



**Data Warehouse/DSS Subsystem
User Manual**
Kentucky MMIS Project

*Cabinet for Health and Family Services
Department for Medicaid Services*

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1 Introduction

This user manual is designed to cover the information necessary to perform the tasks of the Decision Support System/Data Warehouse (DSS/DW) functional area.

This manual covers the following areas:

- Subsystem Overview;
- Getting Started;
- Procedures;
- Windows;
- Reports;
- Letters;
- Glossary of Terms;
- GeoCoding Overview;
- ArcIMS Maps;
- How to Create DSS Queries; and
- Measure Base Information.

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

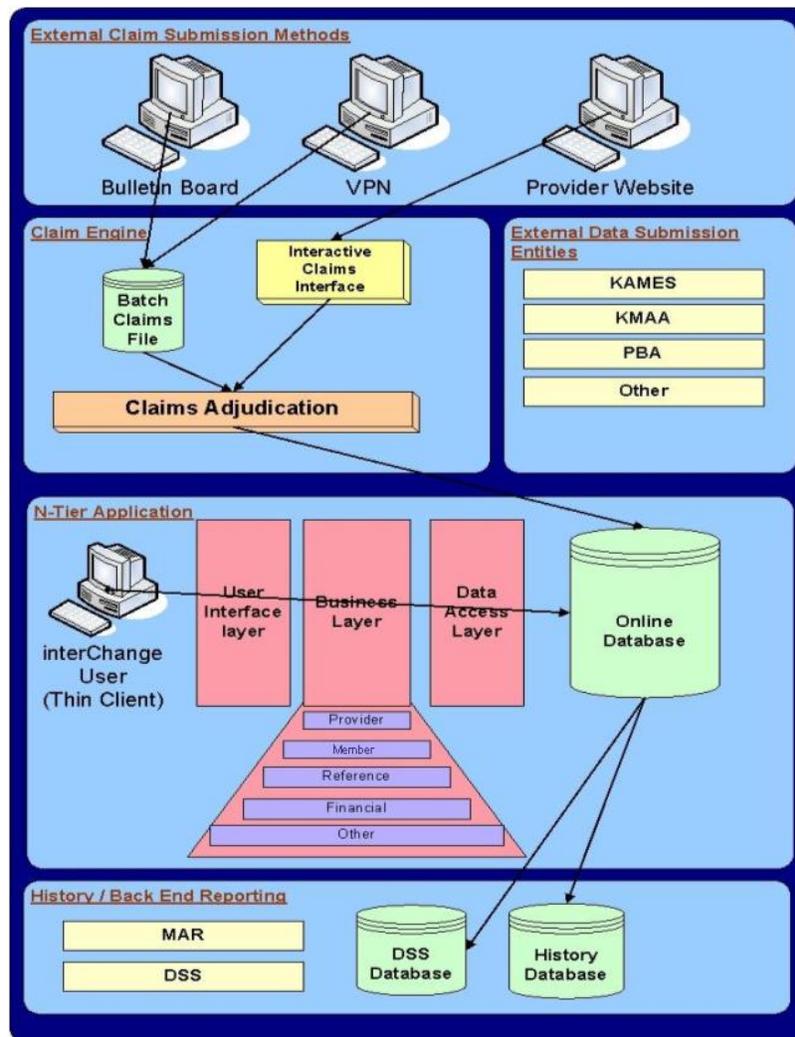
This manual is designed to serve the needs of the following staff:

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

1.2 Overview

1.2.1 interChange System Architecture

The system is logically divided into four primary components: Claims engine, User Interface, Batch, and the History and Back End Reporting. The Claims engine is responsible for receiving interactive transactions from external sources, adjudicating them, and returning the appropriate response. The User Interface is an N-tier application providing segregated and loosely coupled presentation, business logic, and data logic layers. The user interface provides access to the online subsystem functions through a thin client, the web browser. The Batch component is responsible for maintaining and reporting on data contained within the online database. The History and Back End reporting component is responsible for analyzing, reporting, and supporting the management of the activities that have occurred in the two front end systems. The system interfaces with a variety of data sources which influence processing within the system. The External data submission entities are organizations that supply information to the Medicaid Management Information System (MMIS).



1.3 Subsystem Description

1.3.1 Introduction to Decision Support System/Data Warehouse

The interChange DSS/DW subsystem provides access to Kentucky's interChange Medicaid Management Information System (KY MMIS) data. The DSS/DW is an Oracle 10g RDBMS database, which is accessed through the BusinessObjects XI application for query and report development.

Within BusinessObjects, data models that show the relationships among individual elements are created by functional area. These data models are referred to as "Universes". The BusinessObjects "Universes" remove the technical knowledge needed to develop and run queries against the MMIS data within the system.

To simplify the development of queries, data elements are given practical names and logically grouped for easy selection. Users use common Windows-like features, such as drag and drop, to quickly develop queries and gain access to the desired data. Through the DSS/DW users of all experience levels can generate reports ranging from simple queries to more complex reporting and data analysis.

1.3.2 Business Process Flow/Narrative for Decision Support

This section of the document provides a high level narrative overview of the Data Warehouse subsystem functionality. The DSS/DW combines specialized tools and processes to make enterprise data easily accessible for ad hoc query and reporting or for producing regularly scheduled reports.

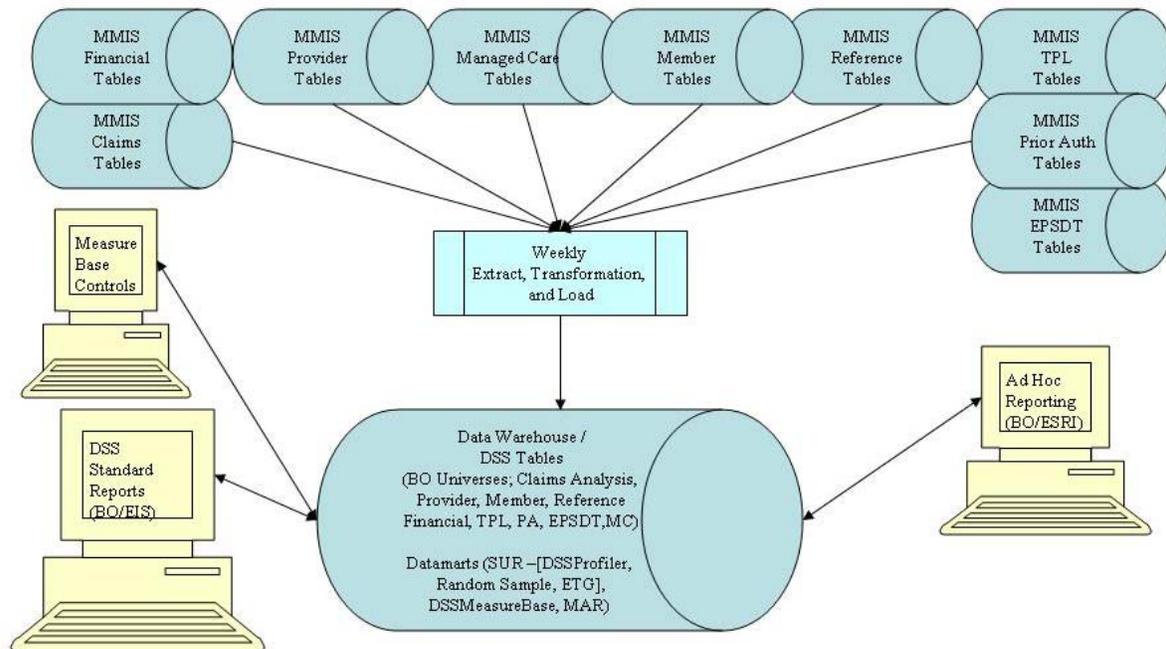
Capitation, encounter, fee for service claims and other MMIS data are included in the DSS/DW so that previously separate subject areas can be combined and formatted into reports by both novice and power users. A data model optimized for data access ensures that data can be returned quickly and accurately with little or no knowledge of the underlying complexity. The DSS/DW is comprised of programs and processes to extract data from the interChange MMIS and store it in an Oracle database accessed by BusinessObjects. The following tools and functionality are included in the DSS/DW:

- High performance data storage and access using Oracle with partitioning option;
- Pre-built BusinessObjects Universes that provide a completely documented semantic layer allowing non-technical users to understand the data and build complex optimized queries to access it; and,
- The BusinessObjects tool suite for reporting, environment control, and monitoring, consists of these components:
 - Reporter to build queries and format advanced reports and graphs;
 - Designer to build universes that document the data and define how it is accessed;
 - Central Management Console to define various levels of users and the data, reports, and functions to which they have access;
 - Scheduler to automate the running of periodic reports and large ad hoc queries at off-peak times; and,

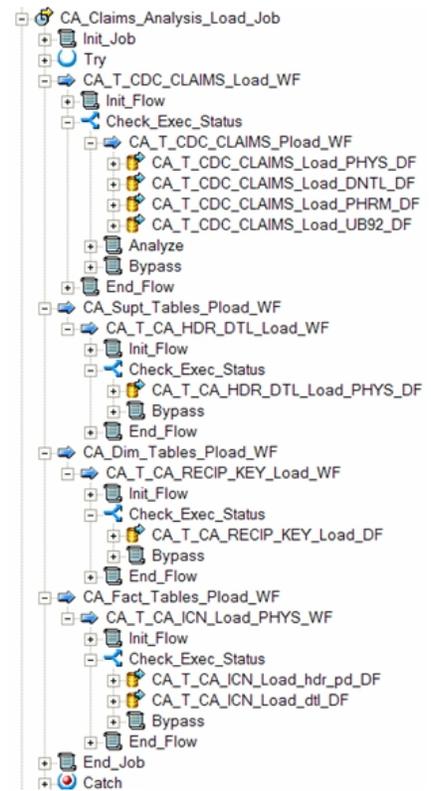
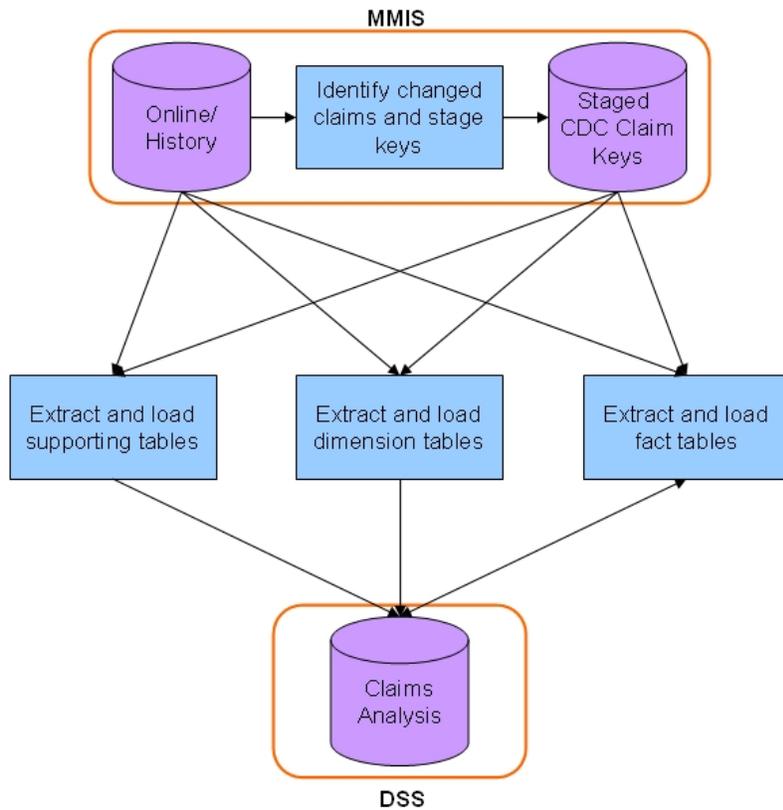
- InfoView to provide a web based common access point and report library to system components and pre-built reports.

1.4 Data Model

The following data model gives a view of the primary entities within the DSS/Data Warehouse functional area.



1.4.1 Claims Analysis ETL Processing Overview



1.4.2 Claims Analysis Table Overview

T CA TIME KEY

SAK_TIME_KEY: NUMBER(9) NOT NULL
DTE_CLAIM_DATE: DATE NOT NULL
DTE_WEEK: NUMBER(6) NOT NULL
DTE_MO: NUMBER(6) NOT NULL
DTE_CTR: NUMBER(6) NOT NULL
DTE_CY: NUMBER(4) NOT NULL
DTE_SFY: NUMBER(4) NOT NULL
DTE_FFY: NUMBER(4) NOT NULL
DAY_OF_WEEK: NUMBER(4) NOT NULL

T CA ICN

SAK_CLAIM: NUMBER(9) NOT NULL
PERF_PROV_KEY: NUMBER(9) NOT NULL
REFER_PROV_KEY: NUMBER(9) NOT NULL
BILL_PROV_KEY: NUMBER(9) NOT NULL
SUBM_PROV_KEY: NUMBER(9) NOT NULL
FAC_PROV_KEY: NUMBER(9) NOT NULL
SURG_PROV_KEY: NUMBER(9) NOT NULL
CLAIM_KEY: NUMBER(9) NOT NULL
RECIP_KEY: NUMBER(9) NOT NULL
DOS_TIME_KEY: NUMBER(9) NOT NULL
PAID_TIME_KEY: NUMBER(9) NOT NULL
AMT_ALWD: NUMBER(10,2) NOT NULL
AMT_REIMBURSED: NUMBER(10,2) NOT NULL
AMT_PAID: NUMBER(10,2) NOT NULL
AMT_STATE_SHARE: NUMBER(10,2) NOT NULL
AMT_FEDERAL_SHARE: NUMBER(10,2) NOT NULL
AMT_ENCOUNTER: NUMBER(10,2) NOT NULL
AMT_TPL: NUMBER(10,2) NOT NULL
AMT_CO_PAY: NUMBER(10,2) NOT NULL
AMT_PAT_LIAB: NUMBER(10,2) NOT NULL
AMT_MGARE_PAID: NUMBER(10,2) NOT NULL
AMT_PD_MCO: NUMBER(10,2) NOT NULL
CNT_CLAIMS_PAID: NUMBER(9) NOT NULL
CNT_CLAIMS_DENIED: NUMBER(9) NOT NULL
QTY_UNITS_ALWD: NUMBER(9,2) NOT NULL
NUM_DAYS_COVD: NUMBER(9) NOT NULL
NUM_DAYS_NCOVD: NUMBER(9) NOT NULL
SAK_RECIP: NUMBER(9) NOT NULL
NUM_RECIP_AGE: NUMBER(4) NOT NULL
NUM_DTL: NUMBER(4) NOT NULL
BUDGET_YR: NUMBER(4) NOT NULL
DTE_BILLED: DATE NOT NULL
DTE_PAID: DATE NOT NULL
DTE_FIRST_SVC: DATE NOT NULL
DTE_LAST_SVC: DATE NOT NULL
DTE_ADMISSION: DATE NOT NULL
DTE_DISCHARGE: DATE NOT NULL
DTE_BIRTH: DATE NOT NULL
NUM_ICN: CHAR(13) NOT NULL
ID_MEDICAID: CHAR(12) NOT NULL
CDE_RELATION: CHAR(1) NOT NULL
NUM_ADJ_ICN: CHAR(19) NOT NULL
CDE_FRQC_PRIM: CHAR(2) NOT NULL
CDE_MODIFIER_1: CHAR(2) NOT NULL
CDE_MODIFIER_2: CHAR(2) NOT NULL
CDE_MODIFIER_3: CHAR(2) NOT NULL
CDE_MODIFIER_4: CHAR(2) NOT NULL
CDE_NDC: CHAR(11) NOT NULL
CDE_DIAG_PRIM: CHAR(7) NOT NULL
CDE_DIAG_2: CHAR(7) NOT NULL
CDE_DIAG_3: CHAR(7) NOT NULL
CDE_DIAG_4: CHAR(7) NOT NULL
CDE_DRG: CHAR(4) NOT NULL
CDE_TYPE_OF_BILL: CHAR(3) NOT NULL
NUM_PRIOR_AUTH: CHAR(10) NOT NULL
CDE_DTL_STATUS: CHAR(1) NOT NULL
ID_CLERK: CHAR(8) NOT NULL
IND_ACCIDENT: CHAR(1) NOT NULL
IND_PRICING: CHAR(1) NOT NULL
NUM_CASE: CHAR(10) NOT NULL
NUM_CHECK: CHAR(9) NOT NULL
IND_REF_EPSDT: CHAR(1) NOT NULL
IND_REF_FAM_PLAN: CHAR(1) NOT NULL
IND_STERILIZATION: CHAR(1) NOT NULL
IND_HYST: CHAR(1) NOT NULL
CDE_EMERGENCY: CHAR(1) NOT NULL
IND_ABORTION: CHAR(1) NOT NULL
CDE_ABORTION: CHAR(1) NOT NULL
CDE_STERILIZATION: CHAR(3) NOT NULL
CDE_CLM_TYPE: CHAR(1) NOT NULL
CDE_PROV_TYPE_BILL: CHAR(2) NOT NULL
CDE_PROV_SPEC_BILL: CHAR(2) NOT NULL
CDE_PROV_TYPE_PERF: CHAR(2) NOT NULL
CDE_PROV_SPEC_PERF: CHAR(2) NOT NULL
CDE_ADJ_VOID: CHAR(1) NOT NULL
IND_MXCD_HLTH: CHAR(1) NOT NULL
IND_RESTRICT_LI: CHAR(1) NOT NULL
IND_CLAIM: CHAR(1) NOT NULL
IND_LATEST_CLM: CHAR(1) NOT NULL
CNT_CLAIMS_CORR: NUMBER(9) NOT NULL
CNT_CLAIMS_OVRD: NUMBER(9) NOT NULL
CNT_CLAIMS_TPL: NUMBER(9) NOT NULL
CNT_CLAIMS_ERRORS: NUMBER(9) NOT NULL
SAK_COPAY_TYPE: NUMBER(9) NOT NULL

T CA RECIP KEY

RECIP_KEY: NUMBER(9) NOT NULL
CDE_RECIP_COUNTY: VARCHAR2(10) NOT NULL
CDE_RACE: CHAR(2) NOT NULL
CDE_ETHNIC: CHAR(2) NOT NULL
CDE_SEX: CHAR(1) NOT NULL
CDE_LIV_APRG: CHAR(2) NOT NULL
CDE_STATE_REGION: CHAR(1) NOT NULL
CDE_AD_CATEGORY: CHAR(2) NOT NULL
CDE_LEVEL_OF_CARE: CHAR(9) NOT NULL
SAK_AGE_GROUP: NUMBER(9) NOT NULL
DSC_RECIP_COUNTY: VARCHAR2(25) NOT NULL
DSC_RACE: VARCHAR2(100) NOT NULL
DSC_ETHNIC: VARCHAR2(50) NOT NULL
DSC_SEX: VARCHAR2(20) NOT NULL
DSC_LIV_APRG: VARCHAR2(50) NOT NULL
DSC_STATE_REGION: CHAR(15) NOT NULL
DSC_AD_CATEGORY: VARCHAR2(50) NOT NULL
DSC_LEVEL_OF_CARE: CHAR(100) NOT NULL
DSC_AGE_GROUP: CHAR(15) NOT NULL

T CA ANALYSIS

CLAIM_KEY: NUMBER(9) NOT NULL
PERF_PROV_KEY: NUMBER(9) NOT NULL
BILL_PROV_KEY: NUMBER(9) NOT NULL
REFER_PROV_KEY: NUMBER(9) NOT NULL
RECIP_KEY: NUMBER(9) NOT NULL
DOS_TIME_KEY: NUMBER(9) NOT NULL
PAID_TIME_KEY: NUMBER(9) NOT NULL
TOT_AMT_BILLED: NUMBER(11,2) NOT NULL
TOT_AMT_ALWD: NUMBER(11,2) NOT NULL
TOT_AMT_REMB: NUMBER(11,2) NOT NULL
TOT_AMT_PAID: NUMBER(11,2) NOT NULL
TOT_AMT_ST_SHARE: NUMBER(11,2) NOT NULL
TOT_AMT_FED_SHARE: NUMBER(11,2) NOT NULL
TOT_AMT_ENCOUNTER: NUMBER(11,2) NOT NULL
TOT_AMT_TPL: NUMBER(11,2) NOT NULL
TOT_AMT_CO_PAY: NUMBER(11,2) NOT NULL
TOT_AMT_PAT_PAID: NUMBER(11,2) NOT NULL
TOT_AMT_MGARE_PAID: NUMBER(11,2) NOT NULL
TOT_AMT_PD_MCO: NUMBER(11,2) NOT NULL
CNT_CLAIMS_PAID: NUMBER(9) NOT NULL
CNT_CLAIMS_DENIED: NUMBER(9) NOT NULL
TOT_CLAIMS_CORR: NUMBER(9) NOT NULL
TOT_CLAIMS_OVRD: NUMBER(9) NOT NULL
TOT_CLAIMS_TPL: NUMBER(9) NOT NULL
TOT_CLAIMS_ERRORS: NUMBER(9) NOT NULL
TOT_QTY_BILLED: NUMBER(11,2) NOT NULL
TOT_QTY_ALWD: NUMBER(11,2) NOT NULL
TOT_DAYS_COVD: NUMBER(9) NOT NULL
TOT_DAYS_NCOVD: NUMBER(9) NOT NULL
DTE_PAID: DATE NOT NULL

T CA CLAIM KEY

CLAIM_KEY: NUMBER(9) NOT NULL
CDE_CLM_TYPE: CHAR(1) NOT NULL
CDE_DTL_STATUS: CHAR(1) NOT NULL
CDE_ADJ_VOID: CHAR(1) NOT NULL
CDE_CLM_REGION: CHAR(2) NOT NULL
CDE_POS: CHAR(2) NOT NULL
CDE_PGM_HEALTH: CHAR(5) NOT NULL
CDE_SOURCE: CHAR(2) NOT NULL
CDE_FUND_CODE: CHAR(3) NOT NULL
CDE_COS_ST: CHAR(2) NOT NULL
CDE_COS_SUB: CHAR(2) NOT NULL
IND_CLAIM: CHAR(1) NOT NULL
IND_CARRIER_DENIED: CHAR(1) NOT NULL
DSC_CLM_TYPE: VARCHAR2(50) NOT NULL
DSC_CLM_STATUS: VARCHAR2(50) NOT NULL
DSC_REGION: VARCHAR2(50) NOT NULL
DSC_POS: VARCHAR2(50) NOT NULL
DSC_PGM_HEALTH: VARCHAR2(50) NOT NULL
DSC_SOURCE: CHAR(50) NOT NULL
DSC_FUND_CODE: CHAR(50) NOT NULL
DSC_COS: CHAR(50) NOT NULL

T CA HDR DTL DN

SAK_CLAIM: NUMBER(9) NOT NULL
CDE_REVENUE_1: CHAR(4) NOT NULL
CDE_PROG_1: CHAR(6) NOT NULL
AMT_ALWD_1: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_1: NUMBER(9,2) NOT NULL
CDE_REVENUE_2: CHAR(4) NOT NULL
CDE_PROG_2: CHAR(6) NOT NULL
AMT_ALWD_2: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_2: NUMBER(9,2) NOT NULL
CDE_REVENUE_3: CHAR(4) NOT NULL
CDE_PROG_3: CHAR(6) NOT NULL
AMT_ALWD_3: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_3: NUMBER(9,2) NOT NULL
CDE_REVENUE_4: CHAR(4) NOT NULL
CDE_PROG_4: CHAR(6) NOT NULL
AMT_ALWD_4: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_4: NUMBER(9,2) NOT NULL
CDE_REVENUE_5: CHAR(4) NOT NULL
CDE_PROG_5: CHAR(6) NOT NULL
AMT_ALWD_5: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_5: NUMBER(9,2) NOT NULL
CDE_REVENUE_6: CHAR(4) NOT NULL
CDE_PROG_6: CHAR(6) NOT NULL
AMT_ALWD_6: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_6: NUMBER(9,2) NOT NULL
CDE_REVENUE_7: CHAR(4) NOT NULL
CDE_PROG_7: CHAR(6) NOT NULL
AMT_ALWD_7: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_7: NUMBER(9,2) NOT NULL
CDE_REVENUE_8: CHAR(4) NOT NULL
CDE_PROG_8: CHAR(6) NOT NULL
AMT_ALWD_8: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_8: NUMBER(9,2) NOT NULL
CDE_REVENUE_9: CHAR(4) NOT NULL
CDE_PROG_9: CHAR(6) NOT NULL
AMT_ALWD_9: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_9: NUMBER(9,2) NOT NULL
CDE_REVENUE_10: CHAR(4) NOT NULL
CDE_PROG_10: CHAR(6) NOT NULL
AMT_ALWD_10: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_10: NUMBER(9,2) NOT NULL
CDE_REVENUE_11: CHAR(4) NOT NULL
CDE_PROG_11: CHAR(6) NOT NULL
AMT_ALWD_11: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_11: NUMBER(9,2) NOT NULL
CDE_REVENUE_12: CHAR(4) NOT NULL
CDE_PROG_12: CHAR(6) NOT NULL
AMT_ALWD_12: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_12: NUMBER(9,2) NOT NULL
CDE_REVENUE_13: CHAR(4) NOT NULL
CDE_PROG_13: CHAR(6) NOT NULL
AMT_ALWD_13: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_13: NUMBER(9,2) NOT NULL
CDE_REVENUE_14: CHAR(4) NOT NULL
CDE_PROG_14: CHAR(6) NOT NULL
AMT_ALWD_14: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_14: NUMBER(9,2) NOT NULL
CDE_REVENUE_15: CHAR(4) NOT NULL
CDE_PROG_15: CHAR(6) NOT NULL
AMT_ALWD_15: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_15: NUMBER(9,2) NOT NULL
CDE_REVENUE_16: CHAR(4) NOT NULL
CDE_PROG_16: CHAR(6) NOT NULL
AMT_ALWD_16: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_16: NUMBER(9,2) NOT NULL
CDE_REVENUE_17: CHAR(4) NOT NULL
CDE_PROG_17: CHAR(6) NOT NULL
AMT_ALWD_17: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_17: NUMBER(9,2) NOT NULL
CDE_REVENUE_18: CHAR(4) NOT NULL
CDE_PROG_18: CHAR(6) NOT NULL
AMT_ALWD_18: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_18: NUMBER(9,2) NOT NULL
CDE_REVENUE_19: CHAR(4) NOT NULL
CDE_PROG_19: CHAR(6) NOT NULL
AMT_ALWD_19: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_19: NUMBER(9,2) NOT NULL
CDE_REVENUE_20: CHAR(4) NOT NULL
CDE_PROG_20: CHAR(6) NOT NULL
AMT_ALWD_20: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_20: NUMBER(9,2) NOT NULL
CDE_REVENUE_21: CHAR(4) NOT NULL
CDE_PROG_21: CHAR(6) NOT NULL
AMT_ALWD_21: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_21: NUMBER(9,2) NOT NULL
CDE_REVENUE_22: CHAR(4) NOT NULL
CDE_PROG_22: CHAR(6) NOT NULL
AMT_ALWD_22: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_22: NUMBER(9,2) NOT NULL
CDE_REVENUE_23: CHAR(4) NOT NULL
CDE_PROG_23: CHAR(6) NOT NULL
AMT_ALWD_23: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD_23: NUMBER(9,2) NOT NULL
DTE_PAID: DATE NOT NULL

T CA PROV KEY

PROV_KEY: NUMBER(9) NOT NULL
SAK_PROV_LOC: NUMBER(9) NOT NULL
ID_PROVIDER_BASE: CHAR(15) NOT NULL
ID_PROVIDER_NPI: CHAR(15) NOT NULL
ID_PROVIDER_MCAID: CHAR(15) NOT NULL
NAM_PROVIDER: CHAR(50) NOT NULL
NAM_TITL: CHAR(15) NOT NULL
IND_NAME_TYPE: CHAR(1) NOT NULL
IND_PROVIDER_PREV: CHAR(15) NOT NULL
CDE_PROV_TYPE_PRIM: CHAR(2) NOT NULL
CDE_PROV_SPEC_PRIM: CHAR(3) NOT NULL
NUM_TAX_ID: CHAR(9) NOT NULL
IND_TAX_ID_TYPE: CHAR(1) NOT NULL
NUM_PROV_LIC: CHAR(10) NOT NULL
CDE_TAXONOMY: CHAR(10) NOT NULL
ADR_SVC_STR11: CHAR(30) NOT NULL
ADR_SVC_STR12: CHAR(30) NOT NULL
ADR_SVC_CITY: CHAR(15) NOT NULL
ADR_SVC_STATE: CHAR(2) NOT NULL
ADR_SVC_ZIP: CHAR(5) NOT NULL
ADR_SVC_ZIP4: CHAR(4) NOT NULL
ADR_SVC_PHONE: CHAR(10) NOT NULL
ADR_SVC_PHO_EXT: CHAR(4) NOT NULL
ADR_SVC_LATITUDE: NUMBER(11,8) NOT NULL
ADR_SVC_LONGITUDE: NUMBER(11,8) NOT NULL
ADR_BILL_STR1: CHAR(30) NOT NULL
ADR_BILL_STR12: CHAR(30) NOT NULL
ADR_BILL_CITY: CHAR(15) NOT NULL
ADR_BILL_STATE: CHAR(2) NOT NULL
ADR_BILL_ZIP: CHAR(5) NOT NULL
ADR_BILL_ZIP4: CHAR(4) NOT NULL
ADR_BILL_PHONE: CHAR(10) NOT NULL
ADR_BILL_PHO_EXT: CHAR(4) NOT NULL
ADR_BILL_LATITUDE: NUMBER(11,8) NOT NULL
ADR_BILL_LONGITUDE: NUMBER(11,8) NOT NULL
CDE_ORGANIZATION: CHAR(1) NOT NULL
PRI_PROV_ID_TYPE_PRT: CHAR(3) NOT NULL
PRI_PROV_ID_TYPE_DSP: CHAR(3) NOT NULL
IND_PROV_HLTH_CARE: CHAR(1) NOT NULL
IND_NPI_VERIFY: CHAR(1) NOT NULL
IND_ON_REVIEW: CHAR(1) NOT NULL
CDE_SVC_STATE_REGION: CHAR(1) NOT NULL
CDE_SVC_COUNTY: VARCHAR2(10) NOT NULL
CDE_PROV_TYPE: VARCHAR2(50) NOT NULL
DSC_PROV_SPEC: VARCHAR2(50) NOT NULL
DSC_SVC_COUNTY: VARCHAR2(50) NOT NULL
DSC_SVC_STATE_REGION: VARCHAR2(50) NOT NULL
DSC_TAXONOMY: VARCHAR2(100) NOT NULL

T CA PROV TAX

PROV_KEY: NUMBER(9) NOT NULL
CDE_TAXONOMY2: CHAR(10) NOT NULL
CDE_TAXONOMY3: CHAR(10) NOT NULL
CDE_TAXONOMY4: CHAR(10) NOT NULL
CDE_TAXONOMY5: CHAR(10) NOT NULL
DSC_TAXONOMY2: VARCHAR2(100) NOT NULL
DSC_TAXONOMY3: VARCHAR2(100) NOT NULL
DSC_TAXONOMY4: VARCHAR2(100) NOT NULL
DSC_TAXONOMY5: VARCHAR2(100) NOT NULL

T_CA_UB92

SAK_CLAIM: NUMBER(9) NOT NULL
 AMT_BASE_DRG: NUMBER(9,2) NOT NULL
 AMT_OUTLIER: NUMBER(9,2) NOT NULL
 AMT_PROV_PER_DIEM: NUMBER(9,2) NOT NULL
 GRP_PAY_RATE: NUMBER(9,2) NOT NULL
 CDE_ADMIT_HOUR: NUMBER(4) NOT NULL
 TIME_DISCHARGE: NUMBER(4) NOT NULL
 CDE_PATIENT_STATUS: CHAR(2) NOT NULL
 CDE_ADMIT_SOURCE: CHAR(1) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_DRUG

SAK_CLAIM: NUMBER(9) NOT NULL
 NUM_DTL: NUMBER(4) NOT NULL
 NUM_DAY_SUPPLY: NUMBER(9) NOT NULL
 QTY_DISPENSE: NUMBER(10,3) NOT NULL
 AMT_BILLED: NUMBER(9,2) NOT NULL
 AMT_ALWD: NUMBER(9,2) NOT NULL
 AMT_PAID: NUMBER(9,2) NOT NULL
 AMT_AWP: NUMBER(9,5) NOT NULL
 AMT_MAC: NUMBER(9,5) NOT NULL
 AMT_EAC: NUMBER(9,5) NOT NULL
 AMT_NDC_PROFEE: NUMBER(9,2) NOT NULL
 CDE_THERA_CLS_AHFS: CHAR(6) NOT NULL
 PATIENT_LOCATION: NUMBER(2) NOT NULL
 LEVEL_OF_SERVICE: NUMBER(2) NOT NULL
 CDE_NDC: CHAR(1) NOT NULL
 QTY_REFILL: CHAR(2) NOT NULL
 NUM_PRSCRIP: CHAR(7) NOT NULL
 IND_DRUG_GENERIC: CHAR(1) NOT NULL
 CDE_CLM_STATUS: CHAR(1) NOT NULL
 CDE_ORGANIZ: CHAR(1) NOT NULL
 IND_BRAND_MED_NEO: CHAR(1) NOT NULL
 IND_PRICING: CHAR(1) NOT NULL
 CDE_DEA: CHAR(1) NOT NULL
 NUM_GCN: NUMBER(5) NOT NULL
 CDE_THERA_CLS_SPEC: CHAR(3) NOT NULL
 DTE_DISPENSE: DATE NOT NULL
 DTE_PRESCRIBE: DATE NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_DENTAL

SAK_CLAIM: NUMBER(9) NOT NULL
 NUM_DTL: NUMBER(4) NOT NULL
 CDE_TOOTH_NBR: CHAR(2) NOT NULL
 CDE_TOOTH_SURFACE_1: CHAR(1) NOT NULL
 CDE_TOOTH_SURFACE_2: CHAR(1) NOT NULL
 CDE_TOOTH_SURFACE_3: CHAR(1) NOT NULL
 CDE_TOOTH_SURFACE_4: CHAR(1) NOT NULL
 CDE_TOOTH_SURFACE_5: CHAR(1) NOT NULL
 CDE_TOOTH_SURFACE_6: CHAR(1) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_LTC

SAK_CLAIM: NUMBER(9) NOT NULL
 NUM_DTL: NUMBER(4) NOT NULL
 AMT_PROV_PER_DIEM: NUMBER(9,2) NOT NULL
 AMT_FAC_LV_ALW: NUMBER(9,2) NOT NULL
 AMT_HOSP_ALW: NUMBER(9,2) NOT NULL
 AMT_CONSURANCE: NUMBER(9,2) NOT NULL
 NUM_HOSPITAL_DAYS: NUMBER(4) NOT NULL
 NUM_LEAVE_DAYS: NUMBER(4) NOT NULL
 NUM_FACILITY_DAYS: NUMBER(4) NOT NULL
 CDE_PATIENT_STATUS: CHAR(2) NOT NULL
 CDE_ADMIT_SOURCE: CHAR(1) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_XOVER

SAK_CLAIM: NUMBER(9) NOT NULL
 AMT_ALWD_MCARE: NUMBER(8,2) NOT NULL
 AMT_PAID_MCARE: NUMBER(8,2) NOT NULL
 AMT_DEDUCT: NUMBER(8,2) NOT NULL
 AMT_DEDUCT_BLOOD: NUMBER(8,2) NOT NULL
 AMT_CONSURANCE: NUMBER(8,2) NOT NULL
 AMT_PSYCH: NUMBER(8,2) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_TCN

SAK_CLAIM: NUMBER(9) NOT NULL
 NUM_TCN: NUMBER(17) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_ICD9_PROC

SAK_CLAIM: NUMBER(9) NOT NULL
 NUM_SEQ: NUMBER(4) NOT NULL
 CDE_PROC_ICD9: VARCHAR(4) NOT NULL
 DTE_ICD_9_CM_PROC: DATE NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_ICD9_PROC_DN

SAK_CLAIM: NUMBER(9) NOT NULL
 DTE_ICD_9_CM_PROC_1: DATE NOT NULL
 DTE_ICD_9_CM_PROC_2: DATE NOT NULL
 DTE_ICD_9_CM_PROC_3: DATE NOT NULL
 DTE_ICD_9_CM_PROC_4: DATE NOT NULL
 DTE_ICD_9_CM_PROC_5: DATE NOT NULL
 DTE_ICD_9_CM_PROC_6: DATE NOT NULL
 CDE_PROC_ICD9_1: VARCHAR(4) NOT NULL
 CDE_PROC_ICD9_2: VARCHAR(4) NOT NULL
 CDE_PROC_ICD9_3: VARCHAR(4) NOT NULL
 CDE_PROC_ICD9_4: VARCHAR(4) NOT NULL
 CDE_PROC_ICD9_5: VARCHAR(4) NOT NULL
 CDE_PROC_ICD9_6: VARCHAR(4) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_DIAG

SAK_CLAIM: NUMBER(9) NOT NULL
 CDE_DIAG_SEQ: CHAR(2) NOT NULL
 CDE_DIAG_CHAR: CHAR(7) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_DIAG_DN

SAK_CLAIM: NUMBER(9) NOT NULL
 NUM_DTL: NUMBER(4) NOT NULL
 CDE_DIAG_5: CHAR(7) NOT NULL
 CDE_DIAG_6: CHAR(7) NOT NULL
 CDE_DIAG_7: CHAR(7) NOT NULL
 CDE_DIAG_8: CHAR(7) NOT NULL
 CDE_DIAG_9: CHAR(7) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_ERROR

SAK_CLAIM: NUMBER(9) NOT NULL
 NUM_DTL: NUMBER(4) NOT NULL
 SAK_PUB_HLTH: NUMBER(9) NOT NULL
 SAK_ESC: NUMBER(9) NOT NULL
 CDE_ESC: NUMBER(4) NOT NULL
 CDE_DISP_STATUS: CHAR(1) NOT NULL
 CDE_STAT_ERROR: CHAR(1) NOT NULL
 CDE_EOB: CHAR(4) NOT NULL
 DTE_ERROR: DATE NOT NULL
 DSC_ESC: CHAR(50) NOT NULL
 DSC_EOB: CHAR(79) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_ERROR_DN

SAK_CLAIM: NUMBER(9) NOT NULL
 NUM_DTL: NUMBER(4) NOT NULL
 SAK_ESC_1: NUMBER(9) NOT NULL
 SAK_ESC_2: NUMBER(9) NOT NULL
 SAK_ESC_3: NUMBER(9) NOT NULL
 SAK_ESC_4: NUMBER(9) NOT NULL
 SAK_ESC_5: NUMBER(9) NOT NULL
 SAK_ESC_6: NUMBER(9) NOT NULL
 DTE_ERROR_1: DATE NOT NULL
 DTE_ERROR_2: DATE NOT NULL
 DTE_ERROR_3: DATE NOT NULL
 DTE_ERROR_4: DATE NOT NULL
 DTE_ERROR_5: DATE NOT NULL
 DTE_ERROR_6: DATE NOT NULL
 CDE_DISP_STATUS_1: CHAR(1) NOT NULL
 CDE_DISP_STATUS_2: CHAR(1) NOT NULL
 CDE_DISP_STATUS_3: CHAR(1) NOT NULL
 CDE_DISP_STATUS_4: CHAR(1) NOT NULL
 CDE_DISP_STATUS_5: CHAR(1) NOT NULL
 CDE_DISP_STATUS_6: CHAR(1) NOT NULL
 CDE_EOB_1: CHAR(4) NOT NULL
 CDE_EOB_2: CHAR(4) NOT NULL
 CDE_EOB_3: CHAR(4) NOT NULL
 CDE_EOB_4: CHAR(4) NOT NULL
 CDE_EOB_5: CHAR(4) NOT NULL
 CDE_EOB_6: CHAR(4) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_ATTACH

SAK_CLAIM: NUMBER(9) NOT NULL
 NUM_DTL: NUMBER(4) NOT NULL
 CDE_ATTACH_CHAR: CHAR(2) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_ATTACH_DN

SAK_CLAIM: NUMBER(9) NOT NULL
 NUM_DTL: NUMBER(4) NOT NULL
 CDE_ATTACH_1: CHAR(2) NOT NULL
 CDE_ATTACH_2: CHAR(2) NOT NULL
 CDE_ATTACH_3: CHAR(2) NOT NULL
 CDE_ATTACH_4: CHAR(2) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_COND

SAK_CLAIM: NUMBER(9) NOT NULL
 CDE_COND_SEQ: CHAR(2) NOT NULL
 CDE_COND_CHAR: CHAR(2) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_COND_DN

SAK_CLAIM: NUMBER(9) NOT NULL
 CDE_COND_1: CHAR(2) NOT NULL
 CDE_COND_2: CHAR(2) NOT NULL
 CDE_COND_3: CHAR(2) NOT NULL
 CDE_COND_4: CHAR(2) NOT NULL
 CDE_COND_5: CHAR(2) NOT NULL
 CDE_COND_6: CHAR(2) NOT NULL
 CDE_COND_7: CHAR(2) NOT NULL
 CDE_COND_8: CHAR(2) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_OCCUR

SAK_CLAIM: NUMBER(9) NOT NULL
 NUM_SEQ: NUMBER(4) NOT NULL
 CDE_OCCURRENCE: CHAR(2) NOT NULL
 DTE_OCCURRENCE: DATE NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_OCCUR_DN

SAK_CLAIM: NUMBER(9) NOT NULL
 DTE_OCCUR_1: DATE NOT NULL
 DTE_OCCUR_2: DATE NOT NULL
 DTE_OCCUR_3: DATE NOT NULL
 DTE_OCCUR_4: DATE NOT NULL
 DTE_OCCUR_5: DATE NOT NULL
 DTE_OCCUR_6: DATE NOT NULL
 DTE_OCCUR_7: DATE NOT NULL
 DTE_OCCUR_8: DATE NOT NULL
 CDE_OCCUR_1: CHAR(2) NOT NULL
 CDE_OCCUR_2: CHAR(2) NOT NULL
 CDE_OCCUR_3: CHAR(2) NOT NULL
 CDE_OCCUR_4: CHAR(2) NOT NULL
 CDE_OCCUR_5: CHAR(2) NOT NULL
 CDE_OCCUR_6: CHAR(2) NOT NULL
 CDE_OCCUR_7: CHAR(2) NOT NULL
 CDE_OCCUR_8: CHAR(2) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_VALUE

SAK_CLAIM: NUMBER(9) NOT NULL
 NUM_SEQ: NUMBER(4) NOT NULL
 AMT_VALUE: NUMBER(9,2) NOT NULL
 CDE_VALUE: CHAR(2) NOT NULL
 DTE_PAID: DATE NOT NULL

T_CA_FIN

SAK_REC'D: NUMBER(9) NOT NULL
CLAIM_KEY: NUMBER(9) NOT NULL
BLL_PROV_KEY: NUMBER(9) NOT NULL
RECIP_KEY: NUMBER(9) NOT NULL
DOS_TIME_KEY: NUMBER(9) NOT NULL
PAID_TIME_KEY: NUMBER(9) NOT NULL
AMT_REIMBURSED: NUMBER(10,2) NOT NULL
AMT_PAID: NUMBER(10,2) NOT NULL
CNT_CLAIMS_PAID: NUMBER(9) NOT NULL
DTE_PAID: DATE NOT NULL
DTE_FIRST_SVC: DATE NOT NULL
DTE_LAST_SVC: DATE NOT NULL
ID_MEDICAID: CHAR(12) NOT NULL
CDE_CLM_TYPE: CHAR(1) NOT NULL

T_CA_HDR_DTL

SAK_CLAIM: NUMBER(9) NOT NULL
NUM_DTL: NUMBER(4) NOT NULL
CDE_REVENUE: CHAR(4) NOT NULL
AMT_BILLED: NUMBER(9,2) NOT NULL
AMT_ALWD: NUMBER(9,2) NOT NULL
AMT_DTL_TPL: NUMBER(9,2) NOT NULL
AMT_PAID: NUMBER(9,2) NOT NULL
AMT_CO_PAY: NUMBER(9,2) NOT NULL
AMT_PD_MCO: NUMBER(9,2) NOT NULL
QTY_UNITS_BILLED: NUMBER(9,2) NOT NULL
QTY_UNITS_ALWD: NUMBER(9,2) NOT NULL
CDE_DTL_STATUS: CHAR(1) NOT NULL
IND_PRICING: CHAR(1) NOT NULL
IND_REF_EPSDT: CHAR(1) NOT NULL
IND_REF_FAM_PLAN: CHAR(1) NOT NULL
IND_STERILIZATION: CHAR(1) NOT NULL
IND_HYST: CHAR(1) NOT NULL
IND_ABORTION: CHAR(1) NOT NULL
CDE_PROC: CHAR(6) NOT NULL
CDE_MODIFIER_1: CHAR(2) NOT NULL
CDE_MODIFIER_2: CHAR(2) NOT NULL
CDE_MODIFIER_3: CHAR(2) NOT NULL
CDE_MODIFIER_4: CHAR(2) NOT NULL
ID_PROV_ATTEND: CHAR(6) NOT NULL
SAK_PROV_LOC_ATTEND: NUMBER(9) NOT NULL
DTE_LAST_SVC: DATE NOT NULL
DTE_FIRST_SVC: DATE NOT NULL
DTE_PAID: DATE NOT NULL

T_CA_PROV_PERFORM

DTE_RPT_PRD: DATE NOT NULL
IND_FFS: CHAR(1) NOT NULL
CDE_PGM_HEALTH: CHAR(5) NOT NULL
CDE_FUND_CODE: CHAR(3) NOT NULL
CDE_PROV_TYPE: CHAR(2) NOT NULL
CDE_PROV_SPEC: CHAR(3) NOT NULL
CDE_SOURCE: CHAR(2) NOT NULL
CDE_COUNTY: VARCHAR2(10) NOT NULL
CDE_STATE_REGION: CHAR(1) NOT NULL
SAK_PROV_LOC: NUMBER(9) NOT NULL
CDE_THRUPUT_TYPE: CHAR(2) NOT NULL
SAK_THRUPUT_GRP: NUMBER(4) NOT NULL
CNT_PC_DAYS: NUMBER(4) NOT NULL
CNT_CL_DOS_DOR: NUMBER(9) NOT NULL
CNT_CL_DOS_DOP: NUMBER(9) NOT NULL
CNT_CL_DOR_DOP: NUMBER(9) NOT NULL

T_CA_OP_PERFORM

DTE_RPT_PRD: DATE NOT NULL
IND_FFS: CHAR(1) NOT NULL
CDE_PGM_HEALTH: CHAR(5) NOT NULL
CDE_FUND_CODE: CHAR(3) NOT NULL
CDE_PROV_TYPE: CHAR(2) NOT NULL
CDE_PROV_SPEC: CHAR(3) NOT NULL
CDE_SOURCE: CHAR(2) NOT NULL
CDE_CLM_TYPE: CHAR(1) NOT NULL
CDE_CLM_REGION: CHAR(2) NOT NULL
CDE_THRUPUT_TYPE: CHAR(2) NOT NULL
SAK_THRUPUT_GRP: NUMBER(4) NOT NULL
CNT_PC_DAYS: NUMBER(4) NOT NULL
CNT_CL_DOS_DOR: NUMBER(9) NOT NULL
CNT_CL_DOS_DOP: NUMBER(9) NOT NULL
CNT_CL_DOR_DOP: NUMBER(9) NOT NULL

T_CA_MR_ERROR

DTE_RPT_PRD: DATE NOT NULL
IND_FFS: CHAR(1) NOT NULL
CDE_PGM_HEALTH: CHAR(5) NOT NULL
CDE_FUND_CODE: CHAR(3) NOT NULL
CDE_PROV_TYPE: CHAR(2) NOT NULL
CDE_PROV_SPEC: CHAR(3) NOT NULL
CDE_SOURCE: CHAR(2) NOT NULL
SAK_PROV_LOC: NUMBER(9) NOT NULL
CDE_COUNTY: VARCHAR2(10) NOT NULL
CDE_STATE_REGION: CHAR(1) NOT NULL
CDE_ESC: NUMBER(4) NOT NULL
CDE_DISP_STATUS: CHAR(1) NOT NULL
CNT_CLAIMS: NUMBER(9) NOT NULL

T_MR_COS_XREF

SAK_REC'D: NUMBER(9) NOT NULL
NUM_DTL: NUMBER(4) NOT NULL
CDE_SOURCE: CHAR(2) NOT NULL
DTE_RPT_PRD: DATE NOT NULL
CDE_COS_ST: CHAR(2) NOT NULL
CDE_PROV_TYPE: CHAR(2) NOT NULL
CDE_COS_SUB: CHAR(2) NOT NULL
CDE_COS_MIS: CHAR(2) NOT NULL
CDE_COS_CMS4_9: CHAR(4) NOT NULL
CDE_COS_CMS4_21: CHAR(4) NOT NULL
CDE_CLM_STATUS: CHAR(1) NOT NULL
CDE_FUND_SRC: CHAR(1) NOT NULL

T_CA_ADJ_XREF

SAK_CLAIM: NUMBER(9) NOT NULL
SAK_CLAIM_ADJ: NUMBER(9) NOT NULL
DTE_PAID: DATE NOT NULL

T_CA_VALUE_DN

SAK_CLAIM: NUMBER(9) NOT NULL
AMT_VALUE_1: NUMBER(9,2) NOT NULL
AMT_VALUE_2: NUMBER(9,2) NOT NULL
AMT_VALUE_3: NUMBER(9,2) NOT NULL
AMT_VALUE_4: NUMBER(9,2) NOT NULL
AMT_VALUE_5: NUMBER(9,2) NOT NULL
AMT_VALUE_6: NUMBER(9,2) NOT NULL
AMT_VALUE_7: NUMBER(9,2) NOT NULL
AMT_VALUE_8: NUMBER(9,2) NOT NULL
AMT_VALUE_9: NUMBER(9,2) NOT NULL
AMT_VALUE_10: NUMBER(9,2) NOT NULL
AMT_VALUE_11: NUMBER(9,2) NOT NULL
AMT_VALUE_12: NUMBER(9,2) NOT NULL
CDE_VALUE_1: CHAR(2) NOT NULL
CDE_VALUE_2: CHAR(2) NOT NULL
CDE_VALUE_3: CHAR(2) NOT NULL
CDE_VALUE_4: CHAR(2) NOT NULL
CDE_VALUE_5: CHAR(2) NOT NULL
CDE_VALUE_6: CHAR(2) NOT NULL
CDE_VALUE_7: CHAR(2) NOT NULL
CDE_VALUE_8: CHAR(2) NOT NULL
CDE_VALUE_9: CHAR(2) NOT NULL
CDE_VALUE_10: CHAR(2) NOT NULL
CDE_VALUE_11: CHAR(2) NOT NULL
CDE_VALUE_12: CHAR(2) NOT NULL
DTE_PAID: DATE NOT NULL

T_CA_MCO_XREF

SAK_CLAIM: NUMBER(9) NOT NULL
NUM_TCN_MCO: CHAR(20) NOT NULL
DTE_MCO_ADJUD: DATE NOT NULL
DTE_PAID: DATE NOT NULL

T_CA_PHYS_VOID

SAK_CLAIM: NUMBER(9) NOT NULL

T_PR_STUDY_GRP1

PROVIDER_ID: CHAR(15) NOT NULL

T_RE_STUDY_GRP1

RECIPIENT_ID: CHAR(12) NOT NULL

T_CA_DRUG_VOID

SAK_CLAIM: NUMBER(9) NOT NULL

T_PR_STUDY_GRP2

PROVIDER_ID: CHAR(15) NOT NULL

T_RE_STUDY_GRP2

RECIPIENT_ID: CHAR(12) NOT NULL

T_CA_UB92_VOID

SAK_CLAIM: NUMBER(9) NOT NULL

T_PR_STUDY_GRP3

PROVIDER_ID: CHAR(15) NOT NULL

T_RE_STUDY_GRP3

RECIPIENT_ID: CHAR(12) NOT NULL

T_CA_DENT_VOID

SAK_CLAIM: NUMBER(9) NOT NULL

T_PR_STUDY_GRP4

PROVIDER_ID: CHAR(15) NOT NULL

T_RE_STUDY_GRP4

RECIPIENT_ID: CHAR(12) NOT NULL

T_CA_VOID_ALL

SAK_CLAIM: NUMBER(9) NOT NULL

T_PR_STUDY_GRP5

PROVIDER_ID: CHAR(15) NOT NULL

T_RE_STUDY_GRP5

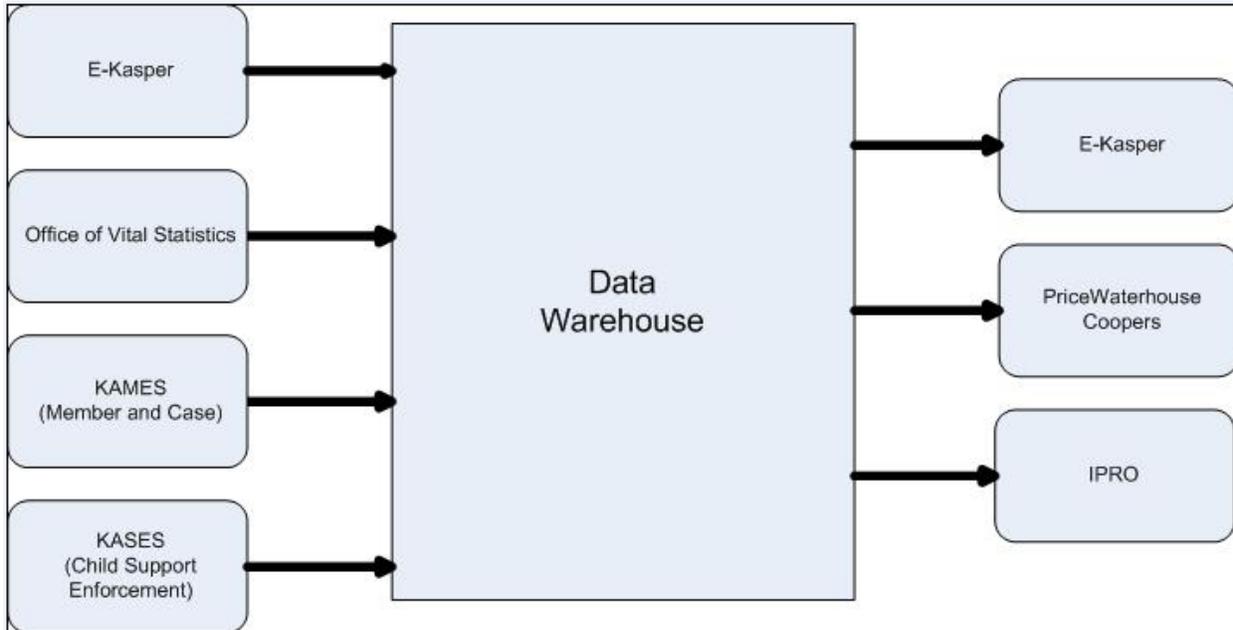
RECIPIENT_ID: CHAR(12) NOT NULL

T_CA_CURRENT_DATES

DTE_PAID: DATE NOT NULL
DTE_PAID_NUM: NUMBER(9) NOT NULL
PAID_DTE_WEEK: NUMBER(6) NOT NULL
PAID_DTE_MONTH: NUMBER(6) NOT NULL
PAID_DTE_QTR: NUMBER(6) NOT NULL
PAID_DTE_SFY: NUMBER(4) NOT NULL
PAID_DTE_CY: NUMBER(4) NOT NULL
PAID_DTE_FFY: NUMBER(4) NOT NULL
FIRST_DAY_MONTH: DATE NOT NULL
LAST_DAY_MONTH: DATE NOT NULL
FIRST_DAY_QTR: DATE NOT NULL
LAST_DAY_QTR: DATE NOT NULL

1.4.3 External System Interfaces

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



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2 Universes

2.1 DSS/MAR/SUR Universes

The BusinessObjects "Universes" remove the technical knowledge needed to develop and run queries against the MMIS data within the system. To simplify the development of queries, data elements are given practical names and logically grouped for easy selection. Users will use common Windows-like features, such as drag and drop, to quickly develop queries and gain access to the desired data. Through the DSS/DW users of all experience levels can generate reports ranging from simple queries to more complex reporting and data analysis.

Universes are updated weekly.

Universe Name	Description
Claims Analysis	This universe contains claim data for all claim types. This claim data includes amounts, dates of service, paid dates, provider, member, procedure, and diagnosis information.
DSSMeasureBase	DSSMeasureBase Stores pre-calculated measures based on the DSSMeasureBase process.
DSSProfiler	The universe will allow access to the DSSProfiler information. By using Profiler Universe, DSS users will be able to generate accurate, up-to-date data about providers, members and associated disease states. This system compares and profiles utilization patterns and payment rankings.
eKASPER	Provides member, provider and claims information regarding controlled substance prescriptions. Information such as, Medicaid Member ID, member personal information, prescription number, NDC, dispensed date, quantity received, days supplied, provider name, city & DEA, dispenser info.
Episode Treatment Grouper (ETG)	The Episode Treatment Grouper (ETG) is a product distributed and licensed by Symmetry Health/Ingenix. The ETG application has the capability of grouping claims information into discrete episode of care. It creates approximately 500 disease conditions or groupings and places the claims within these groups based on the disease and its related comorbidities so that a more thorough analysis of these disease conditions can occur. Our HP Enterprise Services designed ETG processes extract claims information and feed it to the ETG grouper software, creating database tables to store the results of the processes. Each quarterly run of the ETG process pulls in 2 years of claims data (the 8 previous quarters) consisting of Medical, Dental, Inpatient, Outpatient and Pharmacy claims.

Universe Name	Description
Financial	The Financial Universe encompasses claim payment processing, accounts receivable and payable processing, and all other financial transaction processing. The different financial categories are separated into their own classes to allow users to specifically target different financial categories. This universe will allow users to evaluate financial transactions and the details supporting those transactions.
Held Claims	This universe contains claim data for all Held Claims. Held Claims are claims kept in location 98 until they are released to financial. These claims are fiscal pended until time or other criteria is fulfilled. The claim data in this universe includes amounts, dates of service, paid dates, provider, member, procedure, and diagnosis information.
Managed Care	Managed Care is designed to assure members access to necessary medical care, while at the same time controlling medical assistance program costs. Under such models, the state has developed a capitated MCO and individual Managed Care providers who are contracted to provide medical services to <i>KY Medicaid</i> members. Members receive services, covered under the specific capitated program, from the Managed Care provider. In addition, members receive LTC/ Waiver and certain other wrap-around services outside of the Managed Care program.
MAR MSIS	This universe includes tables for each of the five MSIS files sent quarterly to CMS. The tables will contain up to four quarters of data, for the current federal fiscal year (October 1 - September 30). When the files for the first quarter of a federal fiscal year are ready to be loaded, the data for the prior federal fiscal year is unloaded and archived.
MAR Summary Data	This universe includes tables in the MAR summary database. The summary data tables in this universe stand alone, and are not joined in any way to each other.
Member	This Universe contains information on all of the Members enrolled in <i>KY Medicaid</i> . Member information such as program eligibility, aid eligibility, demographics, address, buyin, Managed Care and so on.
PM Universe	This universe is for Dashboard use.
Presumptive Eligibility	Presumptive Eligibility is a program that enables eligible pregnant women to receive prenatal care through Medicaid for up to 90 days while their eligibility for full Medicaid benefits is determined.
Prior Authorization	The Prior Authorization Universe contains information on authorization numbers, members, providers, and procedure code related to prior authorizations. By providing access to prior authorization information in the universe, Data Warehouse users will be able to generate reports for specific prior authorization information.

Universe Name	Description
Provider	This Universe contains information on all of the Providers enrolled in <i>KY Medicaid</i> . Provider information such as type, specialty, address, enrollment, certification, license, Medicare, facility, group, etc.
Random Sample	This is the Surveillance Utilization Review Universe to review Random Sample Results information.
Reference	Reference universe contains information on diagnosis codes, procedure codes, drug codes and other information not contained in Member, Financial and Provider.
TPL	This Universe contains information on TPL resource, carrier, employer, policyholder, coverage, AR dispositions, casualty, attorney, etc. It also, contains member and provider information for those involved in the TPL.
Vital Statistics	This Universe contains Birth and Death Information of an individual. Here you can usually find names, addresses, disease, pregnancy and other demographics information.

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3 Getting Started

3.1 System Access

In KY DDI, all roles and security are maintained through the MEUPS application. The following roles can be selected for each user

User Groups	Description
CreateRefresh	User can create reports and refresh corporate documents. User has access to all universes other than the universes w/special access groups. User has capability to publish to personal folder.
View Only	User can only view corporate documents and/or queries created by other users.
Publish	User can view, refresh, and publish reports to corporate documents.
MeasureBase	User can access MeasureBase windows, universe, and reports.
Profiler	User can access Profiler windows (case maintenance), universe, and reports.
ESRI HP Enterprise Services	User not in Kentucky can access ESRI (arcIMS) base maps.
ESRI KY	User in Kentucky can access ESRI (arcIMS) base maps.
Random Sample	User can access Random Sample windows, universe, and report.
eKASPER	User can access eKASPER windows, universe and report.
Vital Statistics	User can access Vital Statistics universe.
Performance Manager	User can access Performance Manager universe and dashboards.
MAR	User can access the MAR universes: MAR Summary and MSIS.
Export Data	User can export query results to personal schema. Selecting this role will initiate a database request to the DBAs for access to the Production DSS database. In addition, user will have access to export query results from BusinessObjects.

3.2 Accessing the DSS Data Warehouse subsystem

First, login to the MEUPS application.

KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Kentucky Medicaid Web Site

For assistance, email us at KY_EDI_HelpDesk@eds.com or call (800) 205-4696 during normal business hours 7:00 am - 6:00 pm Monday - Friday EST.

Sign in to the KyHealth Choices

- Manage your contact information
- Change your password
- Providers: Manage your agent's access

If you do not have an account, you will need to register.

[Register](#)

Sign in to KyHealth Choices [Help](#)

Username

Password

[Sign In](#)

KyHealth Choices
Forgot your password?

[Contact Us](#)

[Privacy](#) | [Disclaimer](#) | [Individuals with Disabilities](#)

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The MEUPS Home Page will appear.

KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

KyHealth Choices Home

Friday 28 September 2007 09:11 am [Sign Out](#)

Rebecca White, Welcome to KyHealth Choices

Applications	
Application	Description
Account Management	Manages contact information, password, and authorizations for applications.
Authorization Request	Allows a user to request access to applications
DDI Workbook	This is the DDI workbook.
DSS	This is the DSS application
interChange Production	This is the interChange application

Messages	
Date	Message

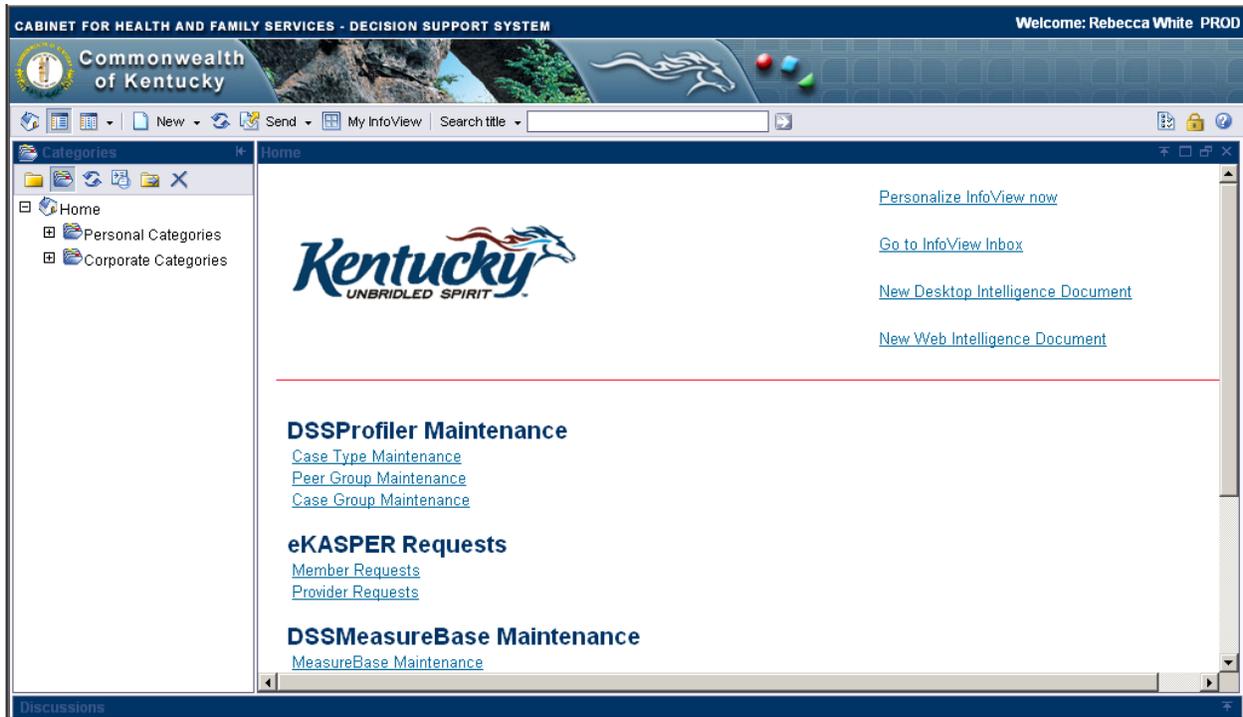
Last Updated: 5/21/2007

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Users with DSS/DW access will see a link on their Applications menu, which appears as DSS in the example above.



4 Windows

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.

4.1.1 DSSMeasureBase - MeasureBase Maintenance

The DSSMeasureBase Maintenance window provides the capability to add or modify a measure. Characteristics of the measure, including measure source, domain, frequency, targets and calculation type, are defined on this window. Qualifier information, which is defined on the Qualifier Maintenance window, is displayed on this window.

4.1.1.1 Technical Name

DSSMB - MeasureBase Maintenance

4.1.1.2 Extra Features

This window has no extra features.

For readability, the layout displays on the next page.

4.1.1.3 DSSMeasureBase - MeasureBase Maintenance Layout

Measure Base Selection
Measure Base Maintenance
Qualifier Maintenance

Measure Base: **1**

Measure Source: **2** Measure Domain: **3**

Measure Target: **4** Min Perf Target: **5**

Calculation Type: **6** Frequency: **7**

Measure Base Description

8 The percentage of enrolled adolescents 13 years of age, who had a second dose of MMR, and three hepatitis B by their 13TH birthday.

	9	10	11	12	13	14	15
Qualifier Type ▲	Seq	Join Type	Group	Part	SeqA0	Qualifier Description	
Denominator	1					Any eligible age 13.	
Denominator	2	NOT IN				Diagnosis Exclusions	
Denominator	3	NOT IN				Diagnosis Exclusions	
Numerator	1	AND IN	2		OR IN	1 MMR	
Numerator	2	AND IN	1			3 HEP B	
Numerator	2	AND IN	2	1	OR IN	3 HEP B	
Numerator	1	AND IN	1	1		1 MEASELS	
Numerator	2	AND IN	2	2	OR IN	Hep B Diagnosis	
Numerator	1	AND IN	1	2	AND IN	1 MUMPS	
Numerator	1	AND IN	1	3	AND IN	1 RUBELLA	

16

- STEP 1 After highlighting a measure on the “MeasureBase Selection” window and selecting “update” from a menu evoked by right clicking the mouse, the “Measure Base Maintenance” window is displayed for the selected measure.
- STEP 2 The user may view the detail criteria for the selected measure on this window. If no changes are to be made the user may do one of the following;
 - a. Return to the “MeasureBase Selection” window by selecting that tab.
 - b. Go to the “Qualifier Maintenance” window by highlighting a qualifier and selecting “update” after right clicking the mouse.
- STEP 3 If non-qualifier changes are to be made the user makes the appropriate changes on the window and selects the “SUBMIT” button to save the changes.
- STEP 4 If qualifier changes are to be made the user does so by selecting “update” after right clicking the mouse to take them to the “Qualifier Maintenance” window.

4.1.1.4 Field Descriptions

Field No.	Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
1	Measure Base	A short description of the measure.	200	Character	Field	T_MM_MEASURE_BASE	MEASURE_BASE_NAME
2	Measure Source	A high-level description of the source of the measure. Example: HEDIS 2005	50	Drop Down List Box	Field	T_MM_MEASURE_BASE	SAK_MEASURE_SOURCE
3	Measure Domain	A method for grouping measures. Examples: Effectiveness of Care, Access/Availability of Care, Use of Services	50	Drop Down List Box	Field	T_MM_MEASURE_BASE	SAK_DOMAIN
4	Measure Target	The target or benchmark of the measure.	5	Number	Field	T_MM_MEASURE_BASE	TARGET
5	Min Perf Target	The minimum performance target for the measure.	5	Number	Field	T_MM_MEASURE_BASE	MIN_PERF_TARGET

Field No.	Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
6	Calculation Type	The type of calculation to be used for the measure. Valid values: Numerator/Denominator, Per 100, Per 1000, Per 10000.	1	Drop Down List Box	Field	T_MM_MEASURE_BASE	CDE_CALC_TYPE
7	Frequency	Indicates the frequency that the measure should be generated. Valid values: Quarterly, Semiannually, Annually	10	Drop Down List Box	Check Box	T_MM_MEASURE_BASE	CDE_FREQUENC Y
8	Measure Base Description	A long description of the measure.	700	Character	Field	T_MM_MEASURE_BASE	DSC_MEASURE_B ASE
9	Qualifier Type	Lists the numerator or denominator subsets used for processing.	11	Character	ListView	T_MM_QUALIFER	CDE_QUAL_TYPE
10	Sequence	Lists the sequence of the numerators and denominators for processing control.	10	Character	ListView	T_MM_QUALIFER	CDE_QUAL_SEQ
11	Join Type	For Part Indicator 'B - Multiple' how the numerators or denominators should be combined	50	Character	ListView	T_MM_QUALIFER	CDE_JOIN_TYPE
12	Group	Lists the group of the qualifier.	18	Character	ListView	T_MM_QUALIFER	CDE_GROUP
13	Part	This indicates if the numerator/denominator has a single or multiple parts	18	Character	ListView	T_MM_QUALIFER	QUAL_PART_IND
14	SeqAO	Value: AND OR Exclude	0	Character	ListView	n/a	n/a
15	Qualifier Description	Lists a short description of the numerators and denominators.	100	Character	ListView	T_MM_QUALIFER	DSC_QUAL

4.1.1.5 Button Descriptions

Button No.	Button	Description
16	Submit	Clicking the Submit button

4.1.1.6 Field Edits

Field	Error Code	Message	Correction
No field edits found for this window.			

4.1.2 DSSMeasureBase - MeasureBase Selection

The DSSMeasureBase Selection page provides the capability to view all measures that are currently defined. The window allows selection by various high level criteria such as Measure Source, Measure Domain, and Frequency. It also provides a search capability to find individual measures.

4.1.2.1 Technical Name

DSSMB - MeasureBase Selection

4.1.2.2 Extra Features

This window has no extra features.

For readability, the layout displays on the next page.

4.1.2.3 DSSMeasureBase - MeasureBase Selection Layout

Measure Base Selection		Measure Base Maintenance	Qualifier Maintenance
Measure Source:	Select a Source 1	Measure Domain:	Select a Domain 2
Calculation Type:	Select a Calculation Type 3	Frequency:	Annual 4 6
			<input type="button" value="Search"/>
← Prev 1 2 3 4 5 6 7 8 Next →		Results: 1 thru 12 of 91	
Measure Base ▲	Measure Source	Measure Domain	
HEDIS - ADOLESCENT IMMUNIZATIONS - Combination 1 5	HEDIS 2005	EFFECTIVENESS OF CARE	
HEDIS - ADOLESCENT IMMUNIZATIONS - Combination 2	HEDIS 2005	EFFECTIVENESS OF CARE	
HEDIS - ADOLESCENT IMMUNIZATIONS - Hep B	HEDIS 2005	EFFECTIVENESS OF CARE	
HEDIS - ADOLESCENT IMMUNIZATIONS - MMR	HEDIS 2005	EFFECTIVENESS OF CARE	
HEDIS - ADOLESCENT IMMUNIZATIONS - VZT	HEDIS 2005	EFFECTIVENESS OF CARE	
HEDIS - ADOLESCENT WELL CHILD VISITS	HEDIS 2005	USE OF SERVICES	
HEDIS - AMBULATORY CARE RECIPIENT ACCESS TO AMBULATORY SURGERY/PROCEDURES	HEDIS 2005	ACCESS/AVAILABILITY OF CARE	
HEDIS - AMBULATORY CARE RECIPIENT ACCESS TO ER VISITS	HEDIS 2005	ACCESS/AVAILABILITY OF CARE	
HEDIS - AMBULATORY CARE RECIPIENT ACCESS TO OBSERVATION SERVICES	HEDIS 2005	ACCESS/AVAILABILITY OF CARE	
HEDIS - ANNUAL DENTAL CARE - AGE 4-21	HEDIS 2005	ACCESS/AVAILABILITY OF CARE	
HEDIS - APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS	HEDIS 2005	EFFECTIVENESS OF CARE	
HEDIS - APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION	HEDIS 2005	EFFECTIVENESS OF CARE	

- STEP 1 After selecting “MeasureBase Maintenance” from the “DSSNavigator - Welcome Window”, all the Annual Measures are displayed on the initial opening window. There are 12 measures displayed per page.
- STEP 2 The user may view all of the measures by using the “prev” and/or “next” links. The user may also advance through the results by selection of the next page they wish to view.
- STEP 3 The user may also search for specific types of measures by using a combination of the 4 drop down selection boxes at the top of the window and selecting the Search Button. The four drop down boxes are:
 - a. Measure Source
 - b. Measure Domain
 - c. Calculation Type
 - d. Frequency
- STEP 4 Highlighting a measure and selecting “update” after right clicking the mouse will take the user to the “Measure Base Maintenance” window.

4.1.2.4 Field Descriptions

Field No.	Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
1	Measure Source	A high-level description of the source of the measure. Example: HEDIS 2005	0	Drop Down List Box	Field	T_MM_MEASURE_BASE	SAK_MEASURE_SOURCE
2	Measure Domain	A method for grouping measures. Examples: Effectiveness of Care, Access/Availability of Care, Use of Services	0	Drop Down List Box	Field	T_MM_MEASURE	SAK_DOMAIN
3	Calculation Type	This indicates how the data will be sampled Values: A - Numerator /Denominator B - Per 1000 C - Per 100 D - Per 10000	13	Drop Down List Box	Field	T_MM_MEASURE_BASE	CDE_CALC_TYPE

Field No.	Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
4	Frequency	Indicates the frequency that the measure should be generated. Examples: Quarterly, Semiannually, Annually	0	Drop Down List Box	Field	T_MM_MEASURE_BASE	CDE_FREQUENCY
5	Measure Base	A short description of the measure.	0	Character	Field	T_MM_MEASURE_BASE	MEASURE_BASE_NAME

4.1.2.5 Button Descriptions

Button No.	Button	Description
6	Search	Clicking the Search button returns search results based on the search criteria.

4.1.2.6 Field Edits

Field	Error Code	Message	Correction
No field edits found for this window.			

4.1.3 DSSMeasureBase - Qualifier Maintenance - DSSMB - Qualifier Maintenance

The DSSMeasureBase Qualifier Maintenance window provides the capability to add or modify the qualifier criteria (numerators and denominators) for a measure.

4.1.3.1 Technical Name

DSSMB - Qualifier Maintenance

4.1.3.2 Extra Features

This window has no extra features.

For readability, the layout displays on the next page.

4.1.3.3 DSSMeasureBase - Qualifier Maintenance Layout

Measure Base Selection	Measure Base Maintenance	Qualifier Maintenance
Qualifier Type: <input type="text" value="Denominator"/> 1	Sequence: <input type="text" value="2"/> 2	
Part: <input type="text"/> 3	Date Range: <input type="text" value="4 years of data"/> 4	
PartInd: <input type="text" value="Multiple"/> 5	Group: <input type="text"/> 6	
PartSeq: <input type="text" value="1"/> 7	SeqAO: <input type="text"/> 8	
Data Source: <input type="text" value="Claims"/> 9	Threshold1: <input type="text" value="1"/> 10	
Count Criteria: <input type="text" value="Claims"/> 11	Threshold2: <input type="text" value="0"/> 12	
Join Type: <input type="text" value="NOT IN"/> 13	Description: <input type="text" value="Diagnosis Exclusions"/> 14	
Qualifier Criteria		
15 Function: <input type="text"/> 16 Criteria: <input type="text"/> 17 Mask: <input type="text"/> 21	<input type="button" value="Add"/>	
18 Operator: <input type="text" value="="/> 19 Value: <input type="text"/>		
Criteria		
<pre>{ DIAG_CODE = 9994 OR DIAG_CODE = 279 OR DIAG_CODE BETWEEN 200 and 208 } AND AGEMNTH BETWEEN 108 and 156</pre> 20		
<input type="button" value="Submit"/> 22		

- STEP 1** After highlighting a qualifier on the “Measure Base Maintenance” window and selecting “update” from a menu evoked by right clicking the mouse, the “Qualifier Maintenance” window is displayed for the selected qualifier.
- STEP 2** The user may view the detail criteria for the selected qualifier on this window. If no changes are to be made the user may leave the screen by doing one of the following
- Return to the “MeasureBase Selection” window by selecting that tab
 - Return to the “MeasureBase Maintenance” window by selecting that tab
- STEP 3** If qualifier changes are to be made the user makes the appropriate changes on the window and selects the “SUBMIT” button to save the changes.

4.1.3.4 Field Descriptions

Field No.	Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
1	Qualifier Type	Indicates the type of qualifier. Valid values: Numerator, Denominator.	11	Drop Down List Box	Field	T_MM_QUALIFER	T_MM_QUALIFIER
2	Sequence	Indicates the sequence of the numerators and denominators for processing control. Valid values: 1-5.	1	Drop Down List Box	Field	T_MM_QUALIFER	CDE_QUAL_SEQ
3	Part	This indicates if the numerator/denominator has a single or multiple parts	18	Drop Down List Box	Field	T_MM_QUALIFER	CDE_PART
4	Date Range	Indicates the date range for the measure. Valid values: 1-Current year, 2-Current and previous year, 3-Current and previous two years, P-Previous year	50	Drop Down List Box	Field	T_MM_QUALIFER	CDE_DATE_RANGE
5	Part Indicator	This indicates if the numerator/denominator has a single or multiple parts Values: A Single B Multiple E The last numerator/denominator of the series on multiple	0	Drop Down List Box	Field	T_MM_QUALIFER	QUAL_PART_IND

Field No.	Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
		numerators/denominators					
6	Group	Lists the group.	18	Drop Down List Box	Field	T_MM_QUALIF ER	CDE_GROUP
7	PartSeq	This indicates the sequence of the parts. Values: A Single B Multiple E The last numerator/denominator of the series on multiple numerators/denominators	18	Drop Down List Box	Field	T_MM_QUALIF ER	CDE_PART_SEQ
8	SeqAO	Value: AND OR Exclude	0	Drop Down List Box	Field	N/A	N/A
9	Data Source	Indicates the source of the measure data. Valid values: C-Claims, E-Eligibility.	50	Drop Down List Box	Field	T_MM_QUALIF ER	SAK_DATA_SOURCE
10	Threshold1	This is a ten-digit number that indicates the threshold used for extraction. It is assumed that the value is based on a member based total.	10	Number	Field	T_MM_QUALIF ER	THRESHOLD_1
11	Count Criteria	Indicates the field that will be counted for the measure. Valid values: M-Members, C-Claims(services), A-Paid Amount, D-Check dates between two claims, T-Days(number of days on a claim)	50	Drop Down List Box	Field	T_MM_QUALIF ER	CDE_CNT_CRIT
12	Threshold2	This is a ten-digit number that indicates the threshold used for extraction. It is assumed that the value is based on a member based total.	10	Number	Field	T_MM_QUALIF ER	THRESHOLD_2

Field No.	Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
13	Join Type	Indicates how the numerator or denominator sets should be combined: Valid values: A-"AND IN", O-"OR IN", X-"NOT IN"	50	Drop Down List Box	Field	T_MM_QUALIFIER	CDE_JOIN_TYPE
14	Description	A brief description of the numerator or denominator.	100	Character	Field	T_MM_QUALIFIER	DSC_QUAL
15	Qualifier Criteria - Function	This field allows the user to combine criteria. Valid values: AND, OR, NOT.	0	Drop Down List Box	Field	N/A	N/A
16	Qualifier Criteria - Criteria	This field allows the user to specify the fields that will be used to determine the measure. For example, diagnosis code, age, etc.	0	Drop Down List Box	Field	T_MM_FILTER	TXT_FILTER
17	Qualifier Criteria - Mask	This field displays the format in which the 'Value' field must be entered.	0	Character	Field	T_MM_FILTER	TXT_MASK
18	Qualifier Criteria - Operator	This field allows the user to select an operator with which to compare the 'Criteria' and 'Value' fields. Valid values: =, <>, , <=, >=, between, like.	0	Drop Down List Box	Field	N/A	N/A
19	Qualifier Criteria - Value	This field allows the user to enter the value that will be used to compare against the 'Criteria' field. Two 'Value' fields will be displayed if the user chooses the "between" operator.	0	Alphanumeric	Field	N/A	N/A

Field No.	Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
20	Criteria	This section displays the information that has been entered in the 'Qualifier Criteria' section.	0	Alphanumeric	Field	N/A	N/A

4.1.3.5 Button Descriptions

Button No.	Button	Description
21	Qualifier Criteria - Add	This button adds the criteria entered by the user in the `Criteria list box`. It will stay disabled until the 'Criteria' and 'Value' fields have been entered.
22	Submit	Submit changes to add or modify.

4.1.3.6 Field Edits

Field	Error Code	Message	Correction
No field edits found for this window.			

4.1.4 DSSNavigator - Corporate Documents

The DSSNavigator - Corporate Documents window displays all of the corporate documents available to the user based on security privileges. The user can view the corporate documents by all categories or by individual categories by selecting the categories from a drop down box at the top of the window. If a document name appears in red, this means the document was created using WebIntelligence. If the document name appears in blue, the document was created using BusinessObjects.

The personal documents window are similar to this window, and provides more privileges to the user that may not be available for the corporate documents such as adding categories and deleting documents.

4.1.4.1 Technical Name

DSSNavigator - Corporate Documents

For readability, the layout displays on the next page.

4.1.4.2 DSSNavigator - Corporate Documents Layout

Commonwealth of Kentucky - DSS InfoView - Microsoft Internet Explorer provided by EDS COE

Address: http://us01wkyvm109:20080/businessobjects/enterprise115/InfoView/main.aspx

CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM

Welcome: Bob Odenweller UAT

Commonwealth of Kentucky

Categories

- Home
- Personal Categories
- Corporate Categories
 - Dashboard
 - DSS Reports
 - DSSMeasureBase
 - EIS Reports
 - Interim DSS Repo
 - Legacy DSS Repo
 - SUR Reports
 - DSS Profiler Repo
 - ETG (Episode Tre
 - Random Sample
 - Targeted Queries

Targeted Queries

Title ¹	Last Run ²	Type ³	Owner ⁴	Instances ⁵
<input type="checkbox"/> Delayed Surgery Summary View Latest Instance Schedule History Properties Modify This report will list all Inpatient claims containing a surgical code where the surgical date is greater than the from date of service. This report will rank the claims based on the number of days a surgery was delayed. The delayed surgery count is calculated by determining the days between the from date of service and the surgical procedure date.	1/29/2007 4:14 PM ⁶	Desktop Intelligence	Administrator	1
<input type="checkbox"/> Facility Visits Exception View Latest Instance Schedule History Properties Modify The Facility Visits Exception Report will display the exception Professional claims submitted by a provider meeting the defined criteria for the report. The SURS Certification Requirement met by this report is: Physicians and other practitioners having instances of. m. Frequent multiple visits on a single day to many recipients at the same facility or location.	3/1/2007 12:44 PM	Desktop Intelligence	Administrator	1
<input type="checkbox"/> Office Visits Exception Schedule History Properties Modify The Office Visits Exception Report will display the exception Professional claims submitted by a provider meeting the defined criteria for the report. The SURS Certification Requirement met by this report is: Physicians and other practitioners having instances of. m. Frequent multiple visits on a single day to many members at the same facility or location.	Never run	Desktop Intelligence	Administrator	0
<input type="checkbox"/> Overlapping Member Services Schedule History Properties Modify This report identifies members receiving services from different, user selected, provider types, on the same or overlapping dates of service. The user can enter Billing Provider Type code(s) and date of service date range.	Never run	Desktop Intelligence	Administrator	0
<input type="checkbox"/> Physician Office Visits by Member Schedule History Properties Modify This report gives a count of physician office visits by recipient.	Never run	Desktop Intelligence	Administrator	0
<input type="checkbox"/> Physician Office Visits by TANF Families Schedule History Properties Modify This report shows counts of physician office visits, by TANF family.	Never run	Desktop Intelligence	Administrator	0
<input type="checkbox"/> Top 20 Diagnosis Codes by Provider Schedule History Properties Modify This report will display the top 20 Diagnosis codes billed by a provider for a specific timeframe.	Never run	Desktop Intelligence	Administrator	0
<input type="checkbox"/> Top 20 DRG Codes by Provider Schedule History Properties Modify This report will display the top 20 DRG codes billed by a provider for a specific timeframe.	Never run	Desktop Intelligence	Administrator	0

Discussions

Local intranet

A listing of all corporate documents for the category selected will appear in the panel.

