



Quality Assurance & Audits Subsystem User Manual

Kentucky MMIS Project

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

October 30, 2009

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1 Introduction

This user manual is designed to cover the information necessary to perform the tasks of the Quality Assurance and Audits functional area.

This manual covers the following areas:

- Subsystem Overview;
- Processes;
- Getting Started;
- Procedures;
- Panels;
- Reports;
- Letters;
- Glossary of Terms; and
- OnBase Report Retrieval Guide.

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

1.1 User Manual Audience

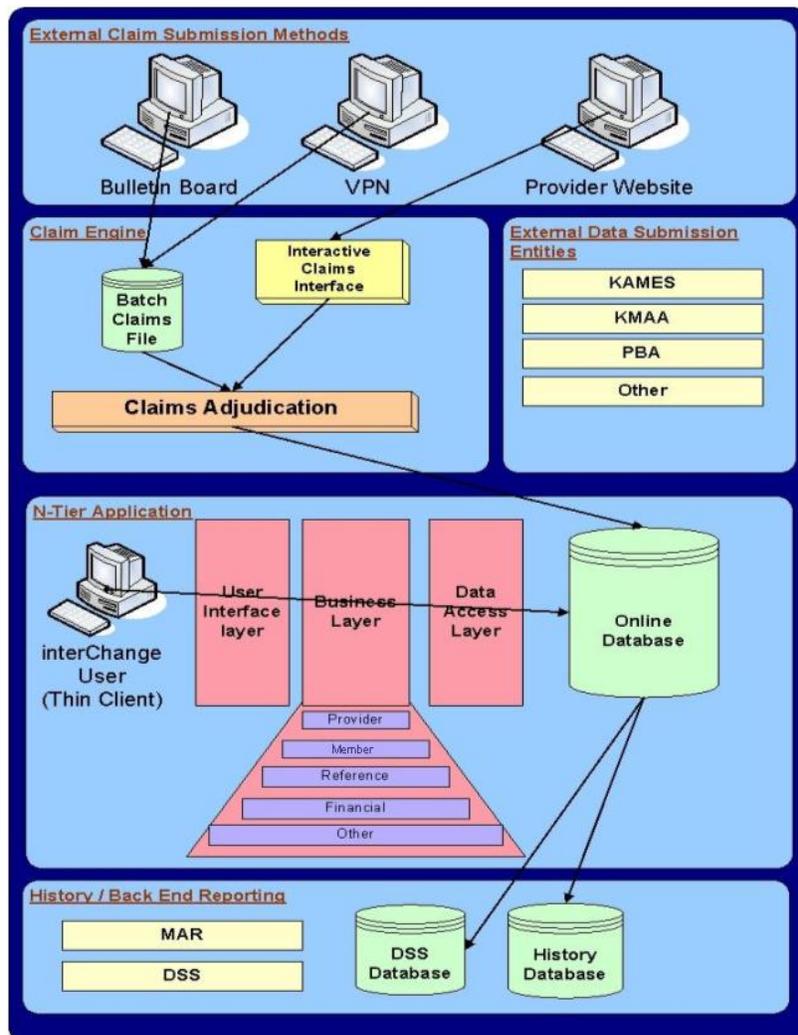
This manual is designed to serve the needs of the following staff:

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

2 Overview

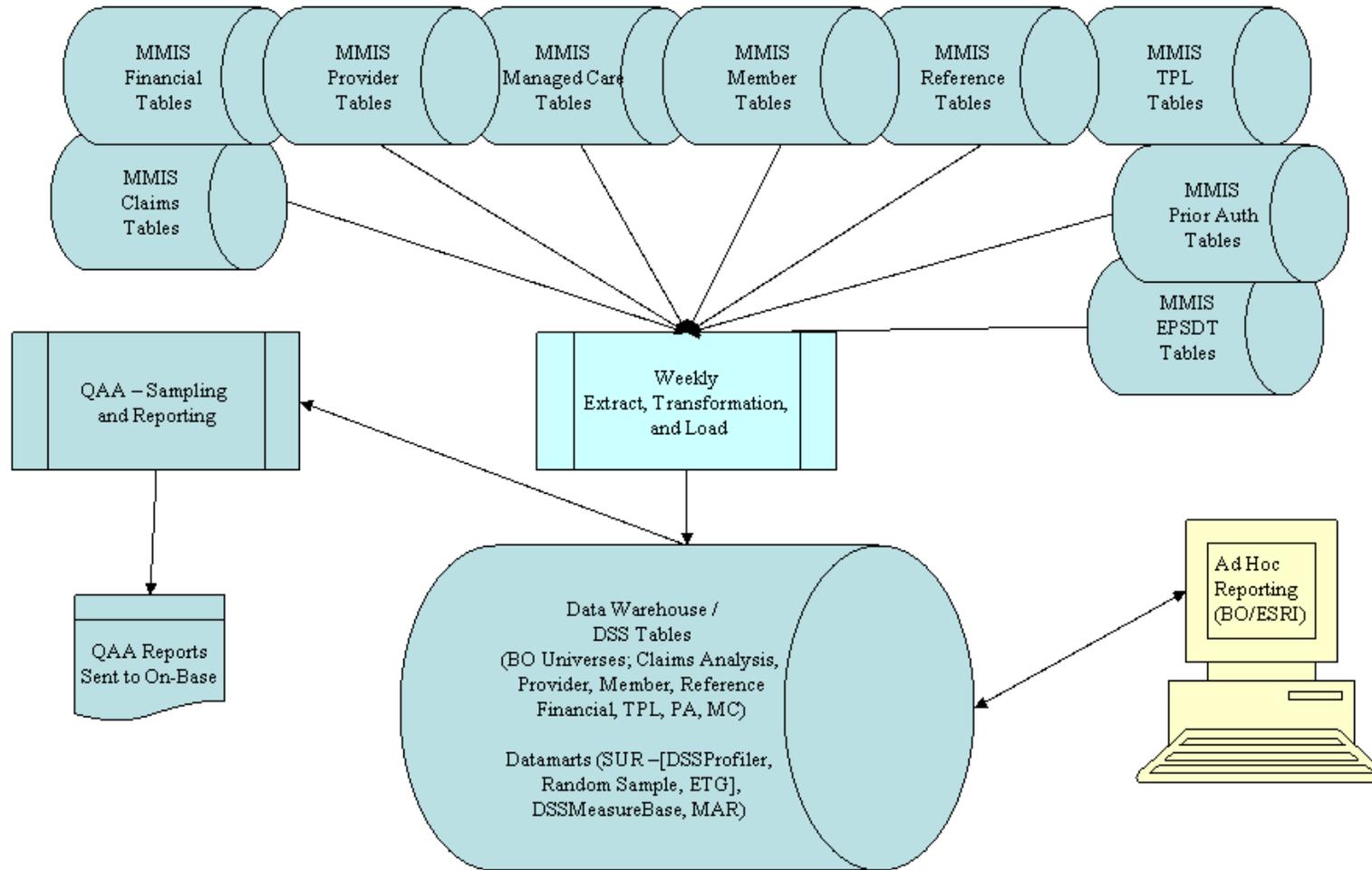
2.1 interChange System Architecture

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).



2.2 System Flow

Quality Assurance and Audits input/output processing is depicted in the following diagram in a production context.

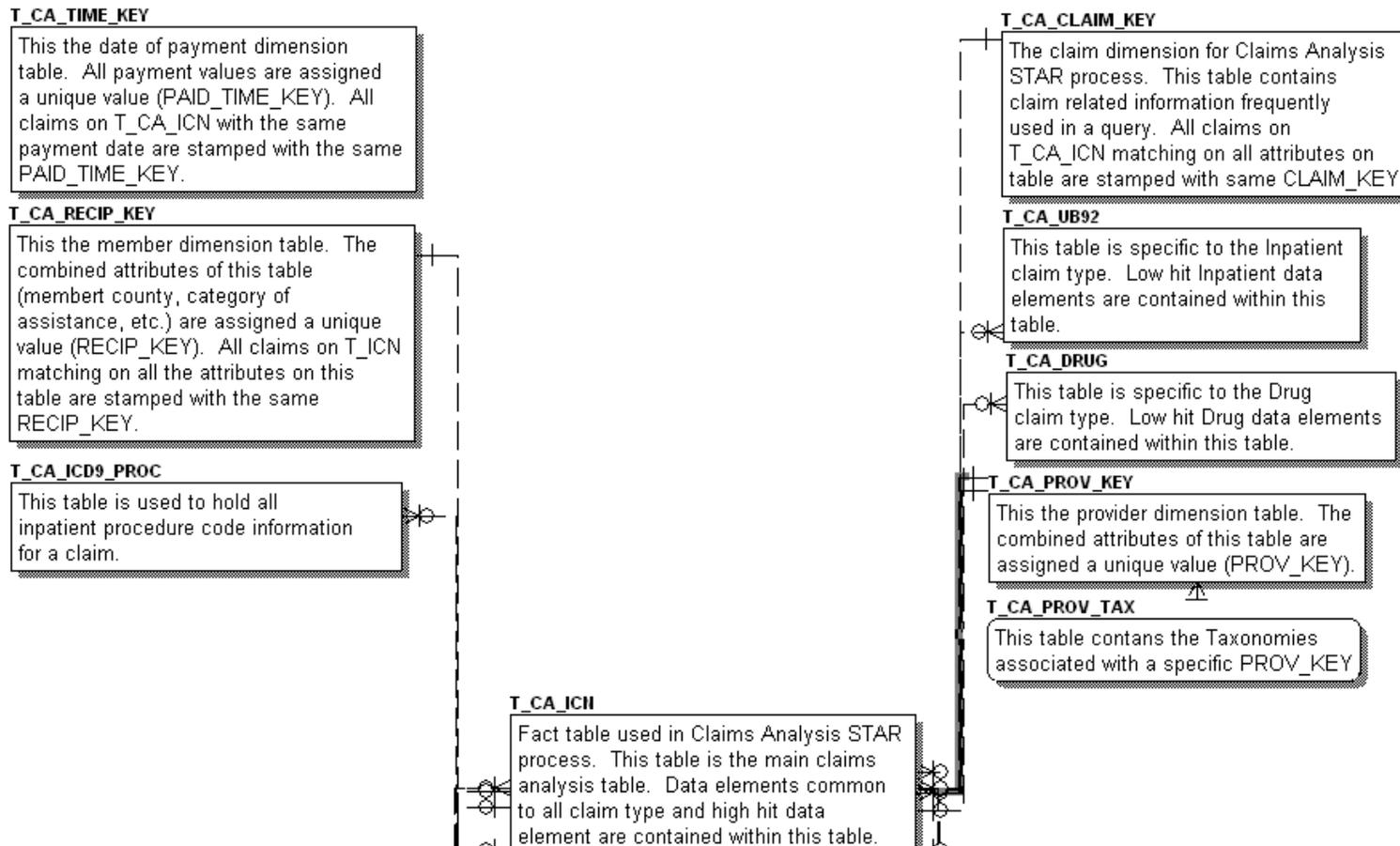


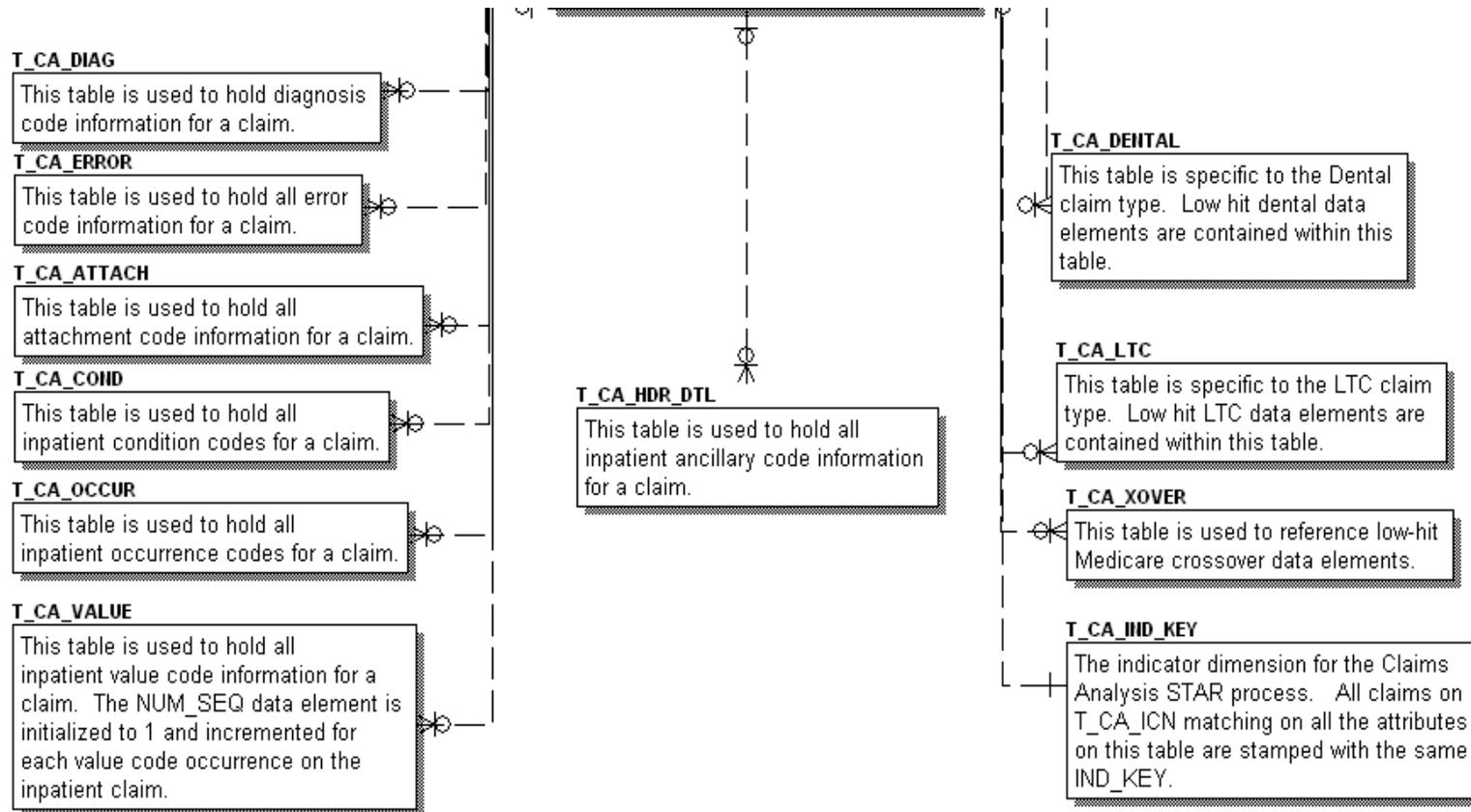
2.3 Data Model

The following data models give a view of the primary entities within the QAA functional area.

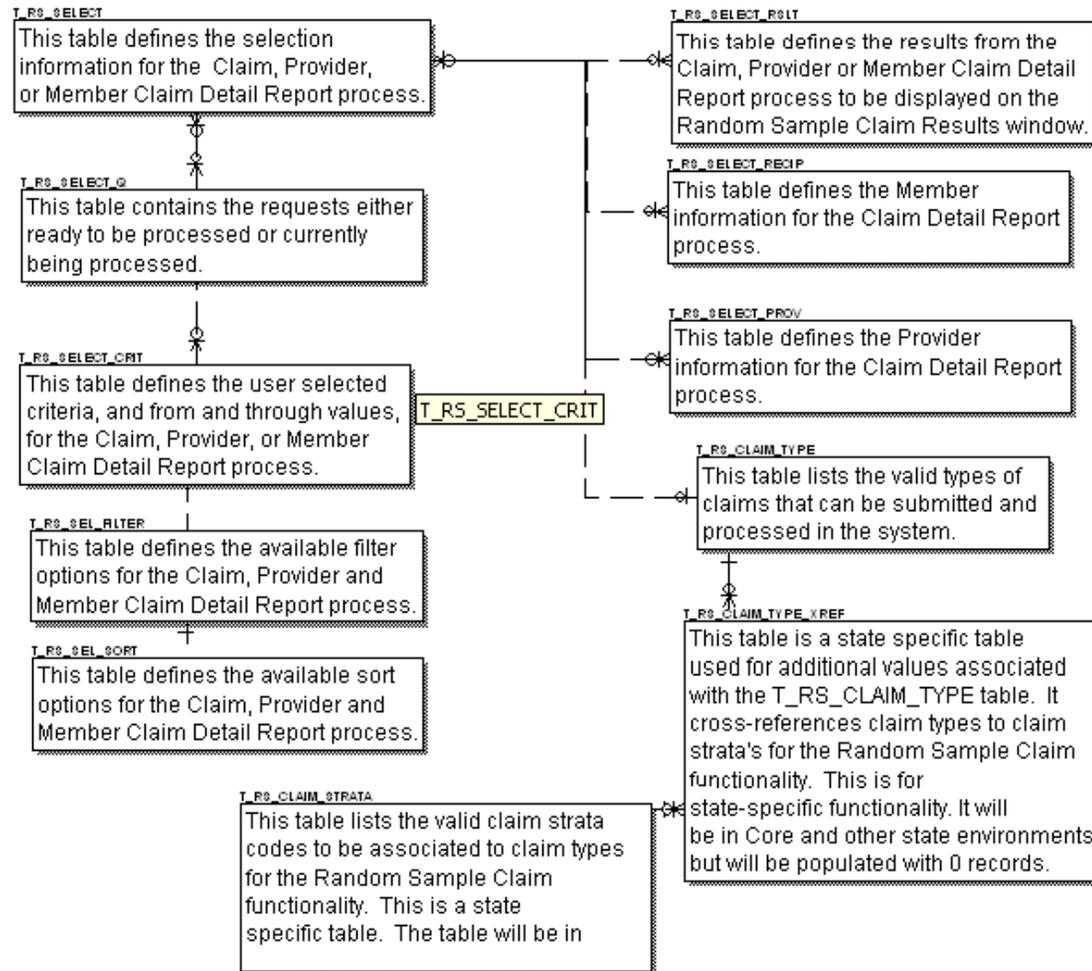
2.3.1 Claims Analysis Entity Relationship Data Model

For readability, the diagram appears on two pages.





2.3.2 Random Sample Entity Relationship Data Model



3 QAA Processes

The QAA functional area produces sampling reports on a monthly basis. The QAA batch process, which runs at the beginning of each month, uses the DSS/DW Random Sample process to load claim samples to the Random Sample datamart. The process creates six Random Sample requests, one for each of the stratum in QAA. Each stratum contains a random sampling of paid claims from the previous month.

3.1 QAA Claim Groupings

Stratum 100: Inpatient Claim, Outpatient Claim, Home Health Claim

Stratum 200: Nursing Home Claim

Stratum 300: Dental Claim, Professional Claim

Stratum 400: Pharmacy Claim, Compound Drug Claim

Stratum 500: Inpatient Xover Claim, Professional Xover Claim, Outpatient Xover Claim

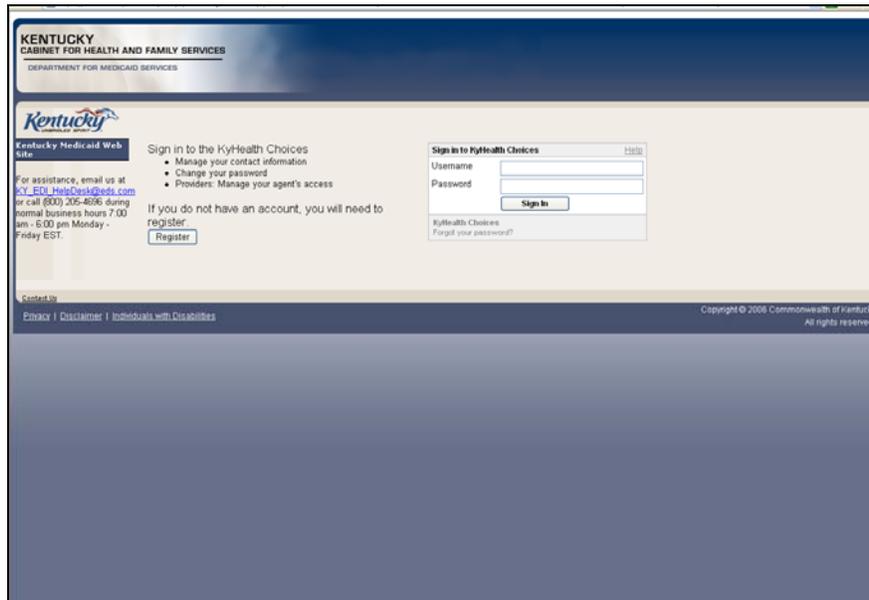
Stratum 600: Acute Care Hospitals Only Claim

Once the transactions are created and loaded to the Random Sample request tables, the Random Sample batch process will randomly select claims that fall into each stratum. When it finishes processing and places the selected claims on the Random Sample results table, the QAA batch process creates the reports using this information along with supplemental information in the DSS/DW to produce the various QAA reports. These reports are loaded to OnBase for review, print and/or distribution.

