	$11.22	$0.00	$7.81	$0.00	$11.22	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
7	$14.01	$0.00	$9.75	$0.00	$14.01	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
8	$8.36	$0.00	$5.82	$0.00	$8.36	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
9	$3.10	$0.00	$2.16	$0.00	$3.10	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
10	$3.24	$0.00	$2.25	$0.00	$3.24	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC

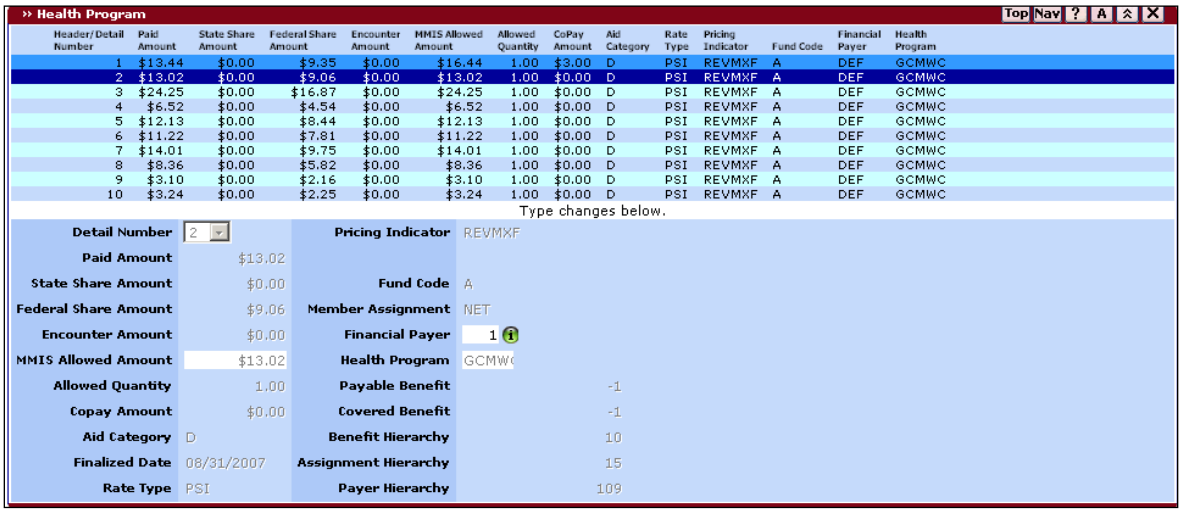
Health Program Panel

10.6.6.2 Claims/Data Corrections/UB92 Claim/Health Program Panel Field Descriptions

Field	Description
Detail Number	Indicates if the row pertains to the claim header or a claim detail line. The claim header is denoted by a zero.
Paid Amount	The amount that is applied toward the check amount.
State Share Amount	The amount that is applied toward the check amount.
Federal Share Amount	The amount of federal share for this payment.
Encounter Amount	Contains amount for encounter services on claim detail indicated by detail number on table.
MMIS Allowed Amount	Amount *KY Medicaid* would pay on given detail information.
Allowed Quantity	Number of units *KY Medicaid* would pay on given procedure code and date span.
Co-pay Amount	The amount of co-pay that is subtracted from the allowed amount.
Aid Category	Aid Category for *KY Medicaid* coverage.

Field	Description
Rate Type	Code used to identify rate type to use in determining provider reimbursement.
Pricing Indicator	Pricing indicator which dictates method by which procedure must be priced or indicates how claim detail was priced.
Fund Code	Indicates the budget category funds used to pay claim/detail.
Financial Payer	Description of financial payer.
Health Program	Name of program from which the header/detail was processed and/or paid.
Payable Benefit	Unique system-assigned that identifies each row on this table.
Covered Benefit	System-assigned key used to identify unique row for benefit covered by member plan. Identifies row to be ignored for benefit.
Benefit Hierarchy	Assignment hierarchy is an ordered set of assignment plans which member/beneficiary may be assigned concurrently. For example, a beneficiary may be assigned to PCP and Health Community Based Services agency at overlapping periods of time.
Assignment Hierarchy	Set of assignment plans for which member/beneficiary may be assigned concurrently.
Payer Hierarchy	Payer Hierarchy identifies order of processing of financial payers, benefit plans, or assignment plans for beneficiaries who are enrolled in multiple entities.

STEP 4. To view additional details about the Health Program, click on the record one time. This will auto-populate the information in the fields below the record.



Header/Detail Number	Paid Amount	State Share Amount	Federal Share Amount	Encounter Amount	MMIS Allowed Amount	Allowed Quantity	CoPay Amount	Aid Category	Rate Type	Pricing Indicator	Fund Code	Financial Payer	Health Program
1	$13.44	$0.00	$9.35	$0.00	$16.44	1.00	$3.00	D	PSI	REVMXF	A	DEF	GCMWC
2	$13.02	$0.00	$9.06	$0.00	$13.02	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
3	$24.25	$0.00	$16.87	$0.00	$24.25	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
4	$6.52	$0.00	$4.54	$0.00	$6.52	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
5	$12.13	$0.00	$8.44	$0.00	$12.13	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
6	$11.22	$0.00	$7.81	$0.00	$11.22	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
7	$14.01	$0.00	$9.75	$0.00	$14.01	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
8	$8.36	$0.00	$5.82	$0.00	$8.36	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
9	$3.10	$0.00	$2.16	$0.00	$3.10	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC
10	$3.24	$0.00	$2.25	$0.00	$3.24	1.00	$0.00	D	PSI	REVMXF	A	DEF	GCMWC

10.6.7 Viewing Medicare Information Institutional Claims

STEP 1. Access a UB92 Claim Information Page for a UB92 Crossover Claim.

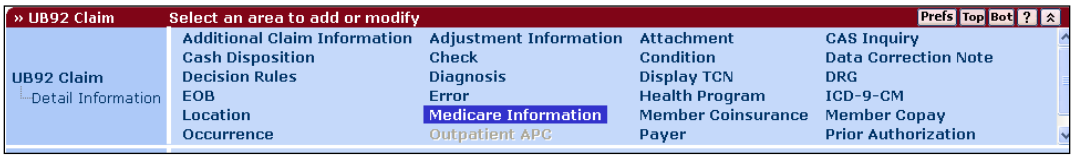
UB92 Claim Information Page

10.6.7.1 Claims/Information/UB92 Claim Panel Field Descriptions

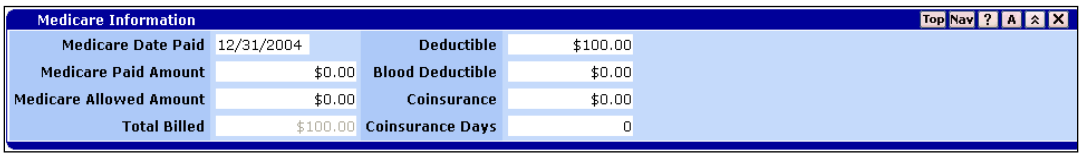
Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's 10-digit *KY Medicaid* ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.
First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	Code used to identify the primary, admitting, emergency or other diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted with claim.
Signature	Indicates where claim was signed by provider or representative.
Admit Source	Indicates source of admission.
Admit type	Code indicating type of admission.
Discharge Hour	Time member is released from hospital or facility.
Type of Bill	Code indicating specific type of bill.
PAN	Patient's unique identification number assigned by provider to track patient's financial records.
Claim Type	Indicates type of claim.
FDOS	Beginning date of service on claim.
TDOS	Ending date of service on claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which claim was adjudicated.
Provider Number	*KY Medicaid* Provider number.
Attending Provider	Attending physician's prescribing number.

Field	Description
Other Provider 1	License number of physician other than attending physician.
Other Provider 2	License number of physician other than attending physician.
Facility ID	Identification number assigned to facility provider and service location.
Admit Date	Date patient was admitted to facility for care.
Admit Time	Time member was admitted to facility for care.
Patient Status	Codes indicating patient's status as of ending service date of period covered on claim.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing Medical Record Number.
Status	Identifies status of claim within system.
Details	Number of detail service lines on claim.
Billed	Amount requested by provider for services rendered.
Spenddown	Amount of member's spend down applied to claim.
Reimbursed	Total amount provider receives.
Paid	Amount paid on claim. Value is computed by adding up all AMT_PAID values for related details.
TPL	Third Party Liability. Amount paid by third party for services, at claim header level.
Total TPL	Sum of Third Party Liability amounts at header and detail levels.
TPL Recovered Amt	Third Party Liability Recovered Amount. Casualty case recovery amount populated from Settlement window.
Total Co-pay	Sum of all detail co-pay amounts applicable to claim.
Total Patient Liability	Amount of patient liability applied to claim.
Total Days	Total number of days billed on claim.
Covered Days	Number of days covered by primary payer.
Days Not Covered	Number of days not covered.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount

STEP 2. Access the UB92 Claim Maintenance Panel. Select the "Medicare Information" link.



STEP 3. The Medicare Information panel is available to view.



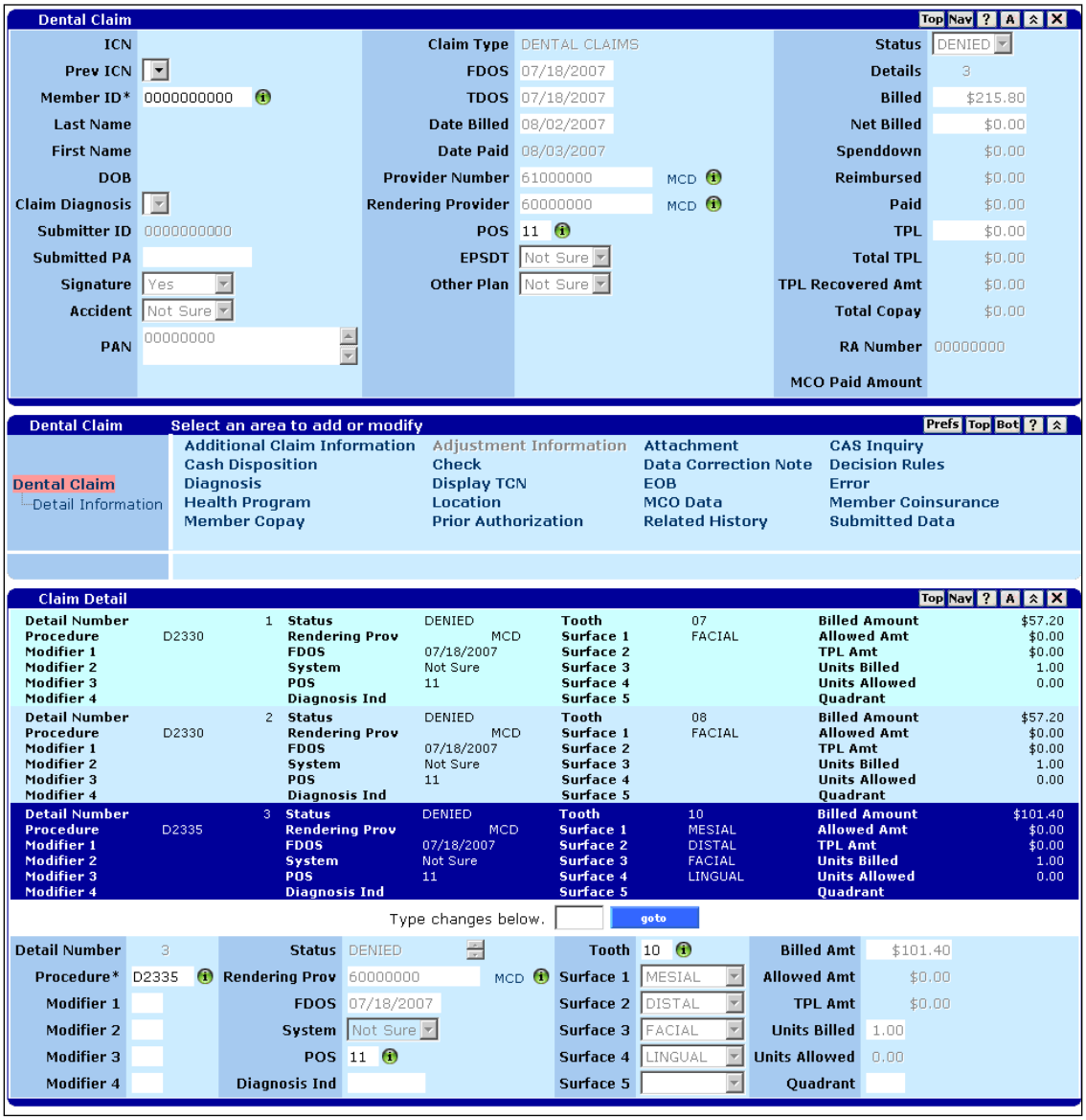
10.6.7.2 Claims/Information/UB92 Claim/Medicare Information Panel Field Descriptions

Field	Description
Medicare Date Paid	The date Medicare pay for the services.
Deductible	The amount the member must pay before Medicare. Format 999999.99.
Medicare Paid Amount	The dollar amount paid by Medicare for the services. Format 999999.99.
Blood Deductible	The amount Medicare has determined that a member must pay for blood procedures performed. Format 999999.99
Medicare Allowed Amount	The dollar amount allowed by Medicare for the services. Format 999999.99.
Coinsurance	The number of coinsurance days billed on the claim.
Total Billed	The amount Medicare has determined that a member must pay. This is a calculated value. (sum of Coinsurance + Deductible). Format 999999.99.
Coinsurance Days	The number of coinsurance days billed on the claim

10.7 Viewing Additional Information on Dental Claims

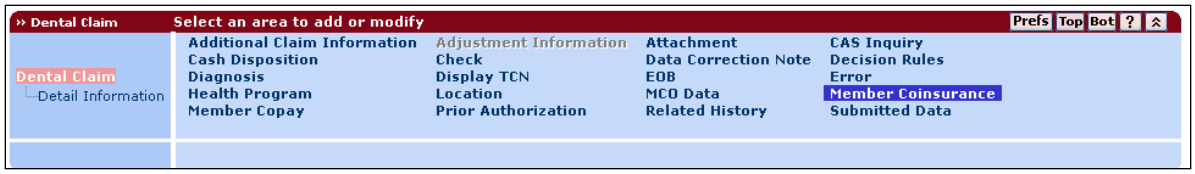
10.7.1 Viewing Member Co-Pay/Co-Insurance Information on Dental Claims

STEP 1. Access a Dental Claim Information Page.

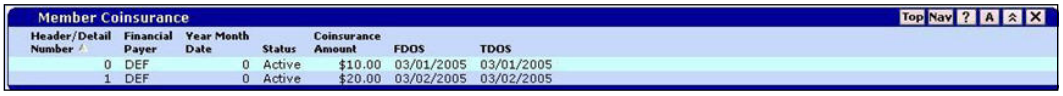


Dental Claim Information Page

STEP 2. Select the Member Co-Insurance link on the Dental Claim Maintenance panel.



This will open the Member Co-Insurance panel.

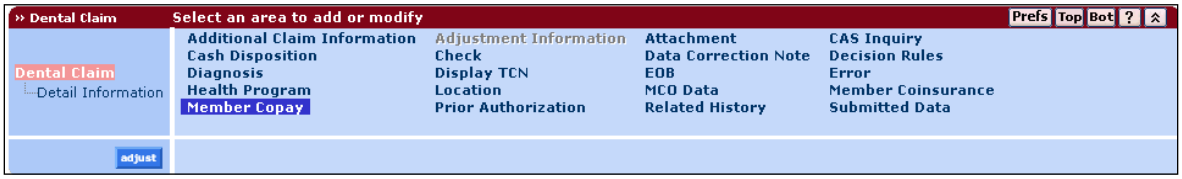


Member Co-Insurance Panel

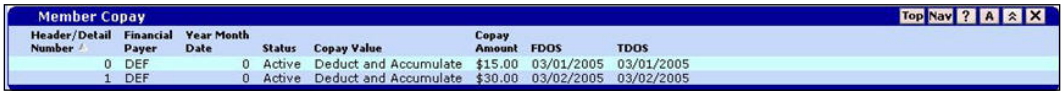
10.7.1.1 Claims/Information/Dental Claim/Member Co-insurance Panel Field Descriptions

Field	Description
Header/Detail Number	The number of the detail on the claim record. A zero represents the header.
Financial Payer	The system-assigned value that identifies a unique payer within interChange.
Year Month Date	This is the year and month of the date of service of the claim that used coinsurance.
Status	Indicates if the record/row is active or inactive. The row becomes inactive only after an adjustment to the claim is released. Only use active ('A') to accumulate coinsurance. Values are: 'A' - Active; 'I' - Inactive
Coinsurance Amount	The coinsurance amount paid by the member for services rendered.
FDOS	The beginning date of service for the claim.
TDOS	The last date of service for the claim.

STEP 3. Select the Member Co-Pay link on the Dental Claim Maintenance panel.



This will open the Member Co-Pay panel.



Member Co-Pay

Header/Detail Number	Financial Payer	Year Month Date	Status	Copay Value	Copay Amount	FDOS	TDOS
0	DEF	0	Active	Deduct and Accumulate	$15.00	03/01/2005	03/01/2005
1	DEF	0	Active	Deduct and Accumulate	$30.00	03/02/2005	03/02/2005

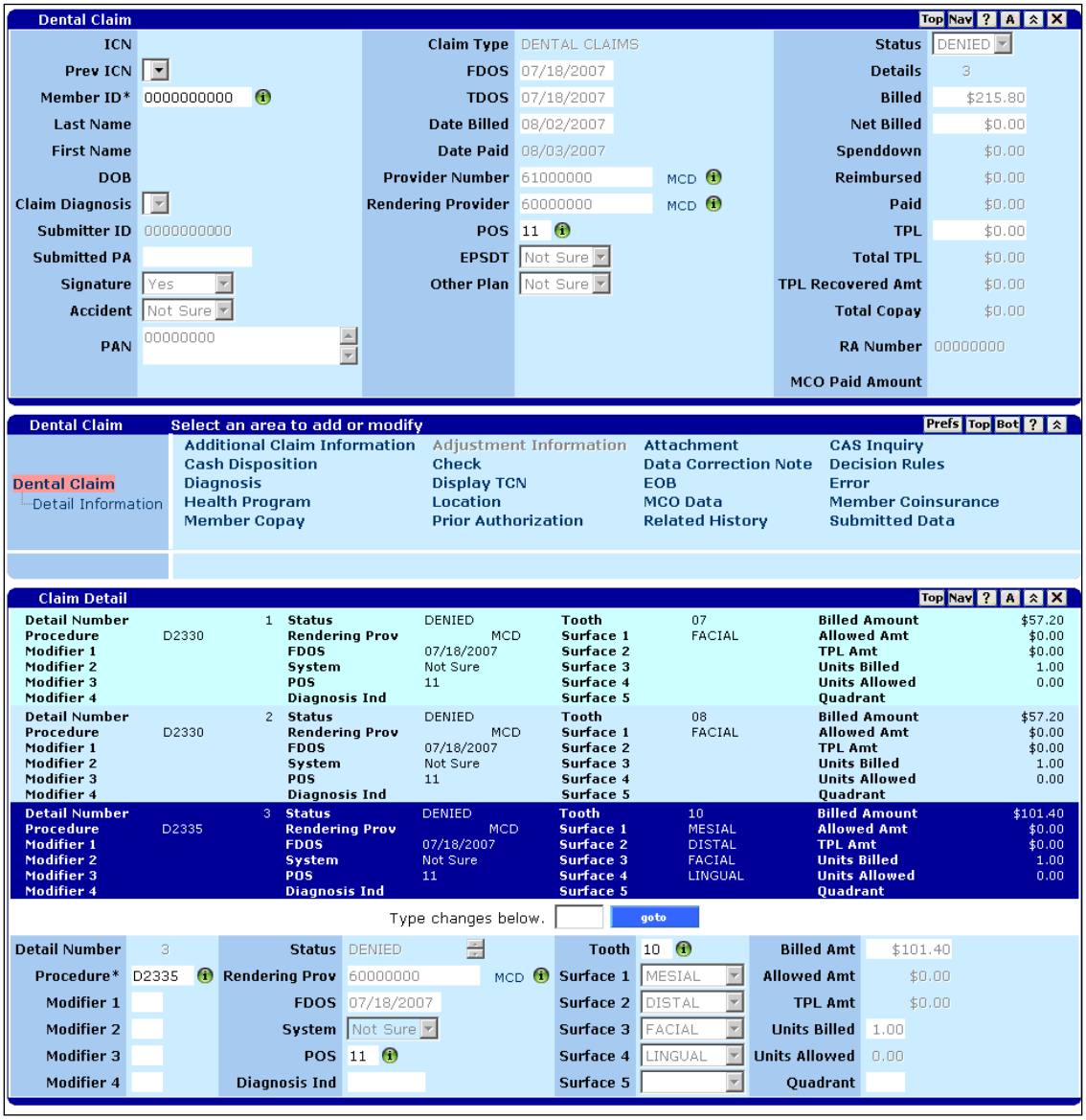
Member Co-Pay Panel

10.7.1.2 Claims/Information/Dental Claim/Member Co-pay Panel Field Descriptions

Field	Description
Header/Detail Number	The number of the detail on the claim record. A zero represents the header.
Financial Payer	The system-assigned value that identifies a unique payer within interChange.
Year Month Date	This is the year and month of the date of service of the claim that used copay.
Status	Indicates if the record/row is active or inactive. The row becomes inactive only after an adjustment to the claim is released. Only use active ('A') to accumulate coinsurance. Values are: 'A' - Active; 'I' - Inactive
Copay Value	Determines if the row has actual copay deducted from the claim or if the copay was just additive and not deducted from the claim. Values are: 'DA' - Deduct and accumulate copay 'OA' - Only accumulate copay
Copay Amount	The copay amount paid by the member for services rendered
FDOS	The beginning date of service for the claim.
TDOS	The last date of service for the claim.

10.7.2 Viewing Procedure Codes on Dental Claims

STEP 1. Access a Dental Claim Information Page.



Dental Claim Information Page

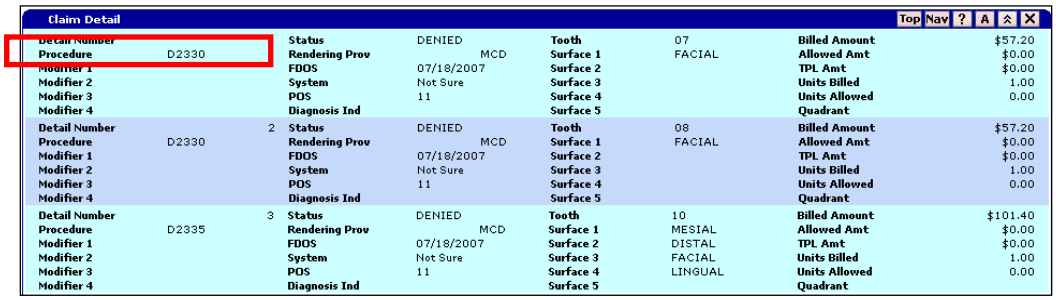
10.7.3 Claims/Information/Dental Claims Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.

Field	Description
Prev ICN	This field allows the user to select any of the other previous ICNs for the claim and view that information. The MCO Original ICN for an encounter claim. Not used on claims other than encounters.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID number. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.
First Name	The first name of the member associated with the Member ID number. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	A code for the condition requiring medical attention.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates the accident reason. It draws its drop down values from the T_ACCIDENT_TYPE table.
PAN	Identification for a member assigned by a provider. (Patient Account Number)
Claim Type	Indicates the type of claim.
FDOS	First Date of Service on the claim.
TDOS	Date of last service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The provider identification number and location that uniquely identifies the provider of services.
Rendering Provider	The Rendering provider identification number and location that uniquely identifies the provider of services.
POS	Place of Service where service was rendered.
EPSDT	Indicates whether claim is EPSDT.
Other Plan	Indicates if another form of insurance was used.
Status	This field displays the status of the claim.

Field	Description
Details	Indicates the number of detail service lines on the claim.
Billed	Amount of money requested for payment by a provider for services rendered.
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL and so on).
Spend-down	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives minus any state share amount (if applicable).
Paid	Amount paid on claim. Amount paid will be the allowed amount minus spend down, coinsurance, deductible, patient liability, dispensing fees, TPL, etc., as applicable depending on services. This value is computed by adding up all the AMT_PAID values on the related details.
TPL	Third Party Liability. The amount paid by a third party for services.
Total TPL	Total Third Party Liability. This is the sum of the copay amounts from Health Program panel records(T_CLM_PGM_XREF table).
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement panel.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records (T_CLM_PGM_XREF table).
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. The procedure code is located in the Claim Detail Panel.



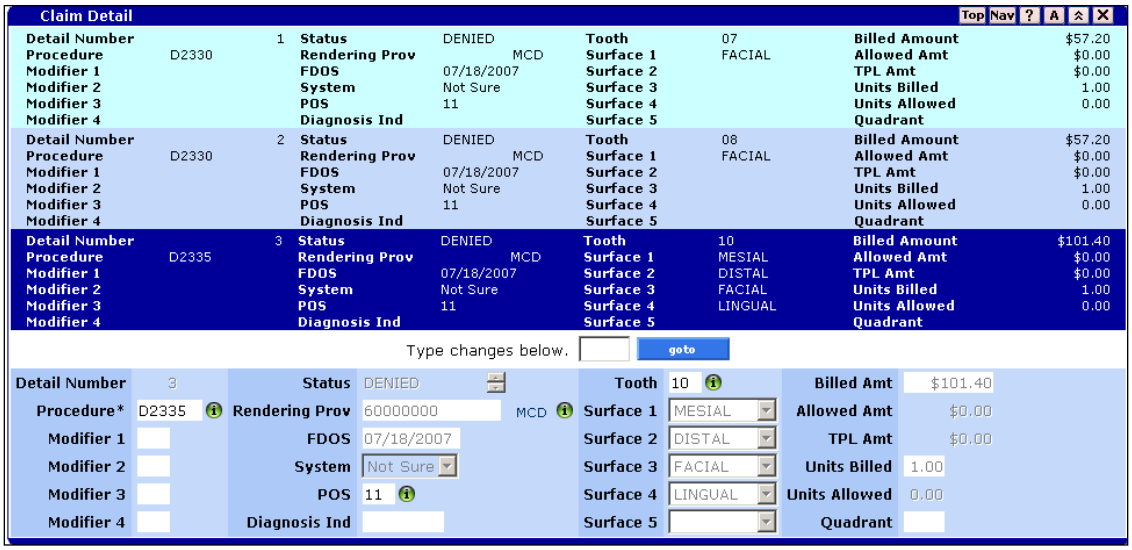
10.7.3.1 Claims/Information/Dental Claims/Dental Claim Detail Panel Field Descriptions

Field	Description

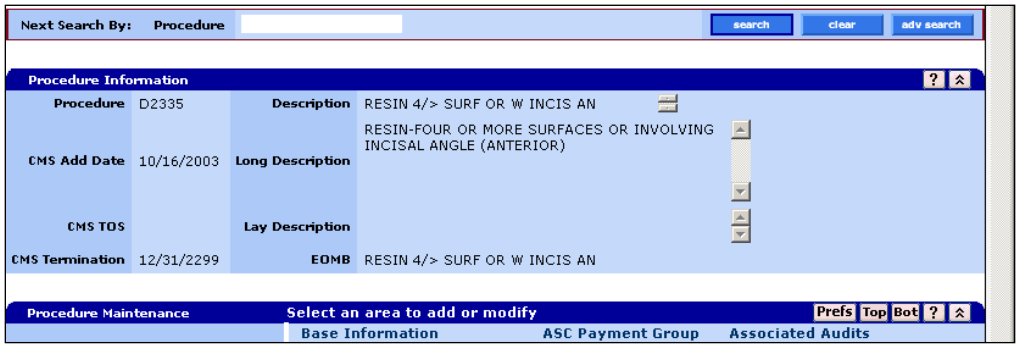
Field	Description
Detail #	The number of the detail on a claim record
Procedure	Code used to identify a Dental procedure
Modifier 1	Code used to identify the modifiers connected to the procedure code.
Modifier 2	Code used to identify the modifiers connected to the procedure code.
Modifier 3	Code used to identify the modifiers connected to the procedure code.
Modifier 4	Code used to identify the modifiers connected to the procedure code.
Status	This field will display the status of the claim
Rendering Prov	The identifier and service location for the performing provider.
FDOS	Date of first service on the claim
System	Indicates whether detail was added by system during claim's processing. Valid values Y - yes or N - no. generated.
POS	Code which indicates the location where service was rendered.
Diagnosis Ind	Indicates which diagnosis (or diagnoses) for which services were provided. Valid values are 1,2,3,4,5,6,7,8. One detail can be associated with a minimum of 1 diagnosis in the header or maximum of 8 diagnoses in the header for non-transportation claims only.
Tooth	The tooth number that identifies the tooth the provider rendered services on. An alpha indicates temporary teeth and numeric indicate permanent teeth.
Surface 1	Code which indicates the tooth surface of a particular tooth.
Surface 2	Code which indicates the tooth surface of a particular tooth.
Surface 3	Code which indicates the tooth surface of a particular tooth.
Surface 4	Code which indicates the tooth surface of a particular tooth.
Surface 5	Code which indicates the tooth surface of a particular tooth.
Billed Amount	Total billed amount. Format 999999.99
Allowed Amt	Amount allowed by the specific program (Medicaid, 590, and so on.) for the procedure. Format 9999999.99

Field	Description
TPL Amount	Third Party Liability. The amount paid by a third party for services, at the claim header level. Format 999999.99
Units Billed	The number of units billed by the provider
Units Allowed	The number of units allowed to the provider
Quadrant	The quadrant of the mouth that the procedure on the claim is related to.

STEP 3. To view the procedure code description, click on the record one time. This will auto-populate the information in the fields below the record.

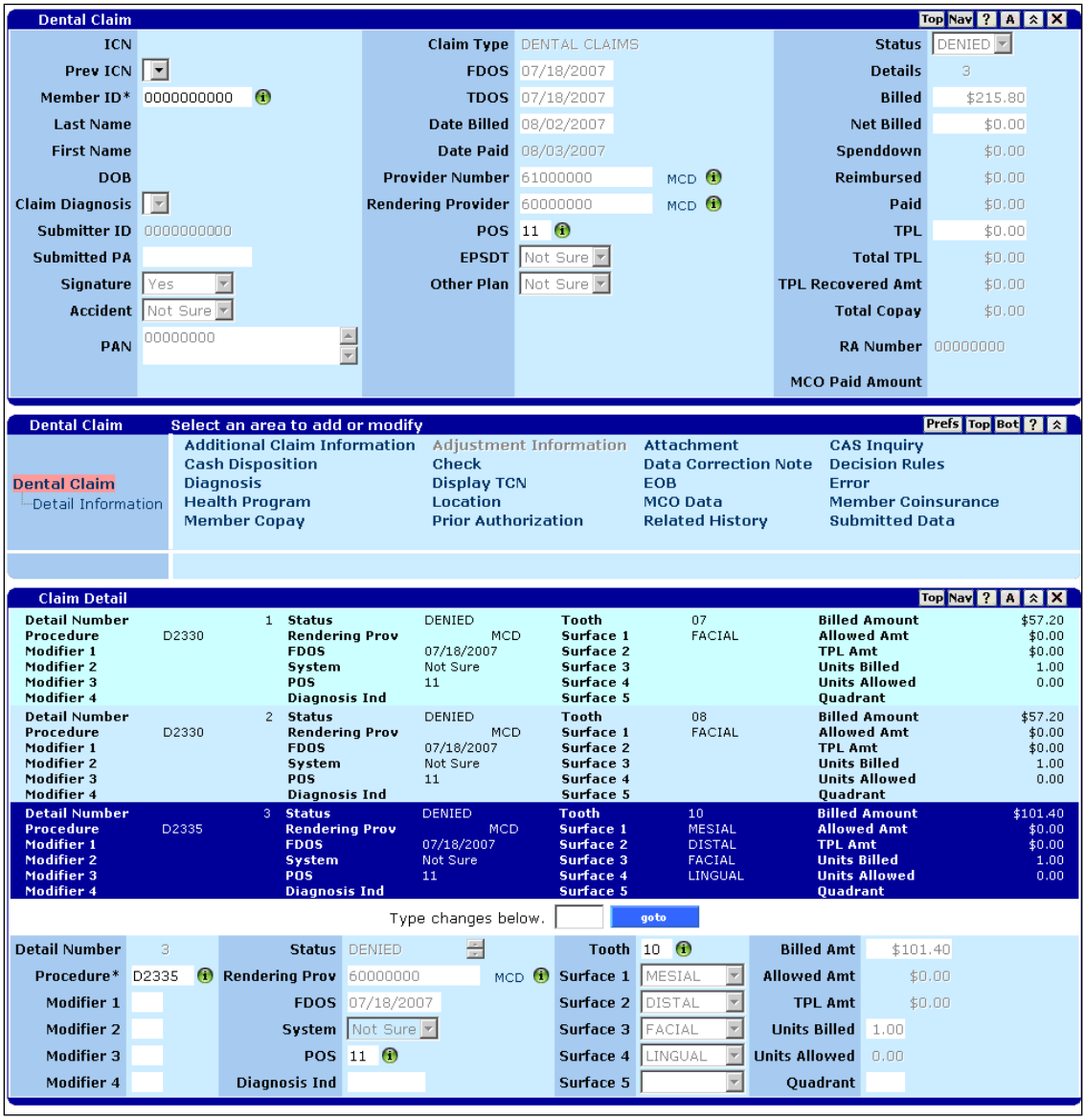


STEP 4. Click on the green "i" button. A pop-up window will appear, which is a link to the procedure code information page. This page will provide a description of the procedure code.



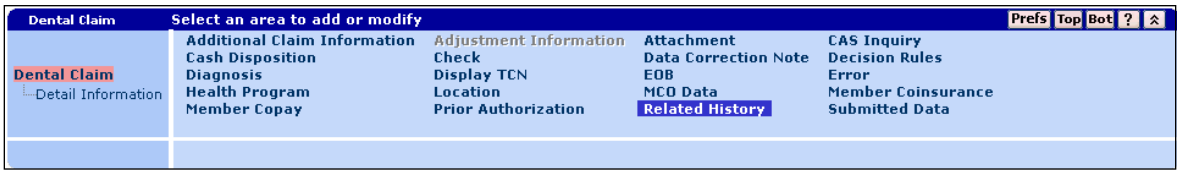
10.7.4 Viewing Claim Related History on Dental Claims

STEP 1. Access a Dental Claim Information Page.

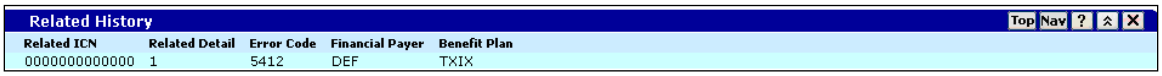


Dental Claim Information Page

STEP 2. Access the Dental Claim Maintenance Panel. Select the "Related History" link.



STEP 3. This will open the Related History panel.