- STEP 1 Click on the document name to view and/or refresh the document
- STEP 2 Click on 'Schedule' beneath the report name to perform a scheduled refresh. You must have appropriate permissions to perform this function.
- STEP 3 Click on 'History' beneath the report name to see a history of past scheduled refreshes of a document.
- STEP 4 Click on 'View Latest Instance' to view the latest scheduled refresh of a document.
- STEP 5 Click on 'Properties' to see detailed document information.
- STEP 6 Click on 'Modify' beneath the report name to modify a document. You must have appropriate permissions to perform this function.

4.1.4.3 Extra Features

This window has no extra features.

4.1.4.4 Field Descriptions

Field No.	Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
1	Title	Name of the document.	0	N/A	Label	N/A	N/A
2	Last Run	The last time a scheduled document was refreshed.	0	N/A	Label	N/A	N/A
3	Type	Specifies whether this is a Desktop Intelligence or Webi document.	0	N/A	Label	N/A	N/A
4	Owner	This indicates the user that published the document to the corporate repository.	0	N/A	Label	N/A	N/A
5	Instances	The number of past completed scheduled versions available for this report.	0	N/A	Label	N/A	N/A

Field No.	Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
6	Date	This indicates when the document was published to the corporate repository.	0	N/A	Label	N/A	N/A

4.1.4.5 Field Edits

Field	Error Code	Message	Correction
No field edits found for this window.			

4.1.5 DSSNavigator - Welcome Window

The DSSNavigator - Welcome Window is displayed once a user successfully logs into DSSNavigator. From this window, users can:

- Access personal documents;
- Access corporate documents, based on user privileges;
- Create new documents from the available universe, based on user privileges;
- Send documents to other InfoView users;
- View documents sent to Scheduler;
- Retrieve documents from their personal InfoView Inbox;
- Search for documents; and,
- Access On-line help for InfoView.

The functions described above can be accessed on the navigation bar on the left-hand side of the window. These functions are described in more detail in the window field name and descriptions.

4.1.5.1 Technical Name

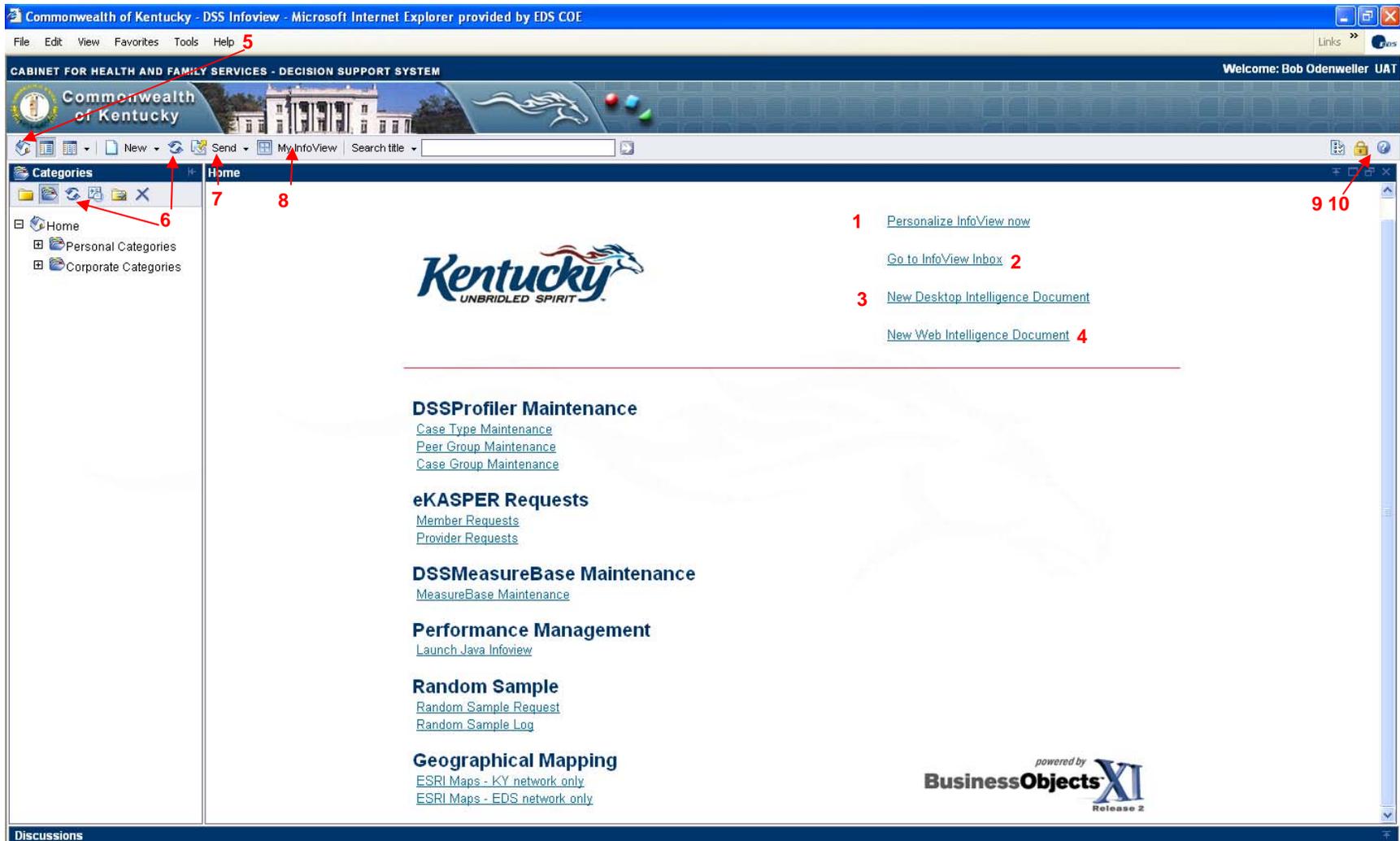
DSSNavigator - Login Window

4.1.5.2 Extra Features

This window has no extra features.

For readability, the layout displays on the next page.

4.1.5.3 DSSNavigator - Welcome Window Layout



The Welcome screen displays icons representing all tasks associated with a person’s access level. Many reporting tasks can be accomplished from the screen by clicking on the desired icon.

STEP 1 To generate a new Infoview document, click on the New Desktop Intelligence Document or New Web Intelligence Document link

STEP 2 To view personal documents saved for personal use or to view or retrieve documents, click on the Go To InfoView Inbox link.

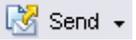
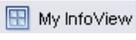
STEP 3 Documents are categorized by folder or category. To look inside folder click on the  icon in the left navigation pane. To search by category, click on the  icon in the left navigation pane. Click on the  icon next to the folder or category to see the sub-folder or sub-categories. Click on the category or folder name to see its contents in the main panel.

4.1.5.4 Field Descriptions

Field No.	Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
1	Personalize Infoview now	This link opens a page to allow the user to set various Infoview preferences. Also available by clicking on the  icon.	0	N/A	Hyperlink	N/A	N/A
2	Go To InfoView Inbox	This link takes a user to a new window that lists all of the documents sent to the user by other users of the Web or BusinessObjects system. The user can then save those documents to a personal storage area or, if the user has the appropriate rights, publish them to a corporate document repository.	0	N/A	Hyperlink	N/A	N/A

Field No.	Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
3	New Desktop Intelligence Document	This link opens the full client version of Desktop Intelligence on the user's PC. Desktop Intelligence must be installed on the PC for this to work. Also available by clicking on the  drop down list.	0	N/A	Hyperlink	N/A	N/A
4	New Web Intelligence Document	This link takes a user to a new window that displays the available universes the user can select to create a report. When a report is created, the user can then distribute the report in any of several ways such as publishing it to the corporate repository to make it available to a broad group(s) of users; save it to the user's personal storage area; or send it to other users. Also available by clicking on the  drop down list.	0	N/A	Hyperlink	N/A	N/A

4.1.5.5 Button Descriptions

Button No.	Button Icon	Description
5		Return to the welcome page
6		Clicking this icon will refresh the portion of the screen where the icon is located.
7		This drop down list allows users to send documents to other users
8		Opens up a new window to allow a user to create a customized 'My Infoview' page.

Button No.	Button Icon	Description
9		This link logs the user out of DSSNavigator.
10		Opens up a new window for online help.

4.1.5.6 Field Edits

Field	Error Code	Message	Correction
No field edits found for this window			

5 Reports

5.1 Introduction

This manual contains a sample page for each report for this system with a short description. The last character of the report name indicates the frequency of the report.

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 DSS Data Warehouse 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.

5.2 Tips for Reading DSS Reports

- The “run” date and time always appear in the top left corner of the report.
- The user ID of the user who ran the report appears in the top right corner of the report.
- The report title appears under the headings “Cabinet for Health and Family Services,” and “Department for Medicaid Services.”
- Numbers which appear in red, in parentheses, represent negative numbers.

5.3 Default Values

The system defaults that the DSS assigns to null or invalid values during the extract, transform, and loads (ETL) are:

Default value for beginning date:	01/01/0101
Default value for ending date:	12/31/2299
Default value for indicator:	'N'
Default value for number:	0
Default value for amount fields:	0.0
Default value for Text:	Filled with space
Default value for code field:	Filled with '#'

5.4 Infoview Report Library

The infoview report library has two classification for the reports, category and folder view. A report can be in both classifications. The category classification allows for further breakdown into subcategories, whereas the folder view is a very high level classification of DSS, SUR or Dashboard.

Categories	Description
Dashboard	Corporate category that contains all KY corporate Medicaid Dashboards.
DSS Reports	Corporate category that contains all DSS reports including DSS Measurebase, EIS, Interim DSS Reports, and Legacy DSS Reports.
DSSMeasureBase Reports	
EIS Reports	
Interim DSS Reports	
Legacy DSS Reports	

Categories	Description
SUR Reports DSS Profiler Reports ETG Reports Random Sample Reports Targeted Queries	Corporate category that contains all SUR reports, including DSS Profiler, ETG, Random Sample, and Targeted Queries.

Folders	Description
Dashboard	Corporate folder that contains all KY corporate Medicaid Dasboards.
DSS Reports	Corporate folder that contains all DSS reports including DSS Measurebase, EIS, Interim DSS Reports, and Legacy DSS Reports.
SUR Reports	Corporate folder that contains all SUR reports, including DSS Profiler, ETG, Random Sample, and Targeted Queries.

5.4.1 DSS - ADHC Monitoring -- ADHC Monitoring

The Adult Day Health Care (ADHC) Monitoring report generates a history of Adult Day Health Care claims during a specific date of service range.

5.4.1.1 Technical Name
DSS - ADHC Monitoring

5.4.1.2 Sort Order:
Original Member ID, Last Date of Service, and Transaction Control Number.

5.4.1.3 ADHC Monitoring Layout

Run Date: 08/09/2006
Run Time: 1:58:09 PM

Cabinet for Health and Family Services

Department for Medicaid Services

ADHC Monitoring Report

User ID: tztsbl

Billing Provider ID(s): 100000039A

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



Billing Provider IDs	Member ID	ICN	From Date of Service	To Date of Service	Paid Amount	Billed Qty	Billed Amount	Member Name for Case	Procedure Description
NPI ID: 1000000011 Medicaid ID: 100000039A Base ID: 10000004	000001288	1234567890123	01/19/2002	01/19/2002	\$121.43	1	\$122.43	SMITH, MIKE	29000 -
NPI ID: 1000000011 Medicaid ID: 100000039A Base ID: 10000004	000001288	1234567890123	05/21/2002	05/21/2002	\$359.50	1	\$360.50	SMITH, MIKE	29885 -
NPI ID: 1000000011 Medicaid ID: 100000039A Base ID: 10000004	000001288	1234567890123	07/01/2002	07/01/2002	\$13.52	1	\$14.52	SMITH, MIKE	99261 -
NPI ID: 1000000011 Medicaid ID: 100000039A Base ID: 10000004	000001305	1234567890123	04/05/2002	04/05/2002	\$360.50	1	\$360.50	SMITH, MIKE	29874 -

End of Report

Report Notes

B

Report Description

The ADHC Monitoring report generates a history of Adult Day Health Care claims during a specific date of service range.

Selection Criteria

- From Date of Service per user input
- FFS Claims only
- Latest Claims only
- Billing Provider ID per user input

5.4.1.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider IDs	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i> .	9	Char	T_CA_ICN	ID_PROV_BILL
Member ID	The first Identification number assigned to a member upon initial certification for participation in <i>KY Medicaid</i> .	12	Char	T_CA_ICN	ID_MEDICAID
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYDDDBBSSS: RR - region, YYDDD - julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN

Field	Description	Length	Data Type	DB Table	DB Attributes
From Date of Service	This is the first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
To Date of Service	This is the last date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC
Paid Amount	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Billed Qty	The number of units administered for the procedure code billed on this line item.	5	Number	T_CA_ICN	QTY_UNITS_BILLED
Billed Amount	A charge for an individual procedure, treatment or service item as submitted by the provider.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
Member Name for Case	The member case name.	30	Char	T_RE_BASE	NAM_FIRST,NAM_LAST
Procedure Description	Code detailing the medical procedure performed for this claim detail.	5	Char	T_CA_HDR_DTL	LCD_PROC

5.4.1.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.2 DSS - AR over Payments by SFY

The Accounts Receivable (AR) Over Payments by State Fiscal Year (SFY) report generates a list of all ARs entered into the system during the SFY and the activity for each to derive the ending balance at the fiscal year end. Report is requested annually by state auditors to review items such as DMS AR outstanding balances, overpayments, and collection activity.

5.4.2.1 Technical Name

DSS - AR over Payments by SFY

5.4.2.2 Sort Order

AR Number.

5.4.2.3 AR Over Payments by SFY Layout

Run Date: 05/11/2007 Run Time: 3:02:32 PM		Cabinet for Health and Family Services Department for Medicaid Services				User ID: tztsbl				
		AR Overpayments by SFY				State Fiscal Year: 2007				
Accounts Receivable Control Number	Provider Numbers	AR Setup Amount	Accounts Receivable Created Date	Adjustments	Recoupments	Amount Increase/Decrease	Interest Calculated	Interest Received	Ending Balance	
0000000100244	NPI Medicaid Number: 56004161 Base Number: 500010479	\$74.00	07/24/2006	\$0.00	\$0.00	\$(74.00)	\$0.00	\$0.00	\$0.00	
0000000101266	NPI Medicaid Number: 56004401 Base Number: 500005816	\$64.00	07/18/2006	\$0.00	\$0.00	\$(64.00)	\$0.00	\$0.00	\$0.00	
0000000101455	NPI Medicaid Number: 56004716 Base Number: 500007337	\$66.00	07/18/2006	\$0.00	\$0.00	\$(66.00)	\$0.00	\$0.00	\$0.00	
000000010157	NPI Medicaid Number: 01007335 Base Number: 500005486	\$264.00	07/07/2006	\$0.00	\$0.00	\$(264.00)	\$0.00	\$0.00	\$0.00	
000000010158	NPI Medicaid Number: 01007335 Base Number: 500005486	\$12.06	07/12/2006	\$0.00	\$0.00	\$(12.06)	\$0.00	\$0.00	\$0.00	
000000010159	NPI Medicaid Number: 01007335 Base Number: 500005486	\$120.00	07/18/2006	\$0.00	\$0.00	\$(120.00)	\$0.00	\$0.00	\$0.00	
0000000102786	NPI Medicaid Number: 60001088 Base Number: 500072027	\$26.00	07/05/2006	\$0.00	\$0.00	\$(26.00)	\$0.00	\$0.00	\$0.00	
0000000102807	NPI Medicaid Number: 60001310 Base Number: 500065835	\$42.00	07/19/2006	\$0.00	\$0.00	\$(42.00)	\$0.00	\$0.00	\$0.00	
0000000102832	NPI Medicaid Number: 60001526 Base Number: 500024238	\$33.00	07/10/2006	\$0.00	\$0.00	\$(33.00)	\$0.00	\$0.00	\$0.00	
0000000102948	NPI Medicaid Number: 60003340 Base Number: 500022204	\$35.00	07/12/2006	\$0.00	\$0.00	\$(35.00)	\$0.00	\$0.00	\$0.00	
0000000103832	NPI Medicaid Number: 60037595 Base Number: 500062829	\$86.00	07/12/2006	\$0.00	\$0.00	\$(86.00)	\$0.00	\$0.00	\$0.00	
000000010541	NPI Medicaid Number: 01008341 Base Number: 500005410	\$110.77	07/25/2006	\$0.00	\$0.00	\$(110.77)	\$0.00	\$0.00	\$0.00	
0000000105533	NPI Medicaid Number: 60044492 Base Number: 500016564	\$362.00	07/19/2006	\$0.00	\$0.00	\$(362.00)	\$0.00	\$0.00	\$0.00	
0000000105723	NPI Medicaid Number: 60045820 Base Number: 500026656	\$88.00	07/20/2006	\$0.00	\$0.00	\$(88.00)	\$0.00	\$0.00	\$0.00	

Accounts Receivable

AR Over Payments by SFY.rep

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Report Notes

Description

The Accounts Receivable (AR) Over Payments by State Fiscal Year (SFY) report generates a list of all AR's entered into the system during the SFY and the activity for each to derive the ending balance at the fiscal year end. Report is requested annually by state auditors to review items such as DMS AR outstanding balances, overpayments and collection activity.

Search Criteria

AR created date range as input by user

5.4.2.4 Field Descriptions

Field Name	Description	Length	Data Type	DB Table	DB Attributes
Accounts Receivable Control Number	A unique number serving to identify each claim transaction received and processed through the MMIS. MYYJJJXXBBBTDDDSS (17). Medium M (1), Year YY (2), Julian Date JJJ (3), Not Used XX (2), Batch BBB (3), Type of Document T (1), Document Number DDD (3), and Sequence No SS (2).	13	Char	T_ACCT_REC	NUM_CONTROL_AR
Accounts Receivable Created Date	Represents the date to begin AR aging. This is also either the letter date on the demand letter or the date a system generated AR is created.	10	Date (MM/DD/CYY)	T_ACCT_REC	DTE_EFFECTIVE
Adjustments	The system adjustment amounts posted to the Accounts Receivable transaction.	13	Number (Decimal)	T_AR_DISP	AMT

Field Name	Description	Length	Data Type	DB Table	DB Attributes
Amount Increase/Decrease	The amount of the disposition that was applied to the accounts receivable. T_AR_DISP_REAS.CDE_REASON_TYPE is not "I" (Interest) or "R" (Recoupment)	13	Number (Decimal)	T_AR_DISP	AMT
AR Setup Amount	The setup amount (original amount) of the AR.	13	Number (Decimal)	T_ACCT_REC	AMT_SETUP
Ending Balance	Original Amount Requested + Adjustments – Recoupment/Payments + Interest Calculated – Interest Received + Penalty Calculated – Penalty Received	13	Number	N/A	Calculated
Interest Calculated	The system calculated interest amount owed on the Accounts Receivable transaction outstanding balance.	13	Number	N/A	Calculated
Interest Received	The total interest charged on a payment plan AR which is for a term of more than 6 months.	13	Number (Decimal)	T_AR_DISP	AMT_APPLIED_INTRST
Provider Numbers	The field displays the NPI, unique state assigned number and the unique interChange assigned number for the provider.	10	Char	T_ACCT_REC	PROV_BILLING_NUMBER
Recoupments	The system recoupment amounts posted or payments dispositional to the Accounts Receivable transaction.	13	Number (Decimal)	T_ACCT_REC	AMT_MAX_RECOUP_AR

5.4.2.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.3 DSS - Accounts Payable Closing Package

The Accounts Payable Closing Package report generates estimates of outstanding payables at the end of the State Fiscal Year.

5.4.3.1 Technical Name

DSS - Accounts Payable Closing Package

5.4.3.2 Sort Order

Paid Month.

5.4.3.3 Accounts Payable Closing Package Layout

A

Run Date: 8/14/2007
Run Time: 11:49:18 AM

Cabinet for Health and Family Services Department for Medicaid Services

User ID: rztdly



Accounts Payable Closing Package

From Date of Service End: 7/1/2006

Payment Date(s): 7/1/2006 - 9/30/2006

Paid Date	Paid Amount Sum	ICN Undup Count
07/07/2006	\$1,860,841.40	22,888
07/14/2006	\$987,453.44	7,582
07/21/2006	\$993,582.67	7,965
07/28/2006	\$814,940.52	5,622
08/04/2006	\$610,879.20	4,233
08/11/2006	\$308,315.88	2,588
08/18/2006	\$317,006.07	2,422
08/25/2006	\$208,492.16	1,999
09/01/2006	\$258,471.38	1,640
09/08/2006	\$167,933.63	1,104
09/15/2006	\$132,231.00	826
09/22/2006	\$269,786.19	970
09/29/2006	\$68,666.90	801
Sum:	\$6,998,600.44	60,640

End of Report

B

Report Notes

Report Description

This report generates estimates of outstanding payables at the end of the State Fiscal Year.

Search Criteria

From Date of Service - Begin date of service <= entered in the prompt
 Payment Date - Payment date range entered in the prompt
 Adjust/Void Indicator - different from 'Y'
 FFS Claims Only - Fee for Service filter
 Paid Claims Only filter

5.4.3.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
ICN Undup Count	Count of unique internal control numbers.	13	Char	T_CA_ICN	NUM_ICN
Paid Amount Sum	The amount paid by Medicaid for the procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Paid Date	The date in which a payment was generated from the MMIS claim transaction	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID

5.4.3.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.4 DSS - Alternate Budget Model

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

5.4.4.1 Technical Name

DSS - Alternate Budget Model

5.4.4.2 Sort Order

Paid Month, and Category of Service.

5.4.4.3 Alternate Budget Model Layout

A

Run Date: 8/9/2007

Run Time: 6:01:15 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: rztdly



Alternate Budget Model

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

Paid Date	State COS Code	Member KCHIP Phase	Paid Amount Sum	Distinct Utilizers
05/0007	##	2	\$(73,088.42)	15
05/0007	##	3	\$(3,966.98)	11
05/0007	##		\$(719,983.14)	455
05/0007	02	2	\$424,487.13	137
05/0007	02	3	\$324,771.90	84
05/0007	02		\$65,003,964.85	16,581
05/0007	03	2	\$205,485.06	31
05/0007	03	3	\$83,856.15	13
05/0007	03		\$2,899,916.82	481
05/0007	04		\$2,433,312.66	1,125

B Report Notes

Report Description

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

Search Criteria

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

5.4.4.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Distinct Utilizers	A count of distinct individual utilizers of service, not total members, reported.	10	Char	T_CA_ICN	ID_MEDICAID
KCHIP Member Phase	Displays the phase of KCHIP in which a group of members is enrolled. Phases are blank, 2 and 3.	2	Char	N/A	Calculated
Paid Amount Sum	The amount paid by Medicaid for the line item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID

Field	Description	Length	Data Type	DB Table	DB Attributes
Paid Date	The month in which a payment was generated from the claim transaction in MM/CCYY format.	7	Date (MM/CCYY)	T_CA_ICN	DTE_PAID
State COS Code	A code defining the category of service rendered (for example, inpatient, pharmacy, physician or home health).	52	Char	T_CA_CLAIM_KEY, T_CDE_COS_VALUES	CDE_COS_ST DSC_COS_VALUES

5.4.4.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.5 DSS - Ancillary Verifications with Names

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

5.4.5.1 Technical Name

DSS - Ancillary Verifications with Names

5.4.5.2 Sort Order

None.

5.4.5.3 Ancillary Verifications with Names Layout

Run Date: 08/04/2006
Run Time: 10:34:24 AM

Cabinet for Health and Family Services

User ID: tztsbl

Department for Medicaid Services

A



Ancillary Verification - Names

Billing Provider ID(s): 0123456789

Revenue Code Range: 0120 - 9999

First Date of Service Range: 07/11/2000 - 08/01/2006

ICN	Billed Amount	Member ID	Member Name	First Date of Service	Last Date of Service	Revenue Code Description
0123456789012	\$1,266.86		SMITH, RICK	07/01/2004	07/08/2004	0320 - Diagnostic X Ray

End of Report

Report Notes

B

Report Description

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

Search Criteria

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

5.4.5.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Amount	A charge for an individual procedure, treatment or service item as submitted by the provider.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
First Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_HDR_DTL	DTE_FIRST_SVC
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number.	13	Char	T_CA_ICN	NUM_ICN
Last Date of Service	This is the line item last date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_HDR_DTL	DTE_LAST_SVC
Member ID	The Medicaid identification number for the member.	12	Char	T_CA_ICN	ID_MEDICAID

Field	Description	Length	Data Type	DB Table	DB Attributes
Member Name	The member's full name.	30	Char	T_RE_BASE	NAM_FIRST,NAM_L AST,NAM_MID_INIT
Revenue Code Description	The line item revenue code billed on the UB-92/UB-04 claim (describes the service performed).	4	Number	T_CA_HDR_DTL	CDE_REVENUE

5.4.5.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.6 DSS - Ancillary per Revenue Code

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

5.4.6.1 Technical Name

DSS - Ancillary per Revenue Code

5.4.6.2 Sort Order

Bill Provider Number ascending, Member Last Name ascending; and Member First Name, ascending.

5.4.6.3 Ancillary per Revenue Code Layout

A

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

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: tztsbl



Ancillary Per Revenue Code

Revenue Code(s): 0320
From Date of Service Range: 01/01/2006 - 01/31/2006

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

End of Report

Report Notes

B

Report Description

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

Search Criteria

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

5.4.6.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Ancillary Total Paid Amount	The dollars paid for Ancillary codes by revenue code.	13	Number (Decimal)	T_CA_HDR_DTL	AMT_PAID
Billed Revenue Amount	A charge for an individual procedure, treatment or service item as submitted by the provider.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i> .	10	Char	T_CA_PROV_KEY	ID_PROV_BILL

Field	Description	Length	Data Type	DB Table	DB Attributes
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYDDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number.	13	Char	T_CA_ICN	CD_ICN
Member Full Name (L,FM)	The member's full name.	19	Char	T_RE_BASE	NAM_FIRST,NAM_LAST,NAM_MID_INIT
Member ID	The Medicaid identification number for the member.	12	Char	T_CA_ICN	ID_MEDICAID
Revenue Code & Description	The line item revenue code billed on the UB-92 claim (describes the service performed) and description.	4	Char	T_CA_HDR_DTL_DN, T_REVENUE_CODE	CDE_REVENUE_1 DSC_REV_CODE

5.4.6.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.7 DSS - Bed Days for Nursing Homes

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

5.4.7.1 Technical Name

DSS - Bed Days for Nursing Homes

5.4.7.2 Sort Order

Bill Provider Number ascending.

5.4.7.3 Bed Days for Nursing Homes Layout

A

Run Date:09/09/2007
Run Time:5:21:16 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: wzt2t5



Bed Days for Nursing Homes

Billing Provider Numbers(s): 12500047
From Date of Service Range: 4/1/2007 12:00:00 AM - 4/1/2007 12:00:00 AM

Billing Provider Numbers	Covered Days Sum	Billing Provider Name
NPI: Medicaid Number: 12500047 Base Number: 500005790	1,063	BELLE MEADE HOME

End of Report

Report Notes

B

Report Description

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

Search Criteria

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

5.4.7.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Name	The full name of the Medicaid provider on file.	50	Char	T_PR_SVC_LOC	NAME
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i> .	10	Char	T_CA_ICN	ID_PROV_BILL
Covered Days Sum	This field is computed by the system using the FROM and TO dates of service. Indicates the total number of days for this claim.	5	Number	T_CA_ICN	NUM_DAYS_COVD

5.4.7.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.8 DSS - Breast and Cervical Cancer Member

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

5.4.8.1 Technical Name

DSS - Breast and Cervical Cancer Member

5.4.8.2 Sort Order

None.

5.4.8.3 Breast and Cervical Cancer Member Layout

A

I

Run Date: 8/9/2006
Run Time: 3:36:18 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: qz00tr



Breast and Cervical Cancer

Member Eligibility Date Range: 1/1/2000 - 12/31/2005

Member ID	Last Name	First Name	Middle Initial	Current Address County Description
012345678	SMITH	JANE		55 -
012345678	SMITH	ANN		55 -
012345678	SMITH	DELORES		55 -
012345678	SMITH	ROBERTA	P	55 -
012345678	SMITH	JENNIFER		55 -
012345678	SMITH	BONNIE	A	55 -

End of Report

B**Report Notes**Report Description

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

Search Criteria

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

5.4.8.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Member County Description	The county code the member resided in at the time the medical service was performed.	15	Char	T_RE_BASE, T_COUNTY	CDE_COUNTY, DSC_COUNTY
Member First Name	The member's first name.	13	Char	T_RE_BASE	NAM_FIRST
Member ID	The Medicaid identification number for the member.	12	Char	T_RE_BASE	ID_MEDICAID
Member Last Name	The member's last name.	15	Char	T_RE_BASE	NAM_LAST

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

5.4.8.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.9 DSS - BusinessObjects Report Template

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

5.4.9.1 Technical Name

DSS - BusinessObjects Report Template

5.4.9.2 Sort Order

Does not apply.

5.4.9.3 BusinessObjects Report Template Layout

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

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: nzjq02



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

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

End of Report

5.4.9.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Cabinet for Health and Family Services	Main Agency name.	38	Character	N/A	N/A
Column Header 1	First report column contained within the body of the report. This is just a place holder column in the report template. This column will be substituted with the actual report columns in the report applying the template.	15	Character	N/A	N/A
Department for Medicaid Services	Department name.	32	Character	N/A	N/A
End of Report	End of report label.	13	Character	N/A	N/A
Page:	Page number the report.	5	Number	N/A	N/A
Column Header 2	Second report column contained within the body of the report. This is just a place holder column in the report template. This column will be substituted with the actual report columns in the report applying the template.	15	Character	N/A	N/A
Report Title	Report title.	50	Character	N/A	N/A
Run Date:	Date the report was last executed.	8	Date (MM/DD/CCYY)	N/A	N/A
Run Time:	Time the report was last executed. (HH:MM:SS)	6	Character	N/A	N/A

5.4.9.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.10 DSS - CMHC Monthly Summary

The CMHC Monthly Summary report generates totals of Community Mental Health Claims (CMHC) paid during the reporting period that have specified procedure codes (H0001, H0006, H0015, H0024, H0025, H0031, H0036, H0047, H2012, 90801, 90804, 90853, 90862, 90887, 96150). Effective with DOS 10/16/2003 and after, reports totals of Community Mental Health claims paid during the reporting period that have procedure codes submitted in conjunction with a `UD' modifier. Note: `UD' denote substance abuse program services. The frequency of this report is monthly.

5.4.10.1 Technical Name

DSS - CMHC Monthly Summary

5.4.10.2 Sort Order

Provider Number, Subcontractor, Provider Name and Procedure Code.

5.4.10.3 CMHC Monthly Summary Layout

A

Run Date: 04/27/2007

Run Time: 6:11:03 PM

Cabinet for Health and Family Services Department for Medicaid Services

User ID: czvtpc



CMHC Monthly Summary Report

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

Billing Provider Numbers	Billing Provider Name	Procedure Code & Desc	First Modifier Code & Desc	Second Modifier Code & Desc	Third Modifier Code & Desc	Fourth Modifier Code & Desc	Member Undup Count	Billed Quantity Sum	Paid Amount Sum
NPI: Medicaid Number: 30601017 Base Number: 500005762	WESTERN KY REG MHMR BD	90804 - Psytch, Office, 20-30 Min	AJ - CLINICAL SOCIAL WORKER	UD - M/CAID CARE LEV 13 STATE DEF	- AUDIT NO MODIFIER	- AUDIT NO MODIFIER	1	3	\$77.79
		90804 - Psytch, Office, 20-30 Min	U5 - M/CAID CARE LEV 5 STATE DEF	UD - M/CAID CARE LEV 13 STATE DEF	- AUDIT NO MODIFIER	- AUDIT NO MODIFIER	1	4	\$103.72
		H0024 - Alcohol And/Or Drug Preventi	U5 - M/CAID CARE LEV 5 STATE DEF	UD - M/CAID CARE LEV 13 STATE DEF	HF - SUBSTANCE ABUSE PROGRAM	- AUDIT NO MODIFIER	3	72	\$1,440.00
Provider Total:							5	79	\$1,621.51

B

Report Notes

Report Description

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

Search Criteria

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

5.4.10.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	Quantity of units billed.	12	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED
Billing Provider Name	Billing Provider full name.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER

Field	Description	Length	Data Type	DB Table	DB Attributes
First Modifier Code & Description	Modifier 1 and description.	2	Char	T_CA_ICN	CDE_MODIFIER_1 DSC_MODIFIER
Fourth Modifier Code & Description	Modifier 4 and description.	2	Char	T_CA_ICN	CDE_MODIFIER_4 DSC_MODIFIER
Member Undup Count	Count of unique members.	12	Number (Decimal)	T_CA_ICN	ID_MEDICIAD
Paid Amount	Total amount paid.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Primary Procedure Code & Desc	Primary procedure code and description.	46	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC_PRIM DSC_PROC
Provider Number IDs	Billing provider number.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
Second Modifier Code & Description	Modifier 2 and description.	2	Char	T_CA_ICN	CDE_MODIFIER_2 DSC_MODIFIER
Third Modifier Code & Description	Modifier 3 and description.	2	Char	T_CA_ICN	CDE_MODIFIER_3 DSC_MODIFIER

5.4.10.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.11 DSS - CMHC Quarterly Summary

The CMHC Quarterly Summary report generates totals of Community Mental Health Claims (CMHC) paid during the reporting period that have specified procedure codes (H0001, H0006, H0015, H0024, H0025, H0031, H0036, H0047, H2012, 90801, 90804, 90853, 90862, 90887, 96150). Effective with DOS 10/16/2003 and after, reports totals of Community Mental Health claims paid during the reporting period that have procedure codes submitted in conjunction with a `UD' modifier. Note: `UD' denote substance abuse program services. The frequency of this report is quarterly.

5.4.11.1 Technical Name

DSS - CMHC Quarterly Summary

5.4.11.2 Sort Order

Provider Number, Subcontractor, Provider Name, Member ID, Procedure Code, Diagnosis Code and First Date of Service.

5.4.11.3 Last Date of Service CMHC Quarterly Summary Layout

A

Run Date: 09/09/2007

Run Time: 5:58:19 PM

Cabinet for Health and Family Services Department for Medicaid Services

User ID: wzt2t5



CMHC Quarterly Summary Report

From Date of Service Range: 8/1/2007 12:00:00 AM - 9/9/2007 12:00:00 AM
To Date of Service Range: 8/1/2007 12:00:00 AM - 9/9/2007 12:00:00 AM

Billing Provider Numbers	Billing Provider Name	Member ID	Procedure Code & Desc	Primary Diagnosis Code & Desc	From Date of Service	To Date of Service	Billed Quantity Sum	Paid Amount Sum
NPI: 1285689711 Medicaid Number: 30603013 Base Number: 500005819	RIVERVALLEY BEHAVIORAL HEALTH		90804 - Psytch, Office, 20-30 Min	29383 - MOOD DIS IN OT CONDITION	08/15/2007	08/15/2007	4	\$99.32
	RIVERVALLEY BEHAVIORAL HEALTH		90804 - Psytch, Office, 20-30 Min	3149 - HYPERKINETIC SYND UNSPEC	08/08/2007	08/08/2007	4	\$99.32
	RIVERVALLEY BEHAVIORAL HEALTH		90862 - Medication Management	3149 - HYPERKINETIC SYND UNSPEC	08/03/2007	08/03/2007	1	\$45.40

B

Report Notes

Report Description

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

Search Criteria

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

5.4.11.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	Quantity of units billed.	12	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Name	Billing Provider full name.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
First Modifier Code & Description	Modifier 1 and description.	2	Char	T_CA_ICN	CDE_MODIFIER_1 DSC_MODIFIER
Fourth Modifier Code & Description	Modifier 4 and description.	2	Char	T_CA_ICN	CDE_MODIFIER_4 DSC_MODIFIER
Member Undup Count	Count of unique members.	12	Number (Decimal)	T_CA_ICN	ID_MEDICIAD
Paid Amount	Total amount paid.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Primary Procedure Code & Desc	Primary procedure code and description.	46	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC_PRIM DSC_PROC
Provider Number IDs	Billing provider number.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
Second Modifier Code & Description	Modifier 2 and description.	2	Char	T_CA_ICN	CDE_MODIFIER_2 DSC_MODIFIER
Third Modifier Code & Description	Modifier 3 and description.	2	Char	T_CA_ICN	CDE_MODIFIER_3 DSC_MODIFIER

5.4.11.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.12 DSS – Central Baptist Neonatal Claims

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

5.4.12.1 Technical Name

DSS - Central Baptist Neonatal Claims

5.4.12.2 Sort Order

None.

5.4.12.3 Central Baptist Neonatal Claims Layout

A

Run Date: 4/11/2007

Run Time: 12:33:55 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: tztsbl



Central Baptist Neonatal Claims

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

ICN	Member ID	Admission Date	Paid Amount Sum	Paid Date	DRG Code & Desc	Member Age	Member Date of Birth
		04/27/2005	\$0.00	06/03/2005	0390 - NEONATE W OTHER SIGNIFICANT PROBLEMS	29	05/07/1975
		05/01/2005	\$0.00	06/03/2005	0388 - PREMATURETY W/O MAJOR PROBLEMS	22	11/15/1982
		10/16/2004	\$10,190.91	06/03/2005	0387 - PREMATURETY W MAJOR PROBLEMS	0	10/16/2004
		04/12/2005	\$0.00	06/03/2005	0388 - PREMATURETY W/O MAJOR PROBLEMS	17	06/06/1987
		08/25/2004	\$37,148.73	06/10/2005	0385 - NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0	08/25/2004
		02/17/2005	\$0.00	06/10/2005	0386 - EXTREME IMMATURETY	0	02/17/2005

B**Report Notes**Report Description

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

Search Criteria

Paid Date - Payment date range entered in the prompt
 Billing Provider Base ID - equal to '0101256600' (Central Baptist Hosp)
 DRG Code - Diagnosis related group # between '385' and '390'

5.4.12.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Admission Date	The date upon which a member was admitted to a medical institution.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_ADMISSION
DRG Code & Description	The DRG (Diagnosis Related Group) number assigned to the claim and its related description.	136	Char	T_CA_ICN	CD_DRG

Field	Description	Length	Data Type	DB Table	DB Attributes
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYDDDBBSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number.	13	Char	T_CA_ICN	NUM_CIN
Member Age	The age of the member at the time the service was rendered, taken from the MMIS claim at the time of adjudication.	3	Char	T_CA_ICN	NUM_RECIP_AGE
Member Date of Birth	The date of birth of the member. This is taken from the MMIS member file at the time the claim was adjudicated.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_BIRTH
Member ID	The Medicaid identification number for the member.	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount Sum	The amount paid by Medicaid for the line item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Payment Date	The date on which a payment was generated from the MMIS claim transaction.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID

5.4.12.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.13 DSS - Certification Failures

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

5.4.13.1 Technical Name

DSS – Certification Failures

5.4.13.2 Sort Order

First Date of Service, ascending.

5.4.13.3 Certification Failures Layout

A

Run Date: 09/09/2007
Run Time: 6:16:56 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: wzt2t5



Certification Failures

Billing Provider Number(s): 12500047

Member ID(s):

From Date of Service Range: 4/1/2007 12:00:00 AM - 4/20/2007 12:00:00 AM

Member ID	Member Full Name (L,FM)	Billing Provider Numbers	Billing Provider Name	Paid Amount Sum	From Date of Service	To Date of Service	ICN
		NPI: Medicaid Number: 12500047 Base Number: 500005790	BELLE MEADE HOME	\$1,493.93	04/01/2007	04/20/2007	4007121044497

End of Report

Report Notes

B

Report Description

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

Search Criteria

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

5.4.13.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	The Base ID is the high level ID assigned by interChange to the unique instance of a provider without regard to service location. The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs. The Medicaid ID of the provider at the service location.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_BASE ID_PROVIDER_NPI ID_PROVIDER_MCAID
Billing Provider Name	Full name of the provider.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
From Date of Service	This is the first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC

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

5.4.13.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.14 DSS - DRG Retro Review - Claims Rebilled Detail

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

There are 2 tabs in this report:

- A. DRG Retro Review - Claims Rebilled Detail
- B. Report Notes tab describing the conditions used to create the report.

5.4.14.1 Technical Name

DSS - DRG Retro Review - Claims Rebilled Detail

5.4.14.2 Sort Order

Provider Number and Original ICN.

For readability, the report layout displays on several pages.

5.4.14.3 DRG Retro Review - Claims Rebilled Detail Layout

A

Run Date: 9/1/2006
Run Time: 1:54:23 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: qz00tr



DRG Retro Review - Financial Adjustments - Rebilled Claims Reporting

From Date of Service Range: 4/1/2004 - 4/30/2005

Billing Provider Numbers	Original ICN	Original Paid Amount	New ICN	New Paid Amount	Difference
NPI ID: 1000000359 Medicaid ID: 100195369B Base ID: 10019537	2005111000020	\$64.00	5205112001007	\$64.00	\$0.00
	2005111130089	\$27.00	5205112001009	\$27.00	\$0.00
	2005108130066	\$0.00	5205121001023	\$0.00	\$0.00
	2005109130013	\$0.00	5205121001024	\$0.00	\$0.00
	5205121001023	\$0.00	5005125250001	\$0.00	\$0.00
	2005119000032	\$64.00	5205130001007	\$64.00	\$0.00
Totals:		\$155.00		\$155.00	\$0.00
Grand Total:		\$155.00		\$155.00	\$0.00

B**Report Notes**Report Description

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

Search CriteriaOriginal Claim data provider:

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

New Claim data provider:

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

Supplemental Documentation

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

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

DRG Claims are only paid at header level.

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

B

Psych DPU Facility

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

Free Standing Psych Facility

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

Long Term Care Acute Hospitals

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

Rehab DPU Facility

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

Free Standing Rehab Facility

Cardinal Hill Rehab 01021237
 Healthsouth Rehab of Central Ky 01022326
 Healthsouth Northern Ky Rehab 01022540
 Southern Ky Rehab (frmly Mediplex) 01000272
 Gateway Rehab of Northern KY 01000447 (old #01000173)
 Gateway Rehab @ Norton 01000439 (old #01000314)

B

Out of State Critical Access Hospitals

01400480
01330034
01600774

Out of State Ventilator

01621895
01542729
01600691

Critical Assess Hospitals

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

5.4.14.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	The provider on the claim	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
Difference	The difference between the original and new claim	13	Number (Decimal)	n/a	calculated
Grand Totals	Totals of each column for entire report	13	Number (Decimal)	n/a	Calculated
New ICN	The new day claim number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYDDDBBSS: RR - region, YYDDD - julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
New Paid Amount	The new day claim paid amount	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Original ICN	The original adjusted claim number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYDDDBBSS: RR - region, YYDDD - julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
Original Paid Amt	The original paid amount of the claim	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Totals	Totals of each column for each provider	13	Number (Decimal)	n/a	Calculated

5.4.14.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.15 DSS - DRG Retro Review - Claims Rebilled Summary by Provider

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

5.4.15.1 Technical Name

DSS - DRG Retro Review - Claims Rebilled Summary by Provider

5.4.15.2 Sort Order

Provider Number and Setup Date.

5.4.15.3 DRG Retro Review - Claims Rebilled Summary by Provider Layout

A

Run Date: 6/27/2007

Run Time: 12:52:22 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: qz00tr



DRG Retro Review - Financial Adjustments - Rebilled Claims Summary

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

Billing Provider Number	Paid Date	Original Paid Amount	New Paid Amount	Difference
NPI: 1851346720 Medicaid Number: 01012871 Base Number: 500005437	07/21/2006	\$0.00	\$0.00	\$0.00
Totals:		\$0.00	\$0.00	\$0.00
NPI: Medicaid Number: 01000165 Base Number: 500011551	06/16/2006	\$2,488.61	\$2,488.61	\$0.00
Totals:		\$2,488.61	\$2,488.61	\$0.00

B**Report Notes**Report Description

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

Search CriteriaOriginal Claim data provider:

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

New Claim data provider:

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

Supplemental Documentation

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

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

DRG Claims are at header level.

All Billing Provider Type Code 01's are considered DRG except for some hospitals. Those hospitals, which are excluded from this report, are listed below.

NOTE: If a hospital is added, removed or the BASE provider # is replaced, then that BASE provider number (8 digits) must be edited in the condition in the query.

B**Psych DPU Facility**

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

Free Standing Psych Facility

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

Rehab DPU Facility

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

Free Standing Rehab Facility

Cardinal Hill Rehab 01021237
Healthsouth Rehab of Central Ky 01022326
Healthsouth Northern Ky Rehab 01022540
Southern Ky Rehab (frmly Medplex) 01000272
Gateway Rehab of Northern KY 01000447 (old #01000173)
Gateway Rehab @Norton 01000439 (old #01000314)

B

Long Term Care Accute Hospitals

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

Out of State Critical Access Hospital:

01400480
 01330034
 01600774

Out of State Ventilator

01621895
 01542729
 01600691

Critical Asscess Hospitals

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

5.4.15.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	The provider on the claim	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
Difference	The difference between the original and new claim	13	Number (Decimal)	n/a	calculated
Grand Totals	Totals of each column for entire report	13	Number (Decimal)	n/a	Calculated
New Paid Amount	The new day claim paid amount of all claims for the same provider/setup date	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Original Paid Amount	The original paid amount of all claims for the same provider/setup date	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Paid Date	FFS claims - date claim was paid; converted FFS claims - adjudication date; encounter claims - date claim was accepted by DPW	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID
Totals	Totals of each column for each provider	13	Number (Decimal)	n/a	Calculated

5.4.15.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.16 DSS - Dental Access

The Dental Access Report generates dental access to members by county, population, and practicing/licensed/enrolled dentists.

5.4.16.1 Technical Name

DSS - Dental Access

5.4.16.2 Sort Order

None

5.4.16.3 Dental Access Layout

A

Run Date: 7/24/2007

Run Time: 10:43:25 AM



**Cabinet for Health and Family Services
Department for Medicaid Services
Dental Access Report**

County	Total Population	# Licensed Dentists	Enrolled Dentists	Billing Dentists	Total Eligible Members	Client/Provider Ratio	U 21 Rec'v Dental Care Spec.56	U 21 Rec'v Dental Care Spec.08	U 21 Rec'v Dental Care Spec.80	U 21 Rec'v Dental Care Spec.88	21 & over Rec'v Dental Care other than Spec.56	21 & over Rec'v Dental Care Spec.56
001 - Adair	17575	5	4	2	3,880	1,940.00	8	108	0	3	45	2
002 - Allen	18541	5	3	3	3,325	1,108.33	6	106	1	4	19	11
003 - Anderson	20099	7	3	2	1,961	960.50	3	44	14	4	24	5
004 - Ballard	8295	1	1	1	1,270	1,270.00	0	19	17	0	7	1
005 - Barren	39473	16	12	9	7,623	847.00	8	193	0	2	94	6
006 - Bath	11538	1	2	1	3,160	3,160.00	2	55	0	2	30	6
007 - Bell	29672	11	9	7	10,637	1,519.57	9	268	22	2	147	18
Sum:	145,193	46	34	25	31,856		36	793	54	17	366	49

End of Report

User ID: tztsbl

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

Date For Age Calculation: 06/30/2006

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

B

Report Notes

Report Description

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

Search Criteria

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

5.4.16.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
# Licensed Dentists	The number of licensed dentists in a particular county.	12	Number	T_PR_SVC_LOC	ID_PROVIDER
% of Members 21 and over rec'v Care	The percentage of members that are 21 and over that is receiving dental care.	3	Number	N/A	CALCULATED
% of Members Under 21 rec'v Care	The percentage of members under the age of 21 receiving dental care.	3	Number	N/A	CALCULATED
21 & Over Rec'v Dental Care Other Than Spec 56	The number of members that are 21 and older that are receiving dental care from the provider with a provider specialty other than 56.	12	Number	T_RE_BASE	ID_MEDICAID

Field	Description	Length	Data Type	DB Table	DB Attributes
21 and Over Rec'v Dental Care Spec 56	The number of members that are 21 and older that are receiving dental care from the provider with a provider specialty of 56.	12	Number	T_RE_BASE	ID_MEDICAID
Billing Dentists	The number of billing dentists in a particular county.	12	Number	T_PR_SVC_LOC	ID_PROVIDER
Client/Provider Ratio	The number of provider to client's ratio.	12	Number	N/A	CALCULATED
County Code	The code and name of the county.	28	Char	T_CA_RECIP_KEY	CD_RECIP_COUNTY , DSC_RECIP_COUNTY
Eligible Members 21 and older	The number of eligible members that are 21 and older.	12	Number	T_RE_BASE	ID_MEDICAID
Eligible Members under 21	The number of eligible members under that age of 21.	12	Number	T_RE_BASE	ID_MEDICAID
Enrolled Dentists	The number of enrolled dentists in a particular county.	12	Number	T_PR_SVC_LOC	ID_PROVIDER
Total Eligible Members	The number of enrolled members in a particular county.	12	Number	T_RE_BASE	ID_MEDICAID
Total Population	The total number of members in a particular county.	12	Number	T_RE_BASE	ID_MEDICAID
U 21 Rec'v Dental Care Spec 08	The number of members under the age of 21 who are receiving dental care from a provider with a specialty code of 08.	12	Number	T_RE_BASE	ID_MEDICAID
U 21 Rec'v Dental Care Spec 56	The number of members under the age of 21 who are receiving dental care from a provider with a specialty code of 56.	12	Number	T_RE_BASE	ID_MEDICAID

Field	Description	Length	Data Type	DB Table	DB Attributes
U 21 Rec'v Dental Care Spec 80	The number of members under the age of 21 who are receiving dental care from a provider with a specialty code of 80.	12	Number	T_RE_BASE	ID_MEDICAID
U 21 Rec'v Dental Care Spec 88	The number of members under the age of 21 who are receiving dental care from a provider with a specialty code of 88.	12	Number	T_RE_BASE	ID_MEDICAID
Undup Member 21 and Over	The number of unduplicated/unique members that are 21 and older receiving care.	12	Number	T_RE_BASE	ID_MEDICAID
Undup Members Under 21	The number of unduplicated/unique members under the age of 21 receiving care.	12	Number	T_RE_BASE	ID_MEDICAID

5.4.16.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.17 DSS - Drug Utilization

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

5.4.17.1 Technical Name

DSS - Drug Utilization

5.4.17.2 Sort Order

None

5.4.17.3 Drug Utilization Layout

A

Run Date: 9/19/2006
Run Time: 4:01:26 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: qz00tr



Drug Utilization

Billing Provider Number(s): 10023828; 20030602

Drug Code(s): 00009002902
00002035102

Payment Date Range: 1/1/2000 - 12/31/2005

NDC Code & Description	Billing Provider Numbers	Member ID	From Date of Service	Payment Date	Quantity Dispensed	Billed Amount	Paid Amount	ICN	Prescription Number	Days Supply	TPL	Amount
00002035102 - DARVO CET-N 50	NPI ID: 1000000478 Medicaid ID: 100238279B Base ID: 10023828		07/01/2001	02/24/2005		\$5.00	\$4.00					\$0.00
00009002902 - XANAX	NPI ID: 1000002028 Medicaid ID: 200306019A Base ID: 20030602		04/26/2004	04/21/2005		\$300.00	\$1.11					\$0.00
00009002902 - XANAX	NPI ID: 1000002028 Medicaid ID: 200306019A Base ID: 20030602		04/26/2004	04/22/2005		\$300.00	\$1.11					\$0.00
00009002902 - XANAX	NPI ID: 1000002028 Medicaid ID: 200306019A Base ID: 20030602		04/05/2005	04/26/2005		\$300.00	\$1.11					\$0.00
00009002902 - XANAX	NPI ID: 1000002028 Medicaid ID: 200306019A Base ID: 20030602		04/26/2004	04/21/2005		\$300.00	\$1.11					\$0.00

B**Report Notes**Report Description

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

Search Criteria

Payment Date - Payment date range entered in the prompt

Billing Provider Number(s) - Provider Base, Medicaid or NPI Number(s) entered in the prompt, separated by a semi-colon

Drug Code(s) - list of drug codes entered in the prompt, separated by a semi-colon

5.4.17.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Amount	The total paid amount for the claim.	13	Number (Decimal)	T_CA_DRUG	AMT_BILLED
Billing Provider Number	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i> .	9	Char	T_CA_ICN	NUM_PROV_BILL
Days Supply	The number of days of supply for a drug for this claim.	9	Number	T_CA_DRUG	NUM_DAY_SUPPLY
First Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC

Field	Description	Length	Data Type	DB Table	DB Attributes
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYDDDBBSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number.	13	Char	T_CA_ICN	NUM_ICN
Member ID	The Medicaid identification number for the member.	12	Char	T_CA_ICN	ID_MEDICAID
NDC Code & Description	The National Drug Code (NDC) identifying the drug.	11	Char	T_CA_ICN	CDE_NDC
Paid Amount	The total paid amount of the line item for paid claims.	13	Number (Decimal)	T_CA_DRUG	AMT_PAID
Payment Date	The date on which a payment was generated from the MMIS claim transaction.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID
Prescription Number	The prescription number related to the drug code billed on this claim.	7	Char	T_CA_DRUG	NUM_PRSCRIP
Qty Dispensed	Number of units of a drug dispensed to a member.	9	Number	T_CA_DRUG	QTY_DISPENSE
TPL Amount	The line item amount paid by a third party.	13	Number (Decimal)	T_CA_ICN	AMT_TPL

5.4.17.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.18 DSS - Encounter Transportation

The Encounter Transportation report generates history of Encounter Transportation Claims by Waiver Eligibility Code.

5.4.18.1 Technical Name

DSS - Encounter Transportation

5.4.18.2 Sort Order

None

5.4.18.3 Encounter Transportation Layout

A

Run Date: 5/8/2007
Run Time: 4:33:56 PM

Cabinet for Health and Family Services User ID: tztsbl
Department for Medicaid Services

Member County Code & Desc	Billing Provider Specialty Code & Desc	Billing Provider Type Code & Desc	Encounter Amount Sum
005 - Barren	263 - Taxi	56 - Non-Emergency Transportation	\$26,556.90
005 - Barren	264 - Common Carrier (Ambulatory)	56 - Non-Emergency Transportation	\$10,012.60
005 - Barren	265 - Common Carrier (Non-ambulatory)	56 - Non-Emergency Transportation	\$13,805.40
005 - Barren	266 - Family Member / Private Auto	56 - Non-Emergency Transportation	\$313.20
007 - Bell	263 - Taxi	56 - Non-Emergency Transportation	\$48.00

B**Report Notes**Report Description

This report generates history of Encounter Transportation Claims by Waiver Eligibility Code.

Search Criteria

From Date of Service - Begin and end date range entered in the prompt

Billing Provider Types - equal to 55, 56, 57 and 58

Encounter Claims Only filter

Latest Claims Only filter - will give you only the latest version of a claim even if it was previously adjusted

5.4.18.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Prov Specialty Code & Desc	A code used to indicate the medical specialty of a physician.	53	Char	T_CA_PROV_KEY	CDE_PROV_SPEC,DSC_PROV_SPEC
Billing Provider Type Code & Desc	A code used to indicate the provider's type.	52	Char	T_CA_PROV_KEY	CDE_PROV_TYPE,DSC_PROV_TYPE
Encounter Amount Sum	The total paid amount of the line item for encounter claims.	13	Number (Decimal)	T_CA_ICN	AMT_ENCOUNTER

Field	Description	Length	Data Type	DB Table	DB Attributes
Member County Code & Description	The code which indicates the county in which the Member resides.	28	Char	T_CA_RECIP_KEY	CD_RECIP_COUNTY, DSC_RECIP_COUNTY

5.4.18.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.19 DSS - Hospice Total Days

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

5.4.19.1 Technical Name

DSS - Hospice Total Days

5.4.19.2 Sort Order

None

5.4.19.3 Hospice Total Days Layout

A

Run Date: 5/14/2007
Run Time: 11:32:43 AM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: tztsbl



Hospice Total Days

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

Revenue Code & Desc	Billing Provider Numbers	Billed Quantity	Paid Amount	Encounter Amount	ICN	From Date of Service	To Date of Service	Member ID
0155 - ROOM & BOARD WARD-HOSPICE	NPI: Medicaid Number: 44010015 Base Number: 500001454	30	\$3,864.03	\$0.00	9999999999999999	06/01/2006	06/30/2006	9999999999
0155 - ROOM & BOARD WARD-HOSPICE	NPI: Medicaid Number: 44010015 Base Number: 500001454	3	\$379.23	\$0.00	9999999999999999	06/28/2006	06/30/2006	9999999999
0155 - ROOM & BOARD WARD-HOSPICE	NPI: Medicaid Number: 44010015 Base Number: 500001454	30	\$4,099.03	\$0.00	9999999999999999	06/01/2006	06/30/2006	9999999999

B

Report Notes

Report Description

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

Search Criteria

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

5.4.19.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	The number of units administered for the procedure code billed on this line item.	9	Number	T_CA_ICN	QTY_UNITS_BILLED
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i> .	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
Encounter Amount	Amount for encounter services on the claim detail indicated by the detail number on the table.	13	Number (Decimal)	T_CA_ICN	AMT_ENCOUNTER
From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYDDDBBBSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number.	13	Char	T_CA_ICN	NUM_ICN
Member ID	The Medicaid identification number for the member.	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount Sum	The amount paid by Medicaid for the line item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Revenue Code & Desc	The line item revenue code & desc. billed on the UB-92 claim (describes the service performed).	74	Char	T_CA_HDR_DTL, T_CDE_REVENUE	CDE_REVENUE DSC_REVENUE
To Date of Service	This is the line item through date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC

5.4.19.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.20 DSS - Hospice Total Dual Eligibles

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

5.4.20.1 Technical Name

DSS - Hospice Total Dual Eligibles

5.4.20.2 Sort Order

Member ID.

5.4.20.3 Hospice Total Dual Eligibles Layout

A

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

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: tztsbl



Hospice Total Dual Eligibles

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

Revenue Code & Desc	Billing Provider Numbers	Billed Quantity Sum	Paid Amount Sum	From Date of Service	To Date of Service	Member ID	ICN
0655 - HOSPICE SERVICES INPATIENT RESPITE CARE	NPI: 44097020 Medicaid Number: 44097020 Base Number: 500006966	5	\$611.06	01/25/2006	01/29/2006	9999999999	999999999999
0655 - HOSPICE SERVICES INPATIENT RESPITE CARE	NPI: 44097020 Medicaid Number: 44097020 Base Number: 500006966	4	\$486.20	02/17/2006	02/20/2006	9999999999	999999999999
0656 - HOSPICE SERVICES GENERAL INPATIENT CARE	NPI: 44034015 Medicaid Number: 44034015 Base Number: 500006966	2	\$669.02	04/06/2006	04/07/2006	9999999999	999999999999

B**Report Notes**Report Description

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

Search Criteria

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

5.4.20.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	Units of services billed for payment.	12	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i> .	15	Char	T_CA_PROV_KEY	D_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
From Date of Service	The amount paid by Medicaid for the line item procedure billed.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
ICN	rocessed in the system; used for control purposes. Unique number in format RYYDDDBBSS: RR - region, YYDDD - julian date, BBB - batch number, SSS - sequence number	13	Char	T_CA_ICN	NUM_ICN
Member ID	The Medicaid identification number for the member.	12	Char	T_RE_BASE_DN	ID_MEDICAID
Paid Amount Sum	The amount paid by Medicaid for the line item procedure billed.	13	Char	T_CA_ICN	AMT_PAID
Revenue Code & Desc	The line item revenue code & desc. billed on the UB-92 claim (describes the service performed).	74	Char	T_CA_ICN, T_CDE_REVENUE	CDE_REVENUE DSC_REVENUE
To Date of Service	Date on which the statement period on the claim ended.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC

5.4.20.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.21 DSS - Hospice Total Inpatient Days -- Hospice Total Inpatient Days

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

5.4.21.1 Technical Name

DSS - Hospice Total Inpatient Days

5.4.21.2 Sort Order

None

5.4.21.3 Hospice Total Inpatient Days Layout

A

Run Date: 5/2/2007
Run Time: 10:15:10 AM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: tztsbl



Hospice Total Inpatient Days

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

Revenue Code & Desc	Billing Provider Numbers	Billed Quantity	Paid Amount	ICN
0655 - HOSPICE SERVICES INPATIENT RESPITE CARE	NPI: Medicaid Number: 44026011 Base Number: 500007297	1	\$124.86	
0655 - HOSPICE SERVICES INPATIENT RESPITE CARE	NPI: Medicaid Number: 44081016 Base Number: 500008180	3	\$361.34	
0655 - HOSPICE SERVICES INPATIENT RESPITE CARE	NPI: Medicaid Number: 44097020 Base Number: 500006966	5	\$611.06	

B

Report Notes

Report Description

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

Search Criteria

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

5.4.21.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	The number of units administered for the procedure code billed on this line item.	7	Number	T_CA_ICN	QTY_UNITS_BILLED

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i> .	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number.	13	Char	T_CA_ICN	NUM_ICN
Paid Amount	The amount paid by Medicaid for the line item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Revenue Code & Desc	The line item revenue code & desc. billed on the UB-92 claim (describes the service performed).	74	Char	T_CA_HDR_DTL	CDE_REVENUE DSC_REVENUE

5.4.21.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.22 DSS - Hospital Inpatient Paid Days

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

5.4.22.1 Technical Name

DSS - Hospital Inpatient Paid Days

5.4.22.2 Sort Order

None

5.4.22.3 Hospital Inpatient Paid Days Layout

A

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

Cabinet for Health and Family Services Department for Medicaid Services

User ID: qz00tr



Hospital Inpatient Paid Days

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

Billing Provider Numbers	Covered Days
	0

End of Report

B

Report Notes

Report Description

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

Search Criteria

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

5.4.22.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Bill Provider Numbers	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i> .	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
Covered Days	The sum of the total number of days for this Provider.	10	Char	T_CA_ICN	NUM_DAYS_COVD

5.4.22.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.23 DSS - IMPACT DCBS

The IMPACT Department for Community Based Services (DCBS) report generates history of paid claims for a given DCBS and Department for Mental Health/Mental Retardation (DMH/MR) IMPACT provider during specific date(s). IMPACT is the Interagency Mobilization for Progress in Adolescent and Children’s Treatment program.

5.4.23.1 Technical Name
DSS - IMPACT DCBS

5.4.23.2 Sort Order
Paid Date.

5.4.23.3 IMPACT DCBS Layout
A

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

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: rztdly



IMPACT DCBS

Paid Date(s): 1/4/2002

Billing Provider Number(s): 1234567893

Billing Provider Numbers	Paid Amount Sum	Paid Date
	\$362.20	01/04/2002

End of Report

B

Report Notes

Report Description

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

Search Criteria

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

5.4.23.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i> .	10	Char	T_CA_ICN	ID_PROV_BILL
Paid Amount	The total paid amount for a claim.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Paid Date	The date on which a payment was generated from the MMIS claim transaction.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID

5.4.23.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.24 DSS - KenPAC Member History

The KenPAC Member History report generates history of KenPAC claims for a given county and date of service range.

5.4.24.1 Technical Name

DSS - KenPAC Member History

5.4.24.2 Sort Order

Member County Description.

5.4.24.3 KenPAC Member History Layout

Run Date: 9/19/2008
 Run Time: 3:00:56 PM

Cabinet for Health and Family Services
 Department for Medicaid Services



Kenpac Member History

Member Code & Description	County	ICN	Claim Type	Claim Indicator	Billing Provider Name	Primary Procedure Code & Desc	State COS Code & Description	Referring Provider Name	Member SSN	Member Full Name FML	Member Date of Birth	Member Phone Number	Member Full Address	NDC Co Descrip	Primary Diagnosis Code & Desc
24 - Garfield		99999999999999	H	F	COUNTRY MEDICAL CLINIC	##### - Unknown	16 - Impact Plus	ANDERSON PHARMACY	999-99-9999	XXXX XXXXXX	MM/DD/YYYY	999-999-9999	XXXXXXXXXX	#####	25000 - IABETES UNCOMPL TYPE II DI
24 - Garfield		99999999999999	H	F	COUNTRY MEDICAL CLINIC	##### - Unknown	16 - Impact Plus	ANDERSON PHARMACY	999-99-9999	XXXX XXXXXX	MM/DD/YYYY	999-999-9999	XXXXXXXXXX	#####	25000 - IABETES UNCOMPL TYPE II DI
24 - Garfield		99999999999999	H	F	COUNTRY MEDICAL CLINIC	##### - Unknown	16 - Impact Plus	ANDERSON PHARMACY	999-99-9999	XXXX XXXXXX	MM/DD/YYYY	999-999-9999	XXXXXXXXXX	#####	25000 - IABETES UNCOMPL TYPE II DI
24 - Garfield		99999999999999	H	F	COUNTRY MEDICAL CLINIC	##### - Unknown	16 - Impact Plus	ANDERSON PHARMACY	999-99-9999	XXXX XXXXXX	MM/DD/YYYY	999-999-9999	XXXXXXXXXX	#####	25000 - IABETES UNCOMPL TYPE II DI

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User ID: qz00tr

Member County Code(s): 24; 25
 Primary Diagnosis Code(s): 25000; 3458
 Billing Provider Number(s): 10021851; 20030526
 Member ID(s):
 Billing Provider Type Code(s): 64; 54
 From Date of Service Range: 1/1/2000 - 12/31/2005

Secondary Diagnosis Code & Desc	Claim Date	Payment Date	Phone Number	Billing Provider Full Address	Paid Amount	Billed Amount
##### -	10/04/2004	03/15/2005	(999) 551-1073	3079 NE 1ST ST PORTLAND, KY 97501-8011	\$0.00	\$200.00
##### -	03/04/2005	03/22/2005	(999) 551-1073	3079 NE 1ST ST PORTLAND, KY 97501-8011	\$188.80	\$200.00
##### -	12/24/2004	04/04/2005	(999) 551-1073	3079 NE 1ST ST PORTLAND, KY 97501-8011	\$0.00	\$200.00
##### -	04/18/2005	04/22/2005	(999) 551-1073	3079 NE 1ST ST PORTLAND, KY 97501-8011	\$0.00	\$1,000.00

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Report Notes

Report Description

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

Search Criteria

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

5.4.24.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Amount	The sum of all charges associated with an individual claim.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
Billed Date	The date a provider enters on a claim indicating when it was prepared.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_BILLED
Billing Provider Full Address	Provider address including city, state, and zip code.	101	Character	T_CA_PROV_KEY	ADR_BILL_<*>, *=STRT1, STRT2,CITY,STATE,ZIP, ZIP4

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Name	The billing provider name.	50	Char	T_PROV_KEY	NAM_PROVIDER
Claim Date	The date a provider enters on a claim indicating when it was prepared.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_BILLED
Claim Indicator	Indicates whether a claim is E=Encounter or F=Fee.	1	Char	T_CA_ICN	IND_CLAIM
Claim Type	Code to indicate type of medical assistance.	1	Character	T_CA_ICN	CDE_CLM_TYPE
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYDDDBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number.	13	Character	T_CA_ICN	NUM_ICN
Member County Code & Desc	The county code and the name of the county.	60	Character	T_CA_RECIP_KEY	CDE_RECIP_COUNTY DSC_COUNTY
Member Date of Birth	The member's date of birth.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_BIRTH
Member Full Address	The address from the MMIS member master file includes city, state, and zip code.	89	Character	T_RE_BASE	ADR_STREET_1,ADR_STREET_2,ADR_CITY,ADR_STATE,ADR_ZIP_CODE
Member Full Name FML	The member's full name.	28	Character	T_RE_BASE	NAM_LAST,NAME_FIRST,NAM_MID_INIT
Member Phone Number	The member's telephone number and area code.	14	Character	T_RE_BASE	NUM_PHONE

Field	Description	Length	Data Type	DB Table	DB Attributes
Member SSN	This field contains member social security number.	9	Character	T_RE_BASE	NUM_SSN
NDC Code & Desc	The NDC code and official nomenclature for a drug accepted by the state.	46	Character	T_CA_ICN, T_DRUG_DN	CDE_NDC DSC_NDC
Paid Amount Sum	The amount paid by Medicaid for the line item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Paid Date	The date on which a payment was generated from the MMIS claim transaction.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID
Phone Number	Provider Billing Location Phone Number.	14	Character	T_CA_PROV_KEY	ADR_BILL_PHONE
Primary Diagnosis Code & Desc	Prompt value for the diagnosis code.	47	Char	T_CA_ICN, T_DIAGNOSIS	CDE_DIAG_PRIM DSC_25
Procedure Code & Desc	The procedure code and generally accepted nomenclature for medical, surgical, dental, etc., procedure.	52	Character	T_CA_ICN, T_CDE_PROC	CDE_PROC_PRM DSC_PROC
Referring Provider Name	The name of the KenPAC provider.	50	Character	T_CA_ICN	NAM_PROVIDER
Secondary Diagnosis Code & Desc	Primary Diagnosis code and description from the claim.	47	Character	T_CA_ICN, T_DIAGNOSIS	CDE_DIAG_2 DSC_25
State COS Code & Desc	The category of service code and description of the type of service provided by the KenPAC provider.	62	Character	T_CA_CLAIM_KEY, T_CDE_COS_VALUES	CDE_COS_ST DSC_COS_VALUE

5.4.24.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.25 DSS - KenPAC Utilization Data

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

5.4.25.1 Technical Name

DSS - KenPAC Utilization Data

5.4.25.2 Sort Order

Specialty or Provider or Specialty Group or County.

5.4.25.3 KenPAC Utilization Data Layout

A



KenPAC Utilization Data
KenPAC Utilization Data By Provider
 For Month of Service: July 2006

Provider Name: AARON K JONAN MEMORIAL CLINIC INC

Your Rates Per 100 Enrollees:

Provider Numbers	E.R. Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits	Average Cost Per Enrollee
NPI: Medicaid Number: 31000664 Base Number: 500010034	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Percentile:	0	0	0	0	0	0	0	0	0

Your County Per 100 Enrollees:

County Code and Description	E.R. Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits	Average Cost Per Enrollee
013 - Breathitt	0.0	6.90	0.0	11.57	3.65	0.24	0.0	46.07	87.64

Your Specialty Per 100 Enrollees:

Provider Specialty Code	E.R. Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits	Average Cost Per Enrollee
082 - Medical Clinic	0.0	0.67	0.0	2.01	0.36	0.02	0.0	6.82	14.42

Your Specialty Group Per 100 Enrollees:

Provider Specialty Code	E.R. Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits	Average Cost Per Enrollee
PRIMARY Care/Rural Health	0.0	0.22	0.0	3.64	0.12	0.01	0.0	15.34	24.74

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Run Date: 5/4/2007
Run Time: 11:50:55 AM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: tztsbl



**KenPAC Utilization Data
KenPAC Utilization Data State Wide
For Month of Service: July 2006**

State Wide Per 100 Enrollees:

Specialty Group	E.R. Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits	Average Cost Per Enrollee
General/Family Practice	0.09	0.10	0.01	7.66	0.03	0.00	40.06	22.82	54.94
Internal Medicine	0.02	0.0	0.07	6.90	0.0	0.0	214.62	10.26	189.18
Large Clinics (3000 + Enrollees)	0.0	0.0	0.0	3.55	0.0	0.0	0.0	10.45	9.50
OB/GYN	0.0	0.0	0.0	74.14	0.0	0.0	391.38	43.10	241.70
Pediatrics	0.02	3.17	0.06	6.58	0.41	0.02	58.35	24.35	57.23
PRIMARY Care/Rural Health	0.0	0.22	0.0	3.64	0.12	0.01	0.0	15.34	24.74
All Specialties:	0.05	0.30	0.01	5.77	0.08	0.01	25.15	18.76	41.48

End of Report

C

Report Notes

Report Description

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

Search Criteria

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

Types of Services:

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

Supplemental Documentation

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

5.4.25.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
All Specialties	Totals of each column for all specialties	9	Number (Decimal)	N/A	Calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
Anesth Services	The rate (per 100 enrollees) of anesthesiology service utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Average Cost Per Enrollee	The average cost per enrollee for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
County Code and Description	The county code and description.	22	Char	T_COUNTY	CDE_COUNTY, DSC_COUNTY
E.R. Visits	The rate (per 100 enrollees) of emergency room visit utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Hospital Admissions	The rate (per 100 enrollees) of hospital admission utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Lab Services	The rate (per 100 enrollees) of lab service utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Office Visits	The rate (per 100 enrollees) of office visit utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Percentile	The percentile associated with each column.	9	Number (Decimal)	N/A	Calculated
Pharmacy Services	The rate (per 100 enrollees) of pharmacy service utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
Physician Referrals	The rate (per 100 enrollees) of physician referral utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Provider Name	Provider Name.	50	Char	T_PR_SVC _LOC	NAME
Provider Numbers	The Base Id is the high level ID assigned by interChange to the unique instance of a provider without regard to service location. The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs. The Medicaid ID of the provider at the service location.	45	Char	T_KENPAC	ID_PROVIDER_NPI, ID_PROVIDER_BASE, ID_PROVIDER_MCAID
Provider Specialty Code	Provider Specialty.	3	Char	T_PR_SPE C	CDE_PROV_SPEC
Radiology Services	The rate (per 100 enrollees) of radiology service utilization for the provider, region, county, specialty, and specialty grouping being reported.	9	Number (Decimal)	N/A	Calculated
Specialty Group	Specialty Group.	32	Char	T_KENPAC	SPECIALTY_GROUP

5.4.25.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.26 DSS - KenPAC Utilization Data All Providers

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

5.4.26.1 Technical Name

DSS - KenPAC Utilization Data All Providers

5.4.26.2 Sort Order

Specialty Group.

5.4.26.3 KenPAC Utilization Data All Providers Layout

A

Run Date: 6/20/2007
Run Time: 5:41:18 PM

Cabinet for Health and Family Services
Department for Medicaid Services

KenPAC Utilization Data All Providers
For Month of Service: July 2006

User ID: tztsbl



All Providers:

Specialty Group	E.R. Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits	Average Cost Per Enrollee
General/Family Practice	0.09	0.10	0.01	7.66	0.03	0.00	40.06	22.82	54.94
Internal Medicine	0.02	0.00	0.07	6.90	0.00	0.00	214.62	10.26	189.18
Large Clinics (3000 + Enrollees)	0.00	0.00	0.00	3.55	0.00	0.00	0.00	10.45	9.50
OB/GYN	0.00	0.00	0.00	74.14	0.00	0.00	391.38	43.10	241.70
Pediatrics	0.02	3.17	0.06	6.58	0.41	0.02	58.35	24.35	57.23
PRIMARY Care/Rural Health	0.00	0.22	0.00	3.64	0.12	0.01	0.00	15.34	24.74
All Specialties	0.05	0.30	0.01	5.77	0.08	0.01	25.15	18.76	41.48

End of Report

B**Report Notes**Report Description

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

Search Criteria

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

Types of Services:

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

Supplemental Documentation

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

5.4.26.4 Field Descriptions

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

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

5.4.26.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.27 DSS - KenPAC Utilization Review Detail

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

5.4.27.1 Technical Name

DSS - KenPAC Utilization Review Detail

5.4.27.2 Sort Order

County code and Description, Provider Number and Provider Name.

5.4.27.3 KenPAC Utilization Review Detail Layout

A

Run Date: 10/9/2006

Run Time: 5:47:40 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: tztsbl

County Code & Description: 073 - McCracken

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

B

Report Notes

Report Description

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

Search Criteria

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

Types of Services:

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

Supplemental Documentation

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

5.4.27.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Anesth Services	The rate (per 100 enrollees) of anesthesiology service utilization for the provider being reported.	6	Number	N/A	Calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
E.R. Visits	The rate (per 100 enrollees) of emergency room visit utilization for the provider being reported.	6	Number (Decimal)	N/A	Calculated
Hospital Admissions	The rate (per 100 enrollees) of hospital admission utilization for the provider being reported.	6	Number (Decimal)	N/A	Calculated
Lab Services	The rate (per 100 enrollees) of lab service utilization for the provider being reported.	6	Number (Decimal)	N/A	Calculated
Office Visits	The rate (per 100 enrollees) of office visit utilization for the provider being reported.	6	Number (Decimal)	N/A	Calculated
Pharmacy Services	The rate (per 100 enrollees) of pharmacy service utilization for the provider being reported.	6	Number (Decimal)	N/A	Calculated
Physician Referrals	The rate (per 100 enrollees) of physician referral utilization for the provider being reported.	6	Number	N/A	Calculated
Provider Name	The name of the provider being reported.	50	Char	T_PR_SVC_LOCN	NAME
Provider Numbers	The provider number of the provider being reported.	10	Char	T_CA_ICN	NUM_PROV_BILL
Radiology Services	The rate (per 100 enrollees) of radiology service utilization for the provider being reported.	6	Number (Decimal)	N/A	Calculated
Total Enrollees	The number of enrollees for the provider being reported.	12	Number (Integer)	T_CA_ICN	ID_MEDICAID

5.4.27.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.28 DSS - KenPAC Utilization Review Exception

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

5.4.28.1 Technical Name

DSS - KenPAC Utilization Review Exception

5.4.28.2 Sort Order

County code and Description, Provider Number and Provider Name.

5.4.28.3 KenPAC Utilization Review Exception Layout

A

Run Date: 10/9/2006
Run Time: 5:50:49 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: tztsbl



KenPAC Utilization Review Exception

For Month of Service: July 2006

County Code & Description: 001 - Adair

Provider Numbers	Provider Name	Per 100 Enrollees:								
		Total Enrollees	E.R. Visits	Physician Referrals	Hospital Admissions	Lab Services	Radiology Services	Anesth Services	Pharmacy Services	Office Visits
NPI: 100000348 Medicaid Number: 100194689A Base Number:			UNDER			UNDER	UNDER		UNDER	UNDER

B**Report Notes**Report Description

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

Search Criteria

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

Types of Services:

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

Supplemental DocumentationFormulas:

- 1.Utilization Rate = (Paid Claims Count) / (Total Enrollees/100)
- 2.OVER = Utilization Rate > (Statewide Average of Utilization Rate + 2*Standard Deviation of Utilization Rate)
- 3.UNDER = Utilization Rate < (Statewide Average of Utilization Rate - 2*Standard Deviation of Utilization Rate)

5.4.28.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Anesth Services	The over or under deviation (per 100 enrollees) of anesthesiology service utilization for the provider being reported.	6	Number	N/A	Calculated
E.R. Visits	The over or under deviation (per 100 enrollees) of emergency room visit utilization for the provider being reported.	6	Number (Decimal)	N/A	Calculated
Hospital Admissions	The over or under deviation (per 100 enrollees) of hospital admission utilization for the provider being reported.	6	Number (Decimal)	N/A	Calculated
Lab Services	The over or under deviation (per 100 enrollees) of lab service utilization for the provider being reported.	6	Number (Decimal)	N/A	Calculated
Office Visits	The over or under deviation (per 100 enrollees) of office visit utilization for the provider being reported.	6	Number (Decimal)	N/A	Calculated
Pharmacy Services	The over or under deviation (per 100 enrollees) of pharmacy service utilization for the provider being reported.	6	Number (Decimal)	N/A	Calculated
Physician Referrals	The over or under deviation (per 100 enrollees) of physician referral utilization for the provider being reported.	6	Number	N/A	Calculated
Provider Name	The name of the provider being reported.	50	Char	T_PR_SVC_LOCN	NAME
Provider Numbers	The provider number of the provider being reported.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI, ID_PROVIDER_BASE, ID_PROVIDER_MCAID

Field	Description	Length	Data Type	DB Table	DB Attributes
Radiology Services	The over or under deviation (per 100 enrollees) of radiology service utilization for the provider being reported.	6	Number (Decimal)	N/A	Calculated

5.4.28.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.29 DSS - KenPAC Utilizers by Provider Specialty

The KenPAC Utilizers by Provider Specialty report lists KenPAC utilizer data by provider specialty for the reporting period. The frequency of this report is monthly.

5.4.29.1 Technical Name

DSS - KenPAC Utilizers by Provider Specialty

5.4.29.2 Sort Order

Member Name, Member Number, Provider, Provider name, Type of Service and Date.

5.4.29.3 KenPAC Utilizers by Provider Specialty Layout

A

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



Cabinet for Health and Family Services
Department for Medicaid Services

KenPAC Utilizers By Provider Type of Service
For Month of Service: June 2006

User ID: czv0vp

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

Provider Name: ANDERSON PHARMACY

Type of Service: E.R.A Visits

Member Full Name	Member ID	Billing Provider Numbers	Billing Provider Name	From Date of Service	Units	Over Utilized
SMITH, MIKE		NPI: 1000000397 Medicaid Number: 100218509E Base Number: 10021851	COUNTRY MEDICAL CLINIC	06/11/2006	2	*
SMITH, MIKE		NPI: 1000000397 Medicaid Number: 100218509E Base Number: 10021851	COUNTRY MEDICAL CLINIC	06/20/2006	1	*
SMITH, MIKE		NPI: 1000000397 Medicaid Number: 100218509E Base Number: 10021851	COUNTRY MEDICAL CLINIC	06/15/2006	2	*
SMITH, MIKE		NPI: 1000000397 Medicaid Number: 100218509E Base Number: 10021851	COUNTRY MEDICAL CLINIC	06/01/2006	4	*

End of Report

B**Report Notes**Report Description

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

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

Search Criteria

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

Types of Services:

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

Supplemental DocumentationFormulas:

- 1.Utilization Rate = (Paid Claims Count) / (Total Enrollees/100)
- 2.OVER = Utilization Rate > (Statewide Average of Utilization Rate + 2*Standard Deviation of Utilization Rate)

5.4.29.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Name	The name of the provider who rendered the service.	50	Char	T_PR_SVC_LOC	NAME
Billing Provider Numbers	Provider Numbers	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI, ID_PROVIDER_BASE, ID_PROVIDER_MCAID
From Date of Service	The date of service.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
Member Full Name	Full member name.	30	Char	T_RE_BASE	NAM_FIRST,NAM_LAST,N AM_MID_INIT
Member ID	The Medicaid identification number.	12	Char	T_RE_BASE	ID_MEDICAID
Over Utilized	The units that are over utilized.	1	Char	Derived	Derived
Units	The number of units.	7	Number	T_CA_ICN	QTY_UNITS_BILLED

5.4.29.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.30 DSS - Measures of Success - Nursing

The function of this report is to monitor the successfulness of the Nursing Facility Initiatives in reducing Medicaid dollars.

5.4.30.1 Technical Name

DSS – Measures of Success – Nursing

5.4.30.2 Sort Order

Month of Service ascending.