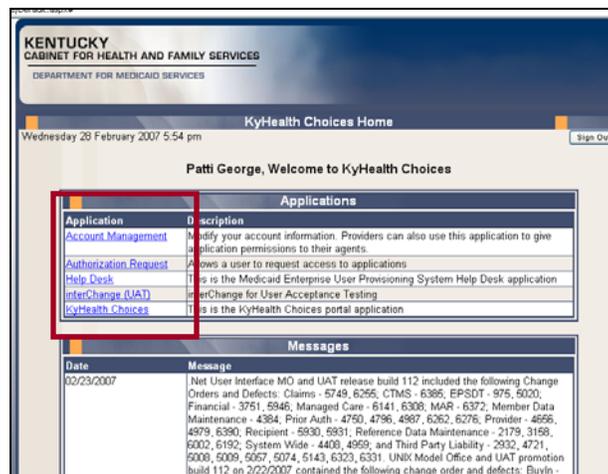
4 Quality Assurance Getting Started

4.1 Accessing the Quality Assurance and Audits subsystem

Quality Assurance and Audit Reports may be accessed via OnBase. A user with OnBase access would log in via the Medicaid Enterprise User Provisioning System (MEUPS).



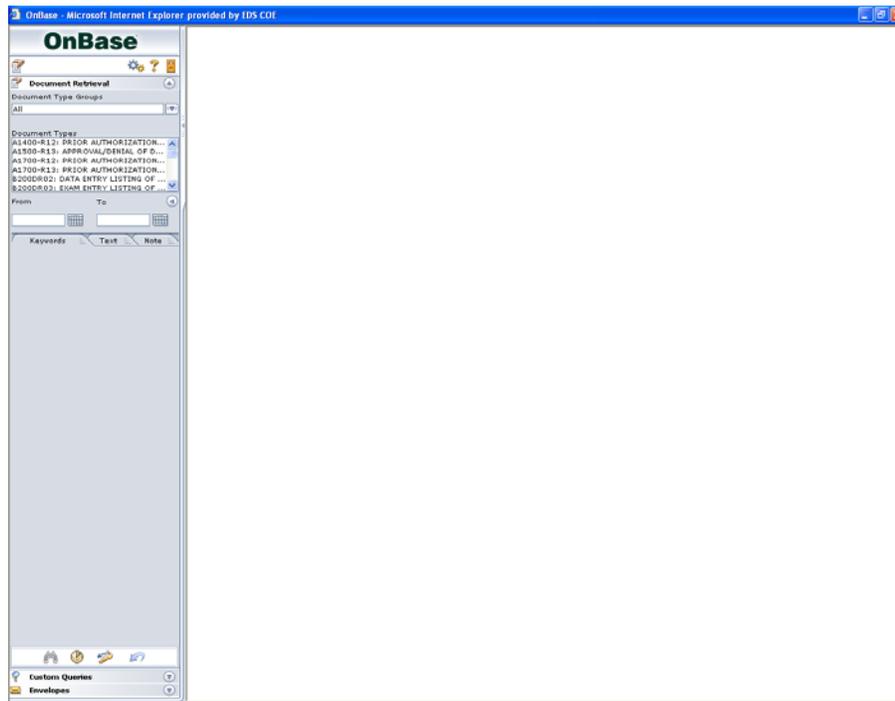
STEP 1. Log in via MEUPS home page.



STEP 2. Click the “OnBase” link to launch the OnBase application.

Note: The OnBase application link does not appear on the example panel, but will appear when a user has access to OnBase post go live. The example panel only serves to illustrate where the link will be accessed.

STEP 3. The OnBase menu will appear.



Refer to the instructions for accessing reports via OnBase in Appendix A.

5 Pages and Panels

The QAA subsystem does not have any pages/panels.

6 Reports

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.

6.1.1 QAA Claims Monitoring Hospital Services

The QAA Claims Monitoring-Hospital Services report provides a sample universe of hospital claims based on a starting point count and interval counter for claims monitoring.

6.1.1.1 Technical Name

QAA Claims Monitoring Hospital Services

6.1.1.2 Sort Order

QC Number

6.1.1.3 QAA Claims Monitoring Hospital Services Layout

QAA Claims Monitoring Hospital Services Report Layout

| QC NUMBER | ICN | MEMBER NAME | MEMBER ID | BILLING PROVIDER NUMBER | FIRST DATE OF SERVICE | ADJUDICATION DATE | PAID AMOUNT |
|-----------|---------------|-------------------|----------------------|-------------------------|-----------------------|-----------------------|---------------|
| 1 | 2005055100001 | ABCDEFGHIJABCDE A | ABCDEFGHIJABCDEFGHIJ | 000002392 | 1000000971 | 09/23/2004 02/24/2005 | \$99999999.99 |
| 2 | 2005117100044 | BILLY ANDERSON | 000041444 | 1000000971 | 02/07/2005 | 04/27/2005 | \$2216.55 |
| 3 | 2205068130011 | JANET GATES | 000041387 | 1000000971 | 04/01/2004 | 03/10/2005 | \$17.00 |
| 4 | 2205068100046 | EDDIE B TYLER | 000040344 | 1000000971 | 03/01/2005 | 03/10/2005 | \$3863.76 |
| 5 | 2005068100073 | ANDY MITCHEL | 000001375 | 1000000971 | 05/20/2004 | 03/10/2005 | \$14735.10 |
| 6 | 2005077100069 | BILLY COX | 000040738 | 1000000971 | 09/15/2004 | 03/22/2005 | \$3694.25 |
| 7 | 2005113100169 | BILLY ANDERSON | 000041444 | 1000000971 | 01/07/2005 | 04/25/2005 | \$2216.55 |
| 8 | 2005060100041 | ZELDA B WATERS | 000001346 | 1000000981 | 01/24/2004 | 03/24/2005 | \$7372.00 |
| 9 | 2005111100093 | BILLY ANDERSON | 000041444 | 1000000971 | 03/18/2005 | 04/21/2005 | \$2216.55 |
| 10 | 2005081100004 | RICK LANE | 000039888 | 1000000981 | 10/01/2004 | 03/22/2005 | \$7760.00 |

As of Date : 12/31/2005

| | | | |
|-----------------------|-----|------------------------|-----|
| Beginning QC Number : | 1 | Ending QC Number : | 100 |
| Claims Universe : | 109 | Total Claims Sampled : | 100 |

*** END OF REPORT ***

6.1.1.4 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-------------------------|---|--------|-------------------|-------------------|---|
| Adjudication Date | The adjudication date. | 10 | Date | T_RS_SELECT_RSLT | DTE_PAID |
| Amount Paid | The reimbursement amount. | 12 | Number | T_RS_SELECT_RSLT | AMT_PAID |
| As of Date | The as of date for which this report is produced | 10 | Date (MM/DD/CCYY) | T_RS_SELECT | DTE_HIST_TO |
| Beginning QC Number | The transaction control number of the first claim on the report. | 9 | Char | T_RS_SELECT_RSLT | SEQ_RANDOM |
| Billing Provider Number | The provider number. | 15 | Char | T_RS_SELECT_RSLT | ID_PROV_BILL |
| Claims Universe | The total number of claims which meet the selection criteria and from which the sample was taken. | 9 | Number | T_RS_SELECT | NUM_POPULATION |
| Ending QC Number | The transaction control number of the last claim on the report. | 9 | Char | T_RS_SELECT_RSLT | SEQ_RANDOM |
| First Date of Service | The first date of service. | 10 | Date | T_RS_SELECT_RSLT | DTE_FIRST_SVC |
| ICN | The transaction control number of the claim selected. | 13 | Char | T_RS_SELECT_RSLT | NUM_ICN |
| Member ID | The Medicaid identification number for the member. | 12 | Char | T_RS_SELECT_RSLT | ID_MEDICAID |
| Member Name | The full member name. | 38 | Char | T_RS_SELECT_RECIP | NAM_LAST, NAM_FIRST, NAM_MID_INIT |
| QC Number | The QC number (a system parameter with beginning number). | 9 | Char | T_RS_SELECT_RSLT | SEQ_RANDOM |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|----------------------|---|--------|-----------|-------------|---------------|
| Total Claims Sampled | The number of claims selected for the sample. | 9 | Number | T_RS_SELECT | CNT_RESULT |

6.1.1.5 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.1.6 QAA Claims Monitoring Hospital Services Detail

The QAA Claims Monitoring-Hospital Svcs-Detail report provides a detail for the sample universe of hospital claims reported by Claims Monitoring-Hospital Services Report.

6.1.1.7 Technical Name

QAA Claims Monitoring Hospital Services Detail

6.1.1.8 Sort Order

QC Number

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

6.1.1.9 QAA Claims Monitoring Hospital Services Detail Layout

QAA Claims Monitoring Hospital Services Detail Report Layout

```

Report : QAA-8101-M                                COMMONWEALTH OF KENTUCKY (M1)                                Run Date: 99/99/9999
Process : QAAJMS10                                MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time: 99:99:99
Location: QAAP8100                                QAA Claims Monitoring Hospital Services Detail Report        Page: #####

ICN      : xxxxxxxxxxxxxxxx          FROM DATE: 99/99/9999          THRU DATE: 99/99/9999          CLM-STAT : x
# LN ITEM: ###                      REGION      : xx                INVOICE D: 99/99/9999          CLAIM TYP: x
#CUR EXCP: xxxx

-----
MEMBER ID: xxxxxxxxxxxxxxxx          BASE MID : xxxxxxxxxxxxxxxx          CASE NO. : xxxxxxxxxxxxxxxx          SSN      : xxxxxxxxxxxxxxxx
HIC      : xxxxxxxxxxxxxxxx          ORG-MBR  : xxxxxxxxxxxxxxxx          MBR PGM  : x                    MBR CNTY : xxx
LAST NAME: xxxxxxxxxxxxxxxxxxxxxxxx  FRST NAME: xxxxxxxxxxxxxxxxxxxxxxx  REVIEW   : x                    BRTH DATE: 99/99/9999
AGE      : ###                      SEX       : x                    RACE     : x                    SPNDD IND: x
MCARE IND: x x                      NH IND   : xx                   HMO CAP  : x                    SOURCE-CD: xxxxx
TP FOLLOW: xx                       LOCK-IN  : x                    MBR STAT : xxx                 LIV ARR  : xxx
KENPAC   : x                       WAIVR ELG: xx                   SUBMIT-ID: xxxxxxxxxxxxxxxxxxxx

-----
BILL-PROV: xxxxxxxxxxxxxxxxxxxx          PROV-COS : xx                   PROV-SPEC: xxx                 OUT OF ST: x
BPRV STAT: xx                         STAT DATE: 99/99/9999          COUNTY   : xxx                 HMO IND  : x
UPIN     : xxxxxxxxxxxxxxxxxxxx          PAYTO PRV: xxxxxxxxxxxxxxxxxxxx  DEA NO.  : xxxxxxxxxxxxxxxx
GROUP PRV: xxxxxxxxxxxxxxxxxxxx          GROUP COS: xx

-----
ADJ. RSN.: xxxx                       CRED IND.: x                   CCN      : xxxxxxxxxxxxxxxx          :
ICN OF CR: xxxxxxxxxxxxxxxxxxxx          ICN TO CR: xxxxxxxxxxxxxxxxxxxx

-----
CLM-CHRG : #####.##                  REIMB AMT: #####.##          NET CHRG : #####.##          MBR PMNT : #####.##
TPL AMT  : #####.##                  MCARE AMT: #####.##          NONCV-AMT: #####.##          PROF-COMP: #####.##
SPENDDOWN: #####.##                  :                               RA NUMBER: #####          WARRANT# : xxxxxxxxxxxxxxx

-----
OLD TCN  : xxxxxxxxxxxxxxxxxxxxxxxx          PA NUMBER: xxxxxxxxxxxxxxxx          OLD P/A  : xxxxxxxxxxxxxxxx          NO. CYCLS: ##
CLERK    : xxxxxxxxxxxx                   OVR EXC  : ###                    OVR CLERK: xxxxxxxxxxxx          CUT BACK : x
MED REC# : xxxxxxxxxxxxxxxxxxxxxxxx          EOB CODES: xxxx xxxx              SPEC PGM : xxx                    FAM PLAN : x

-----
ATTN PROV: xxxxxxxxxxxxxxxxxxxx          PERF PROV: xxxxxxxxxxxxxxxxxxxx          REFR PROV: xxxxxxxxxxxxxxxxxxxx          ALLWD CHG: #####.##
ALLWD SRC: x                             PA IND   : x                    FIN CLASS: x                    TYPE BILL: xx
DSCHRG HR: ##                           PAT STAT : xx                   COV DAYS : ###                    NCOV DAYS: ###
SPC PRICE: x                             UR PERFRM: xx                   ADMIT DTE: 99/99/9999          ADMIT HR  : ##
DIAG CODE: xxxxxxxx                     DIAG CODE: xxxxxxxx              DIAG CODE: xxxxxxxx              DIAG CODE: xxxxxxxx
SURGERY-1: xxxx xxxxxxxxxxxxxxxx          SURGERY-2: xxxx xxxxxxxxxxxxxxxx          SURGERY 3: xxxx xxxxxxxxxxxxxxxx          COND CODE: xx
VALU CODE: xx #####.##                  VALU CODE: xx #####.##          OCCU DATA: xx xxxxxxxxxxxxxxxx          OCCU DATA: xx xxxxxxxxxxxxxxxx
MC APPRV : #####.##                    MC DEDUCT: #####.##
MC COINS  : #####.##                    MC NETPAY: #####.##          SURG PROV: xxxxxxxxxxxxxxxxxxxx

-----
LINE ITEM: ###                          LI FDOS  : 99/99/9999          LI TDOS  : 99/99/9999          LN PROC C: xxxxx xx xx xx xx
LN REVENU: xxxx                          LN UNITS : #####.##          SUBM CHRG: #####.##          ALLW CHRG: #####.##
ALLW CG S: xxxxxxxx                      LN EOB   : xxxx xxxx xxxx xxxx          LN OVRIDE: xx                    LN TOS   : xx
NCOV AMT : #####.##                    PROF COMP: ###.##          UNIT BILL: #####.##
    
```