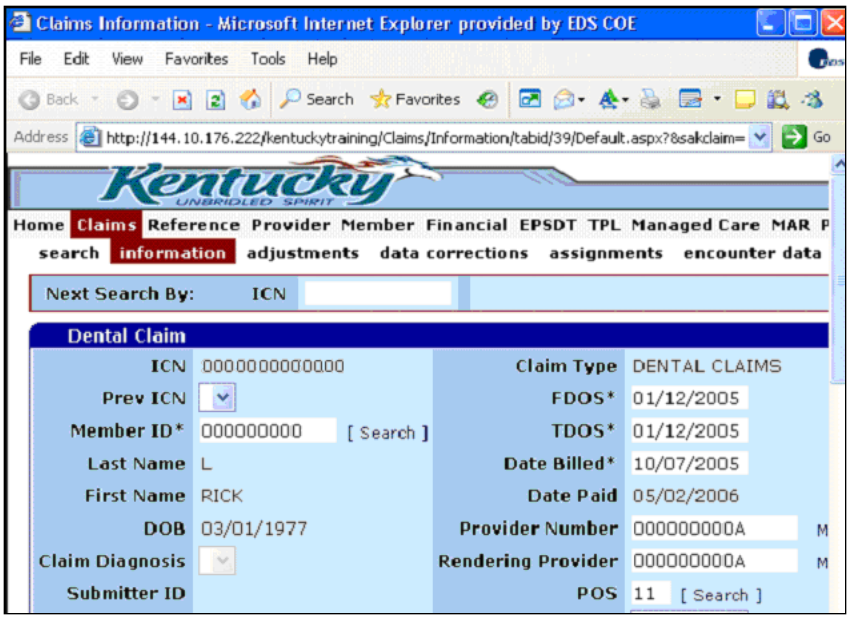


10.7.4.1 Claims/Information/Dental Claim/Related History Field Descriptions

Field	Description
Related ICN	Internal control number which uniquely identifies a claim.
Related Detail	Related detail information to the history claim displayed.
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system.
Financial Payer	The description used to identify the financial payer for the related ICN.
Benefit Plan	The medical assistance program associated with the related ICN.

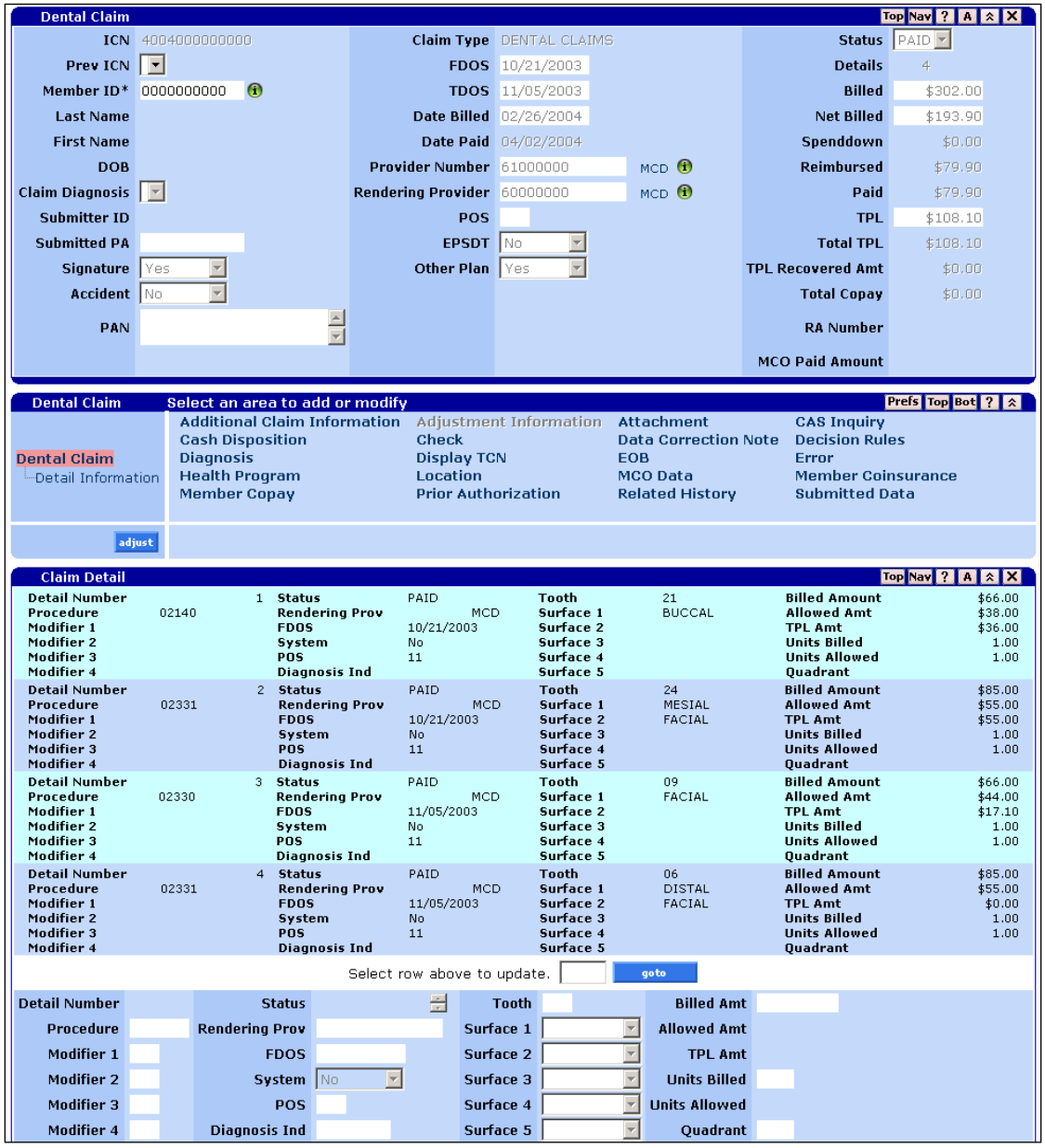
STEP 4. To view the detail information for the related claim, click on the record one time.

STEP 5. A pop-up window will appear, which is a link to the related Claim Information Page.



10.7.5 Viewing Check Information on Dental Claims

STEP 1. Access a Dental Claim Information Page.



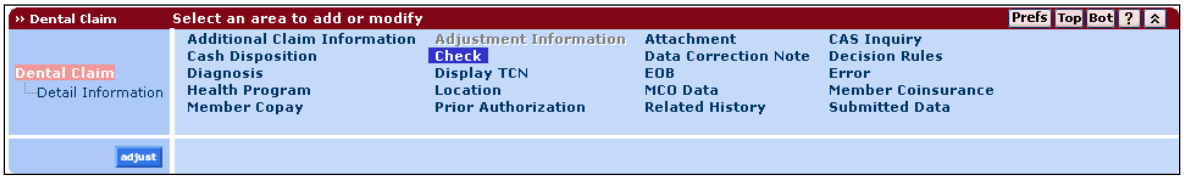
Dental Claim Information Page

10.7.5.1 Claims/Information/Dental Claims Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the other previous ICNs for the claim and view that information. The MCO Original ICN for an encounter claim. Not used on claims other than encounters.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID number. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.
First Name	The first name of the member associated with the Member ID number. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	A code for the condition requiring medical attention.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates the accident reason. It draws its drop down values from the T_ACCIDENT_TYPE table.
PAN	Identification for a member assigned by a provider. (Patient Account Number)
Claim Type	Indicates the type of claim.
FDOS	First Date of Service on the claim.
TDOS	Date of last service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The provider identification number and location that uniquely identifies the provider of services.
Rendering Provider	The Rendering provider identification number and location that uniquely identifies the provider of services.
POS	Place of Service where service was rendered.
EPSDT	Indicates whether claim is EPSDT.
Other Plan	Indicates if another form of insurance was used.

Field	Description
Status	This field displays the status of the claim.
Details	Indicates the number of detail service lines on the claim.
Billed	Amount of money requested for payment by a provider for services rendered.
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL and so on).
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives minus any state share amount (if applicable).
Paid	Amount paid on claim. Amount paid will be the allowed amount minus spend down, coinsurance, deductible, patient liability, dispensing fees, TPL, etc., as applicable depending on services. This value is computed by adding up all the AMT_PAID values on the related details.
TPL	Third Party Liability. The amount paid by a third party for services.
Total TPL	Total Third Party Liability. This is the sum of the copay amounts from Health Program panel records(T_CLM_PGM_XREF table).
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement panel.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records (T_CLM_PGM_XREF table).
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. Access the Dental Claim Maintenance Panel, which is the second panel. Select the "Check" link.



STEP 3. The check information is available to view.

» Check

Warrant Number	Issue Date	Pay To Provider	Total Paid Amount	Check Status	Fund Code	Benefit Plan
000000000	10/12/2006	000000000H	$47.00	I Warrant Issued	A	Title 19
000000000	10/12/2006	000000000H	$47.00	I Warrant Issued	A	Title 19
000000000	10/12/2006	000000000H	$47.00	I Warrant Issued	A	Title 19
000000000	10/12/2006	000000000H	$47.00	I Warrant Issued	A	Title 19
000000000	10/12/2006	000000000F	$15.00	I Warrant Issued	A	Title 19
000000000	10/12/2006	000000000F	$15.00	I Warrant Issued	A	Title 19
000000000	10/12/2006	000000000H	$15.00	I Warrant Issued	A	Title 19
000000000	10/12/2006	000000000H	$15.00	I Warrant Issued	A	Title 19
000000000	10/12/2006	000000000A	$9.80	I Warrant Issued	A	Title 19
000000000	10/12/2006	000000000A	$47.00	I Warrant Issued	A	Title 19
Total:			$642,516.28			

1 2 3 4 5 6 7 8 9 10 ... Next >

Check Panel

10.7.5.2 Claims/Information/Dental Claim/Check Panel Field Descriptions

Field	Description
Warrant Number	The number of the check that the provider received, or the number of the Electronic Funds Transfer.
Issue Date	The date when the check was issued or the EFT was sent.
Pay To Provider	The Provider ID who received the check or EFT.
Total Paid Amount	The total amount that was issued to the provider.
Check Status	The status of the check. Examples are: An 'I' would indicate the check has been issued, a 'V' indicates a VOID, an 'R' indicates the check was reissued, a 'C' indicates a check has CLEARED the bank, an 'S' indicates Stopped and an 'X' for Cancelled by Statute.
Fund Code	The Fund Code assigned to the check or EFT.
Benefit Plan	The Benefit Plan associated with the check or EFT.

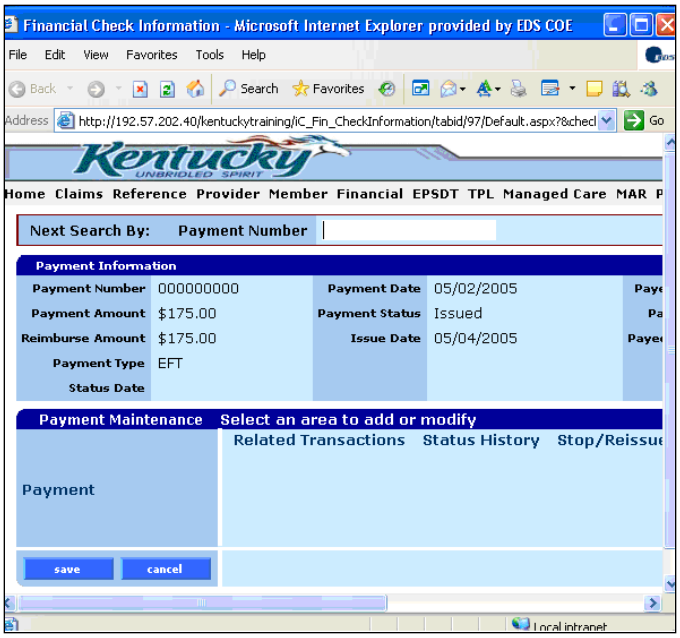
STEP 4. To view the detail information for the check, search for the warrant number that relates to the claim. Click on the record one time.

Check

Warrant Number	Issue Date	Pay To Provider	Total Paid Amount	Check Status	Fund Code	Benefit Plan
0000000000	8/12/2006	000000000A	$100.00	I Warrant Issued	D	Title 19
0000000000	3/31/2005	000000000A	$100.00	I Warrant Issued	H	Title 19
0000000000	11/3/2006	000000000A	$100.00	I Warrant Issued	A	Title 19
0000000000	8/17/2006	000000000A	$100.00	I Warrant Issued	A	Title 19
0000000000	5/4/2005	000000000A	$100.00	I Warrant Issued	C	Title 19
0000000000	3/26/2005	000000000A	$99.30	I Warrant Issued	H	Title 19
0000000000	3/31/2005	000000000A	$99.00	I Warrant Issued	C	Title 19
0000000000	4/27/2005	000000000A	$99.00	S	G	Title 19
0000000000	7/12/2005	000000000A	$99.00	I Warrant Issued	G	Title 19
0000000000	3/3/2006	000000000A	$99.00	I Warrant Issued	H	Benefit Plan independent
Total:			$642,516.28			

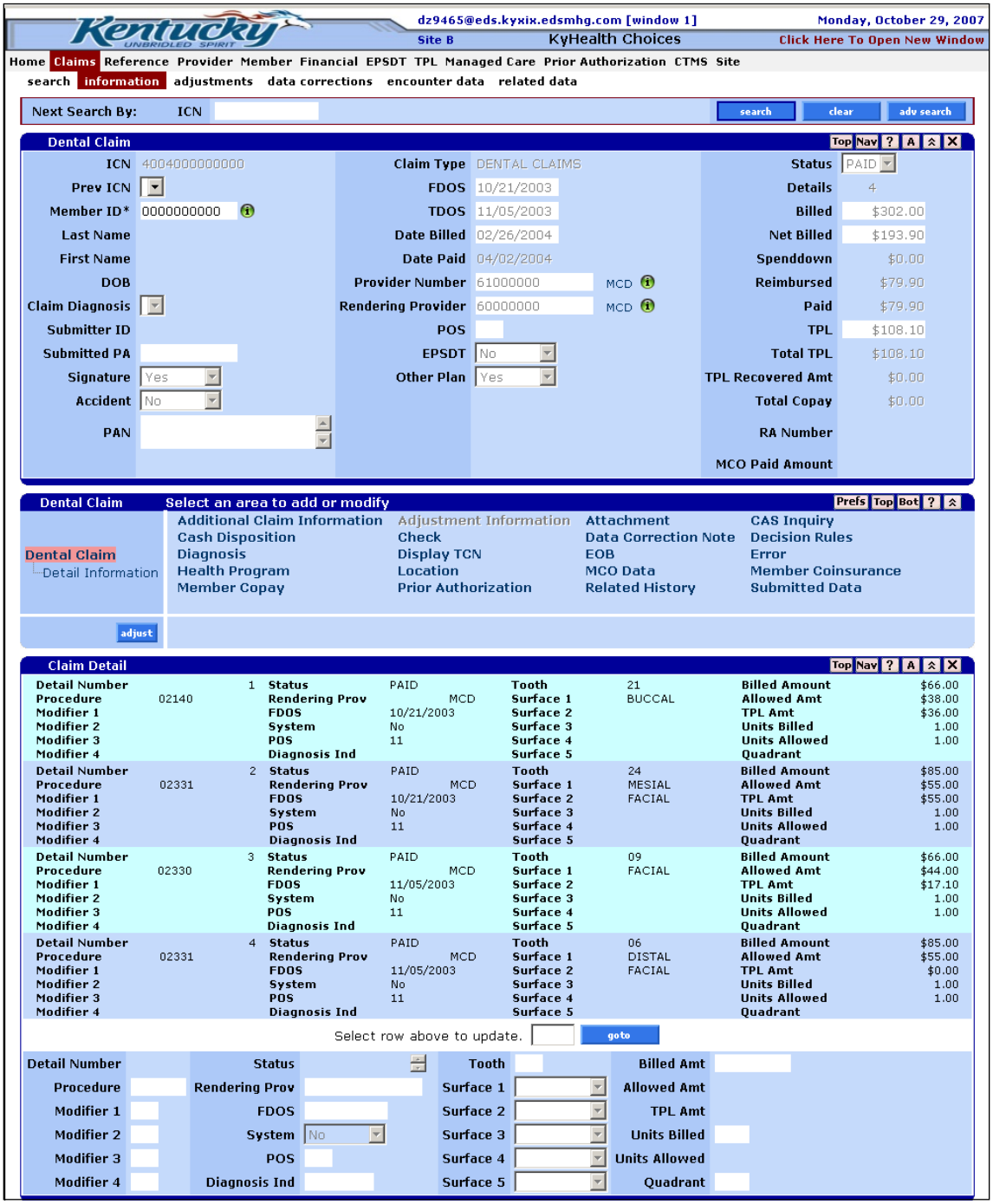
< Previous ... 51 52 53 54 55 56 57 58 59 60 ... Next >

STEP 5. A pop-up window will appear, which is a link to the related Payment Information Page.


Financial Check Information - Microsoft Internet Explorer provided by EDS COE
File Edit View Favorites Tools Help
Back Search Favorites
Address http://192.57.202.40/kentuckytraining/iC_Fin_CheckInformation/tabid/97/Default.aspx?&checl
Go
Kentucky
UNBRIDLED SPIRIT
Home Claims Reference Provider Member Financial EPSDT TPL Managed Care MAR
Next Search By: Payment Number
Payment Information
Payment Number 000000000
Payment Date 05/02/2005
Payment Amount $175.00
Payment Status Issued
Reimburse Amount $175.00
Issue Date 05/04/2005
Payment Type EFT
Status Date
Payment Maintenance Select an area to add or modify
Related Transactions Status History Stop/Reissue
Payment
save cancel
Local intranet

10.7.6 Viewing Health Program Information on Dental Claims

STEP 1. Access a Dental Claim Information Page.



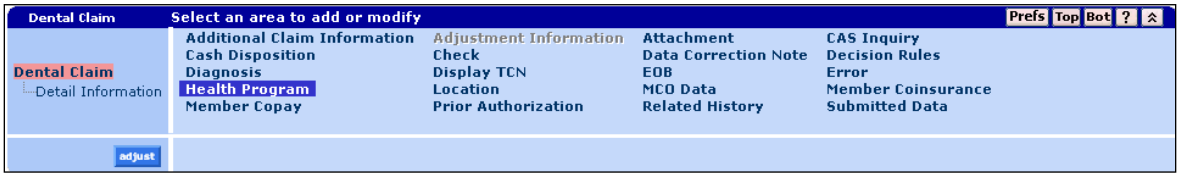
Dental Claim Information Page

10.7.6.1 Claims/Information/Dental Claims Panel Field Descriptions

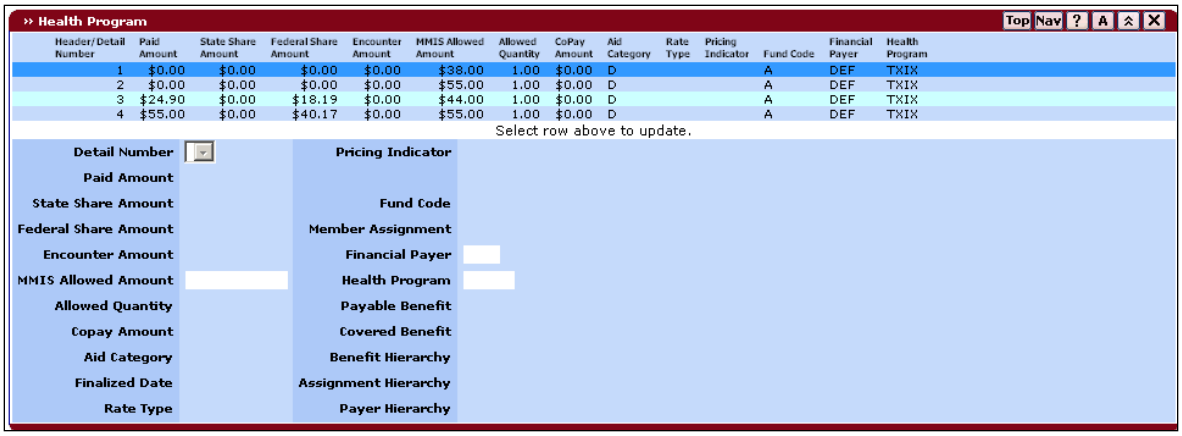
Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the other previous ICNs for the claim and view that information. The MCO Original ICN for an encounter claim. Not used on claims other than encounters.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID number. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.
First Name	The first name of the member associated with the Member ID number. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	A code for the condition requiring medical attention.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates the accident reason. It draws its drop down values from the T_ACCIDENT_TYPE table.
PAN	Identification for a member assigned by a provider. (Patient Account Number)
Claim Type	Indicates the type of claim.
FDOS	First Date of Service on the claim.
TDOS	Date of last service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The provider identification number and location that uniquely identifies the provider of services.
Rendering Provider	The Rendering provider identification number and location that uniquely identifies the provider of services.
POS	Place of Service where service was rendered.
EPSDT	Indicates whether claim is EPSDT.

Field	Description
Other Plan	Indicates if another form of insurance was used.
Status	This field displays the status of the claim.
Details	Indicates the number of detail service lines on the claim.
Billed	Amount of money requested for payment by a provider for services rendered.
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL and so on).
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives minus any state share amount (if applicable).
Paid	Amount paid on claim. Amount paid will be the allowed amount minus spend down, coinsurance, deductible, patient liability, dispensing fees, TPL, etc., as applicable depending on services. This value is computed by adding up all the AMT_PAID values on the related details.
TPL	Third Party Liability. The amount paid by a third party for services.
Total TPL	Total Third Party Liability. This is the sum of the copay amounts from Health Program panel records(T_CLM_PGM_XREF table).
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement panel.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records (T_CLM_PGM_XREF table).
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

STEP 2. Access the Dental Claim Maintenance Panel. Select the “Health Program” link.



STEP 3. The Health Program Panel is available to view.



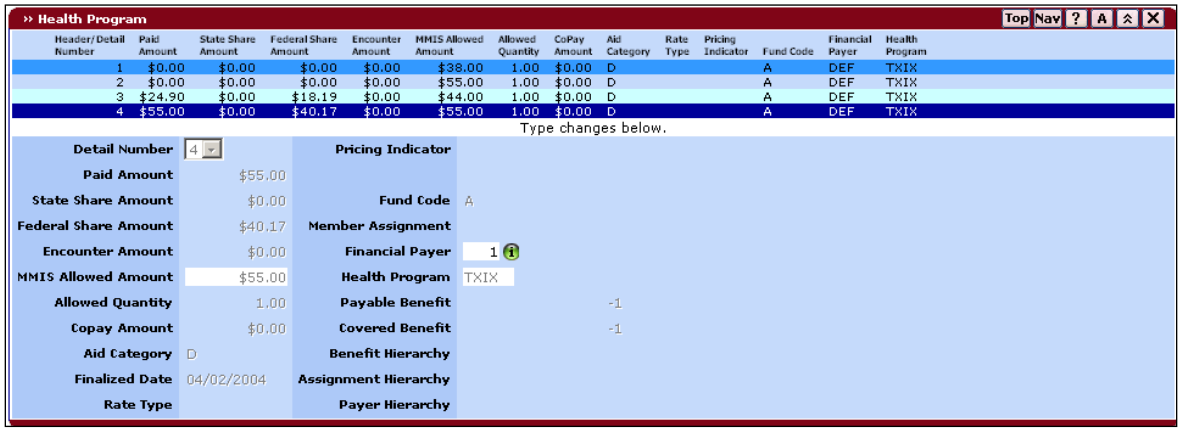
Health Program Panel

10.7.6.2 Claims/Dental Claims/Health Program Panel Field Descriptions

Field	Description
Detail Number	Indicates if the row pertains to the claim header or a claim detail line. The claim header is denoted by a zero.
Paid Amount	The amount that is applied toward the check amount.
State Share Amount	The amount that is applied toward the check amount.
Federal Share Amount	The amount of federal share for this payment.
Encounter Amount	Contains amount for encounter services on claim detail indicated by detail number on table.
Allowed Amount	Amount *KY Medicaid* would pay on given detail information.
Allowed Quantity	Number of units *KY Medicaid* would pay on given procedure code and date span.
Co-pay Amount	The amount of co-pay that is subtracted from the allowed amount.
Aid Category	Aid Category for *KY Medicaid* coverage.
Finalized Date	Date financial finalizes claim for Payer.
Rate Type	Code used to identify rate type to use in determining provider reimbursement.
Pricing Indicator	Pricing indicator which dictates method by which procedure must be priced or indicates how claim detail was priced.
Managed Care Indicator	Identifies claims and or transactions and how they affect the managed care program.
Fund Code	Indicates the budget category funds used to pay claim/detail.

Field	Description
Member Assignment	Group of covered services (benefits) where member is assigned to provider or provider organization in order to receive covered services (benefits).
Financial Payer	Description of financial payer.
Health Program	Name of program from which the header/detail was processed and/or paid.
Payable Benefit	Unique system-assigned that identifies each row on this table.
Covered Benefit	System-assigned key used to identify unique row for benefit covered by member plan. Identifies row to be ignored for benefit.
Benefit Hierarchy	Assignment hierarchy is an ordered set of assignment plans which member/beneficiary may be assigned concurrently. For example, a beneficiary may be assigned to PCP and Health Community Based Services agency at overlapping periods of time.
Assignment Hierarchy	Set of assignment plans for which member/beneficiary may be assigned concurrently.
Payer Hierarchy	Payer Hierarchy identifies order of processing of financial payers, benefit plans, or assignment plans for beneficiaries who are enrolled in multiple entities.

STEP 4. To view additional details about the Health Program, click on the record one time. This will auto-populate the information in the fields below the record.



11 Appendix D – How To Correct Data on Claims

11.1 Data Correcting a Physician Claim

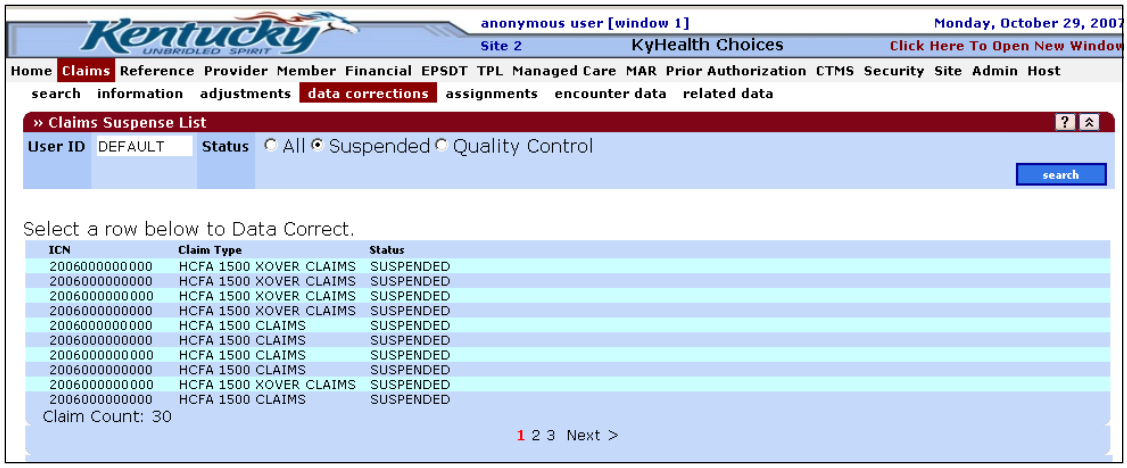
11.1.1 Accessing the Data Correction Page

STEP 1. Access interChange.

STEP 2. Select Claims from the main menu.

STEP 3. Select "Data Corrections" from the Claims sub-menu.

STEP 4. Enter a User ID in the "User ID" field and click the blue "Search" button. Claims assigned to the user ID will appear on the Claims Suspense List Panel.



Claims Suspense List Panel

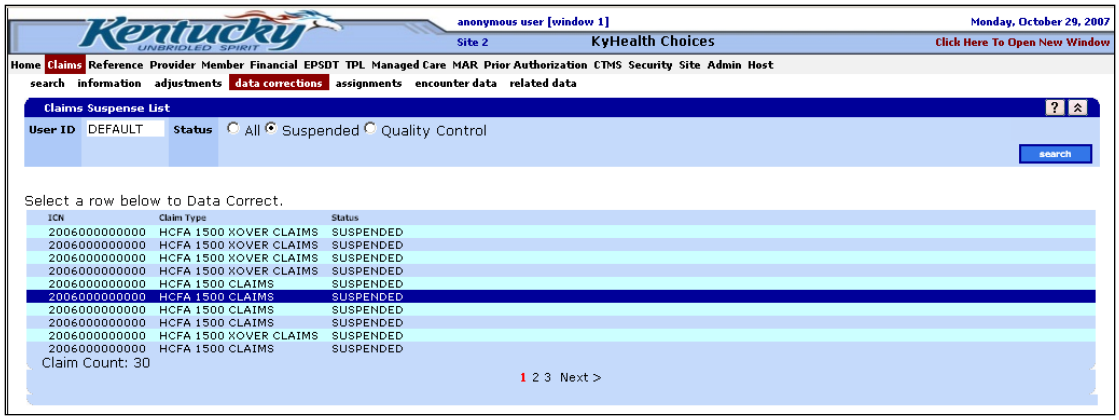
11.1.1.1 Claims Suspense List Panel Field Descriptions

Field	Description
User ID	The ID of the user to whom the claims have been assigned.
Status	The status of the claim within the system.
ICN	Internal control number (ICN) which uniquely identifies a claim.
Claim Type	Description of the type of claim.
Status	The status of the claim within the system.

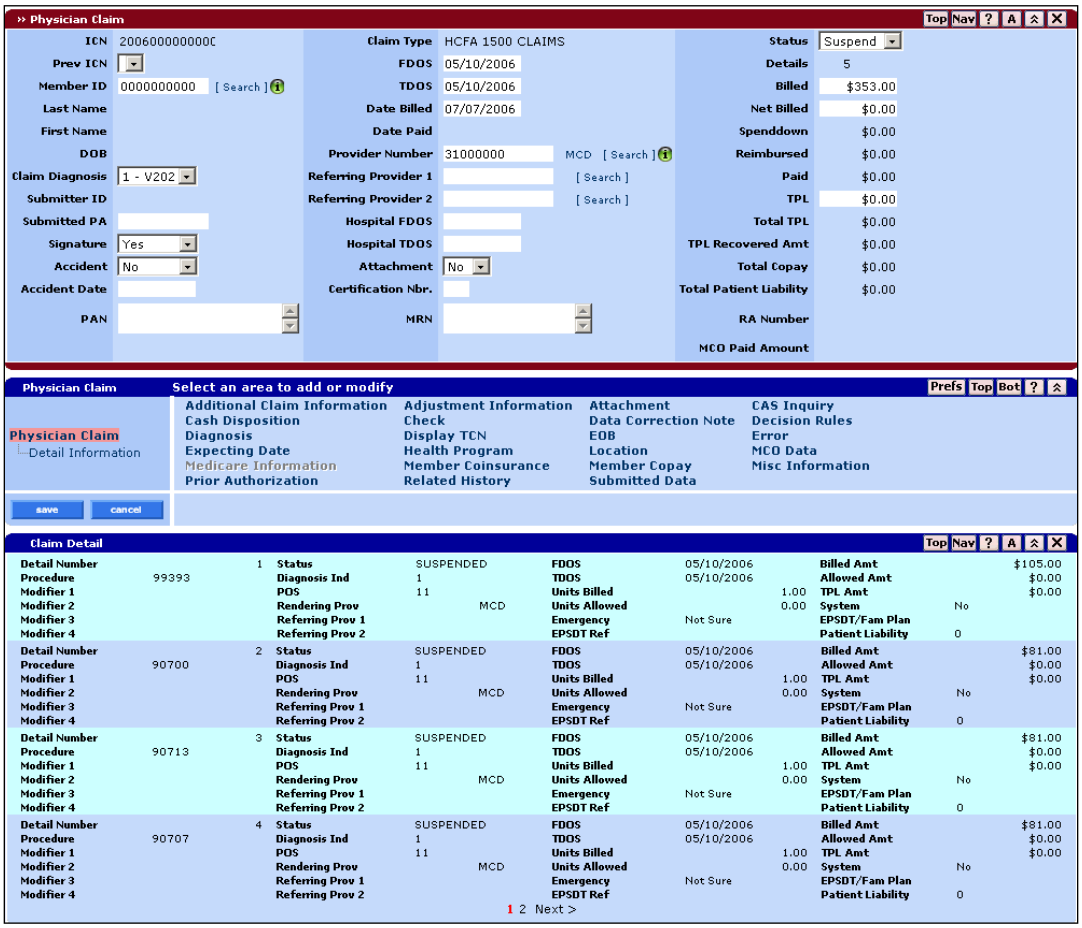
11.1.1.2 Claims Suspense List Panel Button Descriptions

Button	Description
Search	Performs a query on the database and returns the data for the entered search criteria.

STEP 5. Select a claim by clicking the record one time. This will open the Physician Claim Data Correction Page.



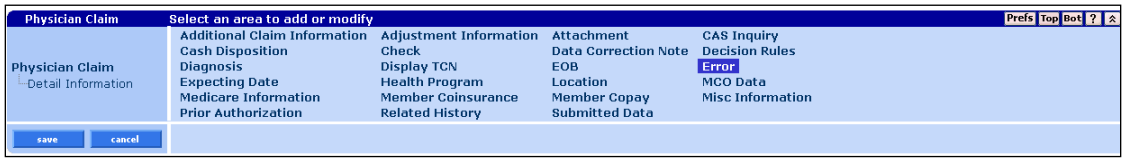
The claim will open.



Physician Claim Data Correction Page

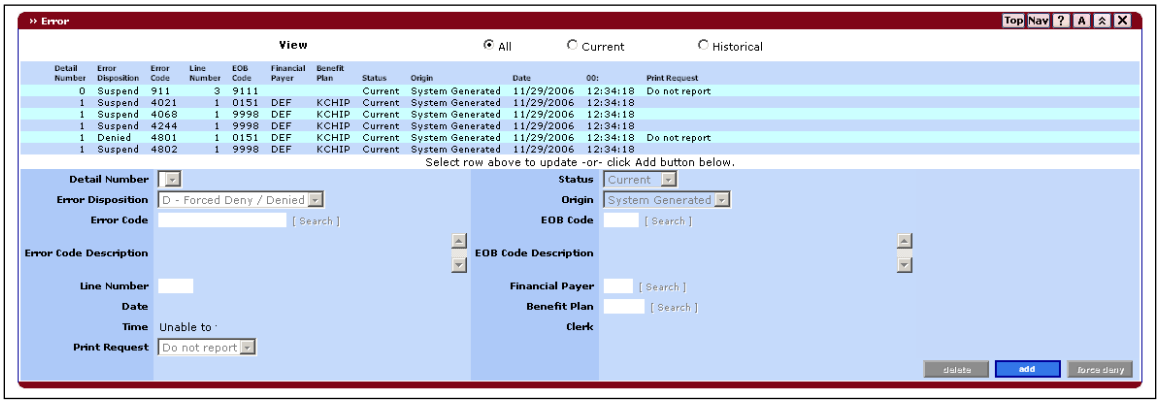
11.1.2 Determining Why a Claim is Suspended

STEP 6. Before you correct a claim, you must determine why the claim is suspended. To do this, open the Error panel by clicking "Error" on the Claim Maintenance Panel.



Physician Claim Maintenance Panel

STEP 7. The Error Code panel will open. Select the error record by clicking on the record one time.