5.4.30.3 Measures of Success - Nursing Layout

A

Run Date: 7/18/2007
Run Time: 3:13:11 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: tztsbl



Measures of Success -Nursing Facility Initiative

Billing Provider Number(s): 12301250; 12504452
From Date of Service Range: 05/01/2006 - 05/31/2006

Total Expenditures	Total XIX Covered Days	Laboratory Revenue Codes 0300-0314 Billed Quantity	X-Ray Revenue Code 0320 Billed Quantity	Oxygen Revenue Code 0410 Billed Quantity	Respiratory Therapy Revenue Code 0412 Billed Quantity	Respiratory Therapy Supplies Revenue Code 0419 Billed Quantity	Physical Therapy Revenue Codes 0420-0424 Billed Quantity	Occupational Therapy Revenue Codes 0430-0433 Billed Quantity	Speech Therapy Revenue Codes 0440-0444 Billed Quantity	Member Unkup Count	Total Medicare Cost Sharing Expenditures
\$4,533.13	372	0	0	0	0	0	0	0	0	12	\$0.00
-\$4,533.13	372	0	0	0	0	0	0	0	0		\$0.00

End of Report

BReport Description

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

Search CriteriaQuery1 - (T CA HDR DTL table when applicable)

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

Union Query 2 - (T CA ICN table)

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

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

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

Supplemental Documentation

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

5.4.30.4 Field Descriptions

Field	Description	Data Type	Length	DB Table	DB Attributes
Lab Rev Cd 300 - 314 Units	Laboratory revenue code 300 through 314 units of service	Number	10	T_CA_HDR_DTL	QTY_BILLED
Occup Therapy Rev Cd 430 - 433 Units	Occupational therapy revenue code 300 through 314 units of service	Number (Decimal)	10	T_CA_HDR_DTL	QTY_BILLED
Phys Therapy Rev Cd 420 - 424 Units	Physical therapy revenue code 420 through 424 units of service	Number	10	T_CA_HDR_DTL	QTY_BILLED
Resp Therapy Rev Cd 419 Units	Repertory therapy revenue code 419 units of service	Number (Decimal)	10	T_CA_HDR_DTL	QTY_BILLED
Speech Therapy Rev Cd 440 - 444 Units	Speech therapy revenue code 440 through 444 units of service	Number	10	T_CA_HDR_DTL	QTY_BILLED
Total Expenditures	Total amount paid	Number	12	T_CA_ICN	TOT_AMT_PAID
Total Medicare Cost Sharing Expenditures	Total Medicare Cost Savings Expenditures	Number	12	T-CA-ANALYSIS	TOT_AMT_MCARE_PAID
Total Number Utilizers	Total number of utilizers	Number	10	T_CA_ICN	RECIP_KEY
Total XIX Covered Days	Total number of Medicaid covered days.	Number	10	T_CA_ICN	NUM_DAY_COVD
X-Ray Rev Cd 320 Units	X-Ray revenue code 320 units of service	Date (MM/DD/CCYY)	10	T_CA_HDR_DTL	QTY_BILLED

5.4.30.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.31 DSS - Medicaid Eligible Children

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

5.4.31.1 Technical Name

DSS - Medicaid Eligible Children

5.4.31.2 Sort Order

None.

5.4.31.3 Medicaid Eligible Children Layout

A

Run Date: 7/18/2006

Run Time: 3:05:29 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: qz00tr



Medicaid Eligible Children Per Month

Member Aid Eligibility Begin Date: 1/1/2000

Member Aid Eligibility End Date: 12/31/2005

Aid Code(s): A;M;I

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

End of Report

B

Report Notes

Report Description

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

Search Criteria

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

5.4.31.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Current Age	The age of the member.	3	Number	T_RE_BASE	DTE_BIRTH
KCHIP Indicator	The KCHIP indicator. Valid values are 'Y' or 'N'.	2	Char	T_RE_BASE	KCHIP_IND
Member Count	The count of the Members who have the criteria described on this line of the report..	12	Char	T_RE_BASE	ID_MEDICAID
Race Description	The code and description which indicates the member's race.	2	Char	T_RE_BASE	CDE_RACE DSC_RACE

5.4.31.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.32 DSS - Medicaid Member History Request

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

5.4.32.1 Technical Name

DSS - Medicaid Member History Request

5.4.32.2 Sort Order

Date of Service.

5.4.32.3 Medicaid Member History Request Layout

A

Run Date: 6/22/2007
Run Time: 12:15:45 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: rztdly



Medicaid Member History Request

Member ID(s)

From Date of Service Range: 5/1/2005 - 12/30/2006

Member ID:

ICN	Billing Provider Phone	Billing Provider Name	Billing Provider Full Address	From Date of Service	Revenue Code & Desc	Procedure Code & Desc	Primary Diagnosis Code & Desc	Billed Date	Billed Amount Sum	Paid Amount Sum	Paid Date	Capitation Amount
	(502) 885-7887 0000	GENTIVA HEALTH SERVICES	P O BOX 277950 ATLANTA, GA 30384-7950	05/03/2005	05/U - HOME HEALTH AIDE GENERAL CLASSIFICATION	***** - Unknown or Not Applicable	3310 - ALZHEIMER'S DISEASE	05/11/2005	\$43.00	\$32.50	06/03/2005	\$0.00
	(502) 885-7887 0000	GENTIVA HEALTH SERVICES	P O BOX 277950 ATLANTA, GA 30384-7950	05/04/2005	0270 - MEDICAL SUPPLIES GENERAL CLASSIFICATION	***** - Unknown or Not Applicable	3310 - ALZHEIMER'S DISEASE	05/11/2005	\$67.68	\$67.68	06/03/2005	\$0.00
	(502) 885-7887 0000	GENTIVA HEALTH SERVICES	P O BOX 277950 ATLANTA, GA 30384-7950	05/04/2005	0550 - SKILLED NURSING GENERAL CLASSIFICATION	***** - Unknown or Not Applicable	3310 - ALZHEIMER'S DISEASE	05/11/2005	\$105.00	\$83.00	06/03/2005	\$0.00

B**Report Notes**Report Description

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

Search Criteria

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

5.4.32.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Amount Sum	The sum of all charges associated with an individual claim.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
Billing Phone Number	The phone number on file at which the provider may be contacted.	14	Char	T_RE_BASE	NUM_PHONE

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Full Address	Provider address including city, state, and zip code.	86	Char	T_PR_ADR	ADR_MAIL_STRT1, ADR_MAIL_STRT2, ADR_MAIL_CITY, ADR_MAIL_STATE, ADR_MAIL_ZIP, ADR_MAIL_ZIP_4
Billing Provider Name	The name of the provider.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
Captiation Amount	The amount paid by Medicaid as a capitation fee for a member in a Managed Care program.				
From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYDDDBBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number.	13	Char	T_CA_ICN	NUM_ICN
Paid Amount Sum	The amount paid by Medicaid for the line item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Paid Date	The date on which a payment was generated from the MMIS claim transaction.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID
Primary Diagnosis Code & Desc	The name or English description of the diagnosis code.	74	Char	T_CA_ICN, T_DIAGNOSIS	CDE_DIAG_PRIM DSC_25

Field	Description	Length	Data Type	DB Table	DB Attributes
Procedure Code & Desc	The generally accepted nomenclature for medical, surgical, dental, etc., procedure.	64	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC DSC_PROC
Revenue Code & Desc	Code detailing the medical procedure performed for this claim detail.	74	Char	T_CA_HDR_DTL, T_CDE_REVENUE	CDE_REVENUE DSC_REVENUE

5.4.32.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.33 DSS - Member History Request

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

5.4.33.1 Technical Name

DSS - Member History Request

5.4.33.2 Sort Order

None

5.4.33.3 Member History Request Layout

A

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

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: qz00tr



Member History Request

Member ID(s):

From Date of Service Range: 1/1/2002 - 12/31/2005

Member County/Case Record Number	Member ID	Member Full Name (L,FM)	From Date of Service	Paid Amount
D092889	999999999	XXXXX XXXXX	03/20/2002	\$3,115.19
			09/01/2004	\$2,714.70
			10/01/2004	\$150.00
			11/01/2004	\$150.00
			Sum:	\$6,129.89

End of Report

B**Report Notes**Report Description

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

Search Criteria

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

5.4.33.4 Field Descriptions

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

Field	Description	Length	Data Type	DB Table	DB Attributes
Member ID	The current identification number assigned to a member.	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount	The total paid amount for the claim.	13	Number (Decimal)	T_CA_ICN	AMT_PAID

5.4.33.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.34 DSS - NF Initiative Ancillary Paid

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

5.4.34.1 Technical Name

DSS - NF Initiative Ancillary Paid

5.4.34.2 Sort Order

Month of Service, ascending and Bill Provider Number, ascending.

5.4.34.3 NF Initiative Ancillary Paid Layout

A

Run Date: 05/02/2007
Run Time: 5:23:44 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: tztsbl



NF Initiative Ancillary Paid

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

From Date of Service	Billing Provider Numbers	Billing Provider Name	Total Accom Paid Amount	Ancillary Paid Amount	Net Patient Paid Amount	TPL Amount	Paid Amount	Crossover Paid Amount	Paid Amount + Crossover Paid Amount
06/2006	NPI: 1033145529 Medicaid Number: 12501375 Base Number: 500004838	BRITTHAVEN OF SOMERSET	\$385,889.93	\$0.00	\$0.00	\$0.00	\$385,889.93	\$0.00	\$385,889.93
06/2006	NPI: 1063451953 Medicaid Number: 12504494 Base Number: 500002217	DAWSON POINTE LLC	\$152,834.36	\$0.00	\$0.00	\$0.00	\$152,834.36	\$0.00	\$152,834.36
06/2006	NPI: 1063458974 Medicaid Number: 12501680 Base Number: 500004816	BRITTHAVEN OF SOUTH LOUIS	\$308,901.66	\$0.00	\$0.00	\$0.00	\$308,901.66	\$0.00	\$308,901.66

Report Notes

B

Report Description

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

Search Criteria

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

Supplemental Documentation

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

5.4.34.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Ancillary Paid Amount	The total amount paid for ancillary charges on the claim.	13	Number (Decimal)	N/A	Calculated
Billing Provider IDs	A unique number assigned by the state to each provider of services participating in the Medicaid program.	9	Char	T_CA_PROV_ KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
Billing Provider Name	The full name of a provider.	50	Char	T_CA_PROV_ KEY	NAM_PROVIDER

Field	Description	Length	Data Type	DB Table	DB Attributes
Covered Days	Indicates the number of days covered for the statement period of the claim.	5	Number	T_CA_ICN	NUM_DAYS_COVD
Crossover Paid Amount	The total paid amount of the line item for encounter claims.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
From Date of Service	This is the line item first date of service for the particular claim detail.	7	Date (MM/CCYY)	T_CA_ICN	DTE_FIRST_SVC
Net Patient Paid Amount	The amount received by the provider from the member. This excludes copay. This is the amount that has been determined to be available from the member as partial payment of the cost of care.	13	Number (Decimal)	T_CA_ICN	AMT_PAT_LIAB
Other Insurance Paid Amount	The amount of payment received by the provider from a third party source.	13	Number (Decimal)	T_CA_ICN	AMT_TPL
Paid Amount	The total paid amount of the line item for encounter claims.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Paid Amount + Crossover Paid Amount	The total sum of encounter claims payment amount and the amount paid by Medicare	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Total Accom Paid Amount	The total paid amount of the line item accommodations charges.	13	Number (Decimal)	N/A	Calculated

5.4.34.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.35 DSS - NF Initiative Ancillary Units

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

5.4.35.1 Technical Name

DSS - NF Initiative Ancillary Units

5.4.35.2 Sort Order

First Date of Service, ascending and Revenue Code, ascending.

5.4.35.3 NF Initiative Ancillary Units Layout

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

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: tztsbl

A



NF Initiative Ancillary Units

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

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

End of Report

Report Notes

B

Report Description

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

Search Criteria

From Date of Service per user input

FFS Claims only

Bill Provider Type equal to 12 (Nursing Home)

Type of Bill between 891 and 894

Latest Claims only

Paid Claims only

Covered Charges only (Patient liability = \$0)

Revenue Code in (0320, 0410, 0412, 0419) or Revenue Code between 0300 and 0314 or Revenue Code between 0420 and 0424 or Revenue Code between 0430 and 0433 or Revenue Code between 0440 and 0444

5.4.35.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Revenue Amount	The total of submitted charges.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
Billed Revenue Quantity	The total units billed.	7	Number	T_CA_ICN	QTY_BILLED
ICN Undup Count	Count of unique internal control numbers.	10	Number	T_CA_ICN	NUM_ICN
Member Undup Count	Total count of unique member identifications.	12	Number	T_CA_ICN	ID_MEDICAID
Revenue Code & Description	The line item revenue code billed on the UB-92 claim (describes the service performed).	75	Char	T_CA_ICN	CDE_REVENUE, DSC_REVENUE

Field	Description	Length	Data Type	DB Table	DB Attributes
Revenue From Date of Service	This is the line item first date of service for the particular claim detail. Format is YYYY/MM.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC

5.4.35.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.36 DSS - Non Actual Budget Model

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

5.4.36.1 Technical Name

DSS - Non Actual Budget Model

5.4.36.2 Sort Order

None

5.4.36.3 Non Actual Budget Model Layout

A

Run Date: 10/26/2006

Cabinet for Health and Family Services

User ID: czv6vp

Run Time: 10:15:23 AM

Department for Medicaid Services



Non Actual Budget Model

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

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

End of Report

B

Report Notes

Report Description

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

Search Criteria

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

5.4.36.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Member Undup Count	A unique count of first Identification number assigned to a member upon initial certification for participation in the program.	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount	A unique count of the amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Paid Date Range	Prompt value for paid date range.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID
State COS Code & Description	A code defining the category of service rendered (for example, inpatient, pharmacy, physician or home health).	2	Char	T_CA_CLAIM_KEY	CDE_COS_ST DSC_COS

5.4.36.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.37 DSS - QIO Monitoring

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

5.4.37.1 Technical Name

DSS - QIO Monitoring

5.4.37.2 Sort Order

Original Member ID, Transaction Control Number and Last Date of Service.

5.4.37.3 QIO Monitoring Layout

A

Run Date: 3/22/2007

Run Time: 10:22:39 AM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: tztsbl



QIO Monitoring

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

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

End of Report

B**Report Notes**Report Description

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

Search Criteria

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

5.4.37.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Amount	The amount billed for the procedure.	13	Number (Decimal)	T_CA_HDR_DTL	AMT_BILLED
Billed Quantity	The number of units administered for the procedure code billed on this line item.	7	Number	T_CA_HDR_DTL	QTY_UNITS_BILLED
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i> .	10	Char	T_CA_ICN	ID_PROV_BILL
From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC

Field	Description	Length	Data Type	DB Table	DB Attributes
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYDDDBBSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number.	13	Char	T_CA_ICN	NUM_ICN
Member Case Name (L,FM)	The member's full name, as it appears in Medicaid case files.	25	Char	T_RE_BASE	NAM_LAST, NAM_FIRST
Member ID	The Medicaid identification number for the member.	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount	The amount paid by Medicaid for the line item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Revenue Code & Description	The line item revenue code billed on the UB-92 claim (describes the service performed).	4	Char	T_CA_HDR_DTL	CD_REVENUE
To Date of Service	This is the line item through date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC

5.4.37.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.38 DSS - Paid Claims DME Providers for Procedure E1399

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

5.4.38.1 Technical Name

DSS - Paid Claims DME Providers for Procedure E1399

5.4.38.2 Sort Order

Billing Provider Number and ICN.

5.4.38.3 Paid Claims DME Providers for Procedure E1399 Layout

A

Run Date: 3/20/2007
Run Time: 10:23:38 AM

Cabinet for Health and Family Services
Department for Medicaid Services
DME Provider Monthly Report

User ID: tztsbl



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

Payment Month: 200703

Billing Provider Numbers	ICN	Billed Amount Sum	Paid Amount Sum	From Date of Service	Paid Date
NPI: Medicaid Number: 90005133 Base Number: 500008994		\$13.95	\$0.00	11/03/2006	03/14/2007
NPI: Medicaid Number: 90005133 Base Number: 500008994		\$13.95	\$0.00	11/03/2006	03/14/2007
NPI: Medicaid Number: 90056045 Base Number: 500009671		\$20.00	\$0.00	10/04/2006	03/02/2007
NPI: Medicaid Number: 90056045 Base Number: 500009671		\$75.00	\$0.00	10/10/2006	03/02/2007
NPI: Medicaid Number: 90056045 Base Number: 500009671		\$12.00	\$0.00	10/19/2006	03/02/2007
NPI: Medicaid Number: 90056045 Base Number: 500009671		\$135.00	\$0.00	10/04/2006	03/02/2007
NPI: Medicaid Number: 90760562 Base Number: 500008356		\$158.65	\$0.00	01/25/2006	03/14/2007

B

Report Notes

Report Description

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

Search Criteria

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

5.4.38.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Amount	The amount billed by the provider on the claim.	13	Number (Decimal)	T_CA_ICN	AMT_BILLED
Billing Provider Numbers	The Medicaid provider number assigned to the provider.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE

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

5.4.38.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.39 DSS - Paid Claims Hi - Low

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

5.4.39.1 Technical Name

DSS - Paid Claims Hi – Low

5.4.39.2 Sort Order

N/A

5.4.39.3 Paid Claims Hi - Low Layout

A

Run Date: 8/3/2006
Run Time: 4:27:20 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: qzndgg



Paid Claims Hi - Low
High Payment Amounts

Claim Type: B - HCFA 1500 XOVER CLAIMS

ICN	Dtl Number	Billing Provider IDs	Member ID	Billed Amount	Medicare Paid Amount	Paid Amount	From Date of Service	Allowed Amount	Blood Deduct	Amount Deduct	Medicare Coinsurance Amount
999999999	0	NPI ID: 1000000182 Medicaid ID: 100096919A Base ID: 10009692	999999999	\$100.00	\$25.00	\$37.00	09/06/2004	\$0.00	\$0.00	\$50.00	\$25.00
999999999	0	NPI ID: 1000000513 Medicaid ID: 100241829I Base ID: 10024183	999999999	\$100.00	\$25.00	\$37.00	10/02/2004	\$0.00	\$0.00	\$50.00	\$25.00
999999999	0	NPI ID: 1000000513 Medicaid ID: 100241829I Base ID: 10024183	999999999	\$100.00	\$25.00	\$37.00	09/06/2004	\$0.00	\$0.00	\$50.00	\$25.00
999999999	0	NPI ID: 1000000513 Medicaid ID: 100241829I Base ID: 10024183	999999999	\$100.00	\$25.00	\$37.00	09/06/2004	\$0.00	\$0.00	\$50.00	\$25.00
999999999	0	NPI ID: 1000000513 Medicaid ID: 100241829I Base ID: 10024183	999999999	\$100.00	\$25.00	\$22.50	09/06/2004	\$0.00	\$0.00	\$50.00	\$25.00
999999999	0	NPI ID: 1000000562 Medicaid ID: 100254269A Base ID: 10025427	999999999	\$100.00	\$25.00	\$18.25	01/15/2005	\$0.00	\$0.00	\$25.00	\$25.00
999999999	0	NPI ID: 1000000562 Medicaid ID: 100254269A Base ID: 10025427	999999999	\$100.00	\$25.00	\$8.75	11/02/2004	\$0.00	\$0.00	\$25.00	\$25.00

B

Run Date: 8/3/2006
Run Time: 4:27:20 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: qzndgg



**Paid Claims Hi - Low
Low Payment Amounts**

Claim Type: B - HCFA 1500 XOVER CLAIMS

ICN	Det Number	Billing Provider IDs	Member ID	Billed Amount	Medicare Paid Amount	Paid Amount	From Date of Service	Allowed Amount	Blood Deduct	Amount Deduct	Medicare Coinsurance Amount
	0	NPI ID: 1000000182 Medicaid ID: 100096919A Base ID: 10009692		\$100.00	\$25.00	\$37.00	09/06/2004	\$0.00	\$0.00	\$50.00	\$25.00
	0	NPI ID: 1000000513 Medicaid ID: 1002418291 Base ID: 10024183		\$100.00	\$25.00	\$37.00	10/02/2004	\$0.00	\$0.00	\$50.00	\$25.00
	0	NPI ID: 1000000513 Medicaid ID: 1002418291 Base ID: 10024183		\$100.00	\$25.00	\$37.00	09/06/2004	\$0.00	\$0.00	\$50.00	\$25.00
	0	NPI ID: 1000000513 Medicaid ID: 1002418291 Base ID: 10024183		\$100.00	\$25.00	\$37.00	09/06/2004	\$0.00	\$0.00	\$50.00	\$25.00
	0	NPI ID: 1000000513 Medicaid ID: 1002418291 Base ID: 10024183		\$100.00	\$25.00	\$22.50	09/06/2004	\$0.00	\$0.00	\$50.00	\$25.00
	0	NPI ID: 1000000562 Medicaid ID: 100254269A Base ID: 10025427		\$100.00	\$25.00	\$18.25	01/15/2005	\$0.00	\$0.00	\$25.00	\$25.00
	0	NPI ID: 1000000562 Medicaid ID: 100254269A Base ID: 10025427		\$100.00	\$25.00	\$8.75	11/02/2004	\$0.00	\$0.00	\$25.00	\$25.00

C

Report NotesReport Description

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

Search Criteria

Select paid claim information for highest and lowest payment amounts for the reporting period, group by claim type.

5.4.39.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A,B) Allowed Amount	Amount approved to pay for services provided to a member.	10	Number (Decimal)	T_CA_ICN	AMT_ALWD
(A,B) Amount Deduct	Amount of Medicare deductible the member must meet before Medicare will pay.	8	Number (Decimal)	T_CA_XOVER	AMT_DEDUCT
(A,B) Billed Amount	Amount of money requested for payment by a provider for services rendered to a member.	10	Number (Decimal)	T_CA_ICN	AMT_BILLED

Field	Description	Length	Data Type	DB Table	DB Attributes
(A,B) Billing Provider IDs	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i> .	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
(A,B) Blood Deduct	The blood deductible amount from the UB92 claim form.	13	Number (Decimal)	T_CA_XOVER	AMT_DEDUCT_BLOOD
(A,B) Claim Type	A code to indicate the type of medical assistance invoice used by the provider to bill omap for the rendered service.	1	Char	T_CA_ICN	CDE_CLM_TYPE
(A,B) Dtl Number	The claim detail number.	4	Number (Integer)	T_CA_ICN	NUM_DTL
(A,B) From Date of Service	Date on which services were first performed for a member.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
(A,B) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYJJJBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Char	T_CA_ICN	NUM_ICN
(A,B) Medicare Coinsurance Amount	The amount of Medicare Co-Insurance paid by the member for this claim.	8	Number (Decimal)	T_CA_XOVER	AMT_COINSURANCE

Field	Description	Length	Data Type	DB Table	DB Attributes
(A,B) Medicare Paid Amount	The amount approved by Medicare for the service. The amount approved by Medicare is the basis for deductible paid and/or coinsurance paid for which the member (Medical Assistance) is responsible.	10	Number (Decimal)	T_CA_XOVER	AMT_PAID_MCARE
(A,B) Member ID	The unique number assigned to the member.	12	Char	T_CA_ICN	ID_MEDICAID
(A,B) Paid Amount	Amount that will be applied toward the check amount.	13	Number (Decimal)	T_CA_ICN	AMT_PAID

5.4.39.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.40 DSS - Paid Claims History

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

5.4.40.1 Technical Name

DSS - Paid Claims History

5.4.40.2 Sort Order

None

5.4.40.3 Paid Claims History Layout

A

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

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: qz00tr



Paid Claims History

Member ID(s):
From Date of Service Range: 3/1/2004 - 3/30/2004

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

End of Report

B

Report Notes

Report Description

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

Search Criteria

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

Supplemental Documentation

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

5.4.40.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Full Address	Provider address including city, state, and zip code.	101	Char	T_PR_ADR	ADR_MAIL_STRT1, ADR_MAIL_STRT2, ADR_MAIL_CITY, ADR_MAIL_STATE, ADR_MAIL_ZIP, ADR_MAIL_ZIP_4

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Name	The name of the provider of Medicaid services as used on official state records.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
Medicare Submitted	The Line item total bill charged to Medicare.	1	Char	N/A	Calculation
Paid Amount	The amount paid by Medicaid for the line item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Payment Date	The date on which a payment was generated from the MMIS claim transaction.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID
Primary Diagnosis Code & Desc	The diagnosis code and name or English description of the diagnosis code.	47	Char	T_CA_ICN, T_DIAGNOSIS	CD_DIAG_PRM
Primary Procedure Code & Desc	The generally accepted nomenclature for medical, surgical, dental, etc., procedure.	46	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC_PRIM DSC_PROC
To Date of Service	This is the line item through date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC

5.4.40.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.41 DSS - Preventive Health Payments – Date Paid

The Preventive Health Payments – Date Paid report generates a history of preventive health claims during a specific paid date range. It determines preventive health payments for reimbursement.

5.4.41.1 Technical Name

DSS - Preventive Health Payments – Date Paid

5.4.41.2 Sort Order

Date of Payment and Procedure Description.

5.4.41.3 Preventive Health Payments – Date Paid Layout

Run Date: 08/09/2006
Run Time: 3:26:37 PM

Cabinet for Health and Family Services

User ID: tztsbl

Department for Medicaid Services

A



Preventive Health Payments - Date Paid

Date Paid Range: 03/01/2005 - 12/1/2005

Payment Date	Primary Procedure Code & Desc	Paid Amount	Billed Quantity	ICN Undup Count
03/24/2005	A4250 -	\$0.00	1	1
03/29/2005	59850 -	\$0.00	2	2
03/29/2005	74280 -	\$0.00	1	1
03/29/2005	99271 -	\$0.00	1	1
03/31/2005	00320 -	\$199.00	1	1
03/31/2005	23035 -	\$898.41	2	1
03/31/2005	23180 -	\$599.00	1	1
03/31/2005	43280 -	\$1,123.00	2	1
03/31/2005	56620 -	\$717.52	5	3
03/31/2005	59850 -	\$117.07	7	5
03/31/2005	63030 -	\$234.25	2	1
03/31/2005	65265 -	\$628.69	2	1
03/31/2005	74280 -	\$58.00	3	1
04/04/2005	99231 -	\$20.00	1	1
04/07/2005	99296 -	\$244.00	1	1

End of Report

B

Report Notes

Report Description

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

Selection Criteria

- Paid date range per user input
- Bill Provider Type equal to 20 (Preventive & Remedial Public Health)
- Fee for Service Claims only
- Paid Claims only
- Latest Claims only

5.4.41.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	The number of units administered for the procedure code billed on this line item.	9	Number	T_CA_ICN	QTY_UNITS_BILLED
ICN Undup Count	Count of unique ICNs	10	Number	T_CA_ICN	NUM_ICN
Paid Amount	The amount paid by Medicaid for the line Item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Payment Date	This is the line item paid date for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
Primary Procedure Code & Description	Code detailing the medical procedure performed for this claim detail.	46	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC_PRIM DSC_PROC

5.4.41.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.42 DSS - Preventive Health Payments - DOS

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

5.4.42.1 Technical Name

DSS - Preventive Health Payments – DOS

5.4.42.2 Sort Order

First Date of Service and Procedure Description.

5.4.42.3 Preventive Health Payments - DOS Layout

A

Run Date: 05/22/2007

Run Time: 12:06:05 PM

Cabinet for Health and Family Services User ID: tztsbl
Department for Medicaid Services



Preventive Health Payments - DOS

From Date of Service Range: 2/1/2005 - 2/28/2005

From Date of Service	Procedure Code & Desc	Paid Amount	Sum Billed	Quantity	Sum ICN	Undup	Count
02/01/2005	81002 - Urinalysis Nonauto W/O Scope	\$2.60		1			1
02/01/2005	82947 - Assay, Glucose, Blood Quant	\$4.22		1			1
02/01/2005	82950 - Glucose Test	\$5.11		1			1
02/01/2005	82962 - Glucose Blood Test	\$2.51		1			1
02/01/2005	85018 - Hemoglobin	\$2.30		2			2
02/01/2005	88141 - Cytopath, C/V, Interpret	\$10.81		1			1
02/01/2005	99212 - Office/Outpatient Visit, Est	\$126.39		11			11
02/01/2005	99213 - Office/Outpatient Visit, Est	\$16.24		1			1
02/01/2005	99214 - Office/Outpatient Visit, Est	\$31.48		1			1
02/01/2005	99391 - Prev Visit, Est, Infant	\$0.00		1			1
02/02/2005	82962 - Glucose Blood Test	\$3.23		1			1

B Report Notes

Report Description

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

Selection Criteria

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

5.4.42.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity Sum	The number of units administered for the procedure code billed on this line item.	9	Number	T_CA_ICN	QTY_UNITS_BILLED
From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
ICN Undup Count	Count of unique ICNs.	10	Char	T_CA_ICN	NUM_ICN
Paid Amount Sum	The amount paid by Medicaid for the line item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Primary Procedure Code & Description	Code detailing the medical procedure performed for this claim detail.	46	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC DSC_PROC

5.4.42.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.43 DSS - Provider Denial Rates Above 50 Percent

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

5.4.43.1 Technical Name

DSS - Provider Denial Rates Above 50 Percent

5.4.43.2 Sort Order

Provider Number.

5.4.43.3 Provider Denial Rates Above 50 Percent Layout

A

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

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: qzndgg



Provider Denial Rates Above 50%

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

End of Report

B

Report Notes

Report Description

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

Search Criteria

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

5.4.43.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider IDs	Provider Number	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
Denial Percentage	The percentage of denied claims for the month.	5	Number (Decimal)	N/A	Calculated
Denied Claim Clount	The number of denied claims for the month.	6	Number (Decimal)	T_CA_ICN	CNT_CLAIMS_DENIED

5.4.43.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.44 DSS - Provider History

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

5.4.44.1 Technical Name

DSS - Provider History

5.4.44.2 Sort Order

Date of Service.

5.4.44.3 Provider History Layout

A

Run Date: 5/30/2007
Run Time: 12:11:41 PM

User ID: tztsbl

**Cabinet for Health and Family Services
Department for Medicaid Services**



Provider History

**Billing Provider Number(s): 31000243
Member ID(s):
From Date of Service Range: 5/1/2005 - 6/30/2005**

Billing Provider Numbers: NPI: - WHITE HOUSE CLINIC MCKEE
Medicaid Number: 31000243
Base Number: 500006205

Member ID:

ICN	Detail Number	Procedure Code & Desc	From Date of Service	To Date of Service	Paid Amount Sum	Billed Quantity Sum	Capitation Amount
	136415	- Routine Venipuncture	05/09/2005	05/09/2005	\$0.00	1	
	136415	- Routine Venipuncture	05/16/2005	05/16/2005	\$0.00	1	
	136415	- Routine Venipuncture	05/23/2005	05/23/2005	\$0.00	1	
	136415	- Routine Venipuncture	05/31/2005	05/31/2005	\$0.00	1	
			06/23/2005	06/23/2005			\$4.00

B**Report Notes**Report Description

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

Search Criteria

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

5.4.44.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity Sum	The sum of all charges associated with an individual claim.	12	Number (Decimal)	T_CA_ICN	QTY_UNITS_BILLED
Billing Provider Number	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i> .	10	Number	T_CA_ICN	ID_PROV_BILL
Detail Number	Number of Detail on Claim	4	Char	T_CA_ICN	NUM_DTL
From Date of Service	This is the line item first date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC

Field	Description	Length	Data Type	DB Table	DB Attributes
ICN	Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYDDDDBBSSS: RR - region, YYDDD - Julian date, BBB - batch number, SSS - sequence number.	48	Char	T_CA_ICN	NUM_ICN
Member ID	The first Identification number assigned to a member upon initial certification for participation in <i>KY Medicaid</i> and the member's full name.	12	Number	T_CA_ICN T_RE_BASE_DN	ID_MEDICAID, NAM_LAST NAM_FIRST N
Paid Amount Sum	The amount paid by Medicaid for the line item procedure billed.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Procedure Code & Desc	Code detailing the medical procedure performed for this claim detail. and the description of the procedure code.	51	Char	T_CA_ICN T_PROC	CDE_PROC_PRM DSC_PROCEDURE
To Date of Service	This is the line item last date of service for the particular claim detail.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC

5.4.44.5 Associated Programs

Program	Description
No associated Programs found.	

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

The Provider Type 55-56 (16) Transportation Expenditures by Procedure report lists summary totals by procedure code by provider type 55 and 56 providers with a specialty of (16) and report totals. The Report is split into claim types N and B. The frequency of this report is monthly.

5.4.45.1 Technical Name

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

5.4.45.2 Sort Order

Procedure Code.

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

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

A

Run Date: 6/5/2007

Run Time: 4:32:27 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: Administrator



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

Payment Date Range: 1/1/2006 - 12/31/2007

Claim Type & Description: B - PROF XOVER CLAIMS

Procedure Code & Desc	Total Claim Count Sum	Denied Claim Count Sum	Paid Amount Sum	Average Paid Amount Per Procedure
00142 - Anesth, Lens Surgery	1	1	\$0.00	\$0.00
01382 - Anesth, Dx Knee Arthroscopy	1	1	\$0.00	\$0.00
94760 - Measure Blood Oxygen Level	2	2	\$0.00	\$0.00
A0380 - Basic Life Support Mileage	4	0	\$0.00	\$0.00
A0382 - Basic Support Routine Suppls	396	152	\$1.02	\$0.00
A0390 - Advanced Life Support Mileag	3	2	\$18.06	\$18.06

B

Report Notes

Report Description

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

Search Criteria

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

5.4.45.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Average Paid Amount Per Procedure	The average expenditure on the given procedure code.	13	Number (Decimal)	N/A	Calculated
Claim Type & Description	Type of claim being reported.	51	Char	T_CA_CLAIM_KEY	CDE_CLM_TYP DSC_CLM_TYPE

Field	Description	Length	Data Type	DB Table	DB Attributes
Denied Claim Count	The denied claim count for the procedure code for the provider.	10	Number (Integer)	T_CA_ICN	CNT_CLAIMS_DENIED
Paid Amount Sum	The total amount paid for the procedure code listed.	13	Number (Decimal)	T_CA_HDR_DTL	AMT_PAID
Procedure Code & Desc	The procedure code and description from the claim.	46	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC DSC_PROC
Total Claims Count	Total claims submitted with the procedure code listed.	10	Number (Integer)	T_CA_ICN	SAK_CLAIM

5.4.45.5 Associated Programs

Program	Description
No associated Programs found.	

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

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

5.4.46.1 Technical Name

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

5.4.46.2 Sort Order

County Name.

5.4.46.3 Sort Order

County Name.

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

A

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

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: qz00tr



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

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

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

End of Report

B**Report Notes**Report Description

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

Search Criteria

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

5.4.46.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
County Name	The county name and county code.	15	Char	T_PR_SVC_LOC, T_COUNTY	CDE_COUNTY, DSC_COUNTY
Total	The total amount of money expended for Provider types 55 and 56 (16) for the county given.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Type 55 – Emergency Transportation	The total amount expended for Provider type 55 in the county listed given.	13	Number (Decimal)	T_CA_ICN	AMT_PAID

5.4.46.6 Associated Programs

Program	Description
No associated Programs found.	

5.4.47 DSS - Q6 Modifier Claims

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

5.4.47.1 Technical Name
DSS - Q6 Modifier Claims

5.4.47.2 Sort Order
Provider Number, Provider Name and First Date of Service.

5.4.47.3 Q6 Modifier Claims

A

Run Date: 5/17/2007
Run Time: 4:13:47 PM

User ID:tztsbl

Cabinet for Health and Family Services
Department for Medicaid Services



**Q6 Modifier Claims
Summary**

* Red means days billed are consecutive

From date of service range: 1/1/2006 - 12/31/2006
Minimum number of days billed: 8

Billing Provider Numbers	Billing Provider Name	Member ID	From Date of Service	To Date of Service	Number of Days Billed
NPI: Medicaid Number: 65907636 Base Number: 500001537	RADIATION ONCOLOGY PSC		05/16/2006	05/26/2006	9
Billing Provider Numbers	Billing Provider Name	Member ID	From Date of Service	To Date of Service	Number of Days Billed
NPI: Medicaid Number: 65907636 Base Number: 500001537	RADIATION ONCOLOGY PSC		05/16/2006	05/26/2006	9

A

Run Date: 5/17/2007
 Run Time: 4:13:47 PM

**Cabinet for Health and Family Services
 Department for Medicaid Services**

User ID:tztsbl



**Q6 Modifier Claims
 Detail**

* Red means days billed are consecutive

From date of service range: 1/1/2006 - 12/31/2006

Number of days billed:8

Billing Provider Numbers	Billing Provider Name	Member ID	ICN	Detail Number	Billed Amount	Paid Amount	From Date of Service
NPI: Medicaid Number: 65907636 Base Number: 500001537	RADIATION ONCOLOGY PSC	999999999	999999999	1	\$553.00	\$0.00	05/16/2006
			999999999	2	\$30.00	\$0.00	05/16/2006
			999999999	3	\$30.00	\$0.00	05/17/2006
			999999999	4	\$30.00	\$0.00	05/18/2006
			999999999	5	\$30.00	\$0.00	05/19/2006
			999999999	6	\$30.00	\$0.00	05/22/2006
			999999999	7	\$325.00	\$4.86	05/23/2006
			999999999	8	\$889.00	\$13.38	05/23/2006
			999999999	1	\$30.00	\$0.00	05/23/2006
			999999999	10	\$1,799.00	\$22.92	05/24/2006
			999999999	2	\$30.00	\$0.00	05/24/2006
			999999999	3	\$30.00	\$0.00	05/25/2006
			999999999	4	\$30.00	\$0.00	05/26/2006

B**Report Notes**Report Description

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

Search Criteria

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

5.4.47.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	The ID of the billing provider.	10	Char	T_CA_ICN	ID_PROV_BILL
Billing Provider Name	The full name of the billing provider.	50	Char	T_PR_SVC_LOC	NAME
From Date of Service	The first date of service.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
Number of Days Billed	The number of days billed. When days billed are consecutive the number will be in red.	13	Char	T_CA_ICN	NUM_ICN

Field	Description	Length	Data Type	DB Table	DB Attributes
To Date of Service	The to date of service	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC

5.4.47.5 Associated Programs

Program	Description
No associated Programs found.	

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

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

5.4.48.1 Technical Name

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

5.4.48.2 Sort Order

Total Paid Amount.

5.4.48.3 Sort Order

Total Paid Amount.

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

A

Run Date: 6/5/2007
Run Time: 4:26:46 PM

Cabinet for Health and Family Services User ID: Administrator
Department for Medicaid Services



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

Payment Date Range: 1/1/2005 - 12/31/2005

Provider Type & Description: 55 - Emergency Transportation

Rank	Billing Provider Numbers	Total Claim Count Sum	Paid Claim Count Sum	Denied Claim Count Sum	Paid Amount Sum
1	NPI: Medicaid Number: 55034110 Base Number: 500012526	256	122	134	\$141,798.34
2	NPI: 1801879606 Medicaid Number: 55000095 Base Number: 500004057	57	49	8	\$87,191.37
3	NPI: Medicaid Number: 55000962 Base Number: 500011946	78	57	21	\$84,358.78

B

Report Notes

Report Description

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

Search Criteria

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

5.4.48.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	The provider identification number used by the provider.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
Grand Total	Total of the specific column for the entire report	9	Number(Decimal)	N/A	Calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
Rank	The relative rank of provider per paid amount.	6	Number (Integer)	N/A	Calculated
Denied Claim Count Sum	Total Claims denied to the provider.	9	Number	T_CA_ICN	CNT_CLAIMS_DENIED
Paid Amount	Total paid to provider.	13	Number (Decimal)	T_CA_ICN	TOT_AMT_PAID
Paid Claim Count Sum	Total Claims paid to the provider.	9	Number (Integer)	T_CA_ICN	CNT_CLAIMS_PAID
Prov Type 55 Totals	Total of the specific column for the entire provider type	9	Number(Decimal)	N/A	Calculated
Total Claim Count Sum	Total Claims submitted by the provider.	9	Number (Integer)	T_CA_ICN	CNT_CLAIMS_PAID,CN T_CLAIMS_DENIED

5.4.48.6 Associated Programs

Program	Description
No associated Programs found.	

5.4.49 DSS - Ray Prior Auth -- Ray Prior Auth

The Ray Prior Auth report generates a list of all SCL providers and Member IDs during a specific date of service range. The output of this report is feed into a monthly Incident Report that covers all of the SCL Providers. (“Ray Prior Auth” is the name of the report as retained from the DSS.)

5.4.49.1 Technical Name

DSS - Ray Prior Auth

5.4.49.2 Sort Order

Provider Number and Original Member ID.

5.4.49.3 Ray Prior Auth Layout

A

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

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: qz00tr



Ray Prior Auth

Authorization End Date: 1/31/2000

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

End of Report

B

Report Notes

Report Description

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

Search Criteria

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

5.4.49.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Authorization Prior Auth End Date	The ending effective date of a Service/Prior Authorization.	10	Date (MM/DD/CCYY)	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Member ID	The Medicaid identification number for the member.	12	Char	T_CA_ICN	ID_MEDICAID
Requesting Provider Medicaid Number	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i> .	10	Char	T_CA_ICN	ID_PROV_BILL

5.4.49.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.50 DSS - SCL 2005 -- SCL 2005

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

5.4.50.1 Technical Name

DSS - SCL 2005

5.4.50.2 Sort Order

None

5.4.50.3 SCL 2005 Layout

A

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

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: qz00tr



SCL 2005

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

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

End of Report

B**Report Notes**Report Description

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

Search Criteria

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

5.4.50.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Quantity	The sum of the number of units administered for the procedure code billed on this line item.	11	Number	T_CA_HDR_DTL	QTY_UNITS_BILLED
Member Undup Count	The unique count of the first Identification number assigned to a member upon initial certification for Participation in the program.	12	Char	T_CA_ICN	ID_MEDICAID
Paid Amount	The amount paid by Medicaid for the line item procedure billed.	11	Number (Decimal)	T_CA_HDR_DTL	AMT_PAID
Primary Procedure Code & Desc	Code detailing the medical procedure performed for this claim detail.	6	Char	T_CA_HDR_DTL	CDE_PROC
Revenue Code & Description	The line item revenue code billed on the UB-92 claim (describes the service performed).	4	Char	T_CA_HDR_DTL	CDE_REVENUE

5.4.50.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.51 DSS - SCL Hi Intensity Summary

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

5.4.51.1 Technical Name

DSS - SCL Hi Intensity Summary

5.4.51.2 Sort Order

Original Member ID, Provider Number, Procedure Description and ICN.

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

5.4.51.3 SCL Hi Intensity Summary Layout

A

Run Date: 3/19/2007
Run Time: 11:17:16 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: tztsbl



SCL Hi Intensity Summary
For Cycle Ending: 03/01/2007

Member ID	Member Full Name (L,FM)	Waiver Days	Hi Days	Hi Intnsty	Billing Provider Numbers	Billing Provider Name	New Ind	Procedure Code & Desc	Paid Amount Sum	Billed Qty	Projected Yearly Cost
999999999	XXXXX XXXXXXXXX	314	2089	N	NPI: Medicaid Number: 64330434 Base Number: 500056808	MAWAD, HANNA W	N	99214 - Office Or Other Outpatient Visit For The	\$0.00	1	\$0.00
								99350 - Home Visit For The Evaluation And Manage	\$159.58	3	\$25.55
999999999	XXXXX XXXXXXXXX	902	889	N	NPI: Medicaid Number: 65926743 Base Number: 500009361	SUMMIT MEDICAL GROUP	N	38415 - Routine Venipuncture Or Finger/Heel/Ear	\$50.70	6	\$18.25
								99214 - Office Or Other Outpatient Visit For The	\$125.91	6	\$51.10
					NPI: Medicaid Number: 65926743 Base Number: 500009361	SUMMIT MEDICAL GROUP	Y	38415 - Routine Venipuncture Or Finger/Heel/Ear	\$16.90	2	\$3.85
								99214 - Office Or Other Outpatient Visit For The	\$41.07	2	\$14.80
999999999	XXXXX XXXXXXXXX	384	990	N	NPI: Medicaid Number: 65922643 Base Number: 500004283	ARH HAZARD PSYCHIATRIC SVC GRP	N	99231 - Subsequent Hospital Care, Per Day, For	\$51.78	2	\$18.25
999999999	XXXXX XXXXXXXXX	382	226	Y	NPI: Medicaid Number: 65922809 Base Number: 500008963	PRIMARY CARE MEDICAL CENTER	N	99213 - Office Or Other Outpatient Visit For The	\$54.12	2	\$83.95
999999999	XXXXX XXXXXXXXX	1,095	820	N	NPI: Medicaid Number: 64094485 Base Number: 500027311	DAY, JAMES	Y	99204 - Office Or Other Outpatient Visit For The	\$146.08	2	\$62.05
999999999	XXXXX XXXXXXXXX	1,095	822	N	NPI: Medicaid Number: 64094485 Base Number: 500027311	DAY, JAMES	Y	99204 - Office Or Other Outpatient Visit For The	\$146.08	2	\$62.05
999999999	XXXXX XXXXXXXXX	1,071	1003	N	NPI: Medicaid Number: 37902780 Base Number: 500008854	CUMBERLAND MED LABS INC	N	80053 - Comprehensive Metabolic Panel	\$11.74	1	\$3.85
								82247 - Bilirubin; Total	\$7.02	1	\$0.00
								82248 - Bilirubin; Direct	\$7.02	1	\$0.00
999999999	XXXXX XXXXXXXXX	1,095	1277	N	NPI: Medicaid Number: 80021702 Base Number: 500013854	SKRIP, RICHARD E	N	11730 - Avulsion Of Nail Plate, Partial Or Compl	\$69.30	2	\$18.25
								99214 - Office Or Other Outpatient Visit For The	\$20.99	1	\$3.85
999999999	XXXXX XXXXXXXXX	2,537	2021	N	NPI: Medicaid Number: 80021702 Base Number: 500013854	SKRIP, RICHARD E	N	11730 - Avulsion Of Nail Plate, Partial Or Compl	\$69.30	2	\$10.85
								99214 - Office Or Other Outpatient Visit For The	\$20.99	1	\$3.85
999999999	XXXXX XXXXXXXXX	384	1931	N	NPI: Medicaid Number: 65925935 Base Number: 500009147	THE MEDICAL SPEC OF KY	N	99214 - Office Or Other Outpatient Visit For The	\$0.00	1	\$0.00

B

Report Notes

Report Description

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

Report Columns:

Member ID - Member ID

Member Full Name - Member name

Waiver Days - Days between the effective date of SCL Waiver and the latest cycle end date.

Hi Days - Days between the SNAP effective date and the SNAP end date or the latest cycle end date, whichever is less

Hi Intsty - High intensity indicator from SNAP file

Billing Provider Numbers - Billing provider Base, NPI, and Medicaid numbers

Billing Provider Name - Billing provider name

New Ind - Indicator set to 'Y' if the claim provider enrollment date >= 1/1/2000, otherwise set to 'N'

Primary Procedure Code & Description - The procedure from the claim

Paid Amount - Paid amount from the claim

Billed Qty - Number of items billed from the claim

Projected Yearly Cost - Paid Amount / Number of Hi Intensity Days truncated to 2 decimal places then multiplied by 365

Selection Criteria

Paid claims only

Latest claims only

From date of service is between SNAP effective and end dates

From date of service is during current fiscal year

Member has SCL Waiver program

Medical claims only (Claim type 'M' and 'B')

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

5.4.51.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Amount Paid	The paid amount for the service being reported.	13	Number (Decimal)	T_CA_ICN	AMT_PAID

Field	Description	Length	Data Type	DB Table	DB Attributes
Billed Qty	The total units of service for the service being reported.	5	Number (Integer)	T_CA_ICN	QTY_UNITS_BILLED
Billing Provider Name	The name of the provider who submitted the claim.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
Billing Provider Numbers	The provider number of the provider who submitted the claim.	10	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
Hi Days	The number of days the member has been Hi-intensity.	5	Number (Integer)	N/A	Calculated
Hi Intensity	High intensity indicator from snap file.	1	Char	N/A	Calculated
Member Full Name (L,FM)	Member name	28	Char	T_RE_BASE	NAM_FIRST,NAM_LAST ,NAM_MID_INIT
Member ID	Member Medicaid ID	12	Char	T_CA_ICN	ID_MEDICIAD
New Ind	Indicates if the provider is considered a 'new' provider.	1	Char	N/A	Calculated
Primary Procedure Code & Desc	The procedure code and description of the service being reported.	40	Char	T_CA_ICN, T_CDE_PROC	CD_PROC_PRIM DSC_PROC
Projected Yearly Cost	The projected yearly cost for the service being reported.	13	Number (Decimal)	N/A	Calculated
Waiv Days	The number of days the member has been SCL-eligible.	5	Number (Integer)	N/A	Calculated

5.4.51.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.52 DSS - School Based Procedure Code Summary

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

5.4.52.1 Technical Name

DSS - School Based Procedure Code Summary

5.4.52.2 Sort Order

Provider Description and Procedure Modifier.

5.4.52.3 School Based Procedure Code Summary Layout

A

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

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: qz00tr



School Based Procedure Code Summary

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

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

End of Report

B

Report Notes

Report Description

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

Search Criteria

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

5.4.52.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
First Modifier Code & Description	The procedure code modifier from the claim.	42	Char	T_CA_ICN, T_MODIFIER	CDE_MODIFIER_1 DSC_MODIFIER
Fourth Modifier Code & Description	The procedure code modifier from the claim.	42	Char	T_CA_ICN, T_MODIFIER	CDE_MODIFIER_4 DSC_MODIFIER

Field	Description	Length	Data Type	DB Table	DB Attributes
Paid Amount	The total claim paid amount for the procedure code.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
Primary Procedure Code & Desc	The procedure code and description of the procedure code on the claim	46	Char	T_CA_ICN, T_CDE_PROC	CDE_PROC DSC_PROC
Procedure Total	The total claim paid amount for the procedure code.	13	Number (Decimal)	N/A	Calculated
Report Total	The total claim paid amount for the entire report.	13	Number (Decimal)	N/A	Calculated
Second Modifier Code & Description	The procedure code modifier from the claim.	42	Char	T_CA_ICN, T_MODIFIER	CDE_MODIFIER_2 DSC_MODIFIER
Third Modifier Code & Description	The procedure code modifier from the claim.	42	Char	T_CA_ICN, T_MODIFIER	CDE_MODIFIER_3 DSC_MODIFIER

5.4.52.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.53 DSS - Support for Community Living Member

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

5.4.53.1 Technical Name

DSS - Support for Community Living Member

5.4.53.2 Sort Order

None

5.4.53.3 Support for Community Living Member Layout

A

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

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: qz00tr



Support for Community Living Member

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

Billing Provider Numbers	Billing Provider Name	Member ID	Member Full Name (L,FM)
NPI ID: 1000000124 Medicaid ID: 100068789A Base ID: 10006879	SMITH, MIKE	012345678	SMITH, SUE
Member ID Count: 1			
NPI ID: 1000000184 Medicaid ID: 100097069A Base ID: 10009707	SMITH, MIKE	012345678	SMITH, SUE
Member ID Count: 1			

End of Report

B**Report Notes**Report Description

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

Search Criteria

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

5.4.53.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Name	The name of the provider.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
Billing Provider Numbers	A unique number assigned by the state to each provider of services participating in <i>KY Medicaid</i>	15	Char	T_CA_PROV_KEY	D_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
Member Full Name (L,FM)	The name of the member.	36	Char	T_RE_BASE	NAM_LAST,NAM_FIRST,NAM_MID_INIT

Field	Description	Length	Data Type	DB Table	DB Attributes
Member ID	The Medicaid identification number for the member.	12	Char	T_CA_ICN	ID_MEDICAID

5.4.53.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.54 DSS - Unduplicated Members

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

5.4.54.1 Technical Name

DSS - Unduplicated Members

5.4.54.2 Sort Order

None

5.4.54.3 Unduplicated Members Layout

Run Date: 08/10/2006

Run Time: 9:05:32 AM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: tztsbl

A



Unduplicated Members

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

Nursing Home Member Count: 1

End of Report

Report Notes

B

Report Description

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

Search Criteria

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

5.4.54.4 Field Descriptions

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

5.4.54.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.55 DSS - University of Louisville Providers Billing Under FEIN 611014882

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

5.4.55.1 Technical Name

DSS - University of Louisville Providers

5.4.55.2 Sort Order

Provider Number.

5.4.55.3 University of Louisville Providers Billing Under FEIN 611014882 Layout

A

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

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: qzndgg



University of Louisville Providers Billing Under FEIN 611014882

For Month: February 2005

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

End of Report

B**Report Notes**Report Description

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

Search Criteria

Select paid claim amounts for providers billing under FEIN 611014882.

5.4.55.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider IDs	Billing provider number.	15	Char	T_CA_ICN	ID_PROV_BILL
Billing Provider Name	Billing provider full name.	50	Char	T_PR_SVC_LOC	NAME
MTD Paid	Month to date paid amount.	13	Number (Decimal)	T_CA_ICN	AMT_PAID
YTD Paid	Year to date paid amount.	13	Number (Decimal)	T_CA_ICN	AMT_PAID

5.4.55.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.56 DSSDM - EIS - Dashboard Measures

The Executive level Dashboard provides a broad view of *KY Medicaid* program status. The dashboard consists of the following analytics:

Durable Medical Equipment

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

Initiatives

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

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

KCHIP Member Counts

This analytic will count the number of children enrolled in Medicaid and KCHIP. The data will be broken down by KCHIP Phase III, KCHIP Phase II, and Non KCHIP Medicaid Children

KCHIP Paid Claims

This analytic will show paid amount for children enrolled in Medicaid and KCHIP Phase II and KCHIP Phase III

Nursing Facility and ICF/MR Paid Claims

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

Waiver Paid Claims

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

5.4.56.1 Technical Name

DSSDM - EIS - Dashboard Measures

5.4.56.2 Sort Order

N/A

5.4.56.3 DSSDM - EIS - Dashboard Measures Layout

InfoView - Microsoft Internet Explorer provided by EDS COE

CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM

Commonwealth of Kentucky

My InfoView Search title

Medicaid EIS Dashboard

Home

Durable Medical Goods

Nursing Facility and ICF/MR Paid Claims

Initiatives - Member Counts

Waiver Paid Claims

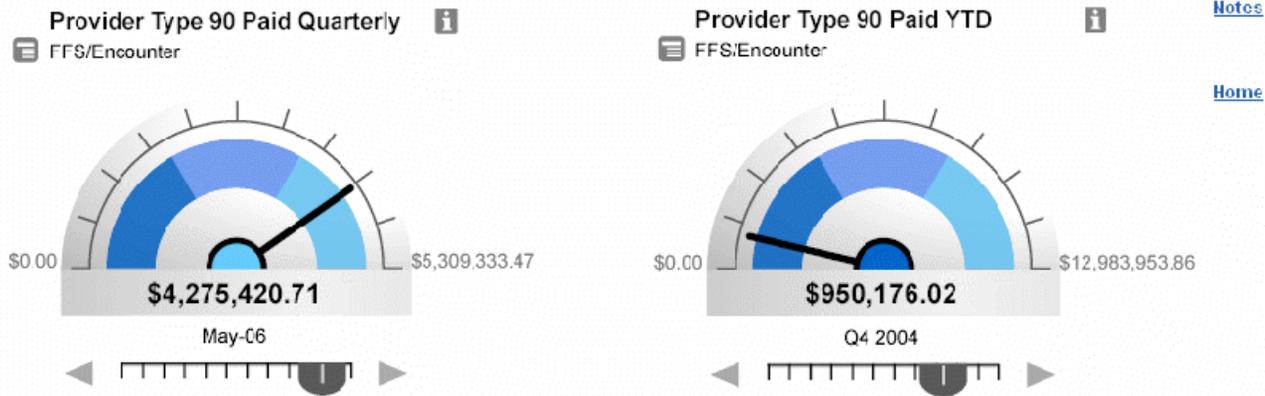
Initiatives - Paid Amounts

KCHIP Member Counts

KCHIP Paid Amounts

1

Durable Medical Goods



1.1

Notes

Durable Medical Goods Analytic Notes

Analytic Descriptor

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

Analytic Selection Criteria

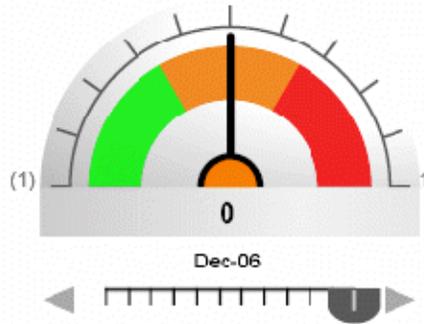
- Paid Claims Only
- Latest Claim Only
- Provider Type 90 (DME Supplier)

Press Backspace key to return to previous page

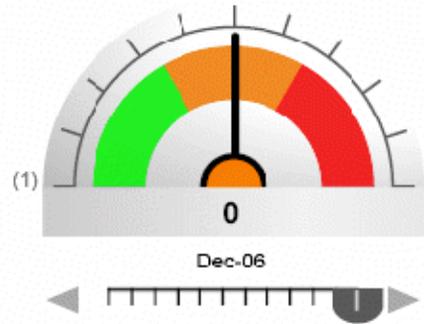
2

Initiatives Member Counts

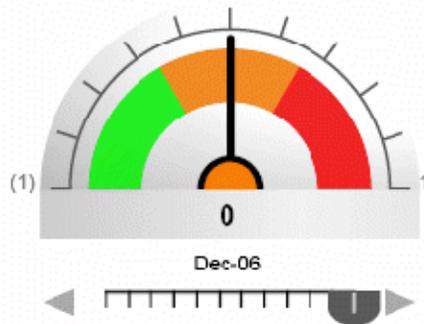
Heart Failure Member Count ⓘ
Billing Provider County



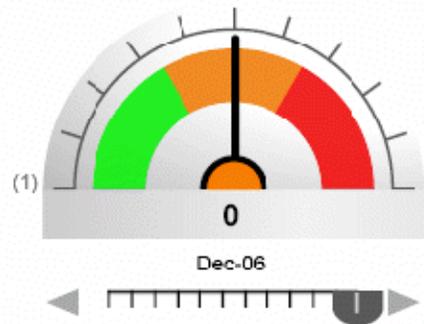
Adult Diabetes Member Count ⓘ
Billing Provider County



Pediatric Asthma Member Count ⓘ
Billing Provider County



Pediatric Obesity Member Count ⓘ
Billing Provider County



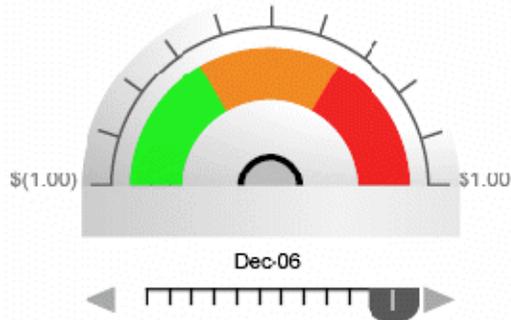
[Initiatives - Paid Amounts](#)

[Home](#)

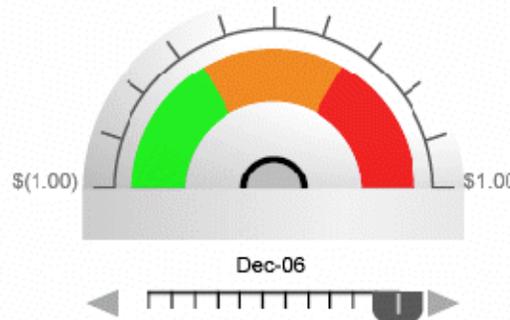
2.1

Initiatives - Paid Amounts

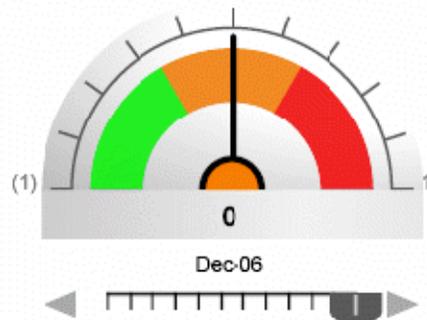
Heart Failure Paid Amount ⓘ
Billing Provider County



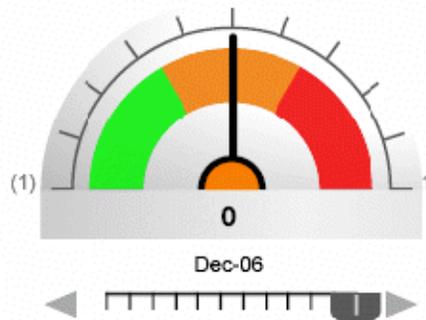
Adult Diabetes Paid Amount ⓘ
Billing Provider County



Pediatric Asthma Paid Amount ⓘ
Billing Provider County

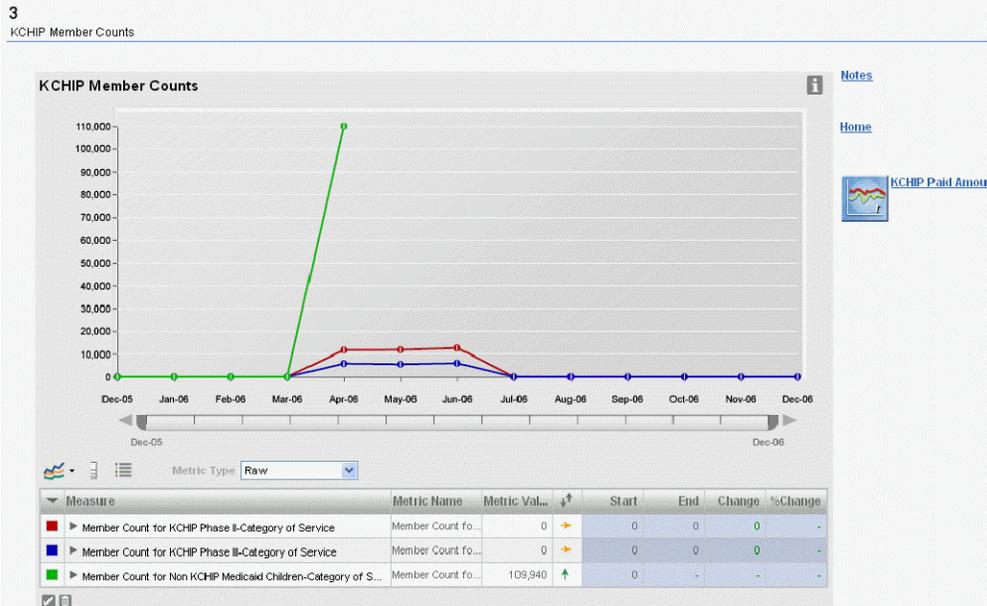


Pediatric Obesity Paid Amount ⓘ
Billing Provider County



[Initiatives - Member Counts](#)

[Home](#)



3.1

Notes

KCHIP Member Counts Analytic Notes

Analytic Description

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

Analytic Selection Criteria

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

KCHIP Phase III

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

KCHIP Phase II

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

Non KCHIP Medicaid Children

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

Press Backspace key to return to previous page

3.2



[KCHIP Paid Amounts Notes](#)

[Home](#)

[KCHIP Member Counts](#)

3.3

[KCHIP Paid Amounts Notes](#)

KCHIP Paid Amounts Analytic Notes

Analytic Description

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

Analytic Selection Criteria

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

KCHIP Phase III

- Aid Category Code is '1', 'P', or 'K'
- Program Status Code is 'P7'

KCHIP Phase II

- Aid Category Code is '1', 'P', or 'K'
- Program Status Code is 'P5' or 'P6'

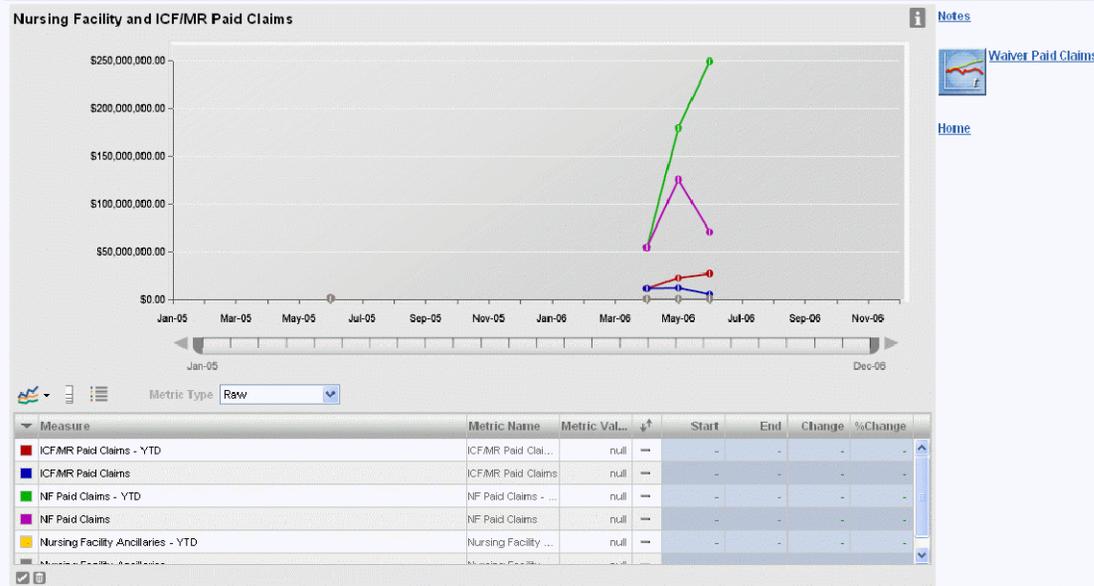
Non KCHIP Medicaid Children

- Aid Category Code is NOT '1', 'P', or 'K'
- Program Status Code is NOT 'P5', 'P6', or 'P7' for KCHIP III
- Age 17 or Less

Press backspace key to return to previous page

4

Nursing Facility and ICF/MR Paid Claims



4.1

Nursing Facility and ICF/MR Paid Claims Notes

Nursing Facility and ICF/MR Paid Claims Analytic Notes

Analytic Description

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

Analytic Selection Criteria

ICF/MR Paid Claims:

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

Nursing Facility Paid Claims:

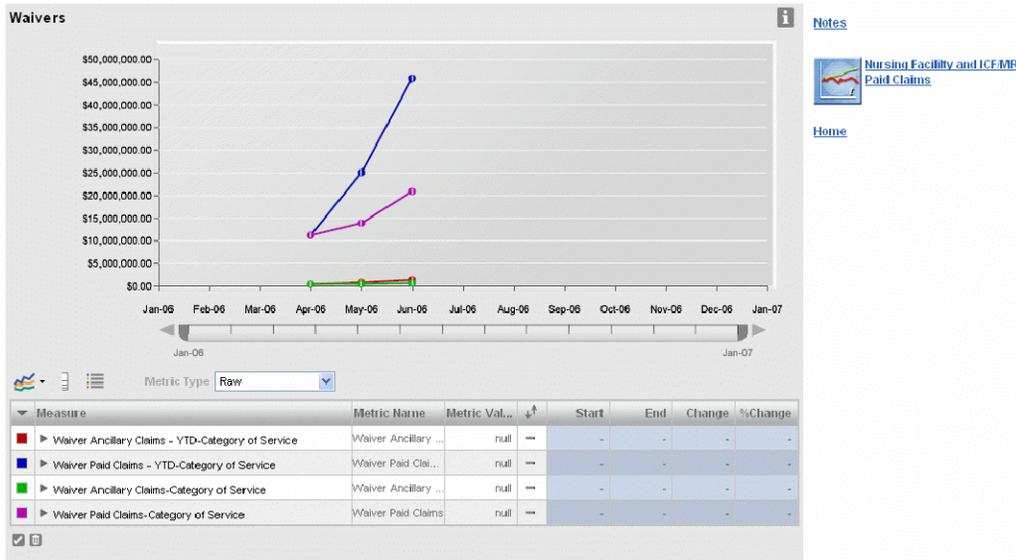
- Paid Claims Only
- Latest Claim Only
- Billing provider type is Nursing Facility (12)

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

- Paid Claims Only
- Latest Claim Only
- Billing provider type is Nursing Facility (12)
- Procedure code in S9129', 'S9131', 'S9128', '97001', '97002', '97003', '97004', '97010', '97012', '97014', '97016', '97018', '97020', '97022', '97024', '97026', '97028', '97032', '97033', '97034', '97035', '97036', '97039', '97110', '97112', '97113', '97116', '97124', '97139', '97140', '97150', '97504', '97520', '97530', '97532', '97533', '97535', '97537', '97542', '97545', '97546', '92507', or '92508
- or revenue code in '0979', '0440', '0441', '0442', '0443', '0444', '0449', '0277', '0544', '0413', or '0240'

5

Waiver Paid Claims



Notes
[Nursing Facility and ICFMR Paid Claims](#)
[Home](#)

5.1

Waiver Paid Claims Analytic Notes

Waiver Paid Claims Analytic Notes

Analytic Description

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

Analytic Selection Criteria

- Paid Claims Only
- Latest ClaimOnly

Waiver Paid Claims:

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

Waiver Ancillaries:

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

Press backspace key to return to previous page

5.4.56.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
No field names are included since the images shown are just examples of what the Dashboard can display.					

5.4.56.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.57 DSSMeasureBase - All Measure Summary

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

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

The tabs on this report are:

- A. Measure Summary -- Displays each measure and the number and percentage of the population meeting the criteria of each measure; and,
- B. Measure List -- Displays a listing of each measure source and measure description found on tab A.

5.4.57.1 Technical Name

DSSMeasureBase - All Measure Summary

5.4.57.2 Sort Order

Measure Code and Description.

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

5.4.57.3 DSSMeasureBase - All Measure Summary Layout

A

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

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv6vp



DSSMeasureBase
Summary of All Measures

Measure Summary

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

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

B

Run Date: 9/11/2006
Run Time: 4:33:58 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv0vp



DSSMeasureBase
Summary of All Measures

Measure List

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

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

C

Report Notes

Report Description

This report displays all pre-defined measures with the number and percentage of the population meeting the criteria of each measure.

The tabs on this report are:

- A. Measure Summary -- Displays each measure and the number and percentage of the population meeting the criteria of each measure.
- B. Measure List -- Displays a listing of each measure source and measure description found on tab A.

Search Criteria

None

5.4.57.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Denominator Count	The number of members meeting the high level selection criteria	6	Number	T_MB_CALC	CNT_DEN
(A) Measure Calculation Type Code and Description	Describes the method of calculation	20	Char	T_MB_CALC	CDE_CALC_TYPE
(A) Measure Code Long Description	Specific description of the measurement including high level selection parameters.	700	Char	T_MM_MEASURE_BASE	DSC_MEASURE_BASE
(A) Measure Domain	Indicates the generalized area the measurement is evaluating.	50	Char	T_MM_DOMAIN	DESC_DOMAIN
(A) Minimum Performance Standard	The minimum performance standard for the measure	4	Number	T_MB_DESC	MIN_PERF_STD

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Numerator Count	The number of members that received services defined in the measure criteria	6	Number	T_MB_CALC	T_MB_CALC
(A) Percent Meeting Measure Criteria	The percentage of members meeting the high level selection criteria that also received services defined in measure criteria.	5	Number	N/A	Calculated
(A) Percent Not Meeting Measure Criteria	The percentage of members meeting the high level selection criteria that did not receive services defined in the measure criteria.	5	Number	N/A	Calculated
(A) Target Value	The desired target value for the measurement criteria.	4	Number	T_MB_DESC	TARGET_VAL
(A, B) Measure Code and Description	Short description of the measurement.	200	Char	T_MM_MEASURE_BASE	MEASURE_BASE_NAME
(A, B) Measure Source	Indicates the source for the measurement criteria.	50	Char	T_MM_MEASURE_SOURCE	DESC_MEASURE_SOURCE

5.4.57.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.58 DSSMeasureBase - Measure Detail

The Measure Details report is created in the DSSMeasureBase. This report displays the count and percentage of members meeting the criteria of a selected measure. The information is calculated and displayed by several different criteria, including county, age, race, gender, eligibility category, member category, geographic service area, funding source, and health plan.

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

The tabs on this report are:

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

5.4.58.1 Technical Name

DSSMeasureBase - Measure Detail

5.4.58.2 Sort Order

Tab A: N/A, Tab B: N/A, Tab C: Member County Code, Tab D: Member Age, Tab E: Member Race Code, Tab F: Member Gender Code, Tab G: Member Aid Category Code and Tab H: Member Program Status Code.

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

5.4.58.3 DSSMeasureBase - Measure Detail Layout

A

Run Date: 9/13/2008
Run Time: 2:54:20 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv8vp



DSSMeasureBase
Measure Detail
Measure Summary

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

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

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

End of Report

B

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



Cabinet for Health and Family Services
Department for Medicaid Services

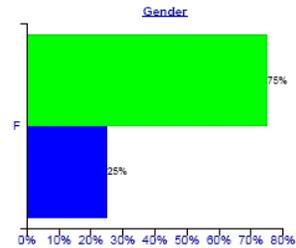
User ID: czv8vp

DSSMeasureBase
Measure Detail

Measure Summary Graphics

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

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

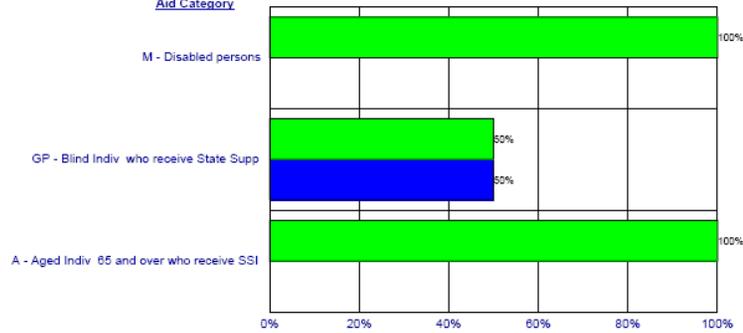


Run Date: 9/13/2006
Run Time: 2:54:20 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv8vp

Aid Category



End of Report

C

Run Date: 5/22/2007
Run Time: 2:49:21 PM

Cabinet for Health and Family Services Department for Medicaid Services

User ID: tztsbl



DSSMeasureBase Measure Detail

County Analysis

For Dates of Service (Core Measure Year): 01/01/2004 - 12/31/2004

Measure Code: 1 - HEDIS - CHILDHOOD IMMUNIZATION STATUS Combination 1

Member County Code and Description	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
001 - Adair	0	2	0.00%	0.28%	0.00%	100.00%
002 - Allen	0	5	0.00%	0.71%	0.00%	100.00%
003 - Anderson	0	2	0.00%	0.28%	0.00%	100.00%

D

Run Date: 9/13/2008
Run Time: 2:54:20 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv0vp



DSSMeasureBase
Measure Detail
Age Analysis

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

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

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

End of Report

E

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

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv0vp



DSSMeasureBase
Measure Detail

Race Analysis

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

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

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

End of Report

F

Run Date: 9/13/2008
Run Time: 2:54:20 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv6vp



DSSMeasureBase
Measure Detail
Gender Analysis

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

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

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

End of Report

G

Run Date: 9/13/2008
Run Time: 2:54:20 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv8vp



DSSMeasureBase
Measure Detail

Aid Category Analysis

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

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

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

End of Report

H

Run Date: 9/13/2008
Run Time: 2:54:20 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv8vp



DSSMeasureBase
Measure Detail

Program Status Analysis

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

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

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

End of Report

I

Report Notes

Report Description

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

The tabs on this report are:

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

B. Measure Summary Graphics -- Displays measure information in chart format by gender and aid category.

C. County Analysis -- Displays measure information by county.

D. Age Analysis -- Displays measure information by age.

E. Race Analysis -- Displays measure information by race.

F. Gender Analysis -- Displays measure information by gender.

G. Aid Category Analysis-- Displays measure information by aid category.

H. Program Status Analysis-- Displays measure information by Program Status.

Search Criteria

Measure Code as specified in the user prompt.

5.4.58.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Denominator Count	The number of members meeting the high level selection criteria	6	Number (Integer)	N/A	Calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Measure Calculation Type Code and Description	Describes the method of calculation	20	Char	T_MB_CALC	CDE_CALC_TYPE
(A) Measure Code and Description	Code and short description of the measurement.	200	Char	T_MM_MEASURE_BASE	MEASURE_BASE_NAME
(A) Measure Code Long Description	Specific description of the measurement including high level selection parameters.	100	Char	T_MM_MEASURE_BASE	DSC_MEASURE_BASE
(A) Measure Domain	Indicates the generalized area the measurement is evaluating.	50	Char	T_MM_DOMAIN	DEESC_DOMAIN
(A) Measure Source	Indicates the source for the measurement criteria.	50	Char	T_MM_MEASURE_SOURCE	DESC_MEASURE_SOURCE
(A) Minimum Performance Standard	The minimum performance standard for the measure.	4	Number (Integer)	N/A	Calculated
(A) Numerator Cnt	The number of members that received services defined in the measure criteria	6	Number (Integer)	N/A	Calculated
(A) Percent Meeting Measure Criteria	The percentage of members meeting the high level selection criteria that also received services defined in measure criteria.	5	Number (Decimal)	N/A	Calculated
(A) Percent Not Meeting Measure Criteria	The percentage of members meeting the high level selection criteria that did not receive services defined in the measure criteria. The percentage of members meeting the high level selection criteria that did not receive services defined in the measure criteria.	5	Number (Decimal)	N/A	Calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Target Value	The desired target value for the measurement criteria.	4	Number (Integer)	N/A	Calculated
(C) Member County Code and Description	The county code and description.	40	Char	T_RE_BASE_DN, T_COUNTY	CDE_COUNTY, DSC_COUNTY
(C-H) All Members For This Measure	The number of members meeting the high level selection criteria.	6	Number (Integer)	N/A	Calculated
(C-H) Members Meeting Criteria	The number of members that received services defined in the measure criteria.	6	Number (Integer)	N/A	Calculated
(C-H) Percent Meeting	The percentage of members meeting the high level selection criteria that also received services defined in measure criteria.	5	Number (Decimal)	N/A	Calculated
(C-H) Percent Not Meeting	The percentage of members meeting the high level selection criteria that did not receive services defined in the measure criteria.	5	Number (Decimal)	N/A	Calculated
(C-H) Percent Of ALL Members Meeting	The percentage of the total number of members meeting the measure criteria. That is, the percentage of the total for column "Members Meeting Criteria".	5	Number (Decimal)	N/A	Calculated
(C-H) Percent Of All Members	The percentage of the total number of members meeting the high level criteria. That is, the percentage of the total for column "All Members For This Measure".	5	Number (Decimal)	N/A	Calculated
(D) Member Age	The age of the members as of the end of the reporting period.	3	Number (Integer)	T_CA_ICN	NUM_RECIP_AGE

Field	Description	Length	Data Type	DB Table	DB Attributes
(E) Member Race Code and Description	The race code and description of the members.	20	Char	T_MB_NUM_RECIP	CDE_RACE DSC_RACE
(F) Member Gender Code	The gender of the members	1	Char	T_MB_NUM_RECIP	CDE_SEX
(G) Member Aid Category Code and Description	The aid category of the members as of the end of the reporting period.	40	Char	T_MB_NUM_RECIP	CDE_AID_CATEGORY
(H) Program Status Code and Description	The Programs status of the members as of the end of the reporting period.	40	Char	T_MB_NUM_RECIP	CDE_PGM_STATUS

5.4.58.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.59 DSSMeasureBase - Members Not Meeting

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

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

The tabs on this report are:

- A. All Members - Displays all members included in the report;
- B. Members by Race - Displays members for a selected race code within the selected measure;
- C. Members by County - Displays members for a selected county code within the selected measure; and,
- D. Report Notes

5.4.59.1 Technical Name

DSSMeasureBase - Members Not Meeting

5.4.59.2 Sort Order

Member ID.

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

5.4.59.3 DSSMeasureBase - Members Not Meeting Layout

A

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

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv8vp



DSSMeasureBase
Members Not Meeting

All Members

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

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

Member ID and Name	Member Mailing Address
012345678 - MIKE SMITH	MIKE SMITH 000 Main Street, Louisville, KY 40202
012345678 - MIKE SMITH	MIKE SMITH 000 Main Street, Louisville, KY 40202
012345678 - MIKE SMITH	MIKE SMITH 000 Main Street, Louisville, KY 40202
3	

B

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

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv8vp



DSSMeasureBase
Members Not Meeting
Members By Race

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

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

Member ID and Name	Member Mailing Address
012345678 – SMITH, MIKE	MIKE SMITH 123 Main Street, Louisville, KY 40202
012345678 – SMITH, MIKE	MIKE SMITH 123 Main Street, Louisville, KY 40202
012345678 – SMITH, MIKE	MIKE SMITH 123 Main Street, Louisville, KY 40202

End of Report

C

Run Date: 9/13/2008
Run Time: 4:07:10 PM

Cabinet for Health and Family Services Department for Medicaid Services

User ID: czv0vp



DSSMeasureBase Members Not Meeting Members By County

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

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

Member ID and Name	Member Mailing Address
000000000 - SMITH, JOHN	JOHN SMITH 123 Main Street, Salem, KY 97501
1	

End of Report

D

Report Notes

Report Description

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

The tabs on this report are:

- A. All Members - Displays all members included in the report.
- B. Members by Race - Displays members for a selected race code within the selected measure.
- C. Members by County - Displays members for a selected county code within the selected measure.

Search Criteria

Measure Code as specified in the user prompt.

5.4.59.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A-C) Member ID and Name	The ID and name of the member.	50	Char	T_RE_BASE	NAM_LAST,NAM_FIRST,NAM_MID_INIT,ID_MEDICAID
(A-C) Member Mailing Address	The ID, name, and full address of the member.	200	Char	T_RE_BASE	ADR_STREET_1,ADR_STREET_2,ADR_CITY,ADR_STATE,ADR_ZIP_CODE

5.4.59.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.60 DSSMeasureBase - Multiple Measure Details

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

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

The tabs on this report are:

- A. Measure Summary -- Displays the selected measures and the number and percentage of members meeting the criteria of the selected measures;
- B. Measure Summary Graphic
- C. County Analysis -- Displays measure information by selected county;
- D. Age Analysis -- Displays measure information by selected age;
- E. Race Analysis -- Displays measure information by selected race;
- F. Gender Analysis -- Displays measure information by selected gender;
- G. Aid Category -- Displays measure information by selected eligibility aid category;
- H. Program Status -- Displays measure information by selected program status;
- I. Report Notes

5.4.60.1 Technical Name

DSSMeasureBase - Multiple Measure Details

5.4.60.2 Sort Order

Measure Code.

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

5.4.60.3 DSSMeasureBase - Multiple Measure Details Layout

A

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

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv0vp



DSSMeasureBase
Multiple Measure Detail
Measure Summary

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

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

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

End of Report

B

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



Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv6vp

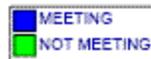
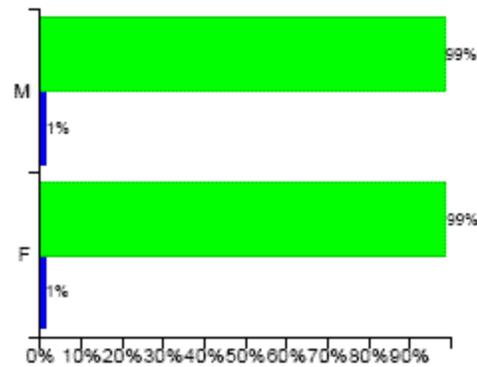
DSSMeasureBase
Multiple Measure Detail

Measure Summary Graphics

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

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

Gender

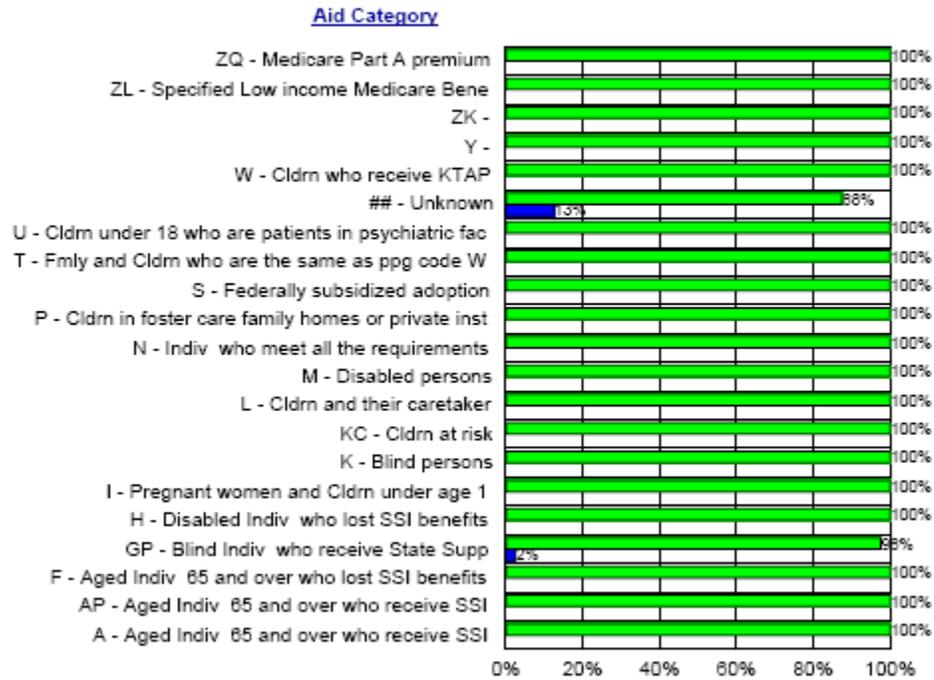


B

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

User ID: czv8vp

**Cabinet for Health and Family Services
Department for Medicaid Services**



End of Report

C

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

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv0vp



DSSMeasureBase
Multiple Measure Detail
County Analysis

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

County: All

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

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

End of Report

D

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

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv6vp



DSSMeasureBase
Multiple Measure Detail

Age Analysis

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

Age: All

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

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

End of Report

E

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

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv0vp



DSSMeasureBase
Multiple Measure Detail

Race Analysis

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

Race: All

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

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

End of Report

F

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: czvövp

Run Date: 9/13/2008
Run Time: 2:44:36 PM



**DSSMeasureBase
Multiple Measure Detail
Gender Analysis**

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

Gender: All

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

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

End of Report

G

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

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv8vp



DSSMeasureBase
Multiple Measure Detail

Aid Category Analysis

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

Aid Category: All

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

Measure Code and Description	Members Meeting Criteria	All Members for This Measure	Percent of All Members Meeting	Percent of All Members	Percent Meeting	Percent Not Meeting
38 - HEDIS ADULT ACCESS TO PREVENTIVE/AMBULATORY CARE	1	155	100.00 %	100.00 %	0.85 %	99.35 %
82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA	1	4	100.00 %	100.00 %	25.00 %	75.00 %
Totals:	2	159	100.00 %	100.00 %	1.26 %	98.74 %

End of Report

H

Run Date: 9/13/2008
Run Time: 2:44:36 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv0vp



DSSMeasureBase
Multiple Measure Detail
Program Status Analysis

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

Program Status: AA

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

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

End of Report

I

Report Notes

Report Description

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

The tabs on this report are:

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

B. Measure Summary Graphics -- Displays measure information in chart format by gender and aid category.

C. County Analysis -- Displays measure information by county.

D. Age Analysis -- Displays measure information by age.

E. Race Analysis -- Displays measure information by race.

F. Gender Analysis -- Displays measure information by gender.

G. Aid Category Analysis-- Displays measure information by aid category.

H. Program Status Analysis-- Displays measure information by Program Status.

Search Criteria

Measure Code as specified in the user prompt.