6.1.1.10 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|---|--------|-----------|---------------------------------|------------------|
| # LN ITEM | The number of line items contained in the claim. | 4 | Number | T_RS_SELECT_RSLT / T_CA_HDR_DTL | NUM_DTL |
| #CUR EXCP | The number of current exceptions appearing on the claim. | 4 | Number | T_CA_ERROR | COUNT(SAK_CLAIM) |
| ADJ. RSN. | The adjustment reason code (will appear on adjusted claims only). | 4 | Char | T_CDE_HIPAA_ADJRSN | CDE_ADJ_RSN |
| ADMIT DTE | The admit date. (STRATUM 100, 200, AND 500 Only) | 10 | Date | T_CA_ICN | DTE_ADMISSION |
| ADMIT HR | The admit hour. (STRATUM 100, 200, AND 500 Only) | 2 | Number | T_CA_UB92 | CDE_ADMIT_HOUR |
| AGE | The member age at the time the services were performed. | 2 | Number | T_RS_SELECT_RSLT | NUM_RECIP_AGE |
| ALLW CG S | The allowed Charge source code. (STRATUM 100, 200, AND 500 Only) | 6 | Char | T_CA_ICN | IND_PRICING |
| ALLW CHRG | The MAC (Maximum Allowed Charge) code. (STRATUM 400 Only) | 9 | Number | T_CA_HDR_DTL / T_CA_ICN | AMT_ALWD |
| ALLWD CHG | The allowed charge for the line item. | 9 | Number | T_RS_SELECT_RSLT | AMT_ALWD |
| ALLWD SRC | The allowed Charge source code. | 6 | Char | T_CA_HDR_DTL / T_CA_ICN | IND_PRICING |
| ATTN PROV | The attending provider license number. (STRATUM 100, 200, AND 500 Only) | 15 | Char | T_CA_HDR_DTL / T_CA_ICN | ID_PROV_ATTEND |
| BASE MID | The unique number assigned to the member. | 12 | Char | T_RS_SELECT_RSLT | ID_MEDCAID |
| BILL-PROV | The billing provider number. | 15 | Char | T_RS_SELECT_RSLT | ID_PROV_BILL |
| BPRV STAT | The billing provider's status code. | 1 | Char | T_PR_HB_LIC | CDE_STATUS1 |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|------------|---|--------|-----------|-------------------|--|
| BIRTH DATE | The member date of birth. | 10 | Date | T_RS_SELECT_RECIP | DTE_BIRTH |
| CASE NO. | The member case number. | 12 | Char | T_CA_ICN | NUM_CASE |
| CCN | The cash control number. | 11 | Char | T_CASH_RECEIPT | CASH_CTL_NO |
| CLAIM TYP | The claim input form indicator. | 1 | Char | T_RS_SELECT_RSLT | CDE_CLM_TYPE |
| CLERK | The clerk identification of the last clerk to update the claim. | 8 | Char | T_CA_ICN | ID_CLERK |
| CLM-CHRG | The total claim Charge submitted by the provider. | 10 | Number | T_CA_ICN | AMT_BILLED |
| CLM-STAT | The claim status code (N = Paid, P = Denied). | 1 | Char | T_CA_ICN | CDE_DTL_STATUS |
| COND CODE | The claim condition code. (STRATUM 100, 200, AND 500 Only) | 2 | Char | T_CA_COND | CDE_COND |
| COUNTY | The billing provider's county code. | 10 | Char | T_CA_PROV_KEY | CDE_SVC_COUNTY |
| COV DAYS | The covered days (STRATUM 100, 200, AND 500 Only) | 4 | Number | T_CA_ICN | NUM_DAYS_COVD |
| CRED IND. | The claim credit indicator. | 1 | Char | T_CA_ICN | CDE_ADJ_VOID |
| CUT BACK | The header cut back reason code. | 1 | Char | T_CA_ERROR | Y if CDE_EOB = '9922' |
| DEA NO. | The provider's DEA number. | 9 | Char | T_PR_SVC_LOC_DN | NUM_DEA |
| DIAG CODE | The diagnosis code that was keyed on the claim. | 7 | Char | T_RS_SELECT_RSLT | CDE_DIAG_PRIM, CDE_DIAG_2, CDE_DIAG_3, CDE_DIAG_4 |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|---------------|--|--------|-----------|-------------------|--|
| DSCHRG HR | The hour the member was disCharged from the hospital. Hour 01 is 1:00 am; hour 24 is midnight. | 2 | Number | T_CA_UB92 | TIME_DISCHARGE |
| EOB CODES | The header explanation of benefits codes. | 4 | Char | T_CA_ERROR_DN | CDE_EOB_1, CDE_EOB_2 |
| FAM PLAN | Procedure indicator (abortion, sterilization, hysterectomy, family planning). (STRATUM 300 AND 400 Only) | 4 | Char | T_CA_IND_KEY | IND_STERILIZATION, IND_ABORTION, IND_HYST, IND_REF_FAM_PLAN |
| FIN CLASS | The financial class code (STRATUM 100, 200, AND 500 Only) | 3 | Char | T_CA_CLAIM_KEY | CDE_FUND_CODE |
| FROM DATE | The header from date of service on the claim. | 10 | Date | T_RS_SELECT_RSLT | DTE_FROM_SVC |
| FRST NAME | The member first name. | 15 | Char | T_RS_SELECT_RECIP | NAM_FIRST |
| GROUP COS | The provider's group category of service. | 2 | Char | T_CA_CLAIM_KEY | CDE_COS_ST |
| GROUP PRV | The provider's group number. | 15 | Char | T_PR_SVC_LOC_DN | ID_PROVIDER_BASE |
| HIC | The member Health Insurance Claim number assigned by Medicare. | 11 | Char | T_RE_EDB | NUM_HIC |
| HMO CAP | The member HMO capitation group. | 1 | Char | T_CA_IND_KEY | IND_MNGD_HEALTH |
| HMO IND | The HMO process indicator. | 1 | Char | T_CA_PROV_KEY | IND_PROV_HLTH_C ARE |
| ICN | The internal control number of the claim pulled for Contract Monitoring review. | 13 | Char | T_RS_SELECT_RSLT | NUM_ICN |
| ICN OF CR | The original ICN if the claim was converted. | 13 | Char | T_CA_ICN | NUM_ADJ_ICN |
| ICN TO CREDIT | ICN to Credit | 13 | Char | T_CA_ICN | NUM_ICN |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|--|--------|-----------|------------------------------------|------------------|
| INVOICE D | Invoice Date | 10 | Date | T_CA_ICN | DTE_BILLED |
| KENPAC | The KenPAC flag. | 1 | Char | T_CA_IND_KEY | IND_KENPAC |
| LAST NAME | The member last name. | 20 | Char | T_RS_SELECT_RECIP | NAM_LAST |
| LI FDOS | The line item first date of service. | 10 | Date | T_CA_HDR_DTL / T_RS_SELECT_RSLT | DTE_FIRST_SVC |
| LI TDOS | The line item to date of service. | 10 | Date | T_CA_HDR_DTL / T_RS_SELECT_RSLT | DTE_LAST_SVC |
| LINE ITEM | The item number of the line whose detail is to follow. | 2 | Number | T_CA_HDR_DTL / T_RS_SELECT_RSLT | NUM_DTL |
| LIV ARR | The living arrangement indicator. | 2 | Char | T_RS_SELECT_RSLT | CDE_LIV_ARNG |
| LN EOB | The line item EOB code. | 4 | Char | T_CA_ERROR_DN | CDE_EOB |
| LN OVRIDE | The line item override code. | 1 | Char | T_CLAIM_ERROR | CDE_STATUS1 |
| LN PROC C | The line item procedure code. (STRATUM 100, 200, AND 500 Only) | 6 | Char | T_CA_HDR_DTL / T_RS_SELECT_RSLT | CDE_PROC |
| LN REVENU | The line item revenue code. (STRATUM 100, 200, AND 500 Only) | 4 | Number | T_CA_HDR_DTL / T_CA_ICN | CDE_REVENUE |
| LN TOS | The line item type of service code. (STRATUM 100, 200, AND 500 Only) | 1 | Char | T_CDE_PROC | CDE_CMS_TOS |
| LN TOS | The line item place of service and type of service. (STRATUM 300 AND 400 Only) | 4 | Char | T_CDE_PROC | CDE_CMS_TOS |
| LN UNITS | The units submitted for the line item. | 9 | Number | T_CA_HDR_DTL / T_CA_ICN | QTY_UNITS_BILLED |
| LOCK-IN | The member lock-in flag. | 1 | Char | T_RS_SELECT_RSLT | IND_RESTRICT_LI |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|--|--------|-----------|------------------|------------------------------------|
| MBR CNTY | The member county code used to identify a geographical/political area in the state. | 3 | Char | T_CA_RECIP_KEY | CDE_COUNTY |
| MBR PGM | The member program code. | 5 | Char | T_CA_CLAIM_KEY | CDE_PGM_HEALTH |
| MBR PMNT | 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. | 9 | Number | T_CA_ICN | AMT_PAT_LIAB |
| MBR STAT | The member status code. | 2 | Char | T_CA_RECIP_KEY | CDE_PGM_STATUS |
| MC APPRV | The sum of 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. | 8 | Number | T_CA_XOVER | AMT_ALWD_MCARE |
| MC COINS | The Medicare coinsurance amount. | 12 | Number | T_CA_XOVER | AMT_COINSURANCE |
| MC DEDUCT | The Medicare deductible amount for the line item. (STRATUM 300 AND 400 Only) | 12 | Number | T_CA_XOVER | AMT_DEDUCT |
| MC NETPAY | The Medicare net pay amount. (STRATUM 100, 200, AND 500 Only) | 12 | Number | T_RS_SELECT_RSLT | AMT_PAID_MCARE |
| MCARE AMT | The amount paid by Medicare. (STRATUM 300 AND 400 Only) | 12 | Number | T_RS_SELECT_RSLT | AMT_PAID_MCARE |
| MCARE IND | The member Medicare coverage indicator. | 1 | Char | T_RE_BASE_DN | IND_MEDICARE_A / IND_MEDICARE_B |
| MED REC# | The medical record number submitted by the provider. | 30 | Char | T_CA_UB92 | CDE_MED_REC_NUM |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|---|--------|-----------|------------------------------------|-----------------------------------|
| MEMBER ID | The Medicaid identification number for the member. | 12 | Char | T_RS_SELECT_RSLT | ID_MEDICAID |
| NCOV AMT | The line item non-covered amount. | 12 | Number | T_CA_HDR_DTL / T_RS_SELECT_RSLT | calculated |
| NCOV DAYS | The non-covered days. (STRATUM 100, 200, AND 500 Only) | 4 | Number | T_CA_ICN | NUM_DAYS_NCOVD |
| NET CHRG | The net claim Charge. | 12 | Number | T_RS_SELECT_RSLT | AMT_PAID |
| NH IND | Indicator (Y or N) denoting if member is in a nursing home. | 1 | Char | T_RS_SELECT_RSLT | CDE_PROV_TYPE |
| NO. CYCLS | The number of cycles this claim processed through until adjudication. | 2 | Number | T_CA_ERROR | calculated |
| NONCV-AMT | The header claim non-covered amount. | 12 | Number | T_CA_HDR_DTL / T_RS_SELECT_RSLT | calculated |
| OCCU DATA | The occurrence code and date. (STRATUM 100, 200, AND 500 Only) | 12 | Char | T_CA_OCCUR | CDE_OCCURRENCE/ DTE_OCCURRENCE |
| OLD P/A | The previous Prior Authorization number of the PA number was converted. | 10 | Char | T_CA_ICN | NUM_PRIOR_AUTH |
| OLD TCN | The HP Enterprise Services ICN if the claim was converted. | 18 | Char | T_CA_ICN | NUM_TCN |
| ORG-MBR | The original member identification number. | 12 | Char | T_RS_SELECT_RSLT | ID_MEDICAID |
| OUT OF ST | The out of state indicator. | 1 | Char | T_PR_SVC_LOC_DN | IND_OOS |
| OVR CLERK | The identification of the clerk who entered the override fields. | 8 | Char | T_CLAIM_ERROR | ID_CLERK |
| OVR EXC | The override exception code. | 4 | Number | T_CA_ERROR | CDE_ESC |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|---|--------|-----------|------------------|----------------------------------|
| PA IND | The long term care prior authorization indicator. (STRATUM 400 Only) | 1 | Char | T_CA_ICN | "Y" if NUM_PRIOR_AUTH is present |
| PA IND | The claim prior authorization indicator.(STRATUM 100, 200, AND 500 Only) | 1 | Char | T_CA_ICN | calculated |
| PA NUMBER | The prior authorization number submitted for the claim. | 10 | Char | T_RS_SELECT_RSLT | NUM_PRIOR_AUTH |
| PAT STAT | The patient status at time of billing. (STRATUM 100, 200, AND 500 Only) | 2 | Char | T_CA_RECIP_KEY | CDE_PGM_STATUS |
| PAYTO PRV | The pay-to provider number. | 15 | Char | T_RS_SELECT_RSLT | ID_PROV_BILL |
| PERF PROV | The performing provider number (STRATUM 100, 200, AND 500 Only) | 15 | Char | T_RS_SELECT_RSLT | ID_PROV_PERF |
| PROF-COMP | The line item professional component amount. | 9 | Number | T_CA_HDR_DTL | AMT_CO_PAY |
| PROV-COS | The billing provider's category of service. | 2 | Char | T_CA_CLAIM_KEY | CDE_COS_SUB |
| PROV-SPEC | The billing provider's specialty code. | 3 | Char | T_PR_SVC_LOC_DN | CDE_PROV_SPEC |
| RA NUMBER | The remittance advice number on which the final adjudication of this claim is reported. | 10 | Number | T_CA_ICN | NUM_RA |
| RACE | The member race code. | 2 | Char | T_CA_RECIP_KEY | CDE_ETHNIC |
| REFR PROV | The prescribing provider's license number. (STRATUM 400 Only) | 10 | Char | T_CA_PROV_KEY | NUM_REFER_LIC |
| REGION | Code which indicates the media on which a claim was submitted (MIS table). | 2 | Char | T_CA_CLAIM_KEY | CDE_REGION |
| REIMB AMT | The total reimbursement amount by Medicaid. | 10 | Number | T_CA_ICN | AMT_REIMBURSED |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|------------|--|--------|----------------------|------------------------------------|---|
| REVIEW | The member-on-review indicator. | 1 | Char | T_CA_ICN | IND_INVESTIGATION |
| SEX | The member sex. | 1 | Char | T_RS_SELECT_RECIP | CDE_SEX |
| SOURCE -CD | The member source code. | 5 | Char | T_RE_BASE_DN | CDE_SOURCE |
| SPC PRICE | Indicates whether the procedure/drug is exempt from the member copayment requirement. | 1 | Char | T_CA_ICN | IND_PRICING |
| SPEC PGM | Code indicating the Special Program under which the services rendered to the patient were performed. Component of Claim Information. | 3 | Char | T_UB92_HDR_EXT_KEY | CDE_SPECIAL_PROGRAM |
| SPENDDOWN | The total amount of spenddown the case is responsible for during the specified time period. | 10 | Number | T_CLM_PATLIAB_X | AMT_PD_PAT_UB92 |
| SPNDD IND | The member spenddown indicator. | 1 | Char | T_RE_SPEND_LIAB | AMT_SPENDDOWN (If amt_spenddown <> 0, spenddown ind = Y) |
| SSN | The member Social Security Number. | 9 | Char | T_RE_BASE_DN | NUM_SSN |
| STAT DATE | The date the billing provider was first active | 10 | Date (MM/DD/CCYY) | T_PR_SVC_LOC_DN | DTE_EFFV |
| SUBM CHRG | The Charge submitted for the line item. | 12 | Number | T_CA_HDR_DTL / T_RS_SELECT_RSLT | AMT_BILLED |
| SUBMIT-ID | The EMC submitter identification number. | 15 | Char | T_RS_SELECT_RSLT | ID_MCO_SUBMITTER |
| SURG PROV | The ID for the surgical provider. | 15 | Char | T_CA_PROV_KEY | ID_PROVIDER_NPI |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|--|---|--------|-----------|-------------------|-------------------------------------|
| SURGERY-1 | The primary surgery code and date performed. | 15 | Char | T_CA_ICD9_PROC_DN | DTE_ICD_9_CM_PROC_1,CDE_PROC_ICD9_1 |
| SURGERY-2 | The secondary surgery code and date performed. | 15 | Char | T_CA_ICD9_PROC_DN | DTE_ICD_9_CM_PROC_2,CDE_PROC_ICD9_2 |
| SURGERY-3 | The tertiary surgery code and date performed. | 15 | Char | T_CA_ICD9_PROC_DN | DTE_ICD_9_CM_PROC_3,CDE_PROC_ICD9_3 |
| THE FIELDS REPORTED WILL VARY DEPENDING ON THE CLAIM TYPE. | N/A | 0 | Char | N/A | N/A |
| THRU DATE | The header thru date of service on the claim. | 10 | Date | T_RS_SELECT_RSLT | DTE_LAST_SVC |
| TP FOLLOW | The TPL follow-up indicator. | 2 | Char | T_CA_IND_KEY | IND_TPL |
| TPL AMT | The third party payment amount. | 12 | Number | T_RS_SELECT_RSLT | AMT_TPL |
| TYPE BILL | The type of facility at which a service was rendered, such as inpatient, outpatient, etc. (STRATUM 100, 200 AND 500 Only) | 2 | Char | T_CA_ICN | CDE_TYPE_OF_BILL |
| UNIT BILL | The per unit bill amount. | 9 | Number | T_RS_SELECT_RSLT | AMT_BILLED/NUM_UNIT_SVC |
| UPIN | The Universal Provider Identification Number. | 16 | Char | T_CA_PROV_KEY | ID_PROVIDER_NPI |
| VALU CODE | The claim value code dollar amount. (STRATUM 100, 200, AND 500 Only) | 2 | Char | T_CA_VALUE_DN | CDE_VALUE_1, CDE_VALUE_2 |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|---|--------|-----------|----------------|---------------|
| WAIVR ELG | The COS waiver eligibility code. | 2 | Char | T_CA_CLAIM_KEY | CDE_COS_ST |
| WARRANT# | The number of the check issued to the provider which included payment for this claim. | 9 | Char | T_CA_ICN | NUM_CHECK |

6.1.1.11 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.2 QAA Contract Monitoring Crossover Services

The CM Crossover Services report lists, by system-assigned QC number, claims selected for processing accuracy assessment. This report is for Stratum 500 which contains only crossover services claims.

6.1.2.1 Technical Name

QAA Contract Monitoring Crossover Services

6.1.2.2 Sort Order

QC Number

For readability, the layout displays on the next page.

6.1.2.3 QAA Contract Monitoring Crossover Services Layout

QAA Contract Monitoring Crossover Services Report Layout

| | | |
|---------------------|--|----------------------|
| Report : QAA-5005-M | COMMONWEALTH OF KENTUCKY | Run Date: 07/24/2006 |
| Process : QAAJMS05 | MEDICAID MANAGEMENT INFORMATION SYSTEM | Run Time: 14:41:03 |
| Location: QAAP5005 | Q&A Contract Monitoring Crossover Services | Page: 1 |

| QC NUMBER | ICN | MEMBER NAME | MEMBER ID | BILLING PROVIDER NUMBER | FIRST DATE OF SERVICE | ADJUDICATION DATE | PAID AMOUNT |
|-----------|---------------|--|-----------|-------------------------|-----------------------|-------------------|---------------|
| 1 | 2005138003004 | ABCDEFGHIJABCDE A ABCDEFGHIJABCDEFGHIJ | 888800043 | 1000000360 | 01/02/2005 | 05/19/2005 | \$99999999.99 |
| 2 | 2005090000010 | CINDY A BILLS | 000001869 | 1000001037 | 09/01/2004 | 03/31/2005 | \$700.00 |
| 3 | 2005066000027 | RICK LANE | 000039888 | 1000001037 | 07/01/2004 | 03/08/2005 | \$125.00 |
| 4 | 2105061003011 | MIKE J ANDERSON | 000001452 | 1000000981 | 08/21/2004 | 03/03/2005 | \$11.53 |
| 5 | 2005105000012 | AMY ANDERSON | 888800041 | 1000000971 | 10/16/2004 | 04/15/2005 | \$1000.00 |
| 6 | 2005090000035 | LYLE MITCHEL | 000039996 | 1000001037 | 07/01/2004 | 04/04/2005 | \$700.00 |
| 7 | 2005105000011 | PAM LANE | 000002470 | 1000000971 | 10/16/2004 | 04/15/2005 | \$1000.00 |
| 8 | 2205175003002 | RICK LANE | 000039888 | 1000000971 | 09/09/2004 | 06/28/2005 | \$3.00 |
| 9 | 2005108000054 | JANET J BILLS | 000001889 | 1000001037 | 02/10/2005 | 04/19/2005 | \$725.50 |
| 10 | 2005111016032 | ZELDA B WATERS | 000001346 | 1000000025 | 04/04/2005 | 04/22/2005 | \$3.75 |
| 11 | 5205110001001 | ZELDA B WATERS | 000001346 | 1000000360 | 02/18/2005 | 04/21/2005 | \$47.00 |
| 12 | 5205112001001 | RICK LANE | 000039888 | 1000000971 | 08/09/2004 | 04/22/2005 | \$3.00 |
| 13 | 5205130001007 | ZELDA B WATERS | 000001346 | 1000000360 | 08/01/2004 | 05/10/2005 | \$64.00 |
| 14 | 2005070016014 | RICK LANE | 000039888 | 1000000394 | 09/06/2004 | 03/15/2005 | \$37.00 |
| 15 | 2005060016007 | MIKE SMITH | 000041515 | 1000000394 | 10/02/2004 | 03/01/2005 | \$37.00 |
| 16 | 2005106000022 | OSCAR MITCHEL | 000039969 | 200308710A | 10/16/2004 | 04/18/2005 | \$1000.00 |
| 17 | 2105061003015 | MIKE J ANDERSON | 000001452 | 1000000981 | 10/21/2004 | 03/03/2005 | \$1.38 |
| 18 | 2005145003003 | ABCDEFGHIJABCDE A ABCDEFGHIJABCDEFGHIJ | 888800043 | 1000000360 | 05/02/2005 | 05/26/2005 | \$84.00 |
| 19 | 2005066000014 | ZELDA B WATERS | 000001346 | 1000001037 | 07/01/2004 | 03/08/2005 | \$700.00 |
| 20 | 2005091000027 | HANK COX | 000001326 | 100760599A | 11/01/2004 | 04/04/2005 | \$150.00 |
| 21 | 5205112001007 | ZELDA B WATERS | 000001346 | 1000000360 | 08/01/2004 | 04/22/2005 | \$64.00 |
| 22 | 2005067000008 | ZELDA B WATERS | 000001346 | 1000000971 | 09/16/2004 | 03/08/2005 | \$1000.00 |
| 23 | 2105074003010 | MIKE J ANDERSON | 000001452 | 1000000981 | 10/21/2004 | 03/15/2005 | \$1.38 |
| 24 | 2005060000016 | ABCDEFGHIJABCDE A ABCDEFGHIJABCDEFGHIJ | 000041450 | 1000001037 | 10/01/2004 | 03/01/2005 | \$750.00 |
| 25 | 2005059016005 | MIKE J ANDERSON | 000001452 | 1000000159 | 09/06/2004 | 03/01/2005 | \$37.00 |
| 26 | 2005112000033 | CINDY A BILLS | 000001869 | 1000001037 | 09/04/2004 | 04/22/2005 | \$700.00 |
| 27 | 2005125000025 | ZELDA B WATERS | 000001346 | 1000000360 | 08/01/2004 | 05/06/2005 | \$64.00 |
| 28 | 2105074003026 | MIKE J ANDERSON | 000001452 | 1000000981 | 10/21/2004 | 03/17/2005 | \$1.38 |
| 29 | 2105067003009 | DEBBIE D LANE | 000002469 | 1000000971 | 08/01/2004 | 03/08/2005 | \$2.50 |
| 30 | 2105074003022 | MIKE J ANDERSON | 000001452 | 1000000981 | 10/21/2004 | 03/17/2005 | \$1.38 |
| 31 | 2005104016045 | HANK W SMITH | 000001261 | 1000000025 | 11/02/2004 | 04/28/2005 | \$8.75 |
| 32 | 2005090000021 | ZELDA B WATERS | 000001346 | 1000000360 | 01/25/2005 | 03/31/2005 | \$49.00 |
| 33 | 2005105016029 | HANK W SMITH | 000001261 | 1000000025 | 01/30/2005 | 04/15/2005 | \$18.25 |
| 34 | 2005077000018 | ZELDA B WATERS | 000001346 | 1000000981 | 01/01/2005 | 03/22/2005 | \$750.00 |
| 35 | 2005091000036 | HANK COX | 000001326 | 100760599A | 10/01/2004 | 04/04/2005 | \$150.00 |
| 36 | 2005110016022 | ZELDA B WATERS | 000001346 | 1000000025 | 01/15/2005 | 04/21/2005 | \$3.75 |
| 37 | 2005070016009 | LYLE R HALL | 000040496 | 1000000394 | 09/06/2004 | 03/15/2005 | \$37.00 |
| 38 | 5205112001002 | DEBBIE D LANE | 000002469 | 1000000394 | 09/06/2004 | 04/22/2005 | \$22.50 |
| 39 | 2005073000011 | ZELDA B WATERS | 000001346 | 1000000981 | 03/01/2005 | 03/15/2005 | \$750.00 |
| 40 | 2005060000015 | PAM LANE | 000002470 | 1000000971 | 11/01/2004 | 03/01/2005 | \$750.00 |
| 41 | 2005079003001 | ZELDA B WATERS | 000001346 | 1000000360 | 02/03/2005 | 03/22/2005 | \$94.00 |
| 42 | 2005069003002 | ZELDA B WATERS | 000001346 | 1000000360 | 01/03/2005 | 03/10/2005 | \$94.00 |
| 43 | 2005110000005 | HANK W SMITH | 000001261 | 1000000360 | 01/27/2005 | 04/20/2005 | \$24.00 |
| 44 | 5005125250002 | ZELDA B WATERS | 000001346 | 1000000025 | 04/04/2005 | 05/06/2005 | \$3.75 |
| 45 | 2105074003014 | MIKE J ANDERSON | 000001452 | 1000000981 | 10/21/2004 | 03/15/2005 | \$1.38 |
| 46 | 2005063000027 | ABCDEFGHIJABCDE A ABCDEFGHIJABCDEFGHIJ | 000041450 | 1000001037 | 07/01/2004 | 03/08/2005 | \$700.00 |