Error Code Panel

11.1.2.1 Physician Claim/Error Panel Field Descriptions

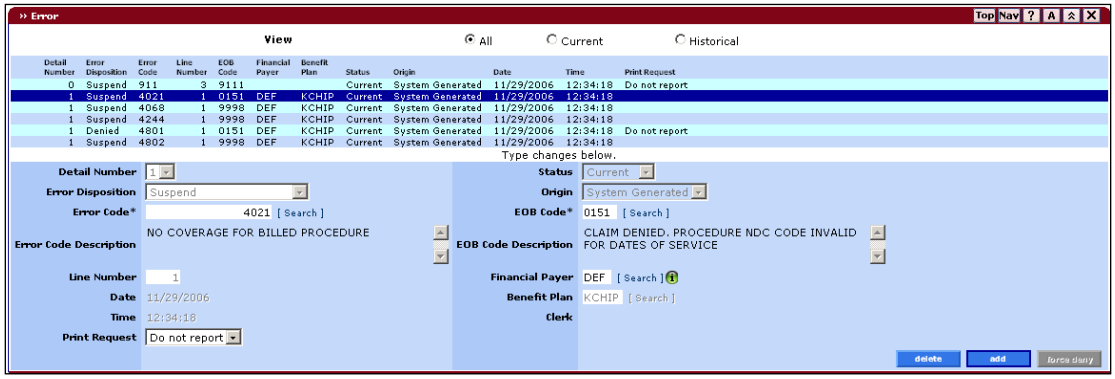
Field	Description
View	Select one from All, Current or Historical.
Detail Number	The number of the header or detail that contains an edit or an audit failure.
Error Disposition	Code that represents the action that is taken on a claim at disposition time: pay (P), deny (D), suspend (S), force override (F), reject (J), or batch suspend (B).
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit.
Error Code Description	Description of indicated error.
Line Number	Line of individual error or EOB.

Field	Description
Date	Date of the error code.
Time	Time of the error code.
Print Request	The valid values are: Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report.
Status	Indicates whether the Errors are current or history.
Origin	Indicates who generated the error code and message.
EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it.
EOB Code Description	Description of indicated EOB.
Financial Payer	A value that identifies a unique payer within interChange.
Benefit Plan	Identifies the medical assistance program that is supported in the system. Use the [Search] panel to select a valid plan.
Clerk	Number used to identify user who last updated error record.

11.1.2.2 Physician Claim/Error Panel Button Descriptions

Button	Description
Add	Add a new record.
Delete	Delete a record.

The error record information will populate in the fields below.



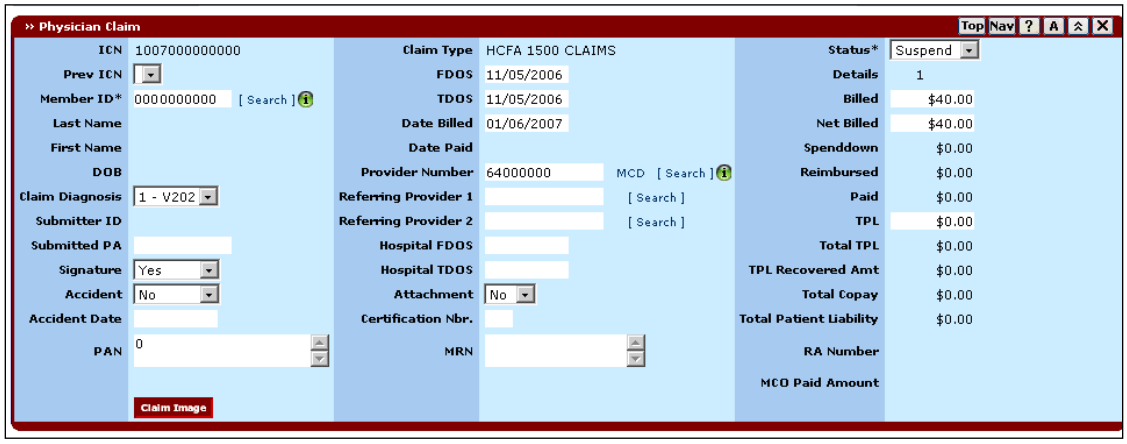
Error Code Panel with Populated Information

STEP 8. Review all the error records by clicking on each error record row. Each time a row is clicked, the information will populate in the fields below.

11.1.3 Viewing the Image of a Paper Claim

To determine if the data from a paper claim is correctly entered into interChange, you must compare the paper claim image in OnBase to the claim information in interChange.

STEP 9. Access the Physician Claim panel. Click the blue "Claim Image" button.



Physician Claim Panel

11.1.3.1 Physician Claim Panel Field Descriptions

Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the claim's prior ICNs and obtain information on them.
Member ID	Member's unique *KY Medicaid* ID number.
Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number the first three characters of the last name that was keyed will be displayed.
First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number the first character of the first name that was keyed will be displayed.
DOB	Date of Birth on record for member.
Claim Diagnosis	Code used to identify the primary or other diagnoses.

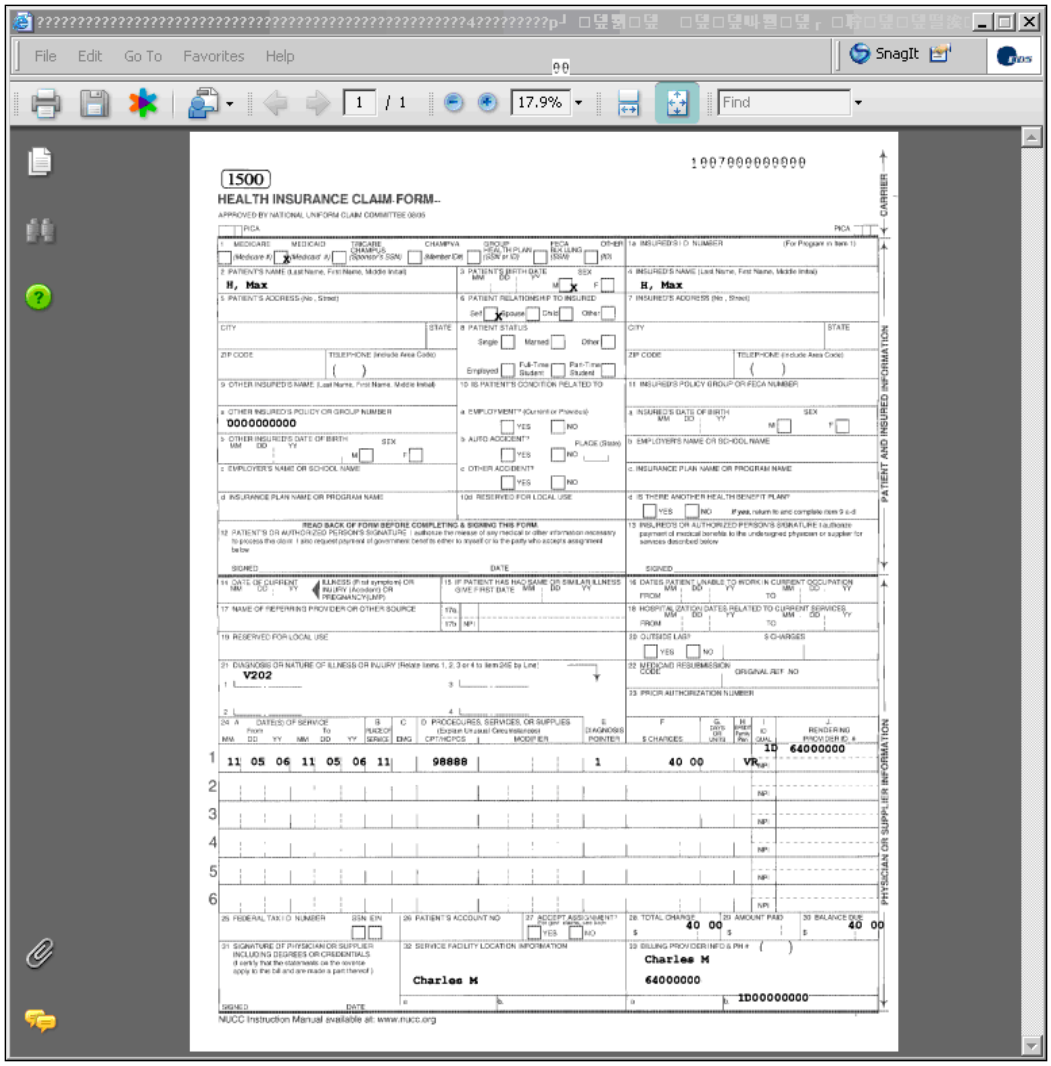
Field	Description
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization Number submitted with claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates whether the service performed was as a result of an accident.
Accident Date	Date of accident.
PAN	Patient's unique identification number assigned by the provider to track the patient's financial records.
Claim Type	Indicates the type of claim.
FDOS	Beginning date of service on the claim.
TDOS	Ending date of service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid. This will not be populated for Suspended claims.
Provider Number	The pay to provider identification number.
Referring Provider 1	The license number of the referring physician and location other than the attending physician.
Referring Provider 2	The license number of the second referring physician other than the attending physician . The unique provider. number of the provider who referred the patient for this service.
Hospital FDOS	First date hospitalized.
Hospital TDOS	Last date hospitalized.
Attachment	Indicates whether an attachment is present.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing the Medical Record Number.
Status	The status of the claim.
Details	The number of detail service lines on the claim.
Billed	Amount requested by the provider for services rendered.
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL and so on).

Field	Description
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives. Format 9999999.99. This field will not be populated for Suspended claims.
Paid	Amount paid on claim. This value is computed by adding up all the AMT_PAID values for the related details. Format 999999.99.
TPL	Amount paid by third party for services, at the claim header level.
Total TPL	This is the sum of the copay amounts from Health Program panel records(T_CLM_PGM_XREF table). Format 9999999.99
TPL Recovered Amt	The casualty case recovery amount populated from the Settlement window. Format 9999999.99. This field will not be populated for Suspended claims.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records(T_CLM_PGM_XREF table). Format 9999999.99.
Total Patient Liability	The amount of patient liability applied to this claim.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles. This field will not be populated for Suspended claims.
MCO Paid Amount	Managed Care Organization Paid Amount.

11.1.3.2 Physician Claim Panel Button Descriptions

Button	Description
Claim Image	To View the Claim Image from the Onbase System. This button will be visible only for paper claims.

The scanned image of the claim will display.



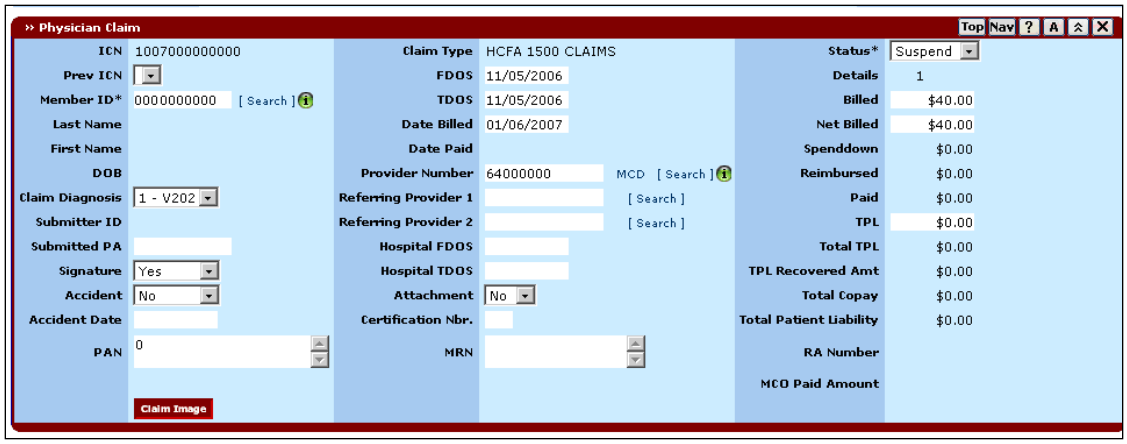
Paper Claim Image in OnBase

STEP 10. Compare the image to the interChange file. If the claim information in interChange does NOT match the claim image in OnBase, correct the claim.

11.1.4 Correcting the Claim Header Information

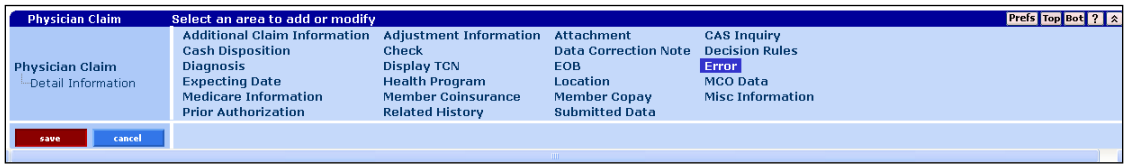
The Physician Claim Panel contains claim header information. Therefore, if a correction is to be made to the claim header, then you will edit the Physician Claim Panel.

STEP 11. The Physician Claim Panel will be active. Edit the information.

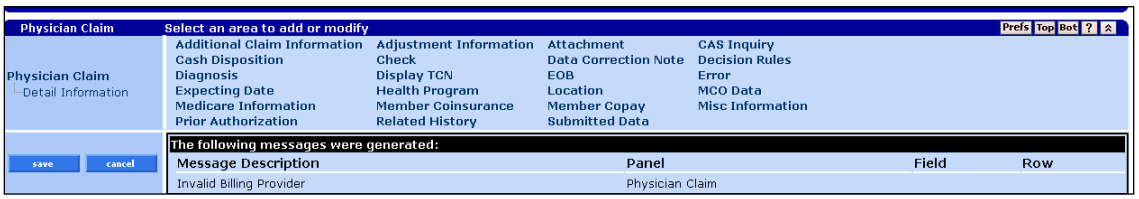


Physician Claim Panel

STEP 12. Click the "Save" button on the Physician Claim Maintenance Panel.

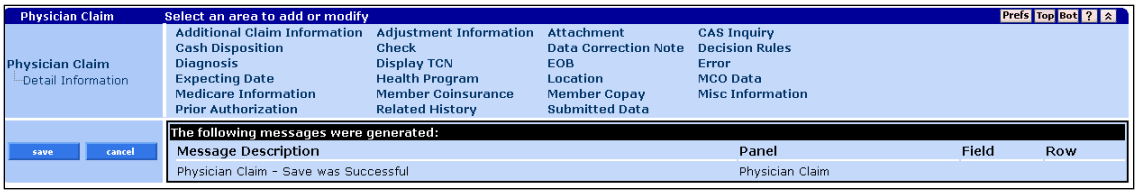


STEP 13. If the save was not successful, an error message will appear. Correct the error(s) as indicated in the Error Message box.



Error Message

STEP 14. Click "save" again. If the save was successful, a "save was successful" message will appear.

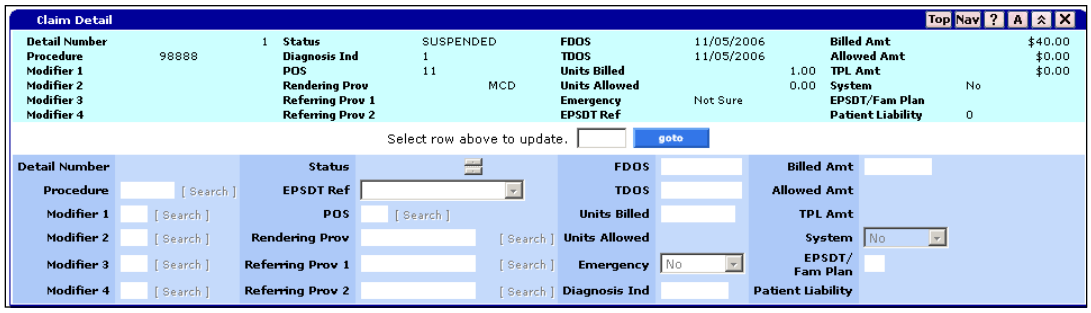


Save was Successful Message

11.1.5 Correcting Detail Information

The detailed lines of information in a claim are contained within the Claim Detail Panel. Therefore, if a correction is to be made to the claim detail information, then you will edit the Claim Detail Panel.

STEP 15. Access the Claim Detail Panel.



11.1.5.1 Physician Claim Detail Panel Field Descriptions

Field	Description
Detail Number	The number of the detail on a claim record.
Procedure	System-assigned key for a procedure code on a detail which indicates the service that was provided.
Modifier 1	Code used to identify the modifiers connected to the procedure code.
Modifier 2	Code used to identify the modifiers connected to the procedure code.
Modifier 3	Code used to identify the modifiers connected to the procedure code.
Modifier 4	Code used to identify the modifiers connected to the procedure code.
Status	Detail adjudication status.
Diagnosis Ind	Indicates which diagnosis (or diagnoses) for which services were provided. Valid values are 1,2,3,4 for paper claims and 1-8 for electronic claims.
POS	Place of Service where service was rendered.
Rendering Prov	The rendering provider identification number and location that uniquely identifies the provider of services.
Referring Prov1	Provider Identification Number that uniquely identifies the referring provider and location that uniquely identifies the provider of services.
Referring Prov2	Provider Identification Number that uniquely identifies the referring provider and location that uniquely identifies the provider of services.
FDOS	Date on which service was first provided.
TDOS	Last service date.

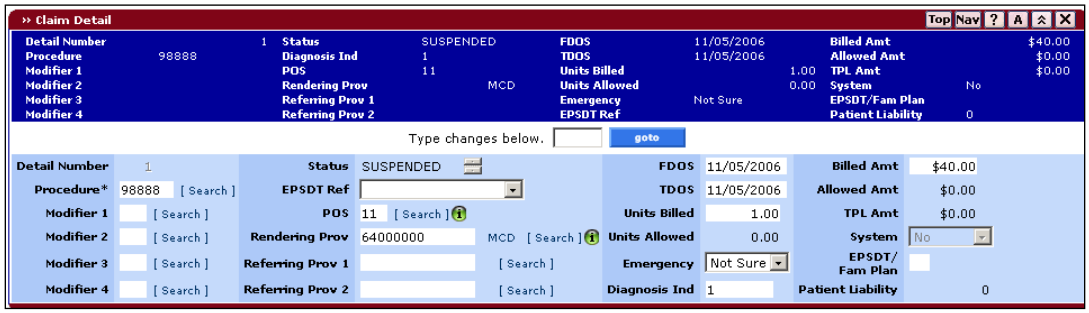
Field	Description
Units Billed	Number of units billed for detail procedure.
Units Allowed	Number of units that can be billed for particular detail procedure code for given date span.
Emergency	Indicates whether service was provided as result of emergency situation.
EPSDT Ref	EPSDT referral/treatment information
Billed Amt	Amount billed for detail line.
Allowed Amt	Amount KyHealthChoices would reimburse given detail line information.
TPL Amt	Amount paid on detail line by primary insurance payer, not Medicare.
System	Indicates whether detail was added by system during claim's processing.
EPSDT/Fam Plan	Code from HCFA 1500 claim form blocks 24 H indicating EPSDT or Family Planning.
Patient Liability	The amount of patient liability applied to this claim.

11.1.5.2 Physician Claim Detail Panel Button Descriptions

Button	Description
Go To	Allows the user to view a specific detail.
Add	Allows the user to add a detail record.
Delete	Allows the user to delete a detail record.

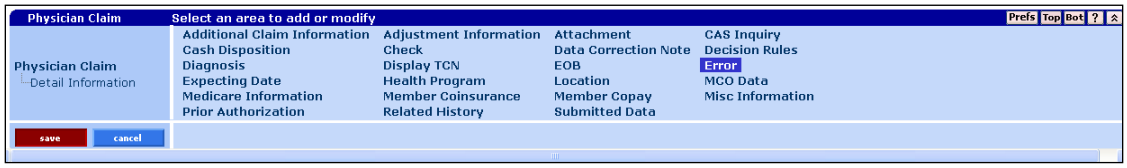
STEP 16. The detail rows are displayed in alternating colors of light green and light blue. And, each line is numbered. Select the detail line by clicking one time anywhere within the row.

The selected row will turn dark blue. Information from that row will populate in the fields below.



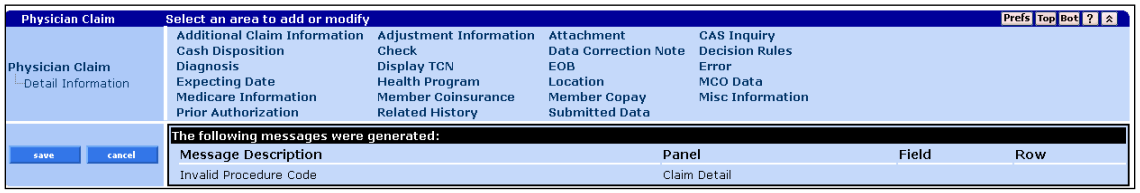
STEP 17. Edit the information in the white field boxes. To edit another detail row, repeat step 14 and edit the information.

STEP 18. Click the "save" button on the Physician Claim Maintenance Panel.



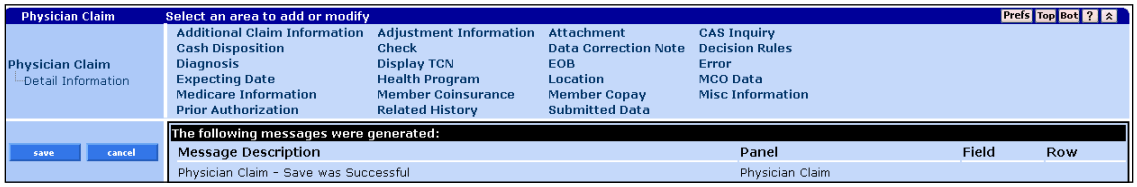
Physician Claim Maintenance Panel

STEP 19. If the save was not successful, an error message will appear. Correct the error(s) as indicated in the Error Message box.



Error Message

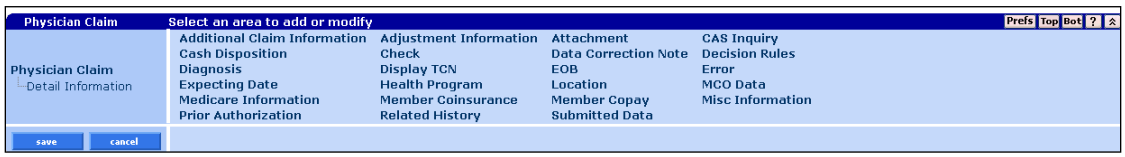
STEP 20. Click "Save" again. If the save was successful, a "Save was Successful" message will appear.



Save was Successful Message

11.1.6 Correcting Information in Other Panels

Some panels contain data-correctable information. The links to these other panels appear on the Physician Claim Maintenance Panel.



The following panels contain data-correctable information:

Data Correction Note

Detail EOB

Detail Error

Detail Health Program

Diagnosis

EOB

Error

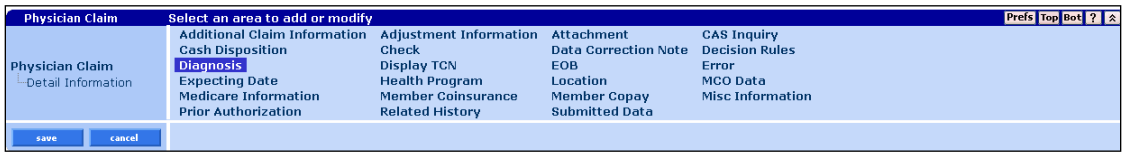
Health Program

Location

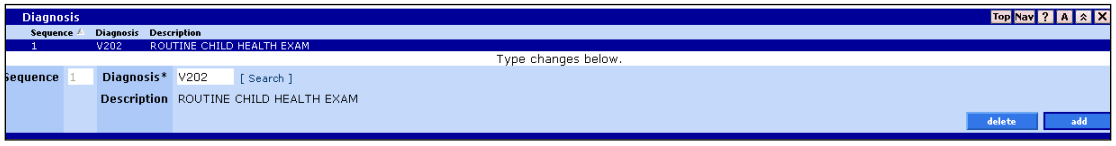
Medicare Information

Misc Information

STEP 21. Access the Physician Claim Maintenance Panel. Select a panel by clicking the link one time.



The panel will display.



Diagnosis Panel

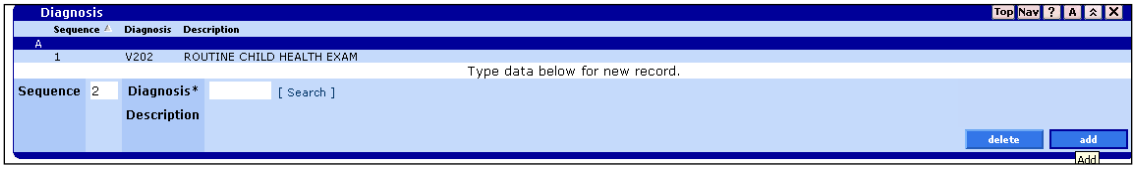
11.1.6.1 Physician Claim/Diagnosis Panel Field Descriptions

Field	Description
Sequence	Sequence numbers for the diagnosis codes. For UB92 claims, the Admiting diagnosis will have a value of 'A' in the Sequence column and Emergency diagnosis will have an 'E' in the Sequence column. For all claim types, Primary diagnosis will have a value of '1'. Other diagnosis codes will have a value of '2' through '24'.
Diagnosis	Indicates the diagnosis codes applicable to the claim. Diagnosis code is a code for the condition requiring medical attention.
Description	Description of the diagnosis code.

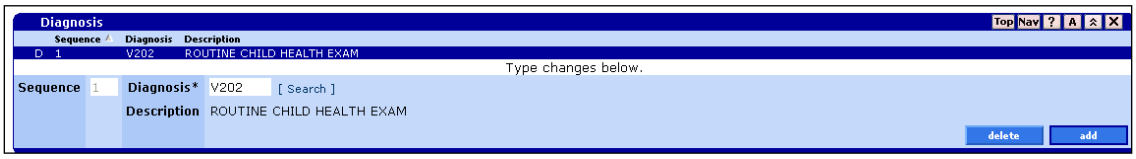
11.1.6.2 Physician Claim/Diagnosis Panel Button Descriptions

Button	Description
Add	Add a diagnosis code.
Delete	Delete a diagnosis code.

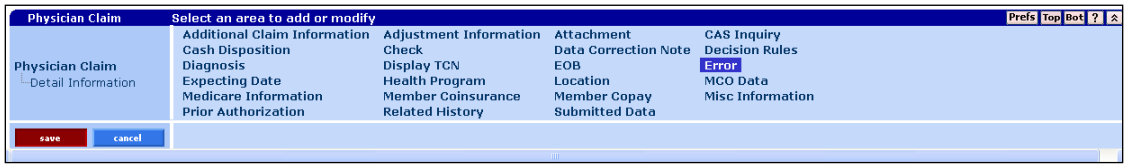
STEP 22. To edit a current record, click the record row one time. The record information will populate in the fields below. Edit the information in the white field boxes.



STEP 24. To delete a current record, select the record by clicking on the row once. Click the "delete" button.

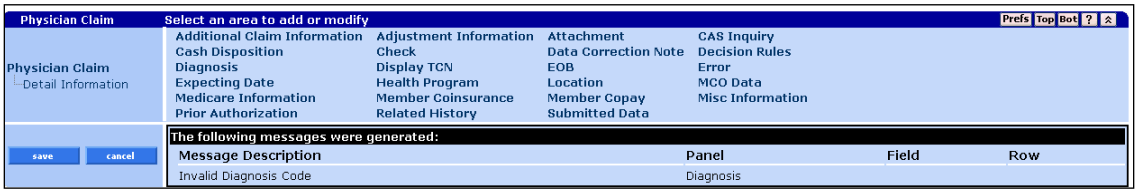


STEP 25. To save changes to the panel, click the "save" button on the Physician Claim Maintenance Panel.



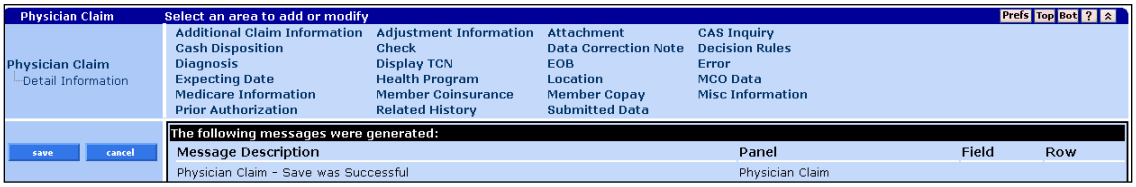
Physician Claim Maintenance Panel

STEP 26. If the save was not successful, an error message will appear. Correct the error(s) as indicated in the Error Message box.



Error Message

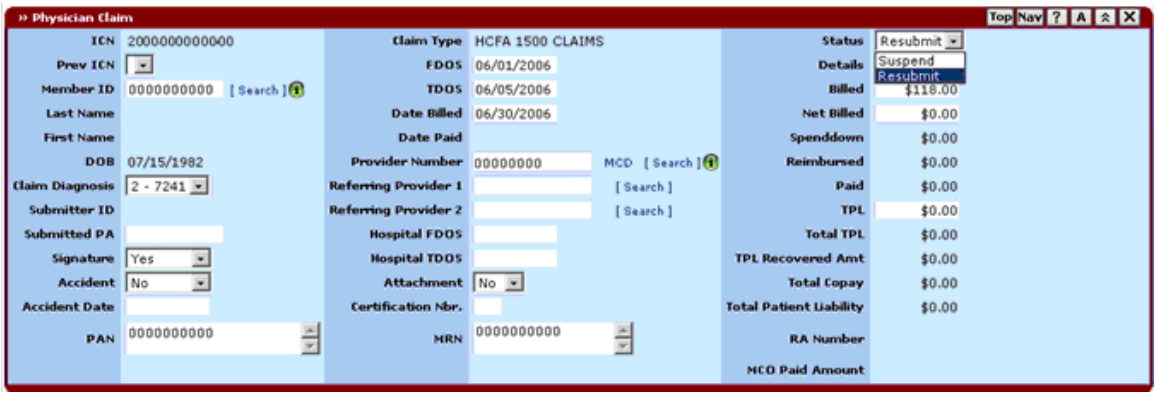
STEP 27. Click "Save" again. If the save was successful, a "Save was Successful" message will appear.



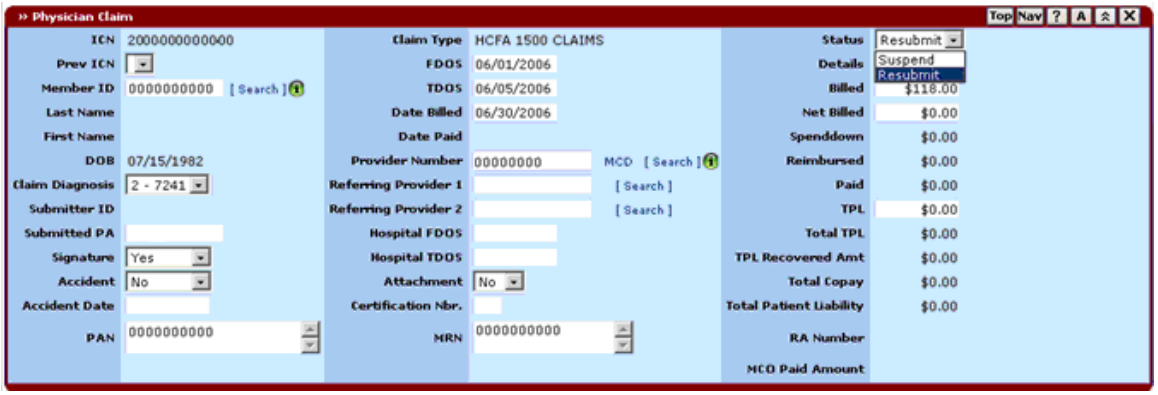
Save was Successful Message

11.1.7 Resubmitting Corrected Claims

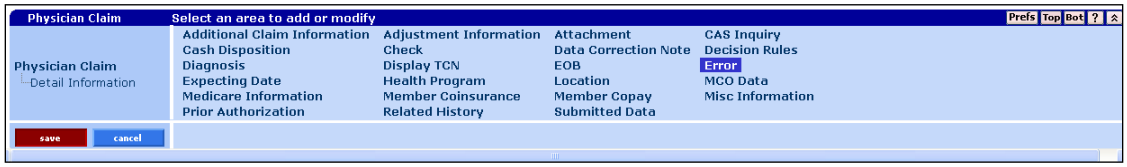
STEP 28. After the claim is corrected, it must be resubmitted for processing. Access the Physician Claim panel. In the "Status" field, there is a drop down box.



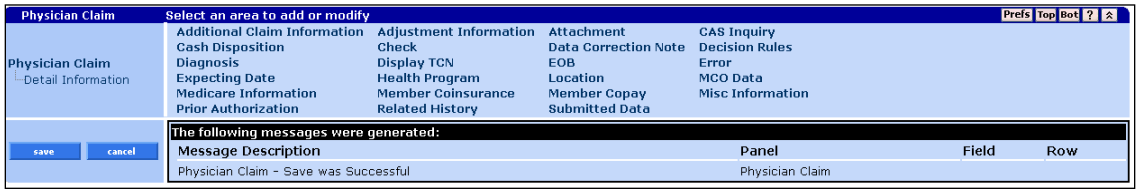
STEP 29. Change the status to "Resubmit".



STEP 30. Click “Save” on the Maintenance Panel.



STEP 31. A “Save was Successful” message will appear.



11.2 Data Correcting a UB92 Claim

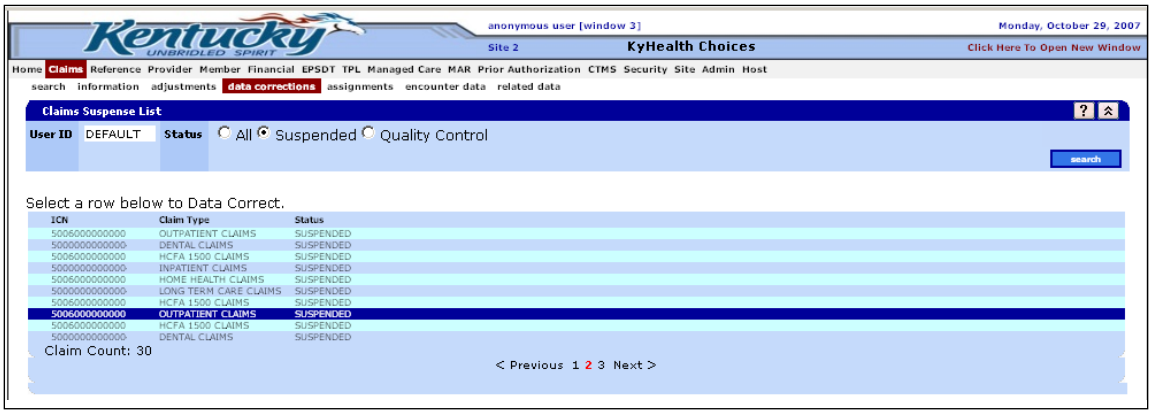
11.2.1 Accessing the Data Correction Page

STEP 1. Access interChange.

STEP 2. Select Claims from the main menu.

STEP 3. Select "Data Corrections" from the Claims sub-menu.

STEP 4. Enter a User ID in the "User ID" field and click the blue "Search" button. Claims assigned to the user ID will appear on the Claims Suspense List Panel.



Claims Suspense List Panel

11.2.1.1 Claims Suspense List Panel Field Descriptions

Field	Description
User ID	The ID of the user to whom the claims have been assigned.
Status	The status of the claim within the system.
ICN	Internal control number (ICN) which uniquely identifies a claim.
Claim Type	Description of the type of claim.
Status	The status of the claim within the system.

11.2.1.2 Claims Suspense List Panel Button Descriptions

Button	Description
Search	Performs a query on the database and returns the data for the entered search criteria.

STEP 5. Select a claim by clicking the record one time. This will open the UB92 Data Correction Page.