5.4.60.4 Field Descriptions

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

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Measure Code and Description	Code and short description of the measurement.	200	Char	T_MM_MEASURE_BASE	MEASURE_BASE_NAME
(A) Measure Code and Long Description	Specific description of the measurement including high level selection parameters.	700	Char	T_MM_MEASURE_BASE	DSC_MEASURE_BASE
(A) Measure Domain	Indicates the generalized area the measurement is evaluating.	50	Char	T_MM_DOMAIN	DESC_DOMAIN
(A) Measure Source	Indicates the source for the measurement criteria.	50	Char	T_MM_MEASURE_SOURCE	DESC_MEASURE_SOURCE
(A) Minimum Performance Standard	The minimum performance standard for the measure.	4	Number	N/A	Calculated
(A) Numerator Count	The number of members that received services defined in the measure criteria	6	Number	N/A	Calculated
(A) Percent Meeting Measure Criteria	The percentage of members meeting the high level selection criteria that also received services defined in measure criteria.	5	Number	N/A	Calculated
(A) Percent Not Meeting Measure Criteria	The percentage of members meeting the high level selection criteria that did not receive services defined in the measure criteria.	5	Number	N/A	Calculated
(A) Target Value	The desired target value for the measurement criteria.	4	Number	N/A	Calculated
(B) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all counties.	5	Number	N/A	Calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
(B) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all counties.	5	Number	N/A	Calculated
(B-H) All Members For This Measure	The number of members meeting the high level selection criteria.	6	Number	N/A	Calculated
(B-H) Measure Code and Description	Short description of the measurement.	200	Char	T_MM_MEASURE_BASE	MEASURE_BASE_NAME
(B-H) Members Meeting Criteria	The number of members that received services defined in the measure criteria.	6	Number	N/A	Calculated
(B-H) Percent Meeting	The percentage of members meeting the high level selection criteria that also received services defined in measure criteria.	5	Number	N/A	Calculated
(B-H) Percent Not Meeting	The percentage of members meeting the high level selection criteria that did not receive services defined in the measure criteria.	5	Number	N/A	Calculated
(B-H) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all ages.	5	Number	N/A	Calculated
(C) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all ages.	5	Number	N/A	Calculated
(D) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all races.	5	Number	N/A	Calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
(D) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all races.	5	Number	N/A	Calculated
(E) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all genders.	5	Number	N/A	Calculated
(E) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all genders.	5	Number	N/A	Calculated
(F) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all eligibility categories.	5	Number	N/A	Calculated
(F) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all eligibility categories.	5	Number	N/A	Calculated
(G) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all member categories.	5	Number	N/A	Calculated
(G) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all member categories.	5	Number	N/A	Calculated
(H) Percent Of All Members	The percentage of the total number of members meeting the high level selection criteria for all geographic service areas.	5	Number	N/A	Calculated

Field	Description	Length	Data Type	DB Table	DB Attributes
(H) Percent Of Members Meeting	The percentage of the total number of members meeting the high level selection criteria and the measure criteria for all geographic service areas.	5	Number	N/A	Calculated

5.4.60.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.61 DSSMeasureBase - Numerator Details

The Numerator Details report is created in the DSSMeasureBase. This report provides claim level detail for members who meet the criteria of the selected measure. The Numerator Details report allows for review of the underlying detail that supports a member meeting the measurement criteria. The report includes claim level information such as billing provider, servicing provider, diagnosis, procedure code, etc.

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

The tabs on this report are:

- A. Numerator Details - Displays all numerator details for the selected measure;
- B. Summary by Servicing Provider - Displays summary of numerator details by servicing provider;
- C. Summary by Member - Displays summary of numerator details by member.
- D. Report Notes

5.4.61.1 Technical Name

DSSMeasureBase - Numerator Details

5.4.61.2 Sort Order

Tab A: Claim Number, Tab B: Servicing Provider Number and Tab C: Member ID.

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

5.4.61.3 DSSMeasureBase - Numerator Details Layout

A

Run Date: 10/23/2008
Run Time: 3:48:11 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv0vp



DSSMeasureBase
Numerator Details

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

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

Claim Number	Claim Type & Description	Member ID	Member Full Name	Age	Aid Category Code & Desc	Program Status Code & Desc	Primary Diagnosis Code & Desc
0123456789123	M - HCFA 1500 CLAIMS	012345678	JONES, SAM	48	GP - Blind indiv who rec State Suppl	-	V581 - CHEMOTHERAPY

Billing Provider Numbers		Billing Provider Name	Servicing Provider Numbers		Servicing Provider Name
NPI: 1000000176 Medicaid Number: 100094589A Base Number: 100094589		JONES, SUE	NPI: 1000000176 Medicaid Number: 100094589A Base Number: 100094589		SMITH, ROBERT

Detail Number	From Date of Service	To Date of Service	Billed Amount	Allowed Amount	Paid Amount	Procedure Code & Desc
1	03/25/2004	03/25/2004	\$0.00	\$0.00	\$0.00	99282 - Emergency Department Visit For The Evalu
2	03/26/2004	03/26/2004	\$200.00	\$0.00	\$0.00	99212 - Office Or Other Outpatient Visit For The

Claim Number	Claim Type & Description	Member ID	Member Full Name	Age	Aid Category Code & Desc	Program Status Code & Desc	Primary Diagnosis Code & Desc
0123456789012	A - UB92 INST XOVER CLAIMS	000001348	JONES, SAM	35	L - Chldrn and their caretaker rel	-	95901 - HEAD INJURY, UNSPECIFIED

Billing Provider Numbers		Billing Provider Name	Servicing Provider Numbers		Servicing Provider Name
NPI: 1000000359 Medicaid Number: 100195389B Base Number: 100195389		SEAMORE X-RAY CLINIC	NPI: ##### Medicaid Number: ##### Base Number: #####		

Detail Number	From Date of Service	To Date of Service	Billed Amount	Allowed Amount	Paid Amount	Procedure Code & Desc
1	08/01/2004	08/01/2004	\$1,000.00	\$0.00	\$0.00	#### -
2	08/01/2004	08/01/2004	\$50.00	\$0.00	\$0.00	72010 - Radiologic Examination, Spine, Entire, S

Total Members: 2
Total Claim/Encounters: 2

B

Run Date: 10/23/2008
Run Time: 3:48:11 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: czv8vp



**DSSMeasureBase
Numerator Details**

Summary by Servicing Provider

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

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

Servicing Provider Numbers	Servicing Provider Name	Billed Amount	Allowed Amount	Paid Amount	Member Count
NPI: 1000000176 Medicaid Number: 100094589A Base Number: 100094589	ROBERTS, TRINA O	\$200.00	\$0.00	\$0.00	1
NPI: ##### Medicaid Number: ##### Base Number: #####		\$1,050.00	\$0.00	\$0.00	1
	Sum:	\$1,250.00	\$0.00	\$0.00	2

End of Report

C

Run Date: 10/23/2008
Run Time: 3:48:11 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv6vp



DSSMeasureBase
Numerator Details
Summary by Member

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

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

Member ID and Name	Billed Amount	Allowed Amount	Paid Amount	Member Count
999999999 - XXXXX XXXXXXXXX	\$1,050.00	\$0.00	\$0.00	1
	\$200.00	\$0.00	\$0.00	1
Sum:	\$1,250.00	\$0.00	\$0.00	2

End of Report

D**Report Notes**Report Description

This report provides claim level detail for members who meet the criteria of the selected measure. The Numerator Details report allows for review of the underlying detail that supports a member meeting the measurement criteria. The report includes claim level information such as billing provider, servicing provider, diagnosis, procedure code, etc.

The tabs on this report are:

- A. Numerator Details - Displays all numerator claim details for the selected measure.
- B. Summary by Servicing Provider - Displays summary of numerator details by servicing provider.
- C. Summary by Member - Displays summary of numerator details by member.

Search Criteria

Measure Code as specified in the user prompt.

5.4.61.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Age	The age of the member.	3	Number	T_CA_ICN	NUM_RECIP_AGE
(A) Aid Category Code & Desc	The member's eligibility category code and the corresponding description.	55	Char	T_CA_RECIP_KEY	CDE_AID_CATEGORY DSC_AID_CATEGORY
(A) Allowed Amount	The amounts allowed of the claim.	13	Number	T_CA_ICN	AMT_ALLOWED
(A) Billed Amount Sum	The amounts billed of the claim.	13	Number	T_CA_ICN	AMT_BILLED
(A) Billing Provider Numbers	The billing provider number.	10	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Claim Number	The ICN, or specific number assigned a claim to allow tracking of claim.	13	Number	T_CA_ICN	NUM_ICN
(A) Claim Type & Description	The claim type from the claim and the corresponding description.	53	Char	T_CA_CLAIM_KEY	CDE_CLM_TYPE DSC_CLM_TYPE
(A) Detail Number	The detail number of the claim.	4	Number	T_CA_ICN	NUM_DTL
(A) From Date Of Service	The from date of service of the claim detail record in MM/DD/YYYY format.	10	Char	T_CA_ICN	DTE_FIRST_SVC
(A) Member Full Name	The full member name in Last name and First name and middle initial format.	50	Char	T_RE_BASE	NAM_LAST, NAM_FIRST, NAM_MID_INIT
(A) Member ID	The member prime ID.	12	Char	T_RE_BASE	ID_MEDICAID
(A) Paid Amount Sum	The amounts paid of the claim.	13	Number	T_CA_ICN	AMT_PAID
(A) Primary Diagnosis Code & Desc	The primary diagnosis code and the corresponding description.	49	Char	T_CA_ICN T_DIAGNOSIS	CDE_DIAG_PRIM DSC_25
(A) Procedure Code & Desc	The procedure code and the corresponding description.	48	Char	T_CA_ICN T_PROC	CDE_PROC_PRIM DSC_PROCEDURE
(A) Program Status Code & Desc	The member's program code and the corresponding description.	55	Char	T_CA_RECIP_KEY	CDE_PGM_STATUS DSC_PGM_STATUS
(A) Servicing Provider Name	The servicing provider full name in last name, first name and middle initial name format.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
(A) Servicing Provider Numbers	The servicing provider number.	10	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) To Date Of Service	The to date of service of the claim detail record in MM/DD/YYYY format.	10	Char	T_CA_ICN	DTE_LAST_SVC
(A) Total Claim/Encounters	The total number of claim/encounters for a selected measure listed on the report.	9	Number	N/A	Calculated
(A) Total Members	The total number of members for a selected measure listed on the report.	9	Number	N/A	Calculated
(B) Servicing Provider Name	The servicing provider full name in last name, first name and middle initial name format.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
(B) Servicing Provider Numbers	The servicing provider number.	10	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
(B-C) Allowed Amount	The amount allowed for services.	13	Number	T_CA_ICN	AMT_ALWD
(B-C) Billed Amount	The amount billed for services.	13	Number	T_CA_ICN	AMT_BILLED
(B-C) Member Count	The number of unduplicated members.	6	Number	N/A	calculated
(B-C) Paid Amount Sum	The amount paid by the Health Plan for services.	13	Number	T_CA_ICN	AMT_PAID
(C) Member ID and Name	The member ID and name.	63	Char	T_RE_BASE	NAM_LAST, NAM_FIRST, NAM_MID_INIT
Billing Provider Name	The billing provider full name in last name, first name and middle initial name format.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER

5.4.61.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.62 DSSMeasureBase - Numerator Members

The Numerator Members report is created in the DSSMeasureBase. This report displays names and addresses of all members who meet the criteria of the selected measure. It allows the user to develop a mailing list for these members.

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

The tabs on this report are:

- A. All Members - Displays all members for the selected measure;
- B. Drill by Race - Displays members for a selected race code within the selected measure;
- C. Drill by County - Displays members for a selected county code within the selected measure; and,
- D. Report Notes

5.4.62.1 Technical Name

DSSMeasureBase - Numerator Members

5.4.62.2 Sort Order

Member ID.

5.4.62.3 DSSMeasureBase - Numerator Members Layout

A

Run Date: 9/13/2008
Run Time: 4:07:49 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv8vp



DSSMeasureBase
Numerator Members

All Members

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

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

Member ID and Name	Member Mailing Address
012345678 - ROBERTS, SAM	ROBERTS, SAM 1257 Main Street, Portland, KY 40000
1	

End of Report

B

Run Date: 9/13/2006
Run Time: 4:07:49 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: czv8vp



DSSMeasureBase
Numerator Members
Members By Race

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

Measure Code: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA
Race code: O - White (Non-Hispanic)

Member ID and Name	Member Mailing Address
012345678 - ROBERTS, SAM	ROBERTS, SAM 1257 Main Street, Portland, KY 40000
1	

End of Report

C

Run Date: 9/13/2008
Run Time: 4:07:49 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: czv8vp



**DSSMeasureBase
Numerator Members
Members By County**

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

Measure: 82 - INPATIENT UTILIZATION - GENERAL HOSPITAL/ACUTE CA
County: 055 - Jackson

Member ID and Name	Member Mailing Address
012345678 - ROBERTS, SAM	ROBERTS, SAM 1257 Main Street, Portland, KY 40000
1	

End of Report

D

Report Notes

Report Description

This report displays names and addresses of all members who meet the criteria of the selected measure. It allows the user to develop a mailing list for these members.

The tabs on this report are:

- A. All Members - Displays all members included in the report.
- B. Members by Race - Displays members for a selected race code within the selected measure.
- C. Members by County - Displays members for a selected county code within the selected measure.

Search Criteria

Measure Code as specified in the user prompt.

5.4.62.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A-C) Mailing Address	The ID, name, and full address of the member.	200	Char	T_RE_BASE	ADR_STREET_1,ADR_STREET_2,ADR_CITY,ADR_STATE,ADR_ZIP_CODE
(A-C) Member ID and Name	The ID and name of the member.	63	Char	T_RE_BASE	NAM_LAST,NAM_FIRST,NAM_MID_INIT,ID_MEDICAID

5.4.62.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.63 EIS - Drug Company File Listing

The EIS - Drug Company File Listing report contain two tabs. The first, Drug Company File Listing by Name, sorts manufacturers in alphabetical order. The second, Drug Company File Listing by Code, sorts by manufacturer code.

5.4.63.1 Technical Name

EIS - Drug Company File Listing

5.4.63.2 Sort Order

Tab A: Labeler Code and Tab B: Labeler Name.

5.4.63.3 EIS - Drug Company File Listing Layout**A**Run Date: 08/29/2006
Run Time: 4:59:41 PM**Cabinet for Health and Family Services**

User ID: wzrdmh

Department For Medicaid Services**Drug Company File Listing****Drug Company File Listing By Code**

Labeler Code	Labeler Name
00003	E.R. SQUIBB & SONS, INC.
00004	HOFFMANN-LA ROCHE
00005	LEDERLE LABORATORIES
00006	MERCK & CO., INC.
00007	NOVARTIS
00008	WYETH LABORATORIES
00009	PFIZER, INC
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS
00013	PFIZER, INC.
00014	PHARMACIA CORPORATION

B

Run Date: 08/29/2006
Run Time: 4:59:41 PM

Cabinet for Health and Family Services

User ID: wzrdmh

Department For Medicaid Services



Drug Company File Listing By Name

Labeler Name	Labeler Code
ABLE LABORATORIES INC.	53265
ABRIKA PHARMACEUTICALS, LLLP	67767
ACCUMED PHARMACEUTICALS, INC.	60876
ACORDA THERAPEUTICS, INC.	10144
ACTELION PHARMACEUTICALS	66215
ADAMS LABORATORIES, INC.	63824
ADH HEALTH PRODUCTS, INC.	60142
ADVANCED NUTRITIONAL BANNER PHARMACAPS	10888
ADVANCED REMEDIES INCORPORATED	57685
ADVANCED VISION RESEARCH	58790
ADVANCE PHARMACEUTICALS, INC.	17714
ADVANCIS PHARMACEUTICAL CORPORATION	11042

5.4.63.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A-B)Labeler Code	This code is used to uniquely identify the labeler of a drug. This code is assigned by CMS and is used as the first 5 characters of the labeler's NDCs.	5	Char	T_DRUG_LBLR	CDE_LABELER
(A-B)Labeler Name	The name of the drug labeler.	39	Char	T_DRUG_LBLR	NAME

5.4.63.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.64 EIS - Member History

The EIS - Member history report contains seven tabs. The first tab represent detailed information on the ICNs for a specific member. The next three tabs show summary information on medical visits, ER visits and perscriptions for that member. The next three tabs show address information for the medical providers, outpatient providers and pharmacy providers who have serviced that member. The last tab presents report notes.

- A. ICN Information - represents the detailed information of the ICN for a specific member.
- B. Summary of Medical Visits- shows the medical visits that a member has made.
- C. Summary of ER Visits - shows the ER visits that a member has made.
- D. Summary of Prescriptions - shows a summary of the prescriptions for a member.
- E. Medical Provider Address Listing - shows the medical provider address listing for a specific member.
- F. Outpatient Provider Address Listing - shows the outpatient provider address listing for a specific member.
- G. Pharmacy Provider Address Listing - shows the pharmacy provider address listing for a specific member.

5.4.64.1 Technical Name

EIS - Member History

5.4.64.2 Sort Order

Tab A: ICN, Tab B: FDOS, Tab C: FDOS, Tab D: Dispensed Date, NDC Code and Description.

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

5.4.64.3 EIS - Member History Layout

A

Run Date: 10/11/2006
 Run Time: 12:28:14 PM

**Cabinet for Health and Family Services
 Department for Medicaid Services**

User ID: rztldy



**Member History
 ICN Information**

Member ID:

From Dates of Service: 01/01/1996 - 12/01/2006

ICN	Claim Type & Description	FDOS	TDOS	Billed Quantity	Billed Amount	Allowed Amount	Reimbursed Amount	Paid Count	Denied Count	Total Claim Count
	D - COMPOUND DRUG CLAIMS	03/05/2003	03/05/2003	1	\$275.00	\$133.74	\$231.74	1	0	1
	P - PHARMACY CLAIMS	07/16/2002	07/16/2002	1	\$35.00	\$2,103.00	\$13.00	1	0	1
	P - PHARMACY CLAIMS	04/01/2003	04/01/2003	1	\$25.00	\$934.00	\$19.00	1	0	1
	P - PHARMACY CLAIMS	07/16/2002	07/16/2002	1	\$35.00	\$2,103.70	\$13.00	1	0	1
	P - PHARMACY CLAIMS	04/01/2003	04/01/2003	1	\$25.00	\$934.98	\$19.00	1	0	1
	Q - COMPOUND DRUG CLAIMS	03/05/2003	03/05/2003	3	\$0.00	\$133.00	\$231.74	3	0	3
	Q - COMPOUND DRUG CLAIMS	03/05/2003	03/05/2003	1	\$275.00	\$0.00	\$0.00	0	1	1

B

Run Date: 10/11/2006
 Run Time: 12:28:14 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: rztdly



Member History
Summary of Medical Visits

Member ID:

From Dates of Service: 01/01/1996 - 12/01/2006

FDOS	Billing Provider Numbers	Billing Provider Name	Primary Diagnosis Code & Desc	Primary Procedure Code & Desc
07/16/2002	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	07882 - EPIDEMIC VOMITING SYND	99211 - Office Or Other Outpatient Visit For The
03/05/2003	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	07882 - EPIDEMIC VOMITING SYND	99211 - Office Or Other Outpatient Visit For The
03/05/2003	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	07882 - EPIDEMIC VOMITING SYND	10160 - Puncture Aspiration Of Abscess, Hematoma
03/05/2003	NPI: Medicaid Number: Base Number:		78660 -	71030 - Radiologic Examination, Chest; Complete

C

Run Date: 10/11/2006
 Run Time: 12:28:14 PM

Cabinet for Health and Family Services
 Department for Medicaid Services

User ID: rztdly



Member History
 Summary of ER Visits

Member ID:
From Dates of Service: 01/01/1996 - 12/01/2006

FDOS	Billing Provider Numbers	Billing Provider Name	Primary Diagnosis Code & Desc	Primary Procedure Code & Desc
08/13/2002	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	1965 - MAL NEO LYMPH-INGUIN/LEG	##### -
		Total Billing Providers:	1	
		Total Number:	1	

D

Run Date: 10/11/2006
 Run Time: 12:28:14 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: rztldj



Member History
Summary of Prescriptions

Member ID:
From Dates of Service: 01/01/1996 - 12/01/2006

Dispensed Date	NDC Code & Description	Quantity Dispensed	Days Supply	Prescription Number	Billing Provider Numbers	Billing Provider Name	Prescribing Provider Numbers	Prescribing Provider Name
07/16/2002	00088120865 - ANZEMET	90	30	2368146	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	NPI: 1000000125 Medicaid Number: 100070859 Base Number: 10007086	NEWLAND, MARK S
03/05/2003	##### -	10	10	2587113	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	NPI: 1000000125 Medicaid Number: 100070859 Base Number: 10007086	NEWLAND, MARK S
03/05/2003	00078024115 - SANDIMMUNE	10	10	2587113	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	NPI: 1000000125 Medicaid Number: 100070859 Base Number: 10007086	NEWLAND, MARK S
03/05/2003	00088120865 - ANZEMET	10	10	2587113	NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	NPI: 1000000125 Medicaid Number: 100070859 Base Number: 10007086	NEWLAND, MARK S

E

Run Date: 10/11/2006
Run Time: 12:28:14 PM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: rztdly



Member History

Medical Provider Address Listing

Member ID:

From Dates of Service: 01/01/1996 - 12/01/2006

Billing Provider Numbers	Provider Name	Street Address	City, State and Zip Code	Billing Prov Specialty Code & Desc	Billing Provider Type Code & Desc
NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	3031 NE 1ST ST	PORTLAND, OR 97501-0000	250 - DME/Medical Supply Dealer	25 - DME/Medical Supply Dealer

End of Report

F

Run Date: 10/11/2006
 Run Time: 12:28:14 PM

Cabinet for Health and Family Services
 Department for Medicaid Services

User ID: rztdly



Member History
 Outpatient Provider Address Listing

Member ID:
From Dates of Service: 01/01/1996 - 12/01/2006

Billing Provider Numbers	Provider Name	Street Address	City, State, Zip Code	Billing Prov Specialty Code & Desc	Billing Provider Type Code & Desc
NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	5906 PARK AVE DROP CODE 10412	SALEM, OR 97501-8184	016 - Emergency	01 - Hospital

End of Report

G

Run Date: 10/11/2006
 Run Time: 12:28:14 PM

Cabinet for Health and Family Services
Department for Medicaid Services
Member History
Pharmacy Provider Address Listing

User ID: rztdly



Member ID:

From Dates of Service: 01/01/1996 - 12/01/2006

Billing Provider Numbers	Billing Provider Name	Street Address	City, State and Zip Code	Billing Prov Specialty Code & Desc	Billing Provider Type Code & Desc
NPI: 1000000335 Medicaid Number: 100191749B Base Number: 10019175	SMITH, JOHN D	5871 NE 1ST ST MAIL STOP 10351	PORTLAND, KY 97501-	318 - General Practitioner	64 - Physician Individual

H

Report Notes

Report Description

This report contains seven tabs. The first represents the detailed information of the ICN for a specific recipient. The second shows the medical visits that a recipient has done. The third shows the ER visits that a recipient has done. The fourth tab shows the summary prescriptions for a recipient. The fifth shows the medical provider address listing for a specific recipient. The sixth shows the outpatient provider address listing for a specific recipient the last tab shows the Pharmacy Provider Address Listing.

Search Criteria:

Member ID specified by the user in a prompt.

From date of service range specified by the user in a prompt.

5.4.64.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Allowed Amount	Total amount approved to pay for services provided to a member. This is the amount before copay and TPL are taken out.	13	Number	T_CA_ICN	AMT_ALWD
(A) Billed Amount	Amount of money requested for payment by a provider for services rendered to a member. Amount of money requested for payment by a provider for services rendered to a member.	13	Number	T_CA_ICN	AMT_BILLED

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Billed Quantity	The units of service billed for payment.	9	Number	T_CA_ICN	QTY_UNITS_BILLED
(A) Claim Type & Description	Displays the claim type which is a code to indicate the type of medical assistance invoice used by the provider to bill for the rendered service and description of that claim type.	51	Char	T_CA_ICN	CDE_CLM_TYPE, DSC_CLM_TYPE
(A) Denied Count	Counts the claim as a denied claim.	13	Number	T_CA_ICN	CNT_CLAIMS_DENIED
(A) ICN	Unique control number assigned to the invoice to allow tracking through the system. Sort order: (A) 1	13	Char	T_CA_ICN	NUM_ICN
(A) Paid Count	Counts the claims as a paid claim.	13	Number	T_CA_ICN	CNT_CLAIMS_PAID
(A) Reimbursed Amount	This is the same as reimbursed amount.	13	Number	T_CA_ICN	AMT_PAID
(A) TDOS	Day procedure was finished.	10	Date (MM/DD/CC YY)	T_CA_ICN	DTE_LAST_SVC
(A) Total Claim Count	Summarized paid and denied claim counts.	13	Number	N/A	Calculated
(A,B,C) FDOS	Day procedure was started. Sort order: (B,C) 1	10	Date (MM/DD/CC YY)	T_CA_ICN	DTE_FIRST_SVC
(B,C) Primary Diagnosis Code & Desc	The primary ICD-9-CM diagnosis code and description.	40	Char	T_CA_ICN	CDE_DIAG_PRIM

Field	Description	Length	Data Type	DB Table	DB Attributes
(B,C) Primary Procedure Code & Desc	The description associated with the primary procedure code.	40	Char	T_CA_ICN	CD_PROC_PRIM
(B,C,E,F,G) Billing Provider Name	The name associated with the organization or person.	50	Char	T_PR_SVC_LOC	NAME
(B,C,E,F,G) Billing Provider Numbers	The concatenation of Provider ID provider ID and service location. Sort order: (B,C) 2, (E,F,G) 1	10	Char	T_CA_ICN	ID_PROV_BILL,CDE_SVC_LOCN
(C) Total Billing Providers	A count of the billing providers on the EIS – Member History Summary of ER Visits.	13	Number	N/A	Calculated
(C) Total Number	A count of the line items on the EIS – Member History Summary of ER Visits.	13	Number	N/A	Calculated
(D) Days Supply	The number of days the prescription should last.	9	Number	T_CA_DRUG	NUM_DAY_SUPPLY
(D) Dispensed Date	The date the prescription was filled. Sort order: (D) 1	0	Date (MM/DD/CCYY)	T_CA_DRUG	DTE_DISPENSE
(D) NDC Code & Description	The NDC code and description. Sort order: (D) 2	40	Char	T_CA_DRUG	CD_NDC
(D) Prescribing Provider Name	Name of the prescribing provider. This can be a personal or business name.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
(D) Prescribing Provider Numbers	ID is used to identify a provider who orders or refers specific services for members	10	Char	T_CA_ICN	ID_PROV_REFER
(D) Prescription Number	The number assigned to the prescription by the provider.	7	Char	T_CA_DRUG	NUM_PRSCRIP

Field	Description	Length	Data Type	DB Table	DB Attributes
(D) Qty Dispensed	The quantity of the drug that was dispensed to the member.	9	Character	T_CA_DRUG	QTY_DISPENSE
(E,F) Provider Name	The name associated with the organization or person.	50	Char	T_PR_SVC_LOC	NAME
(E,F,G) Billing Provider Specialty Code & Desc	The Provider specialty code and description.	50	Char	T_CA_PROV_KEY	DSC_PROV_SPEC
(E,F,G) Billing Provider Type Code & Desc	The code and description associated with the billing provider type code.	50	Char	T_CA_PROV_KEY	DSC_PROV_TYPE
(E,F,G) City, State and Zip Code	Concatenates the provider's city, state and zip code address information into one object.	50	Char	T_PR_ADR	ADR_MAIL_CITY,ADR_MAIL_STATE,ADR_MAIL_ZIP,ADR_MAIL_ZIP_4
(E,F,G) Street Address	Concatenates the provider's street 1 and street 2 address information.	250	Char	T_PR_ADR	ADR_MAIL_STRT1,ADR_MAIL_STRT2

5.4.64.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.65 EIS - Monthly Home Health Visits

The EIS - Monthly Home Health Visits report lists home health visits and costs by provider, and contains five tabs:

- A. Totals by Procedure Code
- B. Totals per Member
- C. Totals per Provider
- D. Totals per Code per Provider
- E. Details
- F. Report Notes

5.4.65.1 Technical Name

EIS - Monthly Home Health Visits

5.4.65.2 Sort Order

Tab A: Primary Procedure Code & Desc; Tab B: Member ID, Tab C: Performing Provider Number, Tab D: Primary Procedure Code & Description, Tab E: Performing Provider Number and ICN.

5.4.65.3 EIS - Monthly Home Health Visits Layout

A

Run Date: 10/11/2006
Run Time: 9:07:24 AM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: rztdly



Monthly Home Health Visits

Totals by Procedure Code

From Dates of Service: 01/01/1997 - 12/31/2006

Primary Procedure Code & Desc	Billed Amount	Allowed Amount	Paid Amount
99211 - Office Or Other Outpatient Visit For The	\$1,500.00	\$17.04	\$17.04
99213 - Office Or Other Outpatient Visit For The	\$4,500.00	\$99.27	\$99.27
99271 - Confirmatory Consultation For A New Or E	\$750.00	\$0.00	\$0.00
99341 - Home Visit For The Evaluation And Manage	\$100.00	\$0.00	\$0.00
99347 - Home Visit For The Evaluation And Manage	\$400.00	\$0.00	\$0.00
A0030 - Ambulance Service, Conventional Air Serv	\$250.00	\$0.00	\$0.00
E0163 - Commode Chair , Stationary, With Fixed A	\$3,000.00	\$152.00	\$152.00

End of Report

B

Run Date: 10/11/2006
 Run Time: 9:07:24 AM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: rztdly



Monthly Home Health Visits
Totals Per Member

From Dates of Service: 01/01/1997 - 12/31/2006

Member ID	Billed Amount	Allowed Amount	Paid Amount
	\$250.00	\$0.00	\$0.00
	\$100.00	\$0.00	\$0.00
	\$250.00	\$0.00	\$0.00
	\$250.00	\$0.00	\$0.00
	\$250.00	\$0.00	\$0.00
	\$300.00	\$0.00	\$0.00
	\$100.00	\$0.00	\$0.00
	\$9,000.00	\$268.31	\$268.31
Sum:	\$10,500.00	\$268.31	\$268.31

End of Report

C

Run Date: 10/11/2006
Run Time: 9:07:24 AM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: rztdly



Monthly Home Health Visits

Totals per Provider

From Dates of Service: 01/01/1997 - 12/31/2006

Performing Provider Numbers	Performing Provider Name	Billed Amount	Allowed Amount	Paid Amount
NPI: 1000000474 Medicaid Number: 100236759B Base Number: 10023676	DALLES, MICKEY A	\$7,500.00	\$251.27	\$251.27
NPI: 1000000477 Medicaid Number: 100238249B Base Number: 10023825	JANES, JILL E	\$1,000.00	\$0.00	\$0.00
NPI: 1000000478 Medicaid Number: 100238279A Base Number: 10023828	SMITH, CALEB U	\$500.00	\$0.00	\$0.00
NPI: 1000000478 Medicaid Number: 100238279B Base Number: 10023828	UNITED NURSING ASSISTANCE CENTER	\$1,500.00	\$17.04	\$17.04
Sum:		\$10,500.00	\$268.31	\$268.31

End of Report

D

Run Date: 10/11/2006
Run Time: 9:07:24 AM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: rztldly



Monthly Home Health Visits

Totals per Code per Provider

For Dates of Service: 01/01/1997 - 12/31/2006

Provider Numbers: NPI: 1000000474
Medicaid Number: 100236759B
Base Number: 10023676

Provider Name: DALLES, MICKEY A

Primary Procedure Code & Desc	Billed Amount	Allowed Amount	Paid Amount
99213 - Office Or Other Outpatient Visit For The	\$4,500.00	\$99.27	\$99.27
E0163 - Commode Chair , Stationary, With Fixed A	\$3,000.00	\$152.00	\$152.00

End of Report

E

Run Date: 10/11/2006
Run Time: 9:07:24 AM

Cabinet for Health and Family Services
Department for Medicaid Services

User ID: rztldy



Monthly Home Health Visits

Details

For Dates of Service: 01/01/1997 - 12/31/2006

ICN	Performing Provider Numbers	Performing Provider Name	Dtl No	Status	Member ID	Primary Procedure Code & Desc	Performing Provider Type Code & Desc	Performing Spec Code & Desc	Prov Code & Desc	Provider County Code & Desc
	NPI: 1000000471 Medicaid Number: 100235819A Base Number: 10023582	DALLES, MICKEY A	1	P	000001403	99213 - Office Or Other Outpatient Visit For The	64 - Physician Individual	318 - General Practitioner	072 - Lyon	
	NPI: 1000000471 Medicaid Number: 100235819A Base Number: 10023582	DALLES, MICKEY A	1	P	000001403	E0163 - Commode Chair , Stationary, With Fixed A	64 - Physician Individual	318 - General Practitioner	072 - Lyon	
	NPI: 1000000471 Medicaid Number: 100235819A Base Number: 10023582	DALLES, MICKEY A	1	P	000001403	99213 - Office Or Other Outpatient Visit For The	64 - Physician Individual	318 - General Practitioner	072 - Lyon	
	NPI: 1000000471 Medicaid Number: 100235819A Base Number: 10023582	DALLES, MICKEY A	1	P	000001403	E0163 - Commode Chair , Stationary, With Fixed A	64 - Physician Individual	318 - General Practitioner	072 - Lyon	
	NPI: 1000000471 Medicaid Number: 100235819A Base Number: 10023582	DALLES, MICKEY A	1	P	000001403	99213 - Office Or Other Outpatient Visit For The	64 - Physician Individual	318 - General Practitioner	072 - Lyon	

Billed Amount	Allowed Amount	Paid Amount
\$1,500.00	\$33.09	\$33.09
\$1,500.00	\$76.00	\$76.00
\$1,500.00	\$33.09	\$33.09
\$1,500.00	\$76.00	\$76.00
\$1,500.00	\$33.09	\$33.09

F

Report Notes

Report Description

This report lists monthly home health visits and costs by provider. There are report totals by Procedure Code, Member, Provider, Code per Provider and Details. The report includes NPI, Medicaid, and Base IDs for each provider.

Search Criteria

Billed date range specified by the user in a prompt.
 Provider type 34 (Home Health)
 Procedure code on claim not empty

5.4.65.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A,D,E)Primary Procedure Code & Desc	Code and description used to identify a medical, dental, or DME procedure. Sort order: (A,D) 1	5	Char	T_CA_ICN, T_CDE_PROC	CD_PROC_PRIM, DSC_PROC
(A-E)Billed Amount	The sum of all charges associated with each individual detail on a claim.	9	Number	T_CA_ICN	AMT_BILLED
(A-E)Allowed Amount	Amount approved to pay for services provided to a member.	9	Number	T_CA_ICN	AMT_ALWD
(A-E)Paid Amount	The computed amount of payment due a provider for a claim or an adjustment transaction.	9	Number	T_CA_ICN	AMT_PAID

Field	Description	Length	Data Type	DB Table	DB Attributes
(B,E)Member ID	Unique identifier for the member. Sort order: (B) 1	12	Char	T_CA_ICN	ID_MEDICAID
(C)PerformingProvider Numbers	Numbers of the provider who performed (rendered) service. Sort order (E) 1	10	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI, ID_PROVIDER_MCAID, ID_PROVIDER_BASE
(E)Dtl No	The number of the detail on a claim record.	2	Char	T_CA_ICN	NUM_DTL
(E)ICN	Number assigned to a claim processed in the system. This number is used for control purposes. Sort order: (E) 2	13	Char	T_CA_ICN	NUM_ICN
(C,E)Provider Name	The complete name of the provider of Medicaid services as used on official state records.	50	Char	T_PR_SVC_LOC	NAME
(E)Performing Prov Spec Code & Desc	A code and description of the Provider Specialty code.	30	Char	T_CA_PROV_KEY	CDE_PROV_SPEC_PRIM, DSC_PROV_SPEC
(E)Performing Provider Type Code & Dsc	A code and description of the Provider Type code.	30	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM, DSC_PROV_TYPE
(E)Status	Indicates the status of the detail in the MMIS.	1	Char	T_CA_ICN	CDE_DTL_STATUS

5.4.65.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.66 EIS - Nursing Facility Statistics

The EIS - Nursing Facility Statistics report contains six tabs containing graphs. The first represents the total paid in each year on nursing facility claims. The second shows the total paid each month while the third shows the number of days covered. The fourth tab illustrates the number of days covered each month. The fifth tab denotes the averages cost per day as well as per member. The last tab shows the average cost per day and per member by month.

This report contains six tabs containing graphs. The tabs are:

- A. Total Expenditures by SFY - It shows the total paid in each year on nursing facility claims.
- B.- Total Monthly Expenditures - It shows the total paid each month.
- C.- Covered Days by SFY - It shows the number of days covered.
- D.- Covered Monthly Days - It shows the number of days covered each month.
- E. Average Daily Cost by SFY - It shows the average cost per day, per member.
- F. Average Daily Cost by Month - It shows the average cost per day, per member by month.

5.4.66.1 Technical Name

EIS - Nursing Facility Statistics

5.4.66.2 Sort Order

N/A

5.4.66.3 EIS - Nursing Facility Statistics Layout

A

Run Date: 9/28/2006
Run Time: 11:44:20 AM

Cabinet for Health and Family Services

User ID: wzrdmh

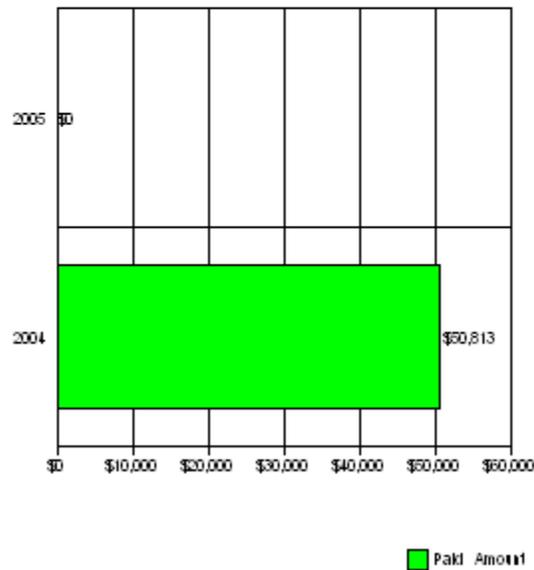
Department for Medicaid Services



Nursing Facility Statistics

Total Expenditures by SFY

State Fiscal Year (SFY) Range: 2000 - 2006



End of Report

B

Run Date: 9/28/2006
Run Time: 11:44:20 AM

Cabinet for Health and Family Services

User ID: wzrdmh



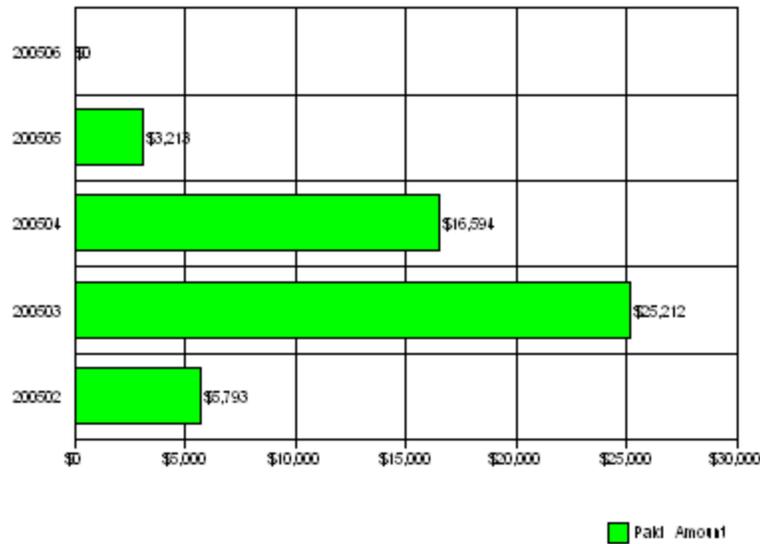
Department for Medicaid Services

Nursing Facility Statistics

Total Monthly Expenditures

State Fiscal Year (SFY) Range: 2000 - 2006

2004



C

Run Date: 9/28/2006
Run Time: 3:59:33 PM

Cabinet for Health and Family Services

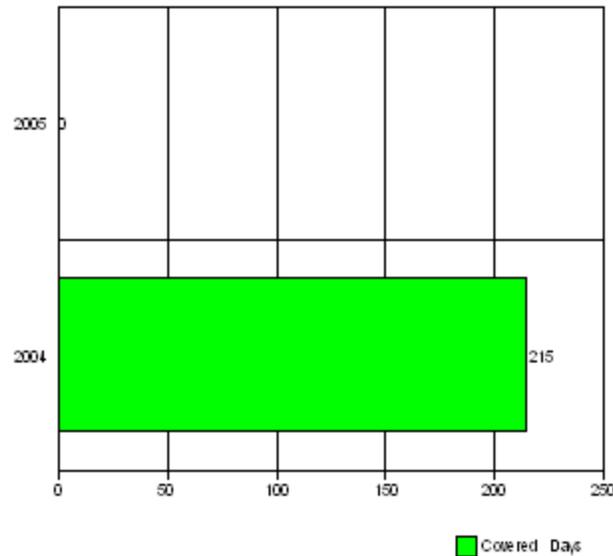
User ID: wzrdmh

Department for Medicaid Services

Nursing Facility Statistics

Covered Days by SFY

State Fiscal Year (SFY) Range: 2000 - 2006



End of Report

D

Run Date: 9/28/2006
Run Time: 3:59:33 PM

Cabinet for Health and Family Services

User ID: wzrdmh

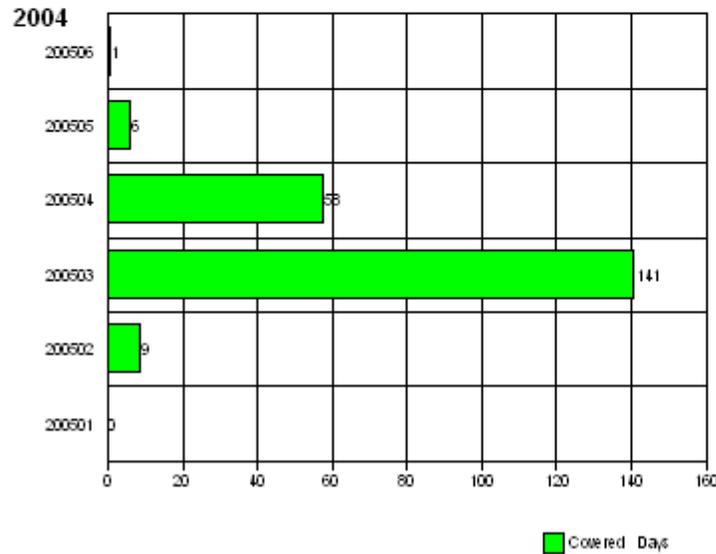
Department for Medicaid Services



Nursing Facility Statistics

Covered Monthly Days

State Fiscal Year (SFY) Range: 2000 - 2006



F

Run Date: 9/28/2006
Run Time: 3:59:33 PM

Cabinet for Health and Family Services
Department for Medicaid Services

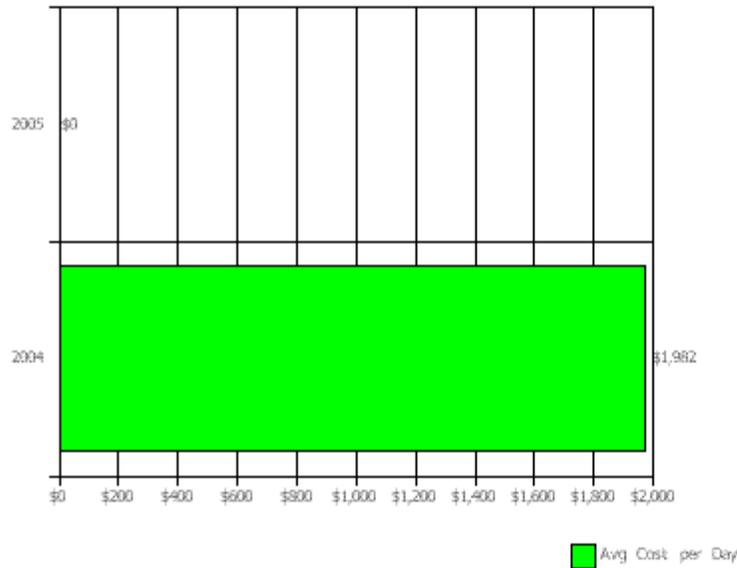
User ID: wzrdmh



Nursing Facility Statistics

Average Daily Cost by SFY

State Fiscal Year (SFY) Range: 2000 - 2006



F

Run Date: 9/28/2006
Run Time: 3:59:33 PM

Cabinet for Health and Family Services

User ID: wzrdmh

Department for Medicaid Services

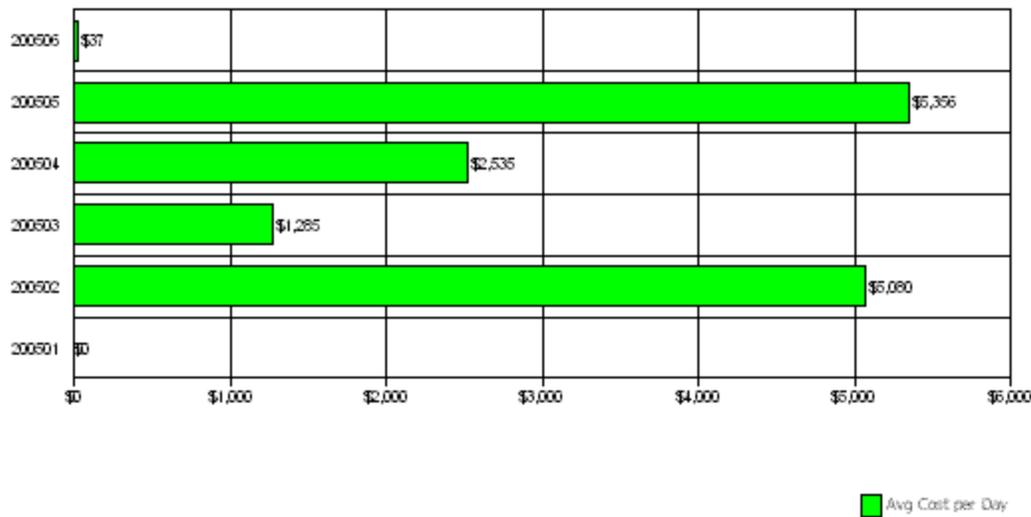
Nursing Facility Statistics

Average Daily Cost by Month



State Fiscal Year (SFY) Range: 2000 - 2006

2004



G Report Notes

Report Description

This report contains six tabs containing graphs.

- 1.- Total Expenditures by SFY - It represents the total paid in each year on nursing facility claims.
- 2.- Total Monthly Expenditures - It shows the total paid each month.
- 3.- Covered Days by SFY - It shows the number of days covered.
- 4.- Covered Monthly Days - It illustrates the number of days covered each month.
- 5.- Average Monthly Days by SFY - It denotes the average cost per day as well per recipient.
- 6.- Average Daily Cost by Month - It shows the average cost per day and per recipient by month.

Search Criteria

Paid date state fiscal year (SFY) range - From begin & end date range (CCYY) of payment entered by the user prompt.

This report shows latest claims only.

The claim type for all graphs equals LTC (Long Term Care).

5.4.66.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Average Cost	The average cost per day and per member.	10	Number	T_CA_LTC	AMT_PROV_PER_DIEM
Average Cost by Month	The average cost per day per month.	10	Number	T_CA_LTC	AMT_PROV_PER_DIEM
Covered Days	The total number of covered days.	10	Number	T_CA_ICN	NUM_DAYS_COVD

Field	Description	Length	Data Type	DB Table	DB Attributes
Covered Days per Month	The total number of covered days per month.	10	Number	T_CA_ICN	NUM_DAYS_COVD
Total Expenditures	The total expenditures.	10	Number	T_CA_ICN	AMT_PAID
Total Expenditures per Month	The total expenditures per month.	10	Number	T_CA_ICN	AMT_PAID

5.4.66.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.67 EIS - Provider History

The EIS - Provider History report contains nine tabs. The first four tabs represent detailed information on the ICN, diagnosis, procedures and place of services that have been done by a specific provider. The next four tabs show information on all the claims types (inpatient, dental, pharmacy, and physician). The last tab presents report notes.

There are 9 tabs in this report:

- A. ICN Information Report
- B. Provider Detail Reports by Diagnosis
- C. Provider Detail Reports by Procedure
- D. Provider Detail Reports by Place of Service
- E. Pharmacy Claims
- F. Dental Claims
- G. UB92 Claims
- H. Physician Claims
- I. Report Notes tab describing the conditions used to create the report.

5.4.67.1 Technical Name

EIS - Provider History

5.4.67.2 Sort Order

Tab A: Claim Type Code and Description, FDOS, TDOS, ICN, Tab B: Billed Quantity; Billed Amount, Tab C: Billed Quantity: Billed Amount, Tab D: Billed Quantity, Tab E: ICN, Tab F: ICN, Tab G: ICN and Tab H: ICN

5.4.67.3 EIS - Provider History Layout

A

Run Date: 1/4/2007
 Run Time: 11:38:15 AM

User ID: tztsbl

Cabinet for Health and Family Services
Department for Medicaid Services



Provider History
 ICN Information

Provider Information: **NPI:**
Medicaid Number: 60038502
Base Number: 500016454
JUSTICE PSC, WILLIAM H
60 - Dentist - Individual
271 - General Dentistry Practitioner
PROF ASSOC BLDG STE 201 PO BOX
2787 PIKEVILLE, KY 41502-0000

Paid Date Range: 1/1/2000 - 1/1/2007

ICN	Claim Type & Description	Claim Indicator	To Date of Service	From Date of Service	Billed Quantity Sum	Billed Amount	Allowed Amount	Paid Amount	Paid Claim Count Sum	Denied Claim Count Sum	Total Claim Count Sum
	D - DENTAL CLAIMS	F	03/14/2005	03/14/2005	2	\$63.00	\$63.00	\$63.00	2	0	2
	D - DENTAL CLAIMS	F	05/05/2005	05/05/2005	4	\$116.00	\$40.00	\$40.00	2	2	4

B

Run Date: 1/4/2007
 Run Time: 11:38:15 AM

User ID: tztsbl

**Cabinet for Health and Family Services
 Department for Medicaid Services**



**Provider History
 Provider Detail Report by Diagnosis**

Provider Information: NPI:
Medicaid Number: 60038502
Base Number: 500016454
JUSTICE PSC, WILLIAM H
60 - Dentist - Individual
271 - General Dentistry Practitioner
PROF ASSOC BLDG STE 201 PO BOX
2787 PIKEVILLE, KY 41502-0000

Paid Date Range: 1/1/2000 - 1/1/2007

Primary Diagnosis Code & Desc	Member Count	Billed Quantity	Billed Amount	Allowed Amount	Paid Amount
##### -	560	560	\$21,891.00	\$14,990.00	\$14,912.00
Sum:	560	560	\$21,891.00	\$14,990.00	\$14,912.00

C

Run Date: 1/4/2007
 Run Time: 11:38:15 AM

User ID: tztsbl

**Cabinet for Health and Family Services
 Department for Medicaid Services**



**Provider History
 Provider Detail Report by Procedure**

Provider Information: NPI:
Medicaid Number: 60038502
Base Number: 500016454
JUSTICE PSC, WILLIAM H
60 - Dentist - Individual
271 - General Dentistry Practitioner
PROF ASSOC BLDG STE 201 PO BOX
2787 PIKEVILLE, KY 41502-0000

Paid Date Range: 1/1/2000 - 1/1/2007

Primary Procedure Code & Desc	Member Count	Billed Quantity	Billed Amount	Allowed Amount	Paid Amount
D0120 -	2	2	\$39.00	\$0.00	\$0.00
D0150 -	76	76	\$2,000.00	\$1,508.00	\$1,502.00
D0220 -	46	46	\$376.00	\$264.00	\$260.00

D

Run Date: 1/4/2007
 Run Time: 11:38:15 AM

User ID: tztsbl

**Cabinet for Health and Family Services
 Department for Medicaid Services**



**Provider History
 Provider Detail Report by Diagnosis**

Provider Information: NPI:
 Medicaid Number: 60038502
 Base Number: 500016454
 JUSTICE PSC, WILLIAM H
 60 - Dentist - Individual
 271 - General Dentistry Practitioner
 PROF ASSOC BLDG STE 201 PO BOX
 2787 PIKEVILLE, KY 41502-0000

Paid Date Range: 1/1/2000 - 1/1/2007

Place of Service Code & Description	Member Count	Billed Quantity Sum	Billed Amount	Allowed Amount	Paid Amount
11 - Office	560	560	\$21,891.00	\$14,990.00	\$14,912.00
Sum:	560	560	\$21,891.00	\$14,990.00	\$14,912.00

E

un Date: 9/28/2006
 un Time: 4:50:04 PM

Cabinet for Health and Family Services
Department for Medicaid Services
Provider History
ICN Information

User ID: qz00tr



Provider Information: NPI: 1000000513
 Medicaid Number: 1002418291
 Base Number: 10024183
 Name: FRANCIS MEMORIAL CLINIC
 Type: 01 - General hospital
 Specialty: 010 - Acute Care
 Address: 3999 NE 1ST ST
 SUITE 9453
 PORTLAND, KY 97501

From Paid Dates: 01/02/2000 - 12/31/2006

ICN	Claim Type Code & Desc	Claim Indicator	To Date of Service	From Date of Service	Billed Quantity	Billed Amount	Allowed Amount	Paid Amount	Paid Claim Count	Denied Claim Count	Total Claim Count
	B - HCFA 1500 XOVER CLAIMS	F	12/20/2002	12/20/2002	1	\$80.00	\$0.00	\$0.00	1	0	1
	H - HOME HEALTH CLAIMS	F	07/18/2004	07/22/2004	1	\$237.00	\$236.00	\$236.00	1	0	1
	O - OUTPATIENT CLAIMS	F	01/25/2002	01/25/2002	1	\$17.75	\$-100.00	\$0.00	0	1	1
	O - OUTPATIENT CLAIMS	F	01/25/2002	01/25/2002	1	\$17.75	\$-100.00	\$0.00	0	1	1
	O - OUTPATIENT CLAIMS	F	01/25/2002	01/25/2002	1	\$17.75	\$-100.00	\$0.00	0	1	1
				Sum:	5	\$350.25	\$-64.00	\$236.00	2	3	5

End of Report

F

Run Date: 9/29/2006
Run Time: 5:26:44 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: qz00tr



**Provider History
Dental Claims**

Provider Information: NPI: 1000000473
Medicaid Number: 100236279A
Base Number: 10023628
Name: DALLES, MICKEY A
Type: 64 - Physician Individual
Specialty: 316 - Family Practitioner
Address: 4036 PARK AVE
DROP CODE 9428
PORTLAND, KY 97501

From Paid Dates: 01/02/2000 - 12/31/2006

ICN	FDOS	TDOS	Paid Date	Member ID	Member Name	Age	Billing Provider Numbers	Billing Provider Name	Performing Provider Numbers	Performing Provider Name
	03/01/2005	03/01/2005	03/22/2005			36	NPI: 1000000473 Medicaid Number: 100236279A Base Number: 10023628	DALLES, MICKEY A	NPI: 1000000473 Medicaid Number: 100236279A Base Number: 10023628	DALLES, MICKEY A
Claim Indicator	Billing Provider Type Code & Desc		Billing Provider Specialty Code & Desc		Performing Provider Type Code & Desc		Performing Provider Specialty Code & Desc			
F	64 - Physician Individual		316 - Family Practitioner		64 - Physician Individual		316 - Family Practitioner			
Dtl No	Primary Procedure Code & Desc	Tooth Number	Billed Qty	Billed Amount	Allowed Amount	Paid Amount				
0	##### - Unknown	-	1	\$85.00	\$534.90	\$85.00				
Sum:			1	\$65.00	\$534.90	\$65.00				

G

Run Date: 9/29/2006
Run Time: 5:26:44 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: qz00tr



**Provider History
UB92 Claims**

Provider Information: NPI: 1000001024
Medicaid Number: 100684979B
Base Number: 10068498
Name: SEAMORE X-RAY CLINIC
Type: 01 - General hospital
Specialty: 010 - Acute Care
Address: PO BOX 3010
DROP CODE 9004
PORTLAND, KY 97501

From Paid Dates: 01/02/2000 - 12/31/2006

ICN	FDOS	TDOS	Admission Date	Paid Date	Member ID	Member Name	Member Aid Category Code & Desc	Billing Provider Numbers	Billing Provider Name	Attending Provider Numbers	Attending Provider Name
2205063250004	05/17/2004	05/31/2004	01/01/0101	03/08/2005	#####		L - Child and their caretaker rel	NPI: 1000001024 Medicaid Number: 100684979B Base Number: 10068498	SEAMORE X-RAY CLINIC	NPI: Medicaid Number: Base Number:	
Claim Type Code & Desc	Claim Indicator	Surgical Code 1 & Desc	Procedure Code 2 & Desc	Surgical Code 3 & Desc	Procedure Code 4 & Desc	Billing Provider Code & Desc	Billing Provider Specialty Code & Desc	Attending Provider Type Code & Desc	Attending Provider Spec Code & Desc		
H - HOME HEALTH CLAIMS	N	-	-	-	-	01 - General hospital	010 - Acute Care	33 - SCL	039 - SCL		
Detail Number	Procedure Code & Desc	Revenue Code & Desc	Billed Amount	Allowed Amount	Paid Amount						
	W3018 - Skilled Home Visit	0320 - DIAGNOSTIC X RAY	\$15,000.00	\$708.00	\$708.00						
Sum:			\$15,000.00	\$708.00	\$708.00						

H

Run Date: 9/29/2006
Run Time: 5:26:44 PM

Cabinet for Health and Family Services
Department for Medicaid Services
Provider History
Physician Claims

User ID: qz00tr



Provider Information: NPI: 1000001024
Medicaid Number: 100684979B
Base Number: 10068498
Name: SEAMORE X-RAY CLINIC
Type: 01 - General hospital
Specialty: 010 - Acute Care
Address: PO BOX 3010
DRDP CODE 9004
PORTLAND, KY 97501

From Paid Dates: 01/02/2000 - 12/31/2006

ICN	FDOS	TDOS	Paid Date	Member ID	Member Name	Age	Member Aid Category Code	Billing Provider Numbers	Billing Provider Name	Performing Provider Numbers	Performing Provider Name
2003142001004	07/11/2001	07/11/2001	03/29/2005	#####	.	-1	K - Blind persons who do not rec SSI or State Suppl	NPI: Medicaid Number: Base Number:		NPI: Medicaid Number: Base Number:	
Claim Type Code & Desc		Claim Indicator	Billing Provider Type Code & Desc		Billing Provider Specialty Code & Desc	Performing Provider Type Code & Desc		Performing Provider Specialty Code & Desc			
M - HCFA 1500 CLAIMS		F	33 - SCL		039 - SCL	33 - SCL		039 - SCL			
Dtl No	Primary Procedure Code & Desc		Primary Diagnosis Code & Desc		Billed Amount	Allowed Amount	Paid Amount				
1	96400 - Chemotherapy Administration, Intralesion		1951 - ALIG NEO THORAX MA		\$23.13	\$0.00	\$0.00				
					\$23.13	\$0.00	\$0.00				

I

Report Notes

Report Description

This report contains nine tabs:

- A. ICN Information - represents the detailed information of the ICN for a specific recipient
- B. Provider Detail Report by Diagnosis - provider information on diagnosis
- C. Provider Detail Report by Procedure - provider information on procedure
- D. Provider Detail Report by Place of Service - provider information on place of service
- E. Pharmacy Claims - detail claim information by claim type = P, Q for the provider
- F. Dental Claims - detail claim information by claim type D for the provider
- G. UB92 Claims - detail claim information by claim type = A,C,I,L,O,H for the provider
- H. Physician Claims - detail claim information by claim type = B , M for the provider

Search Criteria

Payment Date range specified by the user in a prompt

Latest Claims Only

Billing Provider Service Location Information - user can enter Billing Provider NPI, Base or Medicaid Number then choose from a list of service locations

Header or Detail Paid Indicator = H or D

5.4.67.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Denied Claim Count	Number of denied claims	9	Number	T_CA_ICN	CNT_CLAIMS_DENIED
(A) Paid Claim Count	Number of paid claims	9	Number	T_CA_ICN	CNT_CLAIMS_PAID

Field	Description	Length	Data Type	DB Table	DB Attributes
(A) Total Claim Count	Number of paid claims + number of denied claims	9	Number	N/A	Calculated
(A,B,C) Billed Quantity Sum	The units of service billed for payment.	22	Character	T_CA_ICN	QTY_UNITS_BILLED
(A,B,C,D,E,F,G,H) Paid Amount	This is the same as reimbursed amount.	13	Number	T_CA_ICN	AMT_PAID
(A,B,C,D,E,F,H,G) Allowed Amount	Total amount approved to pay for services provided to a member. This is the amount before copay and TPL are taken out.	13	Number	T_CA_ICN	AMT_ALWD
(A,B,C,D,E,F,H,G) Billed Amount	Amount of money requested for payment by a provider for services rendered to a member.	13	Number	T_CA_ICN	AMT_BILLED
(A,E,F,G,H) ICN	Unique control number assigned to the invoice to allow tracking through the system. Sort order: (E,F,G,H) 1	13	Char	T_CA_ICN	NUM_ICN
(A,E,F,GH) Claim Indicator	An indicator identifying a claim as E=Encounter or F=Fee for service claim.	1	Char	T_CA_ICN	IND_CLAIM
(A,F,G,H) FDOS	Day procedure was started.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_FIRST_SVC
(A,F,G,H) TDOS	Day procedure was finished.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_LAST_SVC
(A,G,H) Claim Type Code & Desc	Invoice Type code & description (Sort order 1 (A))	51	Character	T_CA_CLAIM_KEY	CDE_CLM_TYPE DSC_CLM_TYPE
(B,C,D) Member Count	A distinct count based on the individual member ID.	12	Number	T_CA_ICN	ID_MEDICAID

Field	Description	Length	Data Type	DB Table	DB Attributes
(B,H) Primary Diagnosis Code & Desc	The primary ICD-9-CM diagnosis description. Sort order: (B) 1	47	Char	T_CA_ICN, T_DIAGNOSIS	CDE_DIAG_PRIM DSC_25
(C,F,G,H) Primary Procedure Code & Desc	The primary procedure code & description.	46	Char	T_CA_ICN,T_CD E_PROC	CDE_PROC_PRIM DSC_PROC
(D) Place of Service	Code & description to indicate where the service was provided.	52	Char	T_CA_CLAIM_K EY	CDE_POS,DSC_POS
(D,F) Billed Qty	The units of service billed for payment.	22	Character	T_CA_ICN	QTY_UNITS_BILLED
(E) Days Supply	The number of days the prescription should last.	10	Number	T_CA_DRUG	NUM_DAY_SUPPLY
(E) Dispensed Date	The date the prescription was filled.	10	Date (MM/DD/CC YY)	T_CA_DRUG	DTE_DISPENSE
(E) NDC Code & Description	The national drug code & desc for the drug dispensed on claim.	11	Char	T_CA_ICN, T_CA_DRUG	CDE_NDC DSC_NDC
(E) Prescribing Provider Name	The provider name.	50	Char	T_CA_PROV_K EY	NAM_PROVIDER
(E) Prescribing Provider Number	This object contains the referring Base, Medicaid and NPIs that identify a provider.	15	Char	T_CA_PROV_K EY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
(E) Prescription Number	The number assigned to the prescription by the provider.	7	Char	T_CA_DRUG	NUM_PRSCRIP
(E) Qty Dispensed	The quantity of the drug that was dispensed to the member.	10	Number	T_CA_DRUG	QTY_DISPENSE

Field	Description	Length	Data Type	DB Table	DB Attributes
(E,F,G,H) Billing Provider Name	The provider name.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
(E,F,G,H) Billing Provider Number	The provider identification number used by the provider.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
(E,F,G,H) Billing Provider Type Code & Desc	The billing provider's type code and a description of the provider type code.	52	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM DSC_PROV_TYPE
(E,F,G,H) Detail Number	Claim line number.	4	Number	T_CA_ICN	NUM_DTL
(E,F,G,H) Member ID	The Medicaid identification number for the member.	12	Char	T_CA_ICN	ID_MEDICAID
(E,F,G,H) Member Name	Concatenates the member last name, first name and middle initial into one object. The format of the name is: last name, first name and middle initial.	50	Char	T_RE_BASE	NAM_LAST,NAM_FIRST, NAM_MID_INIT
(E,F,G,H) Prescribing Provider Type Code & Desc	The referring provider's type code and a description of the provider type code.	52	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM DSC_PROV_TYPE
(E,F,H) Age	The age of the member	4	Number	T_CA_ICN	NUM_RECIP_AGE
(F) Tooth Number	The tooth Number and description	42	Char	T_CA_DENTAL, T_TOOTH	CDE_TOOTH_NBR DSC_TOOTH_NBR
(F,G,H) Paid Date	The date the service was paid.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_PAID

Field	Description	Length	Data Type	DB Table	DB Attributes
(F,H) Billing Provider Specialty Code & Desc	The code & description of billing Provider Specialty	53	Char	T_CA_PROV_KEY	CDE_PROV_SPEC_PRIM DSC_PROV_SPEC
(F,H) Performing Provider Name	The name associated with the organization or person.	50	Char	T_CA_PROV_KEY	NAM_PROVIDER
(F,H) Performing Provider Number	ID is used to identify a provider who orders or refers specific services for members.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE
(F,H) Performing Provider Specialty Code & Desc	The code & description of performing Provider Specialty	53	Char	T_CA_PROV_KEY	CDE_PROV_SPEC_PRIM DSC_PROV_SPEC
(F,H) Performing Provider Type Code & Desc	The performing provider's type code and a description of the provider type code.	52	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM DSC_PROV_TYPE
(F,H) Prescribing Provider Specialty Code & Desc	The code & description of referring Provider Specialty	53	Char	T_CA_PROV_KEY	CDE_PROV_SPEC_PRIM DSC_PROV_SPEC
(G) Admission Date	Date that the member was admitted by the provider for inpatient care, outpatient services or start of care.	10	Date (MM/DD/CCYY)	T_CA_ICN	DTE_ADMISSION
(G) Attending Provider Name	The referring provider name.	50	Char	T_CA_ICN	NAM_PROVIDER
(G) Attending Provider Number	The referring provider ID.	15	Char	T_CA_PROV_KEY	ID_PROVIDER_NPI ID_PROVIDER_MCAID ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
(G) Attending Provider Specialty Code & Desc	Code & Desc for the referring provider specialty.	53	Char	T_CA_PROV_KEY	CDE_PROV_SPEC_PRIM DSC_PROV_SPEC
(G) Attending Provider Type Code & Desc	The referring provider's type code and a description of the provider type code.	52	Char	T_CA_PROV_KEY	CDE_PROV_TYPE_PRIM DSC_PROV_TYPE
(G) Revenue Code & Desc	Contains the revenue code & description for header paid claims..	74	Char	T_CA_ICN, T_CDE_REVENUE	CDE_REVENUE DSC_REVENUE
(G) Surgical Procedure Code 1 & Desc	The ICD-9-CM code 1 & desc for the service performed for the member.	44	Char	T_CA_ICD9_PROC_DN, T_CDE_PROC	CDE_PROC_ICD9_1 DSC_PROC
(G) Surgical Procedure Code 2 & Desc	The ICD-9-CM code 2 & desc for the service performed for the member.	44	Char	T_CA_ICD9_PROC_DN, T_CDE_PROC	CDE_PROC_ICD9_2 DSC_PROC
(G) Surgical Procedure Code 3 & Desc	The ICD-9-CM code 3 & desc for the service performed for the member.	44	Char	T_CA_ICD9_PROC_DN, T_CDE_PROC	CDE_PROC_ICD9_3 DSC_PROC
(G) Surgical Procedure Code 4 & Desc	The ICD-9-CM code 4 & desc for the service performed for the member.	44	Char	T_CA_ICD9_PROC_DN, T_CDE_PROC	CDE_PROC_ICD9_4 DSC_PROC
(G,H) Member Aid Category Code & Description	Code and description that identifies the type of aid for which a member is eligible.	52	Char	T_CA_RECIP_KEY, T_CDE_PROC	CDE_AID_CATEGORY DSC_AID_CATEGORY

5.4.67.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.68 EIS - Quarterly Growth

The EIS - Quarterly report identifies quarterly growth of a provider type.

5.4.68.1 Technical Name

EIS - Quarterly Growth

5.4.68.2 Sort Order

None

5.4.68.3 EIS - Quarterly Growth Layout

Run Date: 10/10/2006
Run Time: 12:30:55 PM

Cabinet for Health and Family Services

User ID: rztldly

Department for Medicaid Services

Quarterly Growth Report

Quarterly Growth



For Year: 2002

Quarter: 1

Provider Type Code and Description	Specialty Code and Description	Provider Numbers	Provider Name
64 - Physician Individual	345 - General Pediatrician	NPI: 1000000157 Medicaid Number: 100086089A Base Number:	BEAL, TIM J
60 - Dentist - Individual	271 - General Dentistry Practitioner	NPI: 1000000079 Medicaid Number: 100022589A Base Number:	CHRISTY, SHARON N
60 - Dentist - Individual	272 - Oral Surgeon	NPI: 1000000079 Medicaid Number: 100022589A Base Number:	CHRISTY, SHARON N
60 - Dentist - Individual	276 - Oral Pathologist	NPI: 1000000079 Medicaid Number: 100022589A Base Number:	CHRISTY, SHARON N
01 - General hospital	010 - Acute Care	NPI: 1000002025 Medicaid Number: 200305989A Base Number:	CLEAVER, BEN I

5.4.68.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Provider Numbers	The provider identification number used by the provider.	10	Char	T_PR_SVC_LOC	ID_PROVIDER_NPI, ID_PROVIDER_MCAID, ID_PROVIDER_BASE

Field	Description	Length	Data Type	DB Table	DB Attributes
Provider Name	The provider identification number used by the provider.	10	Char	T_PR_SVC_LOC	ID_PROVIDER
Provider Type Code and Description	This is the provider type code for which a provider is licensed and the provider type description.	52	Char	T_PR_TYPE, T_PR_TYPE_CDE	CDE_PROV_TYPE, DSC_PROV_TYPE
Quarter	This is the quarter of the add date.	2	Number	T_PR_APPLN	DTE_FINALIZED
Specialty Code and Description	The specialty code and description represents the specialized area of practice for a provider.	53	Char	T_PR_SPEC, T_PR_SPEC_CDE	CDE_PROV_SPEC, DSC_PROV_SPEC
Year	This is the year of the add date.	4	Char	T_PR_APPLN	DTE_FINALIZED

5.4.68.5 Associated Programs

Program	Description
No associated Programs found.	

5.4.69 EIS - Selected Provider Address

The EIS - Selected Provider Address report lists the top 100 providers ranked by number of claims processed for a specified date range. The providers are sorted in ascending ranking order.

5.4.69.1 Technical Name

EIS - Selected Provider Address

5.4.69.2 Sort Order

Total Claim Count.

5.4.69.3 EIS - Selected Provider Address Layout

Run Date: 2/2/2007
Run Time: 12:41:25 PM

**Cabinet for Health and Family Services
Department for Medicaid Services**

User ID: tztsbl



Selected Provider Address
Top 100 Providers By Claim Count

From Date of Service Range: 1/1/2003 - 2/1/2003

Rank	Billing Provider Numbers	Billing Provider Name	Full Street Address - Billing Addr	City, State and Zip - Billing Addr	Phone Number	Total Claim Count Sum
1	NPI: Medicaid Number: 55006019 Base Number: 500010481	BATH COUNTY AMBULANCE SERVICE	836 4TH AVE.	HUNTINGTON, WV 25701-0000	(550) 060-1900 0000	64
2	NPI: Medicaid Number: 30604011 Base Number: 500005780	LIFESKILLS INC R	PO BOX 6499	BOWLING GREEN, KY 42102-6499	(306) 040-1100 0000	52
3	NPI: Medicaid Number: 65900516 Base Number: 500005937	SURGICAL CARE ASSOCIATES	4003 KRESGE WAY SUITE 100	LOUISVILLE, KY 40207-0000	(659) 005-1600 0000	51

5.4.69.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Name	The name associated with the organization or person.	50	Character	T_CA_PROV_KEY	NAM_PROVIDER

Field	Description	Length	Data Type	DB Table	DB Attributes
Billing Provider Numbers	The concatenation of provider ID and service location.	10	Char	T_CA_ICN	ID_PROVIDER_NPI, ID_PROVIDER_MCAID, ID_PROVIDER_BASE
City, State, and Zip – Billing Addr	Concatenates the provider's city, state and zip code address information into one object.	26	Char	T_CA_PROV_KEY	ADR_BILL_CITY,ADR_BILL_STATE,ADR_BILL_ZIP,ADR_BILL_ZIP4
Full Street Address – Billing Addr	Concatenates the provider's street 1 and street 2 address information.	60	Char	T_CA_PROV_KEY	ADR_BILL_STRT1,ADR_BILL_STRT2
Phone Number	This field contains the provider's phone number.	14	Char	T_CA_PROV_KEY	NUM_PHONE,NUM_PHONE_EXT
Rank	Providers ranked by number of claims processed.	9	Number	T_CA_ICN	CNT_CLAIMS_DENIED,CNT_CLAIMS_PAID
Total Claim Count Sum	The total number of claims per provider.	13	Number	T_CA_ICN	CNT_CLAIMS_DENIED,CNT_CLAIMS_PAID

5.4.69.5 Associated Programs

Program	Description
No associated Programs found.	

6 Letters

The DSS/DW subsystem does not directly produce, send, or receive any letters.

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7 Appendix A- Glossary of Terms

7.1 DSS Specific Terms and Acronyms

BI - Business Intelligence	A business management term which refers to applications and technologies which are used to gather, provide access to, and analyze data and information about their company operations. Business intelligence systems can help companies have a more comprehensive knowledge of the factors affecting their business in order to make better business decisions.
Business Objects	The name of the software used to run queries in the data warehouse.
Criteria	A standard of judgment or criticism, a rule or principle for evaluating or testing something. Within the data warehouse the criteria are the rules that you set up to evaluate the data against your requirements.
Dashboard	A visual representation of the results of a query run on the data warehouse. Usually, the dashboard is created for executive level users for areas of focus such as claim activity, provider utilization, impacts of price changes, etc.
Deskl	An abbreviation for Desktop Intelligence. This is the desktop version of the BusinessObjects software that is used to build queries in the data warehouse.
DSS - Decision Support System	Decision support systems are a class of computer-based information systems including knowledge-based systems that support decision making activities.
DW - Data Warehouse	The main repository of the organization's historical data.
EIS - Executive Information System	A term used to refer to a set of reports from the base interChange system that conveys information useful for executive level analysis.
ESRI - Environmental Systems Research Institute	The name of the company that produces the GIS software used to provide mapping capability for the DSS.

ETG - Episode Treatment Grouper	The name of the software integrated with the data warehouse that identifies episodes of care, which encompass health care services provided to a patient during a single illness.
GeoCoder	A piece of software or a (Web) service that helps in the process of geocoding.
GeoCoding	The process of assigning geographic identifiers (e.g., codes or geographic coordinates expressed as latitude-longitude) to map features and other data records, such as street addresses. With geographic coordinates, the features can then be mapped and entered into Geographic Information Systems.
GIS - Geographic Information System	GIS , or more commonly referred to as a geospatial information system or Geographic Information Science , is a system for capturing, storing, analyzing and managing data and associated attributes which are spatially referenced to the earth. In the strictest sense, it is a computer system capable of integrating, storing, editing, analyzing, sharing, and displaying geographically-referenced information. In a more generic sense, GIS is a tool that allows users to create interactive queries (user created searches), analyze the spatial information, edit data, maps, and present the results of all these operations.
Infoview	BusinessObjects InfoView is the business intelligence (BI) portal that collects, consolidates, and presents your organization's BI information.
Interim	A term used to refer to the current DSS system.
Legacy	A term used to refer to the current mainframe system.
MeasureBase	MeasureBase is an HP Enterprise Services developed tool that allows users to view data in their area in comparison to nationally developed HEDIS measures or allow users to create their own measures to compare data against.
MSIS - Medicaid Statistical Information System	A term used to refer to a system as well as a group of files used by CMS to perform state-to-state and nationwide comparisons of claims and eligibility information. MSIS data is available in the KY data warehouse.
Result	The final consequence of a sequence of actions or events (broadly incidents and accidents) expressed qualitatively or quantitatively, being a loss, injury, disadvantage, advantage, gain, victory or simply a value. There may be a range of possible outcomes associated with an event possibly depending on the point of view, historical distance or relevance. Within the data warehouse a results is

the final consequence of an inquiry into the data using certain criteria.

Universe A logic grouping of data as defined through the BusinessObjects software. For example, all Member information is found in one universe in BusinessObjects.

Webi An abbreviation for **Web Intelligence**. This is the web based version of the BusinessObjects software that is used to build queries in the data warehouse.

7.2 Global Glossary

7.3 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.**

- 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.**
- 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.

7.3.1 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 Group

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 ensures 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.

7.3.2 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)

7.3.3 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.

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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.

- 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)
- 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)

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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

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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.

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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.

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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

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)
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.

7.3.4 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)	<p>The medical classification of a disease or condition according to ICD-9-CM or HCPCS.</p> <p>A numeric code that identifies the patient's condition as determined by the provider of the performed service.</p>
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.
DISENGAGEMENT	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.

7.3.5 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.

E&M **Evaluation and Management**

ELECTRONIC 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.

ELECTRONIC DATA SYSTEMS (HP Enterprise Services) 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.

E&M **Evaluation and Management**

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.

7.3.6 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.

- FAIR HEARING (FH)** A formal meeting where a Hearings Officer listens to all the facts and then makes a decision based on the law.
- 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.

FAIR HEARING (FH)	A formal meeting where a Hearings Officer listens to all the facts and then makes a decision based on the law.
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

FAIR HEARING (FH) A formal meeting where a Hearings Officer listens to all the facts and then makes a decision based on the law.

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.

7.3.7 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: <ol style="list-style-type: none">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

7.3.8 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 ACCOUNTABILITY 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 (HIPPS) 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 PROTOcol (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.

7.3.9 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

7.3.10 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.

7.3.11 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

7.3.12 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)	<p>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.</p> <p>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.</p> <p>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.</p> <p>The message transfer is managed by a transport protocol such as 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.</p>
LOCAL CODES	<p>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.</p>
LOCAL OFFICE	<p>The DCBS office in an individual county. Local county offices are grouped into a management area for administrative efficiency.</p>
LOCK-IN	<p>The punitive restriction of a Medicaid beneficiary to a particular provider for a period of time as determined by the State.</p>
LONG TERM CARE (LTC)	<p>Beneficiary care that includes room, board, and all routine services and supplies. The LTC program includes the SNF, ICF and ICF/MR services.</p>
LPN	<p>Licensed Practical Nurse</p>

7.3.13 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)	<p>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.</p> <p>Beneficiary who has a catastrophic illness and cannot pay the incurred costs. (See “CATEGORICAL NEEDY”). Must still fall into one of the six categories.</p>
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)

7.3.14 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.

7.3.15 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.

7.3.16 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.

7.3.17 Q**QA Quality Assurance**

QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI)	<p>A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level.</p> <p>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.</p>
QUALIFIED MEDICARE BENEFICIARY (QMB)	<p>A State program that pays for a beneficiary's Medicare premiums, coinsurance, and deductible amounts within limits.</p>
QUALIFIED WORKING DISABLED (QWD)	<p>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.</p>
QUARTER	<p>Calendar quarter unless otherwise specified.</p>
QUEUE DIRECTORY	<p>A directory on a hard drive into which batch requests to unit storage are placed. (Imaging)</p>

7.3.18 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 on 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)	The statement mailed to a provider detailing Charges pending, paid, denied.
REMITTANCE ADV	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	<p>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.</p> <p>Measure of imager output capability, usually expressed in dots per inch (DPI).</p> <p>Measure of halftone quality, usually expressed in lines per inch (LPI). (Imaging)</p>
RETRIEVE	<p>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.</p>
RETURN TO PROVIDER (RTP)	<p>Request for additional information from the provider in the form of a letter.</p>
REVENUE CODES	<p>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.</p>
RN	<p>Registered Nurse</p>
RN BSN	<p>Registered Nurse with Bachelor of Science Degree in Nursing</p>
ROUTE TABLE	<p>A database table that specifies resources, such as agent groups or trunks, that calls can be routed to within the telephone system.</p>
RULES BASED PROCESS	<p>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.</p>

7.3.19 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

SAK **System Assigned Key**

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.

SAK **System Assigned Key**

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.

SAK **System Assigned Key**

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.

SAK **System Assigned Key**

**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.

7.3.20 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)	<p>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.</p> <p>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.</p>
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

T-1 CONNECTION	A high-speed connection to the Internet. Required in organizations having a large number of employees accessing the Internet.
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 LIABILITY (TPL)	<p>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.</p> <p>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.</p>
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).

T-1 CONNECTION	A high-speed connection to the Internet. Required in organizations having a large number of employees accessing the Internet.
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.

T-1 CONNECTION A high-speed connection to the Internet. Required in organizations having a large number of employees accessing the Internet.

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.

7.3.21 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.

7.3.22 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.

7.3.23 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)

7.3.24 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

7.3.25 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 B Geocoding Overview

The ESRI system will be used on a daily basis by Commonwealth staff to provide on-demand report mapping capabilities. In addition, the system will support creation of extracts and some federal reporting requirements as well. The users of the system at the Commonwealth need to have training on ESRI due to the fact that the interface for ESRI will be significantly different from the current interface with GeoAccess.

8.1 Purpose

The purpose of this document is to:

- Provide Commonwealth users with a basic understanding of the ESRI tool
- Provide Commonwealth users with the tools to allow them to build ad-hoc layers in the ESRI system
- Provide Commonwealth users with the information needed to format maps for delivery to various parties including managers and executives

8.2 Scope

The scope of this document is limited to covering the basic functionality of the ESRI tool. The basic functionality includes items such as building layers from data, formatting maps, adding legends.

8.3 GEOCODE PROVIDERS TO THE ADDRESS LEVEL

The first step is to collect the data in BusinessObjects. You can do this using a universe or free hand SQL as displayed in the example below.