6.1.2.4 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-------------------------|---|--------|----------------------|-----------------------|---|
| Adjudication Date | The adjudication date. | 10 | Date | T_RS_SELECT_RSL T | DTE_PAID |
| Amount Paid | The reimbursement amount. | 11 | Number (Decimal) | T_RS_SELECT_RSL T | AMT_PAID |
| As of Date | The date of for which this report is produced | 10 | Date (MM/DD/CCYY) | T_RS_SELECT | DTE_HIST_TO |
| Beginning QC Number | The transaction control number of the first claim on the report. | 9 | Number | T_RS_SELECT_RSL T | SEQ_RANDOM |
| Billing Provider Number | The provider number. | 15 | Char | T_RS_SELECT_RSL T | ID_PROV_BILL |
| Claims Universe | The total number of claims which meet the selection criteria and from which the sample was taken. | 9 | Number | T_RS_SELECT | NUM_POPULATION |
| Ending QC Number | The transaction control number of the last claim on the report. | 9 | Number | T_RS_SELECT_RSL T | SEQ_RANDOM |
| First Date of Service | The first date of service. | 10 | Date | T_RS_SELECT_RSL T | DTE_FIRST_SVC |
| ICN | The transaction control number of the claim selected. | 13 | Char | T_RS_SELECT_RSL T | NUM_ICN |
| Member ID | The Medicaid identification number for the member. | 12 | Char | T_RS_SELECT_RSL T | ID_MEDICAID |
| Member Name | The full member name. | 52 | Char | T_RS_SELECT_REC IP | NAM_LAST, NAM_FIRST, NAM_MID_INIT |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|----------------------|---|--------|-----------|----------------------|---------------|
| QC Number | The QC number (a system parameter with beginning number). | 9 | Number | T_RS_SELECT_RSL T | SEQ_RANDOM |
| Total Claims Sampled | The number of claims selected for the sample. | 9 | Number | T_RS_SELECT | CNT_RESULT |

6.1.2.5 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.3 QAA Contract Monitoring Diagnosis Display

The QAA Contract Monitoring Diagnosis Display report displays the data from the Procedure Drug and Diagnosis File for each diagnosis code billed on the claims that are pulled for each of the 5 Contract Monitoring stratum.

6.1.3.1 Technical Name

QAA Contract Monitoring Diagnosis Display

6.1.3.2 Sort Order

For Sample Number

For readability, the layout displays on the next page.

6.1.3.3 QAA Contract Monitoring Diagnosis Display Layout

QAA Contract Monitoring Diagnosis Display Report Layout

| | | |
|--|--|------------------------|
| Report : QAA-6701-M | COMMONWEALTH OF KENTUCKY | Run Date: 08/18/2006 |
| Process : QAAJM671 | MEDICAID MANAGEMENT INFORMATION SYSTEM | Run Time: 16:35:35 |
| Location: QAAP6701 | Contract Monitoring Diagnosis Display Report | Page: 1 |
| | | As of Date: 12/31/2005 |
| For Sample # HOSP2 | | |
| Member Id: 000002469 | | ICN: 2005080130019 |
| Diagnosis | Min Max Sex Emr Fam Preg Att Primary Sub Class | Date of last |
| | Age Age Ind Ind Ind Ind Ind Ind Ind | Transaction |
| 4210 - AC/SUBAC BACT ENDOCARD INCREASED LENGTH | 0 999 B N N N N Y N | 08/04/2006 |
| For Sample # HOSP3 | | |
| Member Id: 000001385 | | ICN: 2005055100104 |
| Diagnosis | Min Max Sex Emr Fam Preg Att Primary Sub Class | Date of last |
| | Age Age Ind Ind Ind Ind Ind Ind Ind | Transaction |
| 95901 - HEAD INJURY, UNSPECIFIED | 0 999 M N N N N Y N | 08/08/2006 |
| For Sample # HOSP4 | | |
| Member Id: 000001385 | | ICN: 2205056100007 |
| Diagnosis | Min Max Sex Emr Fam Preg Att Primary Sub Class | Date of last |
| | Age Age Ind Ind Ind Ind Ind Ind Ind | Transaction |
| 95901 - HEAD INJURY, UNSPECIFIED | 0 999 M N N N N Y N | 08/08/2006 |
| For Sample # HOSP5 | | |
| Member Id: 000040075 | | ICN: 5205119001020 |
| Diagnosis | Min Max Sex Emr Fam Preg Att Primary Sub Class | Date of last |
| | Age Age Ind Ind Ind Ind Ind Ind Ind | Transaction |
| 25000 - DIABETES UNCOMPL ADULT | 0 999 B N N N N Y N | 08/08/2006 |
| *** END OF REPORT *** | | |

6.1.3.4 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|--------------------------|---|--------|-----------|--------------------------------------|-----------------------------------|
| As of Date | The last date of the period for which the report was produced. | 10 | Date | T_RS_SELECT | DTE_HIST_TO |
| Attachment Indicator | Indicates whether documentation is required for the diagnosis. | 1 | Char | T_DIAG_LIMIT | IND_ATTACHMENT |
| Date of Last Transaction | The date of the last update transaction made to the file. | 10 | Date | A_T_DIAG_LIMIT | DTE_SYSDATE |
| Diagnosis | The diagnosis code and description. | 47 | Char | T_RS_SELECT_RSL T, T_DIAGNOSIS | CDE_DIAG_1,2,3 or 4 and DSC_25 |
| Emr Ind | The Emergency indicator associated with this diagnosis code. | 1 | Char | T_DIAG_LIMIT | IND_EMERGENCY |
| Fam Pln | The family planning indicator. | 1 | Char | T_DIAG_LIMIT | IND_FAM_PLAN |
| For Sample # | The type of claim strata along with the QC number assigned to the claim whose diagnosis data follows. | 10 | Char | T_RS_SELECT, T_RS_SELECT_RSL T | ID_RQST_BY, SEQ_RANDOM |
| ICN | The transaction control number of the claim whose diagnosis codes are reported. | 13 | Char | T_RS_SELECT_RSL T | NUM_ICN |
| Max Age | The maximum age required for a member to be diagnosed with this code. | 3 | Number | T_DIAG_LIMIT | QTY_AGE_MAX |
| Member ID | The Medicaid identification number for the member. | 12 | Char | T_RS_SELECT_RSL T | ID_MEDICIAD |
| Min Age | The minimum age required for a member to be diagnosed with this code. | 3 | Number | T_DIAG_LIMIT | QTY_AGE_MIN |
| Pregnancy Ind | Indicates if the diagnosis is for a pregnancy. | 1 | Char | T_DIAG_LIMIT | IND_PREGNANCY |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|--------------|---|--------|-----------|--------------|---------------|
| Primary Ind | Indicates primary diagnosis codes cannot be billed. The valid values are Y/N. | 1 | Char | T_DIAG_LIMIT | IND_PRIMARY |
| Sex Ind | The sex indicator for the diagnosis code. | 1 | Char | T_DIAG_LIMIT | CDE_SEX |
| Subclass Ind | Indicates whether the diagnosis requires further specification. | 1 | Char | T_DIAG_LIMIT | IND_SUB_CLASS |

6.1.3.5 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.4 QAA Contract Monitoring Hospital Services

The Case Management Hospital Services report lists, by Quality Control number, the hospital service claims selected for the claims processing accuracy sample.

6.1.4.1 Technical Name

QAA Contract Monitoring Hospital Services

6.1.4.2 Sort Order

QC Number

For readability, the layout displays on the next page.

QAA Contract Monitoring Hospital Services Report Layout

| | | |
|---------------------|--|----------------------|
| Report : QAA-5001-M | COMMONWEALTH OF KENTUCKY | Run Date: 07/24/2006 |
| Process : QAAJM501 | MEDICAID MANAGEMENT INFORMATION SYSTEM | Run Time: 14:40:42 |
| Location: QAAP5001 | QA&A Contract Monitoring Hospital Services | Page: 1 |

| QC NUMBER | ICN | MEMBER NAME | MEMBER ID | BILLING PROVIDER NUMBER | FIRST DATE OF SERVICE | ADJUDICATION DATE | PAID AMOUNT |
|-----------|---------------|--------------------|-----------|-------------------------|-----------------------|-------------------|---------------|
| 1 | 2105106100001 | ABCDEFGHJIJABCDE A | 000041487 | 200308710A | 11/29/2004 | 04/18/2005 | \$99999999.99 |
| 2 | 2005080130019 | DEBBIE D LANE | 000002469 | 1000000335 | 05/03/2003 | 03/22/2005 | \$50.00 |
| 3 | 2005055100104 | BILLY MITCHEL | 000001385 | 1000000971 | 02/15/2004 | 02/24/2005 | \$8127.35 |
| 4 | 2205056100007 | BILLY MITCHEL | 000001385 | 1000000971 | 10/13/2004 | 03/01/2005 | \$8127.35 |
| 5 | 5205119001020 | TIM J ROSE | 000040075 | 1000000515 | 09/01/2004 | 04/29/2005 | \$37.50 |
| 6 | 2205115130002 | ANDY D SMITH | 000002456 | 1000000669 | 11/21/2004 | 04/25/2005 | \$99.00 |
| 7 | 2005104250042 | RICK VINE | 000002446 | 1000000515 | 07/20/2004 | 04/14/2005 | \$1.16 |
| 8 | 2005091100025 | DEBBIE D LANE | 000002469 | 1000000971 | 03/18/2005 | 04/04/2005 | \$735.85 |
| 9 | 2205068100046 | EDDIE B TYLER | 000040344 | 1000000971 | 03/01/2005 | 03/10/2005 | \$3863.76 |
| 10 | 5205110001006 | HANK W SMITH | 000001261 | 1000000515 | 12/02/2004 | 04/21/2005 | \$184.80 |
| 11 | 2005104130032 | RICK C COX | 000040632 | 1000000360 | 01/04/2005 | 04/14/2005 | \$24.88 |
| 12 | 2005112130108 | YANCY C JAMES | 000001297 | 200307489B | 02/06/2004 | 04/22/2005 | \$4.95 |
| 13 | 2205111130001 | ANDY WATERS | 000039866 | 1000000971 | 12/01/2004 | 04/21/2005 | \$50.00 |
| 14 | 2005081100004 | RICK LANE | 000039888 | 1000000981 | 10/01/2004 | 03/22/2005 | \$7760.00 |
| 15 | 2005091100034 | JANET FILCH | 000041423 | 1000000971 | 08/15/2004 | 04/04/2005 | \$8127.35 |
| 16 | 2005064130003 | JANET FILCH | 000041423 | 1000000971 | 04/23/2004 | 03/08/2005 | \$50.00 |
| 17 | 2005110100140 | FRANK ROSE | 000002431 | 1000001297 | 08/24/2004 | 04/21/2005 | \$7339.97 |
| 18 | 2005069100127 | JANET B ANDERSON | 000001308 | 1000000971 | 11/15/2004 | 03/15/2005 | \$6649.65 |
| 19 | 2205063250009 | NANCY D SMITH | 000041348 | 1000001024 | 06/16/2004 | 03/08/2005 | \$708.00 |
| 20 | 5205121001004 | ANDY SMITH | 000041412 | 1000000971 | 02/15/2005 | 05/02/2005 | \$11779.70 |
| 21 | 2005077100068 | ANDY B JAMES | 000002411 | 1000000971 | 08/15/2004 | 03/22/2005 | \$3694.25 |
| 22 | 2005103250069 | RICK VINE | 000002446 | 1000000515 | 05/20/2004 | 04/14/2005 | \$188.80 |
| 23 | 2205115130001 | ANDY D SMITH | 000002456 | 1000000669 | 10/21/2004 | 04/25/2005 | \$99.00 |
| 24 | 2005063100063 | TIM GATES | 000039931 | 1000000971 | 02/15/2004 | 03/08/2005 | \$11779.70 |
| 25 | 2005069100077 | TIM GATES | 000039931 | 1000000971 | 10/15/2004 | 03/10/2005 | \$3394.90 |
| 26 | 2005056250036 | JANET J JONES | 000041294 | 1000000358 | 07/18/2004 | 03/01/2005 | \$94.40 |
| 27 | 5205109001005 | BILLY MITCHEL | 000001385 | 1000000971 | 03/15/2005 | 04/26/2005 | \$16185.18 |
| 28 | 2105108130135 | ROBIN WILLIAMS | 888800011 | 1000001027 | 10/21/2004 | 04/19/2005 | \$7.00 |
| 29 | 2105055130004 | LYLE COX | 000001423 | 1000000669 | 10/21/2004 | 02/24/2005 | \$12.80 |
| 30 | 2005108130029 | ZELDA B WATERS | 000001346 | 1000000360 | 01/14/2005 | 04/18/2005 | \$10.48 |
| 31 | 2105082130106 | DEBBIE J HALL | 000040540 | 200305069A | 10/11/2004 | 03/24/2005 | \$17.00 |
| 32 | 2005102130067 | GREG SMITH | 000041590 | 1000000971 | 11/21/2004 | 04/14/2005 | \$18.37 |
| 33 | 2005113100169 | BILLY ANDERSON | 000041444 | 1000000971 | 01/07/2005 | 04/25/2005 | \$2216.55 |
| 34 | 2005060100056 | SAM LANE | 000001384 | 1000000971 | 03/15/2004 | 03/01/2005 | \$4404.34 |
| 35 | 2005116100040 | SAM TYLER | 000001865 | 1000000971 | 10/15/2004 | 04/26/2005 | \$10137.71 |
| 36 | 2005055100038 | ANDY WATERS | 000040014 | 1000001297 | 08/08/2004 | 02/24/2005 | \$581.69 |
| 37 | 2005117130096 | YANCY C JAMES | 000001297 | 1000001349 | 08/12/2004 | 04/28/2005 | \$4.95 |
| 38 | 2005112100010 | PAM IZZO | 000041493 | 1000001037 | 08/15/2004 | 04/22/2005 | \$6286.06 |
| 39 | 2005070130018 | TIM J ROSE | 000040075 | 1000000448 | 06/04/2004 | 03/15/2005 | \$197.00 |
| 40 | 2005055100009 | ISABELLA SMITH | 000041221 | 1000000971 | 09/27/2004 | 02/24/2005 | \$735.85 |
| 41 | 2105105130117 | JANET W TYLER | 000040787 | 1000000360 | 08/21/2004 | 04/15/2005 | \$21.37 |
| 42 | 2005096100070 | JERRID L JOBE | 234567899 | 1000001071 | 02/15/2005 | 04/07/2005 | \$8105.13 |

6.1.4.3 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-------------------------|---|--------|-----------|-------------------|---|
| Adjudication Date | The adjudication date. | 10 | Date | T_RS_SELECT_RSLT | DTE_PAID |
| Amount Paid | The reimbursement amount. | 9 | Number | T_RS_SELECT_RSLT | AMT_PAID |
| As of Date | The date of the payment cycle for which this report was produced. | 10 | Date | T_RS_SELECT | DTE_HIST_TO |
| Beginning QC Number | The transaction control number of the first claim on the report. | 4 | Char | T_RS_SELECT_RSLT | NUM_RANDOM |
| Billing Provider Number | The provider number. | 15 | Char | T_RS_SELECT_RSLT | ID_PROV_BILL |
| Claims Universe | The total number of claims which meet the selection criteria and from which the sample was taken. | 4 | Number | T_RS_SELECT | CNT_CRITERIA |
| Ending QC Number | The transaction control number of the last claim on the report. | 4 | Char | T_RS_SELECT_RSLT | NUM_RANDOM |
| First Date of Service | The first date of service. | 10 | Date | T_RS_SELECT_RSLT | DTE_FIRST_SVC |
| ICN | The transaction control number of the claim selected. | 13 | Char | T_RS_SELECT_RSLT | NUM_ICN |
| Member ID | The Medicaid identification number for the member. | 12 | Char | T_RS_SELECT_RSLT | ID_MEDICAID |
| Member Name | The full member name. | 50 | Char | T_RS_SELECT_RECIP | NAM_LAST, NAM_FIRST, NAM_MID_INIT |
| QC Number | The QC number (a system parameter with beginning number). | 4 | Char | T_RS_SELECT_RSLT | SEQ_RANDOM |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|----------------------|---|--------|-----------|-------------|---------------|
| Total Claims Sampled | The number of claims selected for the sample. | 4 | Number | T_RS_SELECT | CNT_RESULT |

6.1.4.4 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.5 QAA Contract Monitoring Kentucky MMIS Claims Details

The QAA Contract Monitoring Kentucky MMIS Claims Details report lists the detail claim record data for each claim pulled for the monthly Contract Monitoring review.