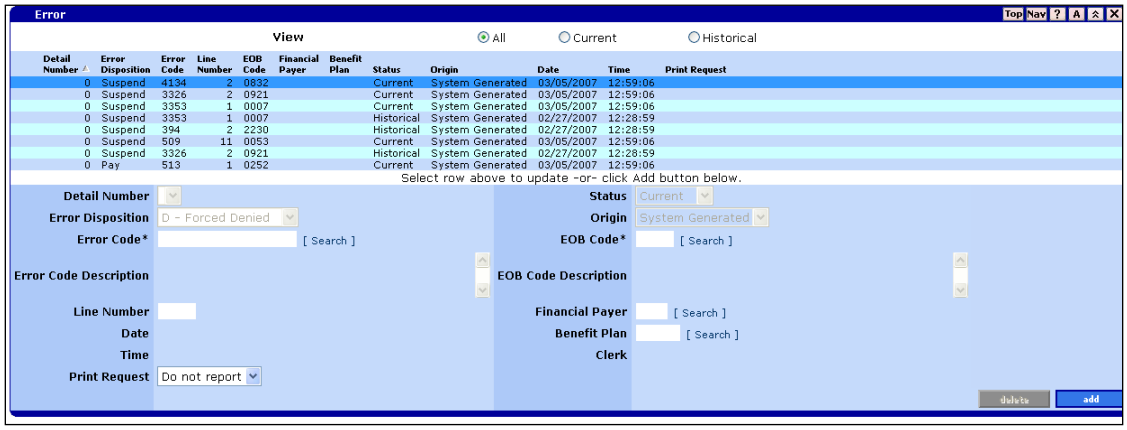
UB92 Data Correction Page

11.2.2 Determining Why a Claim is Suspended

STEP 6. Before you correct a claim, you must determine why the claim is suspended. To do this, open the Error panel by clicking “Error” on the Claim Maintenance Panel.

UB92 Claim Maintenance Panel

STEP 7. The Error Code panel will open. Select the error record by clicking on the record one time.



Error Code Panel

11.2.2.1 UB92 Claim/Error Panel Field Descriptions

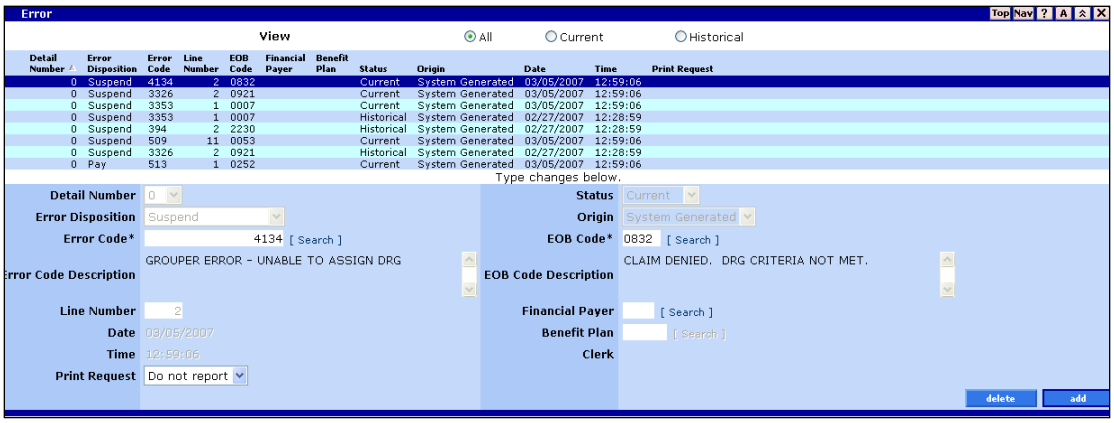
Field	Description
View	Select one from All, Current or Historical.
Detail Number	The number of the header or detail that contains an edit or an audit failure.
Error Disposition	Code that represents the action that is taken on a claim at disposition time: pay (P), deny (D), suspend (S), force override (F), reject (J), or batch suspend (B).
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit.
Error Code Description	Description of indicated error.
Line Number	Line of individual error or EOB.
Date	Date of the error code.
Time	Time of the error code.
Print Request	The valid values are: Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report.
Status	Indicates whether the Errors are current or history.
Origin	Indicates who generated the error code and message.

Field	Description
EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it.
EOB Code Description	Description of indicated EOB.
Financial Payer	A value that identifies a unique payer within interChange.
Benefit Plan	Identifies the medical assistance program that is supported in the system. Use the [Search] panel to select a valid plan.
Clerk	Number used to identify user who last updated error record.

11.2.2.2 UB92 Claim/Error Panel Button Descriptions

Button	Description
Add	Add a new record.
Delete	Delete a record.

The error record information will populate in the fields below.



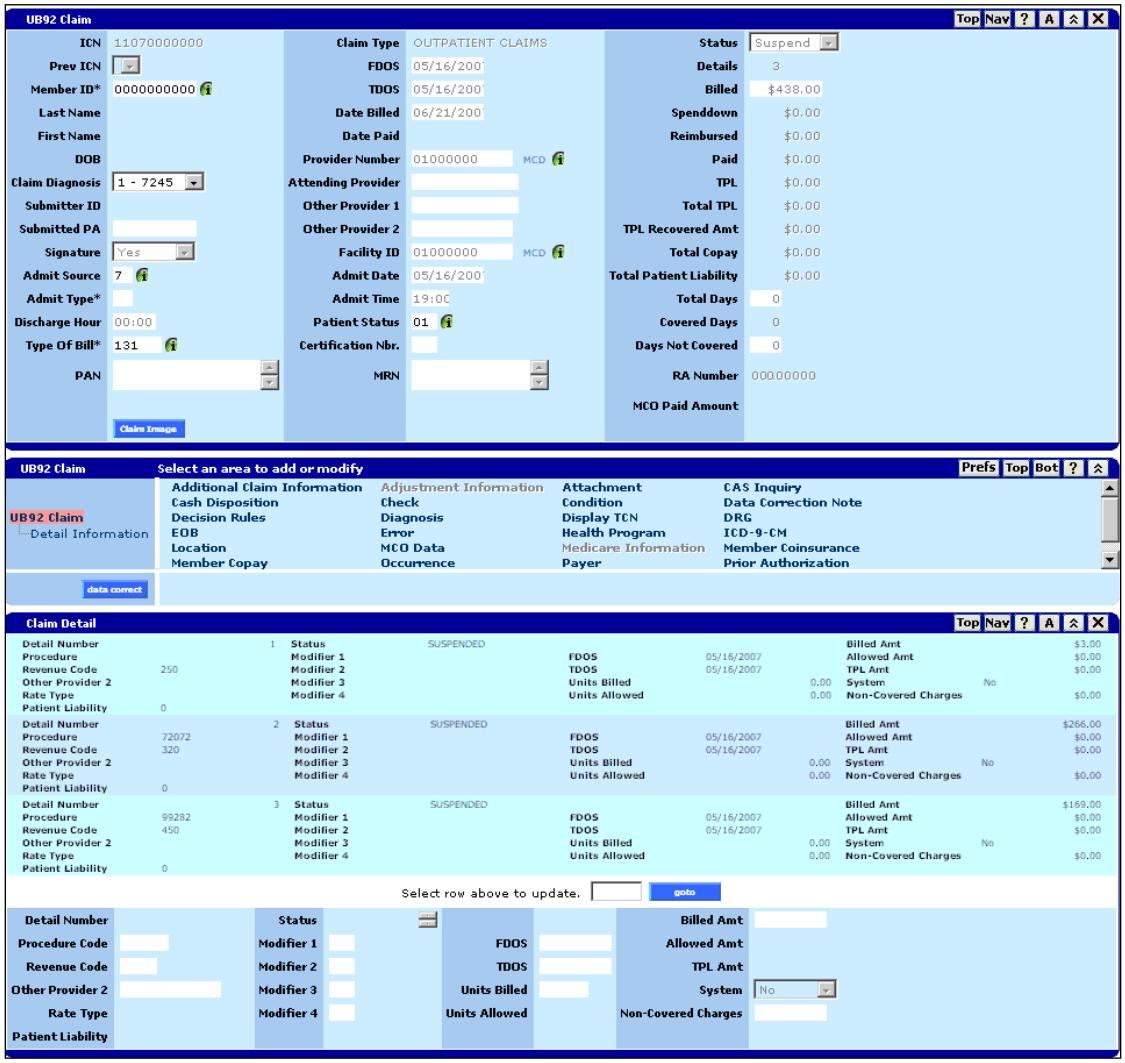
Error Code Panel with Populated Information

STEP 8. Review all the error records by clicking on each error record row. Each time a row is clicked, the information will populate in the fields below.

11.2.3 Viewing the Image of a Paper Claim

To determine if the data from a paper claim is correctly entered into interChange, you must compare the paper claim image in OnBase to the claim information in interChange.

STEP 9. Access the UB92 Claim panel. Click the blue “Claim Image” button.



UB92 Claim Panel

11.2.3.1 UB92 Claim Correction Panel Field Descriptions

Field	Description
ICN	13-digit Internal control number assigned to all incoming claims.
Prev ICN	Last 13-digit assigned to claim before it was adjusted.
Member ID	Member’s unique *KY Medicaid* ID number.
Last Name	The last name of the member associated with the Member ID. If there is no association between the last name and the Member ID number the first three characters of the last name that was keyed will be displayed.

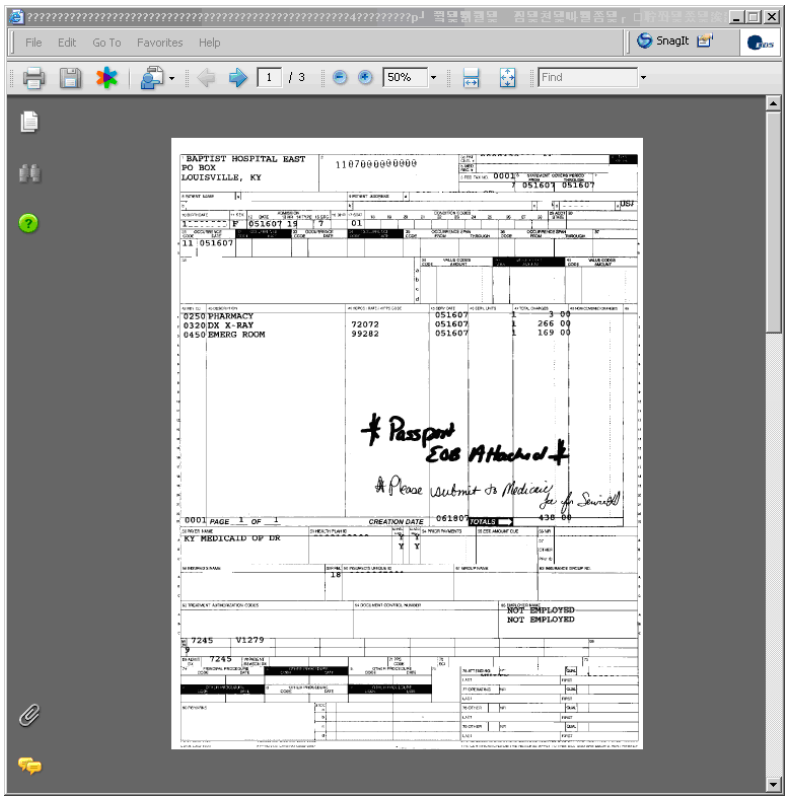
Field	Description
First Name	The first name of the member associated with the Member ID. If there is no association between the first name and the Member ID number the first character of the first name that was keyed will be displayed.
DOB	Date of birth of member in MMIS.
Claim Diagnosis	Code used to identify primary, admitting, emergency or diagnoses.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted with claim.
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
Signature	Indicates where claim was signed by provider or representative
Admit Source	Indicates source of admission.
Admit type	Code indicating type of admission.
Discharge Hour	Time member is released from hospital or facility.
Type of Bill	Code indicating specific type of bill.
PAN	Patient's unique identification number assigned by provider to track patient's financial records.
Claim Type	Indicates type of claim.
FDOS	Beginning date of service on claim.
TDOS	Ending date of service on claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid. This field is not populated on Suspended claims.
Provider Number	*KY Medicaid* Provider number.
Attending Provider	Attending physician's prescribing number.
Other Provider 1	License number of physician other than attending physician.
Other Provider 2	License number of physician other than attending physician.
Facility ID	Identification number assigned to facility provider and service location.
Admit Date	Date patient was admitted to facility for care.
Admit Time	Time member was admitted to facility for care.

Field	Description
Patient Status	Codes indicating patient's status as of ending service date of period covered on claim.
Certification Nbr.	Code used to identify the certification of the member.
MRN	Code representing Medical Record Number.
Status	Identifies status of claim within MMIS.
Details	Number of detail service lines on claim.
Billed	Amount requested by provider for services rendered.
Spenddown	Amount of member's spend down applied to claim.
Reimbursed	Total amount the provider receives. Format 99999999.99. This field is not populated for Suspended claims.
Paid	Amount paid on claim. Format 999999.99. This field is not populated on Suspended claims.
TPL	Amount paid by third party for services, at claim header level.
Total TPL	This is the sum of the copay amounts from Health Program panel records(T_CLM_PGM_XREF table). Format 9999999.99
TPL Recovered Amt	Casualty case recovery amount populated from Settlement window.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records(T_CLM_PGM_XREF table). Format 9999999.99.
Total Patient Liability	Amount of patient liability applied to claim.
Total Days	Total number of days billed on claim.
Covered Days	Number of days covered by primary payer.
Days Not Covered	Number of days not covered.

11.2.3.2 UB92 Claim Panel Button Descriptions

Button	Description
Claim Image	To View the Claim Image from the Onbase System. This button will be visible only for paper claims.

The scanned image of the claim will display.



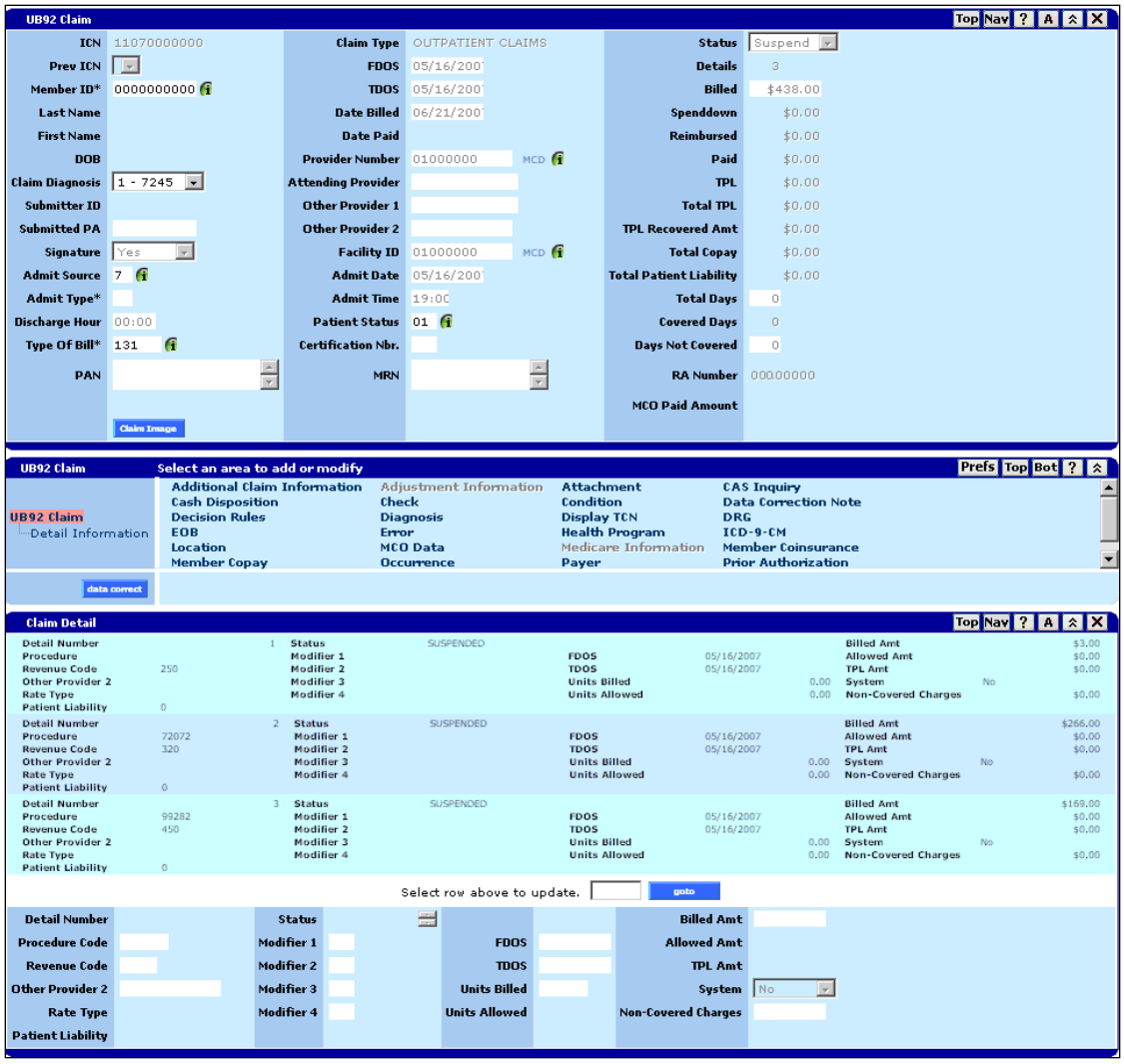
Paper Claim Image in OnBase

STEP 10. Compare the image to the interChange file. If the claim information in interChange does NOT match the claim image in OnBase, correct the claim.

11.2.4 Correcting the Claim Header Information

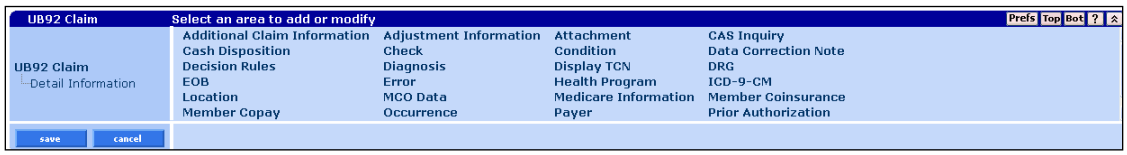
The UB92 Claim Panel contains claim header information. Therefore, if a correction is to be made to the claim header, then you will edit the UB92 Claim Panel.

STEP 11. The UB92 Claim Panel will be active. Edit the information.

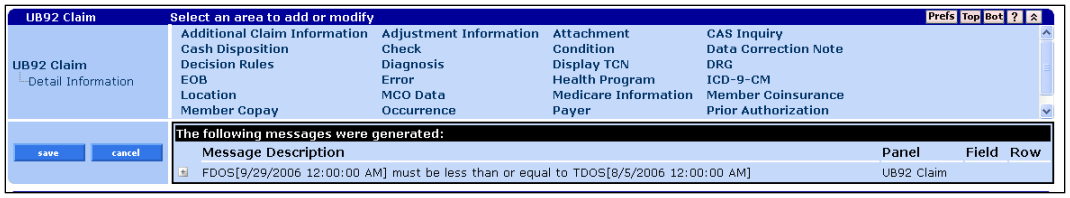


UB92 Claim Panel

STEP 12. Click the "Save" button on the UB92 Claim Maintenance Panel.

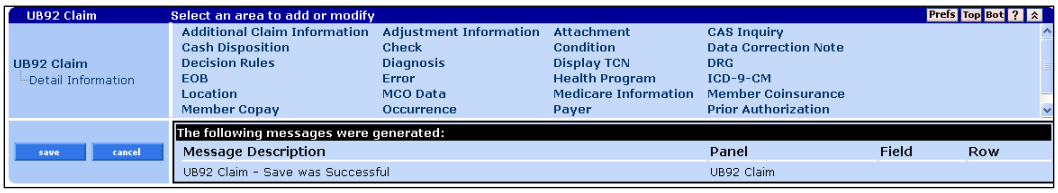


STEP 13. If the save was not successful, an error message will appear. Correct the error(s) as indicated in the Error Message box.



Error Message

STEP 14. Click "save" again. If the save was successful, a "Save was Successful" message will appear.

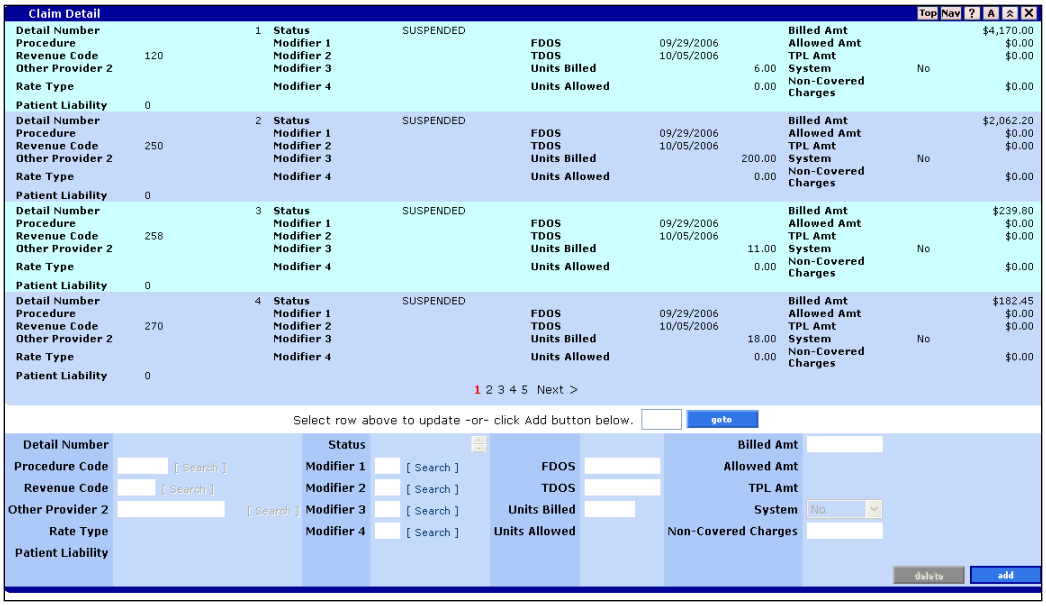


Save was Successful Message

11.2.5 Correcting Detail Information

The detailed lines of information in a claim are contained within the Claim Detail Panel. Therefore, if a correction is to be made to the claim detail information, then you will edit the Claim Detail Panel.

STEP 15. Access the Claim Detail Panel.



11.2.5.1 UB92 Claim Detail Panel Field Descriptions

Field	Description

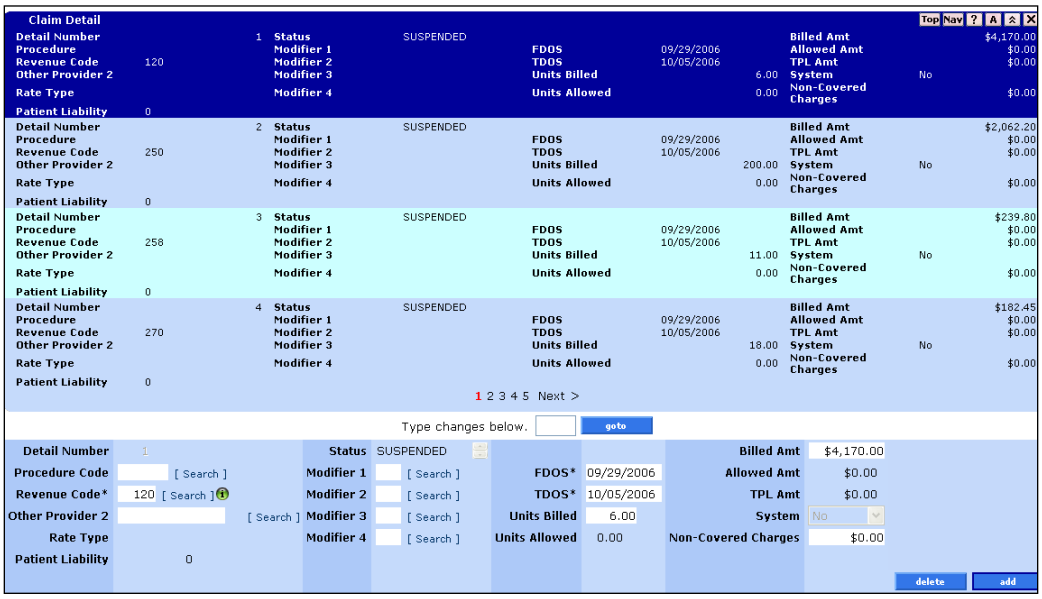
Field	Description
Detail Number	Detail number of claim record.
Procedure Code	Procedure code billed on detail line of claim.
Revenue Code	Revenue code billed on detail line of claim.
Other Provider 2	Or Provider2 and location. LOC=location that uniquely identifies provider of services.
Rate Type	Type of rate the claim is set to pay.
Patient Liability	Amount of patient liability applied to claim.
Status	Identifies status of claim within MMIS.
Modifier 1	Original/Submitted Procedure Modifier 1 for HIPAA 837I.
Modifier 2	Original/Submitted Procedure Modifier 2 for HIPAA 837I.
Modifier 3	Original/Submitted Procedure Modifier 3 for HIPAA 837I.
Modifier 4	Original/Submitted Procedure Modifier 4 for HIPAA 837I.
FDOS	Date on which service was first provided.
TDOS	Date on which service was last provided.
Units Billed	Number of units billed on claim by provider.
Units Allowed	Number of units of service that will be paid for.
Billed Amt	Amount of money requested for payment by provider for services rendered.
Allowed Amt	Amount allowed that will be paid for. Format 9999999.99
TPL Amt	Amount paid by primary insurance, not Medicare.
System	Indicates whether detail was added by system during claim's processing.
Non-Covered Charge	Service Line Non-Covered Charge Amount, Line Item Denied Charge or Non-Covered Charge Amount.

11.2.5.2 UB92 Claim Detail Panel Button Descriptions

Button	Description
Go To	Allows user to view a specific detail.
Add	Allows user to add a detail line.
Delete	Allows user to delete a detail line.

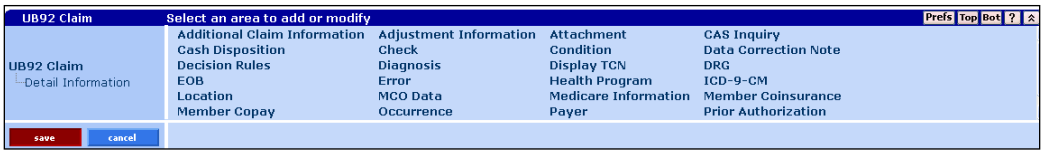
STEP 16. The detail rows are displayed in alternating colors of light green and light blue. And, each line is numbered. Select the detail line by clicking one time anywhere within the row.

The selected row will turn dark blue. Information from that row will populate in the fields below.



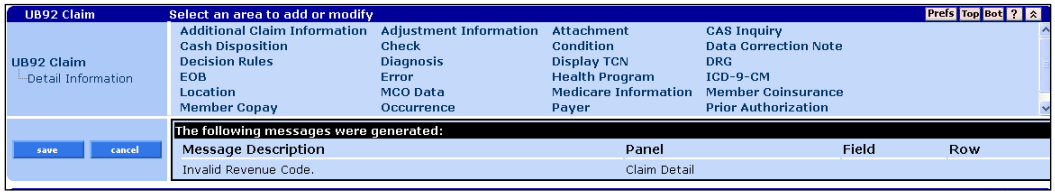
STEP 17. Edit the information in the white field boxes. To edit another detail row, repeat step 16 and edit the information.

STEP 18. Click the "save" button on the UB92 Claim Maintenance Panel.



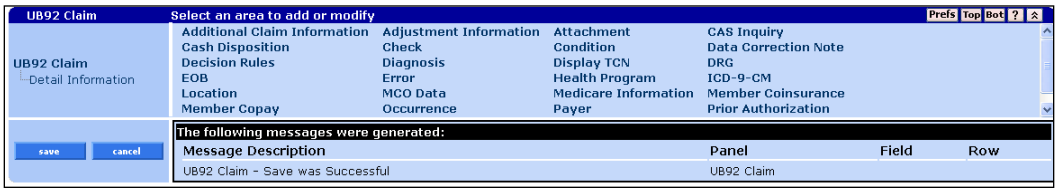
UB92 Claim Maintenance Panel

STEP 19. If the save was not successful, an error message will appear. Correct the error(s) as indicated in the Error Message box.



Error Message

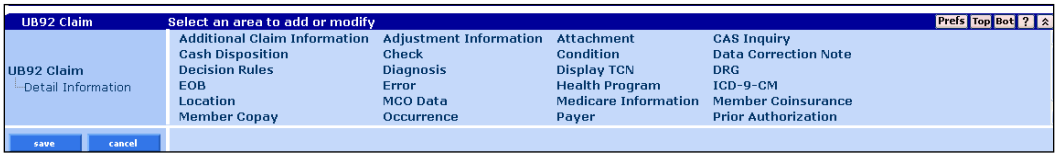
STEP 20. Click “Save” again. If the save was successful, a “Save was Successful” message will appear.



Save was Successful Message

11.2.6 Correcting Information in Other Panels

Some panels contain data-correctable information. The links to these other panels appear on the UB92 Claim Maintenance Panel.



The following panels contain data-correctable information:

Condition

Data Correction Note

Detail EOB

Detail Error

Detail Health Program

EOB

Error

Health Program

ICD-9-CM

Location

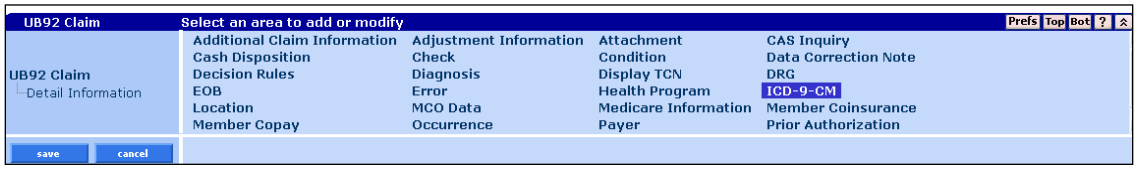
Medicare Information

Occurrence

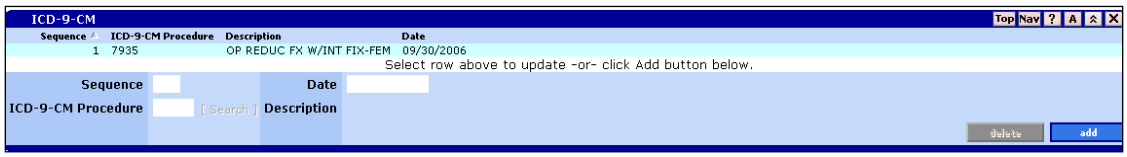
Payer

Value

STEP 21. Access the UB92 Claim Maintenance Panel. Select a panel by clicking the link one time.



The panel will display.



ICD-9-CM Panel

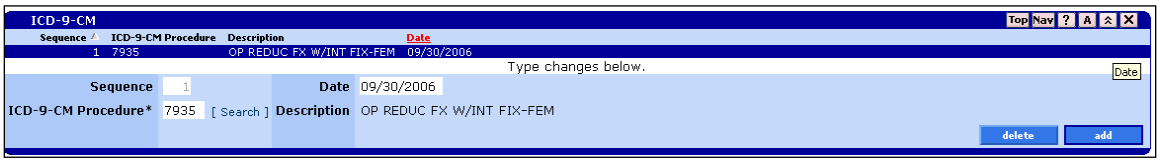
11.2.6.1 UB92 Claim/ICD-9-CM Panel Field Descriptions

Field	Description
Sequence	Contains sequence number of surgical procedure code. Principal procedure is always sequence 1.
ICD-9-CM Procedure	Code used to identify surgical procedure code principle or other.
Date	Date ICD-9-CM procedure was performed.
Description	Description of surgical procedure code.

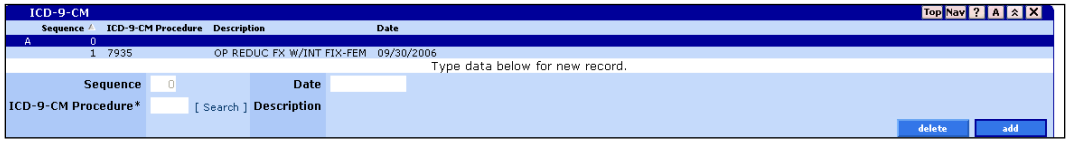
11.2.6.2 UB92 Claim/ICD-9-CM Panel Button Descriptions

Button	Description
Add	Add a new record.
Delete	Delete a record.

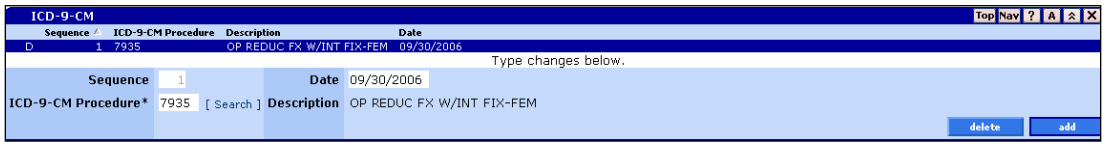
STEP 22. To edit a current record, click the record row one time. The record information will populate in the fields below. Edit the information in the white field boxes.



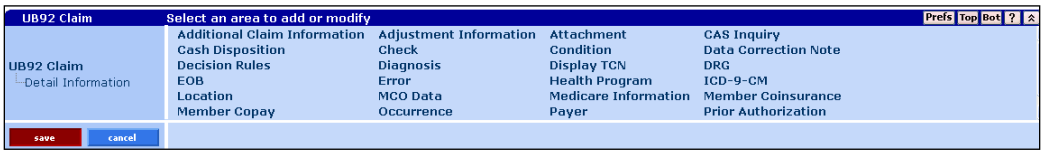
STEP 23. To add a record to a panel, click the "Add" button. The white field boxes will become active. Enter the new record information.



STEP 24. To delete a current record, select the record by clicking on the row once. Click the "delete" button.

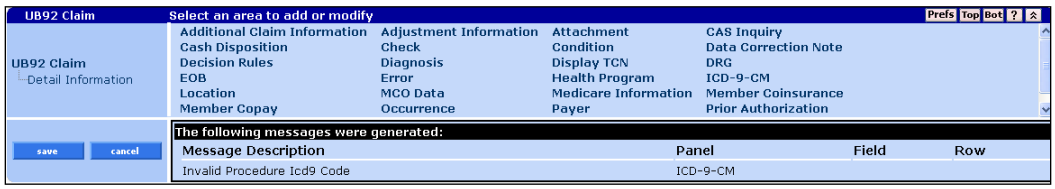


STEP 25. To save changes to the panel, click the "save" button on the UB92 Claim Maintenance Panel.



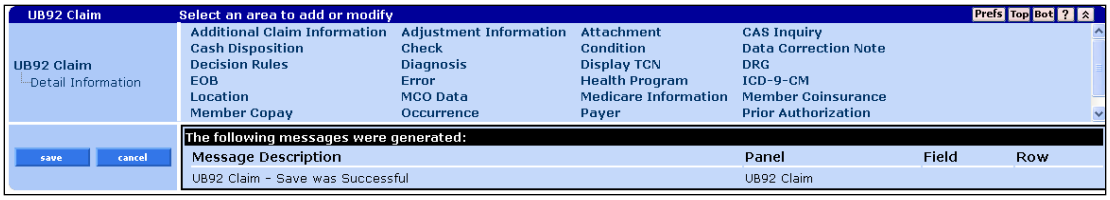
UB92 Claim Maintenance Panel

STEP 26. If the save was not successful, an error message will appear. Correct the error(s) as indicated in the Error Message box.