Select

```
DSS.T_D1_PRV_HFT01.PROV_NUMBER,  
DSS.T_D1_PRV_HFT01.PROV_LAST_NAME,  
DSS.T_D1_PRV_HFT01.PROV_FIRST_NAME,  
DSS.T_D1_PRV_HFT01.PROV_ADDR_LINE_1 as ADDR1,  
DSS.T_D1_PRV_HFT01.PROV_ADDR_LINE_2 as ADDR2,  
DSS.T_D1_PRV_HFT01.PROV_CITY as CITY,  
DSS.T_D1_PRV_HFT01.PROV_STATE as STATE,  
substr(DSS.T_D1_PRV_HFT01.PROV_ZIP_CODE,0,5) as ZIP,  
DSS.T_D1_PRV_HFT01.PROV_TYPE,  
DSS.T_D1_PRV_HFT01.PROV_SPEC_CODE_1,  
DSS.T_D1_PRV_HFT01.PROV_TEL_NUM,  
DSS.T_D1_PRV_HFT01.TOTAL_PCP_MAX_QUOTA,  
DSS.T_D1_PROV_ENROLL.ENROLL_STAT_CODE,  
DSS.T_D1_PROV_ENROLL.ENROLL_STAT_END
```

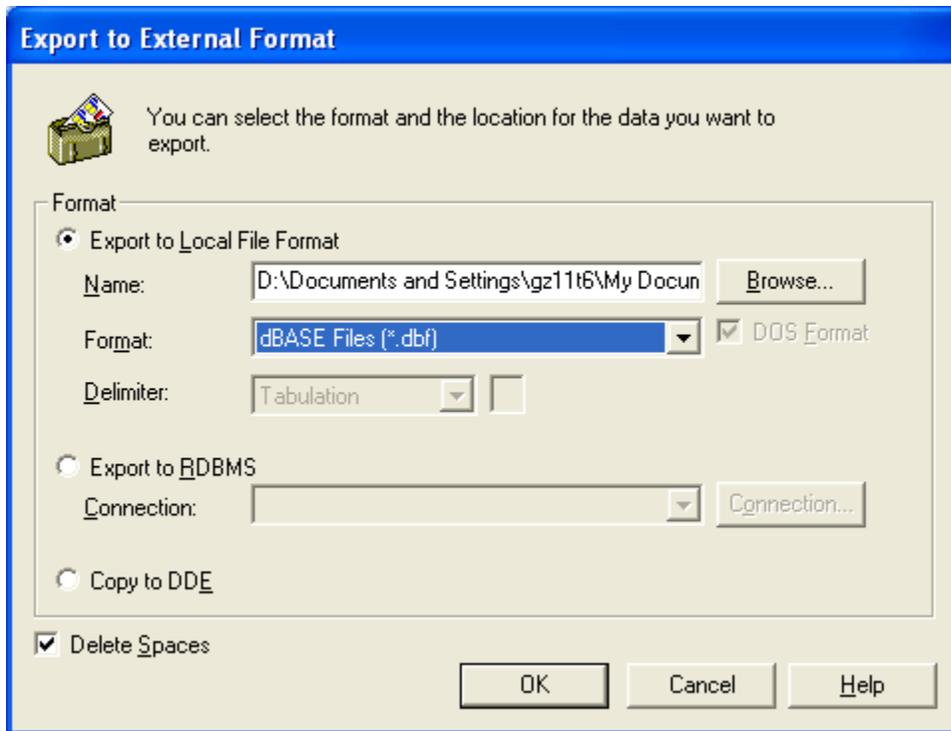
from

```
DSS.T_D1_PRV_HFT01,  
DSS.T_D1_PROV_ENROLL
```

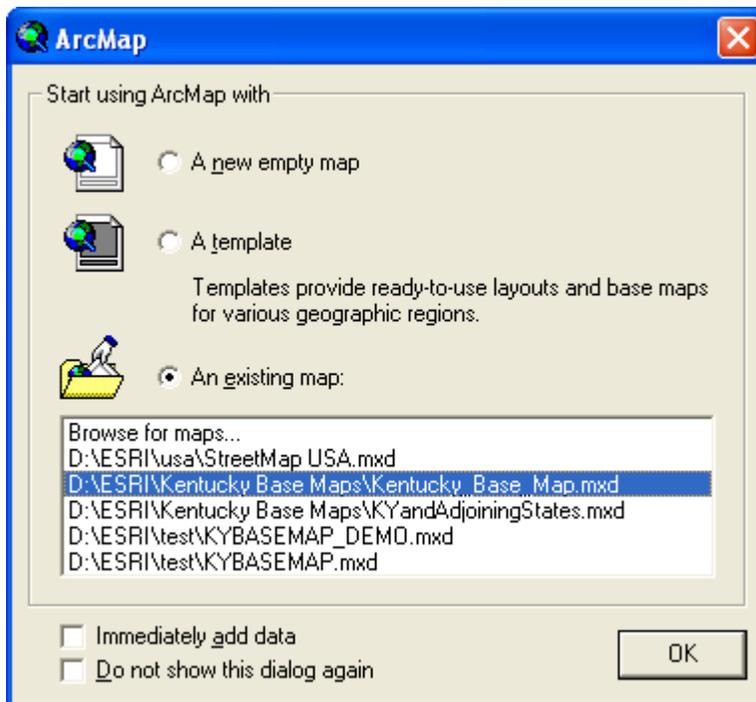
where

```
((DSS.T_D1_PROV_ENROLL.ENROLL_STAT_CODE IN ('1','3'))  
and (DSS.T_D1_PROV_ENROLL.ENROLL_STAT_END >= '01-Jul-2005'))  
and DSS.T_D1_PRV_HFT01.PROV_NUMBER = DSS.T_D1_PROV_ENROLL.PROV_NUMBER
```

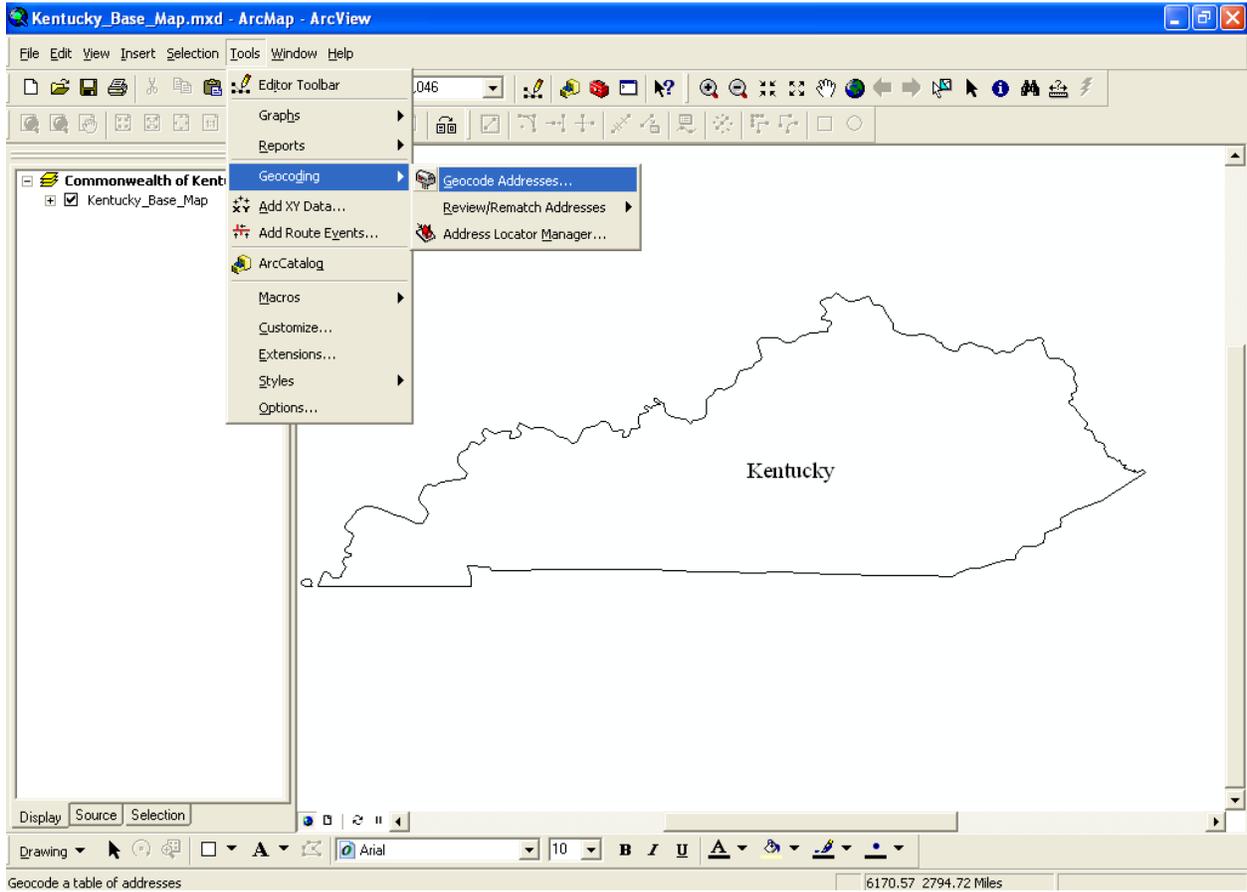
Once you have the data, utilize the export facility in BusinessObjects and export as a dbf file. Keep the file name at a maximum of 8 characters. When geocoding later in this exercise, ESRI only displays the first eight characters.



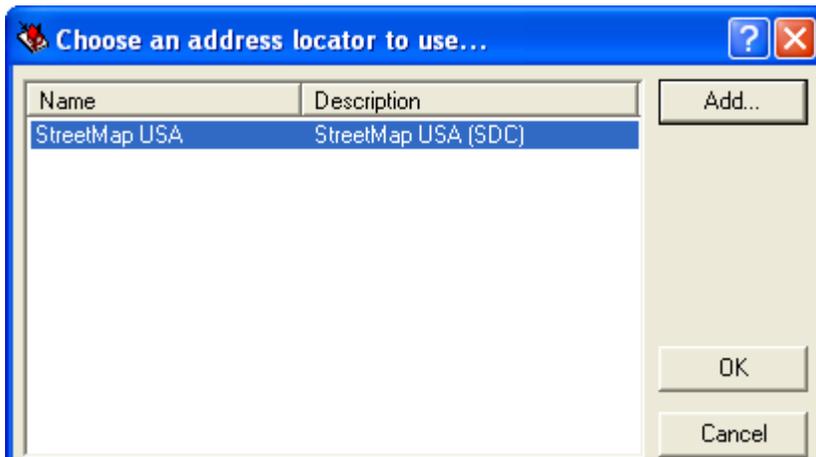
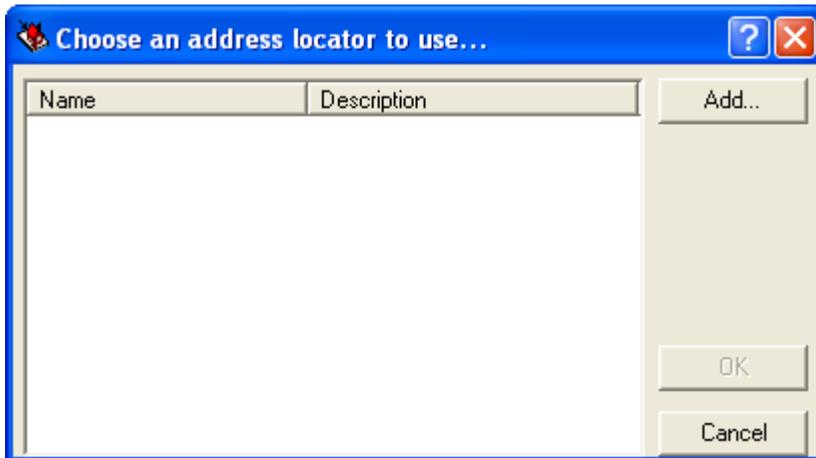
Open ESRI ArcMap and select a base map. You can select a base map by either double-clicking on the map or single clicking and clicking on the OK button.



Next, select from the tools menu. Navigate to the Geocoding sub-menu and move the arrow over until the Geocode Addresses item is highlighted and then click on the item.



Next we need to add an address locator. Click on the Add button shown in the picture below. Once the window opens either double click on the file name or single click on the file and then click the OK button to choose the file. This is a file that specifies the reference data and its relevant attributes. For our example, we will be using the Address Locator (StreetMap USA) provided by ESRI.



Now we need to add the dbf file, as our Address table, that we created in BusinessObjects. We also need to name the shape file to something meaningful. Please note the underscore in the file name. You may not use spaces in the file name.

Geocode Addresses: StreetMap USA

Address table:
LISALEE_.dbf

Address Input Fields

Street: <None>

City: CITY

State: STATE

ZIP: ZIP

Output

Create static snapshot of table inside new feature class

Create dynamic feature class related to table

Output shapefile or feature class:
D:\ESRI\Kentucky Base Maps\Provider_geocode.shp

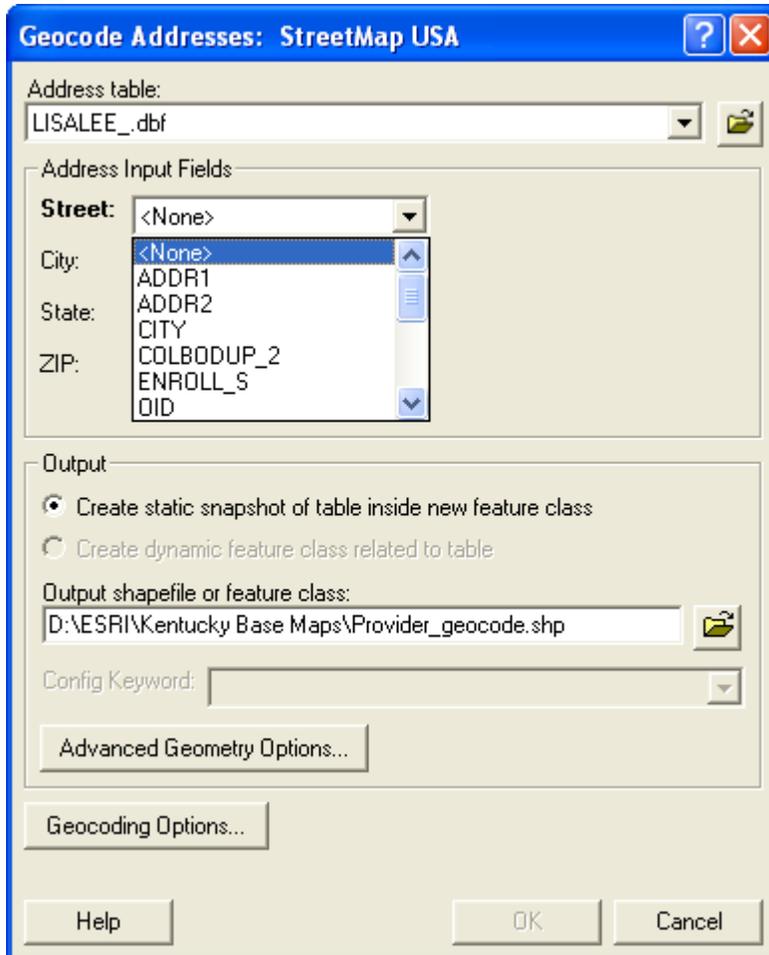
Config Keyword:

Advanced Geometry Options...

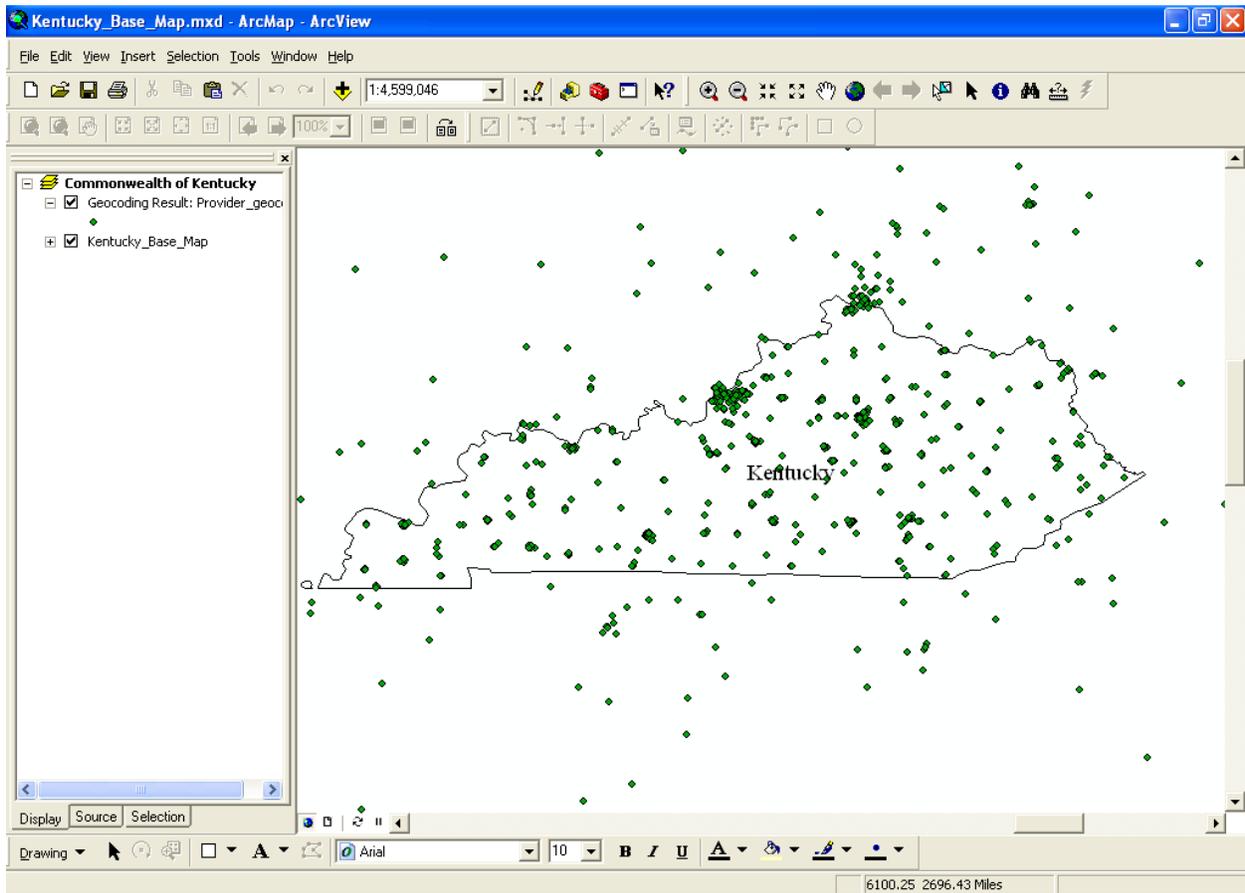
Geocoding Options...

Help OK Cancel

Because we gave the columns in our SQL meaningful names, ESRI was able to populate City, State, and Zip. But because we have two addresses (ADDR1 and ADDR2), it will force us to select one.



For this demo I only pulled 2000 rows to geocode. As you will see, a layer called Provider_geocode has been created and added to our map. The layer is displayed in the table of contents on the left hand side of the map in the upper right hand corner of the box.



Additional layers can be added, labels and visible scale ranges set.

ADDING COUNT DATA TO LAYERS

Now we will look at how to add aggregate data to a layer such as the member count per zip code boundary. For simplicity we will start with a fresh Kentucky base map.

Once again, use BusinessObjects to create a dbf file based on the SQL below

```
SELECT
  DSS_CLM_RUR_RCP_HFT012.RECIP_ZIP_CODE as MemZIP,
  count(distinct(DSS.T_D1_CLM_RUR_HISTORY.RECIP_IDENT_NUMBER)) as MemCOUNT
FROM
  DSS.RCP_HFT01  DSS_CLM_RUR_RCP_HFT012,
  DSS.T_D1_CLM_RUR_HISTORY
WHERE
  ( DSS.T_D1_CLM_RUR_HISTORY.ORIGINAL_RECIP_ID=DSS_CLM_RUR_RCP_HFT012.ORIGINAL_RECIP_ID(+) )
GROUP BY
  DSS_CLM_RUR_RCP_HFT012.RECIP_ZIP_CODE
HAVING
  (count(distinct(DSS.T_D1_CLM_RUR_HISTORY.RECIP_IDENT_NUMBER)) > 0)
```

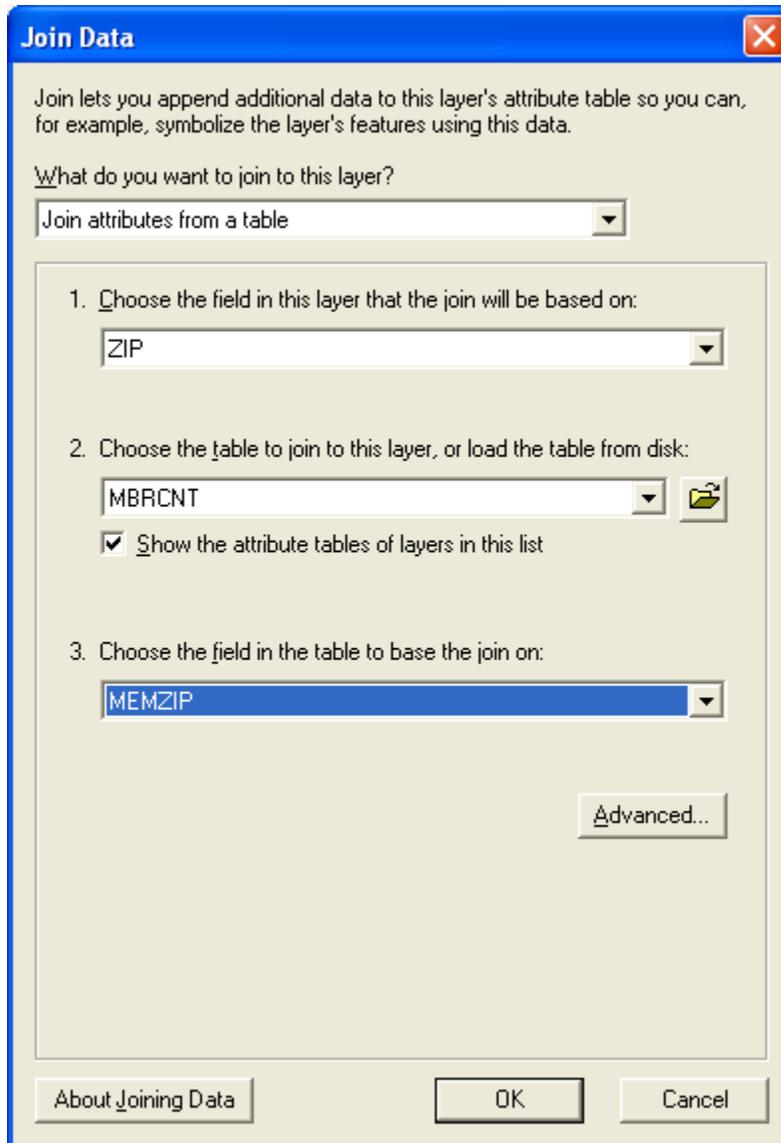
Add the zip code layer to the base map.

Set the label

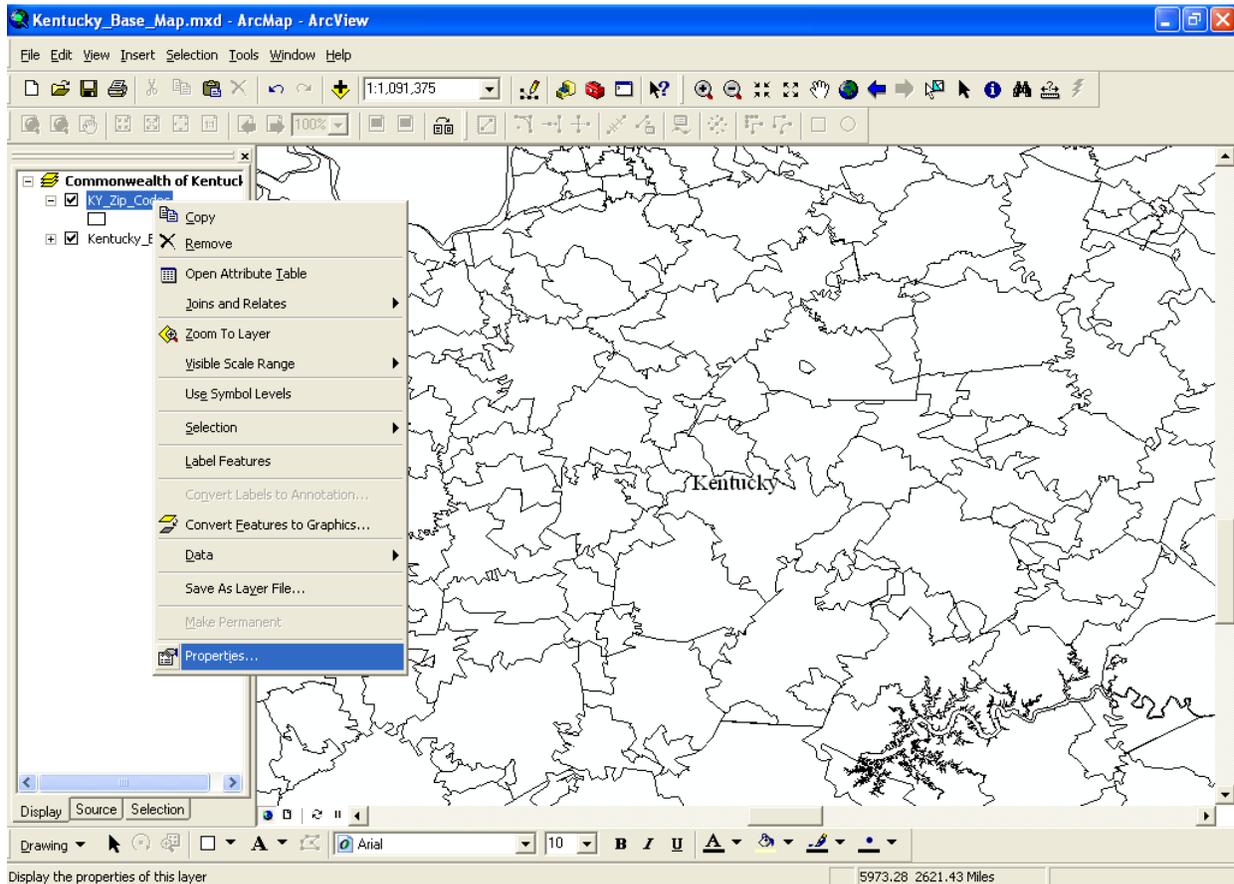
Add the dbf file as a layer

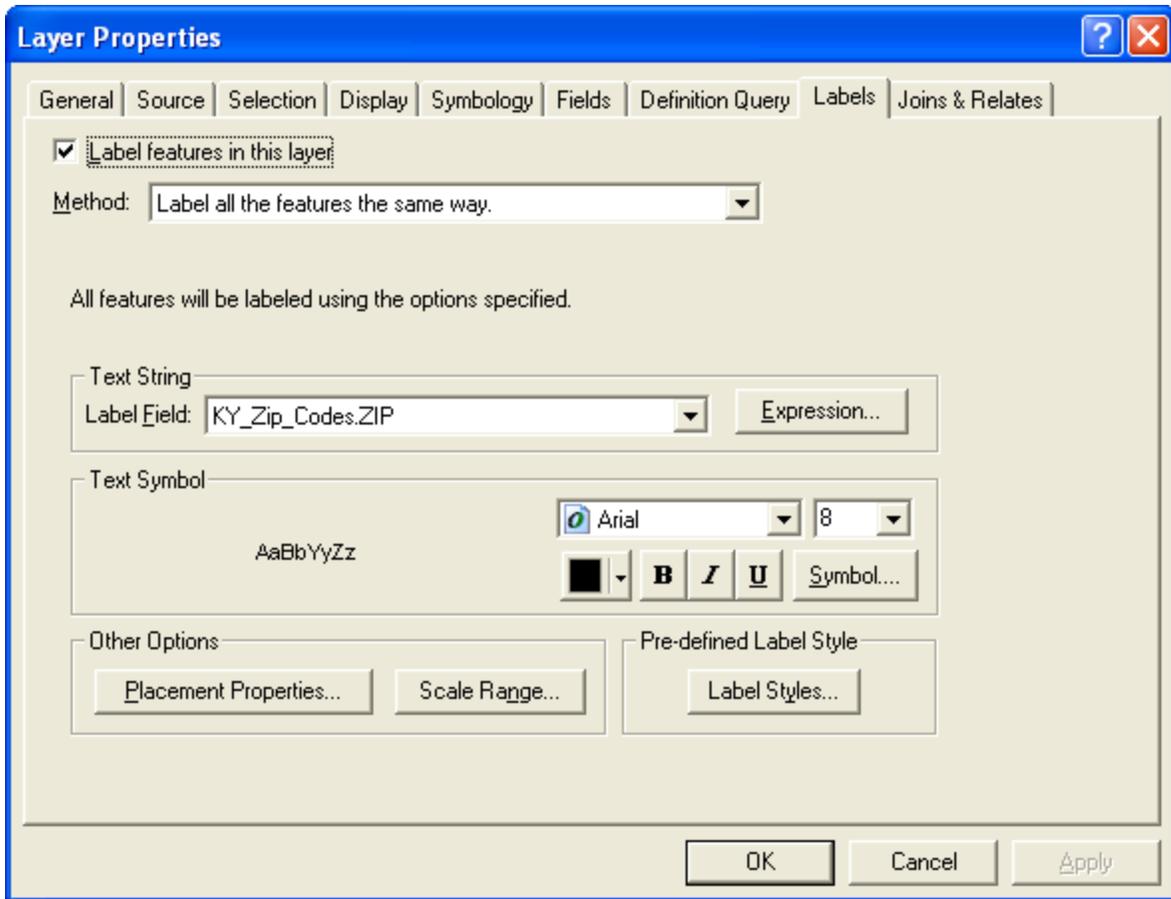
To create the join is a 3 step process:

1. Select the column to join from the zip code layer table. This is done by selecting an item from the drop down box labeled 1 in the picture below.
2. Select the dbf file created with the member counts. This is done by selecting an item from the drop down box labeled 2 in the picture below.
3. Select the column that will join (one-to-one in this case) to the zip code layer table. This is done by selecting an item from the drop down box labeled 3 in the picture below.

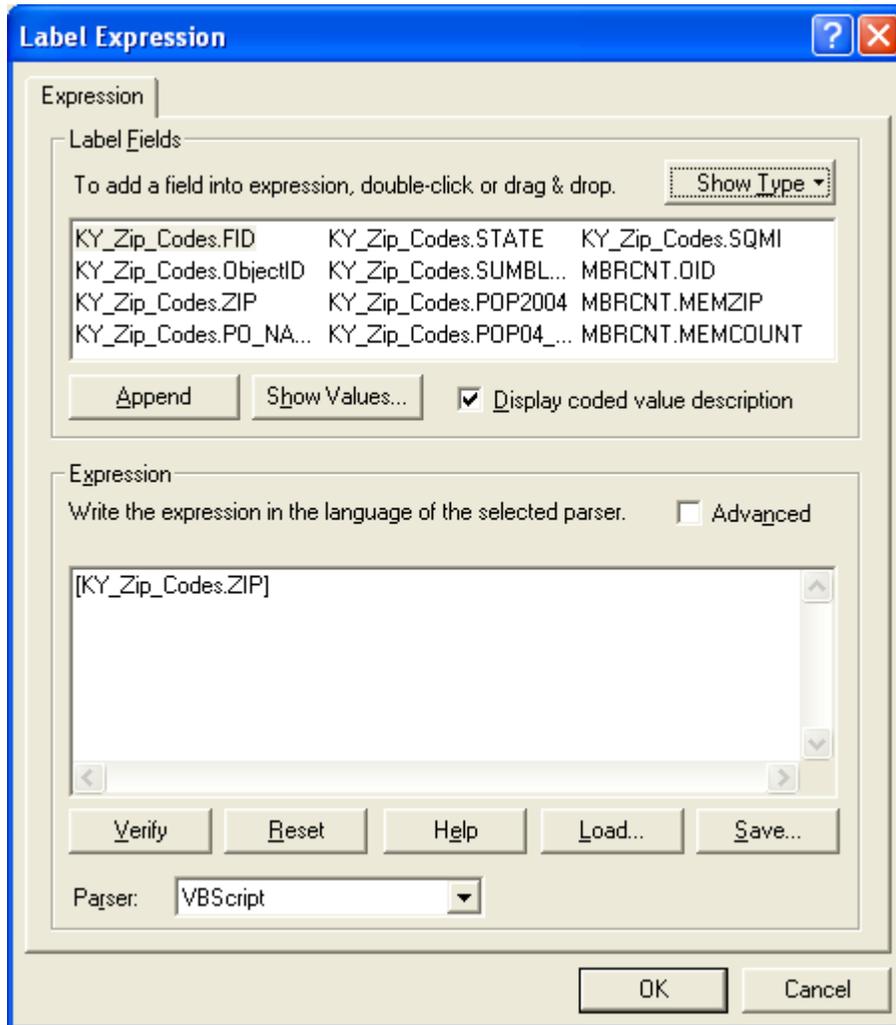


Next, right click on the layer to access the properties of the zip code layer table and select the labels tab.

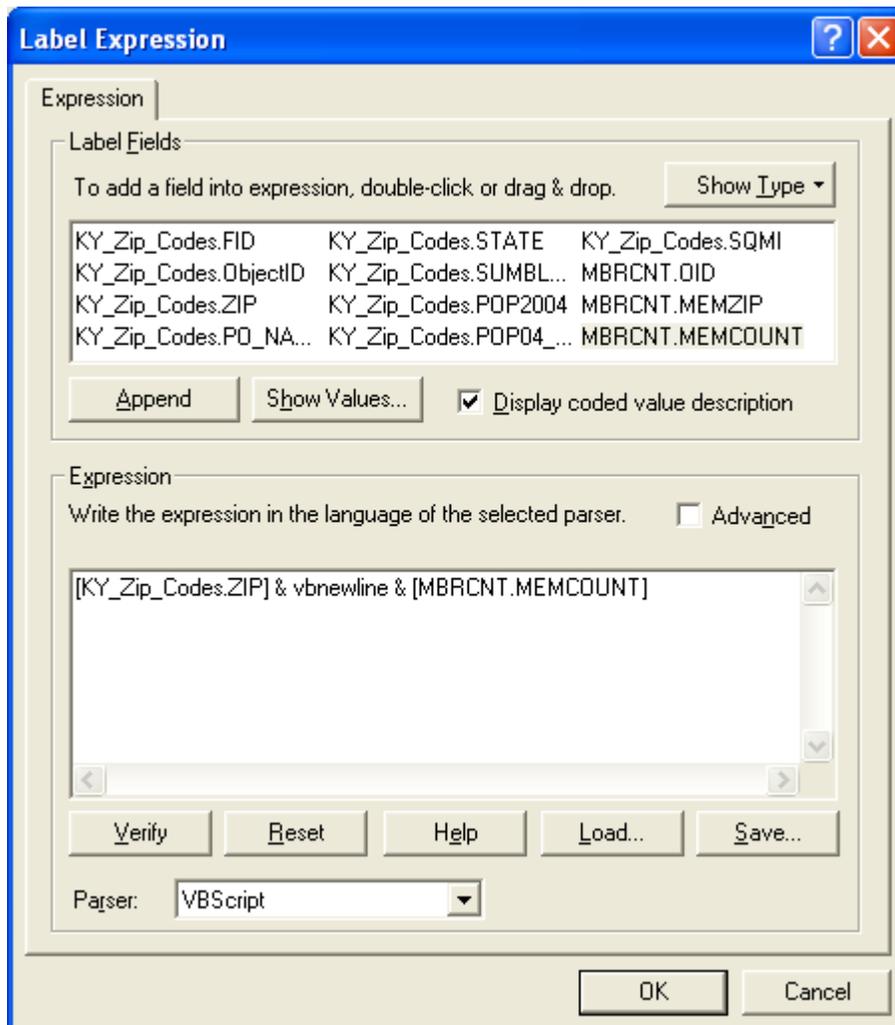




We need to build a simple function to add our counts. Click on 'Expression'

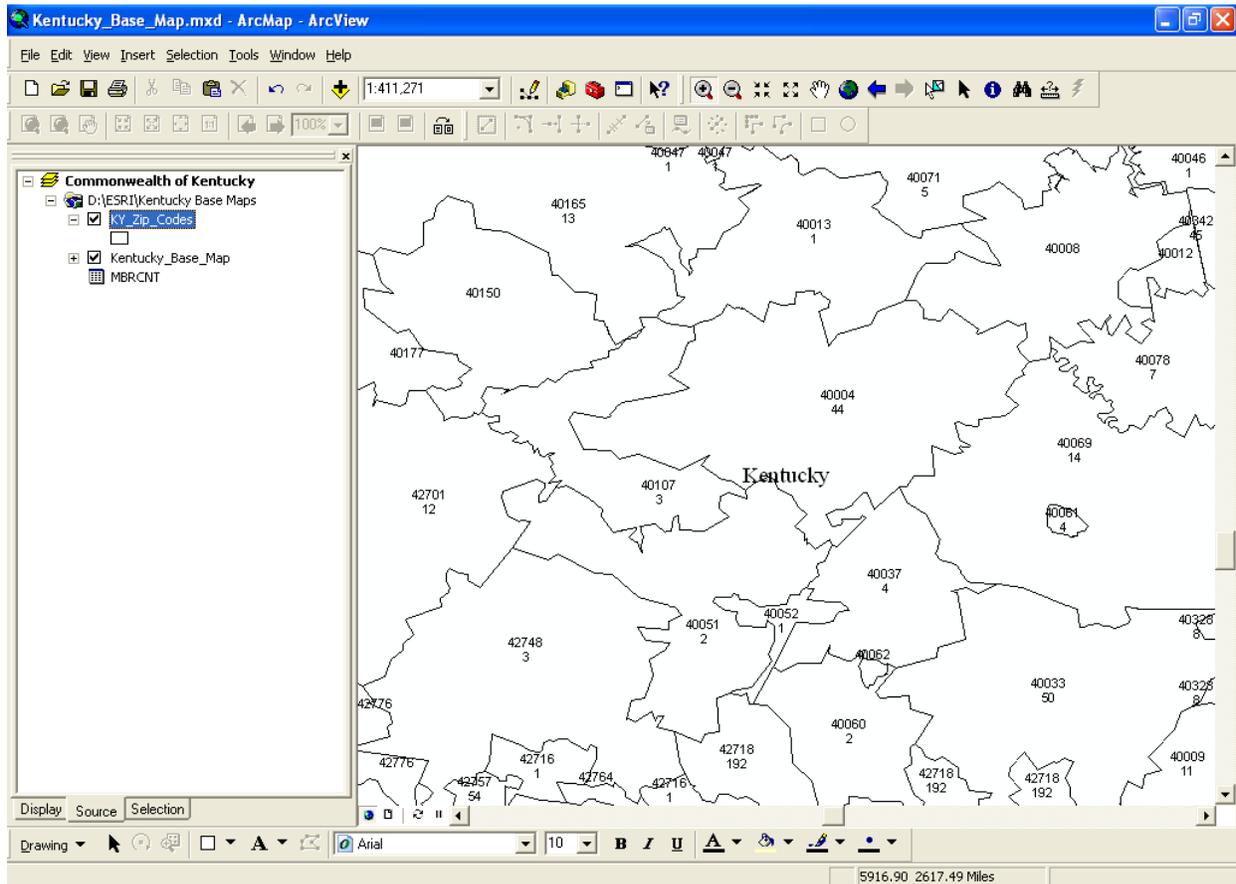


Functions can be built with JScript or VBScript. Below is the simple script we will use.



Notice that the member count from the dbf file has been added to the formula. You can see the difference by comparing this formula to the one seen on the previous page of the training manual. (Please define the components of script listed above and their purpose ie. [KY_Zip_Codes.Zip] represents the column used to produce the label, & is used to indicate the continuation of an expression, vbnewline tells the script to start additional displays for the expression on a new line, etc.)

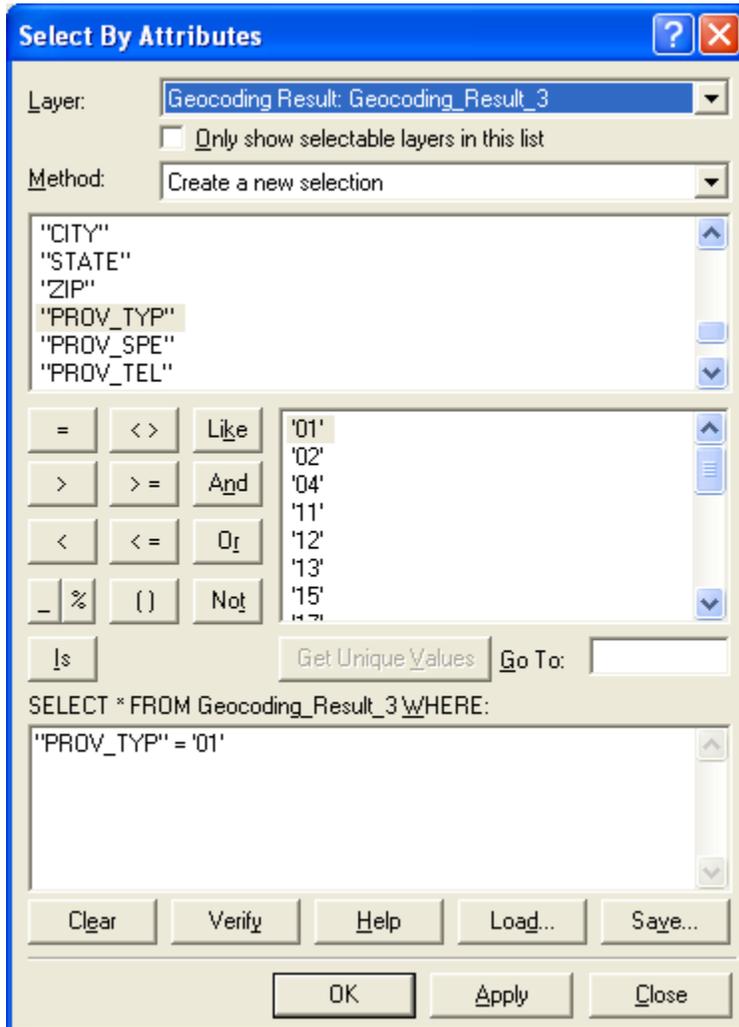
Press OK and the member count has been added as a part of the label below the Zip Code on the map.



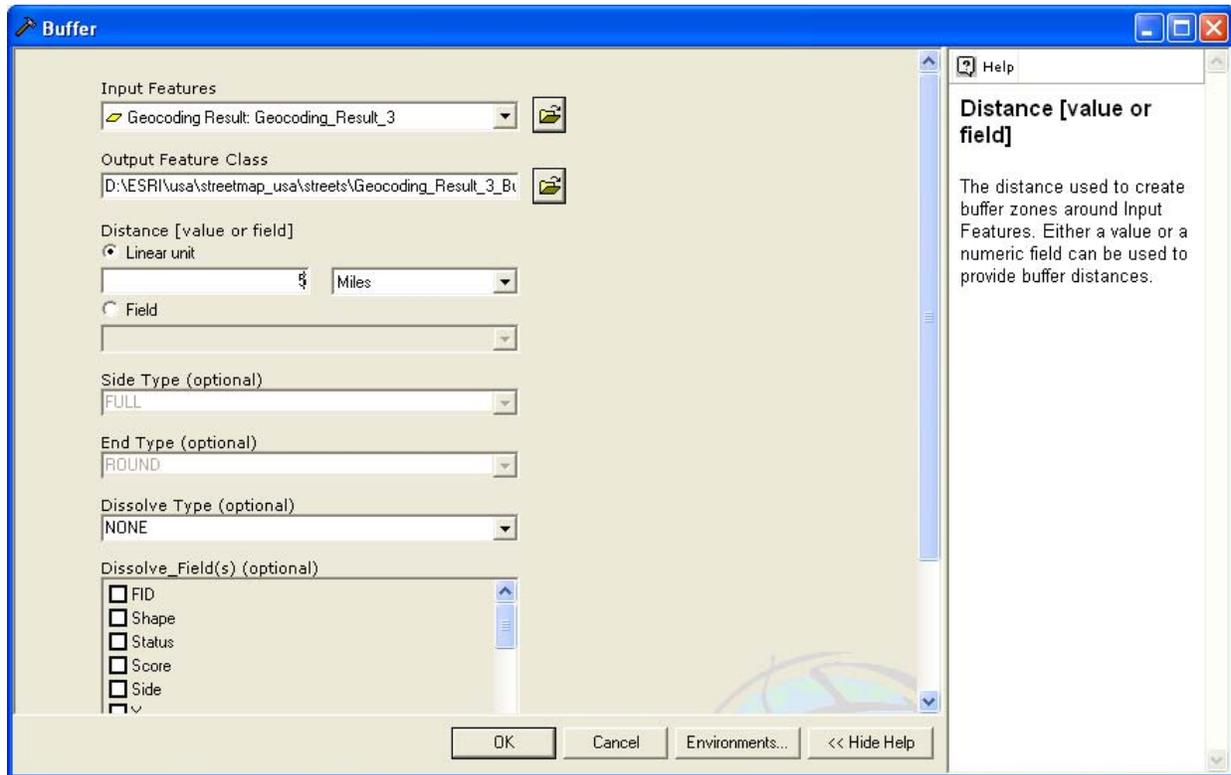
8.4 CREATING MEASUREMENT BUFFERS

First select what items you wish to create a proximity buffer for. In this example PROV_TYPE='01' have been selected.

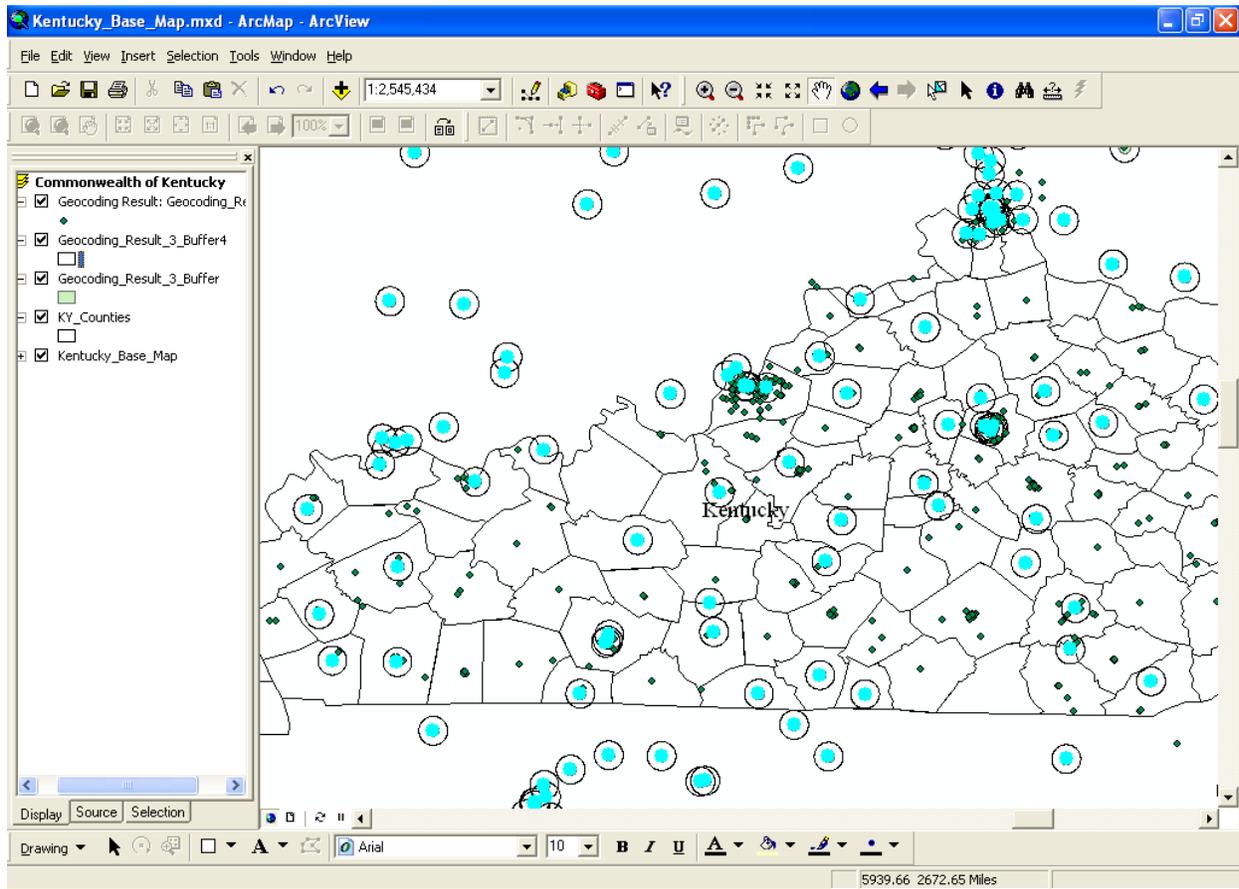
Note: You may also use the selection tool to select one or more map points.



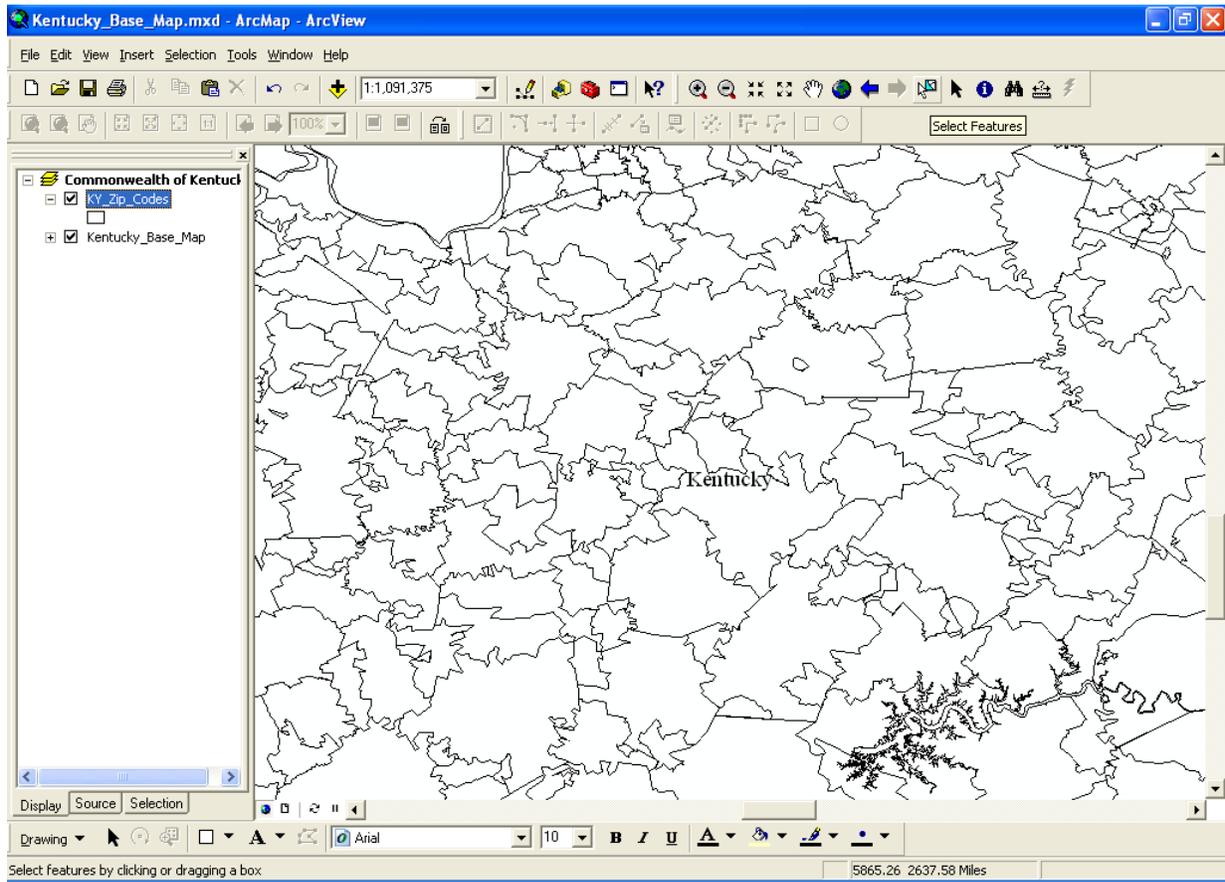
Next open the toolbox and select analysis tools. Then expand 'Proximity' and double click on buffer. In this case select the providers we geocoded which have been refined via the previous selection. In this case, since we wanted a buffer of 5 miles we entered 5 in the linear unit field and selected miles from the drop down menu. We then click OK to accept our choices.



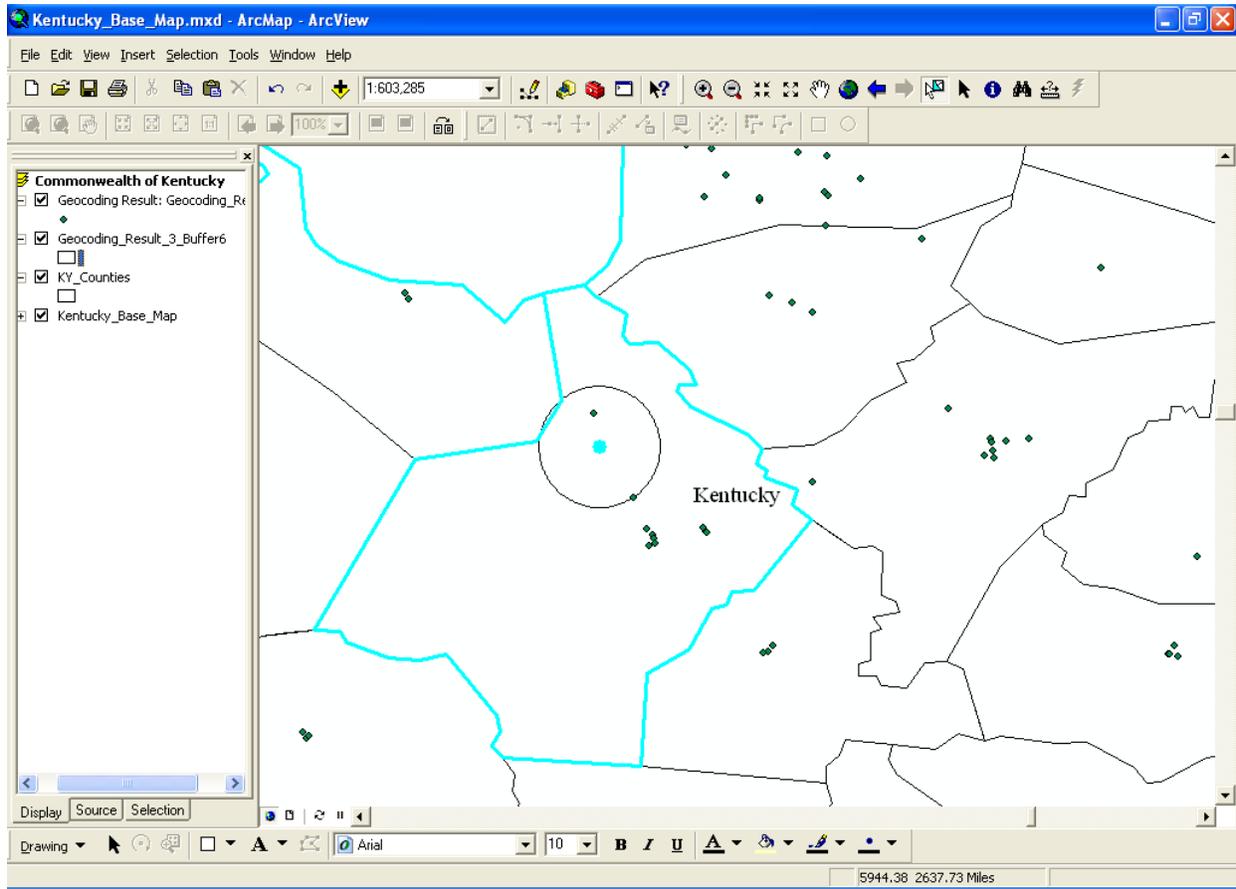
All PROV_TYPE's equal to '01' now have a 5 mile proximity around them. The outer circle around our provider indicates the circumference of the buffer we created and now you can see graphically how much area the provider is able to service.



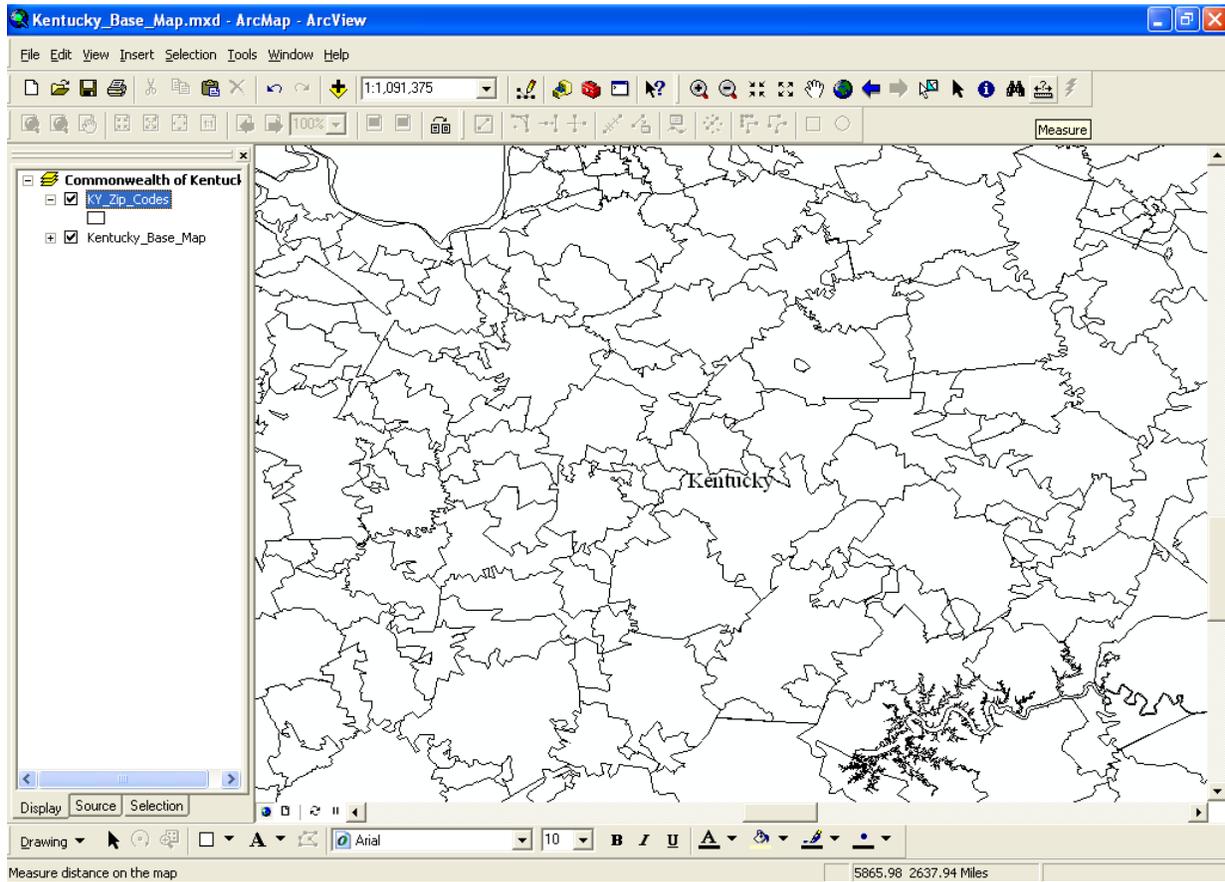
Single provider selected using the select features tool.



Left click on a single provider point and drag a box around that point. The selection of the provider point will change from brown to light blue.



You may also use the Measurement tool to measure point to point distances.



Select the Measure tool and left click once on any point in the map. Move your mouse to the second point on the map and left click once. In the lower left hand of the screen it will display the distance between the two points.

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9 Appendix C- ArcIMS Maps

Map	Map Description
All Kenpac Providers & Members in Kentucky	This map displays all Kenpac Providers and Members in the state of Kentucky. Kenpac Providers and Members are displayed as separate layers, but on the same map.
PCP Provider locations, & MCHIP and SCHIP Member locations	This map displays all Primary Care Physician (PCP) provider locations, Medicaid Children's Health Insurance Program (MCHIP), and State Children's Health Insurance (SCHIP) Member locations. The PCP Providers, and MCHIP and SCHIP Members are displayed as separate layers, but on the same map.

9.1 Technical Specifications for All Kenpac Providers & Members in Kentucky Map

SDE Layer	Business Criteria	Data warehouse SQL
All Kenpac Providers	All Providers with Program Code 'KENP' on Provider Enrollment table	<pre> SELECT T_PR_SVC_LOC_DN.ID_PROVIDER_MCAID, T_PR_ADR_DN.ADR_MAIL_STRT1, T_PR_ADR_DN.ADR_MAIL_STRT2, T_PR_ADR_DN.ADR_MAIL_CITY, T_PR_ADR_DN.ADR_MAIL_STATE, T_PR_ADR_DN.ADR_MAIL_ZIP, T_PR_ADR_DN.ADR_MAIL_ZIP_4 FROM T_PR_PHP_ELIG, T_PR_ENROLL_PGM, T_PR_ADR_DN, T_PR_SVC_LOC_DN WHERE T_PR_ENROLL_PGM.CDE_PROV_PGM = 'KENP' AND T_PR_PHP_ELIG.SAK_PROV_PGM = </pre>

SDE Layer	Business Criteria	Data warehouse SQL
		<pre>T_PR_ENROLL_PGM.SAK_PROV_PGM AND <CURRENT DATE> BETWEEN T_PR_PHP_ELIG.DTE_EFFECTIVE AND T_PR_PHP_ELIG.DTE_END AND T_PR_PHP_ELIG.SAK_PROV = T_PR_ADR_DN.SAK_PROV AND T_PR_SVC_LOC_DN.SAK_PROV = T_PR_ADR_DN.SAK_PROV AND T_PR_SVC_LOC_DN.SAK_PROV_LOC = T_PR_ADR_DN.SAK_PROV_LOC</pre>
All Kenpac Members	All Members with Program Health Code = 'KENP' on Member PMP Assign table.	<pre>SELECT T_RE_BASE_DN.ID_MEDICAID, T_RE_BASE_DN.ADR_STREET_1, T_RE_BASE_DN.ADR_STREET_2, T_RE_BASE_DN.ADR_STREET_3, T_RE_BASE_DN.ADR_CITY, T_RE_BASE_DN.ADR_STATE, T_RE_BASE_DN.ADR_ZIP_CODE, T_RE_BASE_DN.ADR_ZIP_CODE_4 FROM T_RE_PMP_ASSIGN, T_PUB_HLTH_PGM, T_RE_BASE_DN, T_RE_AID_ELIG_DN WHERE T_RE_PMP_ASSIGN.SAK_PUB_HLTH = T_PUB_HLTH_PGM.SAK_PUB_HLTH AND T_PUB_HLTH_PGM.CDE_PGM_HEALTH = 'KENP' AND T_RE_PMP_ASSIGN.SAK_RECIP = T_RE_BASE_DN.SAK_RECIP AND T_RE_PMP_ASSIGN.DTE_EFFECTIVE <</pre>

SDE Layer	Business Criteria	Data warehouse SQL
		T_PUB_HLTH_PGM.DTE_END AND T_RE_PMP_ASSIGN.DTE_END > T_PUB_HLTH_PGM.DTE_EFFECTIVE AND <CURRENT DATE> between T_RE_PMP_ASSIGN.DTE_EFFECTIVE AND T_RE_PMP_ASSIGN.DTE_END AND T_RE_PMP_ASSIGN.CDE_STATUS1 <> 'H' AND T_RE_PMP_ASSIGN.SAK_RECIP = T_RE_AID_ELIG_DN.SAK_RECIP AND T_RE_AID_ELIG_DN.DTE_EFFECTIVE BETWEEN T_RE_PMP_ASSIGN.DTE_EFFECTIVE AND T_RE_PMP_ASSIGN.DTE_END AND T_RE_AID_ELIG_DN.CDE_STATUS1 <> 'H'

9.2 Technical Specifications for PCP Provider locations, & MCHIP and SCHIP Member locations Map

SDE Layer	Business Criteria	Data warehouse SQL
Primary Care Physicians (PCPs)	<p>PCP's Condition #1:</p> <ul style="list-style-type: none"> •Providers with Type Code 20, 31 or 35 •Enrollment Status code 01 or 03 •Enrollment Date greater than date of report run <p>PCP's Condition #2:</p> <ul style="list-style-type: none"> •Providers with Type Code 64 or 65 •Providers with Specialty Codes 01, 16, 11, 25 or 37 •Enrollment Status code 01 or 03 •Enrollment Date greater than date of report run <p>PCP's Condition #3:</p> <ul style="list-style-type: none"> •Providers with Type Code 78 •Providers with Specialty Codes 50, 51, 58 or 52 •Enrollment Status code 01 or 03 •Enrollment Date greater than date of report run 	<pre> SELECT DSS.T_PR_SVC_LOC_DN.ID_PROVIDER_MCAID, DSS.T_PR_ADR_DN.ADR_MAIL_STRT1, DSS.T_PR_ADR_DN.ADR_MAIL_STRT2, DSS.T_PR_ADR_DN.ADR_MAIL_CITY, DSS.T_PR_ADR_DN.ADR_MAIL_STATE, DSS.T_PR_ADR_DN.ADR_MAIL_ZIP, DSS.T_PR_ADR_DN.ADR_MAIL_ZIP_4, FROM DSS.T_PR_SVC_LOC_DN, DSS.T_PR_ADR_DN WHERE (DSS.T_PR_SVC_LOC_DN.CDE_PROV_TYPE_PRIM in ('20', '31', '35') OR (DSS.T_PR_SVC_LOC_DN.CDE_PROV_TYPE_PRIM in ('64', '65') and DSS.T_PR_SVC_LOC_DN.CDE_PROV_SPEC_PRIM in ('01', '16', '11', '25', '37')) OR (DSS.T_PR_SVC_LOC_DN.CDE_PROV_TYPE_PRIM ='78' and DSS.T_PR_SVC_LOC_DN.CDE_PROV_SPEC_PRIM </pre>

SDE Layer	Business Criteria	Data warehouse SQL
		<pre> in ('50', '51', '58', '52'))) AND DSS.T_PR_SVC_LOC_DN.SAK_PROV = DSS.T_PR_ADR_DN.SAK_PROV AND DSS.T_PR_SVC_LOC_DN.SAK_PROV_LOC = DSS.T_PR_ADR_DN.SAK_PROV_LOC </pre>
All Managed Care Health Insurance (MCHIP) Members	MCHIP (Phase II) are members with a status code of P5 or P6	<pre> SELECT DSS.T_RE_BASE_DN.ID_MEDICAID, DSS.T_RE_BASE_DN.ADR_STREET_1, DSS.T_RE_BASE_DN.ADR_STREET_2, DSS.T_RE_BASE_DN.ADR_STREET_3, DSS.T_RE_BASE_DN.ADR_CITY, DSS.T_RE_BASE_DN.ADR_STATE, DSS.T_RE_BASE_DN.ADR_ZIP_CODE FROM DSS.T_RE_BASE_DN, DSS.T_RE_AID_ELIG_DN WHERE DSS.T_RE_AID_ELIG_DN.SAK_RECIP = DSS.T_RE_BASE_DN.SAK_RECIP AND DSS.T_RE_AID_ELIG_DN.CDE_PGM_STAT US in ('P5', P6) </pre>
All State Children's Health Insurance (SCHIP) Members	SCHIP (Phase III) are members with a status code of P7	<pre> SELECT DSS.T_RE_BASE_DN.ID_MEDICAID, DSS.T_RE_BASE_DN.ADR_STREET_1, DSS.T_RE_BASE_DN.ADR_STREET_2, DSS.T_RE_BASE_DN.ADR_STREET_3, DSS.T_RE_BASE_DN.ADR_CITY, DSS.T_RE_BASE_DN.ADR_STATE, </pre>

SDE Layer	Business Criteria	Data warehouse SQL
		DSS.T_RE_BASE_DN.ADR_ZIP_CODE FROM DSS.T_RE_BASE_DN, DSS.T_RE_AID_ELIG_DN WHERE DSS.T_RE_AID_ELIG_DN.SAK_RECIP = DSS.T_RE_BASE_DN.SAK_RECIP AND DSS.T_RE_AID_ELIG_DN.CDE_PGM_STAT US = 'P7'

10 Appendix D- How to Create a DSS query using WebIntelligence

10.1 Querying DSS for providers with a specific provider type

STEP 1. Navigate to MEUPS site. The initial sign-on window will display.

STEP 2. Enter Username and Password and select 'Sign In'.

The screenshot shows the 'Kentucky Medicaid Web Site' sign-in interface. At the top, it reads 'KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES' and 'DEPARTMENT FOR MEDICAID SERVICES'. The main content area features the 'Kentucky UNBRIDLED SPIRIT' logo on the left. Below the logo, there is contact information: 'For assistance, email us at KY_EDJ_HelpDesk@eds.com or call (800) 205-4696 during normal business hours 7:00 am - 6:00 pm Monday - Friday EST.' A 'Contact Us' link is also present. The central section is titled 'Sign in to the KyHealth Choices' and lists three options: 'Manage your contact information', 'Change your password', and 'Providers: Manage your agent's access'. Below this, it states 'If you do not have an account, you will need to register.' with a 'Register' button. On the right, there is a 'Sign in to KyHealth Choices' form with fields for 'Username' and 'Password', a 'Sign In' button, and a 'Help' link. Below the form, there is a 'KyHealth Choices' section with a 'Forgot your password?' link. The footer contains 'Privacy | Disclaimer | Individuals with Disabilities' and 'Copyright © 2006 Commonwealth of Kentucky All rights reserved.' The browser's address bar shows 'Done' and 'Internet'.

STEP 3. Select the DSS/SUR environment to work in by clicking on the link.

KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
 DEPARTMENT FOR MEDICAID SERVICES

KyHealth Choices Home

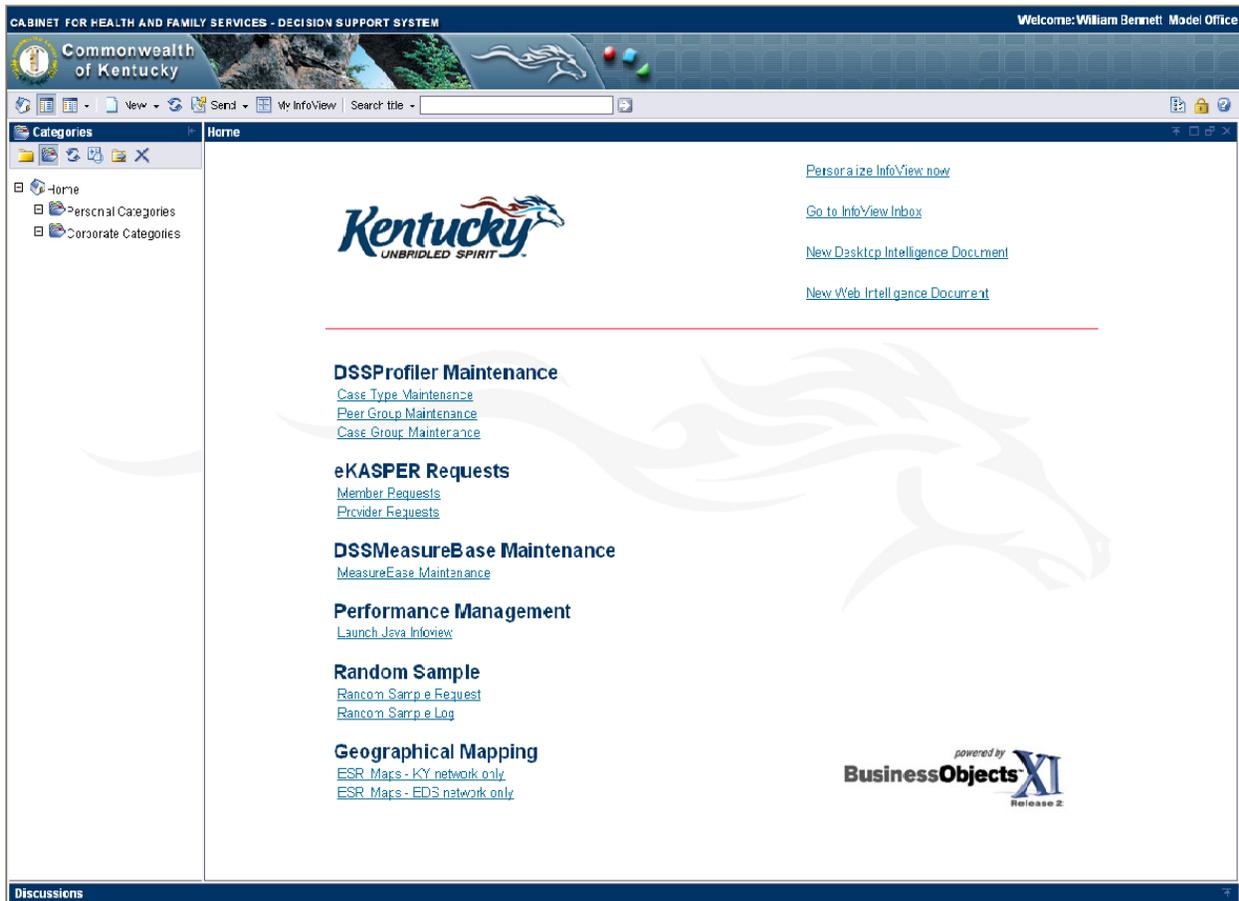
Friday 16 March 2007 6:22 pm Sign Out

Bobby Jones, Welcome to KyHealth Choices

Applications	
Application	Description
Account Management	Modify your account information. Providers can also use this application to give application permissions to their agents.
Authorization Request	Allows a user to request access to applications
DSS/SUR Model Office	This is the Model Office BusinessObjects Infoview for DSS/SUR
DSS/SUR Test	This is the Test BusinessObjects Infoview for DSS/SUR
DSS/SUR UAT	This is the UAT BusinessObjects Infoview for DSS/SUR
KyHealth Choices	This is the KyHealth Choices portal application

Messages	
Date	Message
02/23/2007	.Net User Interface MO and UAT release build 112 included the following Change Orders and Defects: Claims - 5749, 6255; CTMS - 6385; EPSDT - 975, 5020; Financial - 3751, 5946; Managed Care - 6141, 6308; MAR - 6372; Member Data Maintenance - 4384; Prior Auth - 4750, 4796, 4987, 6262, 6276; Provider - 4656, 4979, 6390; Recipient - 5930, 5931; Reference Data Maintenance - 2179, 3158, 6002, 6192; System Wide - 4408, 4959; and Third Party Liability - 2932, 4721, 5008, 5009, 5057, 5074, 5143, 6323, 6331. UNIX Model Office and UAT promotion build 112 on 2/23/2007 contained the following change orders and defects: Buils

The infoview main page will open.



10.1.1 InfoView Panel Sections

Section	Description
Categories	This section of the panel displays the categories of reports that can be accessed by a user depending on their permissions.
Home	This section of the panel displays the access options that a user has access to based on their permissions. Note: Most individuals will not have access to the eKASPER information shown here. If a person does not have access to a function it will not display on the panel.

10.1.2 InfoView Panel Links

Links	Description
Personalize InfoView Now	This link guides the user to a page where they can customize the display properties of the infoView panel displayed when they log into infoView.
Go to InfoView Inbox	This link guides the user to their personal infoView inbox. This allows a user to access documents forwarded to them by other infoView DSS users.

Links	Description
New Desktop Intelligence Document	This link opens a new document using the desktop intelligence version of the BusinessObjects software.
New Web Intelligence Document	This link opens a new document using the web intelligence version of the BusinessObjects software.
Case Type Maintenance	This link opens a page that allows the user to update, add or delete case types that are used in the DSS Profiler process.
Peer Group Maintenance	This link opens a page that allows the user to update, add or delete peer groups that are used in the DSS Profiler process.
Case Group Maintenance	This link opens a page that allows the user to update, add or delete case groups that are used in the DSS Profiler process.
Member Requests	This link opens a pages that allows users with eKASPER access to request information about a member.
Provider Requests	This link opens a pages that allows users with eKASPER access to request information about a provider.
MeasureBase Maintenance	This link opens a pages that allows users with MeasureBase access to add or update measures.
Launch Java InfoView	This link opens up a panel that allows users with Performance Manager access to see executive dashboards.
Random Sample Request	This link opens a pages that allows users to create a random sample request.
Random Sample Log	This link opens a pages that allows users to view the status of an existing random sample request.
ESRI Maps – KY Network Only	This link opens a pages that allows users to access ESRI maps that are available on the KY Network.
ESRI Maps – HP Enterprise Services Network Only	This link opens a pages that allows users to access ESRI maps that are available on the HP Enterprise Services Network.

STEP 4. Select the New Web Intelligence Document Link.

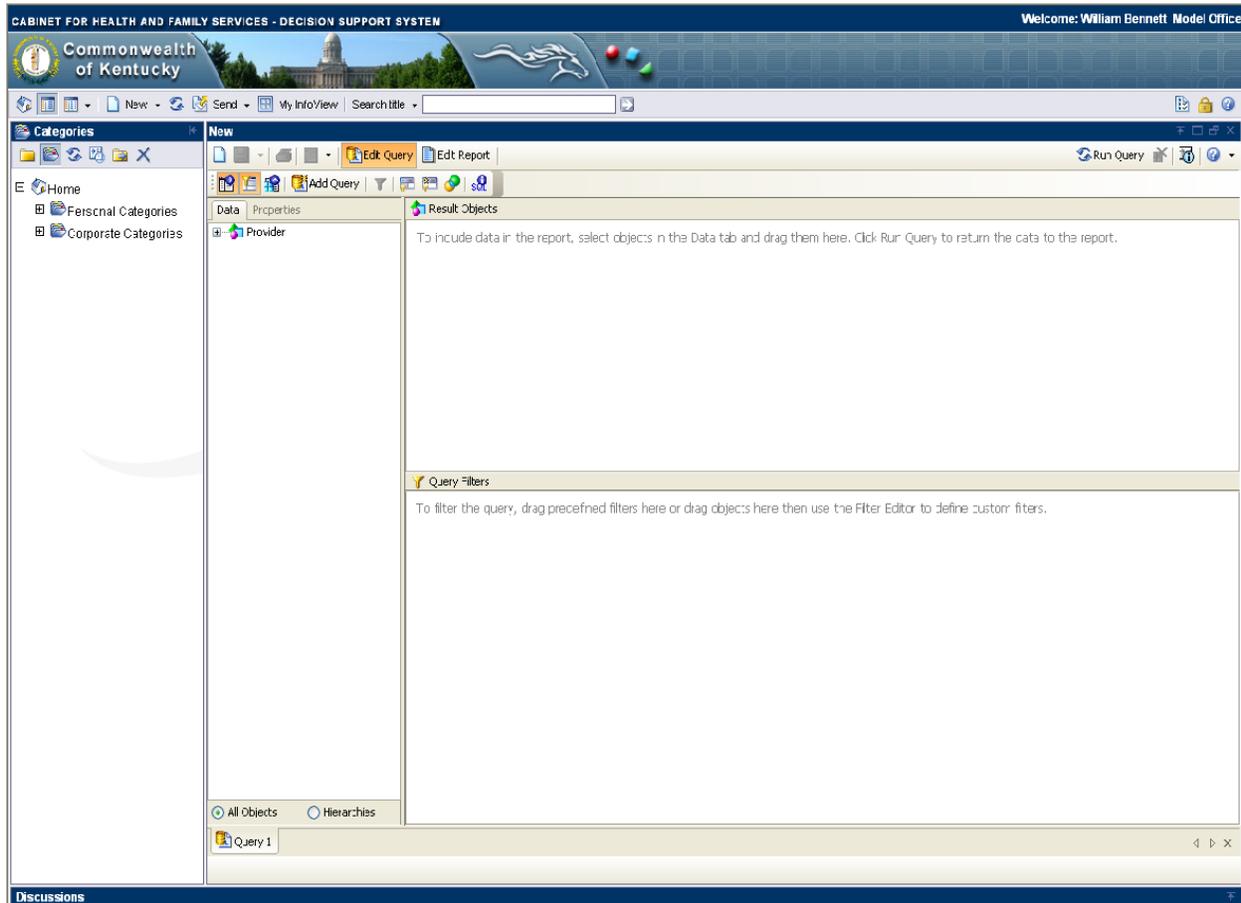
The Web Intelligence universe list page will open.

The screenshot displays the 'New Web Intelligence Document' interface. On the left, there is a navigation pane with 'Categories' and a tree view showing 'Home', 'Personal Categories', and 'Corporate Categories'. The main area is a table listing various universes. The table has three columns: 'Name', 'Owner', and 'Folder'. The 'Folder' column for all entries is 'KY Model Office Universes'. The 'Owner' column lists various users, including 'Administrator', 'tztstbl', and 'rzttdly'. The 'Name' column lists universes such as 'Claims Analysis', 'DSSMeasureBase', 'DSSProfiler', 'eKASPER', 'Episode Treatment Group (ETG)', 'Financial', 'Hel: Claims', 'Managed Care', 'MAR MSIS', 'MAR SummaryData', 'Member', 'PM Metrics', 'Presumptive Eligibility', 'Price Authorization PA', 'Provider', 'Random Sample Universe', 'Reference', 'test', 'TPL', and 'Vital Statistics'.

Name	Owner	Folder
Universe	Administrator	KY Model Office Universes
Claims Analysis	Administrator	KY Model Office Universes
DSSMeasureBase	tztstbl	KY Model Office Universes
DSSProfiler	Administrator	KY Model Office Universes
eKASPER	tztstbl	KY Model Office Universes
Episode Treatment Group (ETG)	Administrator	KY Model Office Universes
Financial	Administrator	KY Model Office Universes
Hel: Claims	tztstbl	KY Model Office Universes
Managed Care	Administrator	KY Model Office Universes
MAR MSIS	tztstbl	KY Model Office Universes
MAR SummaryData	tztstbl	KY Model Office Universes
Member	Administrator	KY Model Office Universes
PM Metrics	tztstbl	KY Model Office Universes
Presumptive Eligibility	tztstbl	KY Model Office Universes
Price Authorization PA	Administrator	KY Model Office Universes
Provider	Administrator	KY Model Office Universes
Random Sample Universe	Administrator	KY Model Office Universes
Reference	rzttdly	KY Model Office Universes
test	Administrator	KY Model Office Universes
TPL	tztstbl	KY Model Office Universes
Vital Statistics	tztstbl	KY Model Office Universes

STEP 5. Click the Provider Link.

The provider universe will open.

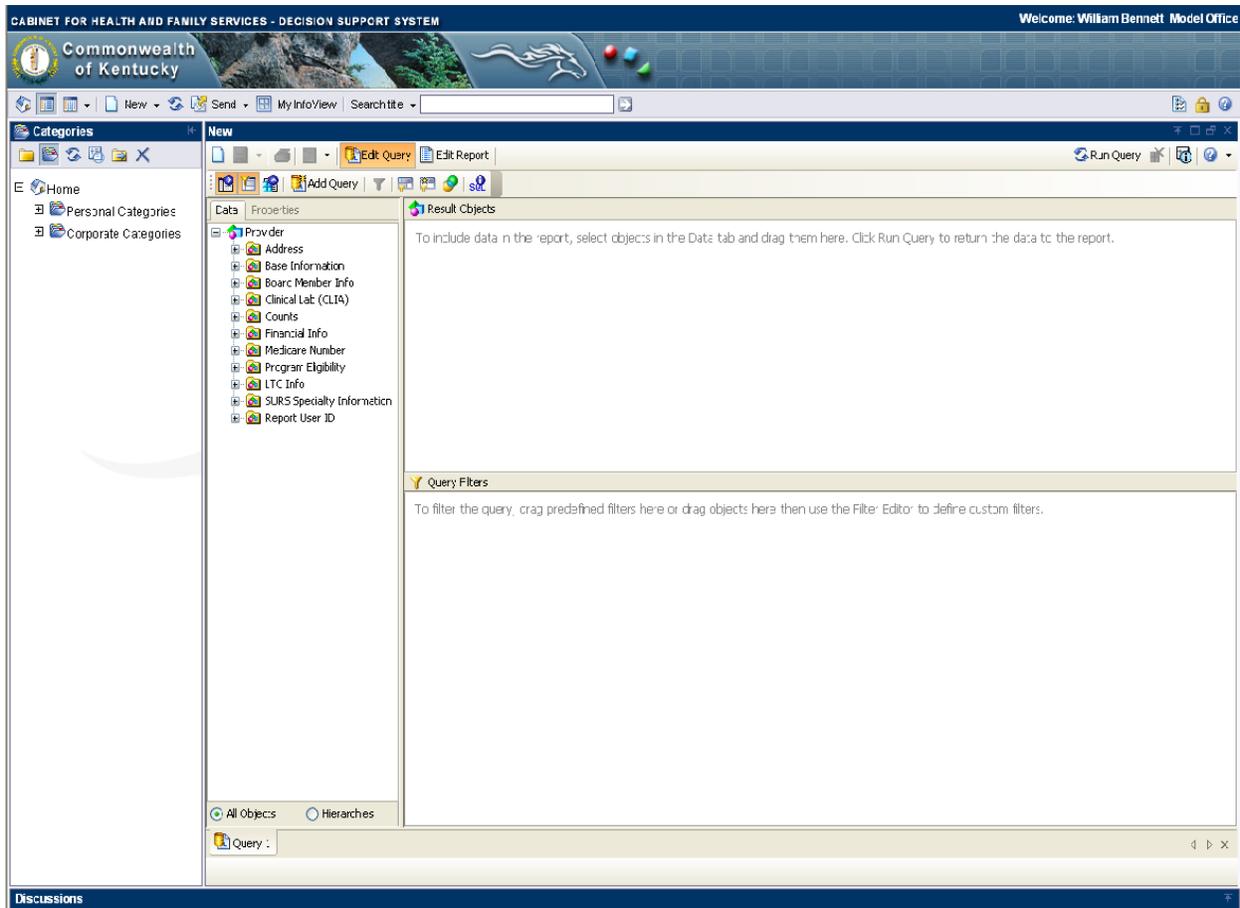


10.1.3 Provider Universe Section Descriptions

Section	Description
Data/Properties	This section serves one of two purposes depending on which tab you are on for the section. The data tab allows the user to access the objects that are used as filters or query results. The properties tab allows the user to control the results that are returned from a query.
Result Objects	This section of the screen displays the objects that will be returned as query results.
Query Filters	This section of the screen displays the objects that will be used as criteria to filter the query in order to produce the desired results.