6.1.5.1 Technical Name

QAA Contract Monitoring Kentucky MMIS Claims Details

6.1.5.2 Sort Order

QC Number

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

6.1.5.4 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|--|---|--------|-----------|-----------------------|-------------------|
| THE FIELDS REPORTED WILL VARY DEPENDING ON THE CLAIM TYPE. | N/A | 0 | Char | N/A | N/A |
| # LN ITEM | The number of line items contained in the claim. | 4 | Number | T_RS_SELECT_RS LT | NUM_DTL |
| #CUR EXCP | The number of current exceptions appearing on the claim. | 4 | Char | T_CA_ICN | CNT_CLAIMS_ERRORS |
| ADJ. RSN. | The adjustment reason code (will appear on adjusted claims only). | 4 | Char | T_EOB_ADJRSN_X REF | CDE_ADJ_RSN |
| ADMIT DTE | The admit date. (STRATUM 100, 200, AND 500 Only) | 10 | Date | T_CA_ICN | DTE_ADMISSION |
| ADMIT HR | The admit hour. (STRATUM 100, 200, AND 500 Only) | 2 | Char | T_CA_UB92 | CDE_ADMIT_HOUR |
| AGE | The member age at the time the services were performed. | 3 | Char | T_RS_SELECT_RS LT | NUM_RECIP_AGE |
| ALLW CG S | The allowed Charge source code. | 6 | Char | T_CA_ICN | IND_PRICING |
| ALLW CHRG | The allowed charge for the line item. | 9 | Number | T_RS_SELECT_RS LT | AMT_ALWD |
| ALLWD SRC | The allowed Charge source code. (STRATUM 100, 200, AND 500 Only) | 2 | Char | T_CA_ICN | IND_PRICING |
| ATTN PROV | The attending provider license number. (STRATUM 100, 200, AND 500 Only) | 15 | Char | T_CA_HDR_DTL | ID_PROV_ATTEND |
| ATTN PROV | The ID for the attending provider. | 15 | Char | T_CA_ICN | ID_PROV_ATTEND_ |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|------------|---|--------|----------------------|-----------------------|-------------------|
| AUTO/OTHER | Indicates whether the service performed was as a result of an accident. | 1 | Char | T_CA_IND_KEY | IND_ACCIDENT |
| BASE MID | The unique number assigned to the member. | 12 | Char | T_RS_SELECT_RS LT | ID_MEDICAID |
| BILL-PROV | The billing provider number. | 15 | Char | T_RS_SELECT_RS LT | ID_PROV_BILL |
| BPRV STAT | The billing provider's status code. | 2 | Char | T_PR_HB_LIC | CDE_STATUS1 |
| BRAND NEC | The brand-necessary indicator. (STRATUM 400 Only) | 1 | Char | T_CA_ICN | IND_BRAND_MED_NEC |
| BIRTH DATE | The member date of birth | 10 | Date (MM/DD/CCYY) | T_RS_SELECT_RE CIP | DTE_BIRTH |
| CASE NO | The member case number. | 12 | Char | T_CA_ICN | NUM_CASE |
| CCN | The cash control number. | 11 | Char | T_CASH_RECEIPT | CASH_CTL_NO |
| 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_RS_SELECT_RS LT | CDE_CLM_TYPE |
| CLERK | The clerk identification of the last clerk to update the claim. | 8 | Char | T_CA_MISC | ID_CLERK |
| CLM-CHRG | The total claim Charge submitted by the provider. | 10 | Char | T_CA_ICN | AMT_BILLED |
| CLM-STAT | The claim status code (N = Paid, P = Denied). | 1 | Char | T_CA_CLAIM_KEY | CDE_DTL_STATUS |
| COMP CODE | The compound drug code. (STRATUM 400 Only) | 11 | Char | T_RS_SELECT_RS LT | CD_NDC |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|--------------|--|--------|-----------|----------------------|--|
| COND CODE | The claim condition code. (STRATUM 100, 200, AND 500 Only) | 2 | Char | T_CA_COND | CDE_COND |
| COUNTY | The billing provider's county code. | 10 | Char | T_RS_SELECT_PR OV | CDE_COUNTY |
| COV DAYS | The covered days (STRATUM 100, 200, AND 500 Only) | 4 | Number | T_CA_ICN | NUM_DAYS_COVD |
| CRED IND. | The claim credit indicator. | 1 | Char | T_CA_CLAIM_KEY | CDE_ADJ_VOID |
| CUST LOC | The customer location code. (STRATUM 400 Only) | 2 | Char | T_CA_DRUG | PATIENT_LOCATION |
| CUT BACK | The header cut back reason code. | 2 | Char | T_CA_ERROR | CDE_EOB |
| DAYS SUPP | The days supply dispensed. (STRATUM 400 Only) | 9 | Number | T_CA_DRUG | NUM_DAY_SUPPLY |
| DEA NO. | The provider's DEA number. | 9 | Char | T_RS_SELECT_PR OV | NUM_DEA |
| DIAG 1,2,3,4 | The diagnosis codes submitted on the claim. (STRATUM 300 AND 400 Only) | 7 | Char | T_RS_SELECT_RS LT | CD_DIAG_1, CD_DIAG_2, CD_DIAG_3, CD_DIAG_4 |
| DIAG CODE | The claim diagnosis codes. (STRATUM 100, 200, AND 500 Only) | 7 | Char | T_RS_SELECT_RS LT | CD_DIAG_1 |
| DIAG DATA | The diagnosis sterilization indicator, diagnosis abortion indicator, diagnosis hysterectomy indicator, and diagnosis family planning indicator. (STRATUM 300 AND 400 Only) | 4 | Char | T_CA_ICN | IND_STERILIZATION, IND_ABORTION, IND_HYST, IND_REF_FAM_PLAN |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|------------|---|--------|-----------|--------------------|---|
| DISP FEE | The dispensing fee. (STRATUM 400 Only) | 12 | Number | T_CA_DRUG | AMT_NDC_PREFEE |
| DRG PRICE | The drug price per unit. If amt_mac <> 0, mac ind = Y (STRATUM 400 Only) | 12 | Number | T_CA_DRUG | AMT_MAC |
| DSCHRG HR | The disCharge hour. (STRATUM 100, 200, AND 500 Only) | 2 | Char | T_CA_UB92 | TIME_DISCHARGE |
| EMERGENCY | The emergency indicator. (STRATUM 300 AND 400 Only) | 1 | Char | T_CA_ICN | CDE_EMERGENCY |
| EMP REL | The employment-related indicator. (STRATUM 300 AND 400 Only) | 2 | Char | T_PHYS_HDR_KEY | CDE_RELATED_CAUSE_1 |
| EOB CODES | The header Explanation of Benefits codes. | 4 | Char | T_CA_ERROR_DN | CDE_EOB_1, CDE_EOB_2 |
| EP/FP/EMG | The EPSDT, Family Planning, and Emergency line-item indicators. (STRATUM 300 AND 400 Only) | 3 | Char | T_CA_ICN | IND_REF_EPSDT, IND_REF_FAM_PLAN, CD_EMERGENCY |
| FACILITY | The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs. | 15 | Char | T_CA_PROV_KEY | ID_PROVIDER_NPI |
| FAM PLAN | The header level family planning indicator. | 1 | Char | T_RS_SELECT_RESULT | IND_FAM_PLAN |
| FIN CLASS | This is the fund code that is used in financial reporting to correctly categorize funds (money). | 2 | Char | T_CA_CLAIM_KEY | CDE_FUND_CODE |
| FIRST NAME | The member first name. | 15 | Char | T_RE_BASE_DN | NAM_FIRST |
| FMLY PLN | The header family planning indicator. (STRATUM 300 AND 400 Only) | 1 | Char | T_RS_SELECT_RESULT | IND_FAM_PLAN |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|--|--------|-----------|----------------------|------------------------|
| FROM DATE | The header from date of service on the claim. | 10 | Date | T_RS_SELECT_RS LT | DTE_FROM_SVC |
| GENERIC C | The generic code of the drug. (STRATUM 400 Only) | 5 | Char | T_CA_DRUG | NUM_GCN |
| GROUP COS | The provider's group category of service. | 2 | Char | T_CA_CLAIM_KEY | CDE_COS_ST |
| GROUP PRV | The provider's group number. | 15 | Char | T_CA_PROV_KEY | ID_PROVIDER_BASE |
| HIC | The member Health Insurance Claim number assigned by Medicare. | 11 | Char | T_RE_EDB | NUM_HIC |
| HMO CAP | Indicates if the member was enrolled in an hmo/hio when the claim was adjudicated. | 1 | Char | T_CA_ICN | IND_MNGD_HEALTH |
| HMO IND | The HMO process indicator. | 1 | Char | T_CA_PROV_KEY | IND_PROV_HLTH_CAR E |
| ICN | The transaction control number of the claim pulled for Contract Monitoring review. | 13 | Char | T_RS_SELECT_RS LT | NUM_ICN |
| ICN OF CR | ICN of Credit | 13 | Char | T_CA_ICN | NUM_ADJ_ICN |
| ICN TO CR | ICN to Credit | 13 | Char | T_CA_ICN | NUM_ICN |
| INVOICE D | Invoice Date | 10 | Date | T_CA_ICN | DTE_BILLED |
| KENPAC | The member KENPAC indicator. | 1 | Char | T_CA_IND_KEY | IND_KENPACE |
| LAST NAME | The member last name. | 20 | Char | T_RE_BASE_DN | NAM_LAST |
| LI FDOS | The line item first date of service. | 10 | Date | T_RS_SELECT_RS LT | DTE_FIRST_SVC |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|---|--------|-----------|------------------------|---|
| LI TDOS | The line item to date of service. | 10 | Date | T_RS_SELECT_RS LT | DTE_LAST_SVC |
| LINE ITEM | The item number of the line whose detail is to follow. | 4 | Char | T_RS_SELECT_RS LT | NUM_DTL |
| LIV ARR | The living arrangement indicator. | 2 | Char | T_RS_SELECT_RS LT | CDE_LIV_ARNG |
| LN EOB | A code which represents a policy for Medicaid claim adjudication. | 4 | Char | T_CA_ERROR_DN | CDE_EOB_1, CDE_EOB_2, CDE_EOB_3, CDE_EOB_4 |
| LN OVRIDE | The line item override code. | 2 | Char | T_CLAIM_ERROR | CDE_STATUS1 |
| LN PROC C | The line item procedure code. (STRATUM 100, 200, AND 500 Only) | 6 | Number | T_RS_SELECT_RS LT | CDE_PROC |
| LN REVENU | The line item revenue code. (STRATUM 100, 200, AND 500 Only) | 4 | Number | T_CA_HDR_DTL | CDE_REVENUE |
| LN TOS | The line item type of service code. (STRATUM 100, 200, AND 500 Only) | 2 | Char | T_RS_SELECT_RE SULT | CDE_CMS_TOS |
| LN UNITS | The units submitted for the line item. | 12 | Number | T_RS_SELECT_RE SULT | NUM_UNITS_SVC |
| LOCK-IN | The member lock-in flag. | 1 | Char | T_CA_ICN | IND_RESTRICT_LI |
| LTC PA | The long term care prior authorization indicator. (STRATUM 400 Only) | 1 | Char | T_RS_SELECT_RE SULT | "Y" if NUM_PRIOR_AUTH present |
| MAC IND | The MAC (Maximum Allowed Charge) code. If amt_mac <> 0, Ind_amt_mac = Y. (STRATUM 400 Only) | 1 | Char | T_CA_DRUG | AMT_MAC |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|---|--------|-----------|----------------------|-----------------|
| MBR CNTY | The member county. | 10 | Char | T_CA_RECIP_KEY | CDE_COUNTY |
| MBR PGM | The member program code. | 2 | Char | T_CA_CLAIM_KEY | CDE_PGM_HEALTH |
| MBR PMNT | 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. | 9 | Number | T_CA_ICN | AMT_PAT_LIAB |
| MBR STAT | The member status code. | 2 | Char | T_CA_RECIP_KEY | CDE_PGM_STATUS |
| MC ALLOW | The amount Medicare allowed for the line item. (STRATUM 300 AND 400 Only) | 6 | Number | T_CA_XOVER | AMT_ALWD_MCARE |
| MC APPRV | 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. | 8 | Number | T_CA_XOVER | AMT_PAID_MCARE |
| MC COINS | The Medicare coinsurance amount. | 12 | Number | T_CA_XOVER | AMT_COINSURANCE |
| MC COV DY | The number of Medicare covered days used. (STRATUM 500 Only) | 4 | Number | T_CA_ICN | NUM_DAYS_COVD |
| MC DEDUCT | The Medicare deductible amount. | 12 | Number | T_CA_XOVER | AMT_DEDUCT |
| MC NETPAY | The Medicare net pay amount. (STRATUM 100, 200, AND 500 Only) | 12 | Number | T_RS_SELECT_RS LT | AMT_PAID_MCARE |
| MC TBILL | The amount paid by Medicare. (STRATUM 300 AND 400 Only) | 12 | Number | T_RS_SELECT_RS LT | AMT_PAID_MCARE |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|--|--------|-----------|----------------------|-----------------------------------|
| MC TOTDED | The Medicare deductible amount for the line item. (STRATUM 300 AND 400 Only) | 12 | Number | T_CA_XOVER | AMT_DEDUCT |
| MCARE AMT | The amount paid by Medicare. | 12 | Number | T_RS_SELECT_RS LT | AMT_PAID_MCARE |
| MCARE IND | The member Medicare coverage indicator. | 1 | Char | T_RE_BASE_DN | IND_MEDICARE_A, IND_MEDICARE_B |
| MED REC# | The medical record number submitted by the provider. | 15 | Char | T_CA_UB92 | CDE_MED_REC_NUM |
| MEMBER ID | The Medicaid identification number for the member. | 12 | Char | T_RS_SELECT_RS LT | ID_MEDICAID |
| NCOV AMT | The line item non-covered amount. | 12 | Number | T_CA_HDR_DTL | AMT_BILLED - AMT_PAID |
| NCOV DAYS | The non-covered days. (STRATUM 100, 200, AND 500 Only) | 4 | Number | T_CA_ICN | NUM_DAYS_NCOVD |
| NDC | The National Drug Code submitted. (STRATUM 400 Only) | 11 | Char | T_RS_SELECT_RS LT | CDE_NDC |
| NET CHRG | The net claim Charge. | 12 | Number | T_CA_ICN | AMT_PAID |
| NH IND | Indicator (Y or N) denoting if member is in a nursing home. | 1 | Char | T_RS_SELECT_PR OV | CD_PROV_SPEC_PRIM |
| NO. CYCLS | The number of cycles this claim processed through until adjudication. | 2 | Char | T_CA_ERROR | DTE_ERROR |
| NONCV AMT | The header claim non-covered amount. | 12 | Number | T_RS_SELECT_RS LT | AMT_BILLED, AMT_PAID |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|---|--------|-----------|----------------------|--|
| OCCU DATA | The occurrence code and date. (STRATUM 100, 200, AND 500 Only) | 2 | Char | T_CA_OCCUR | CDE_OCCURENCE |
| OLD P/A | The previous Prior Authorization number of the PA number was converted. | 10 | Char | T_CA_ICN | NUM_PRIOR_AUTH |
| OLD TCN | The HP Enterprise Services ICN if the claim was converted. | 13 | Char | T_CA_TCN | NUM_TCN |
| ORG-MBR | The original member identification number. | 12 | Char | T_RS_SELECT_RS LT | ID_MEDICAID |
| OUT OF ST | The out of state indicator. | 1 | Char | T_PR_SVC_LOC_D N | IND_OOS |
| OVR CLERK | The identification of the clerk who entered the override fields. | 8 | Char | T_CLAIM_ERROR | ID_CLERK |
| OVR EXC | The override exception code. | 4 | Char | T_CA_ERROR | CDE_ESC |
| PA IND | The claim prior authorization indicator.(STRATUM 100, 200, AND 500 Only) | 1 | Char | T_CA_ICN | "Y" if NUM_PRIOR_AUTH is present |
| PA IND | The prior authorization indicator. If num_prior_auth <> spaces, PA IND = Y (STRATUM 300 AND 400 Only) | 1 | Char | T_CA_ICN | "Y" if NUM_PRIOR_AUTH is present |
| PA NUMBER | The prior authorization number submitted for the claim. | 10 | Char | T_RS_SELECT_RS LT | NUM_PRIOR_AUTH |
| PAT STAT | The patient status at time of billing. (STRATUM 100, 200, AND 500 Only) | 2 | Char | T_CA_RECIP_KEY | CDE_PGM_STATUS |
| PAYTO PRV | The pay-to provider number. | 15 | Char | T_RS_SELECT_RS LT | ID_PROV_BILL |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|--|--------|-----------|----------------------|--|
| PERF PROV | The performing provider number (STRATUM 100, 200, AND 500 Only) | 15 | Char | T_RS_SELECT_RS LT | ID_PROV_PERF |
| POS/TOS | The line item place of service and type of service. (STRATUM 300 AND 400 Only) | 4 | Char | T_RS_SELECT_RS LT | CDE_POS, CDE_TOS |
| PRESC PRV | The prescribing provider's license number. (STRATUM 400 Only) | 15 | Char | T_CA_ICN | NUM_REFER_LIC |
| PROC DATA | Procedure indicator (abortion, sterilization, hysterectomy, family planning). (STRATUM 300 AND 400 Only) | 4 | Char | T_CA_ICN | IND_STERILIZATION, IND_ABORTION, IND_HYST, IND_REF_FAM_PLAN |
| PROF COMP | The line item professional component amount. | 6 | Number | T_CA_HDR_DTL | AMT_CO_PAY |
| PROV-COS | A sub-COS used to provide a more detailed service classification in MAR state reporting. | 2 | Char | T_CA_CLAIM_KEY | CDE_COS_SUB |
| PROV-SPEC | The billing provider's specialty code. | 3 | Char | T_PR_SVC_LOC_D N | CDE_PROV_SPEC |
| QLF MISC | This qualifier identifies the type of information in the CDE_MISC column. Values are: EI - Employee Identification SI - School Identification PT - Pick-up Time (transportation claims). | 2 | Char | T_CA_MISC | QLF_MISC_TYPE |
| RA NUMBER | The remittance advice number on which the final adjudication of this claim is reported. | 10 | Char | T_CA_ICN | NUM_RA |
| RACE | The member race code. | 2 | Char | T_CA_RECIP_KEY | CDE_ETHNIC |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|--|--------|------------------------|------------------------|----------------------------------|
| REFLL IND | The refill indicator code. (STRATUM 400 Only) | 1 | Number | T_CA_DRUG | QTY_REFILL |
| REFR PROV | The referring provider number. | 15 | Char | T_SELECT_RSLT | ID_PROV_REFER |
| REGION | Code which indicates the media on which a claim was submitted (MIS table). | 2 | Char | T_CLAIM_ERROR | CDE_REGION |
| REIMB AMT | The total reimbursement amount by Medicaid. | 12 | Number | T_CA_ICN | AMT_REIMBURSED |
| REVIEW | The member-on-review indicator. | 1 | Char | T_CA_ICN | IND_INVESTIGATION |
| RX NBR | The prescription number. (STRATUM 400 Only) | 7 | Char | T_CA_DRUG | NUM_PRSCRIP |
| SEX | The member sex. | 1 | Char | T_RS_SELECT_RE CIP | CDE_SEX |
| SOURCE-CD | This is the source of the member updates and information. | 1 | Char | T_RE_BASE_DN | CDE_SOURCE |
| SPC PRICE | The special price indicator. (STRATUM 100, 200, AND 500 Only) | 6 | Char | T_CA_ICN | IND_PRICING |
| SPEC PGM | The special program indicator code. | 1 | Char | T_UB92_HDR_EXT _KEY | CDE_SPECIAL_PROGR AM |
| SPENDDOWN | The spenddown amount. | 10 | Char | T_CLM_PATLIAB_X | AMT_PD_PAT_UB92 |
| SPNDD IND | The member spenddown indicator. | 1 | Char | T_CLM_PATLIAB_X | AMT_PD_PAT_UB92/AM T_PAT_LIAB |
| SSN | The member Social Security Number. | 9 | Char | T_RE_BASE_DN | NUM_SSN |
| STAT DATE | The date the billing provider was first active | 10 | Date (MM/DD/CCYY) N | T_PR_SVC_LOC_D N | DTE_EFFV |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|---|--------|-----------|----------------------|---|
| SUBM CHRG | The Charge submitted for the line item. | 12 | Number | T_RS_SELECT_RS LT | AMT_BILLED |
| SUBMIT-ID | The EMC submitter identification number. | 15 | Char | T_RS_SELECT_RS LT | ID_MCO_SUBMITTER |
| SURG PROV | The ID for the surgical provider. | 15 | Char | T_CA_PROV_KEY | ID_PROVIDER_NPI |
| SURGERY-1 | The primary surgery code and date performed. (STRATUM 100, 200, AND 500 Only) | 14 | Char | T_CA_ICD9_PROC DN | DTE_ICD_9_CM_PROC _1, CD_PROC_ICD9_1 |
| SURGERY-2 | The secondary surgery code and date performed. (STRATUM 100, 200, AND 500 Only) | 14 | Char | T_CA_ICD9_PROC DN | DTE_ICD_9_CM_PROC _2, CD_PROC_ICD9_2 |
| SURGERY-3 | The tertiary surgery code and date performed. (STRATUM 100, 200, AND 500 Only) | 14 | Char | T_CA_ICD9_PROC DN | DTE_ICD_9_CM_PROC _3, CD_PROC_ICD9_3 |
| THRU DATE | The header thru date of service on the claim. | 10 | Date | T_RS_SELECT_RS LT | DTE_LAST_SVC |
| TP FOLLOW | The TPL follow-up indicator. | 1 | Char | T_CA_IND_KEY | IND_TPL |
| TPL AMT | The amount received by the provider from private insurers. | 10 | Number | T_CA_ICN | AMT_TPL |
| TPL AMT | The third party payment amount. | 6 | Number | T_RS_SELECT_RS LT | AMT_TPL |
| TYPE BILL | The type of facility at which a service was rendered, such as inpatient, outpatient, etc. (STRATUM 100, 200 AND 500 Only) | 3 | Char | T_CA_ICN | CDE_TYPE_OF_BILL |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|---|--------|-----------|----------------------|-----------------------------|
| UNIT BILL | The per unit bill amount. | 9 | Number | T_RS_SELECT_RS LT | AMT_BILLED/NUM_UNI T_SVC |
| UNIT DOSE | Marks a drug as packaged in unit doses. Unit dose is defined by FDB as all products labeled as Unit Dose by the mfr. This indicator does not apply to injectable products, suppositories, or powder packets. Current codes are: 1=Unit Dose & 0=All other. (STRATUM 400 Only) | 2 | Number | T_DRUG_DN | IND_UNIT_DOSE |
| UPIN | The Universal Provider Identification Number. | 15 | Char | T_CA_PROV_KEY | ID_PROVIDER_NPI |
| UR PERFRM | Code indicating the reason the member was put on review. (STRATUM 100, 200, AND 500 Only) | 2 | Char | T_RE_REV_RSN | CDE_REV_RSN |
| VALU CODE | The claim value code dollar amount. (STRATUM 100, 200, AND 500 Only) | 2 | Char | T_CA_VALUE_DN | CDE_VALUE_1 |
| WAIVR ELG | The COS waiver eligibility code. | 2 | Char | T_CA_CLAIM_KEY | CDE_COS_ST |
| WARRANT# | The number of the check issued to the provider which included payment for this claim. | 9 | Char | T_CA_ICN | NUM_CHECK |

6.1.5.5 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.6 QAA Contract Monitoring Long Term Care Services

The QAA-CM Long Term Care Services report list, by system-assigned QC number, claims selected for accuracy assessment. This report is for Stratum 200 which contains only long term care services.