Error Message

STEP 27. Click "Save" again. If the save was successful, a "Save was Successful" message will appear.

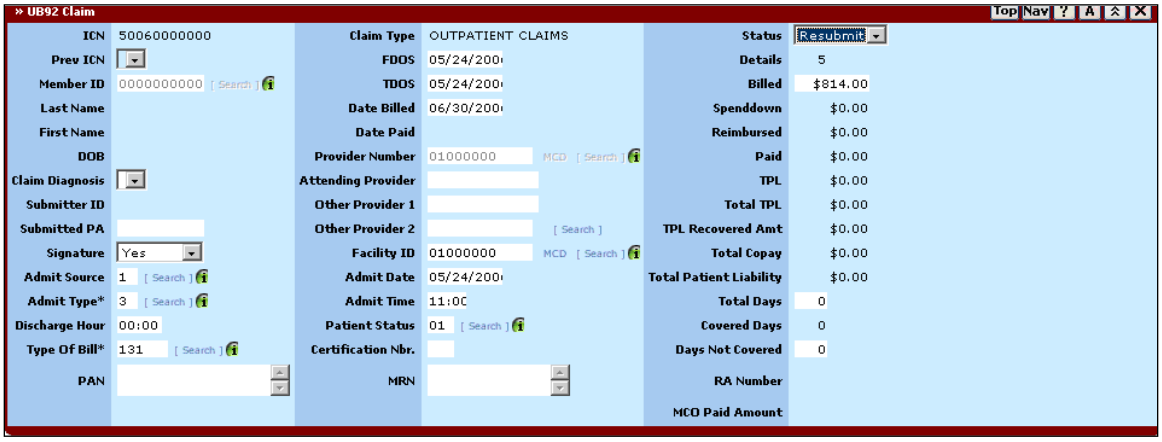


Save was Successful Message

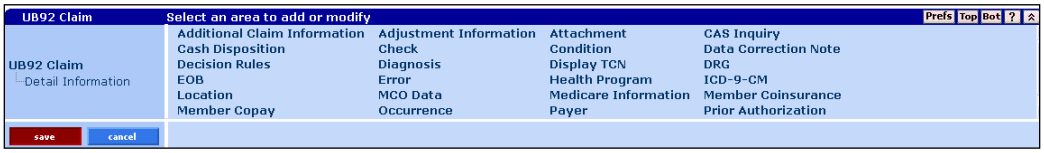
11.2.7 Resubmitting Corrected Claims

STEP 28. After the claim is corrected, it must be resubmitted for processing. Access the UB92 Claim panel. In the "Status" field, there is a drop down box.

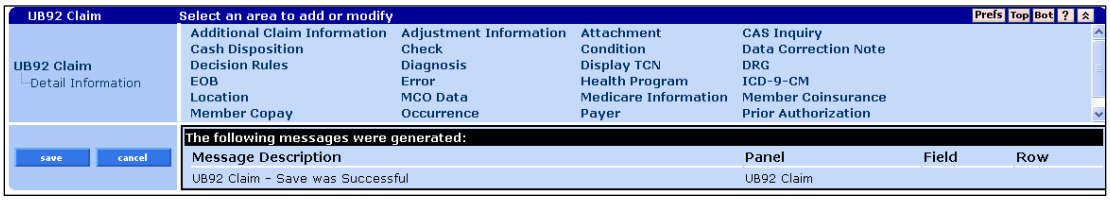
STEP 29. Change the status to "Resubmit".



STEP 30. Click “Save” on the Navigation Panel.



STEP 31. A “Save was Successful” message will appear.



11.3 Data Correcting a Dental Claim

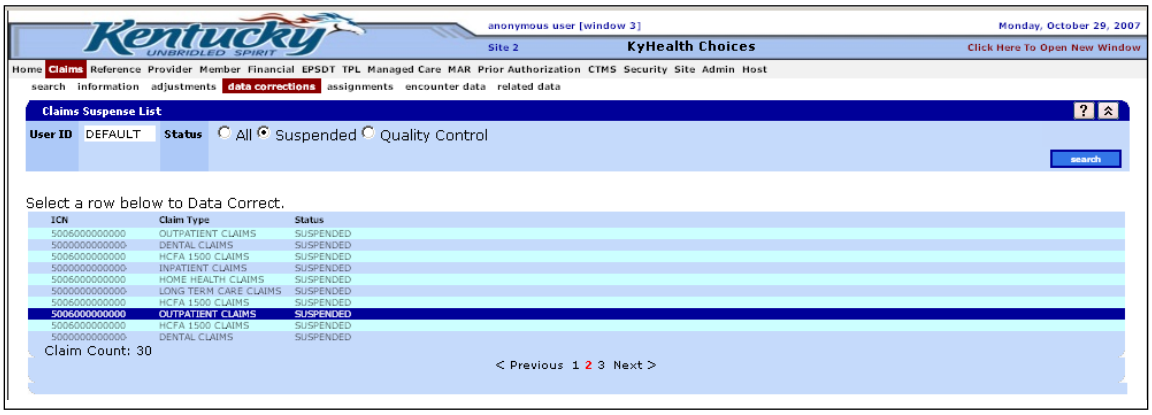
11.3.1 Accessing the Data Correction Page

STEP 1. Access interChange.

STEP 2. Select Claims from the main menu.

STEP 3. Select "Data Corrections" from the Claims sub-menu.

STEP 4. Enter a User ID in the "User ID" field and click the blue "Search" button. Claims assigned to the user ID will appear on the Claims Suspense List Panel.



Claims Suspense List Panel

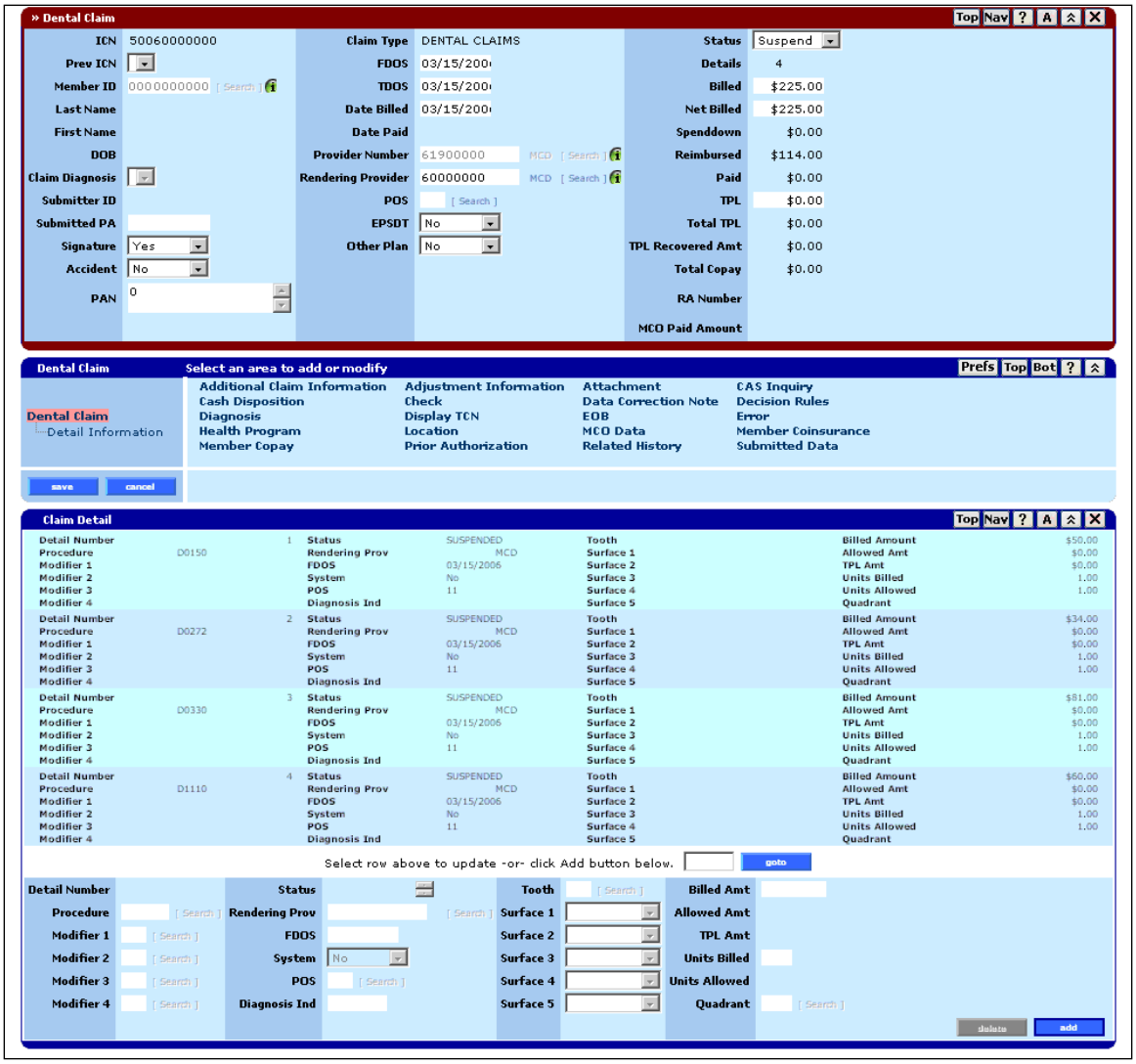
11.3.1.1 Claims Suspense List Panel Field Descriptions

Field	Description
User ID	The ID of the user to whom the claims have been assigned.
Status	The status of the claim within the system.
ICN	Internal control number (ICN) which uniquely identifies a claim.
Claim Type	Description of the type of claim.
Status	The status of the claim within the system.

11.3.1.2 Claims Suspense List Panel Button Descriptions

Button	Description
Search	Performs a query on the database and returns the data for the entered search criteria.

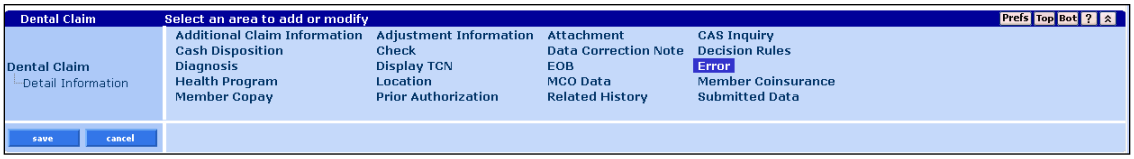
STEP 5. Select a claim by clicking the record one time. This will open the Dental Data Correction Page.



Dental Data Correction Page

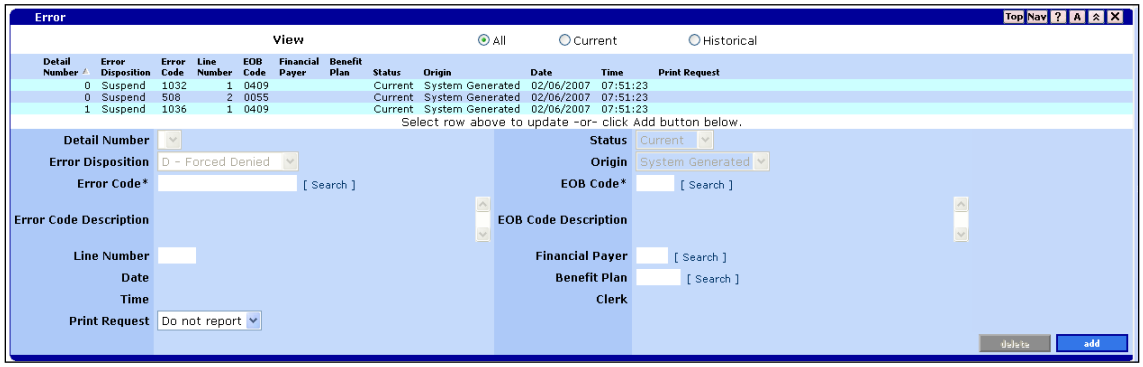
11.3.2 Determining Why a Claim is Suspended

STEP 6. Before you correct a claim, you must determine why the claim is suspended. To do this, open the Error panel by clicking “Error” on the Claim Maintenance Panel.



Dental Claim Maintenance Panel

STEP 7. The Error Code panel will open. Select the error record by clicking on the record one time.



Error Code Panel

11.3.2.1 Dental Claim/Error Panel Field Descriptions

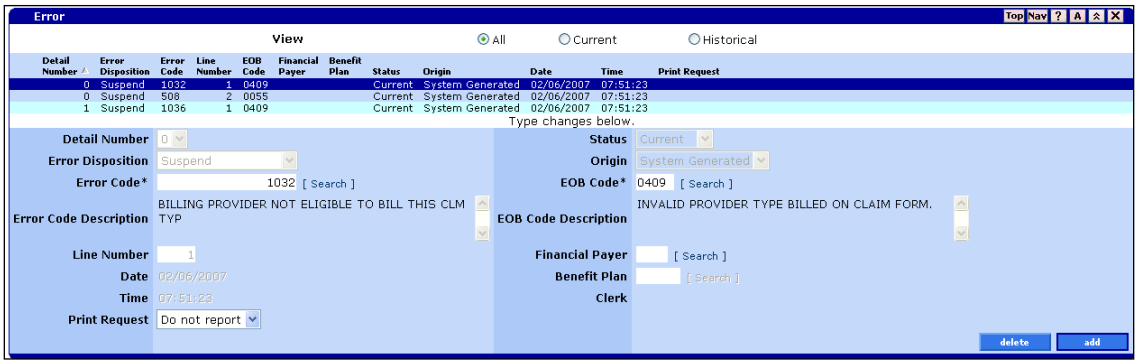
Field	Description
View	Select one from All, Current or Historical.
Detail Number	The number of the header or detail that contains an edit or an audit failure.
Error Disposition	Code that represents the action that is taken on a claim at disposition time: pay (P), deny (D), suspend (S), force override (F), reject (J), or batch suspend (B).
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit.
Error Code Description	Description of indicated error.
Line Number	Line of individual error or EOB.
Date	Date of the error code.
Time	Time of the error code.
Print Request	The valid values are: Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report.
Status	Indicates whether the Errors are current or history.
Origin	Indicates who generated the error code and message.
EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it.
EOB Code Description	Description of indicated EOB.
Financial Payer	A value that identifies a unique payer within interChange.

Field	Description
Benefit Plan	Identifies the medical assistance program that is supported in the system. Use the [Search] panel to select a valid plan.
Clerk	Number used to identify user who last updated error record.

11.3.2.2 Dental Claim/Error Panel Button Descriptions

Button	Description
Add	Add a new record.
Delete	Delete a record.

The error record information will populate in the fields below.



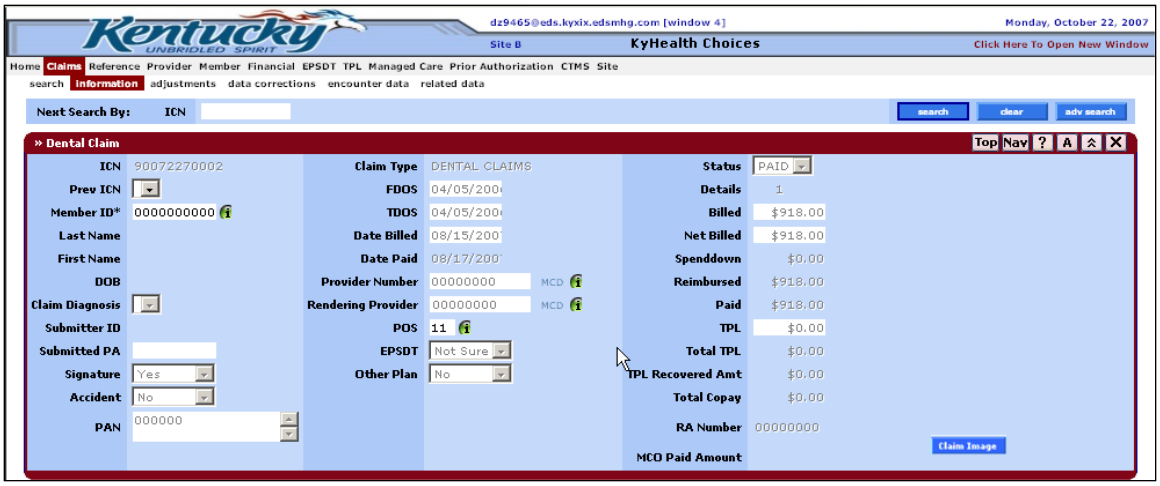
Error Code Panel with Populated Information

STEP 8. Review all the error records by clicking on each error record row. Each time a row is clicked, the information will populate in the fields below.

11.3.3 Viewing the Image of a Paper Claim

To determine if the data from a paper claim is correctly entered into interChange, you must compare the paper claim image in OnBase to the claim information in interChange.

STEP 9. Access the Dental Claim panel. Click the blue “Claim Image” button.



Dental Claim Panel

11.3.3.1 Claims/Information/Dental Claims Data Correction Panel Field Descriptions

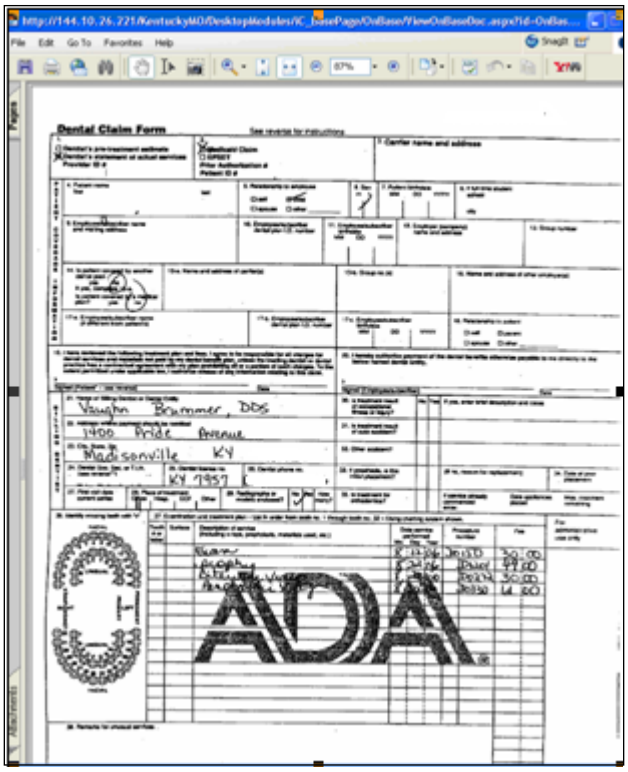
Field	Description
ICN	Internal control number which uniquely identifies a claim.
Prev ICN	This field allows the user to select any of the other previous ICNs for the claim and view that information. The MCO Original ICN for an encounter claim. Not used on claims other than encounters.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
Last Name	The last name of the member associated with the Member ID number. If there is no association between the last name and the Member ID number the first three characters of the last name that was typed is displayed.
First Name	The first name of the member associated with the Member ID number. If there is no association between the first name and the Member ID number the first character of the first name that was typed is displayed.
DOB	Member date of birth.
Claim Diagnosis	A code for the condition requiring medical attention.
Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
Submitted PA	Prior Authorization number submitted on the claim.
Signature	Indicates whether the claim was signed by the provider or representative.
Accident	Indicates the accident reason. It draws its drop down values from the T_ACCIDENT_TYPE table.
PAN	Identification for a member assigned by a provider. (Patient Account Number)
Claim Type	Indicates the type of claim.

Field	Description
FDOS	First Date of Service on the claim.
TDOS	Date of last service on the claim.
Date Billed	Date on which claim was submitted for processing.
Date Paid	Date on which the claim was paid.
Provider Number	The provider identification number and location that uniquely identifies the provider of services.
Rendering Provider	The Rendering provider identification number and location that uniquely identifies the provider of services.
POS	Place of Service where service was rendered.
EPSDT	Indicates whether claim is EPSDT.
Other Plan	Indicates if another form of insurance was used.
Status	This field displays the status of the claim.
Details	Indicates the number of detail service lines on the claim.
Billed	Amount of money requested for payment by a provider for services rendered.
Net Billed	Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL and so on).
Spenddown	Amount of money that the member is responsible for paying for services.
Reimbursed	Total amount the provider receives minus any state share amount (if applicable).
Paid	Amount paid on claim. Amount paid will be the allowed amount minus spend down, coinsurance, deductible, patient liability, dispensing fees, TPL, etc., as applicable depending on services. This value is computed by adding up all the AMT_PAID values on the related details.
TPL	Third Party Liability. The amount paid by a third party for services.
Total TPL	Total Third Party Liability. This is the sum of the copay amounts from Health Program panel records(T_CLM_PGM_XREF table).
TPL Recovered Amt	Third Party Liability Recovered Amount. The casualty case recovery amount populated from the Settlement panel.
Total Co-pay	This is the sum of the copay amounts from Health Program panel records (T_CLM_PGM_XREF table).
RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles.
MCO Paid Amount	Managed Care Organization paid amount.

11.3.3.2 Dental Claim Panel Button Description

Button	Description
Claim Image	To View the Claim Image from the Onbase System. This button will be visible only for paper claims.

The scanned image of the claim will display.



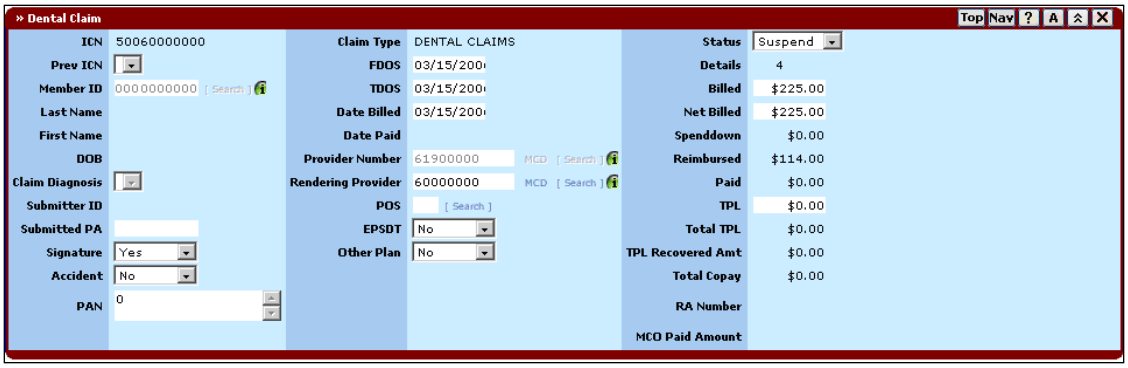
Paper Claim Image in OnBase

STEP 10. Compare the image to the interChange file. If the claim information in interChange does NOT match the claim image in OnBase, correct the claim.

11.3.3.3 Correcting the Claim Header Information

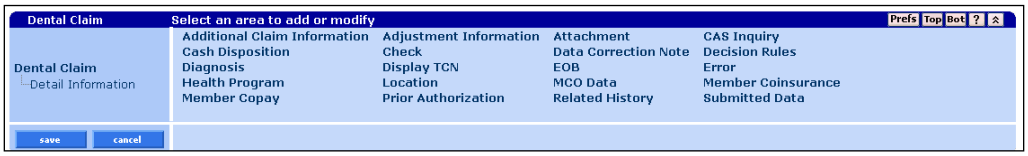
The Dental Claim Panel contains claim header information. Therefore, if a correction is to be made to the claim header, then you will edit the Dental Claim Panel.

STEP 11. The Dental Claim Panel will be active. Edit the information.

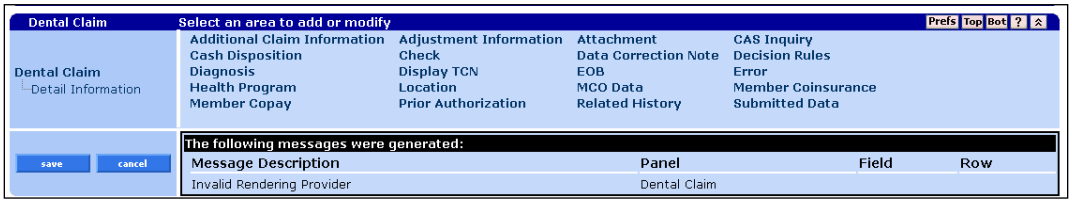


Dental Claim Panel

STEP 12. Click the "Save" button on the Dental Claim Maintenance Panel.

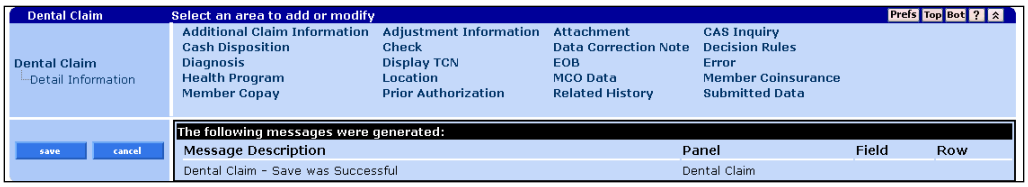


STEP 13. If the save was not successful, an error message will appear. Correct the error(s) as indicated in the Error Message box.



Error Message

STEP 14. Click "save" again. If the save was successful, a "Save was Successful" message will appear.

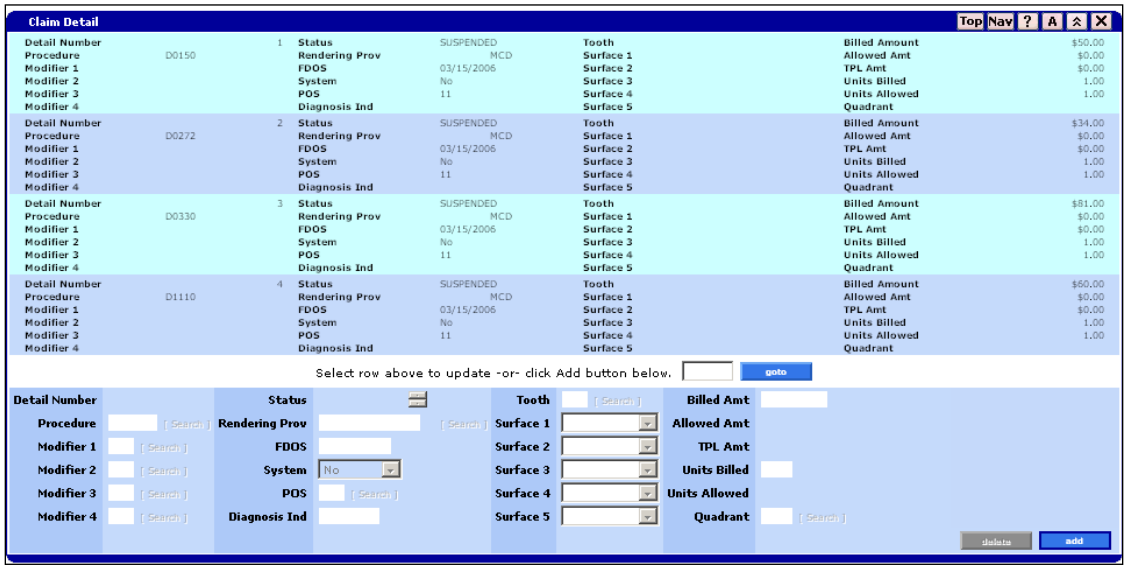


Save was Successful Message

11.3.4 Correcting Detail Information

The detailed lines of information in a claim are contained within the Claim Detail Panel. Therefore, if a correction is to be made to the claim detail information, then you will edit the Claim Detail Panel.

STEP 15. Access the Claim Detail Panel.



11.3.4.1 Dental Claim Detail Panel Field Descriptions

Field	Description
Detail Number	The number of the detail on a claim record.
Procedure	Code used to identify a Dental procedure.
Modifier 1	Code used to identify the modifiers connected to the procedure code.
Modifier 2	Code used to identify the modifiers connected to the procedure code.
Modifier 3	Code used to identify the modifiers connected to the procedure code.
Modifier 4	Code used to identify the modifiers connected to the procedure code.
Status	This field displays the status of the claim.
Rendering Prov	The identifier and service location for the performing provider.
FDOS	Date of first service on the claim.
System	Indicates whether detail was added by system during claim's processing. Valid values Y - yes or N - no. generated.
POS	Code which indicates the location where service was rendered.

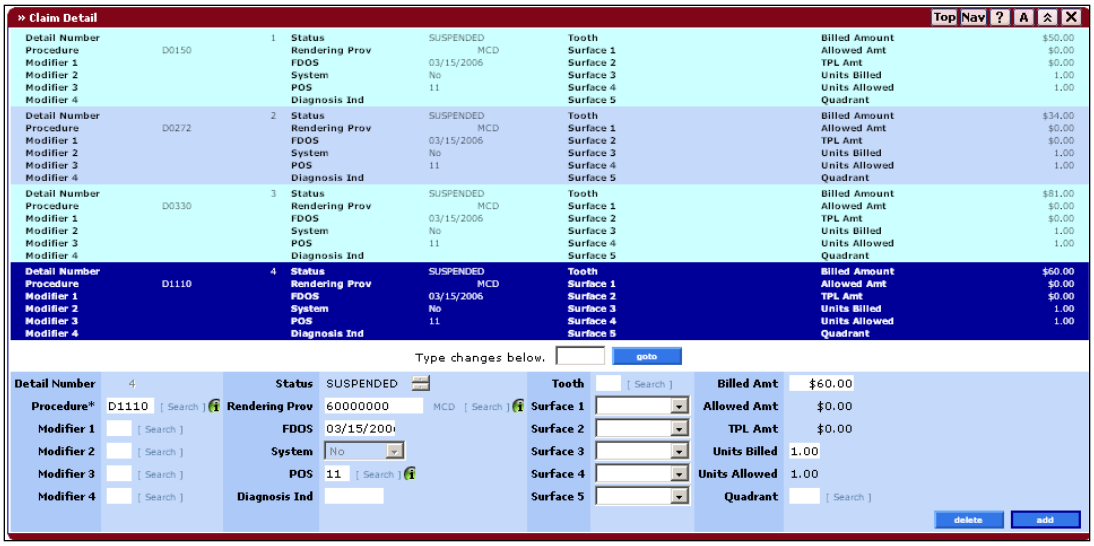
Field	Description
Diagnosis Ind	Indicates which diagnosis (or diagnoses) for which services were provided. Valid values are 1, 2,3,4,5,6,7,8. One detail can be associated with a minimum of 1 diagnosis in the header or maximum of 8 diagnoses in the header for non-transportation claims only.
Tooth	The tooth number that identifies the tooth the provider rendered services on. An alpha indicates temporary teeth and numeric indicate permanent teeth.
Surface 1	Code which indicates the tooth surface of a particular tooth.
Surface 2	Code which indicates the tooth surface of a particular tooth.
Surface 3	Code which indicates the tooth surface of a particular tooth.
Surface 4	Code which indicates the tooth surface of a particular tooth.
Surface 5	Code which indicates the tooth surface of a particular tooth.
Billed Amt	Total billed amount.
Allowed Amt	Amount allowed by the specific program (KyHealthChoices, 590, and so on) for the procedure.
TPL Amt	Amount paid by third party for services, at the claim header level.
Co-pay Amt	This is the amount of co-pay that is subtracted from the allowed amount.
Units Billed	The number of units billed by the provider.
Units Allowed	The number of units allowed to the provider.

11.3.4.2 Dental Claim Detail Panel Button Descriptions

Button	Description
Go To	Allows the user to view a specific detail.
Add	Allows the user to add a detail line.
Delete	Allows the user to delete a detail line.

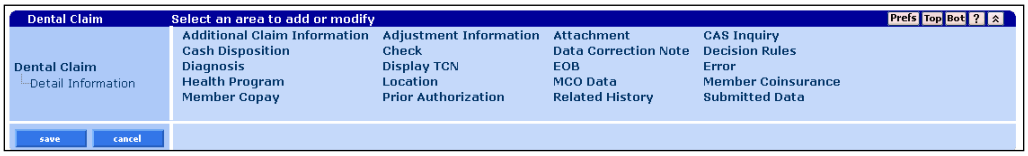
STEP 16. The detail rows are displayed in alternating colors of light green and light blue. And, each line is numbered. Select the detail line by clicking one time anywhere within the row.

The selected row will turn dark blue. Information from that row will populate in the fields below.



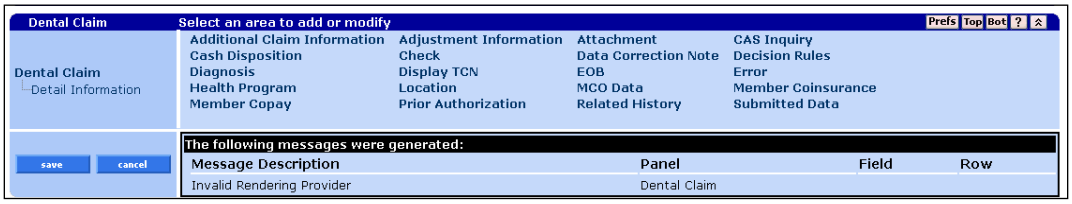
STEP 17. Edit the information in the white field boxes. To edit another detail row, repeat step 16 and edit the information.

STEP 18. Click the "Save" button on the Dental Claim Maintenance Panel.



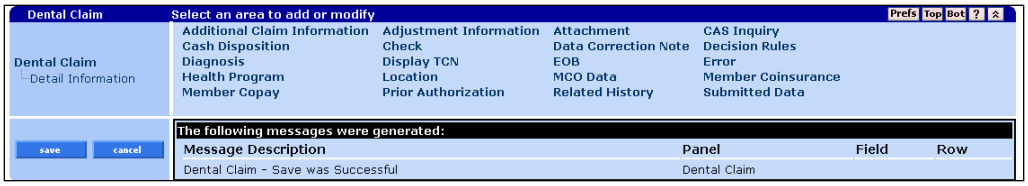
Dental Claim Maintenance Panel

STEP 19. If the save was not successful, an error message will appear. Correct the error(s) as indicated in the Error Message box.



Error Message

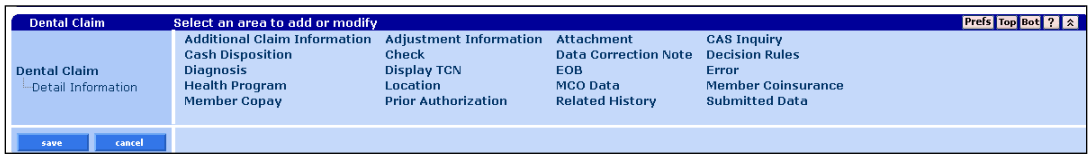
STEP 20. Click "Save" again. If the save was successful, a "Save was Successful" message will appear.



Save was Successful Message

11.3.5 Correcting Information in Other Panels

Some panels contain data-correctable information. The links to these other panels appear on the Dental Claim Maintenance Panel.