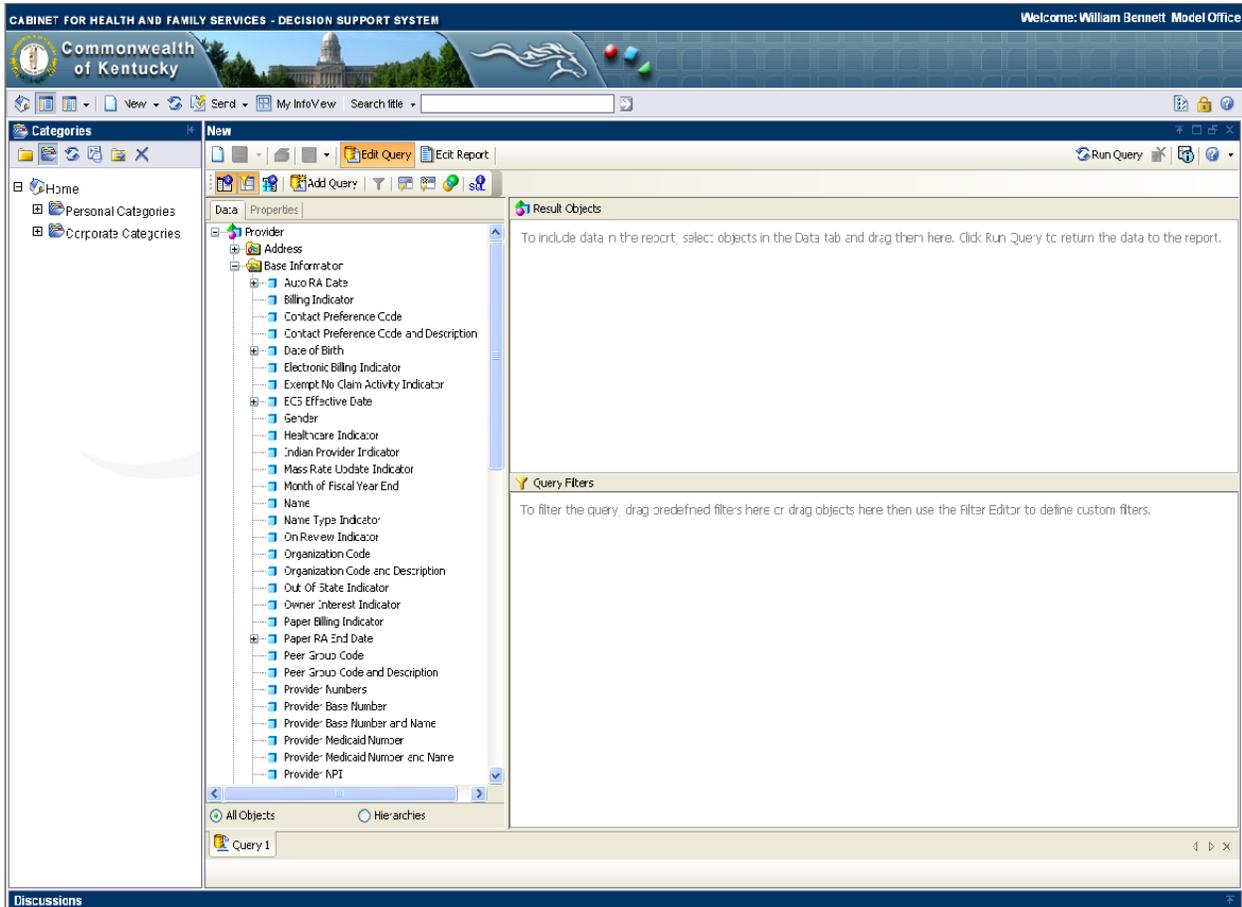
STEP 6. Click on the + sign next to the word “Provider” in the Data/Properties section of the panel.

The list of provider universe objects will open.



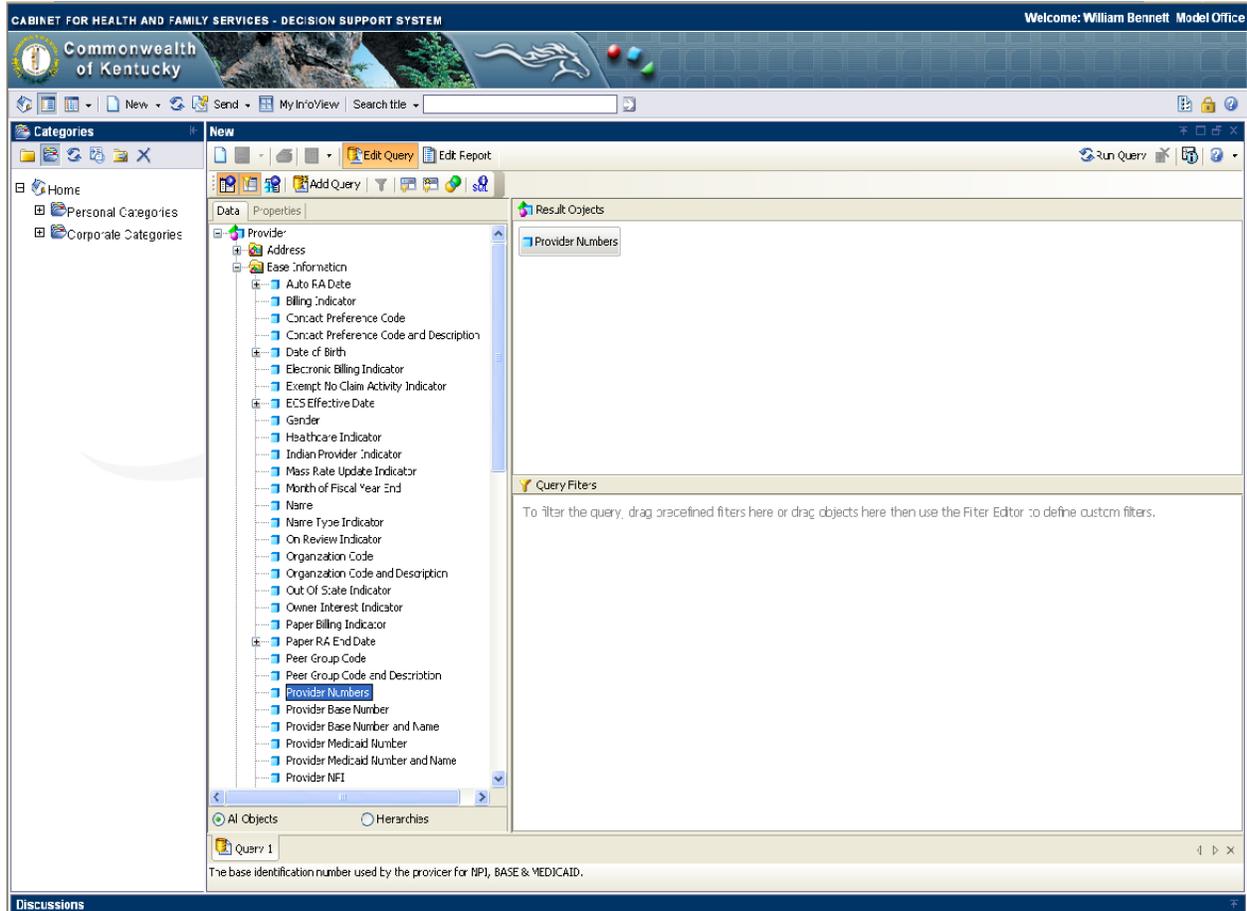
STEP 7. Click on the + sign next to the words “Base Information” in the Data/Properties section of the panel.

The list of provider universe “Base Information” objects will open.



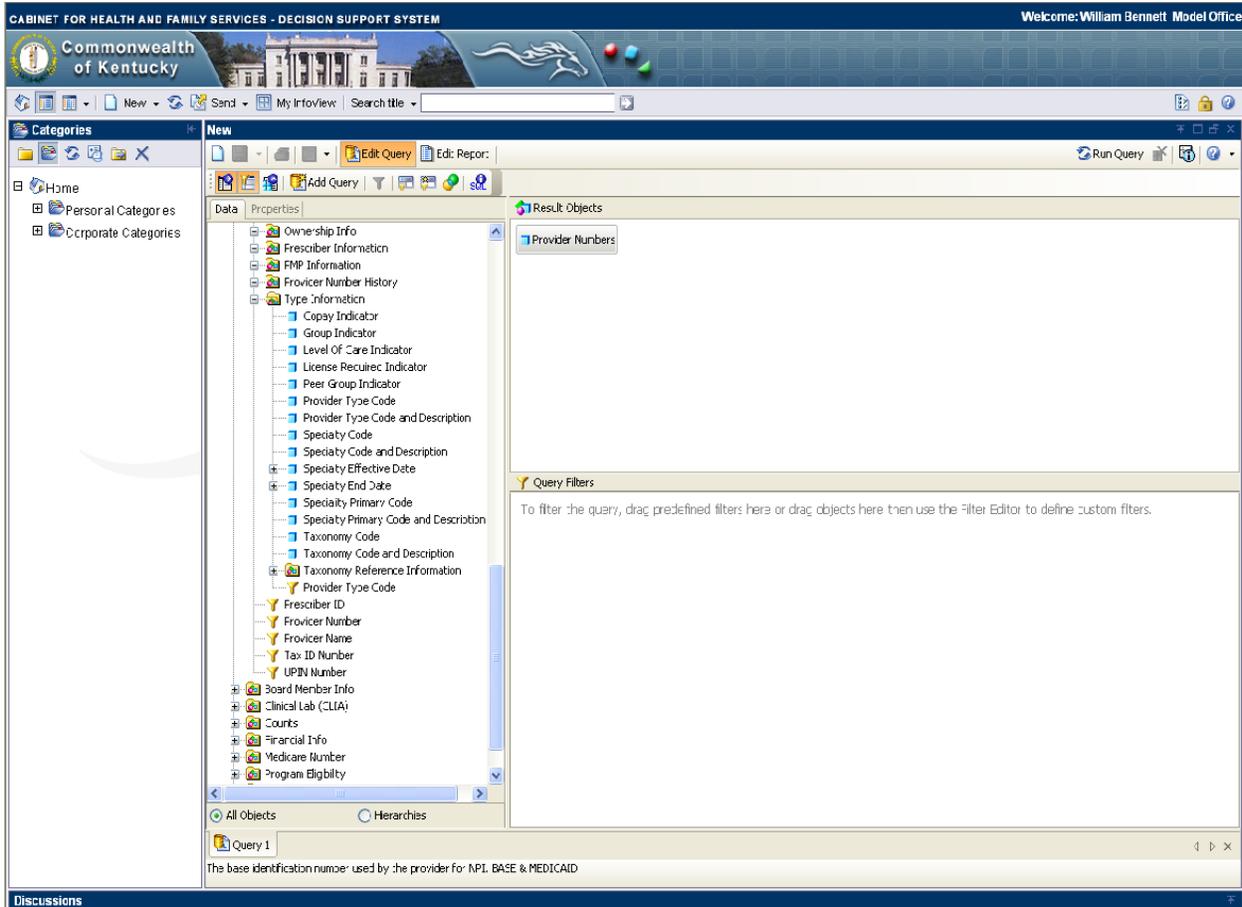
STEP 8. Double click on the “Provider Numbers” object in the Data/Properties section of the panel.

The “Provider Numbers” object will move into the “Results Objects” section of the panel.



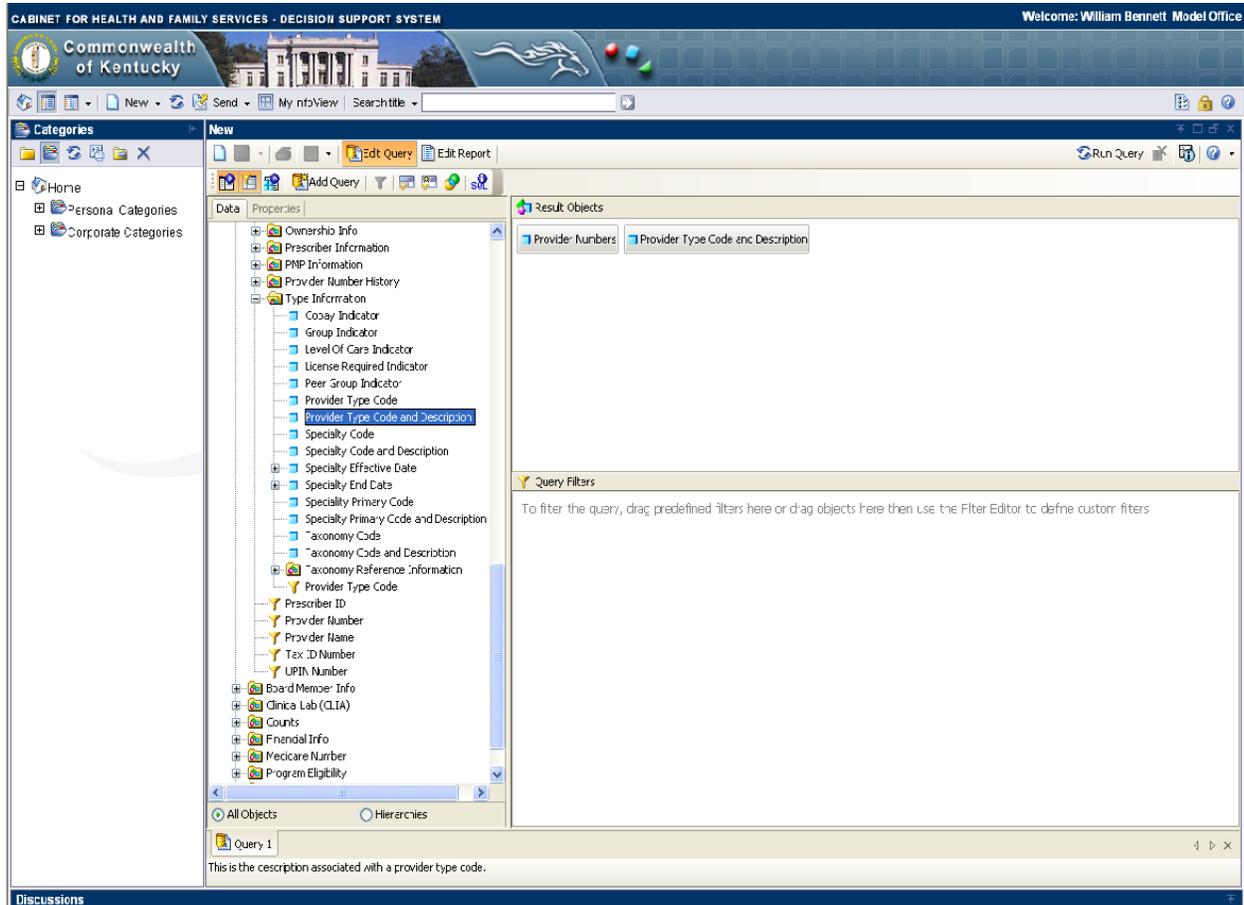
STEP 9. Scroll down and click on the + sign next to the words “Type Information” in the Data/Properties section of the panel.

The list of provider universe “Type Information” objects will open.



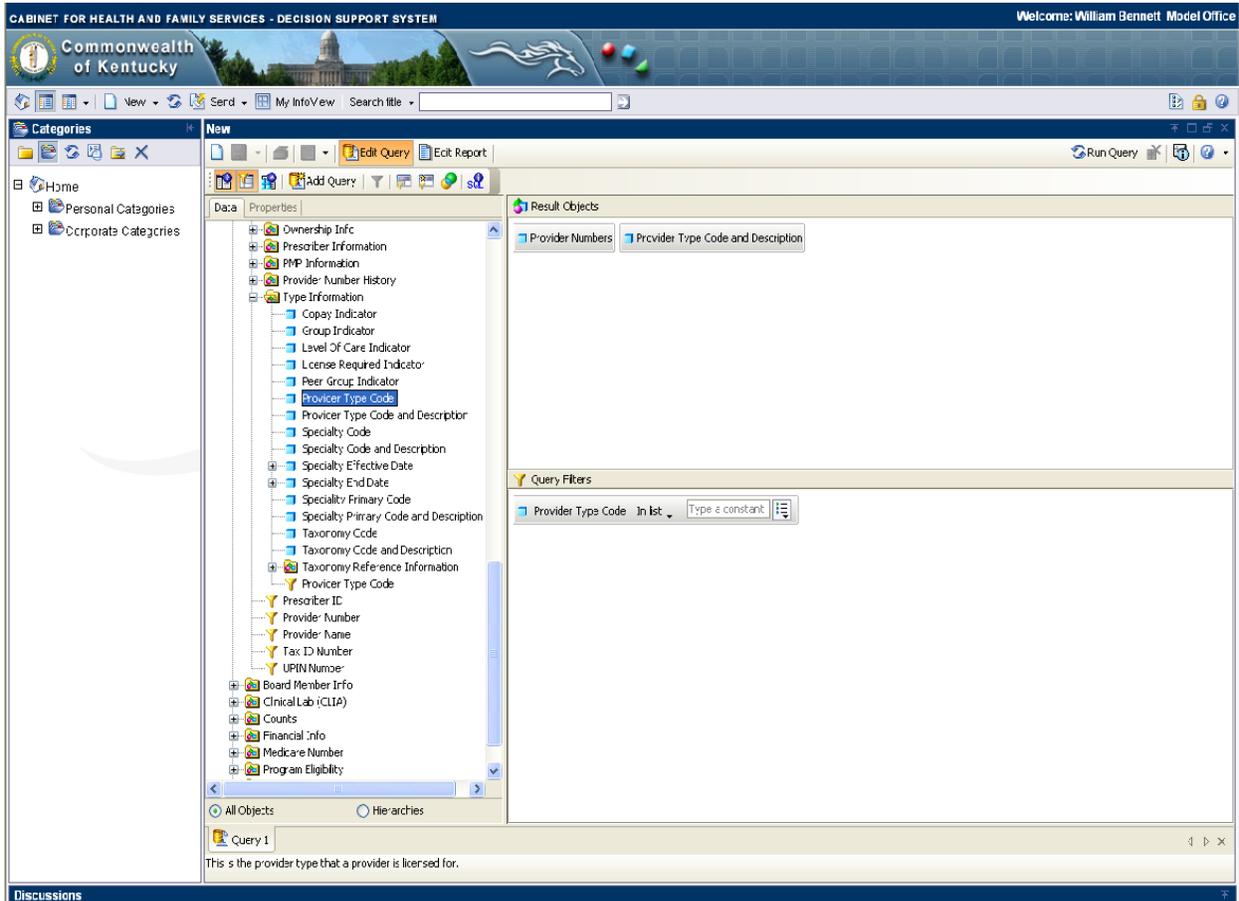
STEP 10. Double click on the “Provider Type Code and Description” object in the Data/Properties section of the panel.

The “Provider Type Code and Description” object will move into the “Results Objects” section of the panel.



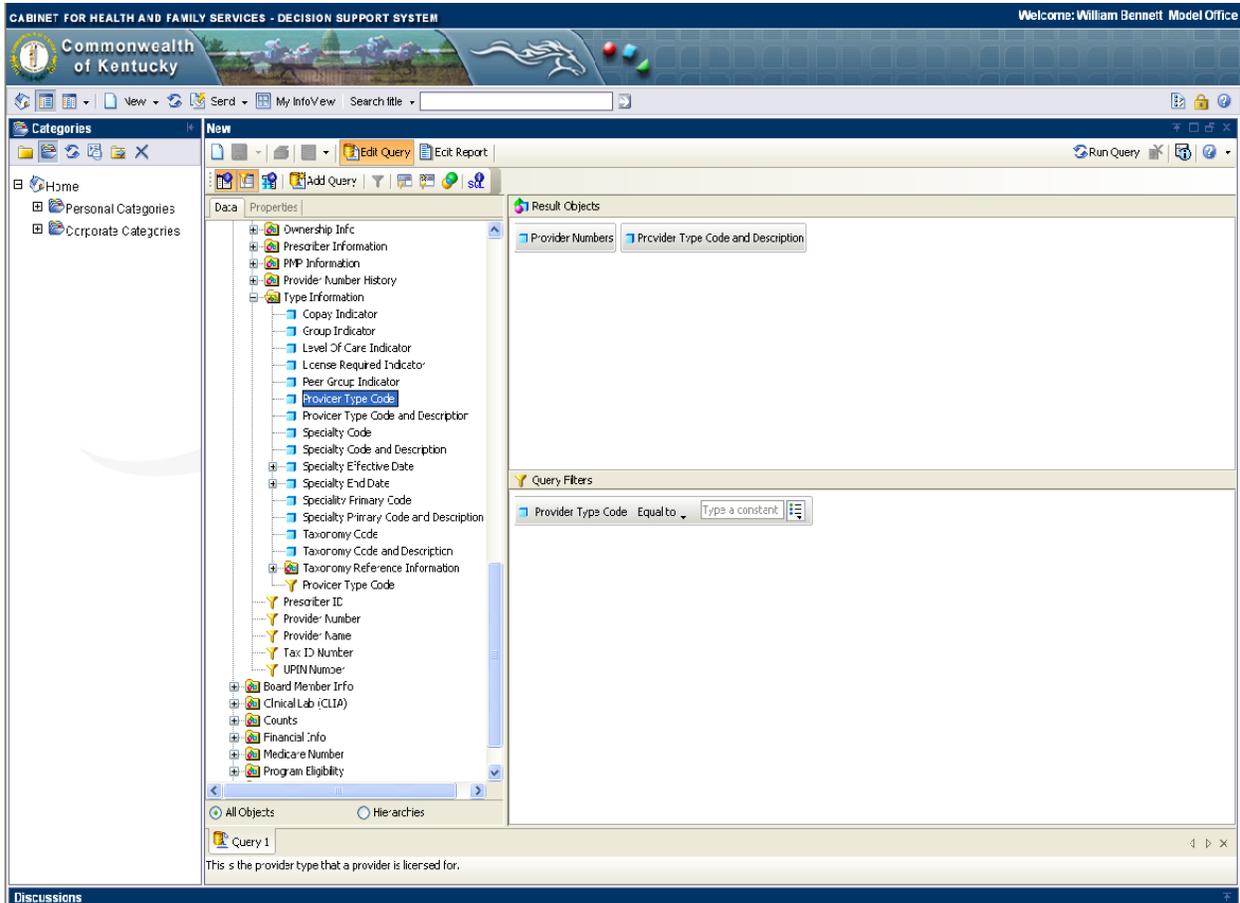
STEP 11. Click the left mouse button and drag the “Provider Type” object in the Data/Properties section of the panel to the Query Filters section of the panel and release the left mouse button.

The “Provider Type Code and Description” object will move into the “Query Filters” section of the panel.



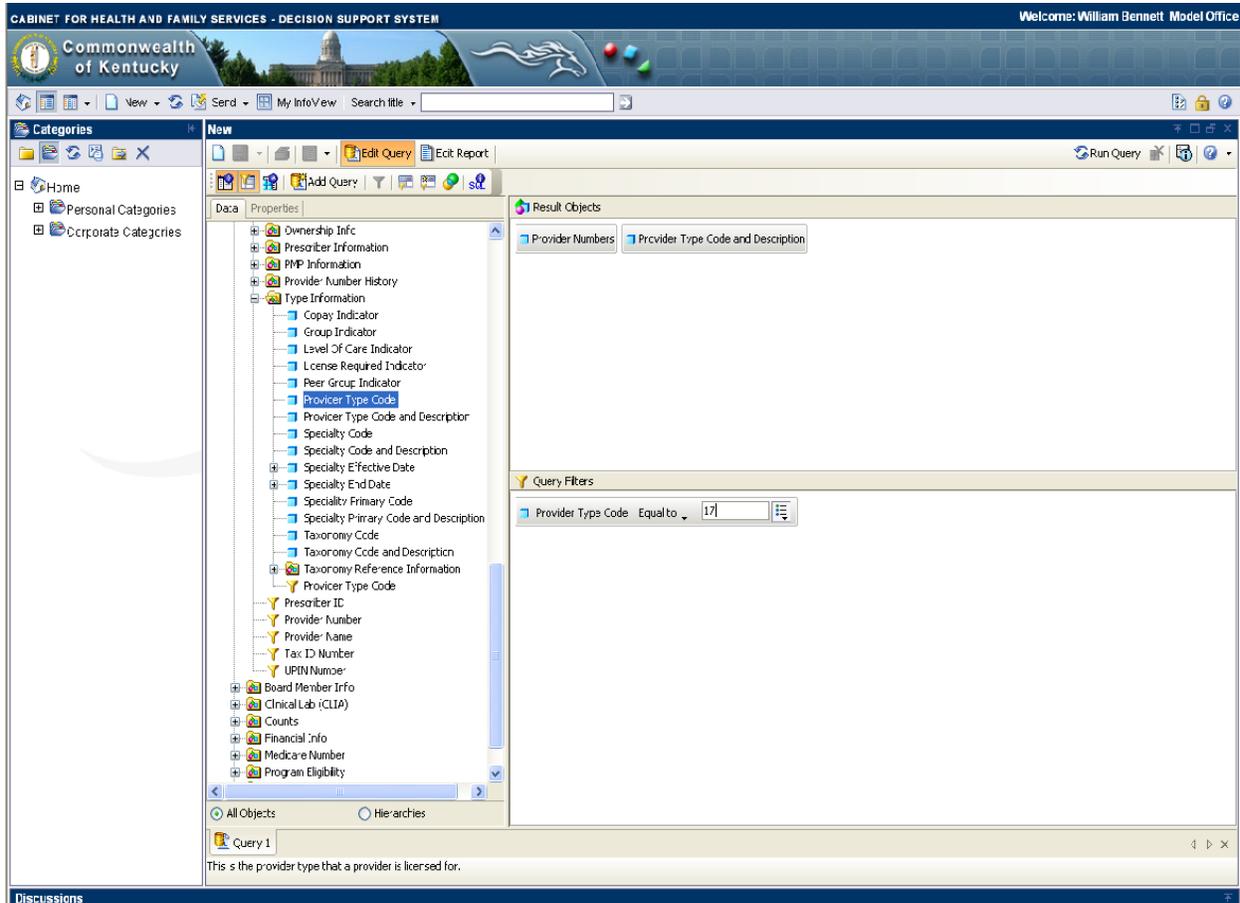
STEP 12. Click the left mouse button on the down arrow next to the in list command on the “Provider Type” object in the Data/Properties section of the panel and scroll down til the “Equal To” phrase is highlighted and release your left mouse button.

The “Provider Type” will display “Equal To” in the “Query Filters” section of the panel.



STEP 13. Click the left mouse button in the area where it states “Type a constant” next to the “Equal To” on the “Provider Type” object in the Data/Properties section of the panel and type “17”.

The “Provider Type” will display “17” in the “Query Filters” section of the panel.



The screenshot displays the 'CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM' interface. The top navigation bar includes the Commonwealth of Kentucky logo and the text 'Welcome: William Bennett Model Office'. The main workspace is divided into several sections:

- Categories:** A tree view on the left showing 'Personal Categories' and 'Corporate Categories'.
- Data/Properties:** A central panel with a tree view of data objects. The 'Provider Type Code' object is selected and highlighted in blue.
- Result Objects:** A panel on the right showing 'Provider Numbers' and 'Provider Type Code and Description'.
- Query Filters:** A section at the bottom showing a filter for 'Provider Type Code' set to 'Equal to' with the value '17' entered in a text box.

At the bottom of the interface, there is a 'Discussions' section and a status bar that reads 'This is the provider type that a provider is licensed for.'

STEP 14. Click on the “Run Query” button in the upper right hand portion of the panel.
 The query results will be returned and display in the panel.

The screenshot shows the 'CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM' interface. The main window displays a report titled 'Report Title' with the following data:

Provider Numbers	Provider Type Code and Description
NPI: Medicaid Number: 17000001 Base Number: 5C0011752	17 - Acquired Brain In,ury
NPI: Medicaid Number: 17000019 Base Number: 5C0001E03	17 - Acquired Brain In,ury
NPI: Medicaid Number: 17000027 Base Number: 5C0003E78	17 - Acquired Brain In,ury
NPI: Medicaid Number: 17000035 Base Number: 5C0011752	17 - Acquired Brain In,ury
NPI: Medicaid Number: 17000043 Base Number: 5C0011752	17 - Acquired Brain In,ury
NPI: Medicaid Number: 17000050 Base Number: 5C0011752	17 - Acquired Brain In,ury
NPI: Medicaid Number: 17000068 Base Number: 5C0011752	17 - Acquired Brain In,ury
NPI: Medicaid Number: 17000076 Base Number: 5C0011752	17 - Acquired Brain In,ury
NPI: Medicaid Number: 17000084 Base Number: 5C0011752	17 - Acquired Brain In,ury

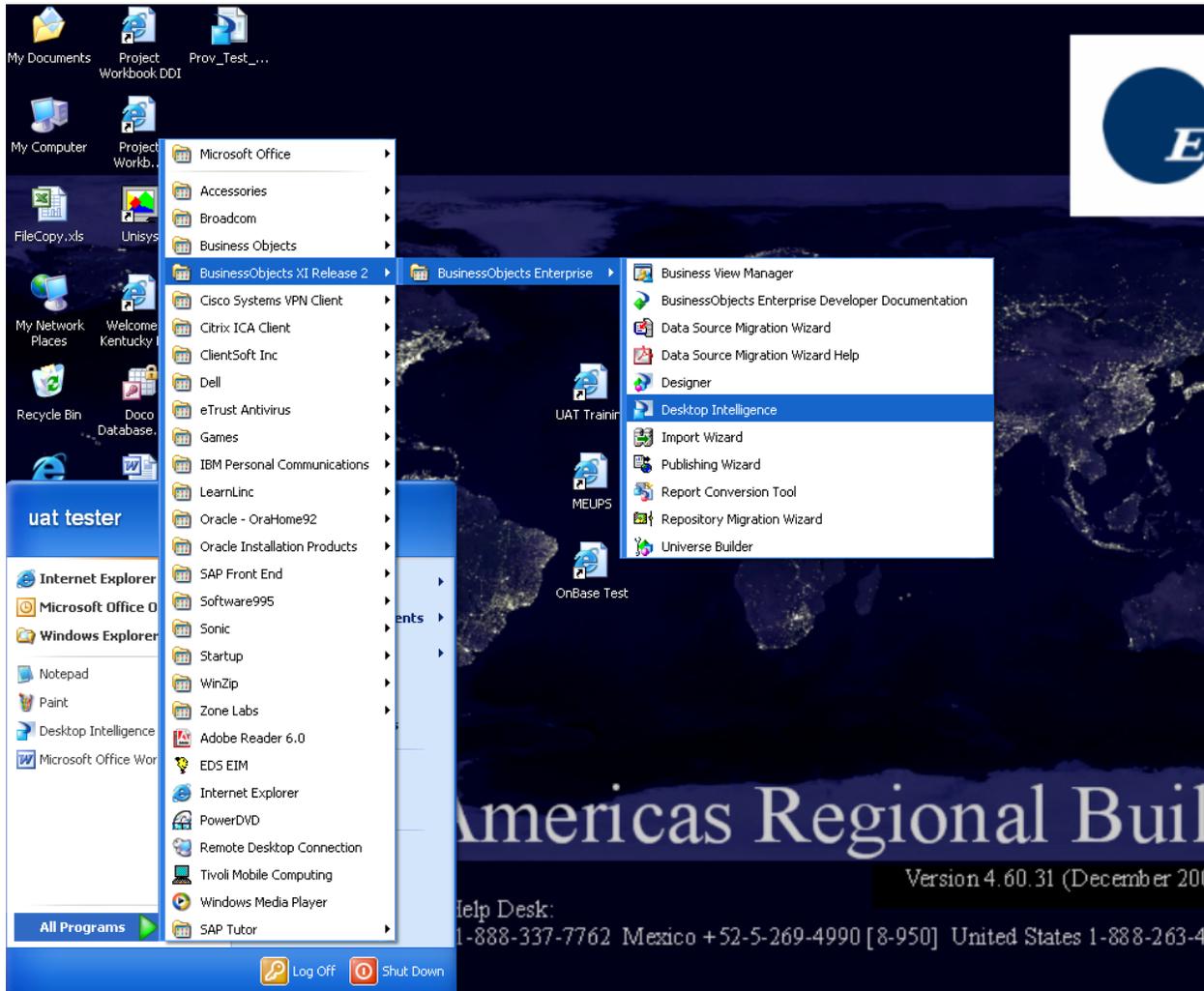
The interface includes a left-hand navigation pane with 'Categories' (Home, Persona Categories, Corporate Categories), a 'New' panel with 'Edit Query' and 'Edit Report' buttons, and a 'Properties' pane with sections for General, Display, Appearance, and Sorts. The status bar at the bottom indicates 'Last Refresh Date: February 28, 2007 8:36:30 PM'.

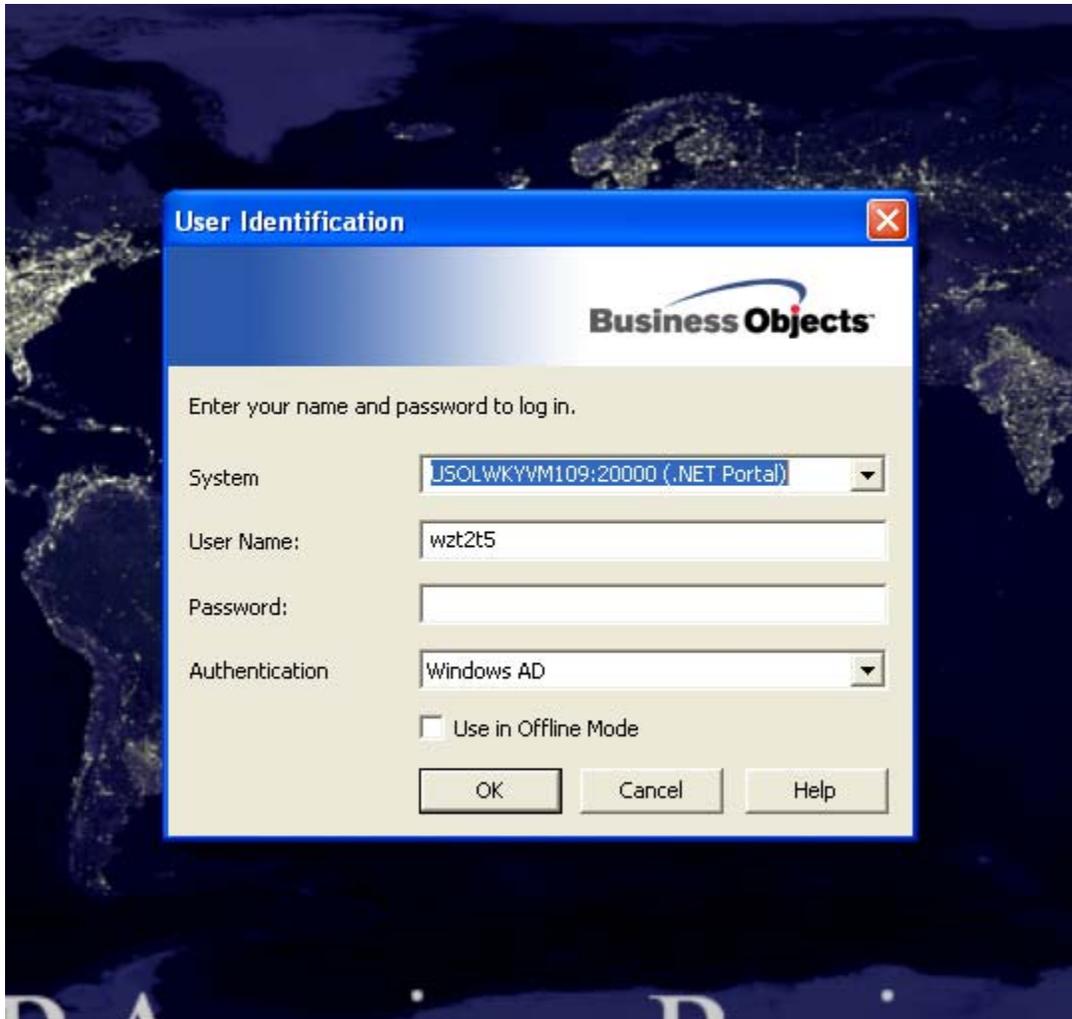
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11 Appendix E- How to Create a DSS query using Desktop Intelligence

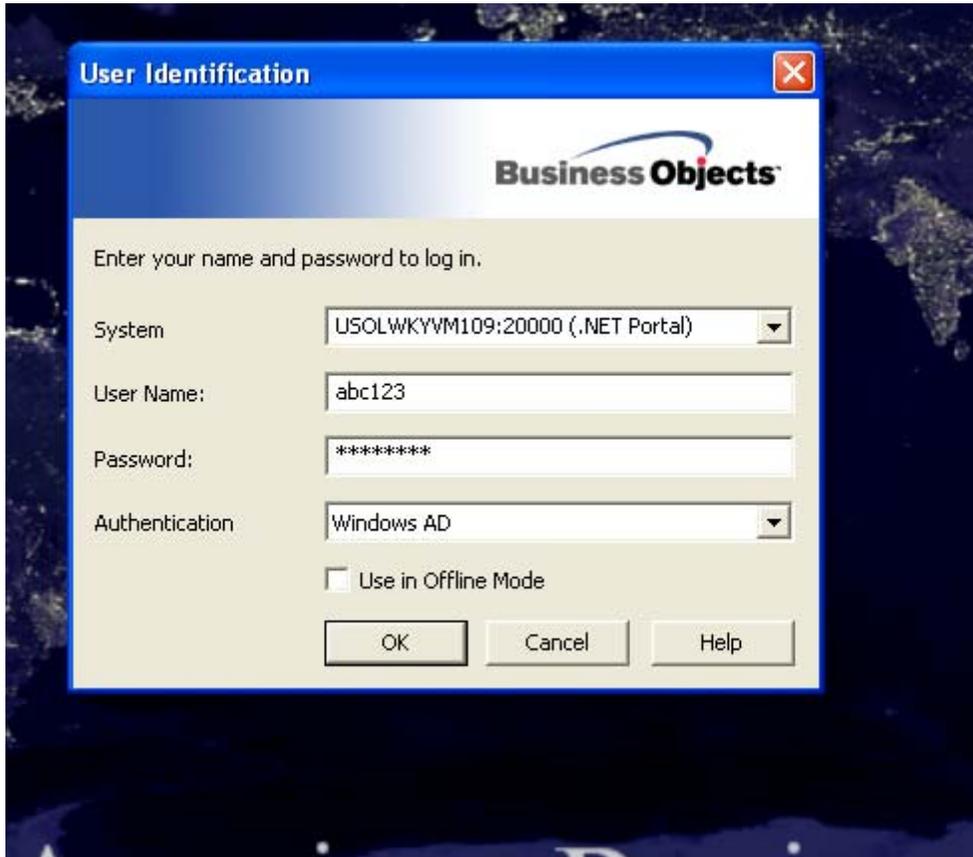
11.1 Querying DSS for providers with a specific provider type

STEP 1. Navigate to Desktop Intelligence Tool Program

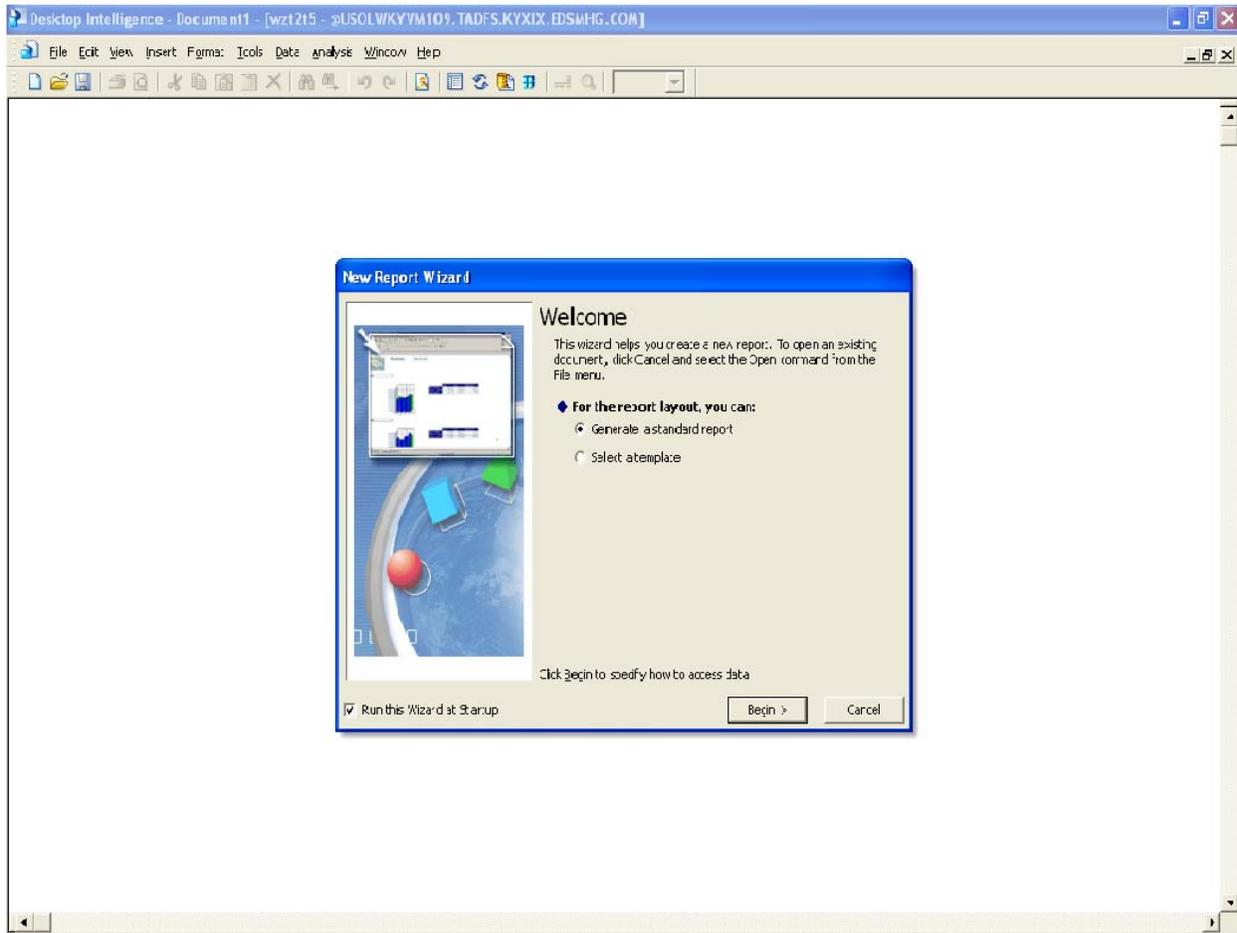




STEP 2. Enter user name and password into initial logon screen and press enter button



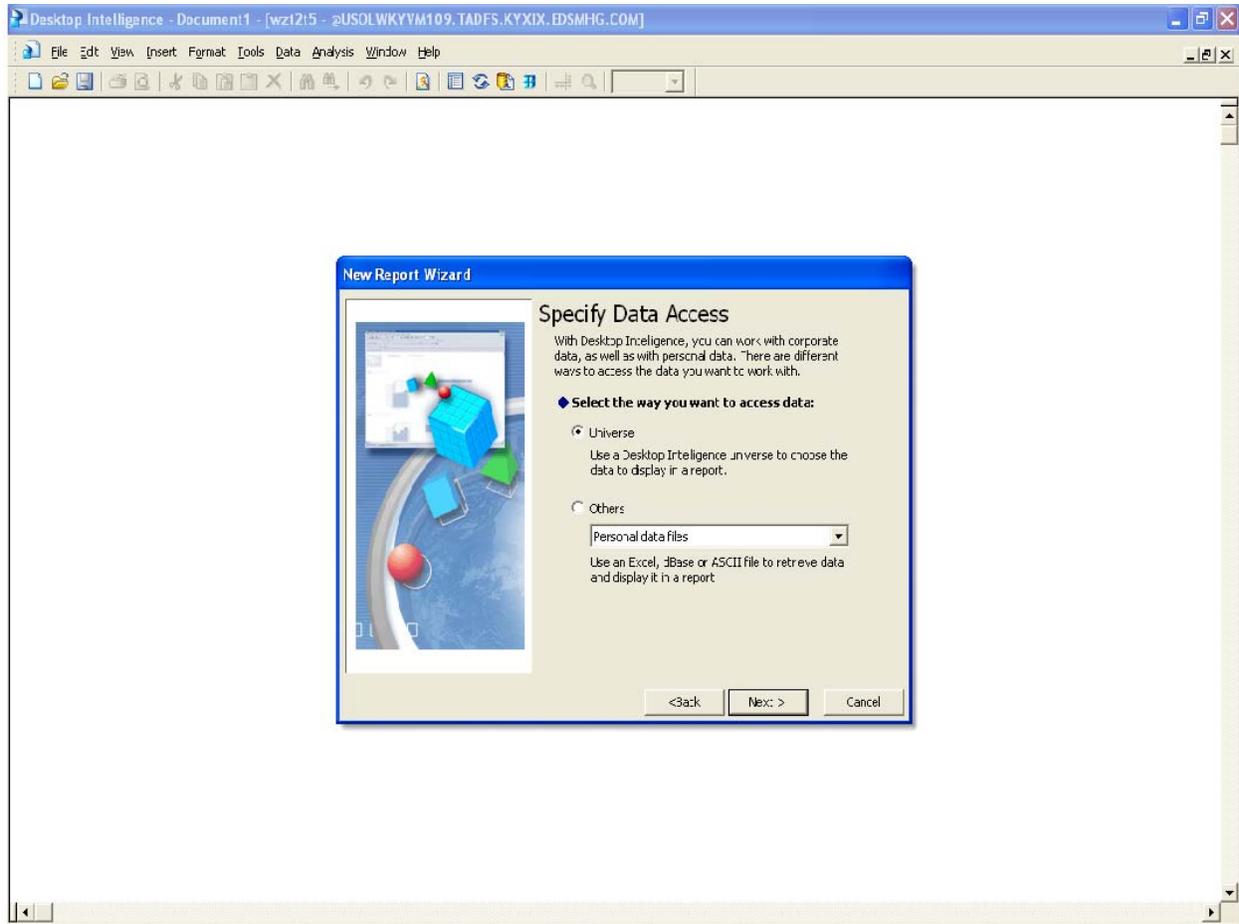
The desktop intelligence program will open and display the report wizard.



11.1.1 Web Intelligence Report Wizard Radio Buttons Panel 1

Button	Description
Generate a standard report	This radio allows you to advance through the panel to create a standard report.
Select a template	This radio button allows you to select a template a create a report using that template.

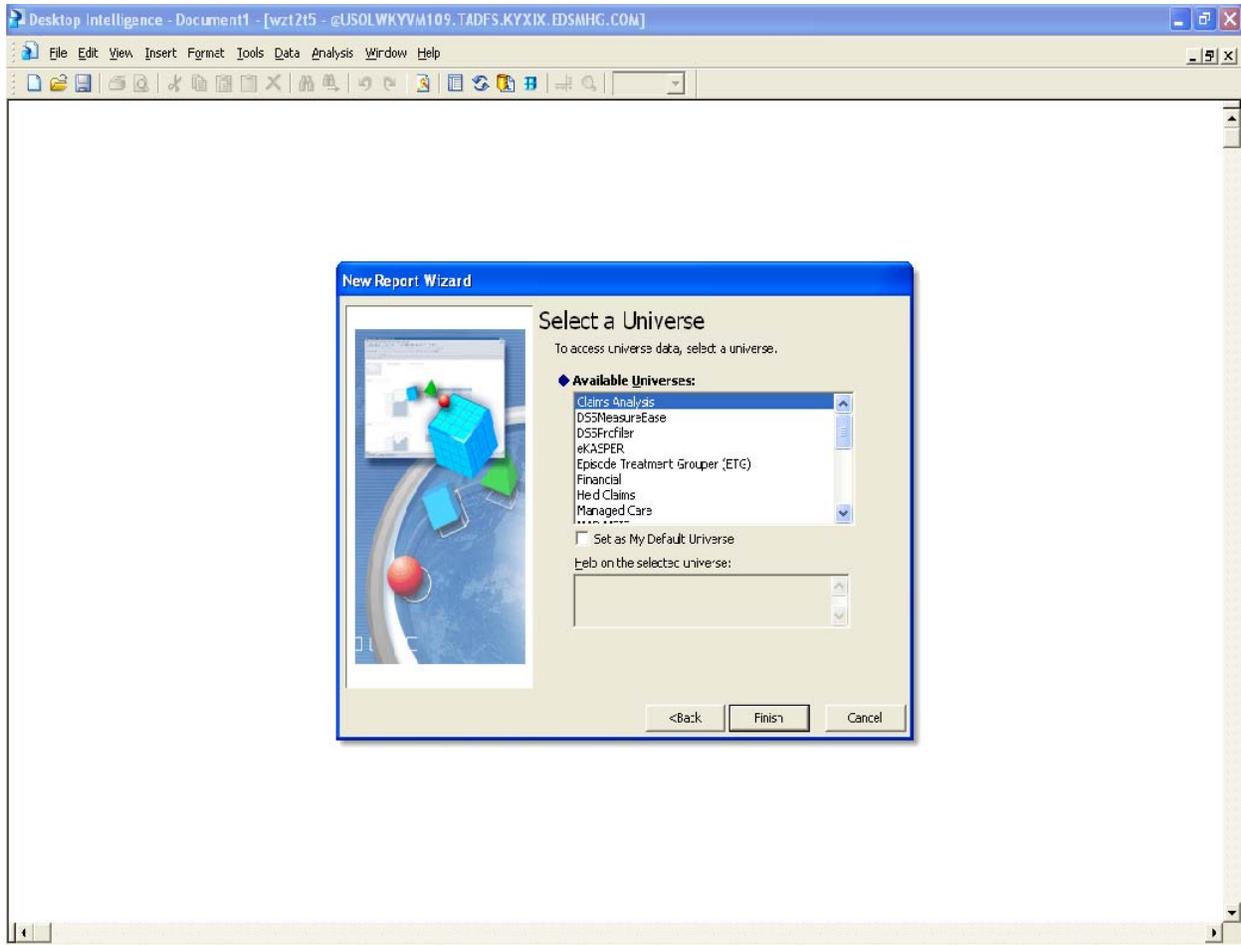
Click the Begin > button to choose “Generate a standard report”



11.1.2 Desktop Intelligence Report Wizard Radio Button 2

Button	Description
Universe	This radio button allows the user to create a BusinessObjects document using universes created for Kentucky.
Others	This radio button allows the user to create a BusinessObjects document using data sources other than a BusinessObjects universe. The other sources include: personal data files, XML data providers or Visual Basic for application procedures

Click the Next > button to choose “Universe”

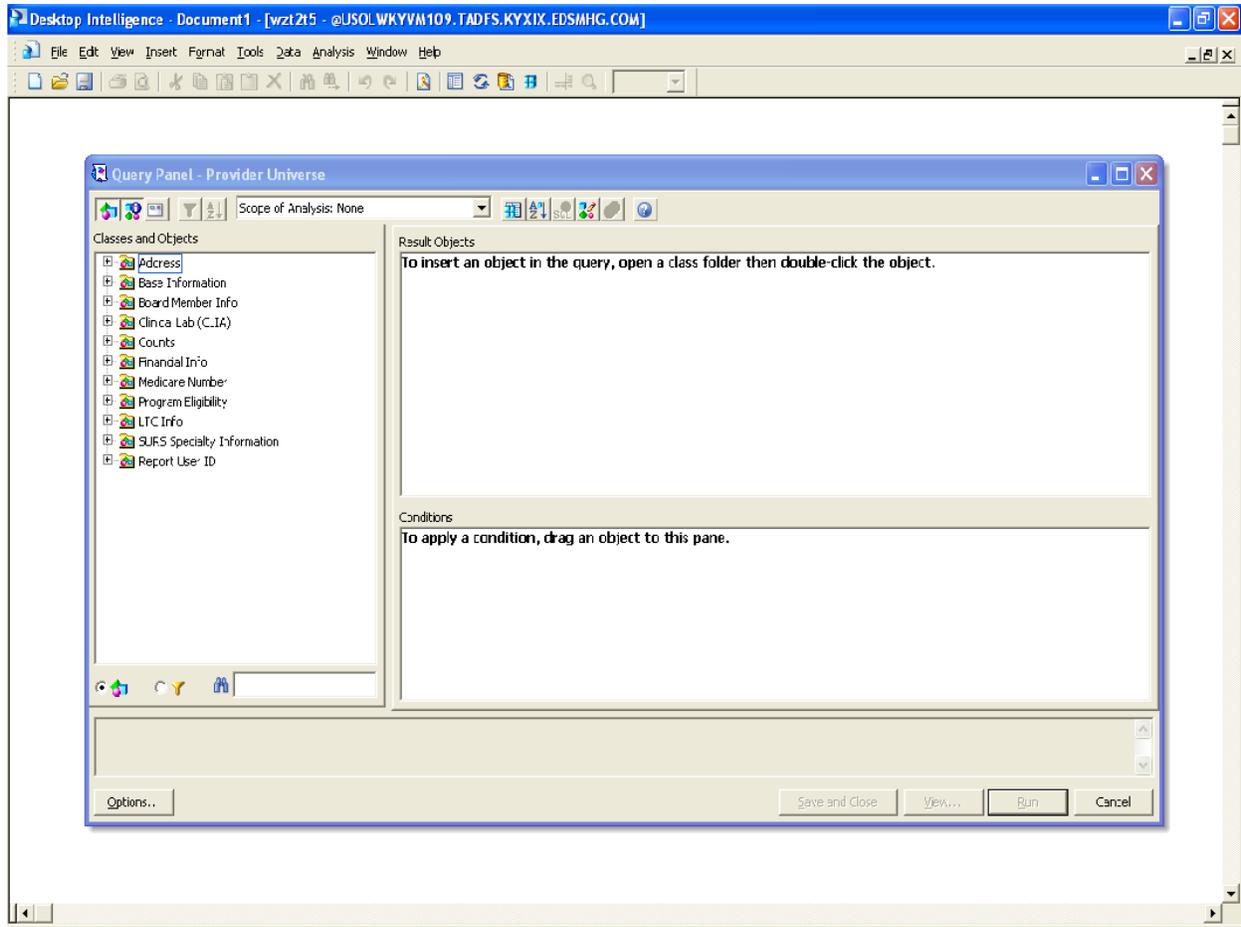


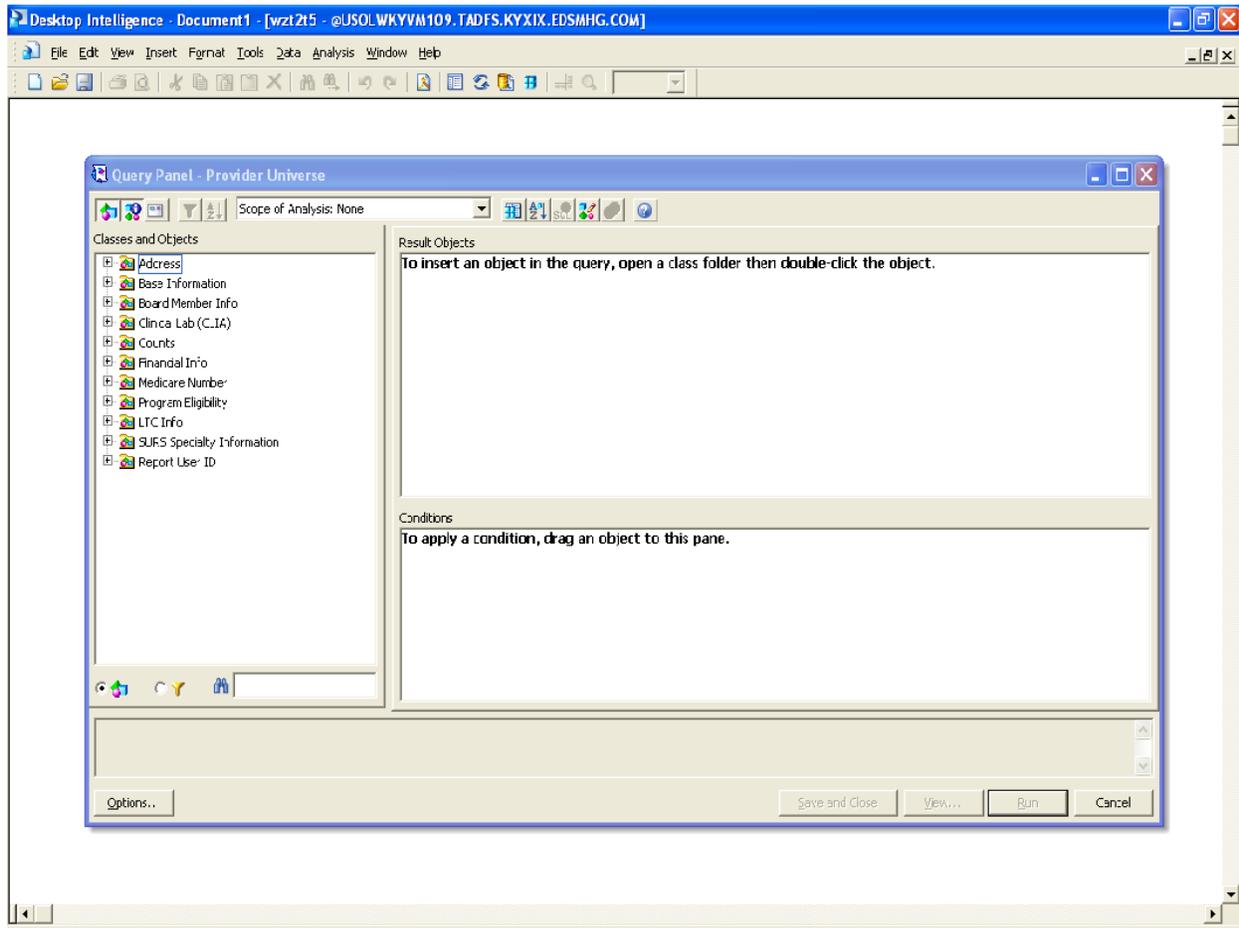
11.1.3 Desktop Intelligence Report Wizard Universe Selection

Universe	Description
Claims Analysis	This universe allows the user to query claims information from the MMIS
DSSMeasureBase	This universe allows a user to review the raw results of the information presented in the DSSMeasureBase reports
DSS Profiler	This universe allows a user to review the raw results of the information presented in the DSSProfiler reports
eKASPER	This universe allows a user to review data collected in support of the eKASPER program
ETG	This universe allows a user to review the raw results of the information presented in the ETG reports
Financial	This universe allows the user to query on financial information from the MMIS
Held Claims	This universe allows the user to query on claims in a not yet finalized status (does not include suspended claims)

Universe	Description
Managed Care	This universe allows the user to query on managed care information from the MMIS
MAR MSIS	This universe allows the user to query on results of the data sent to CMS for the Medicaid Statistical Information Services (MSIS) tapes
MAR Summary	This universe allows the user to query on the raw data used to create some of the MAR reports
Member	This universe allows the user to query on member information from the MMIS
PM	This universe is for Dashboard use.
PM Metrics	This universe is for Dashboard use.
Presumptive Eligibility	This universe allows the user to query on presumptive eligibility information from the MMIS
Prior Authorization	This universe allows the user to query on prior authorization information from the MMIS and maxMC
Provider	This universe allows the user to query on provider information from the MMIS
Random Sample	This universe allows the user to query on raw data used to produce the random sample reports
Reference	This universe allows the user to query on reference information from the MMIS
TPL	This universe allows the user to query on TPL information from the MMIS
Vital Statistics	This universe allows the user to query on vital statistics information from the Kentucky Department of Public Health

Scroll, Select the word Provider and click the Finish > button

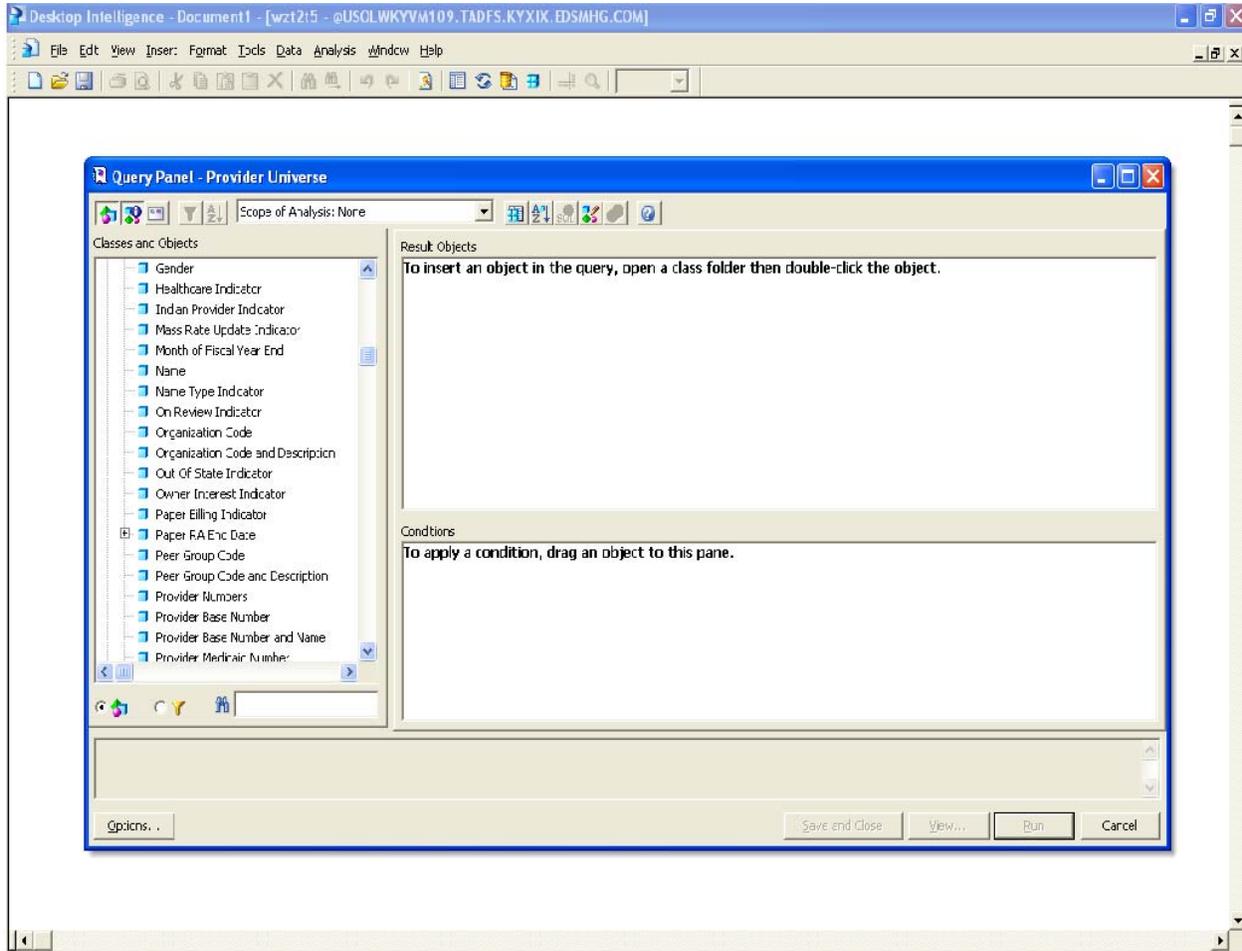


STEP 3. The provider universe will open**11.1.4 Provider Universe Section Descriptions**

Section	Description
Classes and Objects	This section allows the user to access the objects that are used as filters or query results.
Result Objects	This section of the screen displays the objects that will be returned as query results.
Conditions	This section of the screen displays the objects that will be used as criteria to filter the query in order to produce the desired results.

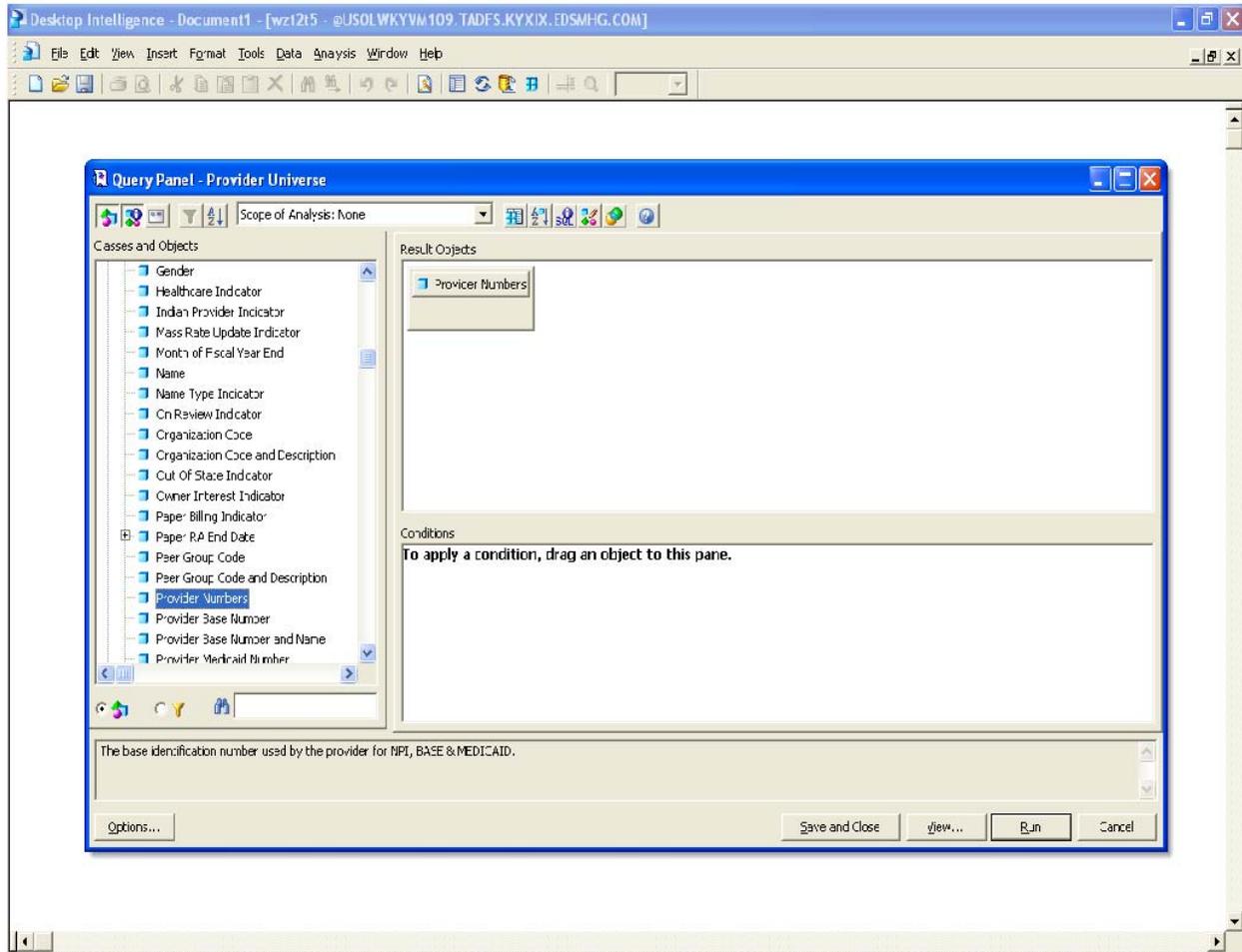
STEP 5. Click on the + sign next to the words “Base Information” in the Data/Properties section of the panel.

The list of provider universe “Base Information” objects will open.



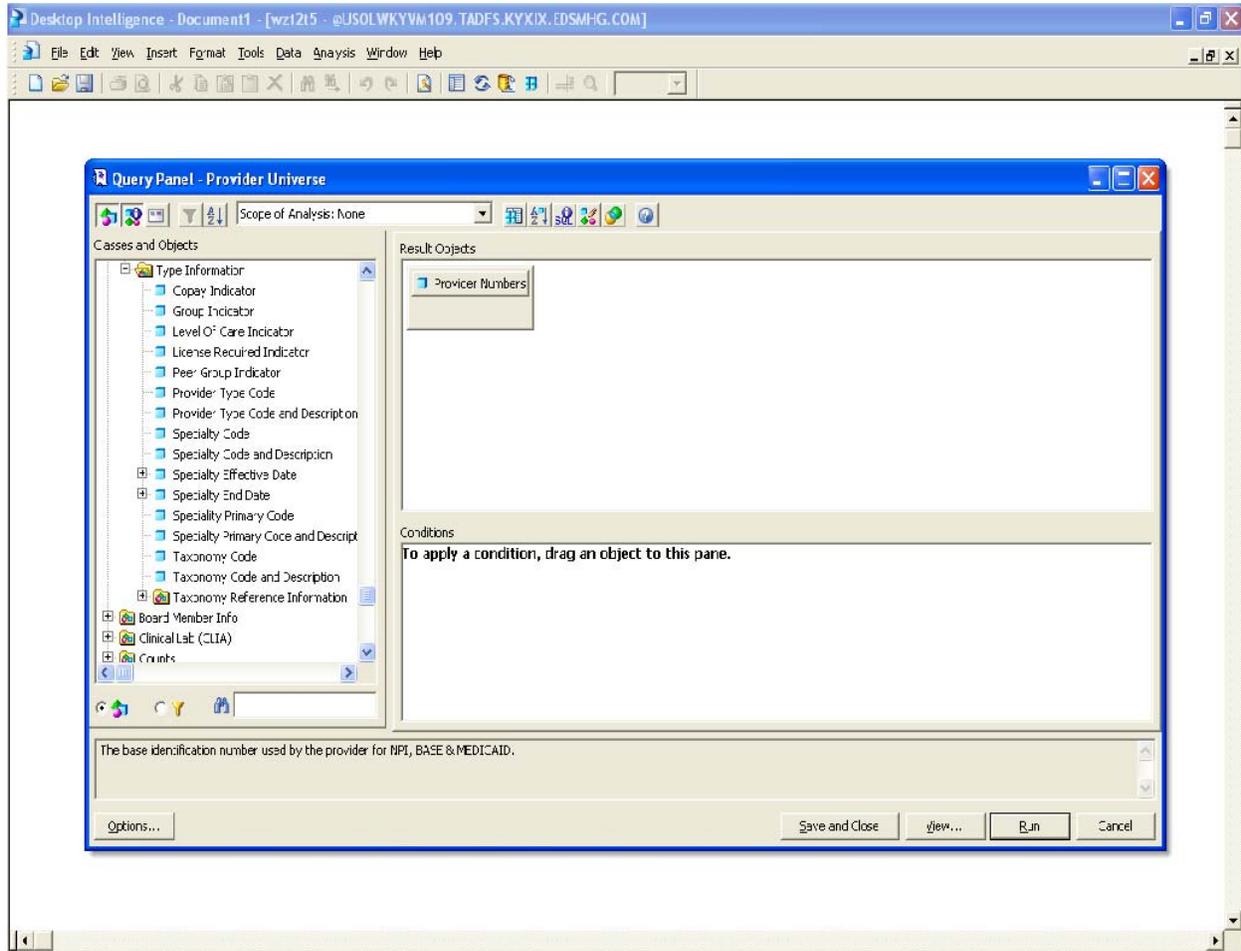
STEP 6. Double click on the “Provider Numbers” object in the Classes and Objects section of the panel.

The “Provider Numbers” object will move into the “Result Objects” section of the panel.



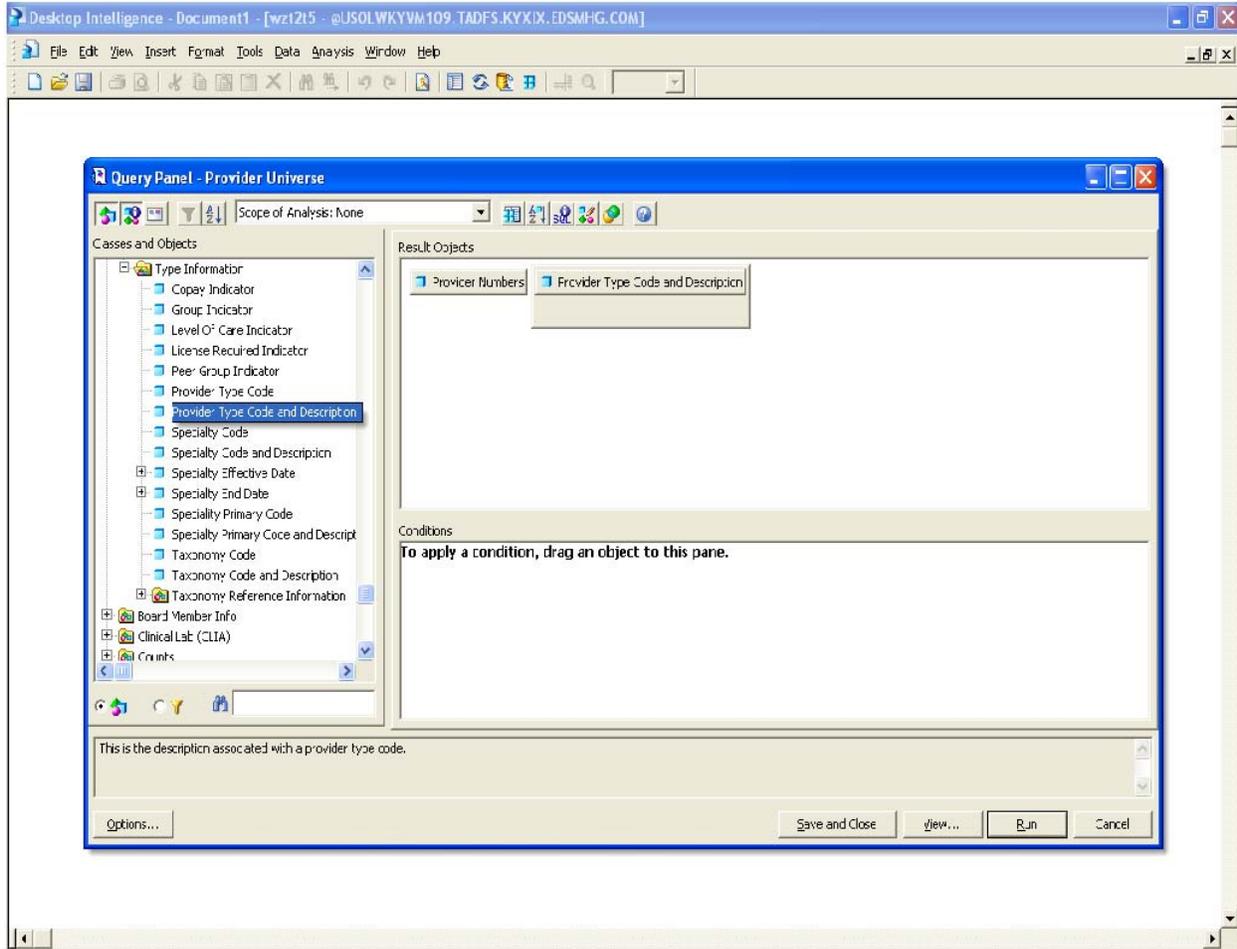
STEP 7. Scroll down and click on the + sign next to the words “Type Information” in the Data/Properties section of the panel.

The list of provider universe “Type Information” objects will open.



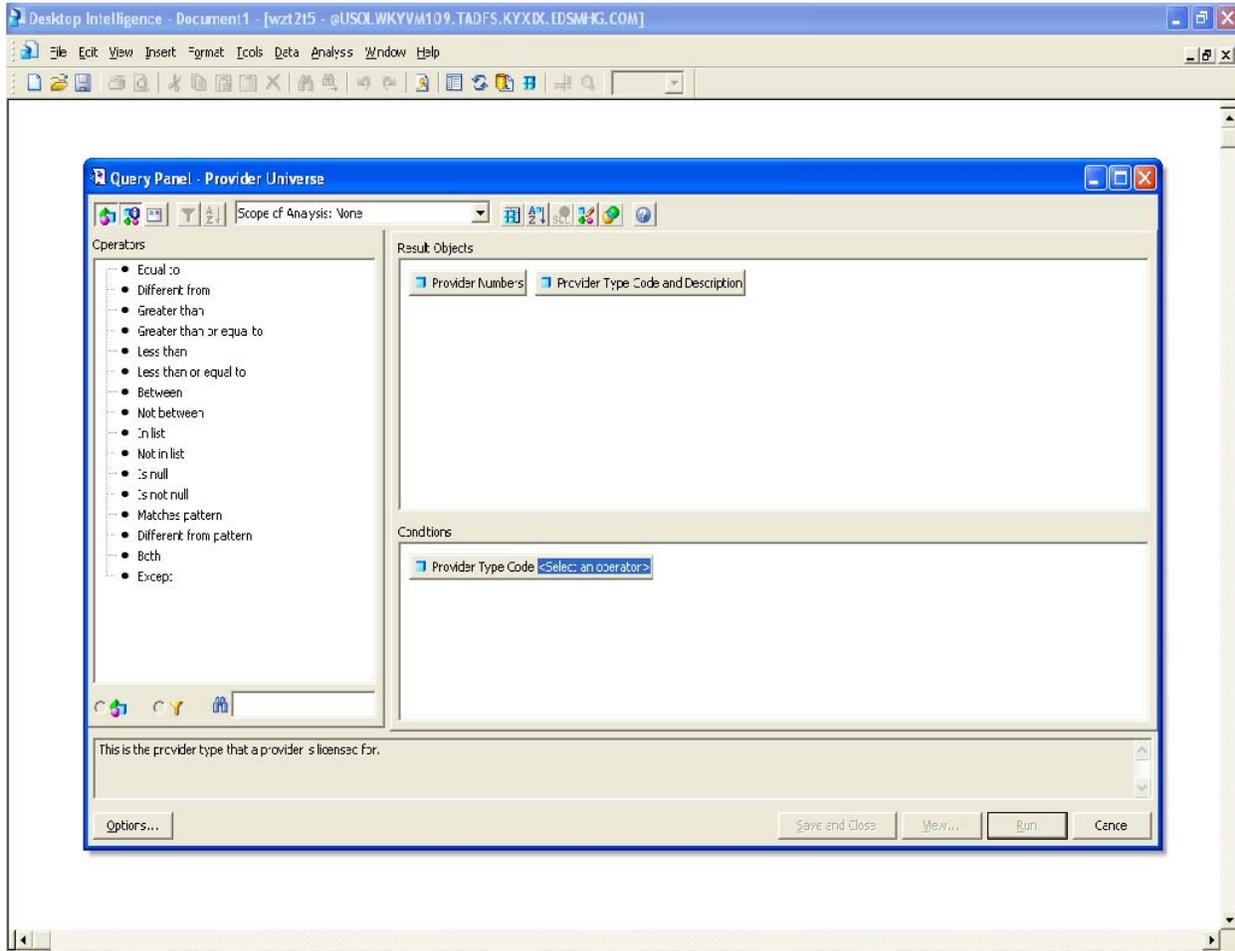
STEP 8. Double click on the “Provider Type Code and Description” object in the Data/Properties section of the panel.

The “Provider Type Code and Description” object will move into the “Results Objects” section of the panel.

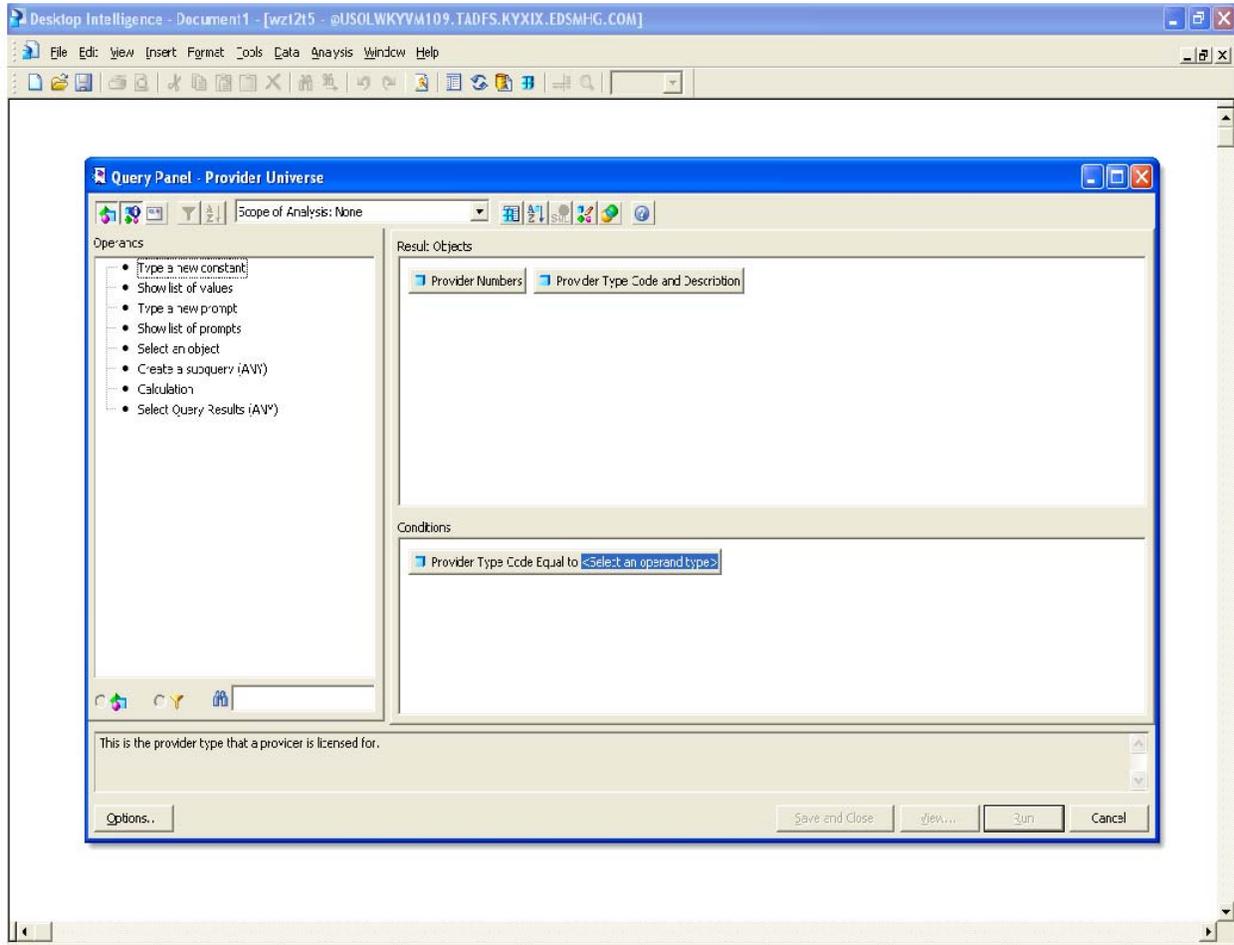


- STEP 9. Click the left mouse button and drag the “Provider Type” object in the Data/Properties section of the panel to the Query Filters section of the panel and release the left mouse button.

The “Provider Type Code and Description” object will move into the “Query Filters” section of the panel.