6.1.6.1 Technical Name

QAA Contract Monitoring Long Term Care Services

6.1.6.2 Sort Order

QC Number

For readability, the layout displays on the next page.

6.1.6.3 QAA Contract Monitoring Long Term Care Services Layout

QAA Contract Monitoring Long Term Care Services Report Layout

| Report : QAA-5002-M | | COMMONWEALTH OF KENTUCKY | | | | Run Date: 07/24/2006 | | |
|---------------------|---------------|--|----------------------|-------------------------|-----------------------|----------------------|-------------|---------------|
| Process : QAAJMS02 | | MEDICAID MANAGEMENT INFORMATION SYSTEM | | | | Run Time: 14:40:49 | | |
| Location: QAAP5002 | | QA&A Contract Monitoring Long Term Care Services | | | | Page: 1 | | |
| QC NUMBER | ICN | MEMBER NAME | MEMBER ID | BILLING PROVIDER NUMBER | FIRST DATE OF SERVICE | ADJUDICATION DATE | PAID AMOUNT | |
| 1 | 2005088150054 | ABCDEFGHIJABCDE A | ABCDEFGHIJABCDEFGHIJ | 000001406 | 1000001641 | 05/01/2004 | 03/29/2005 | \$99999999.99 |
| 2 | 2005068150015 | LYLE S WATERS | 000002518 | 1000001641 | 10/01/2004 | 03/10/2005 | \$2181.51 | |
| 3 | 2005081150054 | RICK LANE | 000039888 | 1000001641 | 05/01/2004 | 03/24/2005 | \$2722.51 | |
| 4 | 5205119001014 | LYLE S WATERS | 000002518 | 1000001641 | 08/01/2004 | 04/29/2005 | \$2722.51 | |
| 5 | 2005091150053 | HANK COX | 000001326 | 100760599A | 11/06/2004 | 04/04/2005 | \$2512.25 | |
| 6 | 2005075150020 | LYLE S WATERS | 000002518 | 1000001641 | 11/01/2003 | 03/17/2005 | \$2181.51 | |
| 7 | 2005106150070 | RICK S DILLARD | 000040643 | 1000001603 | 09/01/2004 | 04/18/2005 | \$3975.60 | |
| 8 | 2005116150025 | RICK LANE | 000039888 | 1000001641 | 03/11/2005 | 04/26/2005 | \$98.19 | |
| 9 | 5205109001012 | LYLE S WATERS | 000002518 | 1000001641 | 08/01/2004 | 04/19/2005 | \$2722.51 | |
| 10 | 2005104150029 | ZELDA B WATERS | 000001346 | 1000001641 | 03/17/2005 | 04/14/2005 | \$196.38 | |
| 11 | 2005091150074 | LYLE S WATERS | 000002518 | 1000001641 | 08/01/2004 | 04/04/2005 | \$2722.51 | |
| 12 | 2005067150019 | LYLE S WATERS | 000002518 | 1000001641 | 09/01/2004 | 03/10/2005 | \$2181.51 | |
| 13 | 2005082150074 | HANK COX | 000001326 | 100760599A | 09/01/2004 | 03/24/2005 | \$2714.70 | |
| 14 | 2005116150010 | RICK LANE | 000039888 | 1000001641 | 01/02/2005 | 04/26/2005 | \$392.76 | |
| 15 | 5205121001014 | LYLE S WATERS | 000002518 | 1000001641 | 08/01/2004 | 05/02/2005 | \$2722.51 | |
| 16 | 2005101150075 | HANK COX | 000001326 | 100760599A | 10/06/2004 | 04/12/2005 | \$602.94 | |
| 17 | 2005108150019 | ZELDA B WATERS | 000001346 | 1000001641 | 03/27/2005 | 04/18/2005 | \$196.38 | |
| 18 | 5205121001016 | RICK ROSE | 000041397 | 1000001578 | 07/01/2004 | 05/02/2005 | \$633.43 | |
| 19 | 5205119001016 | RICK ROSE | 000041397 | 1000001578 | 07/01/2004 | 04/29/2005 | \$633.43 | |
| 20 | 5205130001004 | RICK LANE | 000039888 | 1000001641 | 03/11/2005 | 05/10/2005 | \$98.19 | |
| 21 | 2005081150056 | TIM J HALL | 000001331 | 1000001641 | 07/01/2004 | 03/24/2005 | \$2722.51 | |
| 22 | 2005075150028 | RICK LANE | 000039888 | 1000001641 | 11/01/2004 | 03/17/2005 | \$2847.51 | |
| 23 | 2005081150055 | LYLE S WATERS | 000002518 | 1000001641 | 10/01/2003 | 03/24/2005 | \$2056.51 | |
| 24 | 2005055150019 | LYLE S WATERS | 000002518 | 1000001641 | 04/01/2004 | 02/24/2005 | \$2945.70 | |
| 25 | 2005055150001 | LYLE S WATERS | 000002518 | 1000001641 | 07/01/2004 | 02/24/2005 | \$2847.51 | |
| 26 | 2005082150094 | HANK BILLS | 000001348 | 1000001590 | 09/01/2004 | 03/24/2005 | \$574.90 | |
| 27 | 5205130001003 | RICK LANE | 000039888 | 1000001641 | 01/02/2005 | 05/10/2005 | \$392.76 | |
| 28 | 2005094150068 | RICK ROSE | 000041397 | 1000001578 | 07/10/2004 | 04/04/2005 | \$591.86 | |
| 29 | 2005083150064 | LYLE S WATERS | 000002518 | 1000001641 | 12/01/2004 | 03/24/2005 | \$2181.51 | |
| 30 | 2005075150019 | TIM J HALL | 000001331 | 1000001641 | 11/01/2004 | 03/17/2005 | \$2847.51 | |

As of Date : 12/31/2005

| | | | |
|-----------------------|----|------------------------|----|
| Beginning QC Number : | 1 | Ending QC Number : | 30 |
| Claims Universe : | 30 | Total Claims Sampled : | 30 |

*** END OF REPORT ***

6.1.6.4 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-------------------------|---|--------|-----------|-----------------------|---|
| Adjudication Date | The adjudication date. | 10 | Date | T_RS_SELECT_ RSLT | DTE_PAID |
| Amount Paid | The reimbursement amount. | 12 | Number | T_RS_SELECT_ RSLT | AMT_PAID |
| As of Date | The date of the payment cycle for which this report was produced. | 10 | Date | T_RS_SELECT | DTE_HIST_TO |
| Beginning QC Number | The transaction control number of the first claim on the report. | 9 | Char | T_RS_SELECT_ RSLT | SEQ_RANDOM |
| Billing Provider Number | The provider number. | 15 | Char | T_RS_SELECT_ RSLT | ID_PROV_BILL |
| Claims Universe | The total number of claims which meet the selection criteria and from which the sample was taken. | 4 | Number | T_RS_SELECT | NUM_POPULATION |
| Ending QC Number | The transaction control number of the last claim on the report. | 9 | Char | T_RS_SELECT_ RSLT | SEQ_RANDOM |
| First Date of Service | The first date of service. | 10 | Date | T_RS_SELECT_ RSLT | DTE_FIRST_SVC |
| ICN | The transaction control number of the claim selected. | 13 | Char | T_RS_SELECT_ RSLT | NUM_ICN |
| Member ID | The Medicaid identification number for the member. | 12 | Char | T_RS_SELECT_ RECIP | ID_MEDICAID |
| Member Name | The full member name. | 29 | Char | T_RS_SELECT_ RECIP | NAM_LAST, NAM_FIRST, NAM_MID_INIT |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|----------------------|---|--------|-----------|----------------------|---------------|
| QC Number | The QC number (a system parameter with beginning number). | 9 | Char | T_RS_SELECT_ RSLT | SEQ_RANDOM |
| Total Claims Sampled | The number of claims selected for the sample. | 9 | Number | T_RS_SELECT | CNT_RESULT |

6.1.6.5 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.7 QAA Contract Monitoring Member Eligibility Listing

The QAA-Member Eligibility Listing report displays the data from each of the member file information display panels for the claims that are pulled for each of the five Contract Monitoring stratum.

6.1.7.1 Technical Name

QAA Contract Monitoring Member Eligibility Listing

6.1.7.2 Sort Order

Member Listing for Sample

For readability, the report layout displays over the following pages.

6.1.7.3 QAA Contract Monitoring Member Eligibility Listing Layout

Report : QAA-6101-M COMMONWEALTH OF KENTUCKY Run Dat
 Process : QAAJM610 MEDICAID MANAGEMENT INFORMATION SYSTEM Run Tin
 Location: QAAP6100 CONTRACT MONITORING MEMBER ELIGIBILITY LISTING Page

MEMBER LISTING FOR SAMPLE ***-> A07001

LAST TRANS DATE: 21-JUN-07
 MAID: 0020150991 NAME: SHARP, BLAKE DATE-OF-BIRTH: 26-APR-03 DATE-OF-DEATH: 31-DEC-99
 SOC-SEC: 400618610 ADDR: 230 MORGAN CREEK RD RACE: O
 MCARE-ID: ADDR: TELEPHONE: 8598244543
 ADDR: ZIP CODE: 410102500 SEX: M
 COUNTY: 094 CITY/ST: CORINTH, KY
 CASE: 407211283A CASE-NAME: SHARP, CHRISTINE D
 MEMBER-ON-REV: N TPL-IND: N GROSS-INCOME: 1393.00

----- ELIGIBILITY DATA -----

| NO | BEGIN | END | PRG | MBR-ST | IM-ID | CO-PAY |
|----|-----------|-----------|-----|--------|-------|--------|
| 1 | 01-NOV-06 | 31-DEC-99 | I | P | 05 | N |
| 2 | 01-JUL-06 | 31-DEC-99 | ## | | | N |
| 3 | 01-JUL-06 | 31-OCT-06 | ## | | | N |
| 4 | 01-JUL-06 | 31-OCT-06 | I | P | 05 | N |
| 5 | 01-JUN-06 | 31-DEC-99 | ## | | | N |
| 6 | 01-MAY-06 | 31-DEC-99 | ## | | | N |
| 7 | 01-NOV-05 | 30-JUN-06 | I | P | 05 | Y |
| 8 | 01-NOV-05 | 31-DEC-99 | I | P | 05 | Y |
| 9 | 01-SEP-05 | 31-DEC-99 | I | P | 05 | Y |
| 10 | 01-SEP-05 | 31-OCT-05 | I | P | 05 | Y |
| 11 | 01-JUN-04 | 31-AUG-05 | I | P | 05 | Y |
| 12 | 01-JUN-04 | 31-DEC-99 | I | P | 05 | Y |
| 13 | 01-MAY-04 | 31-DEC-99 | I | P | 05 | Y |
| 14 | 01-MAY-04 | 31-MAY-04 | I | P | 05 | Y |
| 15 | 01-APR-03 | 31-DEC-99 | I | P | 02 | Y |
| 16 | 01-APR-03 | 30-APR-04 | I | P | 02 | Y |

----- MEDICARE ENTITLEMENT DATA -----

| NO | BEGIN | END | SOURCE |
|-----------------|-------|-----|--------|
| MEDICARE PART A | | | |
| NO | BEGIN | END | SOURCE |
| MEDICARE PART B | | | |
| NO | BEGIN | END | SOURCE |
| MEDICARE PART D | | | |
| NO | BEGIN | END | SOURCE |

----- LTC DATA -----

| NO | BEGIN | END | INST-STAT | PROVIDER NUMBER |
|----------|-------|-----|-----------|-----------------|
| HMO DATA | | | | |

----- NEW MAID DATA -----

| NO | BEGIN | END | PROVIDER NUMBER | ADD | TRANS-DT |
|---------------|-------|-----|-----------------|-----|----------|
| NEW MAID DATA | | | | | |

----- ALTERNATE NAME DATA -----

| NO | NAME | TRANS-DT |
|----|--------------|-----------|
| 1 | SHARP, BLAKE | 21-JUN-07 |
| 2 | SHARP, BLAKE | 14-MAY-03 |

----- LOCKIN DATA -----

| NO | BEGIN | END | TRANS-DT | TYPE | PROVIDER NUMBER | SRC |
|------------------|-------|-----|----------|------|-----------------|-----------------|
| HOSPICE DATA | | | | | | |
| NO | BEGIN | END | TRANS-DT | LTC | TYPE | PROVIDER NUMBER |
| WAIVER ELIG DATA | | | | | | |

----- PAY/NO PROVIDER NUMBER SPEC -----

| NO | BEGIN | END | TRANS-DT | PAY/NO | PROVIDER NUMBER | SPEC |
|----|-------|-----|----------|--------|-----------------|------|
|----|-------|-----|----------|--------|-----------------|------|

Report : QAA-6101-M
 Process : QAAJM610
 Location: QAAP6100

COMMONWEALTH OF KENTUCKY
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 CONTRACT MONITORING MEMBER ELIGIBILITY LISTING

Run Date: 07/08/2007
 Run Time: 20:01:03
 Page: 2

```

----- KENPAC DATA -----
NO      BEGIN      END      ADDED-DT  TRANS-DT  PROVIDER NUMBER
  1  01-JUL-07 31-DEC-99 21-JUN-07 01-JAN-01  NPI 1750343216
  2  01-DEC-06 30-JUN-07 23-NOV-06 21-JUN-07  NPI 1750343216
  3  01-AUG-06 31-OCT-06 22-JUL-06 23-OCT-06  NPI 1750343216
  4  01-NOV-05 31-JUL-06 21-OCT-05 22-JUL-06  MCD 65912271
  5  01-JUN-03 31-OCT-05 21-MAY-03 21-OCT-05  NPI 1750343216
----- PATIENT LIABILITY DATA -----
NO      BEGIN      END      LIAB-IND  LIAB_AMT
    
```