The following panels contain data-correctable information:

Data Correction Note

Detail EOB

Detail Error

Detail Health Program

Diagnosis

EOB

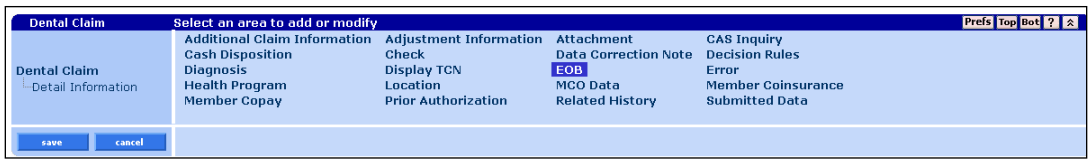
Error

Health Program

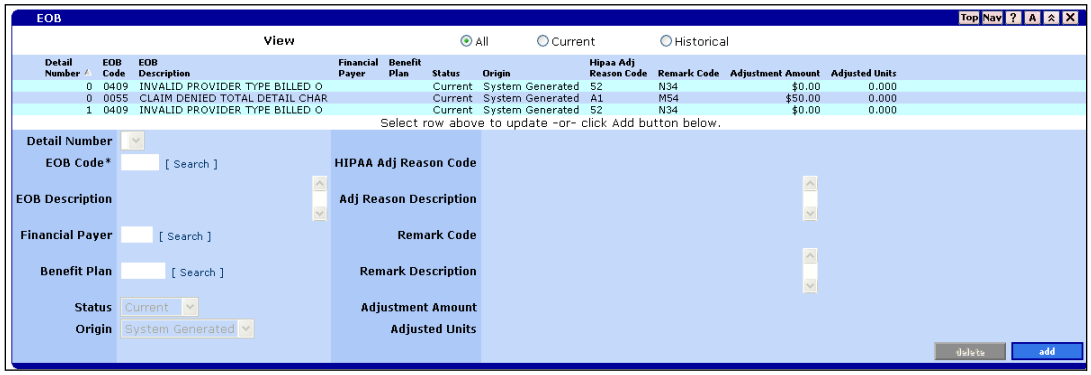
Location

Payer

STEP 21. Access the Dental Claim Maintenance Panel. Select a panel by clicking the link one time.



The panel will display.



EOB Panel

11.3.5.1 Claims/EOB Panel Field Descriptions

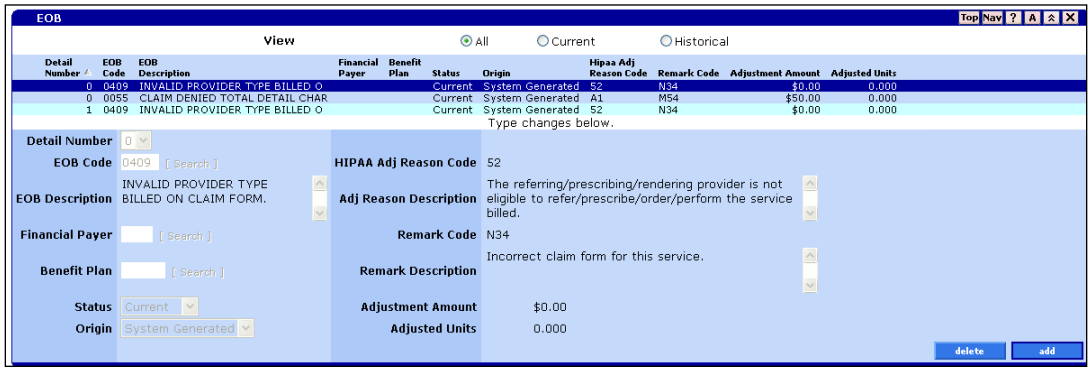
Field	Description
View	Mark one selection from following: All, Current or Historical.
Detail number	Number of individual detail line on claim.
EOB Code	Explanation of benefit code for detail claim line.
EOB Description	First line of text description for EOB code.
Financial Payer	Value that identifies a unique payer within interChange.
Benefit Plan	Identifies the medical assistance program supported in the system.
Status	Indicates whether the EOB is current or history.
Origin	Indicates who generated the EOB code and message.
HIPAA Adjustment Reason Code	HIPAA reason for the adjustment.
Adj Reason Description	Description of Hippa Adj Reason Code
Remark Code	The code for the remarks.
Remark Description	Description of Remark Code
Adjustment Amount	Dollar amount adjusted on the detail.
Adjusted Units	Quantity adjusted on the detail.

11.3.5.2 Dental Claims/EOB Panel Button Descriptions

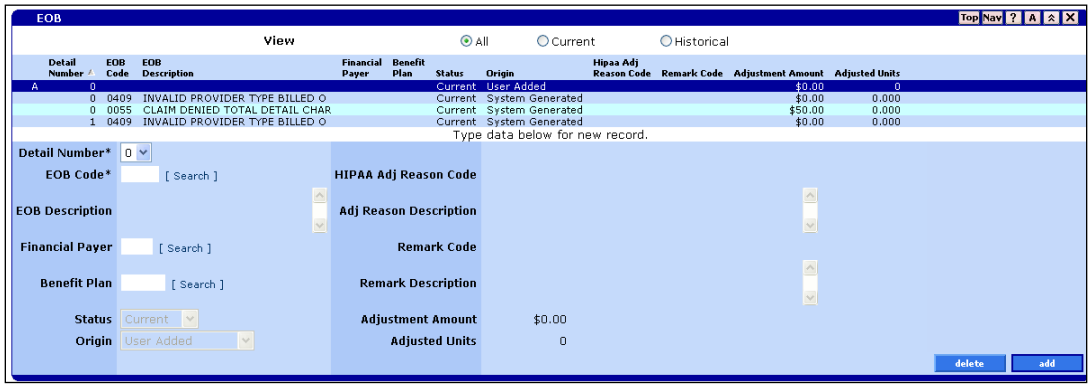
Button	Description
Add	Add a new record.

Button	Description
Delete	Delete a record.

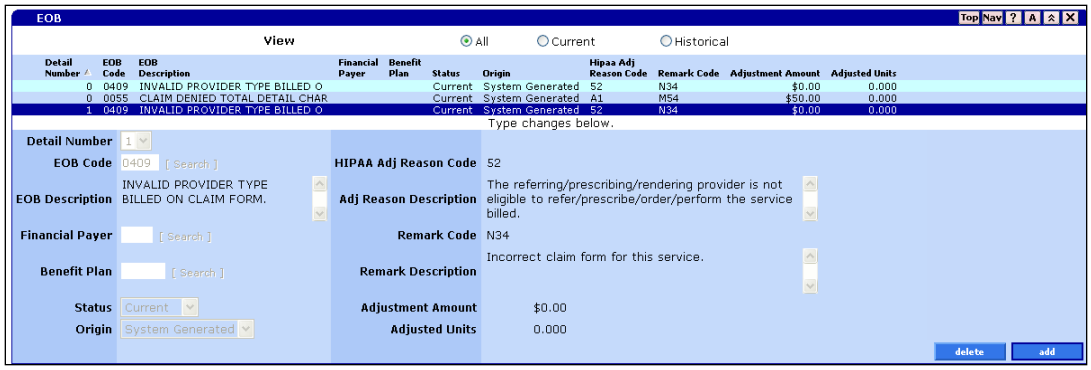
STEP 22. To edit a current record, click the record row one time. The record information will populate in the fields below. Edit the information in the white field boxes.



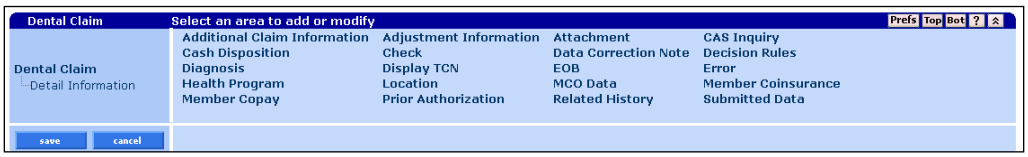
STEP 23. To add a record to a panel, click the "Add" button. The white field boxes will become active. Enter the new record information.



STEP 24. To delete a current record, select the record by clicking on the row once. Click the "delete" button.

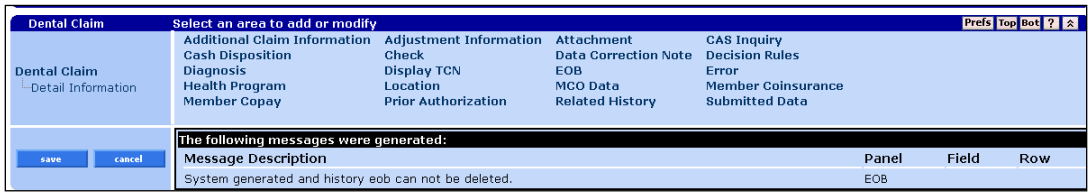


STEP 25. To save changes to the panel, click the "Save" button on the Dental Claim Maintenance Panel.



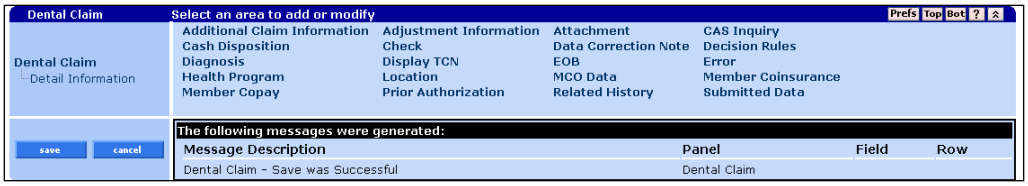
Dental Claim Maintenance Panel

STEP 26. If the save was not successful, an error message will appear. Correct the error(s) as indicated in the Error Message box.



Error Message

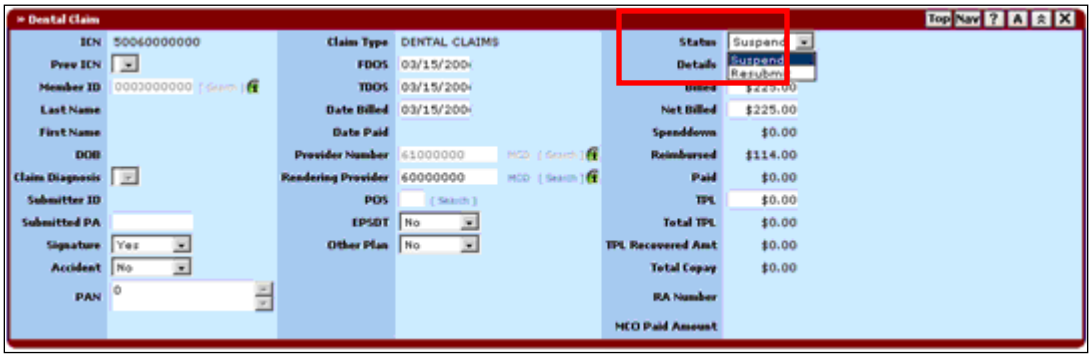
STEP 27. Click "Save" again. If the save was successful, a "Save was Successful" message will appear.



Save was Successful Message

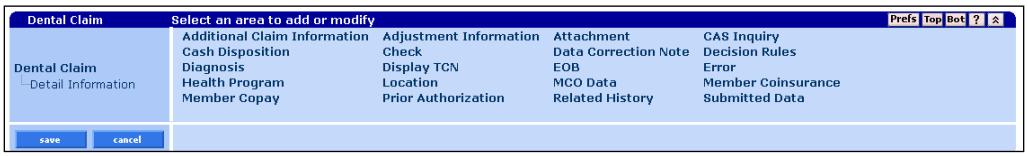
11.3.6 Resubmitting Corrected Claims

STEP 28. After the claim is corrected, it must be resubmitted for processing. Access the Dental Claim panel. In the "Status" field, there is a drop down box.

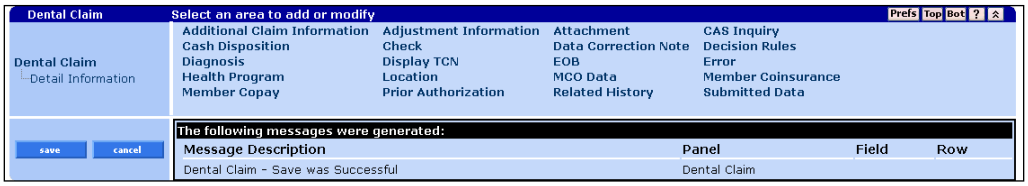


STEP 29. Change the status to "Resubmit".

STEP 30. Click "Save" on the Maintenance Panel.



STEP 31. A "Save was Successful" message will appear.



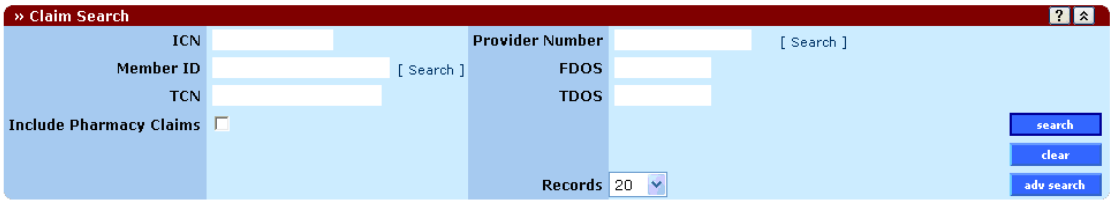
12 Appendix E – How to Adjust Claims

12.1 Adjusting a Single Claim

STEP 1. Access interChange.

STEP 2. Select Claims from the main menu.

STEP 3. The Claim Search Page will display. Search for the claim that needs adjusting by enter the search criteria and click the blue "Search" button.



Claim Search Panel

12.1.1 Claims/Claim Search Panel Field Descriptions

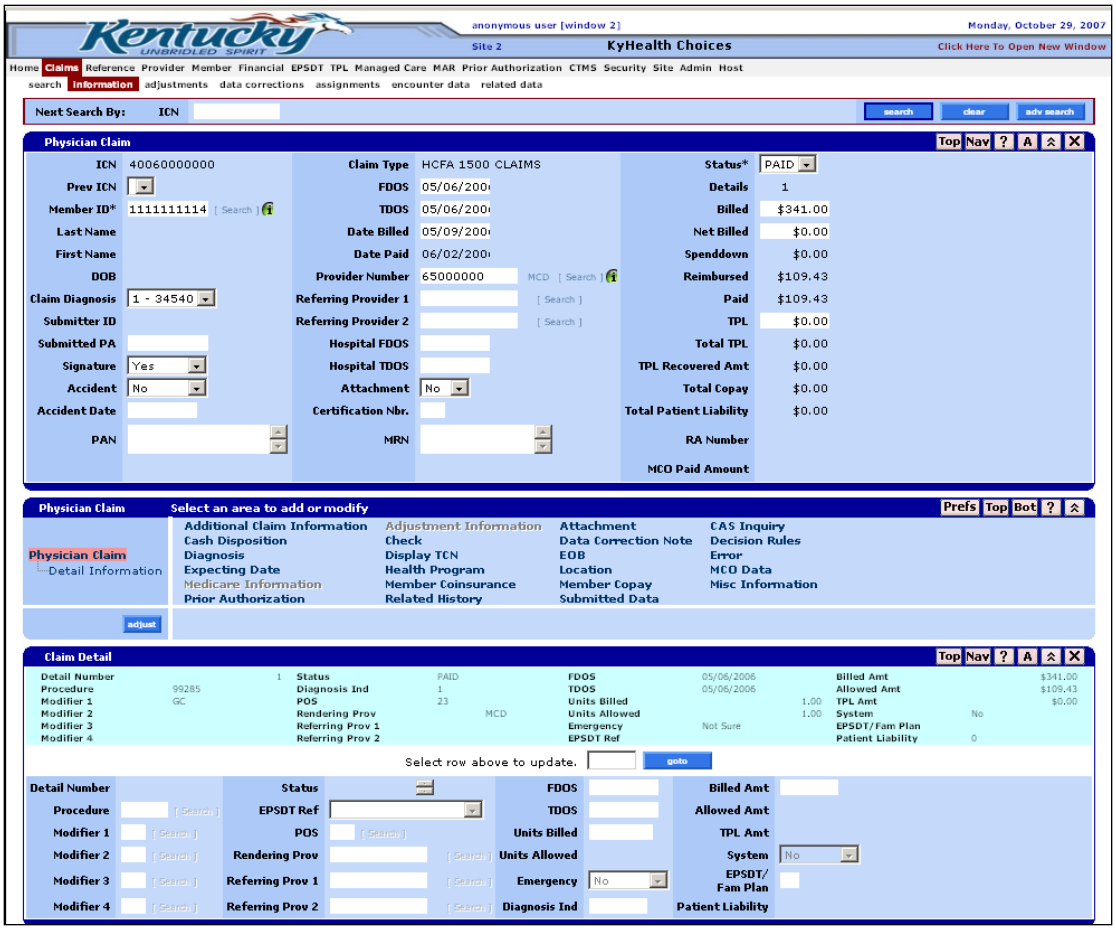
Field	Description
ICN	Internal Control Number that uniquely identifies a claim.
Member ID	Member's 10-digit KY Medicaid ID number. Field is numeric only.
TCN	Transaction Control Number assigned to all claims received in the Legacy system.

Field	Description
Include Pharmacy Claims	When selected, will list all claim types including pharmacy claims; when not selected, will list all claim types except pharmacy claims
Provider Number	Provider Identification Number that uniquely identifies pay to provider.
Rendering Provider ID	Provider Identification Number that uniquely identifies rendering provider.
Prescription Number	Number assigned by pharmacy to identify drug dispensed to member.
Referring Provider	Provider Identification Number that uniquely identifies referring provider.
Records	Maximum number of records that displays per page. Valid Values are: 5 10 20 50 100

12.1.2 Claims/Claim Search Panel Button Descriptions

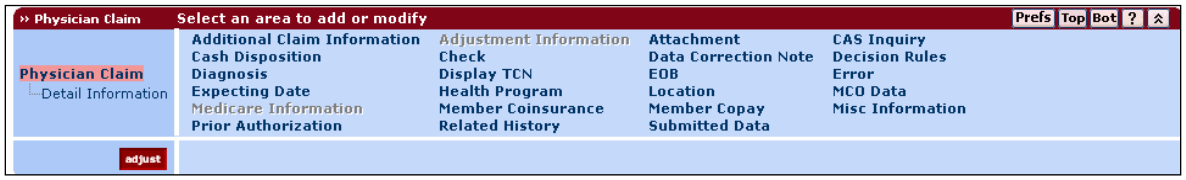
Button	Description
Search	Performs a query on the database and returns the data for the entered search criteria.
Clear	Clears the previous search criteria from the search fields.
Adv Search	The Advanced Search button opens a panel with additional search criteria fields.

The Claim Information Page will display.

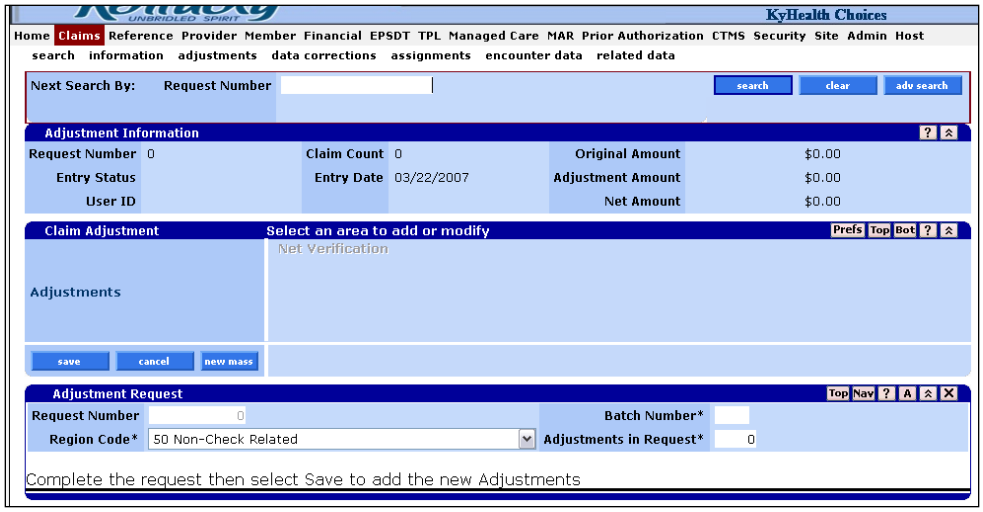


Physician Claim Information Page

STEP 4. Click the "Adjust" button, located in the Claim Maintenance Panel.



The Claim Adjustment Information Page will display.

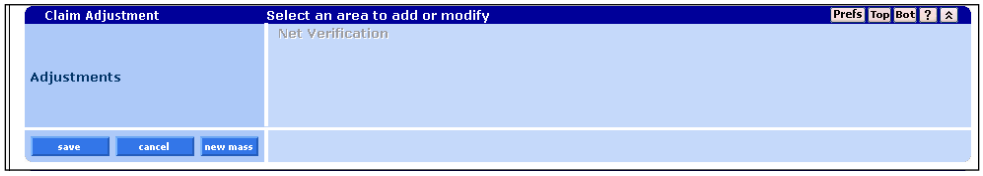


STEP 5. Enter the Batch Number, Region Code, and number of requested adjustments in the "Adjustment Request" panel.

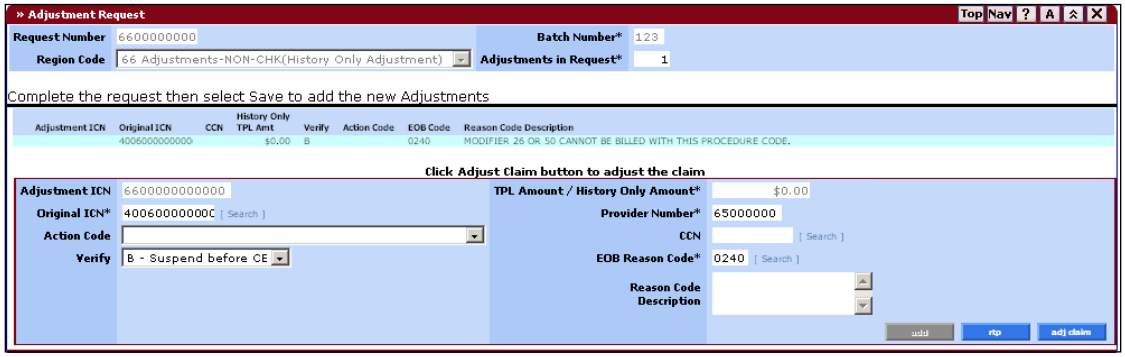
12.1.3 Adjustment Request Panel Field Descriptions

Field	Description
Request Number	A 10 byte unique number that identifies the mass adjustment request . Format: RRYYJJJBBB. (RR - Region, YYJJJ - Julian date, BBB - Batch number). It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.
Region Code	The Adjustment Request category.
Batch Number	The batch number of the record that was subject to the Adjustment Request.
Adjustments in Request	The number of adjustments contained in the Adjustment Request.

STEP 6. Click "Save" in the Claim Adjustment Panel.



STEP 7. The Adjustment Request panel will expand with additional fields. Enter the request information. Click the "Adj Claim" button.



12.1.4 Adjustment Request Panel Field Descriptions

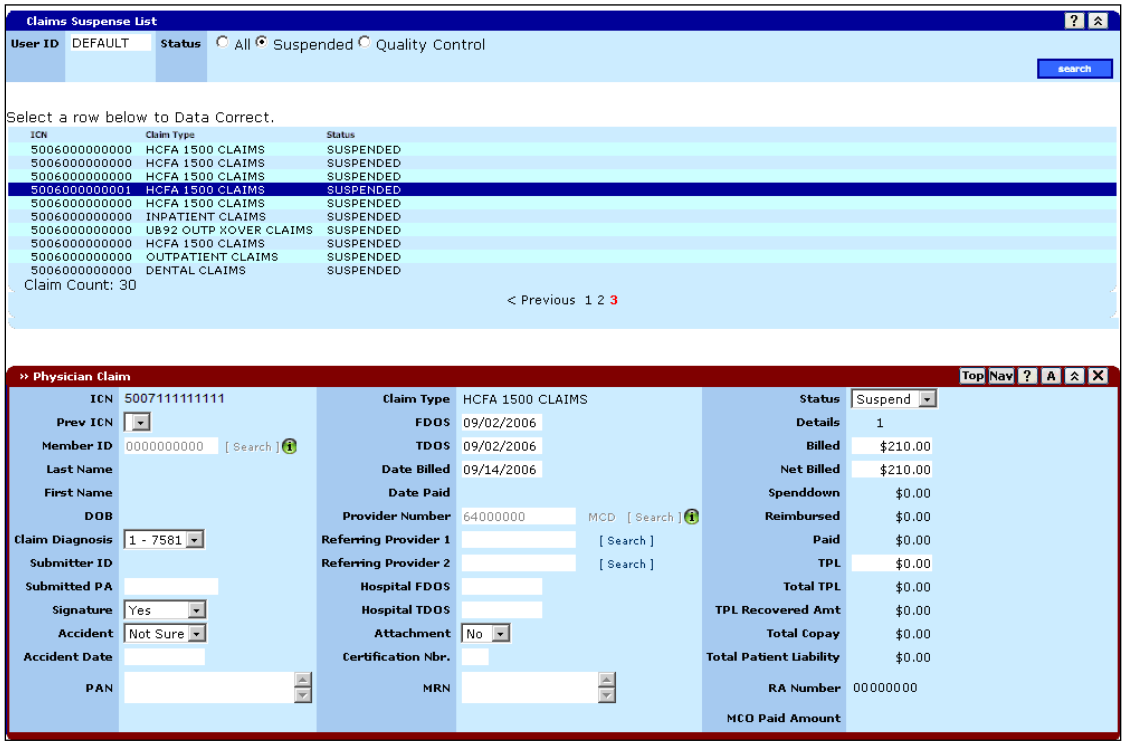
Field	Description
Request Number	A 10 byte unique number that identifies the mass adjustment request . Format: RRYYJJJBBB. (RR - Region, YYJJJ - Julian date, BBB - Batch number). It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.
Region Code	The Adjustment Request category.
Batch Number	The batch number of the record that was subject to the Adjustment Request.
Adjustments in Request	The number of adjustments contained in the Adjustment Request.
Adjustment ICN	This field is calculated based on the value of the Request Number and the Sequence number if the record is being added. If this is an existing request, the Adjustment ICN is obtained from one of the following tables depending on Claim Type: T_ADJ_UB92_XREF, T_ADJ_PHRM_XREF, T_ADJ_PHYS_XREF or T_ADJ_DENT_XREF.
Original ICN	The original ICN of the claim being adjusted.
Action Code	The action that claims engine need to take on this adjustment: A or blank - reprocess the whole claim; H - update history only do not edit, audit, or re-price.
Verify	Force Adjustment to suspend indicator. Values: A -suspend after CE (Claims Engine) processing, B -suspend before CE processing, space - ignore suspense and mark claim available for CE processing.
History Only TPL Amt	Field to add or change Third Party Liability amount for an adjusted claim.

Field	Description
Provider Number	The provider identification number that uniquely identifies the pay to provider. The user must enter the Provider Number that matches the Provider Number on the original claim as a cross-check to make sure the correct ICN is being adjusted.
CCN	Cash Control Number used to assign cash to the adjustment.
EOB Reason Code	EOB code that identifies the reason for the adjustment.
Reason Code Description	The description for the EOB Reason Code.

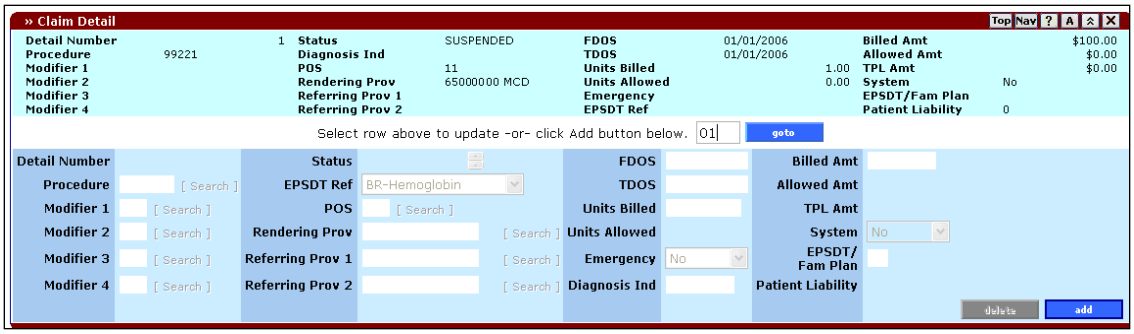
12.1.5 Adjustment Request Panel Button Descriptions

Field	Description
Add	Add a new record.
Delete	Delete an existing record.

The claim will open in a new browser window with a new ICN number.

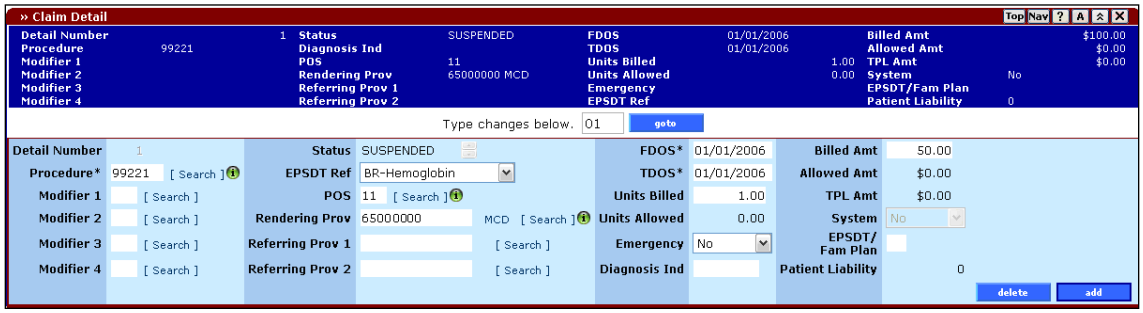


STEP 8. Access the Claim Detail panel.



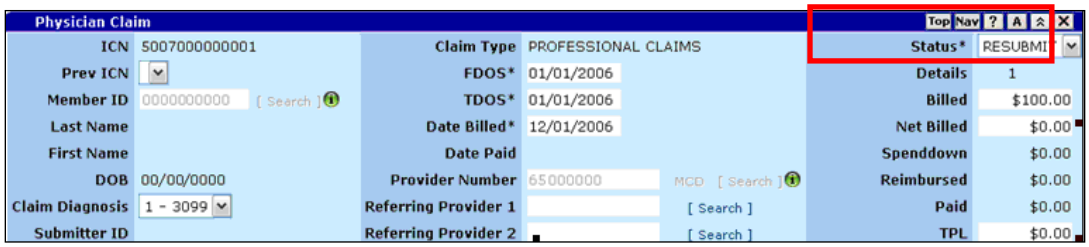
Claim Detail Panel

STEP 9. Select the Detail line that must be adjusted by clicking anywhere within the line one time. The line will turn dark blue and the information from the line will populate in the fields below. Edit the information.

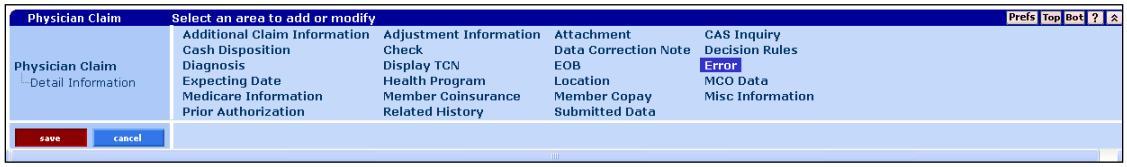


STEP 10. Access the header panel, which is the top panel (Physician Claim Panel, UB92 Claim Panel, or the Dental Claim Panel).

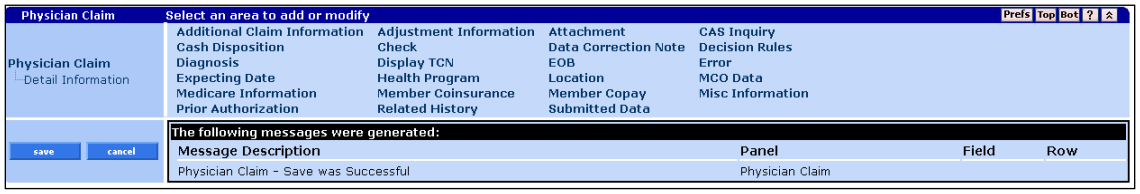
STEP 11. Change the “Status” of the claim to “Resubmit”.



STEP 12. Click the “Save” button on the Claim Maintenance Panel.

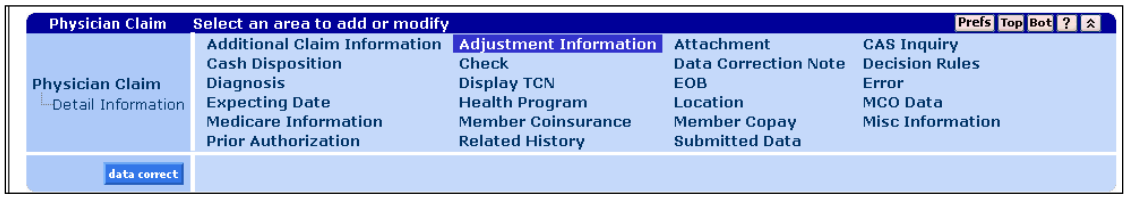


STEP 13. A “Save was Successful” message will appear.

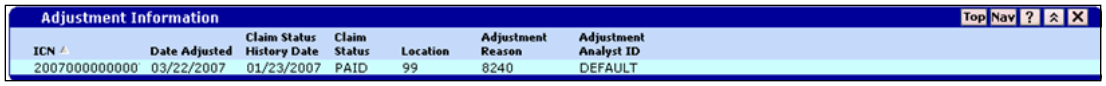


The original claim is called the “Mother” claim. The adjusted claim is called the “Daughter” claim.

STEP 14. To view the original claim, access the Claim Maintenance Panel. Select the Adjustment Information link.



STEP 15. The Adjustment Information panel will display the original (mother) ICN.



NOTE: If you are viewing the original ICN, click on the Adjustment Information panel to view the adjusted claim ICN.

12.1.6 Adjustment Information Panel Field Descriptions

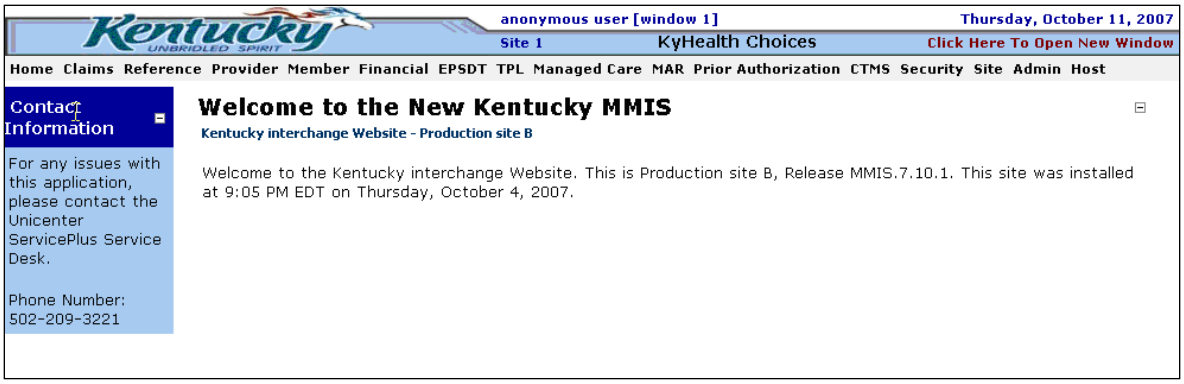
Field	Description
ICN	Internal control number which uniquely identifies a claim.
Date Adjusted	Date on which adjustment request was initiated.

Field	Description
Claim Status History Date	Date on which a claim was processed.
Claim Status	The status of the claim, example "PAID".
Location	Location code of the claim.
Adjustment Reason	Code identifying the detailed reason the adjustment was made.
Adjustment Analyst ID	Identification of the clerk that generated the adjustment request.

12.2 Setting Up a Mass Adjustment

STEP 1. Access interChange.

STEP 2. Select Claims from the main menu.



STEP 3. Select Adjustments from the Claims sub-menu.

STEP 4. Click the blue "New Mass" button.