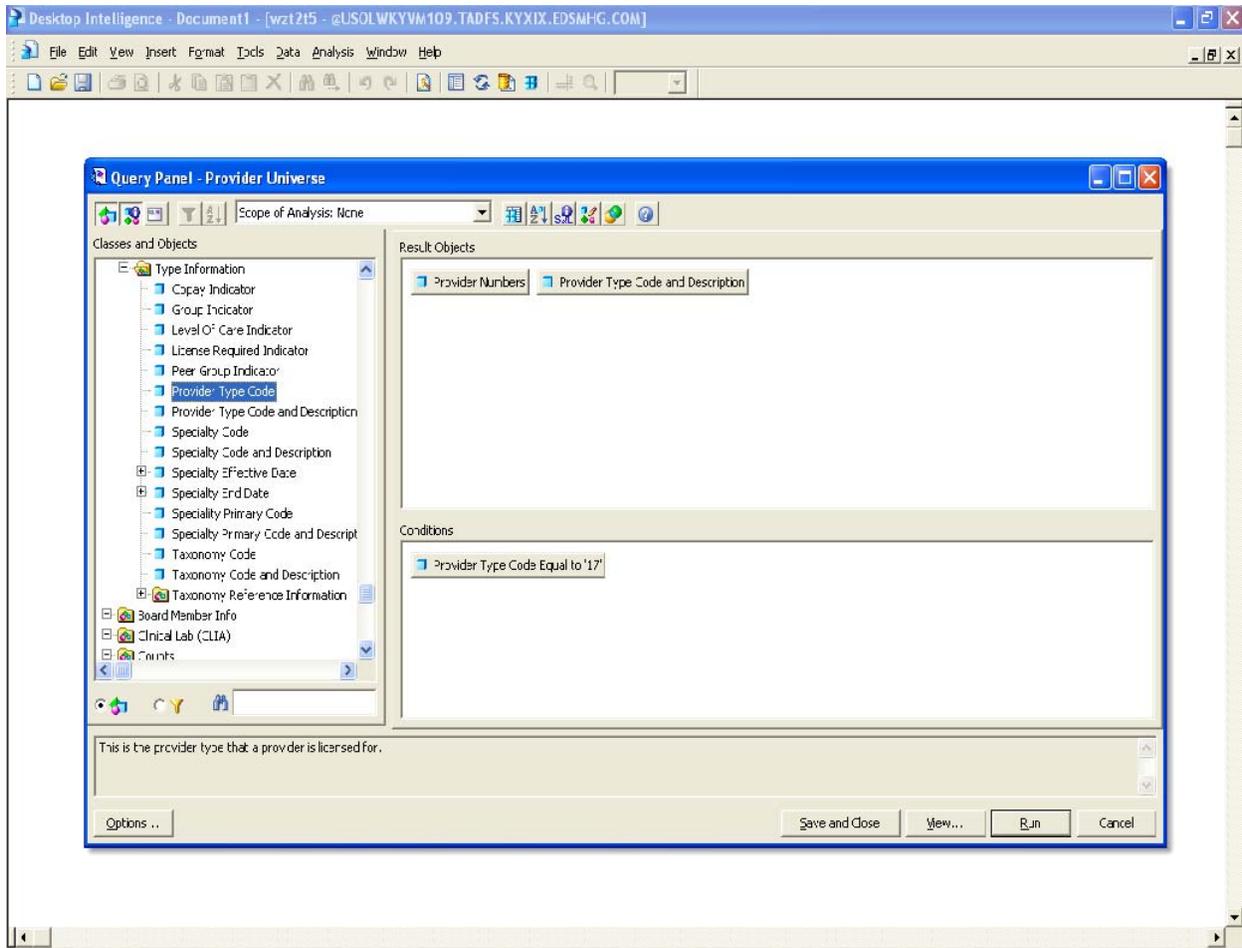


STEP 10. Double click the “Equal To” on the right panel under the word “Operators”.
The “Provider Type” will display “Equal To” in the “Conditions” section of the panel.



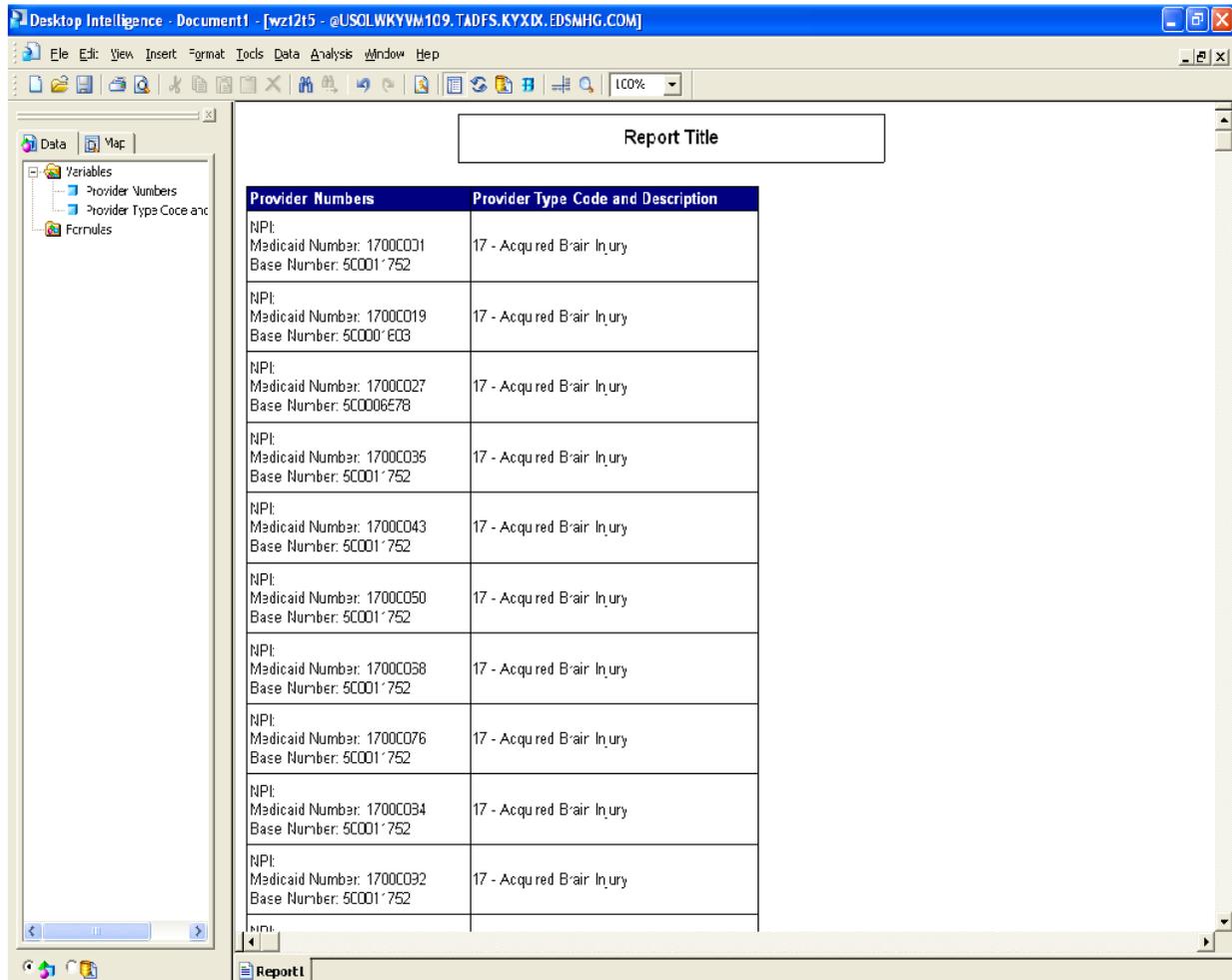
STEP 11. Double click the “Type a New Constant” phrase on the right panel under the word “Operands”. Type “17” into the open area and hit the enter key.

The “Provider Type” will display “17” in the “Conditions” section of the panel.



STEP 12. Click on the “Run” button in the lower right hand portion of the panel.

The query results will be returned and display in the panel.



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12 Appendix F- DSS MeasureBase

12.1 Viewing Information on a Specific Measure

STEP 1. Navigate to MEUPS site. The initial sign-on window will display.

STEP 2. Enter Username and Password and select 'Sign In'.

The screenshot shows the login interface for the Kentucky Medicaid Web Site. At the top, the header reads "KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES" and "DEPARTMENT FOR MEDICAID SERVICES". The main content area features the "Kentucky UNBRIDLED SPIRIT" logo on the left. Below the logo, there is contact information: "For assistance, email us at KY_EDJ_HelpDesk@eds.com or call (800) 205-4696 during normal business hours 7:00 am - 6:00 pm Monday - Friday EST." A "Contact Us" link is also present. The central section is titled "Sign in to the KyHealth Choices" and lists three options: "Manage your contact information", "Change your password", and "Providers: Manage your agent's access". Below this, it states "If you do not have an account, you will need to register." with a "Register" button. On the right, there is a "Sign in to KyHealth Choices" form with fields for "Username" and "Password", a "Sign In" button, and a "Help" link. Below the form, there is a "KyHealth Choices" section with a "Forgot your password?" link. The footer contains "Privacy | Disclaimer | Individuals with Disabilities" and "Copyright © 2006 Commonwealth of Kentucky All rights reserved." The browser status bar at the bottom shows "Done" and "Internet".

STEP 3. Select the DSS/SUR environment to work in by clicking on the link.

KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
 DEPARTMENT FOR MEDICAID SERVICES

KyHealth Choices Home

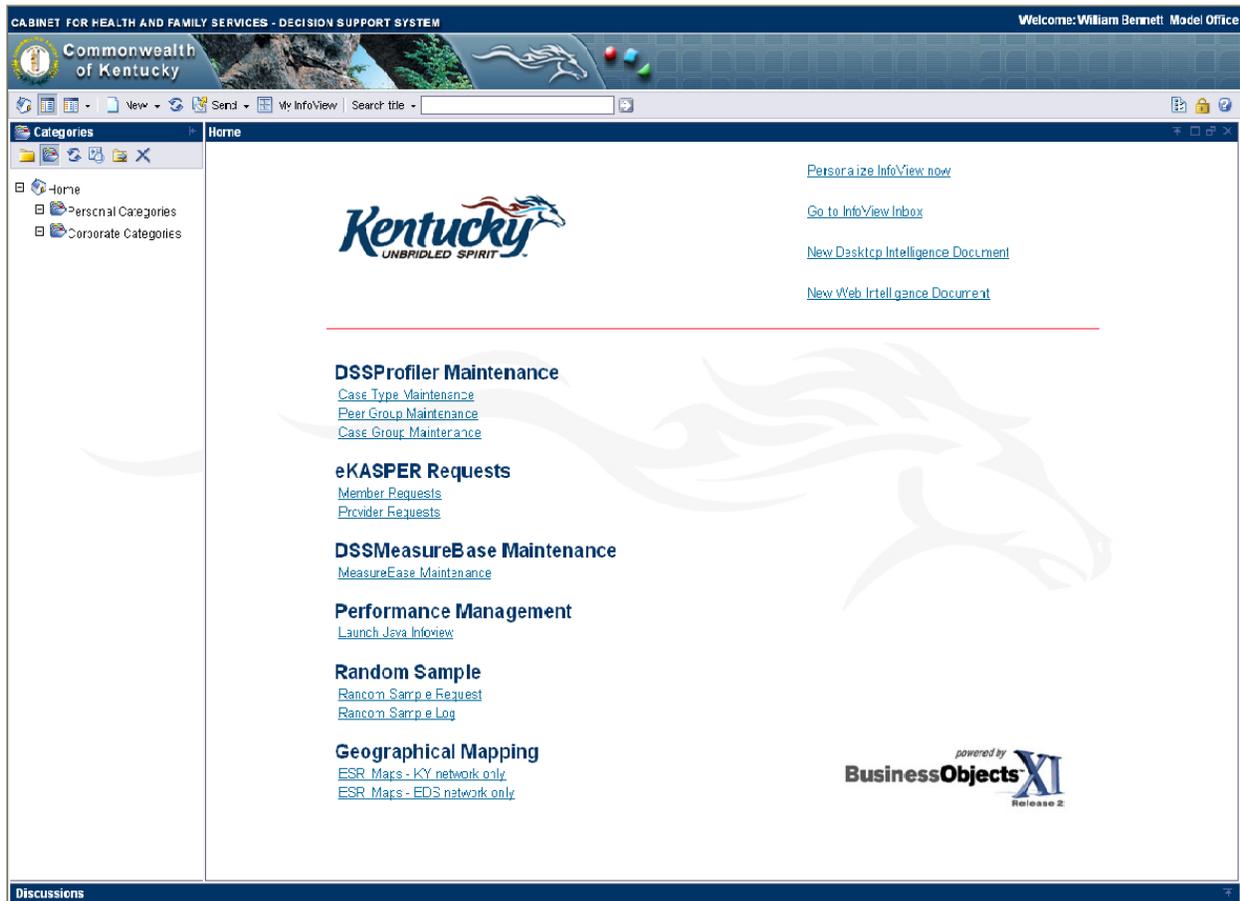
Friday 16 March 2007 6:22 pm Sign Out

Bobby Jones, Welcome to KyHealth Choices

Applications	
Application	Description
Account Management	Modify your account information. Providers can also use this application to give application permissions to their agents.
Authorization Request	Allows a user to request access to applications
DSS/SUR Model Office	This is the Model Office BusinessObjects Infoview for DSS/SUR
DSS/SUR Test	This is the Test BusinessObjects Infoview for DSS/SUR
DSS/SUR UAT	This is the UAT BusinessObjects Infoview for DSS/SUR
KyHealth Choices	This is the KyHealth Choices portal application

Messages	
Date	Message
02/23/2007	.Net User Interface MO and UAT release build 112 included the following Change Orders and Defects: Claims - 5749, 6255; CTMS - 6385; EPSDT - 975, 5020; Financial - 3751, 5946; Managed Care - 6141, 6308; MAR - 6372; Member Data Maintenance - 4384; Prior Auth - 4750, 4796, 4987, 6262, 6276; Provider - 4656, 4979, 6390; Recipient - 5930, 5931; Reference Data Maintenance - 2179, 3158, 6002, 6192; System Wide - 4408, 4959; and Third Party Liability - 2932, 4721, 5008, 5009, 5057, 5074, 5143, 6323, 6331. UNIX Model Office and UAT promotion build 112 on 2/23/2007 contained the following change orders and defects: Build

The infoview main page will open.



12.1.1 InfoView Panel Sections

Section	Description
Categories	This section of the panel displays the categories of reports that can be accessed by a user depending on their permissions.
Home	This section of the panel displays the access options that a user has access to based on their permissions. Note: Most individuals will not have access to the eKASPER information shown here. If a person does not have access to a function it will not display on the panel.

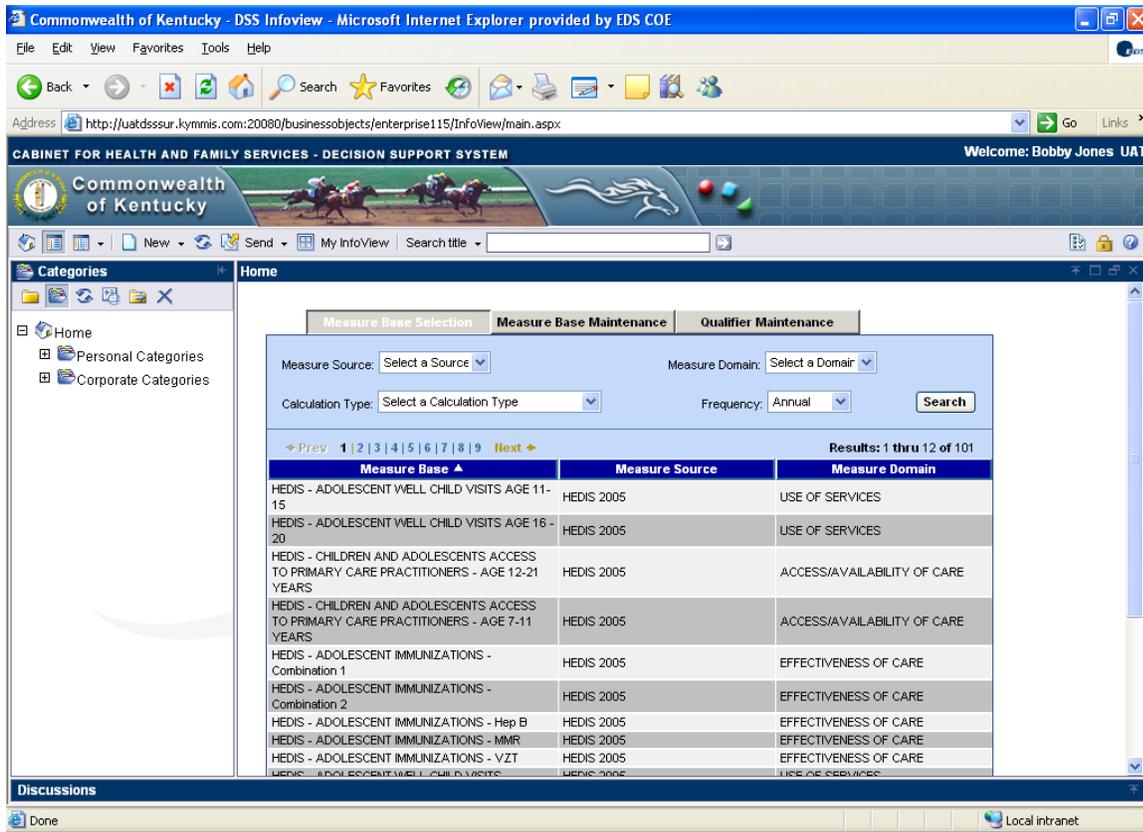
12.1.2 InfoView Panel Links

Links	Description
Personalize InfoView Now	This link guides the user to a page where they can customize the display properties of the infoView panel displayed when they log into infoView.

Links	Description
Go to InfoView Inbox	This link guides the user to their personal infoView inbox. This allows a user to access documents forwarded to them by other infoView DSS users.
New Desktop Intelligence Document	This link opens a new document using the desktop intelligence version of the BusinessObjects software.
New Web Intelligence Document	This link opens a new document using the web intelligence version of the BusinessObjects software.
Case Type Maintenance	This link opens a page that allows the user to update, add or delete case types that are used in the DSS Profiler process.
Peer Group Maintenance	This link opens a page that allows the user to update, add or delete peer groups that are used in the DSS Profiler process.
Case Group Maintenance	This link opens a page that allows the user to update, add or delete case groups that are used in the DSS Profiler process.
Member Requests	This link opens a pages that allows users with eKASPER access to request information about a member.
Provider Requests	This link opens a pages that allows users with eKASPER access to request information about a provider.
MeasureBase Maintenance	This link opens a pages that allows users with MeasureBase access to add or update measures.
Launch Java InfoView	This link opens up a panel that allows users with Performance Manager access to see executive dashboards.
Random Sample Request	This link opens a pages that allows users to create a random sample request.
Random Sample Log	This link opens a pages that allows users to view the status of an existing random sample request.
ESRI Maps – KY Network Only	This link opens a pages that allows users to access ESRI maps that are available on the KY Network.
ESRI Maps – HP Enterprise Services Network Only	This link opens a pages that allows users to access ESRI maps that are available on the HP Enterprise Services Network.

STEP 4. Select the MeasureBase Maintenance Link under the DSSMeasureBase Maintenance Section.

The DSSMeasureBase Selection page will open. It will show all available measures..



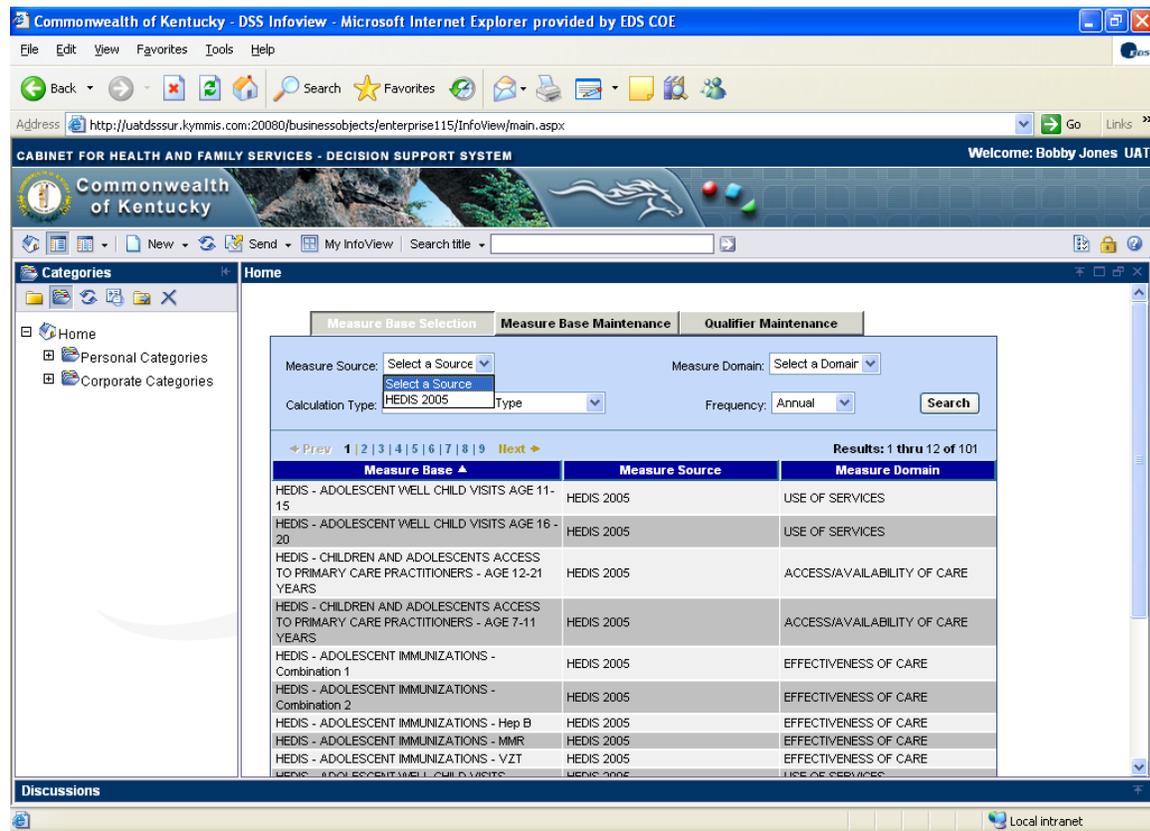
12.1.3 MeasureBase Selection Field Descriptions

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Calculation Type	This indicates how the data will be sampled Values: A - Numerator /Denominator B - Per 1000 C - Per 100 D - Per 10000	13	Drop Down List Box	Field	T_MM_MEASURE_BASE	CDE_CALC_TYPE
Frequency	Indicates the frequency that the measure should be generated. Examples: Quarterly, Semiannually, Annually	0	Drop Down List Box	Field	T_MM_MEASURE_BASE	CDE_FREQUENCY
Measure Base	A short description of the measure.	0	Character	Field	T_MM_MEASURE_BASE	MEASURE_BASE_NAME

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Measure Domain	A method for grouping measures. Examples: Effectiveness of Care, Access/Availability of Care, Use of Services	0	Drop Down List Box	Field	T_MM_MEASURE	SAK_DOMAIN
Measure Source	A high-level description of the source of the measure. Example: HEDIS 2005	0	Drop Down List Box	Field	T_MM_MEASURE_BASE	SAK_MEASURE_SOURCE
Search	Provides the capability to search for specific measures.	0	N/A	Button	n/a	n/a

STEP 5. Selection of Search Criteria

Click on the Measure Source List and select 'HEDIS 2005' from the List.



Click on the Calculation Type List and select 'NUM/DENUM' from the list.

The screenshot shows the 'DSS Infoview' application interface. The 'Measure Base Selection' tab is active. The 'Calculation Type' dropdown menu is open, showing 'Num/Denum' as the selected option. The 'Measure Source' is set to 'HEDIS 2005' and the 'Measure Domain' is 'Select a Domain'. The 'Frequency' is set to 'Annual'. A search button is visible. Below the search criteria, a table displays the results of the search, showing various HEDIS measures and their corresponding sources and domains.

Measure Source	Measure Domain
HEDIS - ADOLESCENT WELL CHILD VISITS - AGE 16-20	USE OF SERVICES
HEDIS - ADOLESCENT WELL CHILD VISITS - AGE 16-20	USE OF SERVICES
HEDIS - CHILDREN AND ADOLESCENTS ACCESS TO PRIMARY CARE PRACTITIONERS - AGE 12-21 YEARS	ACCESS/AVAILABILITY OF CARE
HEDIS - CHILDREN AND ADOLESCENTS ACCESS TO PRIMARY CARE PRACTITIONERS - AGE 7-11 YEARS	ACCESS/AVAILABILITY OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Combination 1	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Combination 2	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Hep B	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - MMR	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - VZT	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT WELL CHILD VISITS	USE OF SERVICES

Click on the Measure Domain List and select 'USE OF SERVICES' from the list.

The screenshot shows the 'DSS Infoview' application interface. At the top, there's a navigation bar with 'Home', 'Personal Categories', and 'Corporate Categories'. The main content area has three tabs: 'Measure Base Selection', 'Measure Base Maintenance', and 'Qualifier Maintenance'. Under 'Measure Base Selection', there are dropdowns for 'Measure Source' (set to 'HEDIS 2005'), 'Calculation Type' (set to 'Num/Denum'), and 'Measure Domain' (set to 'USE OF SERVICES'). A 'Search' button is also present. Below the search area is a table with the following data:

Measure Base ▲	Measure Source	Measure Domain
HEDIS - ADOLESCENT WELL CHILD VISITS AGE 11-15	HEDIS 2005	USE OF SERVICES
HEDIS - ADOLESCENT WELL CHILD VISITS AGE 16-20	HEDIS 2005	USE OF SERVICES
HEDIS - CHILDREN AND ADOLESCENTS ACCESS TO PRIMARY CARE PRACTITIONERS - AGE 12-21 YEARS	HEDIS 2005	ACCESS/AVAILABILITY OF CARE
HEDIS - CHILDREN AND ADOLESCENTS ACCESS TO PRIMARY CARE PRACTITIONERS - AGE 7-11 YEARS	HEDIS 2005	ACCESS/AVAILABILITY OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Combination 1	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Combination 2	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Hep B	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - MMR	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - VZT	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT WELL CHILD VISITS	HEDIS 2005	USE OF SERVICES

STEP 6. Click on the Search button on the right side of the window.

Commonwealth of Kentucky - DSS Infoview - Microsoft Internet Explorer provided by EDS COE

Address: http://uatdssur.kymmis.com:20080/businessobjects/enterprise115/InfoView/main.aspx

CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM

Welcome: Bobby Jones UAT

Commonwealth of Kentucky

Categories: Home, Personal Categories, Corporate Categories

Measure Base Selection | Measure Base Maintenance | Qualifier Maintenance

Measure Source: HEDIS 2005 | Measure Domain: USE OF SERVICE

Calculation Type: Num/Denum | Frequency: Annual | Search

Results: 1 thru 12 of 101

Measure Base	Measure Source	Measure Domain
HEDIS - ADOLESCENT WELL CHILD VISITS AGE 11-15	HEDIS 2005	USE OF SERVICES
HEDIS - ADOLESCENT WELL CHILD VISITS AGE 16-20	HEDIS 2005	USE OF SERVICES
HEDIS - CHILDREN AND ADOLESCENTS ACCESS TO PRIMARY CARE PRACTITIONERS - AGE 12-21 YEARS	HEDIS 2005	ACCESS/AVAILABILITY OF CARE
HEDIS - CHILDREN AND ADOLESCENTS ACCESS TO PRIMARY CARE PRACTITIONERS - AGE 7-11 YEARS	HEDIS 2005	ACCESS/AVAILABILITY OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Combination 1	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Combination 2	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Hep B	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - MMR	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - VZT	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT WELL CHILD VISITS	HEDIS 2005	USE OF SERVICES

Discussions

Local intranet

The list of Measures meeting the Search criteria will be displayed.

The screenshot shows a web browser window titled "Commonwealth of Kentucky - DSS Infoview - Microsoft Internet Explorer provided by EDS COE". The address bar shows the URL: http://uatdssur.kymmis.com:20080/businessobjects/enterprise115/InfoView/main.aspx. The page header includes "CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM" and a welcome message for Bobby Jones. The main content area is titled "Home" and contains a search interface with the following parameters:

- Measure Source: HEDIS 2005
- Measure Domain: USE OF SERVICE
- Calculation Type: Num/Denum
- Frequency: Annual

The search results are displayed in a table with the following data:

Measure Base	Measure Source	Measure Domain
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 4 SERVICES	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 3 SERVICES	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 2 SERVICES	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 1-4 SERVICES	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 1 SERVICE	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN 5th YEAR OF LIFE	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN 4th YEAR OF LIFE	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN 3rd, 4th, 5th and 6th YEARS OF LIFE	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN 3rd YEAR OF LIFE	HEDIS 2005	USE OF SERVICES
HEDIS - ADOLESCENT WELL CHILD VISITS	HEDIS 2005	USE OF SERVICES
HEDIS - ADOLESCENT WELL CHILD VISITS AGE 16	HEDIS 2005	USE OF SERVICES

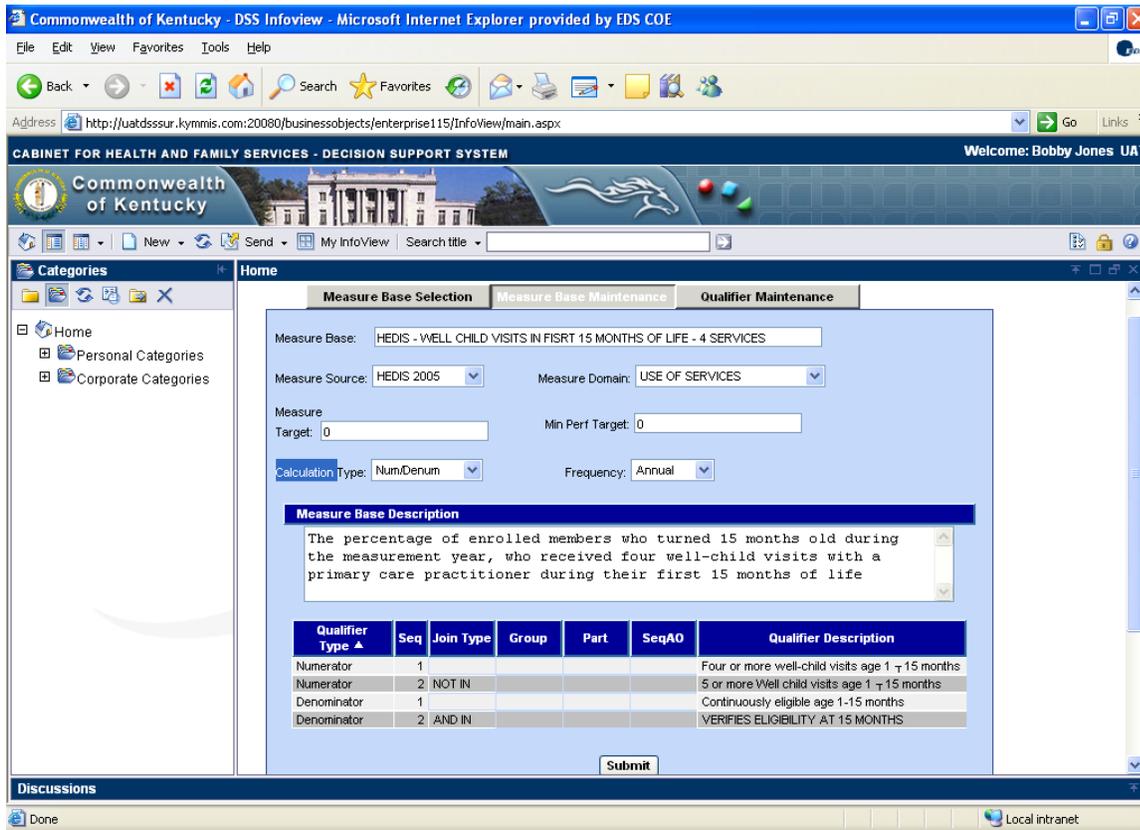
STEP 7. Click on the First Measure which will highlight it.

Double-Click on the highlighted measure

The screenshot shows the 'DSS Infoview' application interface. At the top, there are navigation tabs: 'Measure Base Selection', 'Measure Base Maintenance', and 'Qualifier Maintenance'. Below these, search filters are set: 'Measure Source: HEDIS 2005', 'Measure Domain: USE OF SERVICE', 'Calculation Type: Num/Denum', and 'Frequency: Annual'. A 'Search' button is present. The results section shows a table with 12 of 25 results. The first row is highlighted in yellow.

Measure Base	Measure Source	Measure Domain
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 4 SERVICES	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 3 SERVICES	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 2 SERVICES	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 1-4 SERVICES	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 1 SERVICE	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN 5th YEAR OF LIFE	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN 4th YEAR OF LIFE	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN 3rd, 4th, 5th and 6th YEARS OF LIFE	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN 3rd YEAR OF LIFE	HEDIS 2005	USE OF SERVICES
HEDIS - ADOLESCENT WELL CHILD VISITS	HEDIS 2005	USE OF SERVICES
HEDIS - ADOLESCENT WELL CHILD VISITS AGE 16	HEDIS 2005	USE OF SERVICES

The MeasureBase Maintenance page for the selected measure will open.



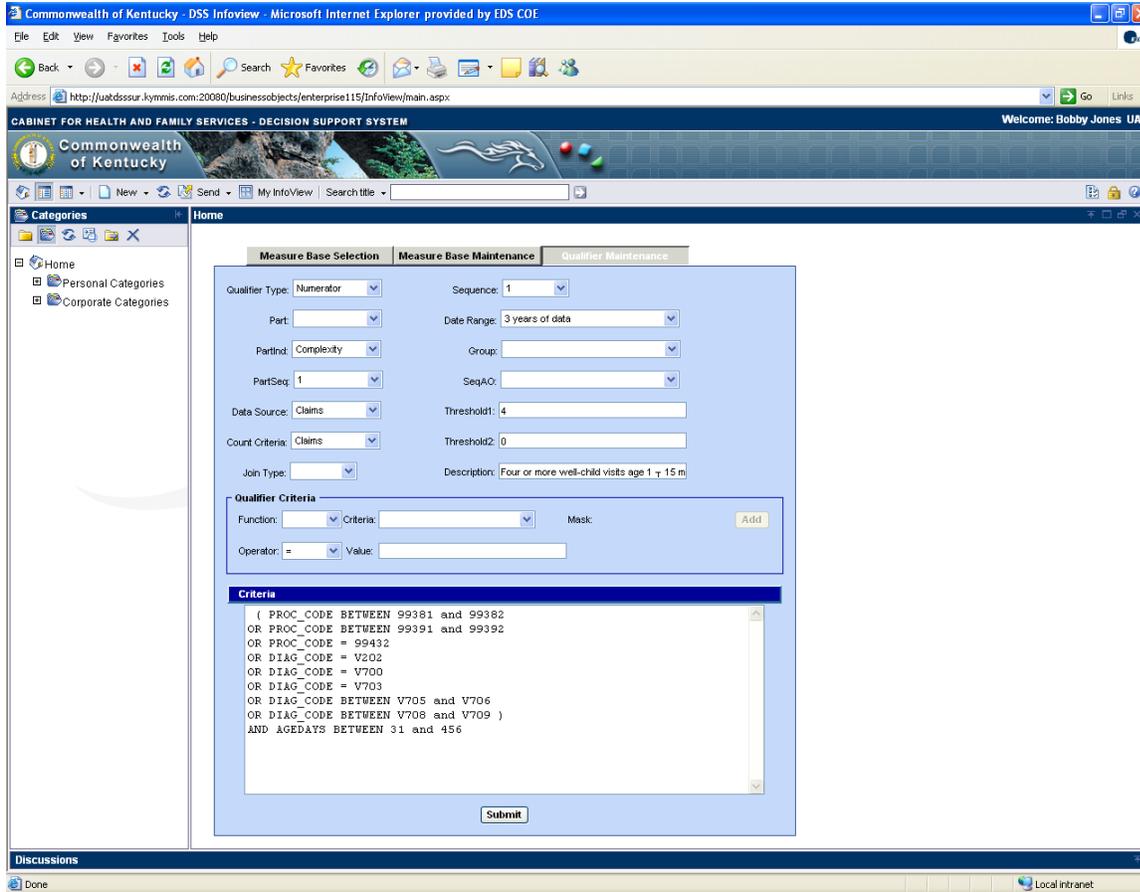
12.1.4 MeasureBase Maintenance Field Descriptions

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Calculation Type	The type of calculation to be used for the measure. Valid values: Numerator/Denominator, Per 100, Per 1000, Per 10000.	1	Drop Down List Box	Field	T_MM_MEASUREBASE	CDE_CALC_TYPE
Frequency	Indicates the frequency that the measure should be generated. Valid values: Quarterly, Semiannually, Annually	10	Check Box	Check Box	T_MM_MEASUREBASE	CDE_FREQUENCY
Group	Lists the group of the qualifier.	18	Character	ListView	T_MM_QUALIFIER	CDE_GROUP

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Join Type	For Part Indicator 'B - Multiple' how the numerators or denominators should be combined	50	Character	ListView	T_MM_QUALIFIER	CDE_JOIN_TYPE
Measure Base	A short description of the measure.	200	Character	Field	T_MM_MEASURE_BASE	MEASURE_BASE_NAME
Measure Base Description	A long description of the measure.	700	Character	Field	T_MM_MEASURE_BASE	DSC_MEASURE_BASE
Measure Domain	A method for grouping measures. Examples: Effectiveness of Care, Access/Availability of Care, Use of Services	50	Drop Down List Box	Field	T_MM_MEASURE_BASE	SAK_DOMAIN
Measure Source	A high-level description of the source of the measure. Example: HEDIS 2005	50	Drop Down List Box	Field	T_MM_MEASURE_BASE	SAK_MEASURE_SOURCE
Measure Target	The target or benchmark of the measure.	5	Number	Field	T_MM_MEASURE_BASE	TARGET
Min Perf Target	The minimum performance target for the measure.	5	Number	Field	T_MM_MEASURE_BASE	MIN_PERF_TARGET
Part	This indicates if the numerator/denominator has a single or multiple parts	18	Character	ListView	T_MM_QUALIFIER	QUAL_PART_IND
Qualifier Description	Lists a short description of the numerators and denominators.	100	Character	ListView	T_MM_QUALIFIER	DSC_QUALIFIER
Qualifier Type	Lists the numerator or denominator subsets used for processing.	11	Character	ListView	T_MM_QUALIFIER	CDE_QUAL_TYPE
SeqAO	Value: AND OR Exclude	0	Character	ListView	n/a	n/a
Sequence	Lists the sequence of the numerators and denominators for processing control.	10	Character	ListView	T_MM_QUALIFIER	CDE_QUAL_SEQ

STEP 8. Double click on the first Numerator shown on the MeasureBase Maintenance Screen.

The Qualifier Maintenance page for the chosen Numerator will display.



12.1.5 Qualifier Maintenance Field Descriptions

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Count Criteria	Indicates the field that will be counted for the measure. Valid values: M-Members, C-Claims(services), A-Paid Amount, D-Check dates between two claims, T-Days(number of days on a claim)	50	Drop Down List Box	Field	T_MM_QUALIFER	CDE_CNT_CRIT
Criteria	This section displays the information that has been entered in the 'Qualifier	0	Alphanumeric	Field	n/a	n/a

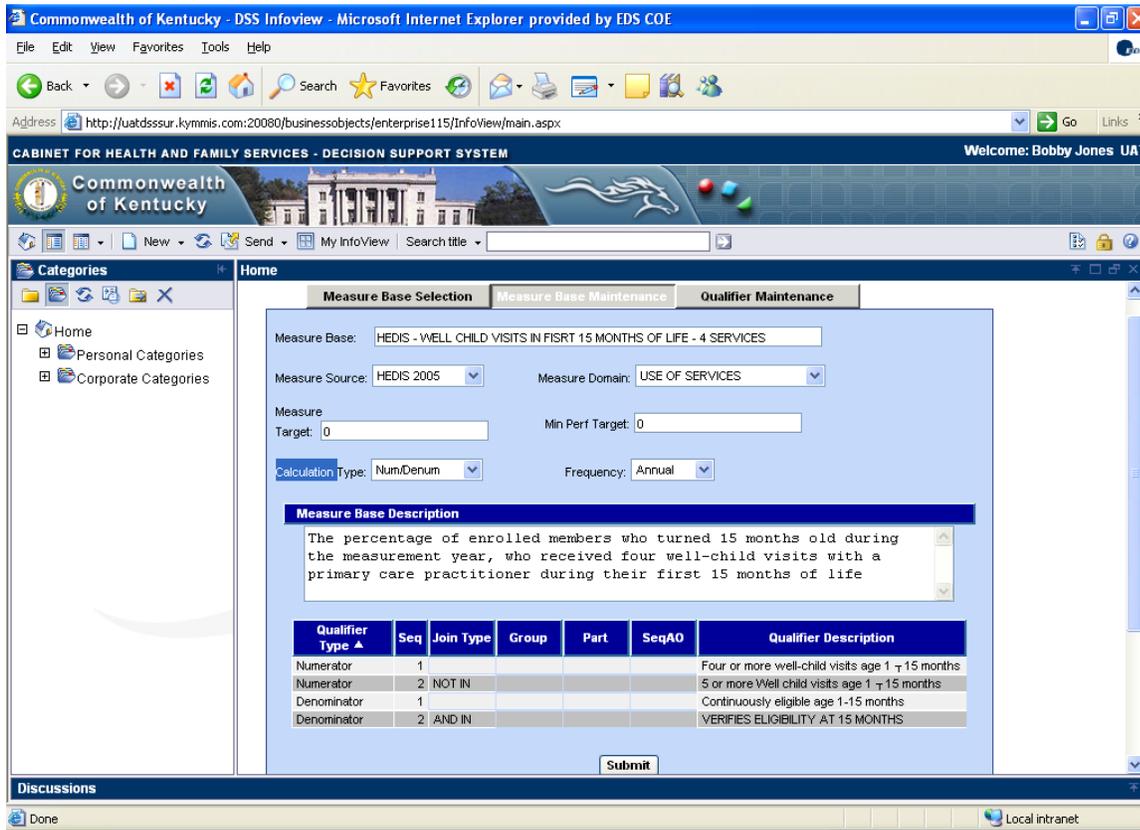
Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
	Criteria' section.					
Data Source	Indicates the source of the measure data. Valid values: C-Claims, E-Eligibility.	50	Drop Down List Box	Field	T_MM_QUALIFER	SAK_DATA_SOURCE
Date Range	Indicates the date range for the measure. Valid values: 1-Current year, 2-Current and previous year, 3-Current and previous two years, P-Previous year	50	Drop Down List Box	Field	T_MM_QUALIFER	CDE_DATE_RANGE
Description	A brief description of the numerator or denominator.	100	Character	Field	T_MM_QUALIFER	DSC_QUAL
Group	Lists the group.	18	Drop Down List Box	Field	T_MM_QUALIFER	CDE_GROUP
Join Type	Indicates how the numerator or denominator sets should be combined: Valid values: A-"AND IN", O-"OR IN", X-"NOT IN"	50	Drop Down List Box	Field	T_MM_QUALIFER	CDE_JOIN_TYPE
Part	This indicates if the numerator/denominator has a single or multiple parts	18	Drop Down List Box	Field	T_MM_QUALIFER	CDE_PART
Part Indicator	This indicates if the numerator/denominator has a single or multiple parts Values: A Single B Multiple E The last numerator/denominator of the series on multiple numerators/denominators	0	Drop Down List Box	Field	T_MM_QUALIFER	QUAL_PART_IND
PartSeq	This indicates the sequence of the parts. Values: A Single B	18	Drop Down List	Field	T_MM_QUALIFER	CDE_PART_SEQ

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
	Multiple E The last numerator/denominator of the series on multiple numerators/denominators		Box			
Qualifier Criteria - Add	This button adds the criteria entered by the user in the 'Criteria list box'. It will stay disabled until the 'Criteria' and 'Value' fields have been entered.	0	N/A	Button	n/a	n/a
Qualifier Criteria - Criteria	This field allows the user to specify the fields that will be used to determine the measure. For example, diagnosis code, age, etc.	0	Drop Down List Box	Field	T_MM_FILTER	TXT_FILTER
Qualifier Criteria - Function	This field allows the user to combine criteria. Valid values: AND, OR, NOT.	0	Drop Down List Box	Field	n/a	n/a
Qualifier Criteria - Mask	This field displays the format in which the 'Value' field must be entered.	0	Character	Field	T_MM_FILTER	TXT_MASK
Qualifier Criteria - Operator	This field allows the user to select an operator with which to compare the 'Criteria' and 'Value' fields. Valid values: =, <>, <=, >=, between, like.	0	Drop Down List Box	Field	n/a	n/a
Qualifier Criteria - Value	This field allows the user to enter the value that will be used to compare against the 'Criteria' field. Two 'Value' fields will be displayed if the user chooses the "between" operator.	0	Alphanumeric	Field	n/a	n/a

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Qualifier Type	Indicates the type of qualifier. Valid values: Numerator, Denominator.	11	Drop Down List Box	Field	T_MM_QUALIFIER	T_MM_QUALIFIER
SeqAO	Value: AND OR Exclude	0	Drop Down List Box	Field	n/a	n/a
Sequence	Indicates the sequence of the numerators and denominators for processing control. Valid values: 1-5.	1	Drop Down List Box	Field	T_MM_QUALIFIER	CDE_QUAL_SEQ
Submit	Submit changes to add or modify.	0	N/A	Button	n/a	n/a
Threshold 1	This is a ten-digit number that indicates the threshold used for extraction. This correlates to the Count Criteria field to determine the level at which a Member meets the Numerator or Denominator. For example, if the Count Criteria is Claims and Threshold1 is 1, then the member must have 2 claims that meet that criteria to include them in the Numerator or Denominator	10	Number	Field	T_MM_QUALIFIER	THRESHOLD_1
Threshold 2	This is a ten-digit number that indicates the threshold used for extraction. This threshold is only used when the criteria is a range like days between count Criteria. In that case Threshold1 is a begin value and Threshold2 is	10	Number	Field	T_MM_QUALIFIER	THRESHOLD_2

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
	an end value.					

STEP 9. Click on the MeasureBase Maintenance Tab to return to the previous Page.



Highlight and double click on any Qualifier to display it's detail information.

Repeat steps 7 and 8 until all desired Qualifiers have been displayed.

STEP 10. Click on the MeasureBase Selection tab to return to the List of Measures found in the initial search..

The screenshot shows a web browser window titled "Commonwealth of Kentucky - DSS Infview - Microsoft Internet Explorer provided by EDS COE". The address bar shows the URL: <http://uatdssur.kymmis.com:20080/businessobjects/enterprise115/InfoView/main.aspx>. The page header includes "CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM" and "Welcome: Bobby Jones UAT".

The main content area is titled "Home" and features three tabs: "Measure Base Selection" (active), "Measure Base Maintenance", and "Qualifier Maintenance". Below the tabs is a search form with the following fields:

- Measure Source: HEDIS 2005
- Measure Domain: USE OF SERVICE
- Calculation Type: Num/Denum
- Frequency: Annual
- Search button

Below the search form, there is a table of results. The table has three columns: "Measure Base", "Measure Source", and "Measure Domain". The results are as follows:

Measure Base	Measure Source	Measure Domain
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 4 SERVICES	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 3 SERVICES	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 2 SERVICES	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 1-4 SERVICES	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN FISRT 15 MONTHS OF LIFE - 1 SERVICE	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN 5th YEAR OF LIFE	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN 4th YEAR OF LIFE	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN 3rd, 4th, 5th and 6th YEARS OF LIFE	HEDIS 2005	USE OF SERVICES
HEDIS - WELL CHILD VISITS IN 3rd YEAR OF LIFE	HEDIS 2005	USE OF SERVICES
HEDIS - ADOLESCENT WELL CHILD VISITS	HEDIS 2005	USE OF SERVICES
HEDIS - ADOLESCENT WELL CHILD VISITS AGE 16	HEDIS 2005	USE OF SERVICES

The table also includes navigation links: "Prev 1 | 2 | 3 Next" and "Results: 1 thru 12 of 25".

12.2 Add a Measure

STEP 1. Navigate to MEUPS site. The initial sign-on window will display.

STEP 2. Enter Username and Password and select 'Sign In'.

The screenshot shows the 'KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES' website. The header includes the state name and department. The main content area features the 'Kentucky UNBROKEN SPIRIT' logo and a 'Sign in to the KyHealth Choices' section. This section lists options like managing contact information and passwords, and includes a 'Register' button. To the right is a 'Sign in to KyHealth Choices' form with fields for 'Username' and 'Password', a 'Sign In' button, and a 'Forgot your password?' link. A 'Help' link is also present. The footer contains 'Contact Us', 'Privacy', 'Disclaimer', and 'Individuals with Disabilities' links, along with a copyright notice for 2006. The browser's address bar shows 'Done' and 'Internet'.

KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Kentucky
UNBROKEN SPIRIT

Kentucky Medicaid Web Site

For assistance, email us at KY_EDL_HelpDesk@eds.com or call (800) 205-4696 during normal business hours 7:00 am - 6:00 pm Monday - Friday EST.

Sign in to the KyHealth Choices

- Manage your contact information
- Change your password
- Providers: Manage your agent's access

If you do not have an account, you will need to register.

[Register](#)

Sign in to KyHealth Choices [Help](#)

Username

Password

[Sign In](#)

KyHealth Choices
[Forgot your password?](#)

[Contact Us](#)

[Privacy](#) | [Disclaimer](#) | [Individuals with Disabilities](#)

Copyright © 2006 Commonwealth of Kentucky
All rights reserved.

Done [Internet](#)

STEP 3. Select the DSS/SUR environment to work in by clicking on the link.

KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
 DEPARTMENT FOR MEDICAID SERVICES

KyHealth Choices Home

Friday 16 March 2007 6:22 pm Sign Out

Bobby Jones, Welcome to KyHealth Choices

Applications	
Application	Description
Account Management	Modify your account information. Providers can also use this application to give application permissions to their agents.
Authorization Request	Allows a user to request access to applications
DSS/SUR Model Office	This is the Model Office BusinessObjects Infview for DSS/SUR
DSS/SUR Test	This is the Test BusinessObjects Infview for DSS/SUR
DSS/SUR UAT	This is the UAT BusinessObjects Infview for DSS/SUR
KyHealth Choices	This is the KyHealth Choices portal application

Messages	
Date	Message
02/23/2007	.Net User Interface MO and UAT release build 112 included the following Change Orders and Defects: Claims - 5749, 6255; CTMS - 6385; EPSDT - 975, 5020; Financial - 3751, 5946; Managed Care - 6141, 6308; MAR - 6372; Member Data Maintenance - 4384; Prior Auth - 4750, 4796, 4987, 6262, 6276; Provider - 4656, 4979, 6390; Recipient - 5930, 5931; Reference Data Maintenance - 2179, 3158, 6002, 6192; System Wide - 4408, 4959; and Third Party Liability - 2932, 4721, 5008, 5009, 5057, 5074, 5143, 6323, 6331. UNIX Model Office and UAT promotion build 112 on 2/23/2007 contained the following change orders and defects: Build

The infview main page will open.

The screenshot displays the user interface for the Commonwealth of Kentucky MMIS Data Warehouse/DSS Subsystem. At the top, the header reads "CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM" and "Welcome: William Bennett Model Office". The main content area features the Kentucky logo and a list of links for various maintenance and request functions. The left sidebar shows a "Categories" menu with "Home", "Personal Categories", and "Corporate Categories".

Categories

- Home
- Personal Categories
- Corporate Categories

Home

[Personalize InfoView now](#)

[Go to InfoView Inbox](#)

[New Desktop Intelligence Document](#)

[New Web Intelligence Document](#)

DSSProfiler Maintenance

- [Case Type Maintenance](#)
- [Peer Group Maintenance](#)
- [Case Group Maintenance](#)

eKASPER Requests

- [Member Requests](#)
- [Provider Requests](#)

DSSMeasureBase Maintenance

- [MeasureCase Maintenance](#)

Performance Management

- [Launch Java Infoview](#)

Random Sample

- [Random Sample Request](#)
- [Random Sample Log](#)

Geographical Mapping

- [ESR Maps - KY network only](#)
- [ESR Maps - EDS network only](#)

powered by **BusinessObjects XI** Release 2

Discussions

12.2.1 InfoView Panel Sections

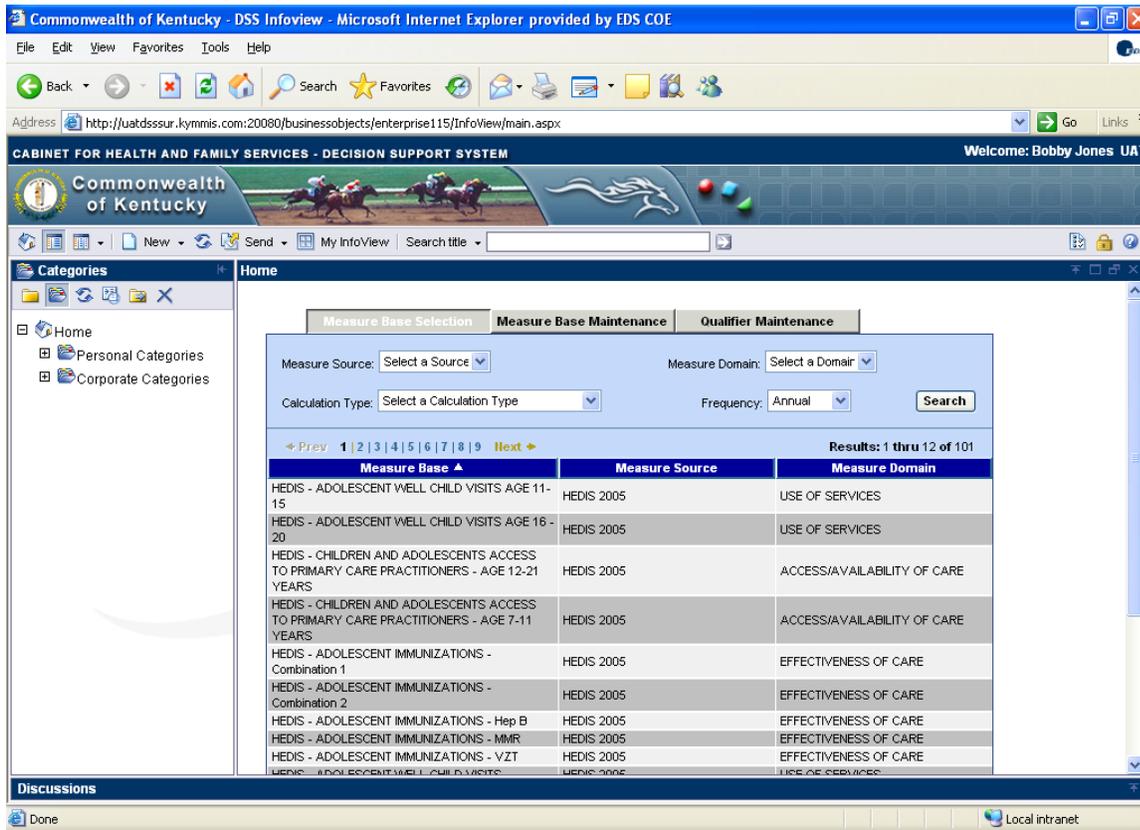
Section	Description
Categories	This section of the panel displays the categories of reports that can be accessed by a user depending on their permissions.
Home	This section of the panel displays the access options that a user has access to based on their permissions. Note: Most individuals will not have access to the eKASPER information shown here. If a person does not have access to a function it will not display on the panel.

12.2.2 InfoView Panel Links

Links	Description
Personalize InfoView Now	This link guides the user to a page where they can customize the display properties of the infoView panel displayed when they log into infoView.
Go to InfoView Inbox	This link guides the user to their personal infoView inbox. This allows a user to access documents forwarded to them by other infoView DSS users.
New Desktop Intelligence Document	This link opens a new document using the desktop intelligence version of the BusinessObjects software.
New Web Intelligence Document	This link opens a new document using the web intelligence version of the BusinessObjects software.
Case Type Maintenance	This link opens a page that allows the user to update, add or delete case types that are used in the DSS Profiler process.
Peer Group Maintenance	This link opens a page that allows the user to update, add or delete peer groups that are used in the DSS Profiler process.
Case Group Maintenance	This link opens a page that allows the user to update, add or delete case groups that are used in the DSS Profiler process.
Member Requests	This link opens a pages that allows users with eKASPER access to request information about a member.
Provider Requests	This link opens a pages that allows users with eKASPER access to request information about a provider.
MeasureBase Maintenance	This link opens a pages that allows users with MeasureBase access to add or update measures.
Launch Java InfoView	This link opens up a panel that allows users with Performance Manager access to see executive dashboards.
Random Sample Request	This link opens a pages that allows users to create a random sample request.
Random Sample Log	This link opens a pages that allows users to view the status of an existing random sample request.
ESRI Maps – KY Network Only	This link opens a pages that allows users to access ESRI maps that are available on the KY Network.
ESRI Maps – HP Enterprise Services Network Only	This link opens a pages that allows users to access ESRI maps that are available on the HP Enterprise Services Network.

STEP 4. Select the MeasureBase Maintenance Link under the DSSMeasureBase Maintenance Section.

The DSSMeasureBase Selection page will open. It will show all available measures..

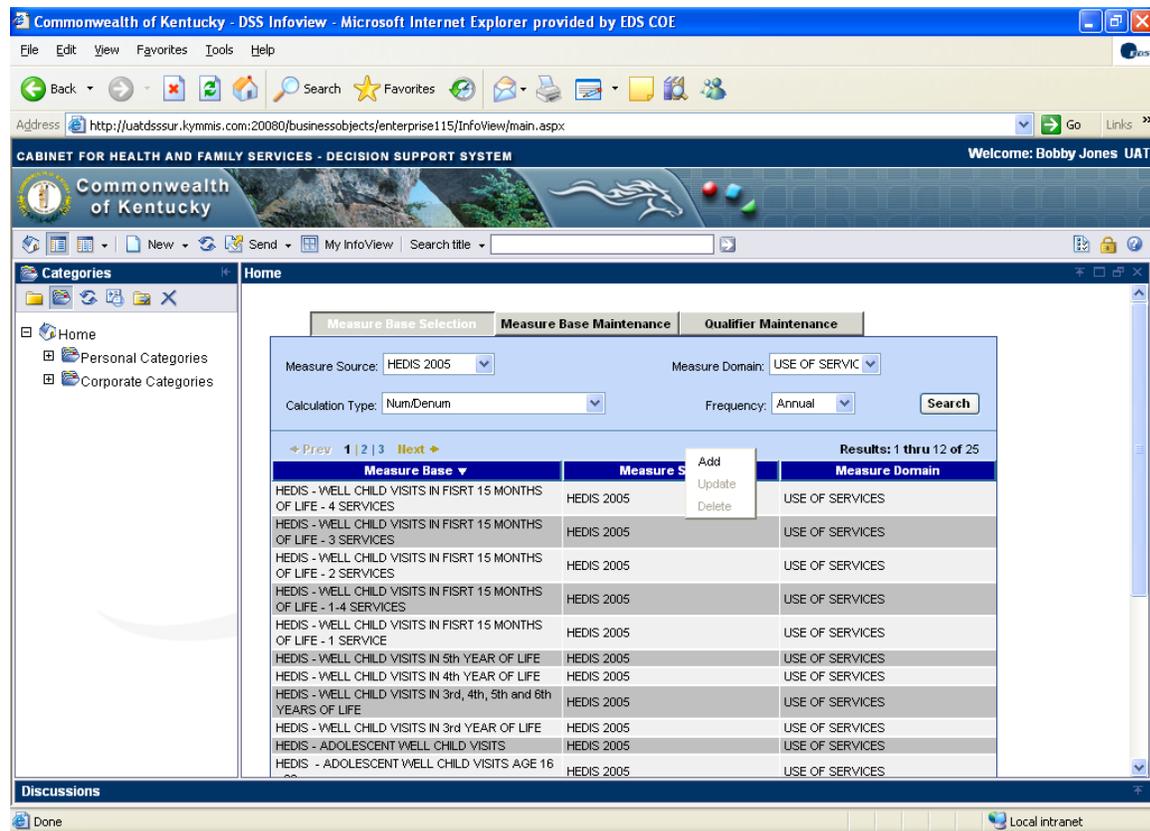


12.2.3 MeasureBase Selection Field Descriptions

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Calculation Type	This indicates how the data will be sampled Values: A - Numerator /Denominator B - Per 1000 C - Per 100 D - Per 10000	13	Drop Down List Box	Field	T_MM_MEASURE_BASE	CDE_CALC_TYPE
Frequency	Indicates the frequency that the measure should be generated. Examples: Quarterly, Semiannually, Annually	0	Drop Down List Box	Field	T_MM_MEASURE_BASE	CDE_FREQUENC Y
Measure Base	A short description of the measure.	0	Character	Field	T_MM_MEASURE_BASE	MEASURE_BASE_ NAME
Measure Domain	A method for grouping measures. Examples: Effectiveness of Care, Access/Availability of Care, Use of Services	0	Drop Down List Box	Field	T_MM_MEASURE	SAK_DOMAIN

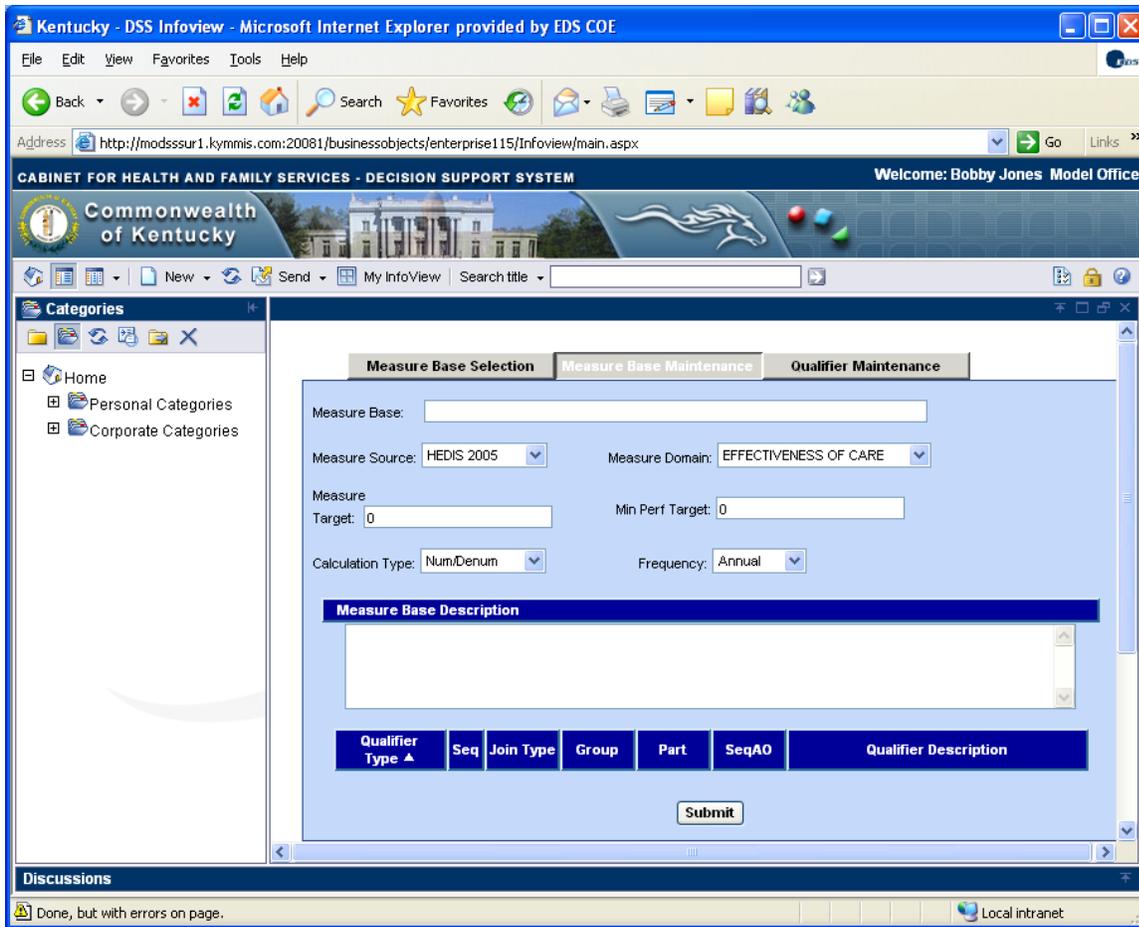
Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Measure Source	A high-level description of the source of the measure. Example: HEDIS 2005	0	Drop Down List Box	Field	T_MM_MEASURE_BASE	SAK_MEASURE_SOURCE
Search	Provides the capability to search for specific measures.	0	N/A	Button	n/a	n/a

STEP 5. Right Click with the cursor anywhere at the top of the window.



Click on 'ADD' from the list

The MeasureBase Maintenance page will display with default values in selected fields

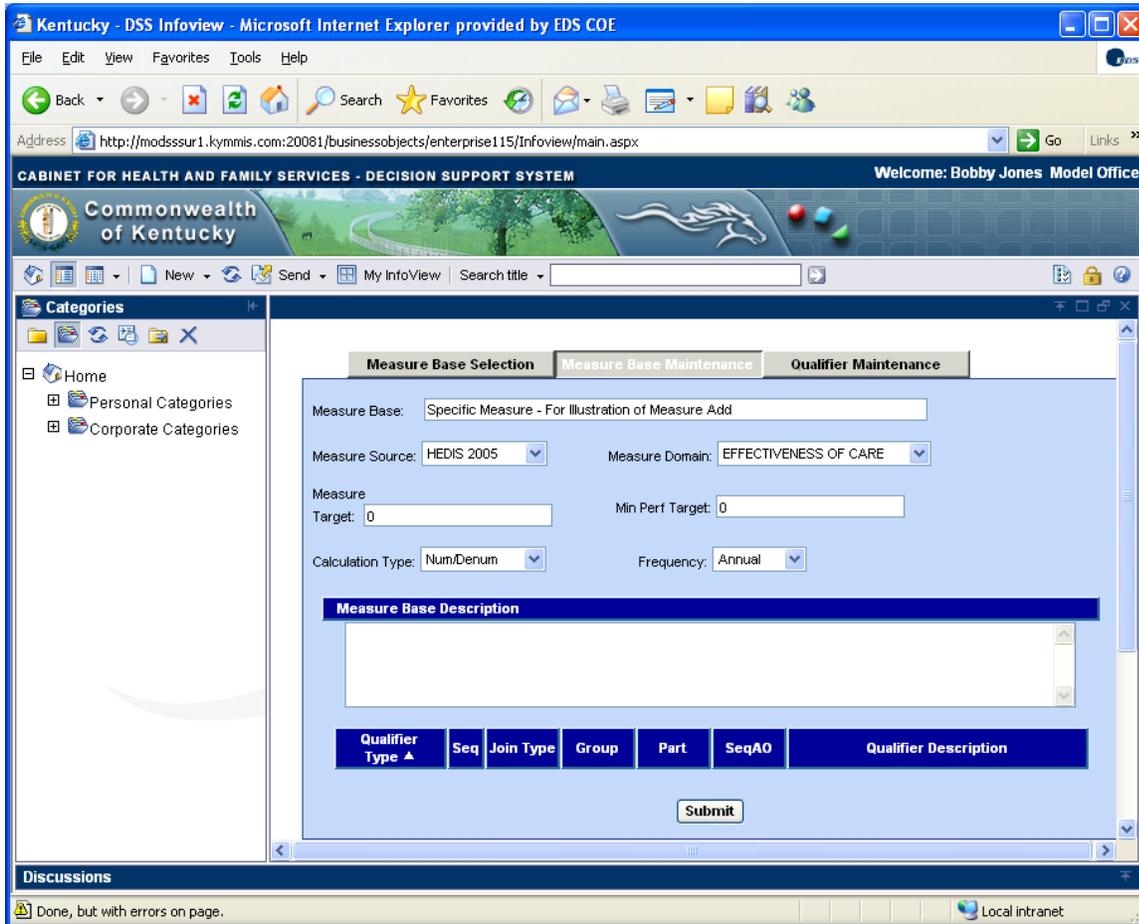


12.2.4 MeasureBase Maintenance Field Descriptions:

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Calculation Type	The type of calculation to be used for the measure. Valid values: Numerator/Denominator, Per 100, Per 1000, Per 10000.	1	Drop Down List Box	Field	T_MM_MEASUREBASE	CDE_CALC_TYPE
Frequency	Indicates the frequency that the measure should be generated. Valid values: Quarterly, Semiannually, Annually	10	Check Box	Check Box	T_MM_MEASUREBASE	CDE_FREQUENCY
Group	Lists the group of the qualifier.	18	Character	ListView	T_MM_QUALIFIER	CDE_GROUP
Join Type	For Part Indicator 'B - Multiple' how the numerators or denominators should be combined	50	Character	ListView	T_MM_QUALIFIER	CDE_JOIN_TYPE

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Measure Base	A short description of the measure.	200	Character	Field	T_MM_MEASURE_BASE	MEASURE_BASE_NAME
Measure Base Description	A long description of the measure.	700	Character	Field	T_MM_MEASURE_BASE	DSC_MEASURE_BASE
Measure Domain	A method for grouping measures. Examples: Effectiveness of Care, Access/Availability of Care, Use of Services	50	Drop Down List Box	Field	T_MM_MEASURE_BASE	SAK_DOMAIN
Measure Source	A high-level description of the source of the measure. Example: HEDIS 2005	50	Drop Down List Box	Field	T_MM_MEASURE_BASE	SAK_MEASURE_SOURCE
Measure Target	The target or benchmark of the measure.	5	Number	Field	T_MM_MEASURE_BASE	TARGET
Min Perf Target	The minimum performance target for the measure.	5	Number	Field	T_MM_MEASURE_BASE	MIN_PERF_TARGET
Part	This indicates if the numerator/denominator has a single or multiple parts	18	Character	ListView	T_MM_QUALIFIER	QUAL_PART_IND
Qualifier Description	Lists a short description of the numerators and denominators.	100	Character	ListView	T_MM_QUALIFIER	DSC_QUALIFIER
Qualifier Type	Lists the numerator or denominator subsets used for processing.	11	Character	ListView	T_MM_QUALIFIER	CDE_QUAL_TYPE
SeqAO	Value: AND OR Exclude	0	Character	ListView	n/a	n/a
Sequence	Lists the sequence of the numerators and denominators for processing control.	10	Character	ListView	T_MM_QUALIFIER	CDE_QUAL_SEQ

STEP 6. Enter the Description of the Measure being added



STEP 7. Click on the Drop Down box for Measure Domain.

The screenshot shows the 'Measure Base Selection' tab in the 'CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM'. The 'Measure Domain' dropdown menu is open, displaying three options: 'EFFECTIVENESS OF CARE', 'ACCESS/AVAILABILITY OF CARE', and 'USE OF SERVICES'. The 'EFFECTIVENESS OF CARE' option is currently selected. Other form fields include: 'Measure Base' (Specific Measure - For Illustration of Measure Add), 'Measure Source' (HEDIS 2005), 'Measure' (Specific Measure - For Illustration of Measure Add), 'Target' (0), 'Calculation Type' (Num/Denum), and 'Frequency' (Annual). A 'Measure Base Description' text area is present below the form fields. At the bottom of the form, there are buttons for 'Qualifier Type', 'Seq', 'Join Type', 'Group', 'Part', 'SeqAO', and 'Qualifier Description', along with a 'Submit' button.

STEP 8. Enter Rest of desired criteria as follows:

Enter 1 into Measure Target

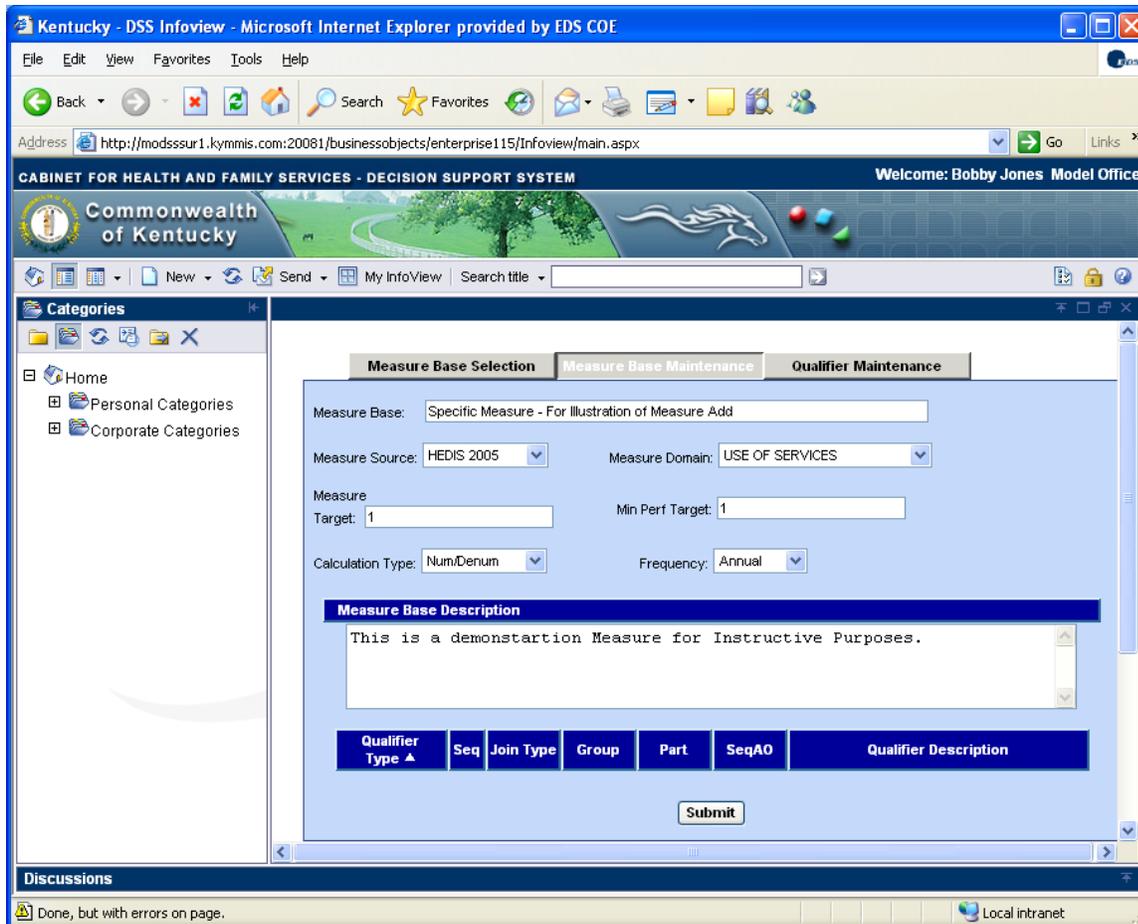
Enter 1 into Min Perf Target

Leave the Default in Calculation Type

Leave the Default in Frequency.

Enter a detailed description in the Measure Base Description area

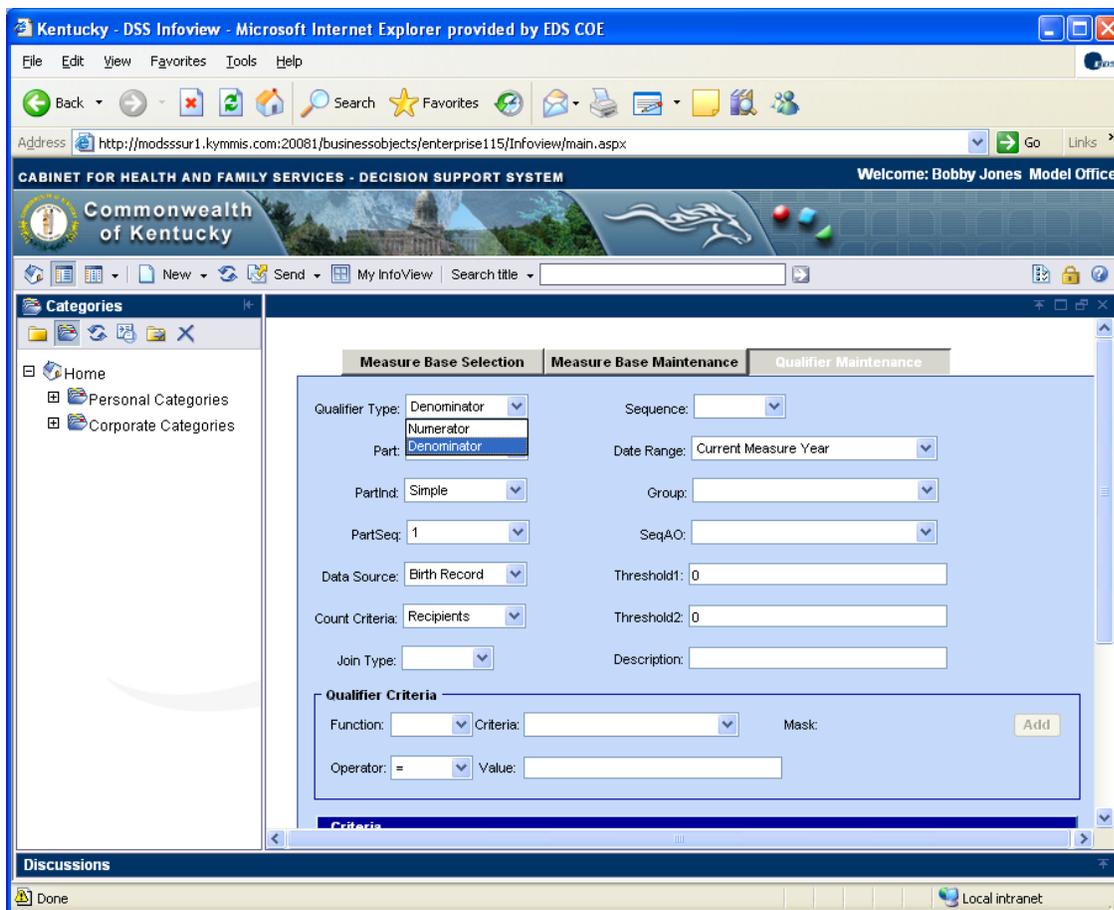
Page now looks like this:



Click on the Submit button

STEP 9. The Qualifier Maintenance page for the chosen Numerator will display with selected default values displayed.

Select the Drop Down box for Qualifier Type



12.2.5 Qualifier Maintenance Field Descriptions

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Count Criteria	Indicates the field that will be counted for the measure. Valid values: M- Members, C- Claims(services), A- Paid Amount, D- Check dates between two claims, T-Days(number of days on a claim)	50	Drop Down List Box	Field	T_MM_QUALIFER	CDE_CNT_CRIT
Criteria	This section displays the information that has been entered in the 'Qualifier Criteria' section.	0	Alphanumeric	Field	n/a	n/a

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Data Source	Indicates the source of the measure data. Valid values: C-Claims, E-Eligibility.	50	Drop Down List Box	Field	T_MM_QUA LIFER	SAK_DATA_S OURCE
Date Range	Indicates the date range for the measure. Valid values: 1-Current year, 2-Current and previous year, 3-Current and previous two years, P-Previous year	50	Drop Down List Box	Field	T_MM_QUA LIFER	CDE_DATE_R ANGE
Description	A brief description of the numerator or denominator.	100	Character	Field	T_MM_QUA LIFER	DSC_QUAL
Group	Lists the group.	18	Drop Down List Box	Field	T_MM_QUA LIFER	CDE_GROUP
Join Type	Indicates how the numerator or denominator sets should be combined: Valid values: A-"AND IN", O-"OR IN", X-"NOT IN"	50	Drop Down List Box	Field	T_MM_QUA LIFER	CDE_JOIN_T YPE
Part	This indicates if the numerator/denominator has a single or multiple parts	18	Drop Down List Box	Field	T_MM_QUA LIFER	CDE_PART
Part Indicator	This indicates if the numerator/denominator has a single or multiple parts Values: A Single B Multiple E The last numerator/denominator or of the series on multiple numerators/denominators	0	Drop Down List Box	Field	T_MM_QUA LIFER	QUAL_PART_ IND

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
PartSeq	This indicates the sequence of the parts. Values: A Single B Multiple E The last numerator/denominator of the series on multiple numerators/denominators	18	Drop Down List Box	Field	T_MM_QUALIFER	CDE_PART_SEQ
Qualifier Criteria - Add	This button adds the criteria entered by the user in the 'Criteria list box'. It will stay disabled until the 'Criteria' and 'Value' fields have been entered.	0	N/A	Button	n/a	n/a
Qualifier Criteria - Criteria	This field allows the user to specify the fields that will be used to determine the measure. For example, diagnosis code, age, etc.	0	Drop Down List Box	Field	T_MM_FILTER	TXT_FILTER
Qualifier Criteria - Function	This field allows the user to combine criteria. Valid values: AND, OR, NOT.	0	Drop Down List Box	Field	n/a	n/a
Qualifier Criteria - Mask	This field displays the format in which the 'Value' field must be entered.	0	Character	Field	T_MM_FILTER	TXT_MASK
Qualifier Criteria - Operator	This field allows the user to select an operator with which to compare the 'Criteria' and 'Value' fields. Valid values: =, <>, , <=, >=, between, like.	0	Drop Down List Box	Field	n/a	n/a

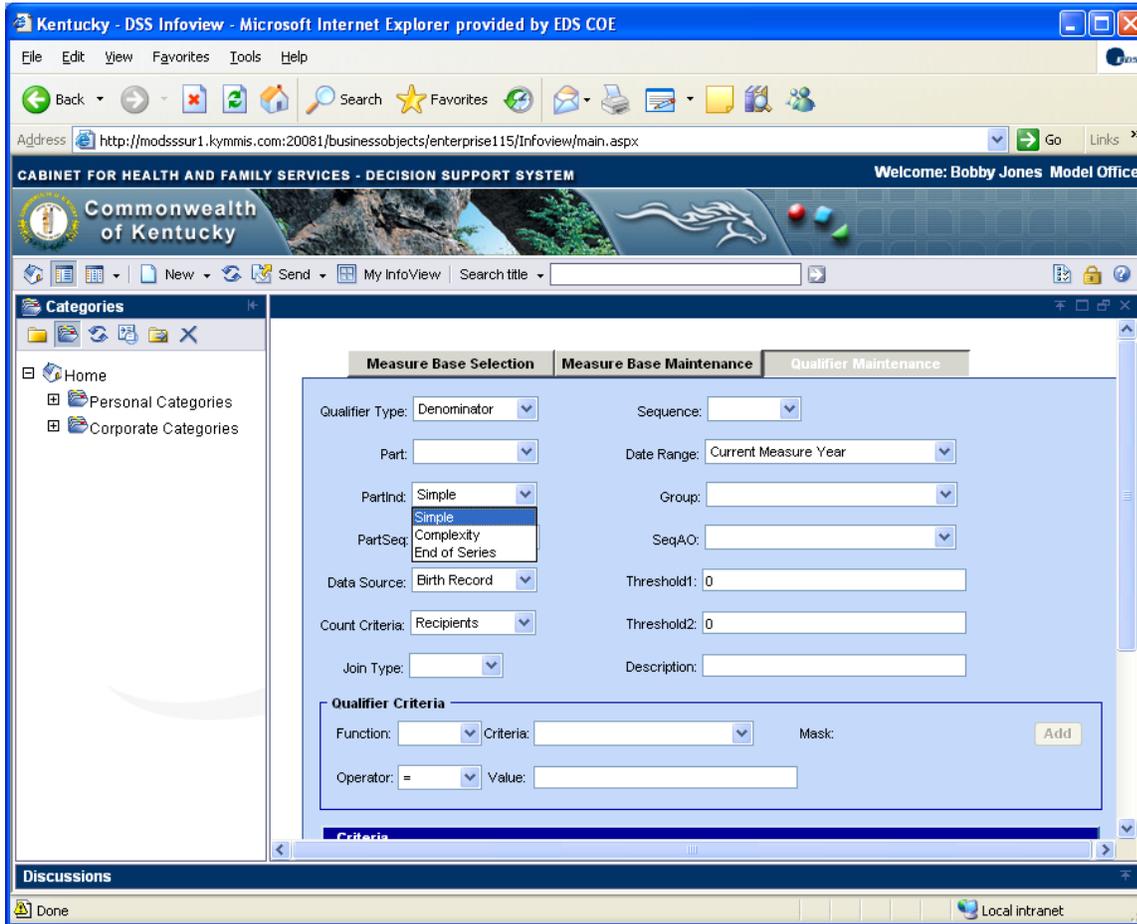
Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Qualifier Criteria - Value	This field allows the user to enter the value that will be used to compare against the 'Criteria' field. Two 'Value' fields will be displayed if the user chooses the "between" operator.	0	Alphanumeric	Field	n/a	n/a
Qualifier Type	Indicates the type of qualifier. Valid values: Numerator, Denominator.	11	Drop Down List Box	Field	T_MM_QUALIFER	T_MM_QUALIFIER
SeqAO	Value: AND OR Exclude	0	Drop Down List Box	Field	n/a	n/a
Sequence	Indicates the sequence of the numerators and denominators for processing control. Valid values: 1-5.	1	Drop Down List Box	Field	T_MM_QUALIFER	CDE_QUAL_SEQ
Submit	Submit changes to add or modify.	0	N/A	Button	n/a	n/a
Threshold 1	This is a ten-digit number that indicates the threshold used for extraction. It is assumed that the value is based on a member based total.	10	Number	Field	T_MM_QUALIFER	THRESHOLD_1
Threshold 2	This is a ten-digit number that indicates the threshold used for extraction. It is assumed that the value is based on a member based total.	10	Number	Field	T_MM_QUALIFER	THRESHOLD_2

STEP 10. Click on each drop down box and select the value needed for the build of the measure.