6.1.7.4 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|------------------------|---|--------|-----------------|----------------|---|
| ADDR | The first line of the member's street address. | 32 | Char | T_RE_BASE_DN | ADR_STREET_1 |
| ADDR | The second line of the member's street address. | 32 | Char | T_RE_BASE_DN | ADR_STREET_2 |
| ADDR | The third line of the member's street address. | 32 | Char | T_RE_BASE_DN | ADR_STREET_3 |
| ALT NAME DATA:NAME | The member's previous names | 35 | Char | T_RE_NAME_XREF | NAM_LAST, NAM_FIRST, NAM_MID_INIT |
| ALT NAME DATA:NO | Segment number for the Alternate Name data report section. | 2 | Number | N/A | N/A |
| ALT NAME DATA:TRANS-DT | The date that the Medicaid member's name was changed. | 10 | Date (DD/MM/YY) | T_RE_NAME_XREF | DTE_LAST_CHANGE |
| CASE | Number used to identify a group of members that are in a case created by DHS. | 11 | Char | T_RE_CASE | NUM_CASE |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|------------------|---|--------|-----------------|------------------|---------------------------------|
| CASE-NAME | The member's last name, first and middle initial. | 32 | Char | T_RE_CASE | NAM_LAST,NAM_FIRST,NAM_MID_INIT |
| CITY/ST | The city and state in which a member resides. | 32 | Char | T_RE_BASE_DN | ADR_CITY,ADR_STATE |
| COUNTY | The county in which a member resides. | 4 | Char | T_RE_BASE_DN | CDE_COUNTY |
| DATE-OF-BIRTH | The Date of Birth for the member. | 10 | Date (DD/MM/YY) | T_RE_BASE_DN | DTE_BIRTH |
| DATE-OF-DEATH | The date of death for the member. | 10 | Date (DD/MM/YY) | T_RE_BASE_DN | DTE_DEATH |
| ELIG DATA:BEGIN | Eligibility segment effective date. | 10 | Date (DD/MM/YY) | T_RE_AID_ELIG_DN | DTE_EFFECTIVE |
| ELIG DATA:CO-PAY | Yes/No indicator used to identify programs that qualify for copay calculations during claims payment determination. | 1 | Char | T_PUB_HLTH_PGM | IND_COPAY |
| ELIG DATA:END | Eligibility segment end date | 10 | Date (DD/MM/YY) | T_RE_AID_ELIG_DN | DTE_END |
| ELIG DATA:IM-ID | The relationship indicator. | 2 | Char | T_RE_AID_ELIG_DN | CDE_IMID |
| ELIG DATA:MBR-ST | Identifies whether or not the eligibility aid segment is active. A blank means that the segment is active. An 'H' means that the segment is history and no longer active. | 2 | Char | T_RE_AID_ELIG_DN | CDE_STATUS1 |
| ELIG DATA:NO | Eligibility segment sequence number. | 2 | Number | N/A | N/A |
| ELIG DATA:PRG | Identifies the type of aid for which a member is eligible. | 1 | Char | T_CDE_AID | CDE_AID_CATEGORY |
| GROSS-INCOME | The member's total income. | 10 | Number | T_RE_BASE_DN | AMT_INCOME |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|------------------------------|--|--------|--------------------|---------------------------|---|
| HMO DATA:ADD | Date that the PMP assignment was created/inserted. | 10 | Date (DD/MM/YY) | T_RE_PMP_ASSIGN | DTE_ADDED |
| HMO DATA:BEGIN | The HMO eligibility effective date. | 10 | Date (DD/MM/YY) | T_RE_PMP_ASSIGN | DTE_EFFECTIVE |
| HMO DATA:END | The HMO eligibility end date. | 10 | Date (DD/MM/YY) | T_RE_PMP_ASSIGN | DTE_END |
| HMO DATA:NO | The HMO segment sequence number. | 2 | Number | N/A | N/A |
| HMO DATA:PROVIDER NUMBER | This field combines the three-byte derived provider type (NPI, MCD, and BSE) with the HMO billing provider number. | 18 | Char | T_PR_SVC_LOC_DN | ID_PROVIDER_NPI or ID_PROVIDER_MCAID or ID_PROVIDER_BASE |
| HMO DATA:TRANS-DT | This is the date that the PMP assignment was last updated. | 10 | Date (DD/MM/YY) | T_RE_PMP_ASSIGN | DTE_CHANGED |
| HOSPICE DATA:BEGIN | The Hospice eligibility effective date. | 10 | Date (DD/MM/YY) | T_RE_ASSIGN_PLA N | DTE_EFFECTIVE |
| HOSPICE DATA:END | The Hospice eligibility end date. | 10 | Date (DD/MM/YY) | T_RE_ASSIGN_PLA N | DTE_END |
| HOSPICE DATA:LTC | This is the value of the assignment plan's code. | 1 | Char | T_RE_ASSIGN_PLN _CODES | CDE_ASGN_VALUE |
| HOSPICE DATA:NO | Segment number for the Hospice data report section. | 2 | Number | N/A | N/A |
| HOSPICE DATA:PROVIDER NUMBER | This field combines the 3 byte derived provider type (NPI, MCD, BSE) with the Hospice billing provider number. | 18 | Char | T_PR_SVC_LOC_DN | ID_PROVIDER_NPI or ID_PROVIDER_MCAID or ID_PROVIDER_BASE |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|------------------------------|---|--------|-----------------|-----------------------|--|
| HOSPICE DATA:TRANS-DT | This is the date that the Hospice record was last updated. | 10 | Date (DD/MM/YY) | T_RE_ASSIGN_PLANN | DTE_LAST_UPDATED |
| HOSPICE DATA:TYPE | This is the value of the assignment plan's code. | 1 | Char | T_RE_ASSIGN_PLN_CODES | CDE_ASGN_VALUE |
| KENPAC DATA: PROVIDER NUMBER | This field combines the three-byte derived provider type (NPI, MCD, and BSE) with the KenPAC billing provider number. | 18 | Char | T_PR_SVC_LOC_DN | ID_PROVIDER_NPI or ID_PROVIDER_MCAID or ID_PROVIDER_BASE |
| KENPAC DATA:ADDED-DT | Date that the KenPAC assignment was created/inserted. | 10 | Date (DD/MM/YY) | T_RE_PMP_ASSIGN | DTE_ADDED |
| KENPAC DATA:BEGIN | The KenPAC eligibility effective date. | 10 | Date (DD/MM/YY) | T_RE_PMP_ASSIGN | DTE_EFFECTIVE |
| KENPAC DATA:END | The KenPAC eligibility end date. | 10 | Date (DD/MM/YY) | T_RE_PMP_ASSIGN | DTE_END |
| KENPAC DATA:NO | Segment number for the KenPAC data report section. | 2 | Number | N/A | N/A |
| KENPAC DATA:TRANS-DT | This is the date that the KenPAC record was last updated. | 10 | Date (DD/MM/YY) | T_RE_PMP_ASSIGN | DTE_LAST_UPDATED |
| LAST TRANS DATE | The date that the member was last updated. | 10 | Date (DD/MM/YY) | T_RE_BASE_DN | DTE_LAST_UPDATE |
| LOCKIN DATA:BEGIN | The Lockin eligibility effective date. | 10 | Date (DD/MM/YY) | T_RE_ASSIGN_PLANN_LI | DTE_EFFECTIVE |
| LOCKIN DATA:END | The Lockin eligibility end date. | 10 | Date (DD/MM/YY) | T_RE_ASSIGN_PLANN_LI | DTE_END |
| LOCKIN DATA:NO | Segment number for the Lockin data report section. | 2 | Number | N/A | N/A |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------------------------------|---|--------|--------------------|---------------------------|---|
| LOCKIN DATA:PROVIDER NUMBER | This field combines the three-byte derived provider type (NPI, MCD, and BSE) with the Lockin billing provider number. | 18 | Char | T_PR_SVC_LOC_DN | ID_PROVIDER_NPI or ID_PROVIDER_MCAID or ID_PROVIDER_BASE |
| LOCKIN DATA:SRC | This is the source of the Lockin member updates and information. | 1 | Char | T_RE_ASSIGN_PLA N_LI | CDE_SOURCE |
| LOCKIN DATA:TRANS-DT | This is the date that the Lockin record was last updated. | 10 | Date (DD/MM/YY) | T_RE_ASSIGN_PLA N_LI | DTE_LAST_UPDATED |
| LTC:BEGIN | The Long Term Care eligibility effective data. | 10 | Date (DD/MM/YY) | T_RE_AID_ELIG_DN | DTE_EFFECTIVE |
| LTC:END | The Long Term Care eligibility end data. | 10 | Date (DD/MM/YY) | T_RE_AID_ELIG_DN | DTE_END |
| LTC:INST-STAT | This is the value of the assignment plan's code. | 2 | Char | T_RE_ASSIGN_PLN _CODES | CDE_ASGN_VALUE |
| LTC:NO | The LTC segment sequence number. | 2 | Number | N/A | N/A |
| LTC:PROVIDER NUMBER | This field combines the three-byte derived provider type (NPI, MCD, and BSE) with the long term care billing provider number. | 18 | Char | T_PR_SVC_LOC_DN | ID_PROVIDER_NPI or ID_PROVIDER_MCAID or ID_PROVIDER_BASE |
| MAID | The member's unique identifier. | 12 | Char | T_RE_BASE_DN | ID_MEDICAID |
| MBR-ON-REVIEW | Identifies members who have been put on review. | 1 | Char | T_RECIP_REVIEW | SAK_RECIP |
| MC ENT DATA PTA:BEGIN | The Medicare Entitlement Part A eligibility effective date. | 10 | Date (DD/MM/YY) | T_RE_MEDCARE_A | DTE_EFFECTIVE |
| MC ENT DATA PTA:END | The Medicare Entitlement Part A eligibility end date. | 10 | Date (DD/MM/YY) | T_RE_MEDCARE_A | DTE_END |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|------------------------------|---|--------|--------------------|----------------------|---------------|
| MC ENT DATA PTA:NO | Segment number for the Medicare Entitlement Part A data report section. | 2 | Number | N/A | N/A |
| MC ENT DATA PTA:SOURCE | This is the source of the member updates and information. | 1 | Char | T_RE_MEDCARE_A | CDE_SOURCE |
| MC ENT DATA PTB:BEGIN | The Medicare Entitlement Part B eligibility effective date. | 10 | Date (DD/MM/YY) | T_RE_MEDCARE_B | DTE_EFFECTIVE |
| MC ENT DATA PTB:END | The Medicare Entitlement Part B eligibility end date. | 10 | Date (DD/MM/YY) | T_RE_MEDCARE_B | DTE_END |
| MC ENT DATA PTB:NO | Segment number for the Medicare Entitlement Part B data report section. | 2 | Number | N/A | N/A |
| MC ENT DATA PTB:SOURCE | This is the source of the member updates and information. | 1 | Char | T_RE_MEDCARE_B | CDE_SOURCE |
| MC ENT DATA PTD:BEGIN | The Medicare Entitlement Part D eligibility effective date. | 10 | Date (DD/MM/YY) | T_RE_MEDCARE_D | DTE_EFFECTIVE |
| MC ENT DATA PTD:END | The Medicare Entitlement Part D eligibility end date. | 10 | Date (DD/MM/YY) | T_RE_MEDCARE_D | DTE_END |
| MC ENT DATA PTD:NO | Segment number for the Medicare Entitlement Part D data report section. | 2 | Number | N/A | N/A |
| MC ENT DATA PTD:SOURCE | This is the source of the member updates and information. | 1 | Char | T_RE_MEDCARE_D | CDE_SOURCE |
| MCARE-ID | The members current or previous Medicare ID (HIB). | 11 | Char | T_RE_HIB | ID_MEDICARE |
| MEMBER LISTING FOR SAMPLE | The QC number assigned to the claim. | 8 | Char | T_RS_SELECT_RSL T | SAK_RQST |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-------------------------|--|--------|-----------------|-------------------|---------------------------------|
| NAME | The member's last name, first and middle initial. | 32 | Char | T_RE_BASE_DN | NAM_LAST,NAM_FIRST,NAM_MID_INIT |
| NEW MAID DATA:CHNG-DATE | This date field tells us when the transaction was initially processed. | 10 | Date (DD/MM/YY) | T_RECIP_LINK_XREF | DTE_PROCESSED |
| NEW MAID DATA:NEW MAID | The member's new Medicaid Id. | 12 | Char | T_RE_BASE_DN | ID_MEDICAID |
| NEW MAID DATA:NO | Segment number for the New Medicaid Id report section. | 2 | Number | N/A | N/A |
| PAT LIAB DATA:BEGIN | The Patient Liability eligibility effective date. | 10 | Date (DD/MM/YY) | T_RE_PAT_LIAB | DTE_EFFECTIVE |
| PAT LIAB DATA:END | The Patient Liability eligibility end date. | 10 | Date (DD/MM/YY) | T_RE_PAT_LIAB | DTE_END |
| PAT LIAB DATA:LIAB-IND | Indicate which program to apply patient obligation to. N = Nursing Home; P = Personal Care | 1 | Char | T_RE_PAT_LIAB | CDE_TYPE |
| PAT LIAB DATA:LIAB_AMT | The patient financial liability amount that must be paid by the member before Medicaid will make payment on the claim. This is a monthly amount. | 9 | Number | T_RE_PAT_LIAB | AMT_PATNT_LIAB |
| PAT LIAB DATA:NO | Segment number for the Patient Liability data report section. | 2 | Number | N/A | N/A |
| RACE | The member's race. | 2 | Char | T_RE_BASE_DN | CDE_RACE |
| SEX | The member's gender. | 1 | Char | T_RE_BASE_DN | CDE_SEX |
| SOC-SEC | The member's Social Security number. | 9 | Char | T_RE_BASE_DN | NUM_SSN |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-------------------------------|--|--------|-----------------|---------------------------|---|
| TELEPHONE | The member's telephone number. | 10 | Char | T_RE_BASE_DN | NUM_PHONE |
| TPL-IND | Indicates if a member has third party liability which is any entity other than Medicaid that could be responsible for payment of medical benefits for a Medicaid member. | 1 | Char | T_TPL_RESOURCE | SAK_RECIP |
| WVR ELIG DATA:BEGIN | The Waiver Eligibility effective date. | 10 | Date (DD/MM/YY) | T_RE_ASSIGN_PLA N | DTE_EFFECTIVE |
| WVR ELIG DATA:END | The Waiver Eligibility end date. | 10 | Date (DD/MM/YY) | T_RE_ASSIGN_PLA N | DTE_END |
| WVR ELIG DATA:NO | Segment number for the Waiver Eligibility data report section. | 2 | Number | N/A | N/A |
| WVR ELIG DATA:PAY/NO | This is the value of the assignment plan's code. | 1 | Number | T_RE_ASSIGN_PLN _CODES | CDE_ASGN_VALUE |
| WVR ELIG DATA:PAY/NO | This is the value of the assignment plan's code. | 1 | Char | T_RE_ASSIGN_PLN _CODES | CDE_ASGN_VALUE |
| WVR ELIG DATA:PROVIDER NUMBER | This field combines the 3 byte derived provider type (NPI, MCD, BSE) with the Waiver Eligibility billing provider number. | 18 | Char | T_PR_SVC_LOC_DN | ID_PROVIDER_NPI or ID_PROVIDER_MCAID or ID_PROVIDER_BASE |
| WVR ELIG DATA:TRANS-DT | This is the date that the Waiver Eligibility record was last updated. | 10 | Date (DD/MM/YY) | T_RE_ASSIGN_PLA N | DTE_LAST_UPDATED |
| ZIP CODE | The member's zip code. | 10 | Char | T_RE_BASE_DN | ADR_ZIP_CDOE,ADR_ZIP_CODE_4 |

6.1.7.5 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.8 QAA Contract Monitoring Member TPL Resources

The QAA Contract Monitoring Member TPL Resources report displays the member TPL Resource File data for all claims pulled in the five Contract Monitoring stratum whose members have TPL coverage.

6.1.8.1 Technical Name

QAA Contract Monitoring Member TPL Resources

6.1.8.2 Sort Order

Grouped by Claim Type

Sorted by Sample Number

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

6.1.8.3 QAA Contract Monitoring Member TPL Resources Layout

QAA Contract Monitoring Member TPL Resources Report Layout

```

Report : QAA-6301-M                                COMMONWEALTH OF KENTUCKY (M1)                                Run Date: 99/99/9999
Process : QAAJM630                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time: 99:99:99
Location: QAAP6300                                QAA Contract Monitoring Member TPL Resources                                Page: 1

AS OF 99/99/9999                                FOR SAMPLE NUMBER DRUG #
MEMBER ID: xxxxxxxxxxxx                                DATE-OF-LAST-TRANS: 99/99/9999 USER: xxxxxxxx
                                                    LAST-BATCH-UPDATE: 99/99/9999

-----TPL DATA-----
ORIG MEMBER ID: xxxxxxxxxxxx                                SEX: x
NAME: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx                                BIRTH: 99/99/9999                                DEATH: 99/99/9999

POL-SEG-NUM: 99 OF 99                                SOURCE: x                                ADD-DT: 99/99/9999                                SEG-TRM: 99/99/9999
COST-AVOID: x                                DATE: 99/99/9999                                VERIFY: x                                VERIFY-DATE: 99/99/9999
POLICY BEGIN DATE: 99/99/9999                                END DATE: 99/99/9999                                GRP-NUM: xxxxxxxxxxxxxxxxxxxx
POLICY NUM: xxxxxxxxxxxxxxxxxxxx                                TYPE: x
POLHLDR SSN: xxxxxxxxxxxx                                REL-CD: x                                CARRIER-ID: xxxxxxxx
POLHLDR: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
ADDRESS: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

CITY: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xx xxxxx-xxxx

CV   BEGIN   END   ADD DATE   COV DOT   EX   EX DOT   COPAYMENT   DEDUCTIBLE
xx  99/99/9999 99/99/9999 99/99/9999 99/99/9999 xx 99/99/9999 #####.## #####.##

ABS-PARENT: A COURT-ORDERED: x NAME: xxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxx xx                                BOS: x                                SC: x
ADDRESS: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx SSN: xxxxxxxx DOB: 99/99/9999 ADD-DT: 99/99/9999

CITY: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx xx xxxxx-xxxx

Report : QAA-6301-M                                COMMONWEALTH OF KENTUCKY (M1)                                Run Date: 99/99/9999
Process : QAAJM630                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time: 99:99:99
Location: QAAP6300                                QAA Contract Monitoring Member TPL Resources                                Page: 220

*** END OF REPORT ***
    
```

6.1.8.4 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|------------|---|--------|-------------------|-----------------|---------------|
| ABS Add-Dt | This is the date the record was added to the table. | 10 | Date (MM/DD/CCYY) | T_TPL_AC_PARENT | DTE_ADDED |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-------------------|--|--------|----------------------|-----------------|---|
| ABS Address | The first address line of the absent parent used for correspondence. Could be an international address if country code is not US. | 55 | Char | T_TPL_AC_PARENT | ADR_STREET_1 |
| ABS BOS | The absent parent's branch of service code. | 2 | Char | T_TPL_AC_PARENT | CDE_MILITARY_BRANCH |
| ABS City | This is the absent parent's city, state, and zip where the correspondence is sent to. Could be an out of country city if country code is not US. | 40 | Char | T_TPL_AC_PARENT | ADR_CITY, ADR_STATE, ADR_ZIP |
| ABS Court-Ordered | This code identifies the type of court-ordered insurance that must be provided by an absent parent. | 1 | Char | T_TPL_RESOURCE | CDE_COURT_ORDER |
| ABS DOB | Absent parents date of birth | 10 | Date (MM/DD/CCYY) | T_TPL_AC_PARENT | DTE_BIRTH |
| ABS Name | This is the last name, first name, middle initial of the member's absent or custodial parent. | 28 | Char | T_TPL_AC_PARENT | NAM_LAST, NAM_FIRST, NAM_MID_INIT |
| ABS SC | This is the Military status of the absent parent. Recommended values are 'A' - Active, 'D' - 100% DAV, 'E' - MEPCOM Enlistee, 'N' - National Guard, 'R' - Retired, 'V' - Reserve, 'X' - Other, 'Z' - Unknown, Space - Not Military | 2 | Char | T_TPL_AC_PARENT | CDE_MILITARY_STATUS |
| ABS SSN | This is the absent parent's Social Security number. | 9 | Char | T_TPL_AC_PARENT | NUM_SSN |
| ABS-Parent | This field is used to describe the type of absent parent. Recommended values are as follows: 'A' = ABSENT PARENT; 'C' = CUSTODIAL PARENT | 1 | Char | T_TPL_AC_PARENT | CDE |
| Add-Dt | The date the segment was added to the file. | 10 | Date | T_TPL_RESOURCE | DTE_ADDED |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|---------------|---|--------|----------------------|-------------------|---------------------|
| Address | The street address of the policy holder. | 55 | Char | T_TPL_CARRIER | ADR_MAIL_STR T1 |
| As of Date | The last date of the period for which the report was produced. | 10 | Date | n/a | Calculated |
| Birth | The birth date of the member. | 10 | Date | T_RS_SELECT_RECIP | DTE_BIRTH |
| C Ex DOT | Contains the date that this record was last changed to help support audit trail research. | 10 | Date (MM/DD/CCYY) | T_COVERAGE_XREF | DTE_LAST_CHANGE |
| CV | The coverage type code. | 2 | Char | T_COVERAGE_XREF | CDE_COVERAGE |
| CV Add Date | This is the date the resource was originally added to the system. | 10 | Date (MM/DD/CCYY) | T_TPL_RESOURCE | DTE_ADDED |
| CV Begin | The coverage type begin date. | 10 | Date | T_COVERAGE_XREF | DTE_EFFECTIVE |
| CV Copayment | This is the coinsurance amount that a member is responsible for on a specific coverage type of a policy. | 8 | Number | T_TPL_COIN_DED | AMT_CO_PAY |
| CV Cov DOT | Contains the date that this record was last changed to help support audit trail research. | 10 | Date (MM/DD/CCYY) | T_TPL_RESOURCE | DTE_LAST_CHANGE |
| CV Deductible | This is the individual deductible amount a member is responsible for on a specific coverage type of a policy. | 9 | Number | T_TPL_COIN_DED | AMT_DEDUCT_I NDV |
| CV End | The coverage type end date. | 10 | Date | T_COVERAGE_XREF | DTE_END |
| Carrier ID | The carrier identification number of the policy. | 7 | Char | T_TPL_CARRIER | CDE_CARRIER |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|--------------------|--|--------|-----------|--------------------|---|
| City | The policy holder's city, state, and zip. | 40 | Char | T_TPL_CARRIER | ADR_MAIL_CITY, ADR_MAIL_STATE, ADR_MAIL_ZIP |
| Court Ordered | The court-ordered indicator code. | 1 | Char | T_TPL_RESOURCE | CDE_COURT_ORDER |
| Date-of-Last-Trans | The date the last update was made to the file. | 10 | Date | T_CA_ICN | DTE_PAID |
| Death | The member's date of death. | 10 | Date | T_RS_SELECT_RECEIP | DTE_DEATH |
| EX | This indicates if a member TPL has been exhausted. | 1 | Char | T_COVERAGE_XREF | IND_EXHAUST |
| End Date | The date the policy expires. | 10 | Date | T_TPL_RESOURCE | DTE_END |
| For Sample # | The QC number assigned to the claim. | 9 | Char | T_RS_SELECT_RSLT | SAK_REQUEST |
| Grp-Numr | The group number to which the member belongs. | 16 | Char | T_TPL_RESOURCE | NUM_GROUP |
| Member ID | The Medicaid identification number for the member. | 12 | Char | T_RS_SELECT_RECEIP | ID_MEDICAID |
| Name | The first and last name of the member. | 36 | Char | T_RS_SELECT_RECEIP | NAM_LAST, NAM_FIRST, NAM_MID_INIT |
| Orig Member ID | The original member identification number. | 12 | Char | T_RS_SELECT_RECEIP | ID_MEDICAID |
| PolHldr | The name of the policy holder. | 29 | Char | T_RE_BASE_DN | NAM_LAST, NAM_FIRST, NAM_MID_INIT |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-------------------|--|--------|-----------|--------------------|-----------------|
| PolHldr SSN | The policy holder's Social Security Number. | 9 | Char | T_RE_BASE_DN | NUM_SSN |
| Policy Begin Date | The date the policy coverage begins. | 10 | Date | T_TPL_RESOURCE | DTE_EFFECTIVE |
| Policy Num | The policy number. | 16 | Char | T_TPL_RESOURCE | NUM_TPL_POLICY |
| Rel Code | The policy holder's relationship code. | 2 | Char | T_TPL_RESOURCE | CDE_RELATION |
| Seg-Trn | The date this segment was last updated. | 10 | Date | T_TPL_RESOURCE | DTE_LAST_CHANGE |
| Sex | The sex of the member. | 1 | Char | T_RS_SELECT_RECEIP | CDE_SEX |
| Type | The policy type code. | 2 | Char | T_TPL_RESOURCE | CDE_POLICY_TYPE |
| User | The user identification number of the clerk responsible for the last update. | 8 | Char | T_RESULT | ID_RQST_BY |

6.1.8.5 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.9 QAA Contract Monitoring Other Services

The CM Other Services report list claims selected for processing accuracy assessment by system-assigned Quality Control (QC) number. This report is for Stratum 300 which contains only other individual practitioners, clinics, and services.

6.1.9.1 Technical Name

QAA Contract Monitoring Other Services

6.1.9.2 Sort Order

QC Number

For readability, the layout displays on the next page.