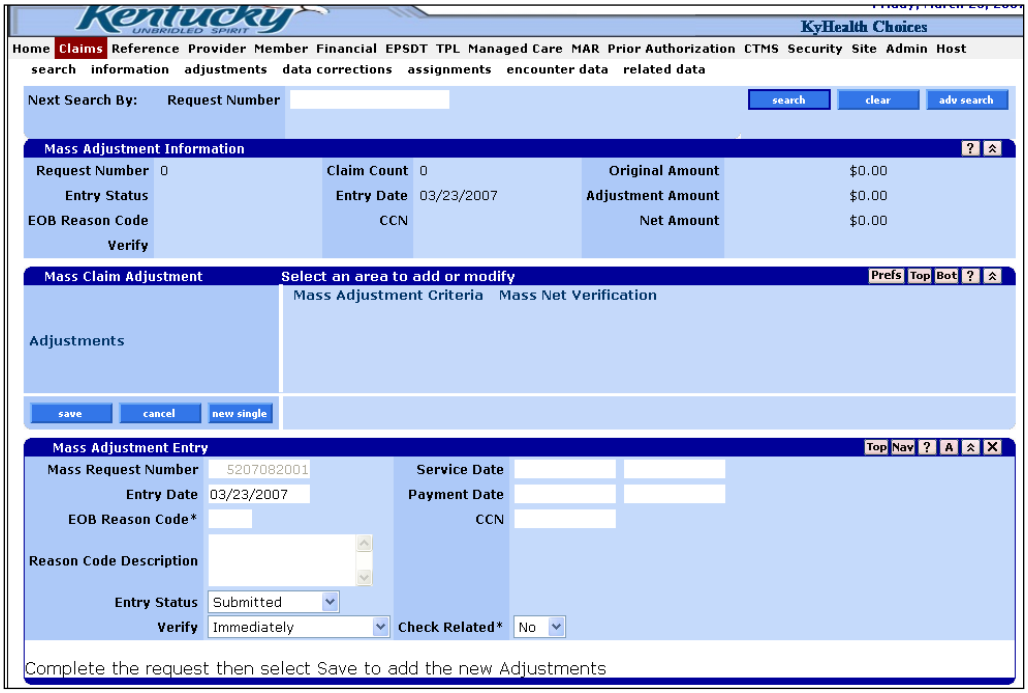
12.2.1 Adjustments Search Panel Field Descriptions

Field	Description
Request Number	Request number to be associated with adjustments for batch. Format is RRYYDDDBBB; RR region, YYDDD Julian year and day, BBB batch number.
Date	Date of the adjustment request.
Entry Status	The status of the claim when adjustment request was made.
User ID	ID of the user who made the request.
Records	The maximum number of records to be displayed per page.

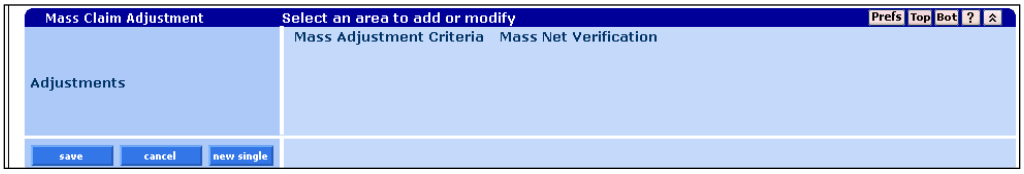
12.2.2 Adjustments Search Panel Button Descriptions

Button	Description
Search	Initiates Search for records that meet the search criteria.
Clear	Clears data in the search fields.
New Mass	Allows user to access a panel to begin or continue entering information for a mass adjustment of claims.
New Single	Allows user to access a panel to begin or continue entering information to adjust a single claim.

The Mass Adjustment Information page will display.



STEP 5. Access the Mass Claim Adjustment Maintenance Panel. Select the "Mass Adjustment Criteria" link.



STEP 6. The Mass Adjustment Criteria panel will display.

Kentucky UNBRIDLED SPIRIT — anonymous user [window 1] — Site 2 — KyHealth Choices — Tuesday, October 23, 2007 — Click Here To Open New Window

Home Claims Reference Provider Member Financial EPSDT TPL Managed Care MAR Prior Authorization CTMS Security Site Admin Host

search information adjustments data corrections assignments encounter data related data

Next Search By: Request Number — search clear adv search

Mass Adjustment Information

Request Number	0	Claim Count	0	Original Amount	$0.00
Entry Status		Entry Date	10/23/2007	Adjustment Amount	$0.00
EOB Reason Code		CCN		Net Amount	$0.00
Verify					

Mass Claim Adjustment — Select an area to add or modify — Prefs Top Bot

Mass Adjustment Criteria | Mass Net Verification

Adjustments

save cancel new single

Mass Adjustment Entry — Top Nav

Mass Request Number	5207296001	Service Date	
Entry Date	10/23/2007	Payment Date	
EOB Reason Code*	[Search]	CCN	[Search]
Reason Code Description			
Entry Status	Submitted		
Verify	B - Suspend before CE	Check Related*	No

Complete the request then select Save to add the new Adjustments

» Mass Adjustment Criteria — Top Nav

Aid Category
*** No rows found ***
Click add to insert
Program Code [Search]
delete add

Claim Type Selection
*** No rows found ***
Click add to insert
Type
delete add

Member ID
*** No rows found ***
Click add to insert
Member ID [Search]
delete add

ESC
*** No rows found ***
Click add to insert
Type both detail header
ESC [Search]
delete add

DRG
*** No rows found ***
Specify Drg Code, then click Add Range to insert.
Drg From* [Search] Drg To* [Search]
delete add range

Diagnosis Code
*** No rows found ***
Specify Diagnosis Code, then click Add Range to insert.
Diagnosis From* [Search] Diagnosis To* [Search]
delete add range

Gender/Age Min/Age Max
*** No rows found ***
Click add to insert
Gender both Min Max
delete add

NDC
*** No rows found ***
Click add to insert
NDC [Search]
delete add

Procedure Modifier
*** No rows found ***
Specify Procedure Code and Modifiers, then click Add Range to insert.
Procedure From* [Search] Procedure To* [Search]
Modifier 1: [Search] 2: [Search]
3: [Search] 4: [Search]
delete add range

Revenue Code
*** No rows found ***
Specify Revenue Code, then click Add Range to insert.
Revenue From* [Search] Revenue To* [Search]
delete add range

Provider Number
*** No rows found ***
Click add to insert
Provider Number [Search]
delete add

Provider Type
*** No rows found ***
Click add to insert
Provider Type
delete add

Provider Specialty
*** No rows found ***
Click add to insert
Provider Spec
delete add

Health Program Selection
*** No rows found ***
Click add to insert
Pgm
delete add

Region Code
*** No rows found ***
Click add to insert
Region
delete add

Pay As Billed
*** No rows found ***
Click add to insert; Select row to delete.
Paid Amount Equals Billed* Include Exclude
delete add

12.2.3 Mass Adjustment Criteria Panel Field Descriptions

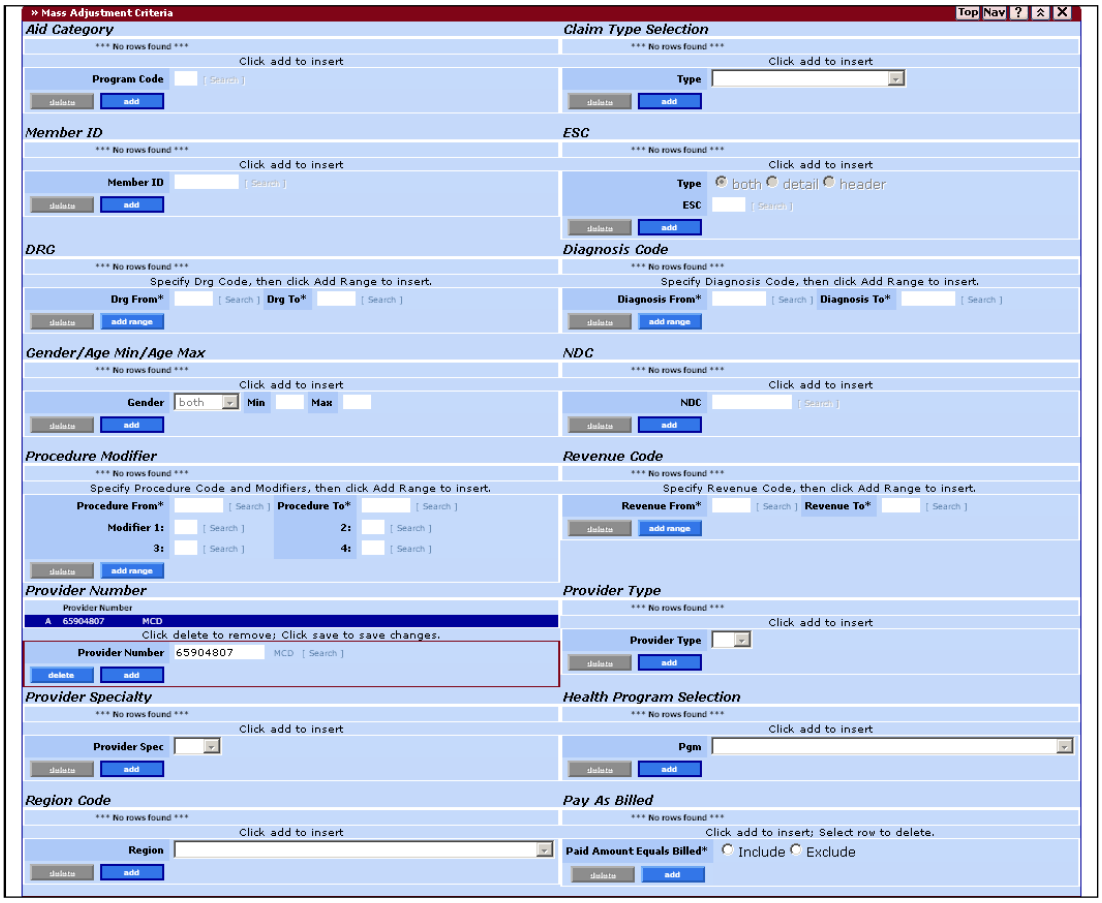
Field	Description
Aid Category Program Code	The aid category entered as criteria.
Member ID	Displays the member ID used for criteria.
DRG From / DRG To	Diagnosis Related Group. DRG is a code identifying the classification of diagnoses in which patients demonstrate similar resource consumption and length of stay patterns.
Gender	The gender of the member.
Min	The low age of the member age range.
Max	The high age of the member age range.
Procedure From / To	Field used to enter range of codes which indicates service provided as criteria.
Modifier 1 - 4	First, second, third, and fourth modifier to be used as criteria.
Provider Number	Provider number(s) chosen as criteria
Provider Specialty	Code used to identify the specialty of the provider.
Region Code	Region codes chosen from the list at the bottom of the window.
Claim Type Selection	Claim type chosen as criteria.
ESC	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit.
Diagnosis Code From / To	Range of diagnosis codes used as criteria. Diagnosis code specifies the condition requiring medical attention.
NDC	National Drug Code(s).
Revenue From / To	Range of revenue codes used as criteria. This identifies a specific accommodation or ancillary service. Revenue codes are determined by HCFA.
Provider Type	Code used to identify the type of the provider.
Health Program Selection / Pgm	Medical Assistance Programs chosen from the list at the bottom of the window.
Pay as Billed	Radio button used to include or exclude claims in which paid amount equals billed amount.

12.2.4 Claims/Adjustments/Mass Adjustment Criteria Panel Button Descriptions

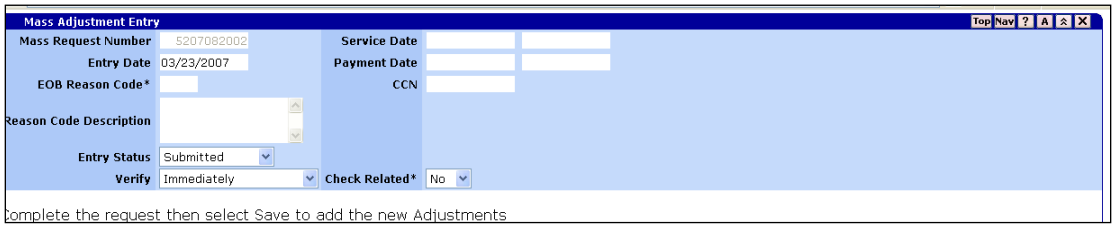
Button	Description

Button	Description
Add	Add a segment.
Add Range	Add a segment.
Delete	Delete a segment.

STEP 7. Enter the adjustment criteria.



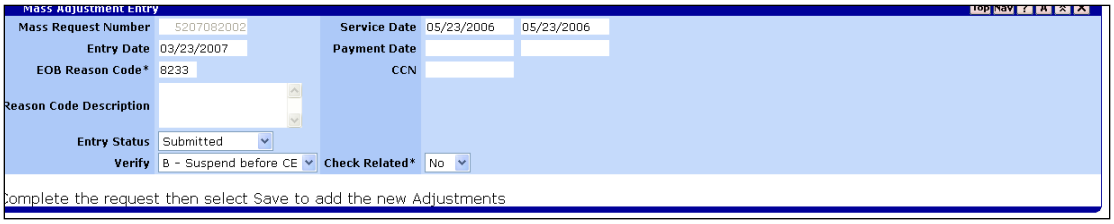
STEP 8. Access the Mass Adjustment Entry Panel.



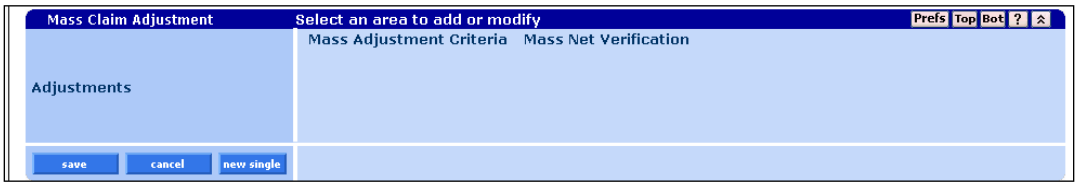
12.2.5 Claims/Adjustments/Mass Adjustment Entry Panel Field Descriptions

Field	Description
Mass Request Number	The system-assigned number for a Mass Adjustment Request.
Entry Date	Indicates the date the request was entered, system-assigned.
EOB Reason code	The Explanation of Benefits Reason identifies the reason for the request. The type of EOB also controls the processing action for editing and auditing purposes. Valid values: 8232 thru 8238, inclusive.
Reason Code Description	Explanation of the EOB Reason Code.
Entry Status	Indicates the status of the request, system determined.
Verify	Valid Values are: Indicates the mass adjustment should suspend for review, the adjustment processes through the Claims Engine and suspends for review at the end of processing. A - Suspend after running through the claims engine, B - suspend before running through the claims engine.
Service Date	Indicates the service dates as stated on the claim.
Payment Date	Indicates the from payment dates of the claim.
CCN	The cash or check control number used to describe the receipt of cash.
Check Related	Indicates whether the system-assigned key is cash receipts.

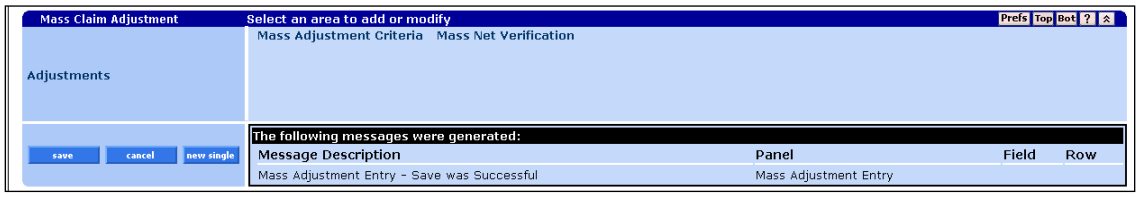
STEP 9. Enter the adjustment request criteria.



STEP 10. Click “Save” in the Mass Claim Adjustment Maintenance Panel.



A “Save was Successful” message will appear.



STEP 11. To identify the claims that meet the criteria of the mass adjustment request, access the Mass Claim Adjustment Maintenance Panel. Click on the Mass Net Verification Panel.

12.2.6 Mass Net Verification Panel Field Descriptions

Field	Description
Action Code	The action code determining how the adjustment is processed in batch. Values: 'A' - reprocess entire claim, 'P' - only reprocess claim details, 'H' - history only, do not edit, audit, or re-price.
Original ICN	Field to add or change original Internal Control Number of an adjusted claim.
Adjustment ICN	Field to add or change new Internal Control Number of an adjusted claim.
Original Amount	The original amount of the claim. This is a calculated value obtained by adding the Paid Amount and the State Share amount from the original Claim (from the T_CLM_PGM_XREF table). Format 99999999.99.
Adjusted Amount	The adjusted amount of the claim. This is a calculated value obtained by adding the Paid Amount and the State Share amount from the adjusted claim (from the T_CLM_PGM_XREF table).
Net Amount	The amount by which the Original Amount is adjusted. This is a calculated value determined by subtracting the Adjustment Amount from the Original Amount.
Adjusted Status	Indicates the status of the claim which is being adjusted.

Field	Description
New Claim Status	The status of the adjusted claim.
CCN	Cash or check receipt control number used in disposition the adjustment with the cash received.
EOB	Indicates the Explanation of Benefits code entered for the claim.

12.2.7 Claims/Adjustments/Mass Net Verification Panel Button Descriptions

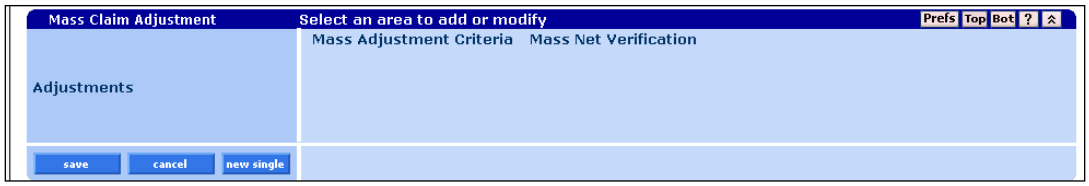
Field	Description
Resubmit All	Sets the Adjustment Status field to R for all records
Resubmit Selected	The user may select the checkboxes to the left of the claims and click this button to set the Adjustment Status field to R for the selected claims.
Delete All	Sets the Adjustment Status field to D for all records.
Delete Selected	The user may select the checkboxes to the left of the claims and click this button to delete the selected claims.
Data Correct	Opens up the Corrections window for the selected claim.

STEP 12. Select the claim(s) that must be re-processed for the adjustment.

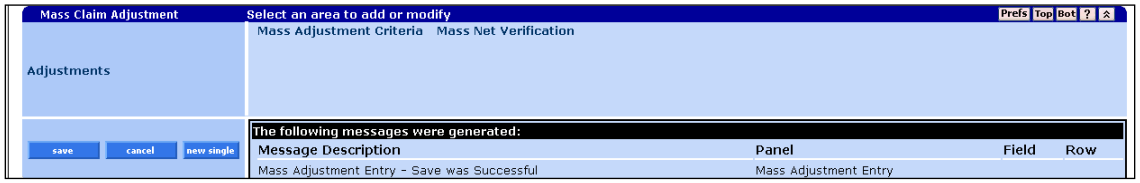
To re-submit all the claims listed, click “Resubmit All”.

To re-submit a specific claim or claims, click the white box located to the left of the claim. Then, click “Resubmit Selected”.

STEP 13. Click “Save” on the Mass Claim Adjustment Maintenance Panel.



A “Save was Successful” message will appear.



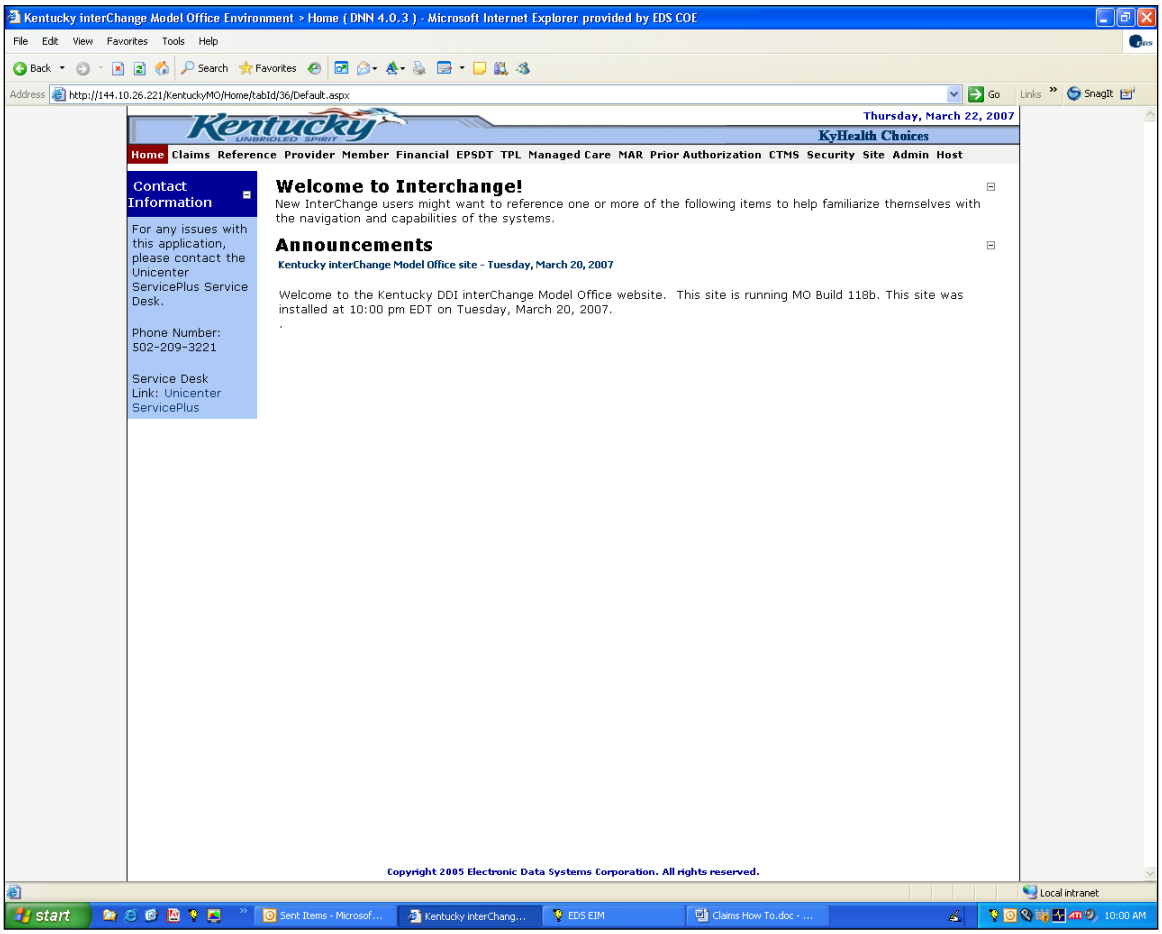
13 Appendix F – How to Schedule and Assign Claims

13.1 Scheduling Claims

Claims can be distributed, or scheduled, to users on a daily basis. Claims may be assigned by claim type, or all claim types can be assigned at once.

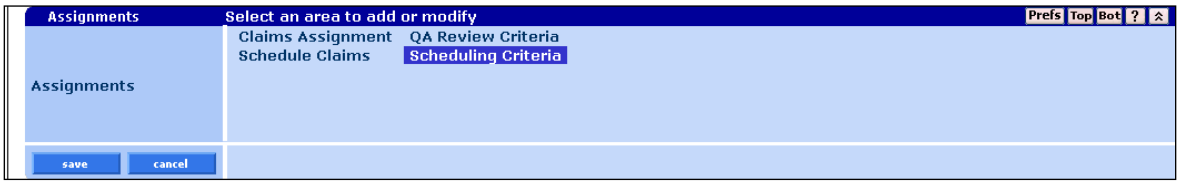
STEP 1. Access interChange.

STEP 2. Select Claims from the main menu.

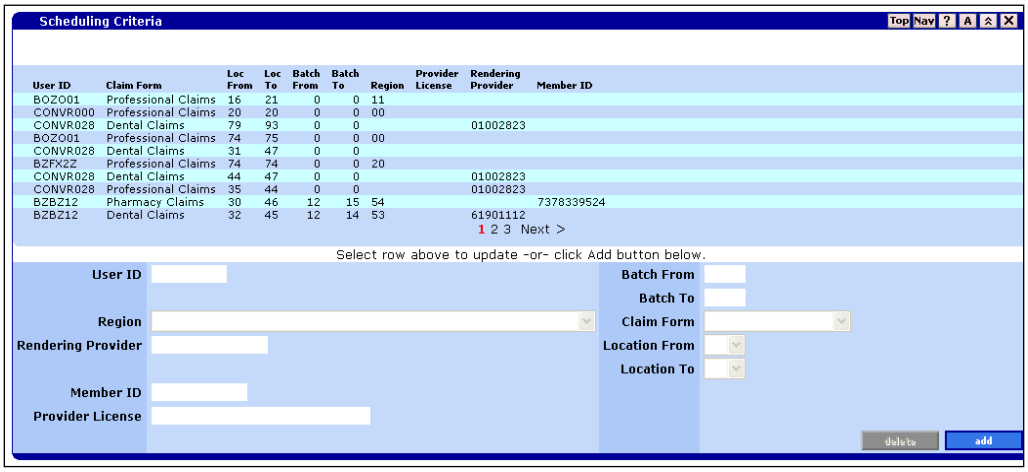


STEP 3. Select Assignments from the Claims sub-menu

STEP 4. The Assignment Maintenance Panel will display. Click the “Scheduling Criteria” link.



STEP 5. The Scheduling Criteria panel will display. To set up a new schedule for a user, click the “Add” button.



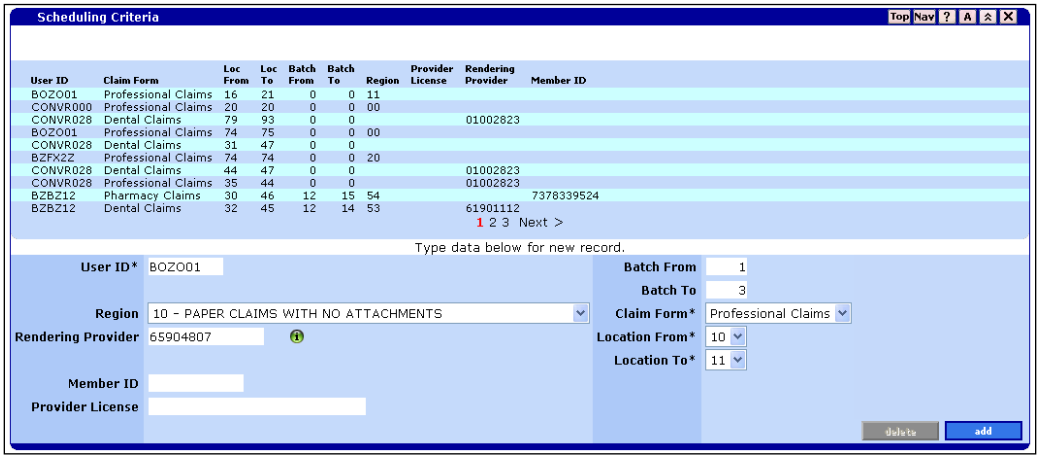
13.1.1 Scheduling Criteria Panel Field Descriptions

Field	Description
User ID	Indicates the user the claims are assigned to. Select a valid User Id from the [Search] panel.
Region	The beginning region code of the claims assigned to the user.
Rendering Provider	The provider identification number that uniquely identifies the provider and provider's service location. Select a valid Provider Id from the [Search] panel.
Member ID	A system-assigned number which uniquely identifies a member. Claims for a specific Member ID may be assigned to a selected user. Select a valid Member ID from the [Search] panel.
Provider License	License number of the provider of services.
Batch From	The beginning batch number used to identify the grouping of the claims.
Batch To	The ending batch number used to identify the grouping of the claims.
Claim Form	Indicates the type of claim assigned to the user for review.
Location From	The beginning location of the claims assigned to the user.
Location To	The ending location of the claims assigned to the user.

13.1.2 Claims/Assignments/Scheduling Criteria Panel Button Descriptions

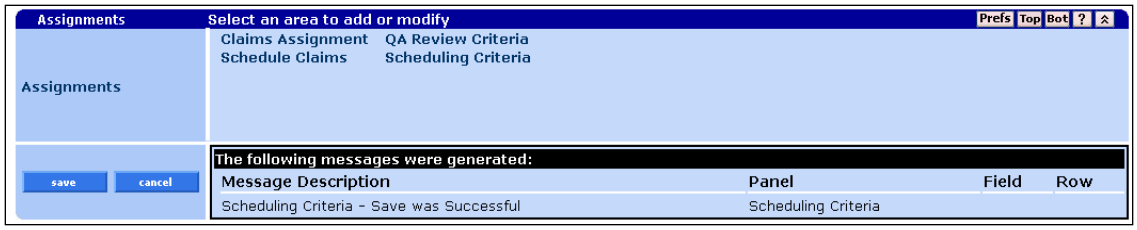
Button	Description
Add	Add a new record.
Delete	Delete a record.

STEP 6. Enter the new scheduling criteria in the fields located in the lower half of the panel. A User ID and a Claim Form must be entered.

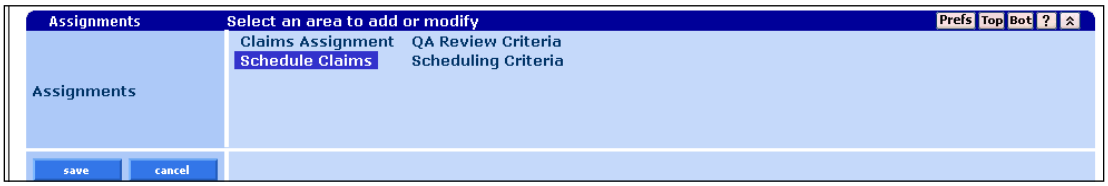


STEP 7. Click the “Save” button on the Assignments Maintenance Panel.

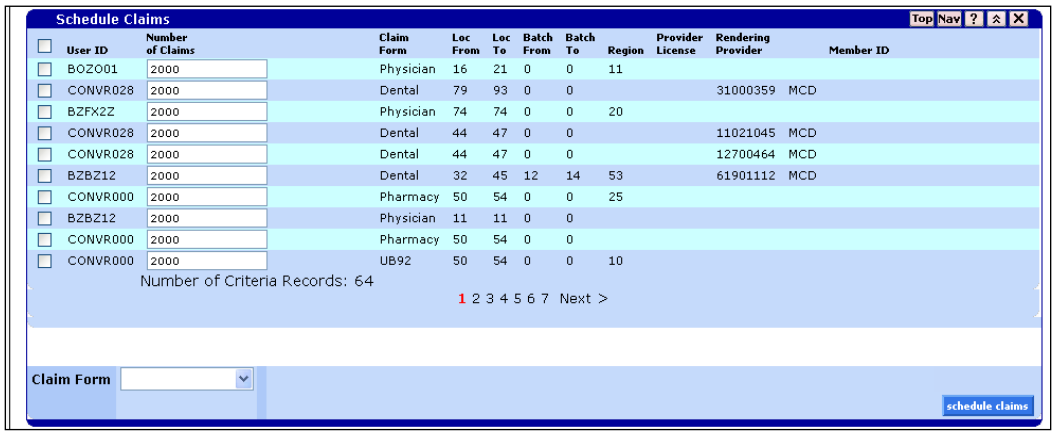
A “Save was Successful” message will be displayed.



STEP 8. Access the Assignments Maintenance Panel. Click the "Schedule Claims" link.



The Schedule Claims panel will display.



Schedule Claims Panel

13.1.3 Schedule Claims Panel Field Descriptions

Field	Description
User ID	Indicates the user the claims are assigned to.
Number of Claims	This is the total number of claims found for the User.
Claim Form	Indicates the type of claim assigned to the user for review.
Loc From	The beginning location of the claims assigned to the user.
Loc To	The ending location of the claims assigned to the user.
Batch From	The beginning batch number used to identify the grouping of the claims.

Field	Description
Batch To	The ending batch number used to identify the grouping of the claims.
Region	The beginning region code of the claims assigned to the user.
Provider License	License number of the provider of services.
Rendering Provider	The provider identification number that uniquely identifies the rendering provider.
Member ID	Member's unique *KY Medicaid* ID number. Claims for a specific Member ID may be assigned to a selected user.

13.1.4 Schedule Claims Panel Button Descriptions

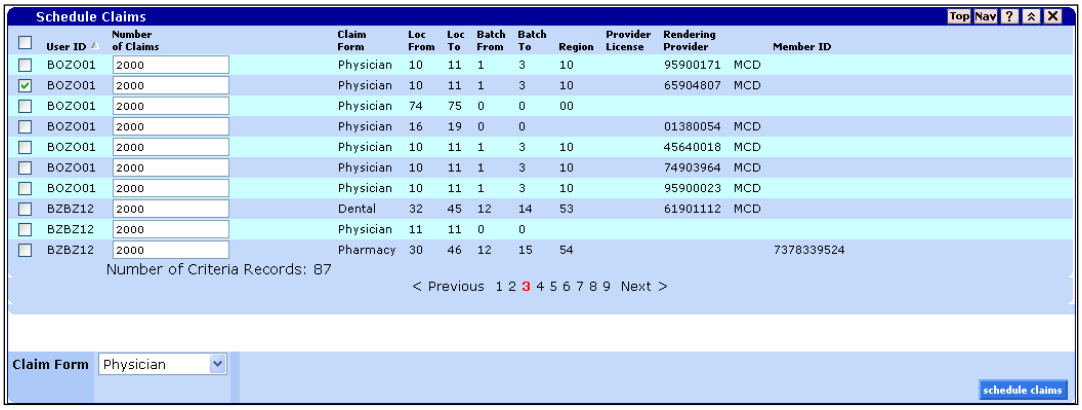
Button	Description
Schedule Claims	Updates the schedule claims information.

STEP 9. Select the User ID.

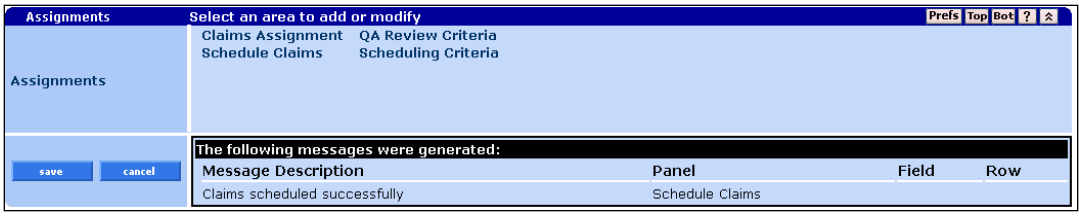
To select all the users, click the white box located next to the "User ID" heading.

To select a specific user, click the white box to the left of each USER ID.

STEP 10. Select a Claim Form from the drop down menu. And, click the "Schedule Claims" button.



A "Save was Successful" message will be displayed.