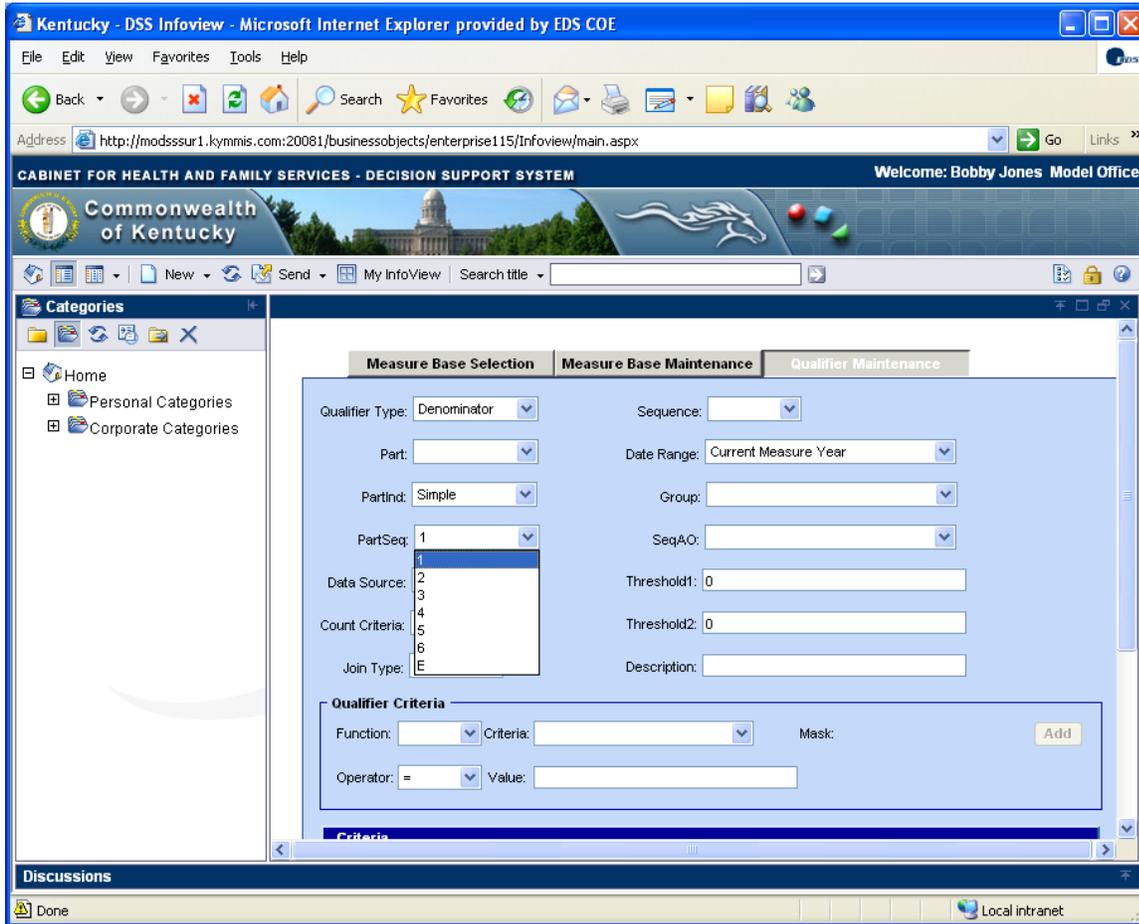
Click on the 'Part:' drop down box and select the value needed to build the measure.

The screenshot shows a Microsoft Internet Explorer browser window displaying the 'Kentucky - DSS Infoview' application. The browser's address bar shows the URL: <http://modsssur1.kymmis.com:20081/businessobjects/enterprise115/Infoview/main.aspx>. The page header includes 'CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM' and a welcome message for 'Bobby Jones Model Office'. The main content area is titled 'Measure Base Selection' and contains several form fields and dropdown menus. The 'Part:' dropdown menu is open, showing a list of options: 1, 2, 3, 4, 5, and 6. Other fields include 'Qualifier Type' (set to 'Denominator'), 'Sequence', 'Date Range' (set to 'Current Measure Year'), 'Group', 'SeqAO', 'Threshold1', 'Threshold2', 'Description', 'Count Criteria' (set to 'Recipients'), and 'Join Type'. There is also a section for 'Qualifier Criteria' with fields for 'Function', 'Criteria', 'Mask', 'Operator' (set to '='), and 'Value'. The browser's status bar at the bottom shows 'Done' and 'Local intranet'.

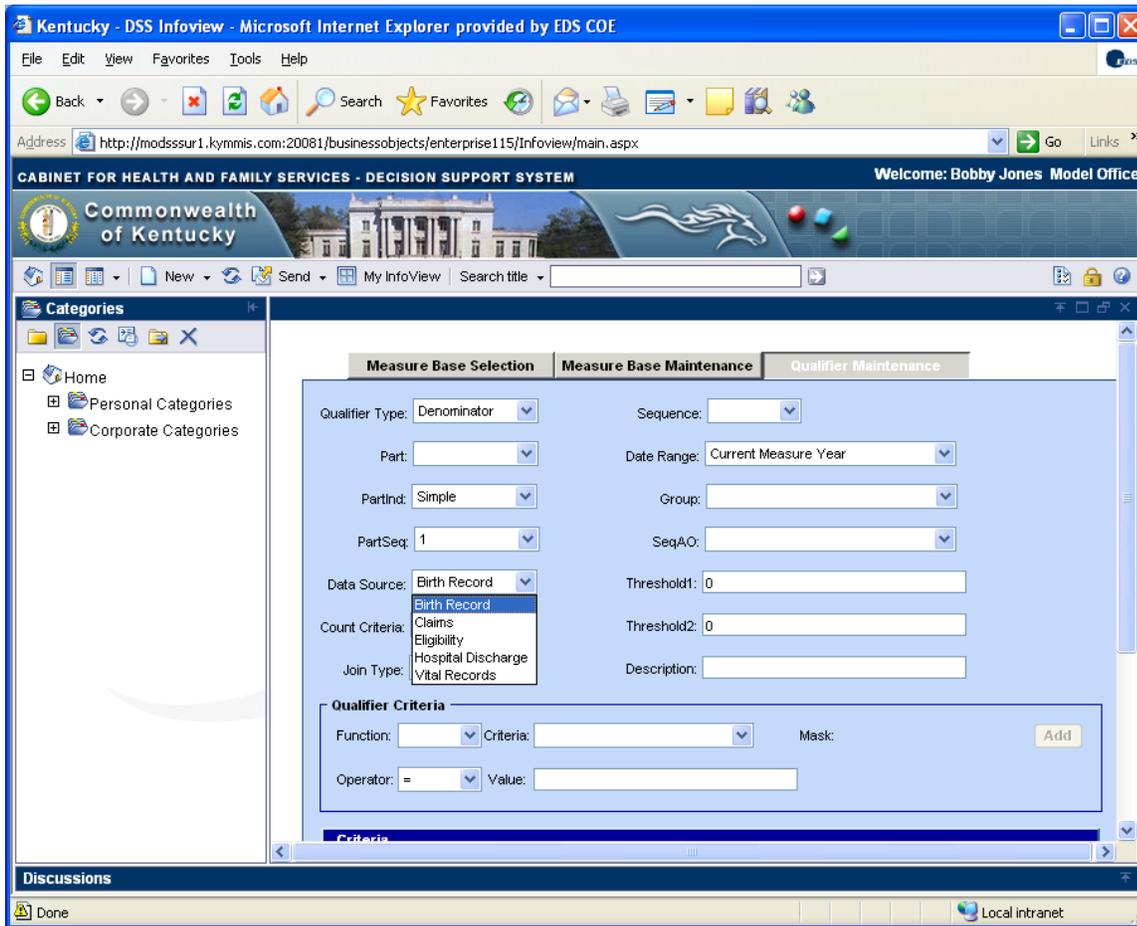
Click on the 'Parting:' drop down box and select the value needed to build the measure.



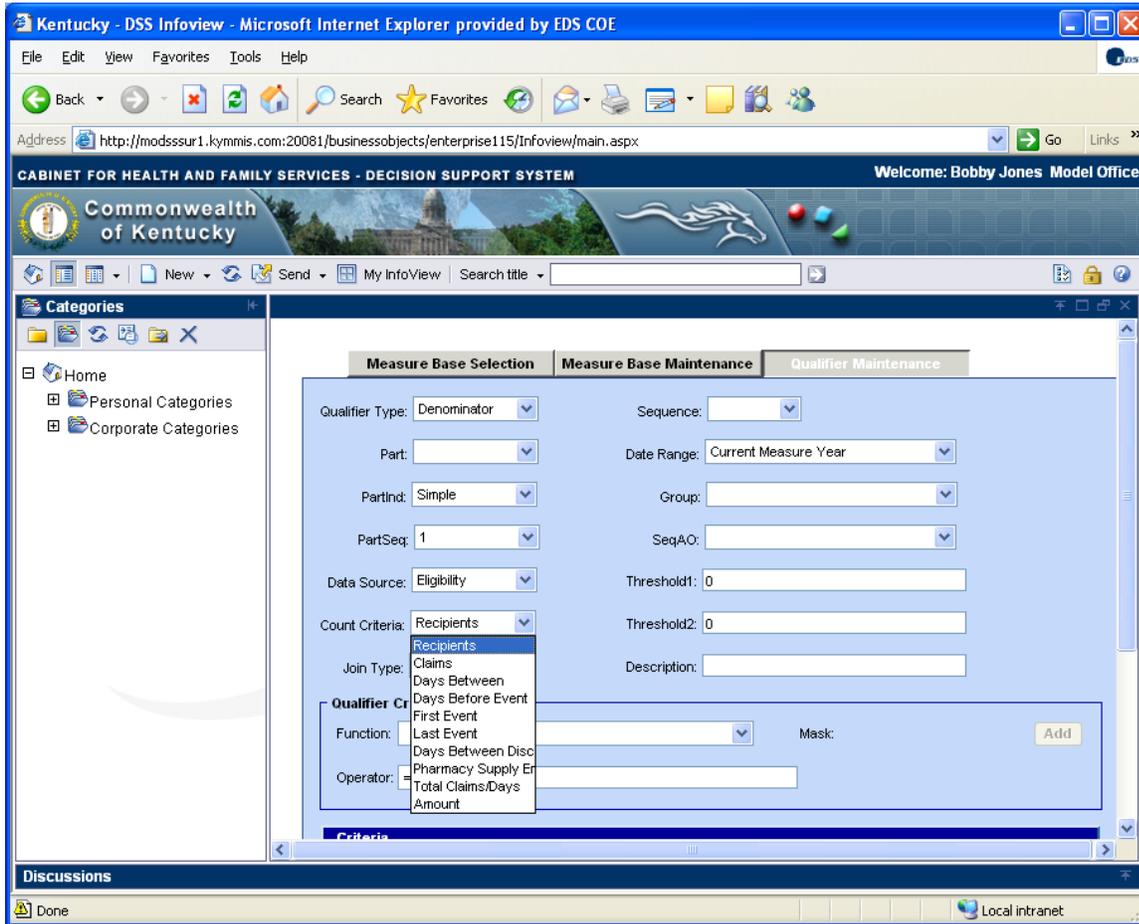
Click on the 'Partseq:' drop down box and select the value needed to build the measure.



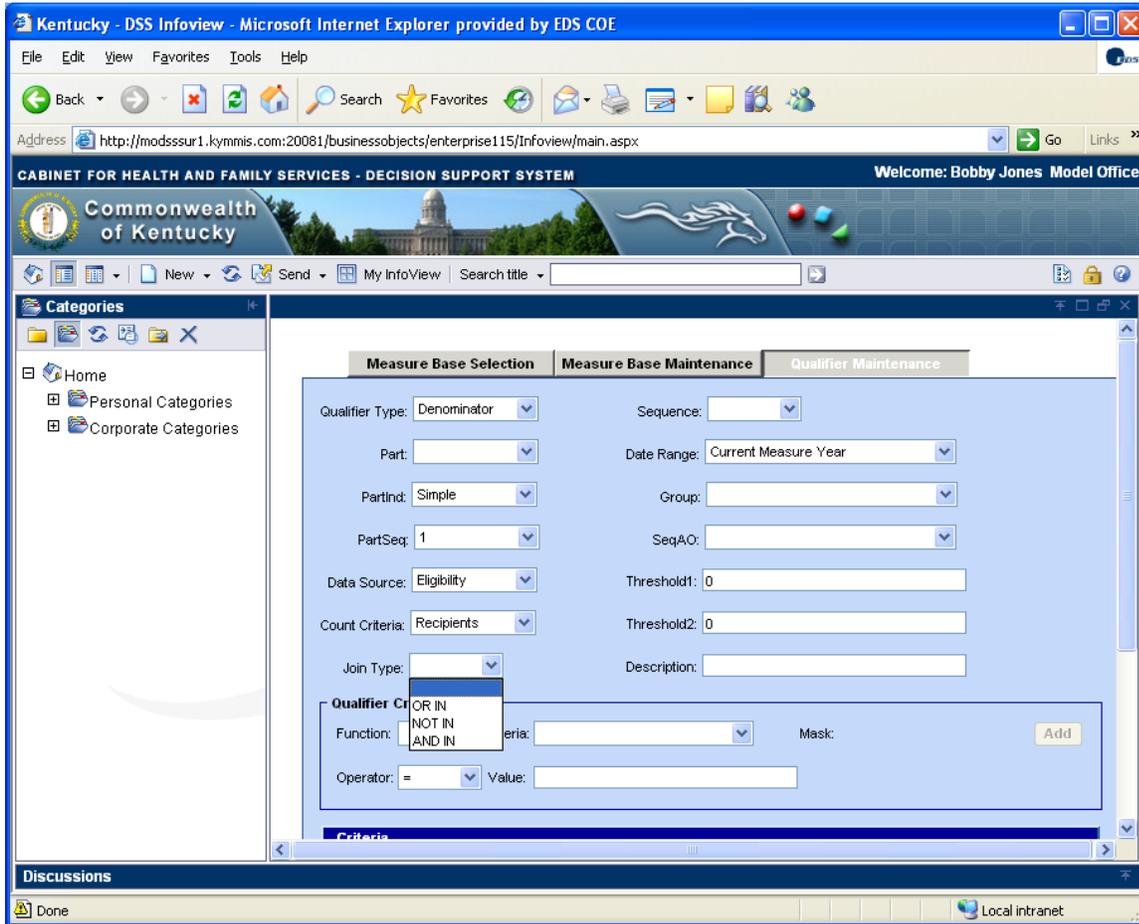
Click on the 'Data Source:' drop down box and select the value needed to build the measure.



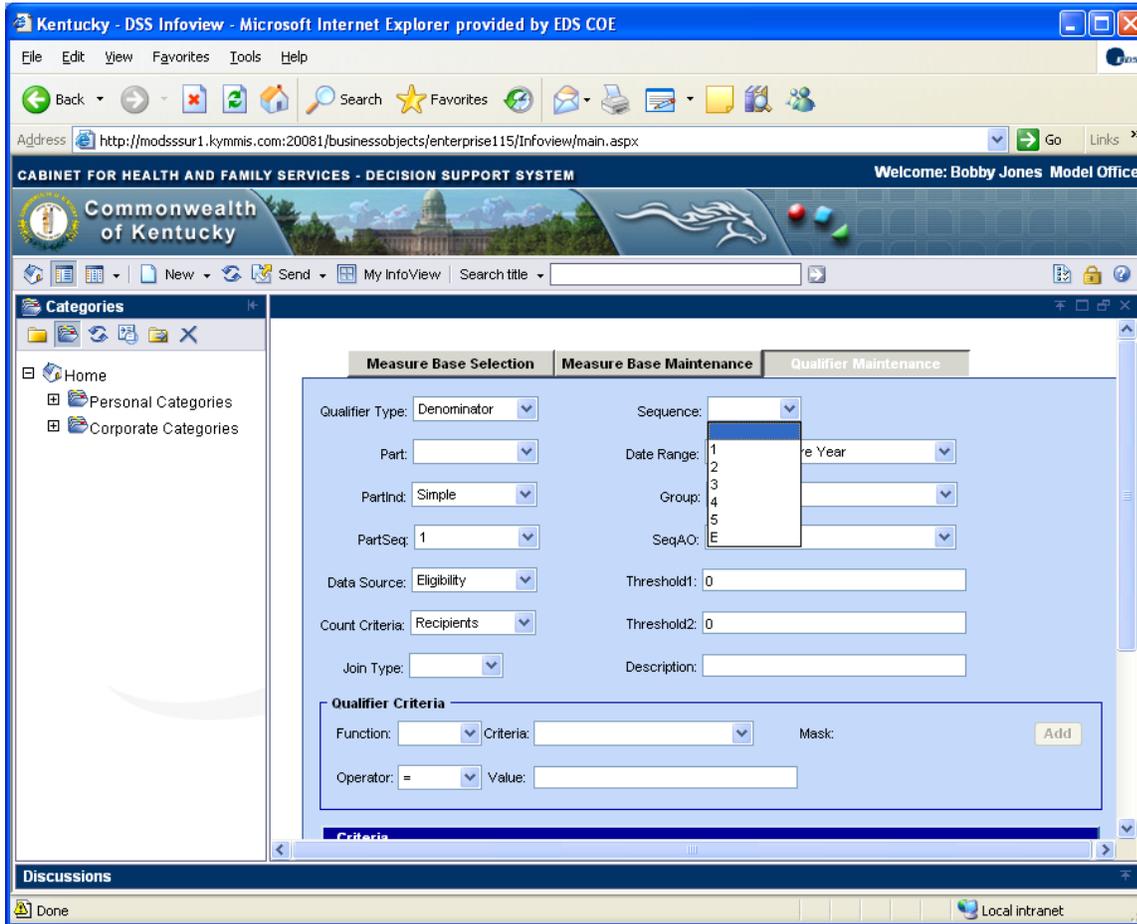
Click on the 'Count Criteria' drop down box and select the value needed to build the measure.



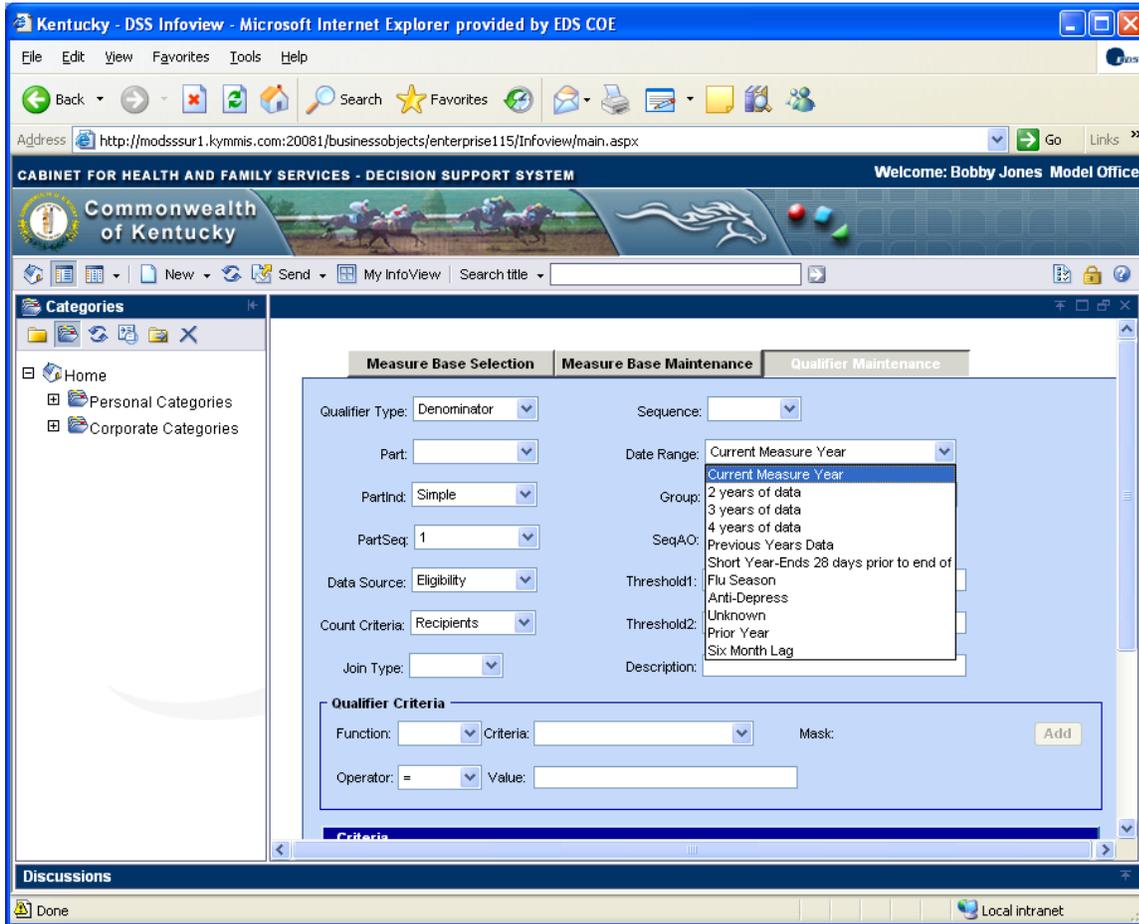
Click on the 'Join Type:' drop down box and select the value needed to build the measure.



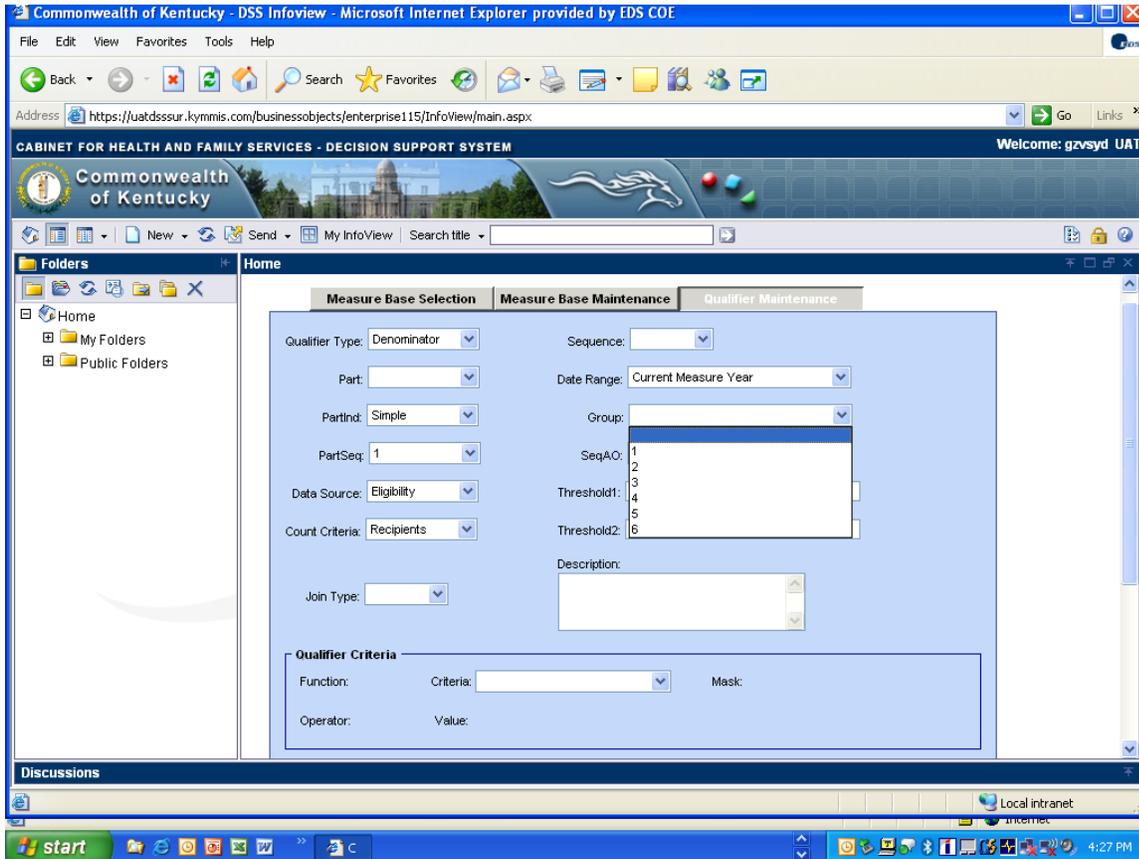
Click on the 'Sequence:' drop down box and select the value needed to build the measure.



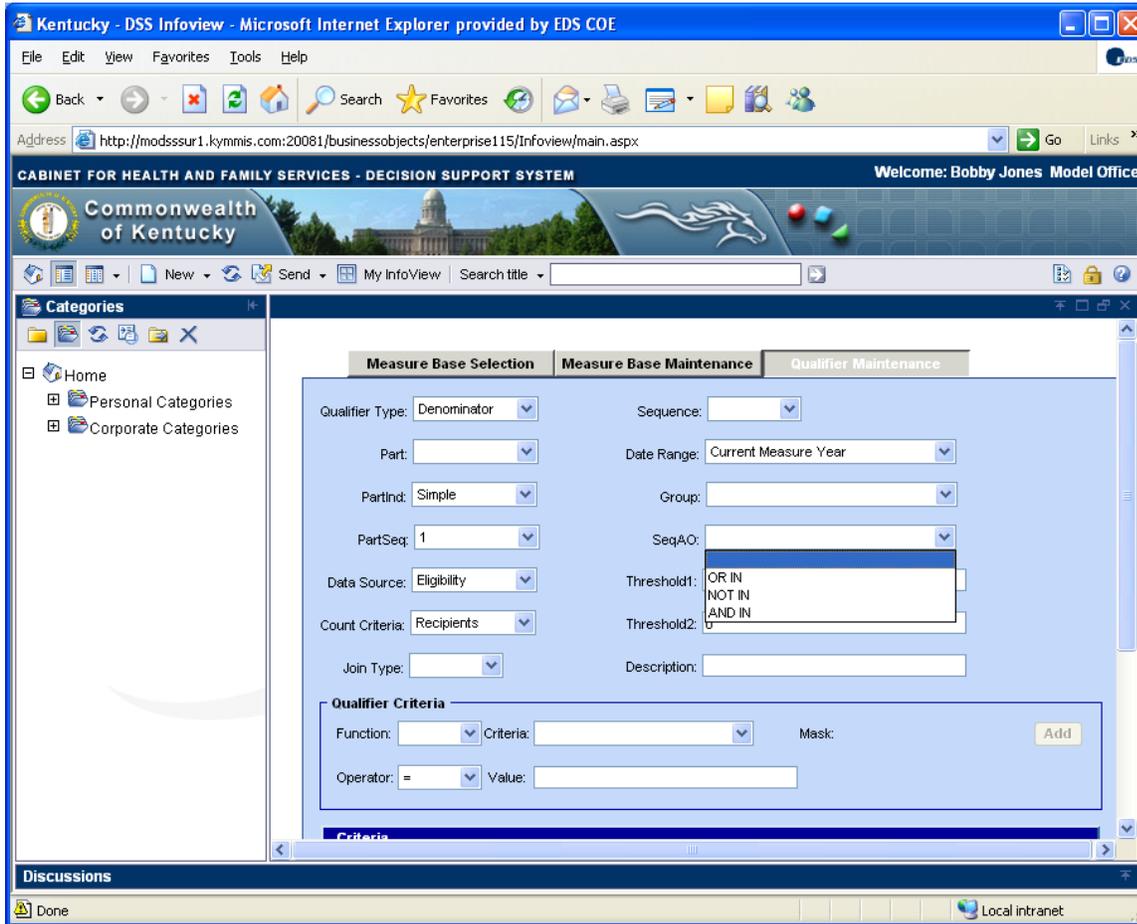
Click on the 'Date Range:' drop down box and select the value needed to build the measure.



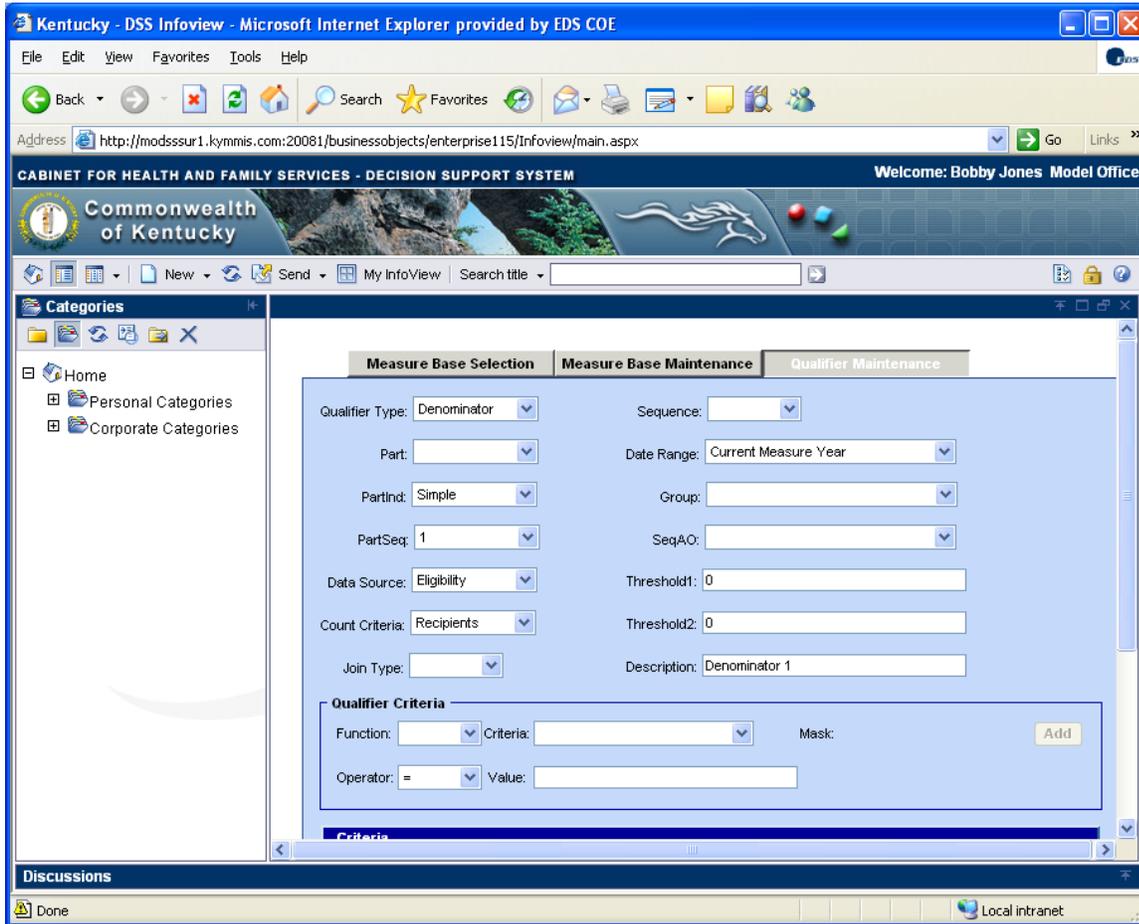
Click on the 'Group:' drop down box and select the value needed to build the measure.



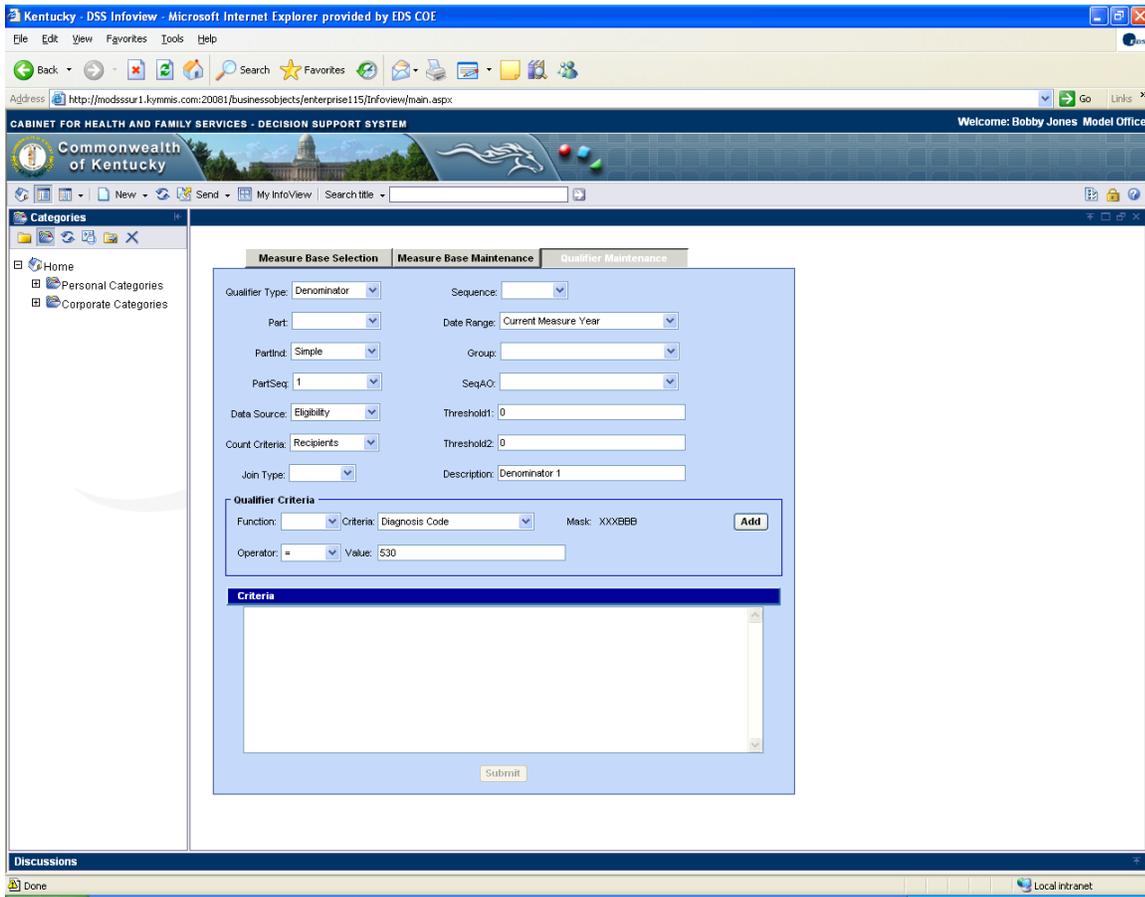
Click on the 'SeqAO:' drop down box and select the value needed to build the measure.



Enter the 'Threshold1:' and 'Threshold2' number which apply to the measure



Once criteria is added select the 'Submit' button.

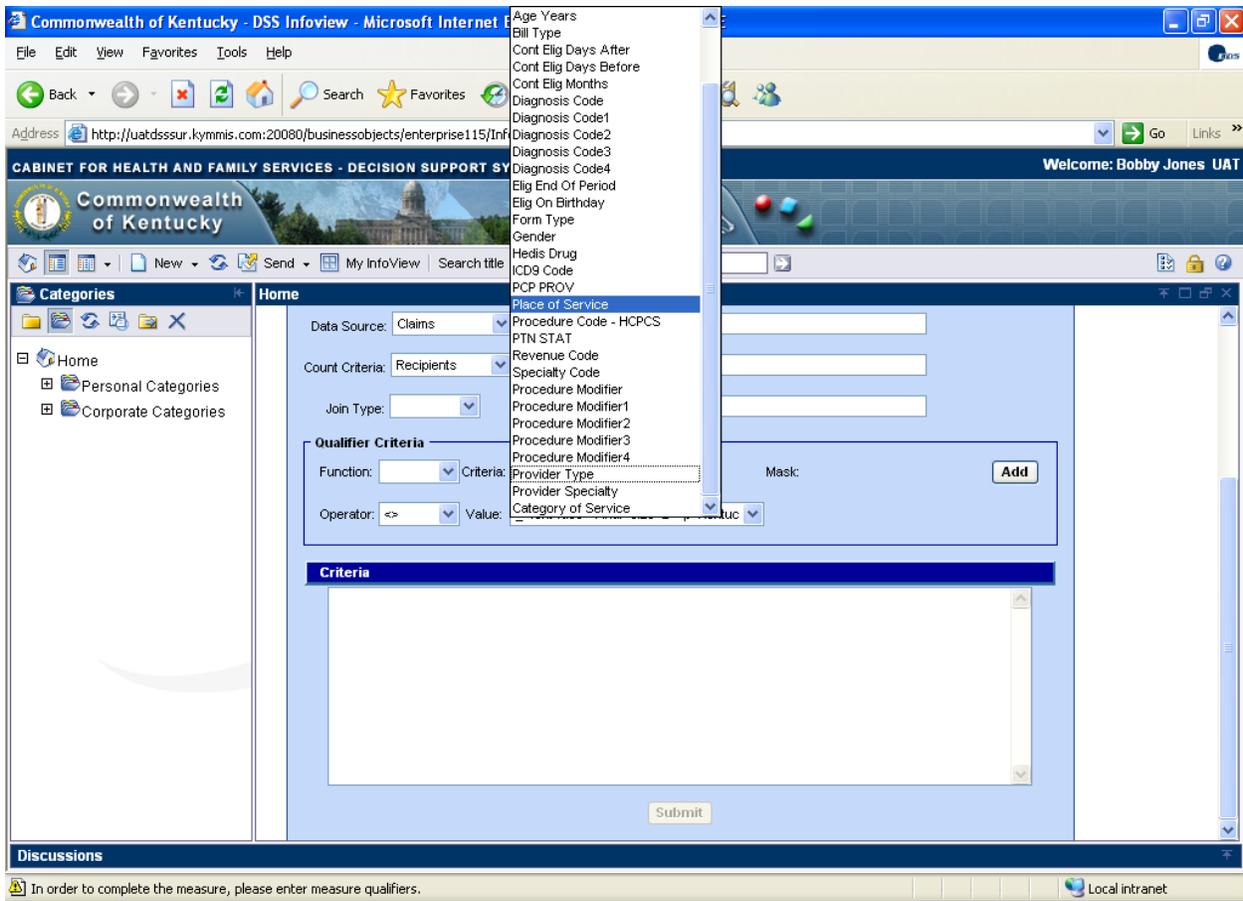


STEP 11. Adding Qualifier Criteria..

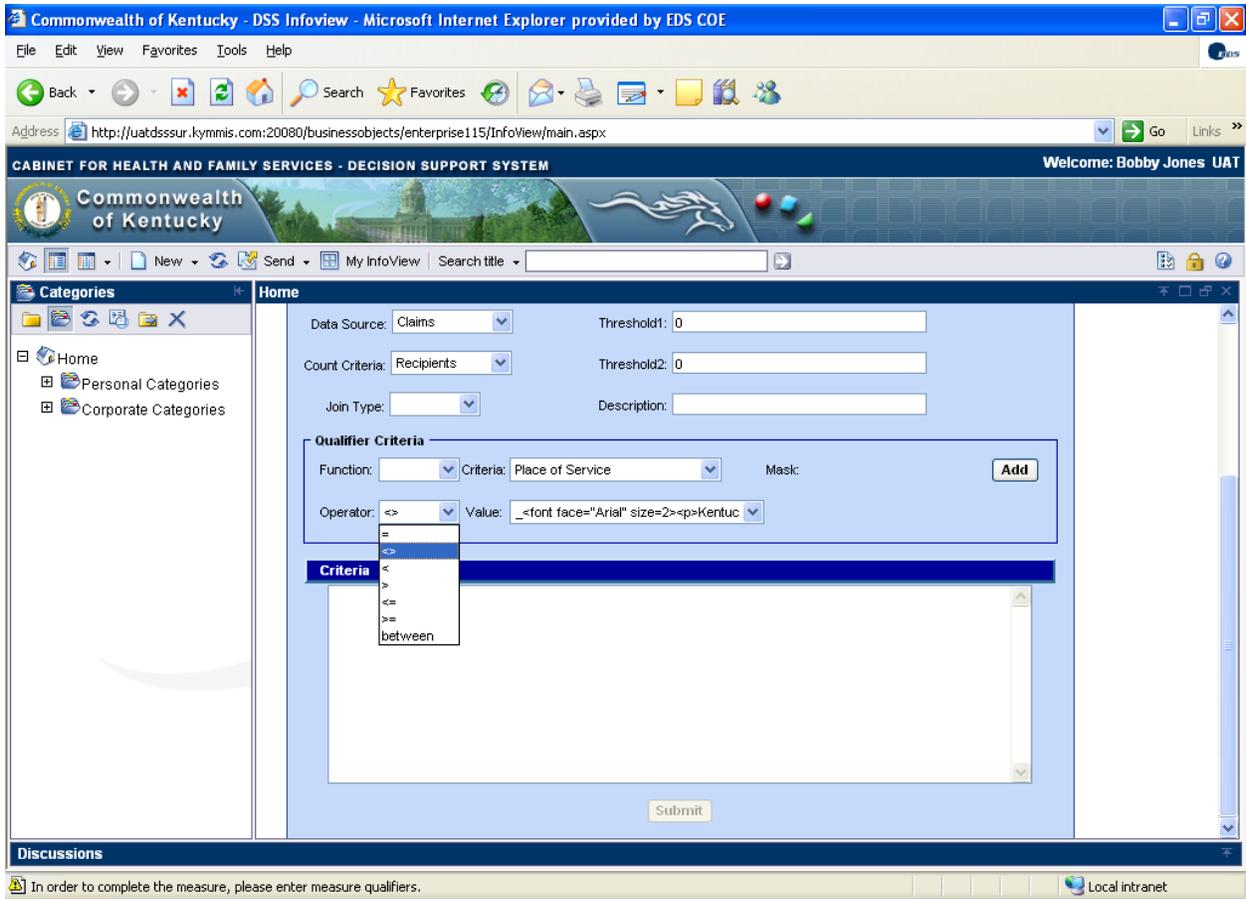
Select the Drop down box for the type of function being chosen Select the Needed Function

The screenshot shows a web browser window displaying the 'DSS InfoView' application. The browser title is 'Commonwealth of Kentucky - DSS Infoview - Microsoft Internet Explorer provided by EDS COE'. The address bar shows the URL: 'http://uatdssur.kymmis.com:20080/businessobjects/enterprise115/InfoView/main.aspx'. The application header includes 'CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM' and a user greeting 'Welcome: Bobby Jones UAT'. The main content area is titled 'Home' and contains several form fields: 'Data Source: Claims', 'Threshold1: 0', 'Count Criteria: Recipients', 'Threshold2: 0', 'Join Type: [dropdown]', and 'Description: [text box]'. Below these is the 'Qualifier Criteria' section, which includes a 'Function:' dropdown menu (currently open), a 'Criteria:' dropdown menu (set to 'Place of Service'), a 'Mask:' field, and an 'Add' button. The 'Operator:' dropdown is set to 'AND', and the 'Value:' field contains the text '<p>Kentuc'. Below the 'Qualifier Criteria' section is a 'Criteria' section with a large empty text area and a 'Submit' button at the bottom. The left sidebar shows a 'Categories' tree with 'Home', 'Personal Categories', and 'Corporate Categories'. The bottom status bar displays the message 'In order to complete the measure, please enter measure qualifiers.' and 'Local intranet'.

Select the drop down box for the Criteria which will be used. Select the desired Criteria.



Select the drop down box for the logical operator which will be used. Select the desired operator



Enter the desired value to be used in the criteria.

Commonwealth of Kentucky - DSS Infoview - Microsoft Internet Explorer provided by EDS COE

File Edit View Favorites Tools Help

Address http://uatdssur.kymmis.com:20080/businessobjects/enterprise115/InfoView/main.aspx

CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM Welcome: Bobby Jones UAT

Commonwealth of Kentucky

Categories Home

Home
Personal Categories
Corporate Categories

Data Source: Claims Threshold1: 0

Count Criteria: Recipients Threshold2: 0

Join Type: Description:

Qualifier Criteria

Function: Criteria: Mask: undefined Add

Operator: <=> Value:

Criteria

Submit

Discussions

In order to complete the measure, please enter measure qualifiers. Local intranet

STEP 12. Adding Qualifier Criteria

Click on the Add Button to add the Selected Qualifier Criteria to the Criteria Box.

Kentucky - DSS Infoview - Microsoft Internet Explorer provided by EDS COE

Address: http://modssur1.kymmis.com:20081/businessobjects/enterprise115/Infoview/main.aspx

CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM

Welcome: Bobby Jones Model Office

Commonwealth of Kentucky

Categories

- Home
- Personal Categories
- Corporate Categories

Measure Base Selection | Measure Base Maintenance | **Qualifier Maintenance**

Qualifier Type: Denominator | Sequence: |

Part: | Date Range: Current Measure Year |

PartIncl: Simple | Group: |

PartSeq: 1 | SeqAO: |

Data Source: Eligibility | Threshold1: 0 |

Count Criteria: Recipients | Threshold2: 0 |

Join Type: | Description: Denominator 1 |

Qualifier Criteria

Function: | Criteria: Diagnosis Code | Mask: XXXBBB | Add

Operator: = | Value: 530

Filer Code Not Found in Table.

Criteria

DIAG_CODE = 530

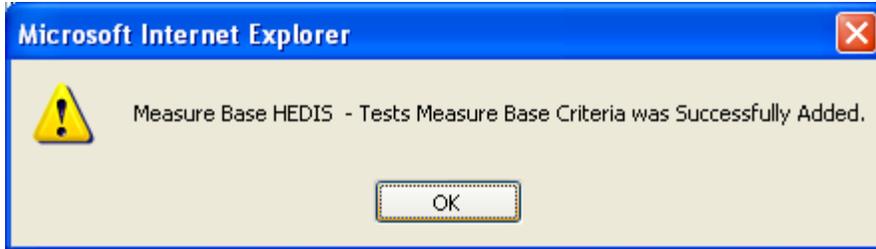
Submit

Discussions

Done Local Intranet

STEP 13. Repeat Steps 9-10 until the Desired criteria has been built in the Criteria area.

STEP 14. Once All Qualifiers have been entered select the Submit button .

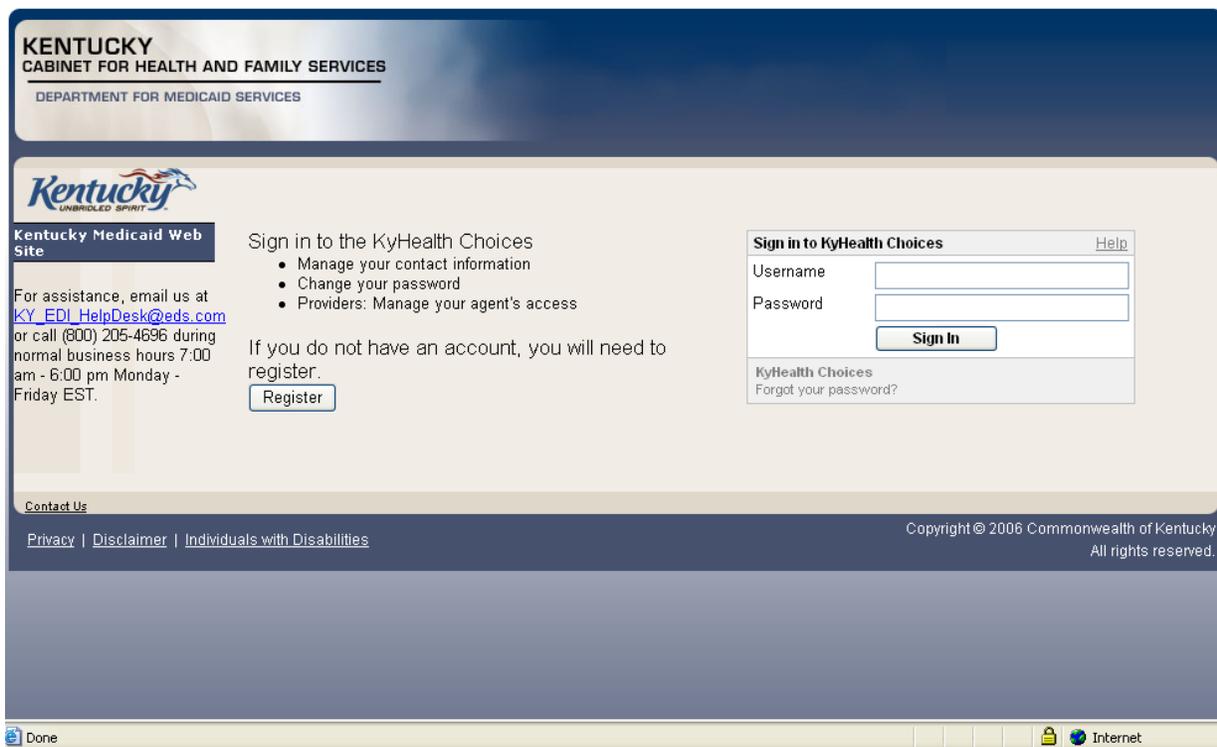


Click on OK button to confirm.

12.3 Update a Specific Measure

STEP 1. Navigate to MEUPS site. The initial sign-on window will display.

STEP 2. Enter Username and Password and select 'Sign In'.



STEP 3. Select the DSS/SUR environment to work in by clicking on the link.

KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
 DEPARTMENT FOR MEDICAID SERVICES

KyHealth Choices Home

Friday 16 March 2007 6:22 pm Sign Out

Bobby Jones, Welcome to KyHealth Choices

Applications	
Application	Description
Account Management	Modify your account information. Providers can also use this application to give application permissions to their agents.
Authorization Request	Allows a user to request access to applications
DSS/SUR Model Office	This is the Model Office BusinessObjects Infview for DSS/SUR
DSS/SUR Test	This is the Test BusinessObjects Infview for DSS/SUR
DSS/SUR UAT	This is the UAT BusinessObjects Infview for DSS/SUR
KyHealth Choices	This is the KyHealth Choices portal application

Messages	
Date	Message
02/23/2007	.Net User Interface MO and UAT release build 112 included the following Change Orders and Defects: Claims - 5749, 6255; CTMS - 6385; EPSDT - 975, 5020; Financial - 3751, 5946; Managed Care - 6141, 6308; MAR - 6372; Member Data Maintenance - 4384; Prior Auth - 4750, 4796, 4987, 6262, 6276; Provider - 4656, 4979, 6390; Recipient - 5930, 5931; Reference Data Maintenance - 2179, 3158, 6002, 6192; System Wide - 4408, 4959; and Third Party Liability - 2932, 4721, 5008, 5009, 5057, 5074, 5143, 6323, 6331. UNIX Model Office and UAT promotion build 112 on 2/23/2007 contained the following change orders and defects: Build

The infview main page will open.

12.3.1 InfoView Panel Sections

Section	Description
Categories	This section of the panel displays the categories of reports that can be accessed by a user depending on their permissions.
Home	This section of the panel displays the access options that a user has access to based on their permissions. Note: Most individuals will not have access to the eKASPER information shown here. If a person does not have access to a function it will not display on the panel.

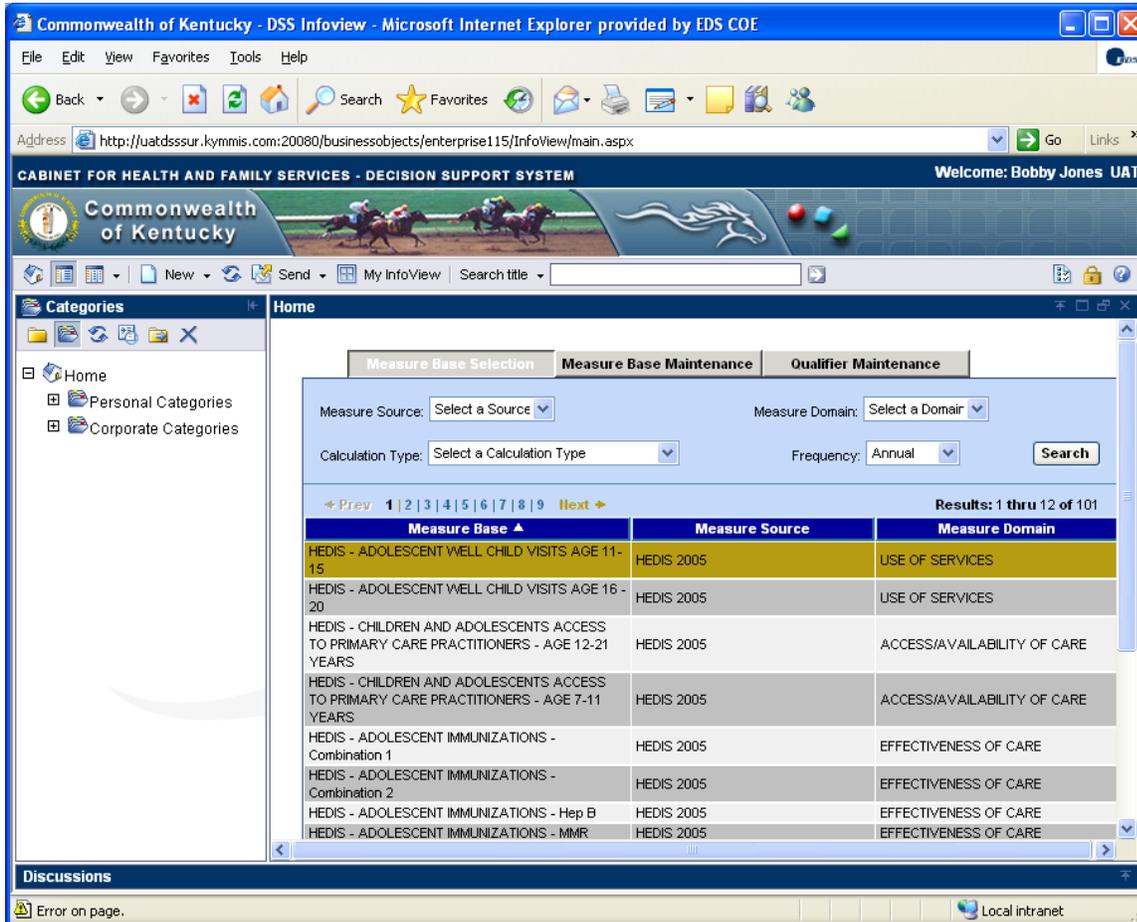
12.3.2 InfoView Panel Links

Links	Description
Personalize InfoView Now	This link guides the user to a page where they can customize the display properties of the infoView panel displayed when they log into infoView.
Go to InfoView Inbox	This link guides the user to their personal infoView inbox. This allows a user to access documents forwarded to them by other infoView DSS users.
New Desktop Intelligence Document	This link opens a new document using the desktop intelligence version of the BusinessObjects software.
New Web Intelligence Document	This link opens a new document using the web intelligence version of the BusinessObjects software.
Case Type Maintenance	This link opens a page that allows the user to update, add or delete case types that are used in the DSS Profiler process.
Peer Group Maintenance	This link opens a page that allows the user to update, add or delete peer groups that are used in the DSS Profiler process.
Case Group Maintenance	This link opens a page that allows the user to update, add or delete case groups that are used in the DSS Profiler process.
Member Requests	This link opens a pages that allows users with eKASPER access to request information about a member.
Provider Requests	This link opens a pages that allows users with eKASPER access to request information about a provider.
MeasureBase Maintenance	This link opens a pages that allows users with MeasureBase access to add or update measures.
Launch Java InfoView	This link opens up a panel that allows users with Performance Manager access to see executive dashboards.
Random Sample Request	This link opens a pages that allows users to create a random sample request.
Random Sample Log	This link opens a pages that allows users to view the status of an existing random sample request.
ESRI Maps – KY Network Only	This link opens a pages that allows users to access ESRI maps that are available on the KY Network.
ESRI Maps – HP Enterprise Services Network Only	This link opens a pages that allows users to access ESRI maps that are available on the HP Enterprise Services Network.

STEP 4. Select the MeasureBase Maintenance Link under the DSSMeasureBase Maintenance Section.

The DSSMeasureBase Selection page will open. It will show all available measures.

Highlight the Measure to be Updated.



12.3.3 MeasureBase Selection: Field Descriptions

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Calculation Type	This indicates how the data will be sampled Values: A - Numerator /Denominator B - Per 1000 C - Per 100 D - Per 10000	13	Drop Down List Box	Field	T_MM_MEASURE_BASE	CDE_CALC_TYPE
Frequency	Indicates the frequency that the measure should be generated. Examples: Quarterly, Semiannually, Annually	0	Drop Down List Box	Field	T_MM_MEASURE_BASE	CDE_FREQUENCY

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Measure Base	A short description of the measure.	0	Character	Field	T_MM_MEASURE_BASE	MEASURE_BASE_NAME
Measure Domain	A method for grouping measures. Examples: Effectiveness of Care, Access/Availability of Care, Use of Services	0	Drop Down List Box	Field	T_MM_MEASURE	SAK_DOMAIN
Measure Source	A high-level description of the source of the measure. Example: HEDIS 2005	0	Drop Down List Box	Field	T_MM_MEASURE_BASE	SAK_MEASURE_SOURCE
Search	Provides the capability to search for specific measures.	0	N/A	Button	n/a	n/a

STEP 5. Right Click on the highlighted measure

Commonwealth of Kentucky - DSS InfoView - Microsoft Internet Explorer provided by EDS COE

Address: http://uatdssur.kymmis.com:20080/businessobjects/enterprise115/InfoView/main.aspx

CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM

Welcome: Bobby Jones UAT

Categories: Home, Personal Categories, Corporate Categories

Home

Measure Base Selection | Measure Base Maintenance | Qualifier Maintenance

Measure Source: Select a Source | Measure Domain: Select a Domain

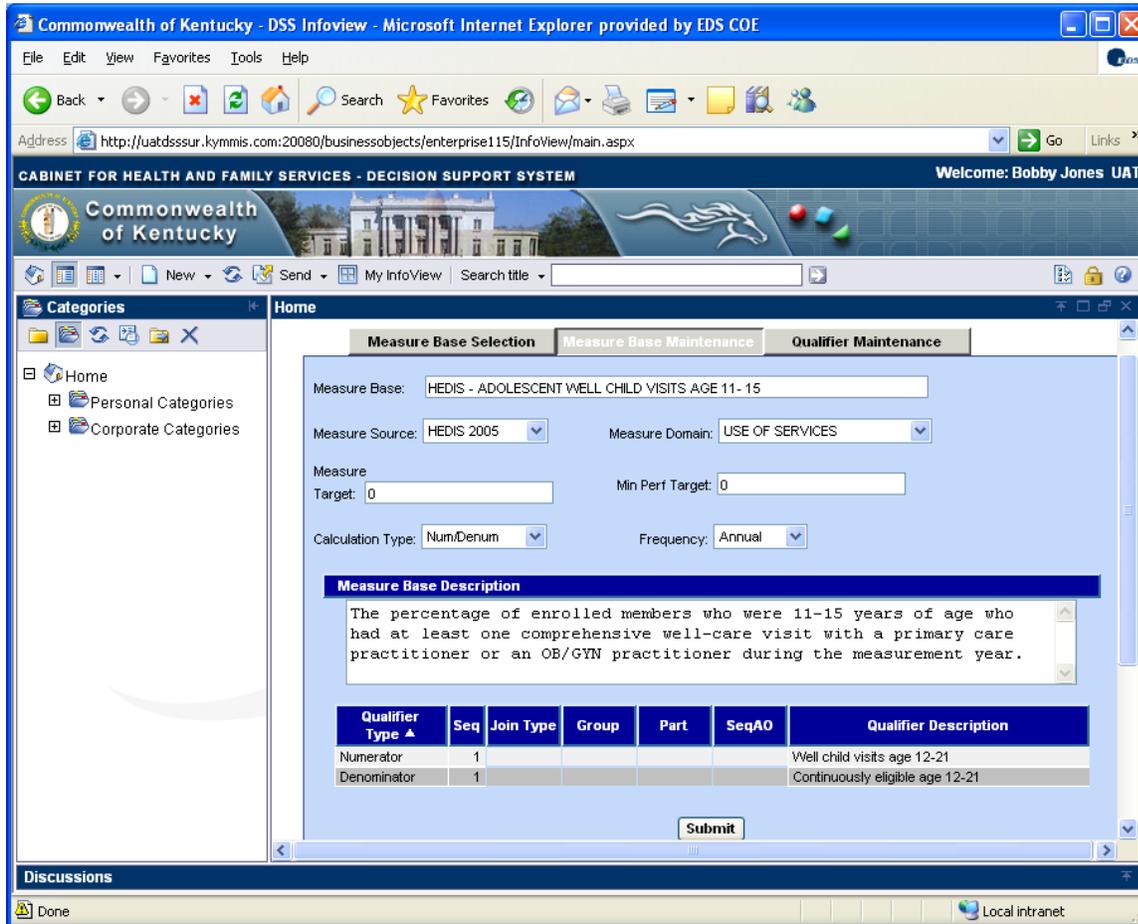
Calculation Type: Select a Calculation Type | Frequency: Annual | Search

Results: 1 thru 12 of 101

Measure Base	Measure Source	Measure Domain
HEDIS - ADOLESCENT WELL CHILD VISITS AGE 16 - 20	Add	USE OF SERVICES
HEDIS - CHILDREN AND ADOLESCENTS ACCESS TO PRIMARY CARE PRACTITIONERS - AGE 12-21 YEARS	Update	ACCESS/AVAILABILITY OF CARE
HEDIS - CHILDREN AND ADOLESCENTS ACCESS TO PRIMARY CARE PRACTITIONERS - AGE 7-11 YEARS	DELETE	ACCESS/AVAILABILITY OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Combination 1	HEDIS 2005	ACCESS/AVAILABILITY OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Combination 2	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Hep B	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - MMR	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - VZT	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT WELL CHILD VISITS	HEDIS 2005	USE OF SERVICES

Select Update from the Drop down list.

STEP 6. The MeasureBase Maintenance page for the Measure will be displayed.



12.3.4 MeasureBase Maintenance Field Descriptions

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Calculation Type	The type of calculation to be used for the measure. Valid values: Numerator/Denominator, Per 100, Per 1000, Per 10000.	1	Drop Down List Box	Field	T_MM_MEASUREBASE	CDE_CALC_TYPE
Frequency	Indicates the frequency that the measure should be generated. Valid values: Quarterly, Semiannually, Annually	10	Check Box	Check Box	T_MM_MEASUREBASE	CDE_FREQUENCY
Group	Lists the group of the qualifier.	18	Character	ListView	T_MM_QUALIFIER	CDE_GROUP

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Join Type	For Part Indicator 'B - Multiple' how the numerators or denominators should be combined	50	Character	ListView	T_MM_QUALIFIER	CDE_JOIN_TYPE
Measure Base	A short description of the measure.	200	Character	Field	T_MM_MEASURE_BASE	MEASURE_BASE_NAME
Measure Base Description	A long description of the measure.	700	Character	Field	T_MM_MEASURE_BASE	DSC_MEASURE_BASE
Measure Domain	A method for grouping measures. Examples: Effectiveness of Care, Access/Availability of Care, Use of Services	50	Drop Down List Box	Field	T_MM_MEASURE_BASE	SAK_DOMAIN
Measure Source	A high-level description of the source of the measure. Example: HEDIS 2005	50	Drop Down List Box	Field	T_MM_MEASURE_BASE	SAK_MEASURE_SOURCE
Measure Target	The target or benchmark of the measure.	5	Number	Field	T_MM_MEASURE_BASE	TARGET
Min Perf Target	The minimum performance target for the measure.	5	Number	Field	T_MM_MEASURE_BASE	MIN_PERF_TARGET
Part	This indicates if the numerator/denominator has a single or multiple parts	18	Character	ListView	T_MM_QUALIFIER	QUAL_PART_IND
Qualifier Description	Lists a short description of the numerators and denominators.	100	Character	ListView	T_MM_QUALIFIER	DSC_QUALIFIER
Qualifier Type	Lists the numerator or denominator subsets used for processing.	11	Character	ListView	T_MM_QUALIFIER	CDE_QUAL_TYPE
SeqAO	Value: AND OR Exclude	0	Character	ListView	n/a	n/a
Sequence	Lists the sequence of the numerators and denominators for processing control.	10	Character	ListView	T_MM_QUALIFIER	CDE_QUAL_SEQ

STEP 7. Make the needed change on the page.

Here the MeasureBase Description is updated. .

The screenshot shows the 'Measure Base Selection' tab in the 'DSS InfoView' application. The 'Measure Base' field is set to 'HEDIS - ADOLESCENT WELL CHILD VISITS AGE 11-15'. The 'Measure Source' is 'HEDIS 2005' and the 'Measure Domain' is 'USE OF SERVICES'. The 'Target' is '0' and the 'Min Perf Target' is '0'. The 'Calculation Type' is 'Num/Denum' and the 'Frequency' is 'Annual'. The 'Measure Base Description' field contains the text: 'The percentage of enrolled members who were 11-15 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. Description Extension for Demonstration.'

Qualifier Type ▲	Seq	Join Type	Group	Part	SeqA0	Qualifier Description
Numerator	1					Well child visits age 12-21
Denominator	1					Continuously eligible age 12-21

A 'Submit' button is located at the bottom of the form.

STEP 8. Click the Submit Button once needed update has been made. .

The confirmation dialogue box will be displayed.



12.4 Delete a Specific Measure

STEP 1. Navigate to MEUPS site. The initial sign-on window will display.

STEP 2. Enter Username and Password and select 'Sign In'.

The screenshot shows the 'Kentucky Medicaid Web Site' sign-in interface. At the top, it reads 'KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES' and 'DEPARTMENT FOR MEDICAID SERVICES'. The main content area features the 'Kentucky' logo with the tagline 'UNBROKEN SPIRIT'. Below the logo, there is a 'Sign in to the KyHealth Choices' section with a bulleted list of options: 'Manage your contact information', 'Change your password', and 'Providers: Manage your agent's access'. A 'Register' button is provided for users without accounts. To the right, a 'Sign in to KyHealth Choices' form contains fields for 'Username' and 'Password', a 'Sign In' button, and a 'Forgot your password?' link. The footer includes 'Contact Us', 'Privacy | Disclaimer | Individuals with Disabilities', and 'Copyright © 2006 Commonwealth of Kentucky All rights reserved.' The browser's taskbar at the bottom shows 'Done' and 'Internet'.

STEP 3. Select the DSS/SUR environment to work in by clicking on the link.

KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
 DEPARTMENT FOR MEDICAID SERVICES

KyHealth Choices Home

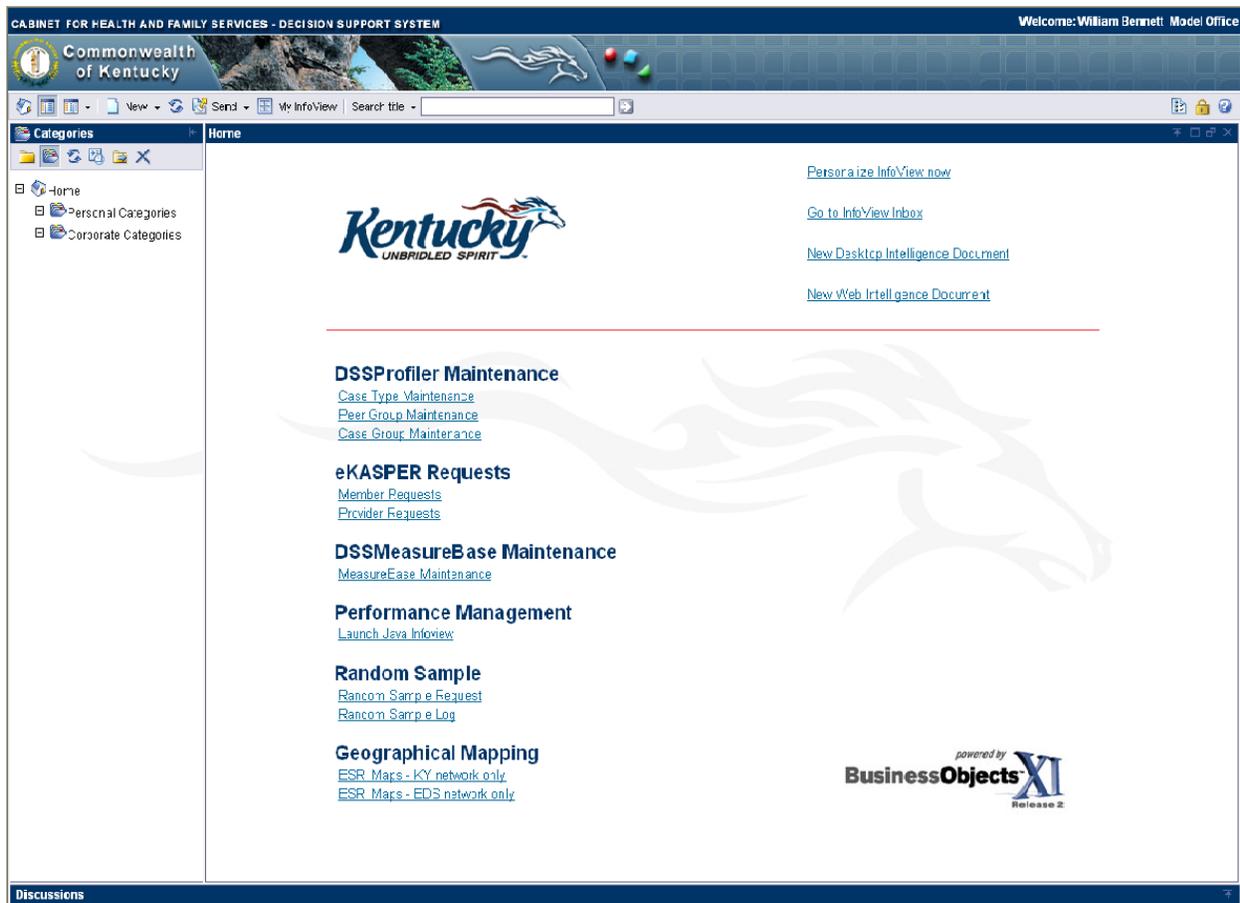
Friday 16 March 2007 6:22 pm Sign Out

Bobby Jones, Welcome to KyHealth Choices

Applications	
Application	Description
Account Management	Modify your account information. Providers can also use this application to give application permissions to their agents.
Authorization Request	Allows a user to request access to applications
DSS/SUR Model Office	This is the Model Office BusinessObjects Infview for DSS/SUR
DSS/SUR Test	This is the Test BusinessObjects Infview for DSS/SUR
DSS/SUR UAT	This is the UAT BusinessObjects Infview for DSS/SUR
KyHealth Choices	This is the KyHealth Choices portal application

Messages	
Date	Message
02/23/2007	.Net User Interface MO and UAT release build 112 included the following Change Orders and Defects: Claims - 5749, 6255; CTMS - 6385; EPSDT - 975, 5020; Financial - 3751, 5946; Managed Care - 6141, 6308; MAR - 6372; Member Data Maintenance - 4384; Prior Auth - 4750, 4796, 4987, 6262, 6276; Provider - 4656, 4979, 6390; Recipient - 5930, 5931; Reference Data Maintenance - 2179, 3158, 6002, 6192; System Wide - 4408, 4959; and Third Party Liability - 2932, 4721, 5008, 5009, 5057, 5074, 5143, 6323, 6331. UNIX Model Office and UAT promotion build 112 on 2/23/2007 contained the following change orders and defects: Build

The infview main page will open.



12.4.1 InfoView Panel Sections

Section	Description
Categories	This section of the panel displays the categories of reports that can be accessed by a user depending on their permissions.
Home	This section of the panel displays the access options that a user has access to based on their permissions. Note: Most individuals will not have access to the eKASPER information shown here. If a person does not have access to a function it will not display on the panel.

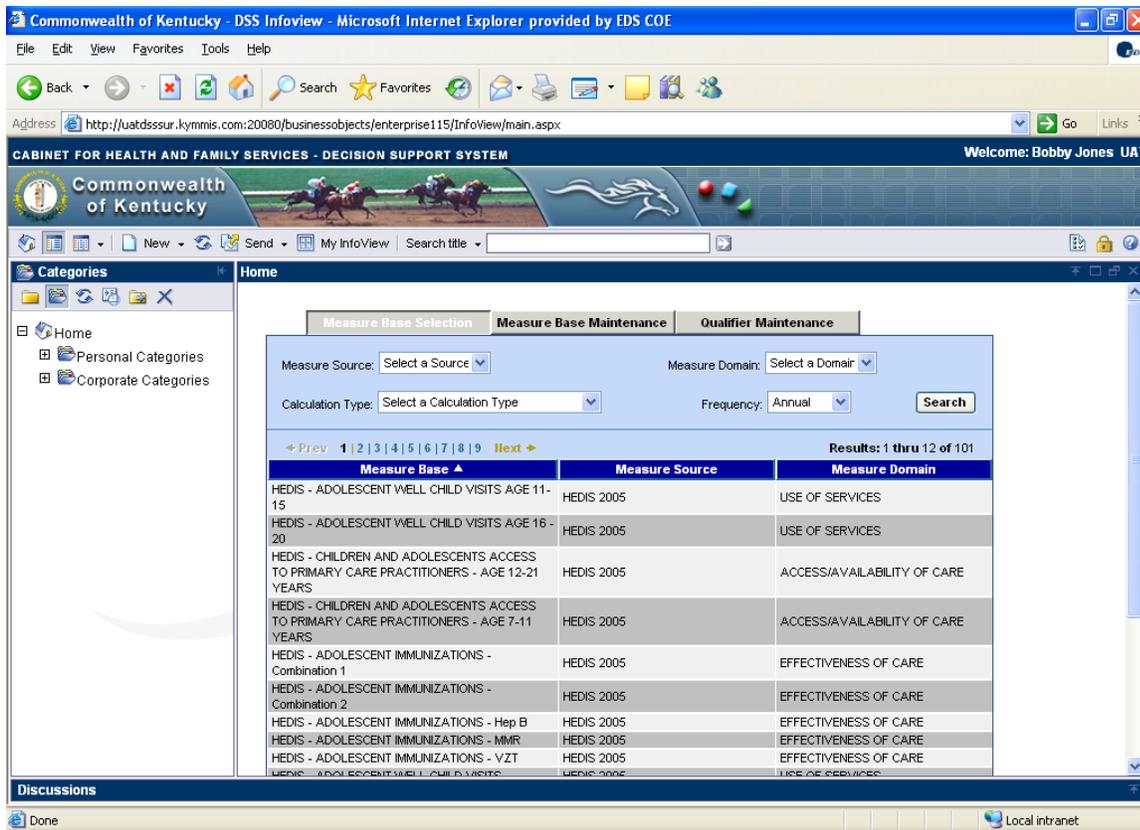
12.4.2 InfoView Panel Links

Links	Description
Personalize InfoView Now	This link guides the user to a page where they can customize the display properties of the infoView panel displayed when they log into infoView.

Links	Description
Go to InfoView Inbox	This link guides the user to their personal infoView inbox. This allows a user to access documents forwarded to them by other infoView DSS users.
New Desktop Intelligence Document	This link opens a new document using the desktop intelligence version of the BusinessObjects software.
New Web Intelligence Document	This link opens a new document using the web intelligence version of the BusinessObjects software.
Case Type Maintenance	This link opens a page that allows the user to update, add or delete case types that are used in the DSS Profiler process.
Peer Group Maintenance	This link opens a page that allows the user to update, add or delete peer groups that are used in the DSS Profiler process.
Case Group Maintenance	This link opens a page that allows the user to update, add or delete case groups that are used in the DSS Profiler process.
Member Requests	This link opens a pages that allows users with eKASPER access to request information about a member.
Provider Requests	This link opens a pages that allows users with eKASPER access to request information about a provider.
MeasureBase Maintenance	This link opens a pages that allows users with MeasureBase access to add or update measures.
Launch Java InfoView	This link opens up a panel that allows users with Performance Manager access to see executive dashboards.
Random Sample Request	This link opens a pages that allows users to create a random sample request.
Random Sample Log	This link opens a pages that allows users to view the status of an existing random sample request.
ESRI Maps – KY Network Only	This link opens a pages that allows users to access ESRI maps that are available on the KY Network.
ESRI Maps – HP Enterprise Services Network Only	This link opens a pages that allows users to access ESRI maps that are available on the HP Enterprise Services Network.

STEP 4. Select the MeasureBase Maintenance Link under the DSSMeasureBase Maintenance Section.

The DSSMeasureBase Selection page will open. It will show all available measures..



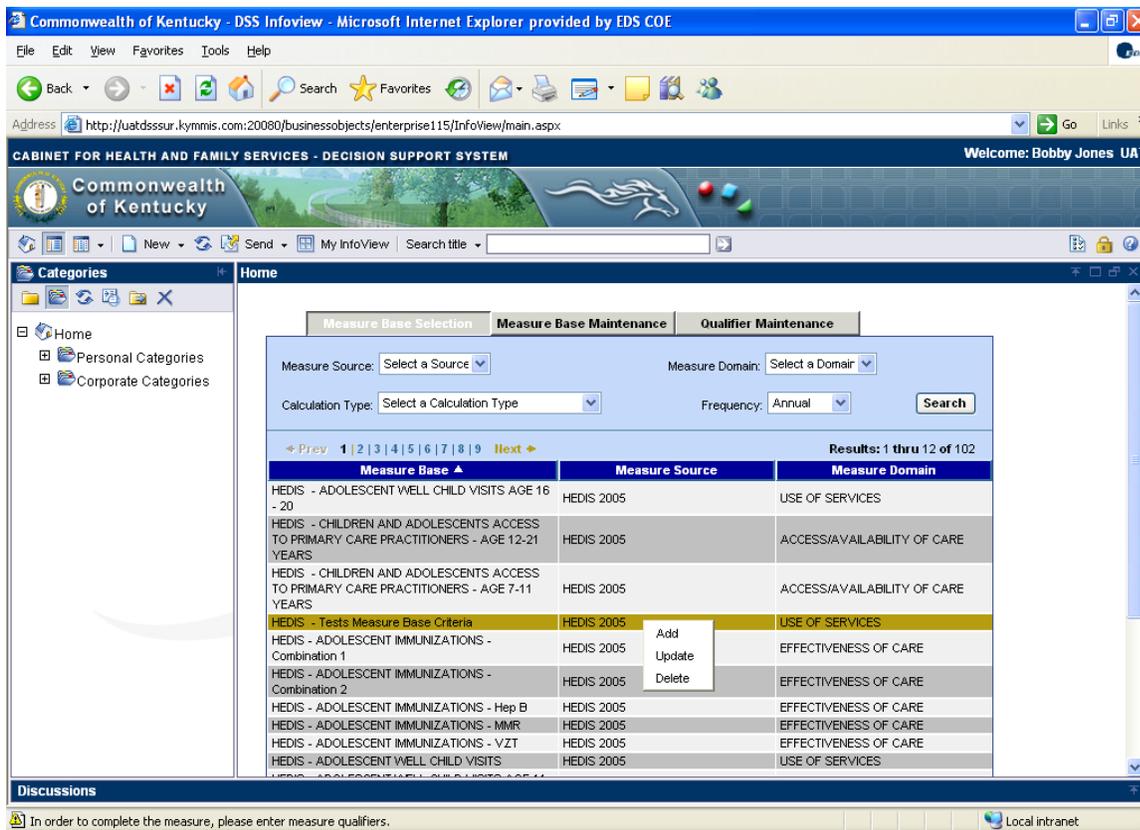
12.4.3 MeasureBase Selection Field Descriptions

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Calculation Type	This indicates how the data will be sampled Values: A - Numerator /Denominator B - Per 1000 C - Per 100 D - Per 10000	13	Drop Down List Box	Field	T_MM_MEASURE_BASE	CDE_CALC_TYPE
Frequency	Indicates the frequency that the measure should be generated. Examples: Quarterly, Semiannually, Annually	0	Drop Down List Box	Field	T_MM_MEASURE_BASE	CDE_FREQUENC Y
Measure Base	A short description of the measure.	0	Character	Field	T_MM_MEASURE_BASE	MEASURE_BASE_ NAME
Measure Domain	A method for grouping measures. Examples: Effectiveness of Care, Access/Availability of Care, Use of Services	0	Drop Down List Box	Field	T_MM_MEASURE	SAK_DOMAIN

Field	Description	Length	Data Type	Field Type	DB Table	DB Attributes
Measure Source	A high-level description of the source of the measure. Example: HEDIS 2005	0	Drop Down List Box	Field	T_MM_MEASURE_BASE	SAK_MEASURE_SOURCE
Search	Provides the capability to search for specific measures.	0	N/A	Button	n/a	n/a

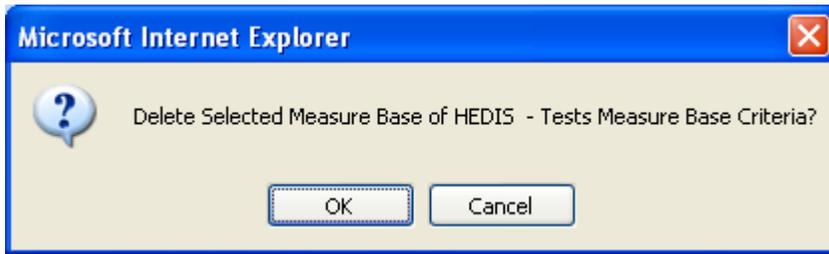
STEP 5. Selection and highlight the Measure to be deleted

Right Click on the highlighted measure to display the drop down action list.



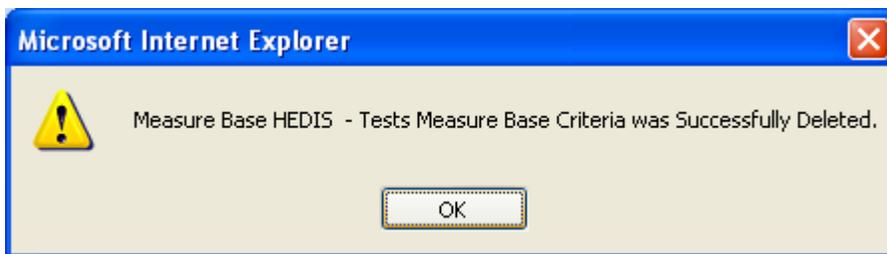
Select Delete from the list.

STEP 6. The dialogue box asking for confirmation of the delete will be displayed.



Select OK.

STEP 7. The Deletion will be confirmed..



STEP 8. The Measurebase Selection List is redisplayed..

Commonwealth of Kentucky - DSS Infoview - Microsoft Internet Explorer provided by EDS COE

Address: http://uatdssur.kymmis.com:20080/businessobjects/enterprise115/InfoView/main.aspx

CABINET FOR HEALTH AND FAMILY SERVICES - DECISION SUPPORT SYSTEM

Welcome: Bobby Jones UAT

Commonwealth of Kentucky

Categories: Home, Personal Categories, Corporate Categories

Measure Base Selection | Measure Base Maintenance | Qualifier Maintenance

Measure Source: Select a Source | Measure Domain: Select a Domain

Calculation Type: Select a Calculation Type | Frequency: Annual | Search

Results: 1 thru 12 of 101

Measure Base	Measure Source	Measure Domain
HEDIS - ADOLESCENT WELL CHILD VISITS AGE 16 - 20	HEDIS 2005	USE OF SERVICES
HEDIS - CHILDREN AND ADOLESCENTS ACCESS TO PRIMARY CARE PRACTITIONERS - AGE 12-21 YEARS	HEDIS 2005	ACCESS/AVAILABILITY OF CARE
HEDIS - CHILDREN AND ADOLESCENTS ACCESS TO PRIMARY CARE PRACTITIONERS - AGE 7-11 YEARS	HEDIS 2005	ACCESS/AVAILABILITY OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Combination 1	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Combination 2	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - Hep B	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - MMR	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT IMMUNIZATIONS - VZT	HEDIS 2005	EFFECTIVENESS OF CARE
HEDIS - ADOLESCENT WELL CHILD VISITS	HEDIS 2005	USE OF SERVICES
HEDIS - ADOLESCENT WELL CHILD VISITS AGE 11-15	HEDIS 2005	USE OF SERVICES

Discussions

In order to complete the measure, please enter measure qualifiers.

Local intranet