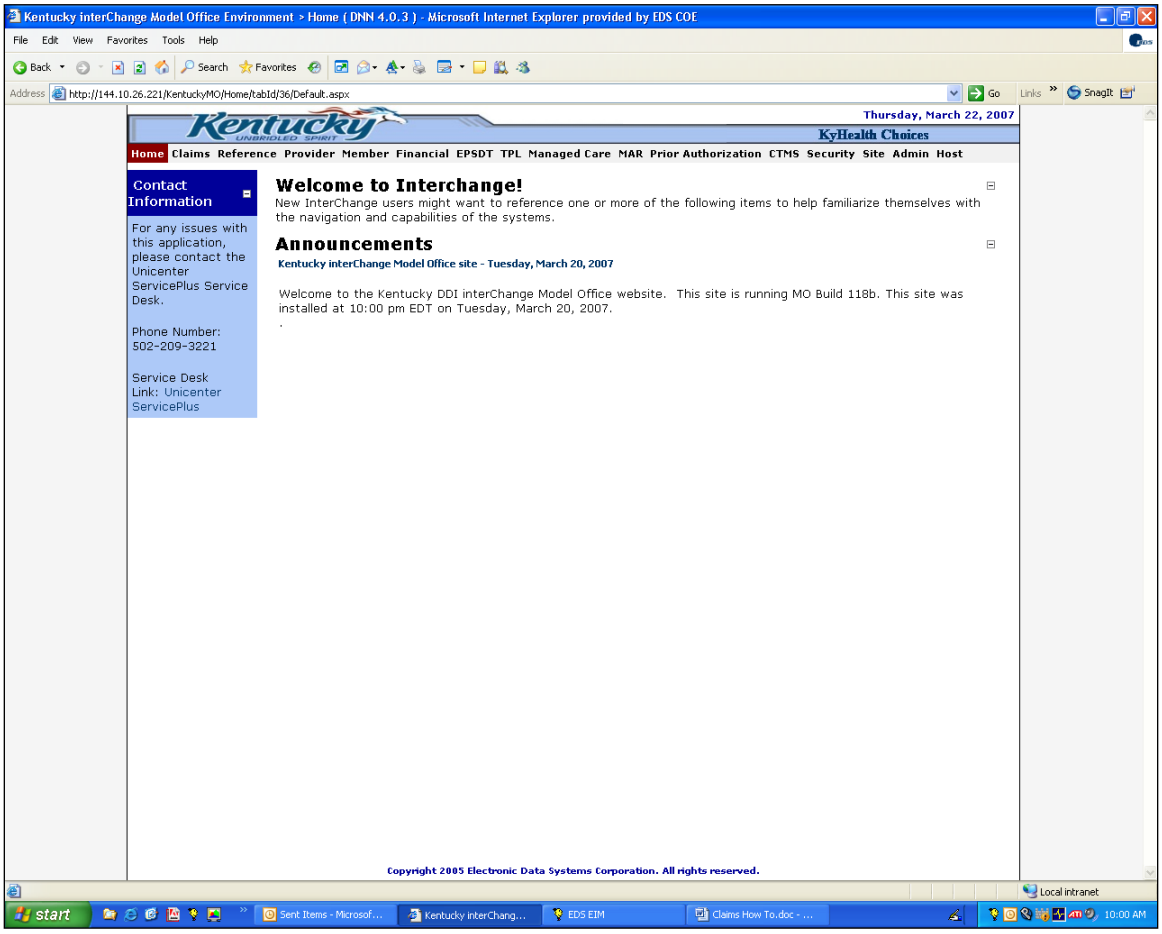

Assignments
Select an area to add or modify
Prefs Top Bot ?
Claims Assignment
QA Review Criteria
Schedule Claims
Scheduling Criteria
Assignments
save
cancel
The following messages were generated:
Message Description
Panel
Field
Row
Claims scheduled successfully
Schedule Claims

13.2 Assigning Claims

Claims can be assigned to another user by changing the User ID associated with a claim.

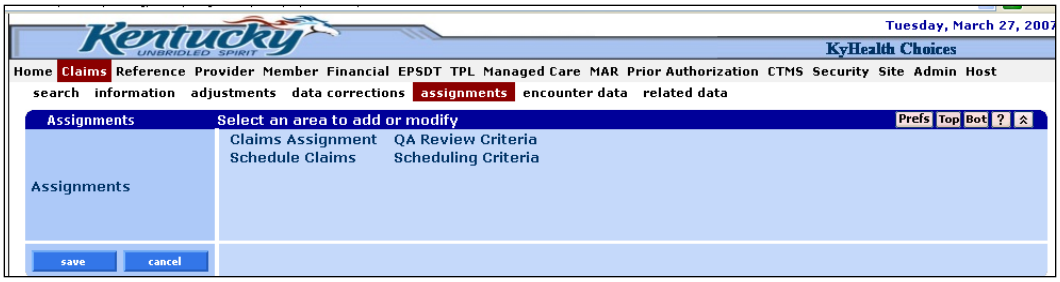
STEP 1. Access interChange.

STEP 2. Select Claims from the main menu.



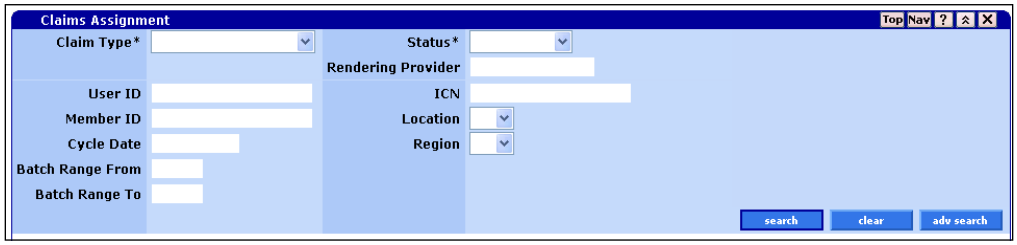
STEP 3. Select Assignments from the Claims sub-menu

STEP 4. The Assignments page will display. Click the “Claims Assignment” link.



STEP 5. The Claims Assignment panel will display. Click the "Adv Search" button to display additional search criteria fields.

STEP 6. The Advanced Search panel will display.



Claims Assignment Advanced Search Panel

13.2.1 Claims Assignment Advanced Search Panel Field Descriptions

Field	Description
Claim Type	Indicates the claim type assigned to the user.
User ID	Indicates the User ID assigned to the claims.
Member ID	Allows the manager to limit the selection to a specific Member ID number.
Cycle Date	Allows the manager to limit the selection to a specific cycle date.
Batch Range From	Batch Range From value that allows the manager to limit the selection of claims to a specific batch range.
Batch Range To	Batch Range To value that allows the manager to limit the selection of claims to a specific batch range.

Field	Description
Status	Displays the claims selected by the user depending on the status selected.
Rendering Provider	Allows the manager to limit the selection of claims to the individual provider number from the claims.
ICN	Internal control number that uniquely identifies a claim.
Location	Allows the manager to limit the selection of claims to a specific location.
Region	Allows the manager to limit the selection of claims to a specific region.

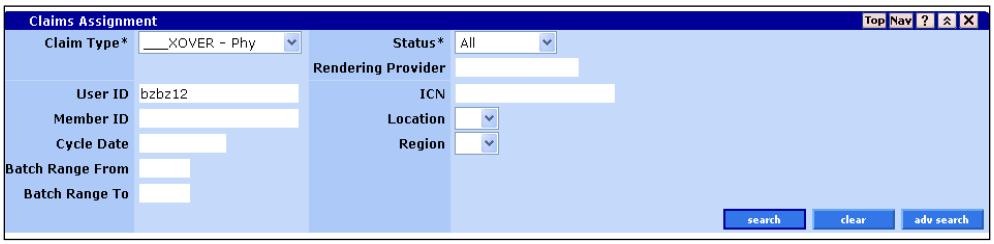
13.2.2 Claims Assignment Advanced Search Panel Button Descriptions

Button	Description
Search	Performs a query on the database and returns the data for the entered search criteria.
Clear	Clears the previous search criteria from the search fields.
Adv Search	Opens a panel with additional search criteria fields.

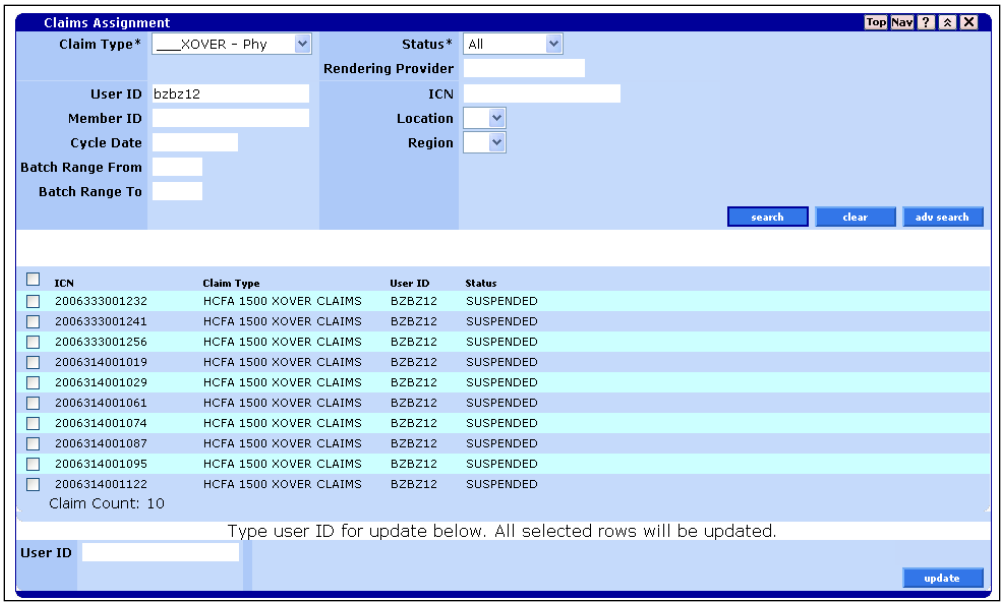
STEP 7. Enter the search criteria to view a list of claims that can be reassigned.

NOTE: Claim Type and Claim Status must be entered. All other fields are optional.

STEP 8. Click the blue “Search” button.



The Claims Assignment panel will expand and a list of claims that can be re-assigned will display.



Claims Assignment Search Results Panel

13.2.3 Claims Assignment Search Results Panel Field Descriptions

Field	Description
ICN	Internal control number that uniquely identifies a claim.
Claim Type	Indicates the claim type assigned to the user.
User ID	Indicates the User ID assigned to the claims.
Status	Displays the claims selected by the user depending on the status selected.

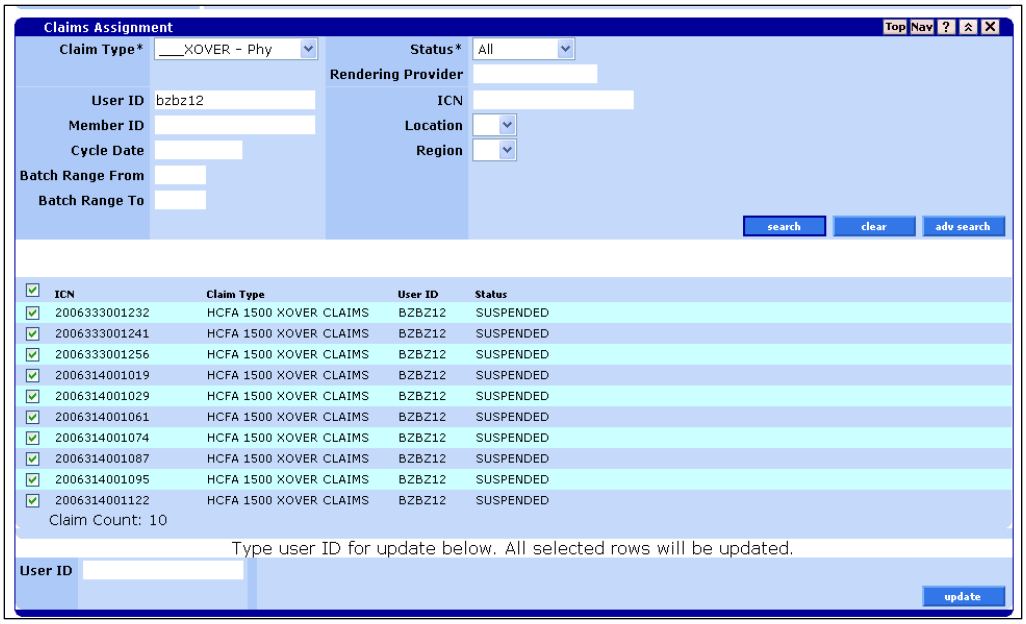
13.2.4 Claims Assignment Search Results Panel Button Descriptions

Button	Description
Update	Assigns the User ID entered to the selected claims.

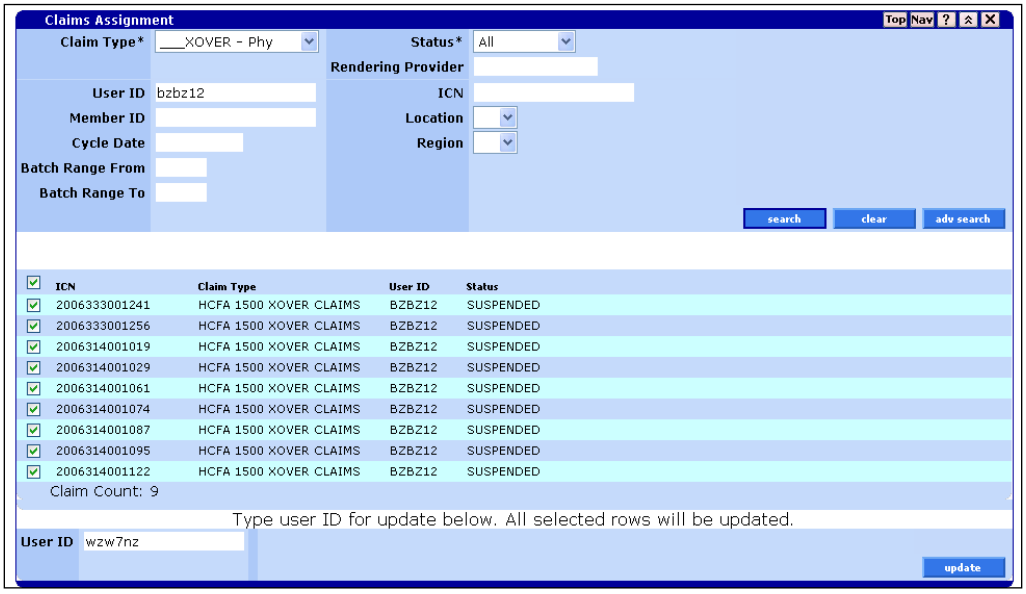
STEP 9. Select the claims that must be re-assigned.

To select individual claims, click the white box to the right of each ICN. A checkmark will appear in the box to indicate that it is selected.

To select all claims, click the white box at the top of the panel to the left of the ICN column heading. The screen will refresh and all the boxes will be check marked.

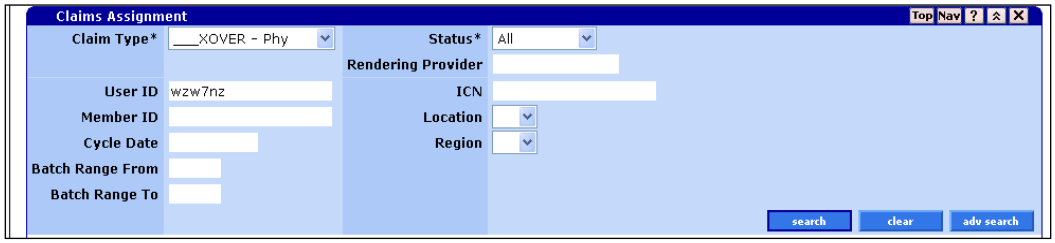


STEP 10. Enter the User ID of the person who will be assigned the selected claim(s). Click the "Update" button.



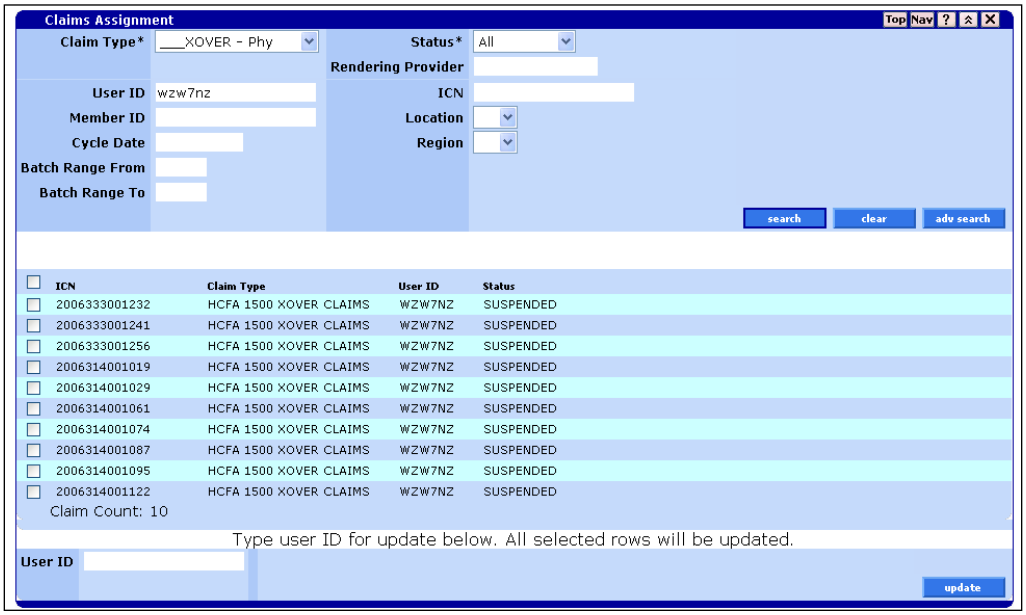
The claim(s) will be assigned to the User ID specified in STEP 10.

STEP 11. To view the claim(s) assigned to the User ID, enter the search criteria at the top of the panel, including the "User ID". Click the blue "Search" button.



Claims Assignment Search Panel

The re-assigned claim(s) will display.

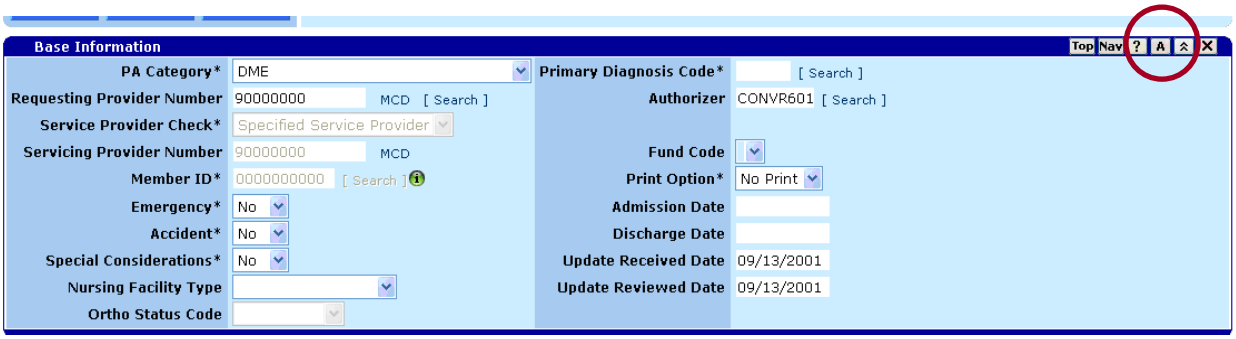


Claims Assignment Search Results

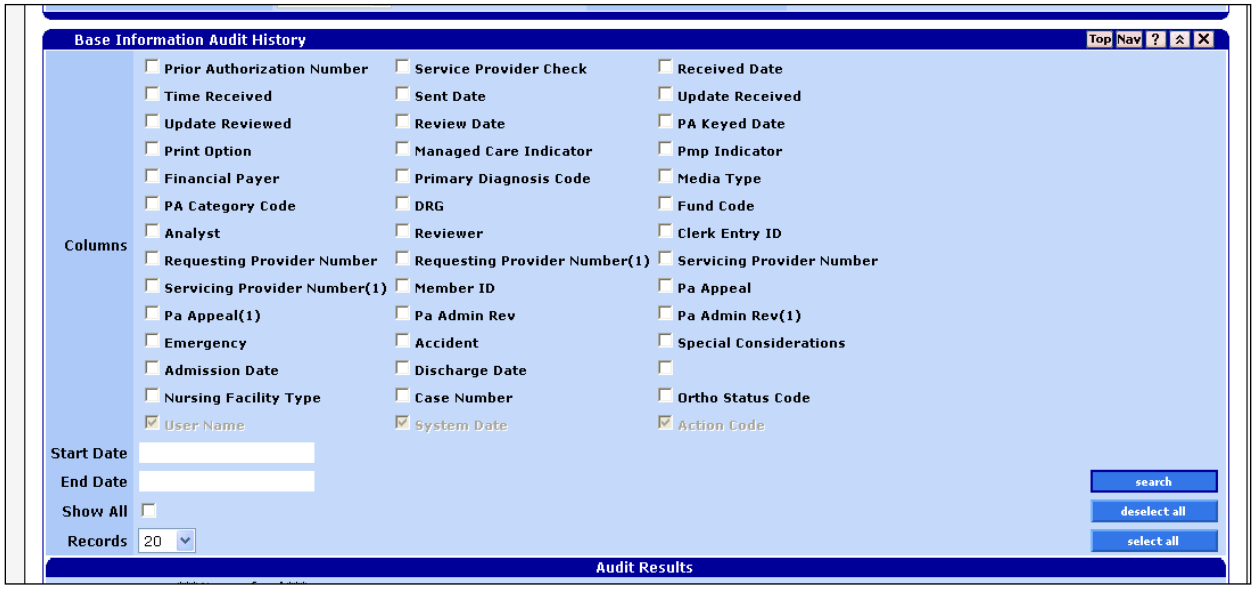
14 Appendix G – Using the Audit Trail

The Audit Trail provides information about changes and updates to the MMIS. Each panel which has add/update functionality has an audit trail. This is accessed via the "A" button in the top right corner of the panel.

STEP 1. Click the "A" button on the panel.



The Audit History panel will open.

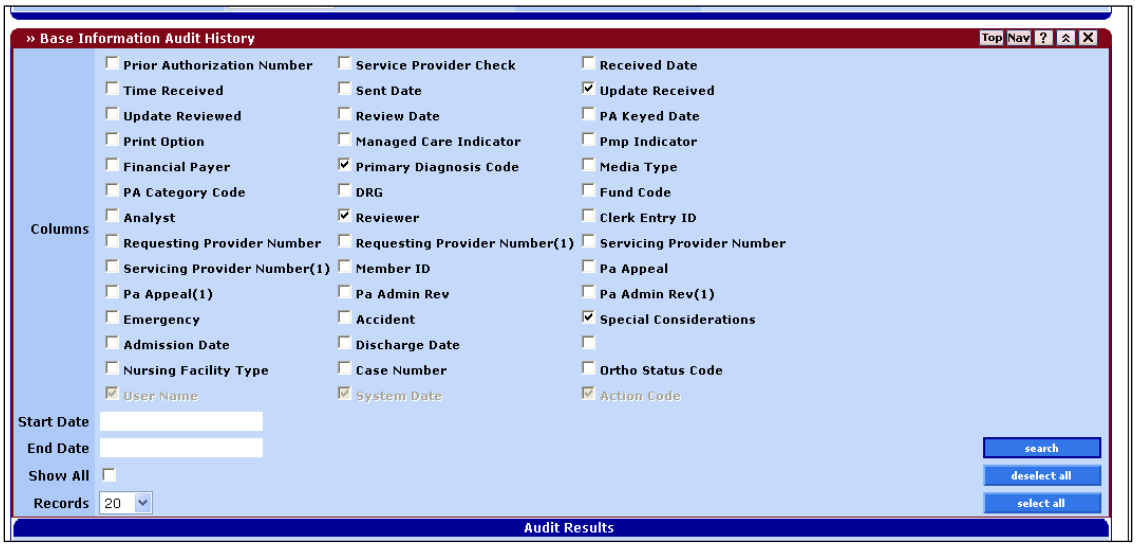


Audit History Panel

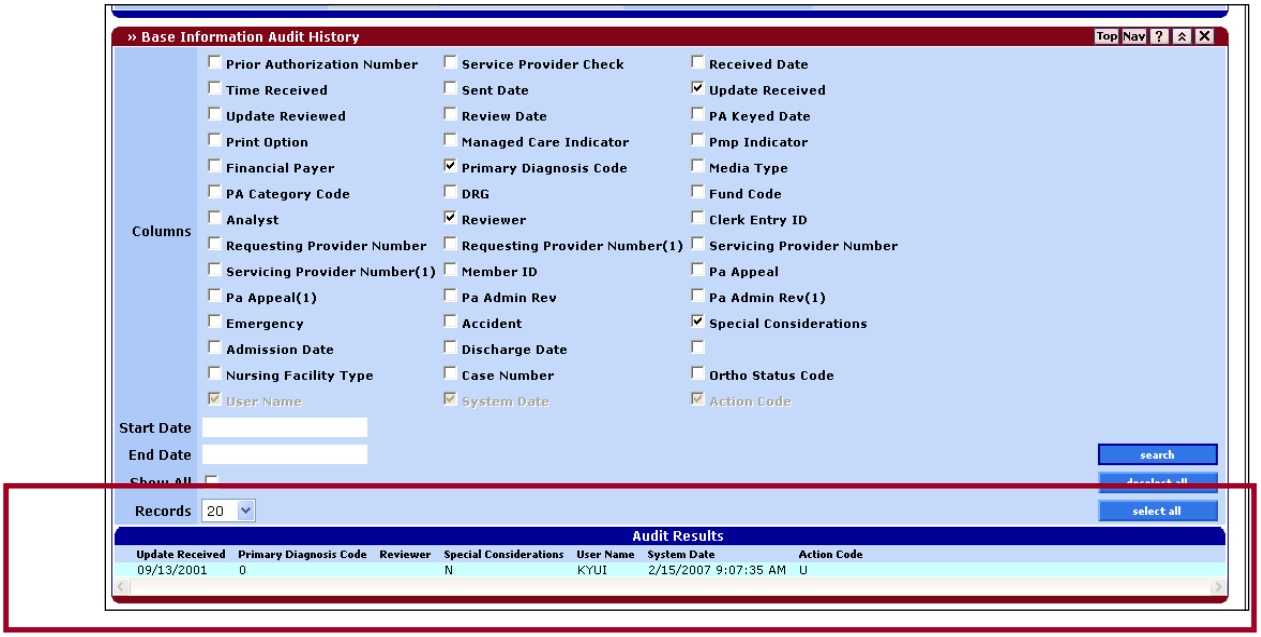
The Audit History panel will show a "check box" for each updatable field on the panel. Clicking a box instructs interChange to display the update/change record for that field. You may limit the time frame of your search by entering "Start Date" and "End Date," or, you may click "Show All" to see all change records for the fields in question.

EXAMPLE: If you wanted to see if a change was made in the PA Category Code after a claim paid in June 2005, but before a claim paid in October 2005, you would click the box to the right of "PA Category Code" and enter a Start Date after June 2005, and an end date before October 2005.

STEP 2. Select the fields and enter a date range, if applicable.



Search results will be displayed at the bottom of the Audit History panel.



Audit Results

14.1 Audit Results Field Descriptions

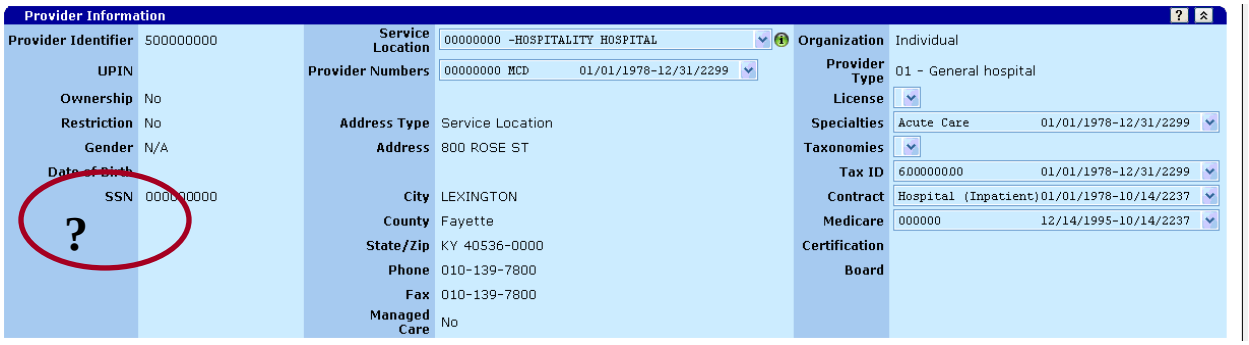
Field	Description
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.

Field	Description
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.
User Name	The User who made the change/update.
System Date	Date the change/update was made.
Action Code	What type of change was made; U= Update, D= Delete, A= Add.

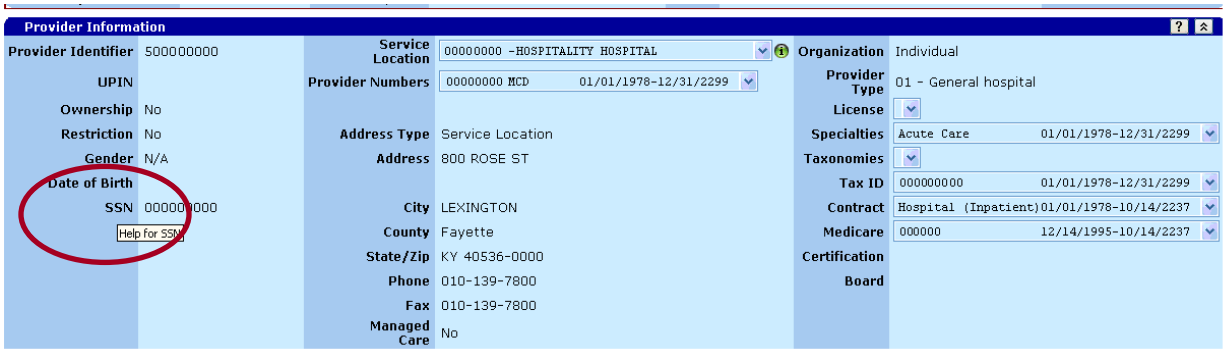
15 Appendix H– Using the Help Functions

interChange includes built in “Help” functions on each panel.

Each field label displays a question mark on mouse-over, alerting the user that help is available.



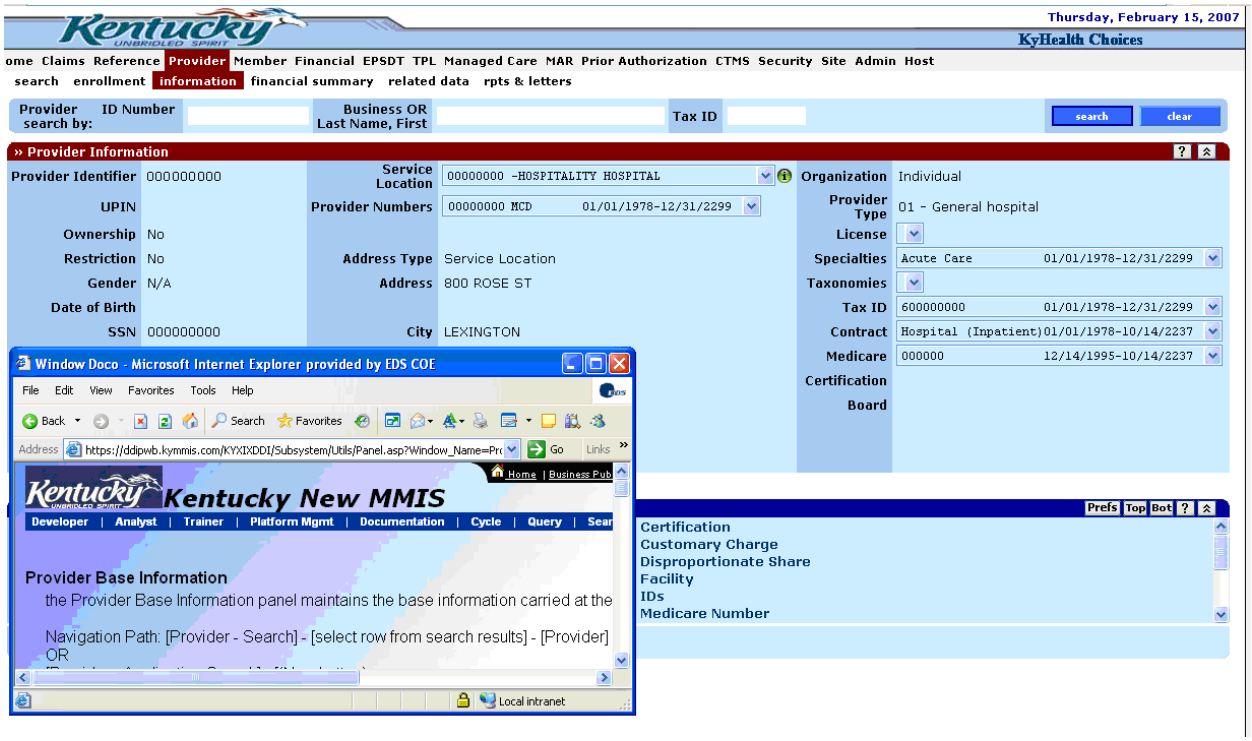
An alt tag will appear if the mouse “hovers” over a field label. The alt tag alerts the user that clicking the field label will go to “Help.”



15.1 Accessing Help for a Field

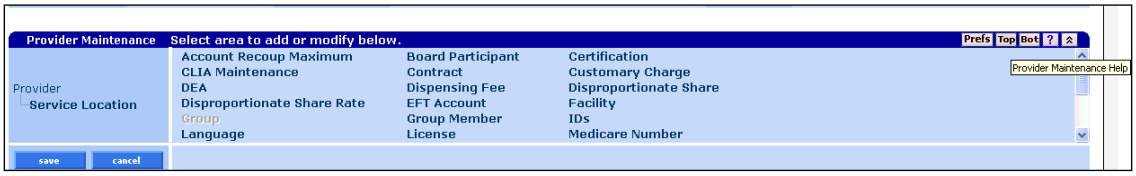
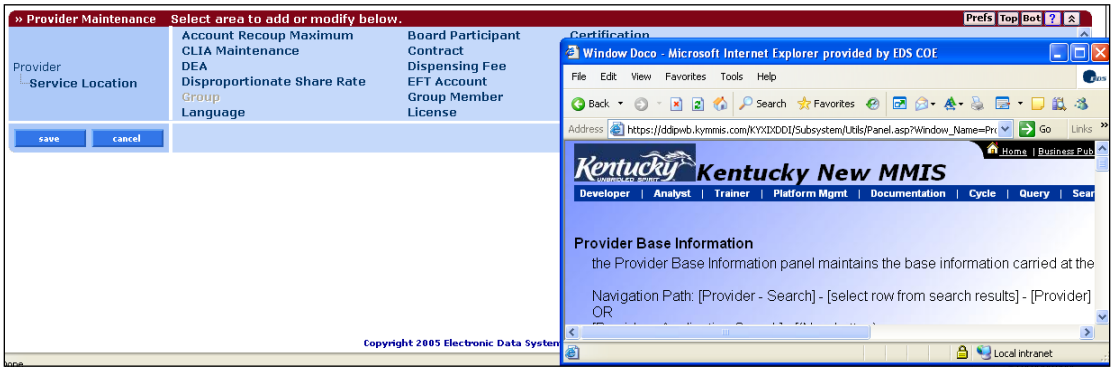
STEP 1. Click the field label.

A new browser will open. The Project Workbook page for the panel will be displayed.



15.2 Accessing Help for a Panel

STEP 1. Click the question mark button in the upper right corner of the panel.



A new browser will open. The Project Workbook page for the panel will be displayed.