6.1.9.3 QAA Contract Monitoring Other Services Layout

QAA Contract Monitoring Other Services Report Layout

| | | |
|---------------------|---|----------------------|
| Report : QAA-5003-M | COMMONWEALTH OF KENTUCKY | Run Date: 07/24/2006 |
| Process : QAAJM503 | MEDICAID MANAGEMENT INFORMATION SYSTEM | Run Time: 14:40:54 |
| Location: QAAP5003 | QA&A Contract Monitoring Other Services | Page: 1 |

| QC NUMBER | ICN | MEMBER NAME | MEMBER ID | BILLING PROVIDER NUMBER | FIRST DATE OF SERVICE | ADJUDICATION DATE | PAID AMOUNT |
|-----------|---------------|-------------------|-----------|-------------------------|-----------------------|-------------------|---------------|
| 1 | 2003161600715 | ABCDEFGHIJABCDE A | 000001394 | 200307299A | 02/12/2001 | 02/24/2005 | \$99999999.99 |
| 2 | 2005055600029 | NANCY ROSE | 000002453 | 1000000394 | 05/21/2004 | 02/24/2005 | \$136.25 |
| 3 | 2005063050085 | ZELDA B WATERS | 000001346 | 1000000153 | 08/01/2004 | 03/08/2005 | \$178.62 |
| 4 | 2003260600029 | VICTOR D SMITH | 000001419 | 200308419A | 07/01/2003 | 02/24/2005 | \$13.11 |
| 5 | 2003309600001 | DEBBIE JAMES | 000001399 | 1000000394 | 08/17/2003 | 02/24/2005 | \$24.00 |
| 6 | 2003142600492 | HANK R HALL | 000002468 | 200307299A | 11/11/2000 | 02/24/2005 | \$85.00 |
| 7 | 2003260600094 | RICK S ROSE | 000001291 | 200308409A | 04/01/2003 | 02/24/2005 | \$79.00 |
| 8 | 2005082050096 | JANET B ANDERSON | 000001308 | 200308680A | 09/02/2004 | 03/24/2005 | \$78.58 |
| 9 | 2005076050067 | JANET B ANDERSON | 000001308 | 200308680A | 09/02/2004 | 03/22/2005 | \$78.58 |
| 10 | 2005113600471 | MIKE H GATES | 1868 | 1000000837 | 03/15/2005 | 04/25/2005 | \$3.11 |
| 11 | 2003255600672 | PAM D SMITH | 000002375 | 1000000406 | 09/03/2003 | 02/24/2005 | \$21.37 |
| 12 | 2003269767732 | ANDY WATERS | 000002383 | 1000000394 | 10/21/2002 | 02/24/2005 | \$42.72 |
| 13 | 2003311600020 | PAM D WATERS | 000001265 | 1000000394 | 11/07/2002 | 02/24/2005 | \$25.00 |
| 14 | 2005095600034 | JANET W TYLER | 000040787 | 1000000008 | 01/25/2005 | 04/05/2005 | \$13.11 |
| 15 | 2003309600005 | DEBBIE JAMES | 000001399 | 1000000394 | 08/01/2003 | 02/24/2005 | \$49.00 |
| 16 | 2003269767719 | SAM BILLS | 000002387 | 1000000394 | 09/21/2002 | 02/24/2005 | \$63.96 |
| 17 | 2005117600188 | JILL BONNER | 000041889 | 1000000320 | 02/07/2005 | 04/27/2005 | \$311.72 |
| 18 | 2003167600001 | EDDIE D JAMES | 000001351 | 1000000020 | 04/30/2003 | 02/24/2005 | \$52.09 |
| 19 | 2005055050015 | HANK SMITH | 000001392 | 200307419A | 10/07/2004 | 02/24/2005 | \$640.57 |
| 19 | 2005055050015 | HANK SMITH | 000001392 | 200307419A | 10/07/2004 | 02/24/2005 | \$72.51 |
| 20 | 2005110600453 | RICK VINE | 000002446 | 200305539A | 04/17/2005 | 04/20/2005 | \$8.00 |
| 21 | 2003255600062 | LYLE FILCH | 000002418 | 1000000332 | 09/01/2003 | 02/24/2005 | \$25.00 |
| 22 | 2003142600361 | CINDY J ROSE | 000002512 | 1000001555 | 01/13/2001 | 02/24/2005 | \$226.02 |
| 23 | 2005101600160 | SAM ROSE | 000001843 | 200306599A | 01/29/2005 | 04/12/2005 | \$20.00 |
| 24 | 2003147002007 | RICK HALL | 000001357 | 1000000069 | 08/04/2002 | 02/24/2005 | \$7.09 |
| 25 | 2205080600007 | OSCAR MITCHEL | 000001389 | 1000000371 | 07/15/2001 | 03/22/2005 | \$130.00 |
| 26 | 2005110600645 | ZELDA B WATERS | 000001346 | 1000000698 | 03/02/2005 | 04/20/2005 | \$13.11 |
| 27 | 2003142601150 | HANK W SMITH | 000001261 | 1000000064 | 07/07/2001 | 02/24/2005 | \$16.73 |
| 28 | 2205178050001 | SAM SMITH | 000040235 | 1000000508 | 09/09/2004 | 06/28/2005 | \$16.48 |
| 29 | 2005055600059 | GREG J COX | 000002388 | 100760599B | 04/15/2004 | 02/24/2005 | \$2.89 |
| 30 | 2003142600640 | JANET C MITCHEL | 000001341 | 1000000371 | 05/02/2001 | 02/24/2005 | \$62.64 |
| 30 | 2003142600640 | JANET C MITCHEL | 000001341 | 1000000371 | 05/22/2001 | 02/24/2005 | \$62.64 |
| 31 | 2003190600171 | MIKE MITCHEL | 000002447 | 200308409A | 05/01/2003 | 02/24/2005 | \$30.00 |
| 32 | 2003190600141 | WILLIAM N WATERS | 000001383 | 200308419A | 07/08/2003 | 02/24/2005 | \$15.00 |
| 33 | 2003142600150 | KIM J COX | 000002359 | 1000000188 | 06/05/2001 | 02/24/2005 | \$22.35 |
| 34 | 2003259600118 | VICTOR D SMITH | 000001419 | 200308419A | 12/30/2001 | 02/24/2005 | \$12.88 |
| 35 | 2003142600405 | JANET GATES | 000002457 | 1000000069 | 06/06/2002 | 02/24/2005 | \$474.00 |
| 36 | 2005095600421 | CINDY LANE | 000039963 | 1000000177 | 08/25/2004 | 04/05/2005 | \$10.00 |
| 37 | 2003311600001 | PAM D WATERS | 000001265 | 1000000394 | 10/31/2003 | 02/24/2005 | \$25.00 |
| 38 | 2003142600009 | HANK W SMITH | 000001261 | 1000001555 | 02/19/2001 | 02/24/2005 | \$15.73 |
| 38 | 2003142600009 | HANK W SMITH | 000001261 | 1000001555 | 02/20/2001 | 02/24/2005 | \$15.73 |
| 39 | 2003190600170 | MIKE MITCHEL | 000002447 | 200308409A | 02/15/2003 | 02/24/2005 | \$30.00 |
| 40 | 2205096600001 | MIKE H GATES | 1868 | 1000000837 | 03/01/2005 | 04/07/2005 | \$12.11 |
| 41 | 2003142601043 | ABCDEFGHIJABCDE A | 000001394 | 1000000137 | 03/29/2001 | 02/24/2005 | \$744.99 |

6.1.9.4 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-------------------------|---|--------|----------------------|-------------------|---|
| Adjudication Date | The date the claim adjudicated. | 10 | Date | T_RS_SELECT_RSLT | DTE_PAID |
| As of Date | The date as of which the report is generated | 10 | Date (MM/DD/CCYY) | T_RS_SELECT | DTE_HIST_TO |
| Beginning QC Number | The first QC number assigned to the first selected claim. | 9 | Char | T_RS_SELECT_RSLT | SEQ_RANDOM |
| Billing Provider Number | The billing provider number from the claim. | 15 | Char | T_RS_SELECT_RSLT | ID_PROV_BILL |
| Claims Universe | The total number of claim history records which met the criteria for the selection. | 4 | Number | T_RS_SELECT | CNT_CRITERIA |
| Ending QC Number | The last QC number assigned to the last selected claim. | 9 | Char | T_RS_SELECT_RSLT | SEQ_RANDOM |
| First Date of Service | The first date of service from the claim. | 10 | Date | T_RS_SELECT_RSLT | DTE_FIRST_SVC |
| ICN | The transaction control number of the selected claim. | 13 | Char | T_RS_SELECT_RSLT | NUM_ICN |
| Member ID | The Medicaid identification number for the member. | 12 | Char | T_RS_SELECT_RECIP | ID_MEDICAID |
| Member name | The full member name | 29 | Char | T_RS_SELECT_RECIP | NAM_LAST, NAM_FIRST, NAM_MID_INIT |
| Paid Amount | The reimbursement amount from the claim. | 12 | Number | T_RS_SELECT_RSLT | AMT_PAID |
| QC Number | The QC number assigned to the randomly pulled claim by the system. | 9 | Char | T_RS_SELECT_RSLT | SEQ_RANDOM |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|----------------------|--|--------|-----------|-------------|---------------|
| Total Claims Sampled | The number of claims chosen for the selection. | 9 | Number | T_RS_SELECT | CNT_RESULT |

6.1.9.5 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.10 QAA Contract Monitoring PRO Review Display

The QAA Contract Monitoring Peer Review Organization (PRO) Review Display report displays the data from the PRO Review Data Display Panel 1 for the claims pulled in the Contract Monitoring Stratum 100 selection (Hospital Services).

6.1.10.1 Technical Name

QAA Contract Monitoring PRO Review Display

6.1.10.2 Sort Order

For Sample Number

For readability, the layout displays on the next page.

6.1.10.3 QAA Contract Monitoring PRO Review Display Layout

QAA Contract Monitoring PRO Review Display Report Layout

| | | | | | | | | |
|------------------------|---|----------------------|-------------------|-----------|---------|-----------|------------------|------------|
| Report : QAA-6801-M | COMMONWEALTH OF KENTUCKY | Run Date: 08/23/2006 | | | | | | |
| Process : QAAJM681 | MEDICAID MANAGEMENT INFORMATION SYSTEM | Run Time: 13:39:32 | | | | | | |
| Location: QAAP6801 | Contract Monitoring PRO Review Display Report | Page: 1 | | | | | | |
| | As of Date: 12/31/2005 | | | | | | | |
| For Sample # HOSP59 | | | | | | | | |
| Member Id : 000040075 | Name : TIM ROSE J | | | | | | | |
| Birth Date : 17-DEC-84 | Sex : M | | | | | | | |
| Line No. | Reference Number | Provider No | Date of Admission | Days Stay | PRO IND | Add Date | Date of Last Txn | Srcce Code |
| A | 5005090001 | 051000000515 | 15-MAR-04 | 1 | 04 | 31-MAR-05 | 06/14/2006 | 2 |
| For Sample # HOSP83 | | | | | | | | |
| Member Id : 000001841 | Name : PAM ROSE | | | | | | | |
| Birth Date : 01-OCT-89 | Sex : M | | | | | | | |
| Line No. | Reference Number | Provider No | Date of Admission | Days Stay | PRO IND | Add Date | Date of Last Txn | Srcce Code |
| A | 5002162000 | 011000000360 | 01-OCT-10 | 0 | 24 | 11-JUN-02 | - | 2 |
| For Sample # HOSP85 | | | | | | | | |
| Member Id : 000001841 | Name : PAM ROSE | | | | | | | |
| Birth Date : 01-OCT-89 | Sex : M | | | | | | | |
| Line No. | Reference Number | Provider No | Date of Admission | Days Stay | PRO IND | Add Date | Date of Last Txn | Srcce Code |
| A | 5002162000 | 011000000360 | 01-OCT-10 | 0 | 24 | 11-JUN-02 | - | 2 |
| *** END OF REPORT *** | | | | | | | | |

6.1.10.4 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-------------------|---|--------|-----------|----------------------------------|---|
| Date of last tx | The date of the last transaction update to the segment. | 10 | Date | A_T_PA_LINE_ITEM | DTE_SYSDATE |
| Medicaid ID | The Medical Assistance identification number of the claim whose PRO codes are reported. | 12 | Char | T_RS_SELECT_RSLT | ID_MEDICAID |
| Name | The member's last and first names. | 38 | Char | T_RS_SELECT_RECIP | NAM_LAST, NAM_FIRST, NAM_MID_INIT |
| Add date | The date the segment was added to the file. | 10 | Date | T_PA_PAUTH_DN | DTE_PA_KEYED |
| Birth date | The member's birth date | 10 | Date | T_RS_SELECT_RECIP | DTE_BIRTH |
| Date of admission | The admit date for the PRO approved stay. | 10 | Date | T_PA_LINE_ITEM | DTE_PA_AUTH_EFF |
| Days stay | The number of approved days for the hospital stay. | 8 | Number | T_PA_LINE_ITEM | QTY_UNT_SVC_AT H |
| Line no | The line number from the member's PRO Review Data Display Screen 1. | 2 | Number | T_PA_LINE_ITEM | NUM_PA_LINE_ITEM |
| Pro ind | The approved PRO indicator code. | 1 | Char | T_PA_PAUTH_DN | CDE_PA_ASSIGN |
| Provider # | The 2-digit provider type followed by the 8-digit provider number. | 17 | Char | T_RS_SELECT_RSLT | CDE_PROV_TYPE, ID_PROV_BILL |
| Reference number | The PRO reference number for the line item. | 10 | Char | T_RS_SELECT_RSLT | NUM_PRIOR_AUTH |
| Sample # | The request ID along with the sequence number assigned to the sample | 8 | Char | T_RS_SELECT, T_RS_SELECT_RSLT | ID_RQST_BY, SEQ_RANDOM |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|--|--------|-----------|-------------------|----------------|
| Sex | The member's sex. | 1 | Char | T_RS_SELECT_RECIP | CDE_SEX |
| Srce code | The code indicating the source of the PRO segment. | 1 | Char | T_PA_PAUTH_DN | CDE_MEDIA_TYPE |

6.1.10.5 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.10.6 QAA Contract Monitoring Prescribed Drugs

The CM Prescribed Drugs report lists, by system-assigned QC number, claims selected for processing accuracy assessment. This report is for Stratum 400 which contains only prescribed drug claims.

6.1.10.7 Technical Name

QAA Contract Monitoring Prescribed Drugs

6.1.10.8 Sort Order

QC Number

For readability, the layout displays on the next page.

6.1.10.9 QAA Contract Monitoring Prescribed Drugs Layout

QAA Contract Monitoring Prescribed Drugs Report Layout

| | | |
|---------------------|---|----------------------|
| Report : QAA-5004-M | COMMONWEALTH OF KENTUCKY | Run Date: 07/24/2006 |
| Process : QAAJM504 | MEDICAID MANAGEMENT INFORMATION SYSTEM | Run Time: 14:40:59 |
| Location: QAAP5004 | QA&A Contract Monitoring Prescribed Drugs | Page: 1 |

| QC NUMBER | ICN | MEMBER NAME | MEMBER ID | BILLING PROVIDER NUMBER | FIRST DATE OF SERVICE | ADJUDICATION DATE | PAID AMOUNT |
|-----------|---------------|---|-----------|-------------------------|-----------------------|-------------------|--------------|
| 1 | 2005083130012 | ABCDEFGHIJABCDEF A ABCDEFGHIJABCDEFGHIJ | 000041450 | 1000001020 | 01/21/2004 | 03/24/2005 | \$9999999.99 |
| 2 | 2005076300039 | OSCAR A SMITH | 000041247 | 200307329A | 04/13/2003 | 03/22/2005 | \$24.00 |
| 3 | 2005097300093 | ANDY TYLER | 000041578 | 1000000354 | 11/04/2004 | 04/08/2005 | \$509.76 |
| 4 | 2005098300022 | TAMMY G SEDGWICK | 000941888 | 100714379 | 03/05/2005 | 04/08/2005 | \$47.88 |
| 5 | 2005077130001 | ZELDA B WATERS | 000001346 | 1000000354 | 03/01/2005 | 03/22/2005 | \$65.00 |
| 6 | 2005080300085 | ZELDA B WATERS | 000001346 | 1000000354 | 02/01/2005 | 03/22/2005 | \$25.30 |
| 7 | 5205109001007 | ANDY TYLER | 000041578 | 1000000354 | 11/15/2004 | 04/19/2005 | \$405.93 |
| 8 | 2005055300026 | SAM GATES | 000002424 | 200307329A | 04/03/2003 | 02/24/2005 | \$23.00 |
| 9 | 2003262300004 | JANET D SMITH | 000001832 | 200307329A | 07/06/2003 | 02/24/2005 | \$24.00 |
| 10 | 2003238300002 | JANET B WATERS | 000001462 | 200307329A | 07/16/2002 | 02/24/2005 | \$18.00 |
| 11 | 2005055300025 | TIM BILLS | 000039898 | 200307329A | 04/03/2003 | 02/24/2005 | \$23.00 |
| 12 | 2005111300057 | RICK C COX | 000040632 | 200307329A | 01/02/2005 | 04/21/2005 | \$498.00 |
| 13 | 2003150130006 | OSCAR MITCHEL | 000001389 | 200307329A | 05/05/2003 | 02/24/2005 | \$231.74 |
| 14 | 2004219300093 | LYLE J KNIGHT | 000001866 | 200307329A | 02/05/2003 | 02/24/2005 | \$9.00 |
| 15 | 2003262300002 | JANET D SMITH | 000001832 | 200307329A | 04/06/2003 | 02/24/2005 | \$24.00 |
| 16 | 2003309130002 | DEBBIE JAMES | 000001401 | 200307329A | 03/15/2003 | 02/24/2005 | \$3.06 |
| 17 | 2005068130010 | ABCDEFGHIJABCDEF A ABCDEFGHIJABCDEFGHIJ | 000041450 | 1000001020 | 10/21/2004 | 03/10/2005 | \$2.90 |
| 18 | 2005111300053 | HANK T MITCHEL | 000001266 | 1000001082 | 04/26/2004 | 04/21/2005 | \$1.11 |
| 19 | 2005091300022 | TIM J ROSE | 000040075 | 200307329A | 03/05/2005 | 04/04/2005 | \$1049.85 |
| 20 | 2005064130043 | BILLY ROSE | 000001381 | 1000001020 | 09/21/2004 | 03/08/2005 | \$0.52 |
| 21 | 2005074300105 | JANET A COX | 000040374 | 1000001074 | 06/03/2004 | 03/17/2005 | \$24.00 |
| 22 | 2005145300039 | ABCDEFGHIJABCDEF A ABCDEFGHIJABCDEFGHIJ | 888800043 | 1000000354 | 05/01/2005 | 05/26/2005 | \$489.09 |
| 23 | 2004219300097 | PAM ROSE | 000001841 | 200307329A | 02/05/2003 | 02/24/2005 | \$24.00 |
| 24 | 2003237300002 | OSCAR MITCHEL | 000001389 | 200307329A | 07/16/2002 | 02/24/2005 | \$33.00 |
| 25 | 2005109300046 | RICK C COX | 000040632 | 200307329A | 03/15/2005 | 04/19/2005 | \$980.17 |
| 26 | 2004219300105 | JANET J BILLS | 000001889 | 200307329A | 02/25/2003 | 02/24/2005 | \$34.00 |
| 27 | 2004219300063 | DEBBIE A SMITH | 000001294 | 1000000364 | 07/01/2001 | 02/24/2005 | \$4.00 |
| 28 | 2003147300013 | CINDY WATERS | 000001934 | 200307329A | 04/01/2003 | 02/24/2005 | \$19.00 |
| 29 | 2005076300050 | CINDY GATES | 000041256 | 200307329A | 04/03/2003 | 03/22/2005 | \$24.00 |
| 30 | 2005055300022 | LYLE LANE | 000041504 | 200307329A | 04/03/2003 | 02/24/2005 | \$23.00 |
| 31 | 2005098300037 | SORROS GEORGE | 888800040 | 100714379 | 03/05/2005 | 04/08/2005 | \$47.88 |
| 32 | 2005069300117 | TIM J ROSE | 000040075 | 200307329A | 04/20/2004 | 03/15/2005 | \$163.00 |
| 33 | 2005061300036 | RICK C WATERS | 000001824 | 100714379 | 02/27/2005 | 03/03/2005 | \$47.88 |
| 34 | 5205119001001 | ZELDA B WATERS | 000001346 | 200305619A | 08/21/2004 | 04/29/2005 | \$12.00 |
| 35 | 2005064130054 | BILLY ROSE | 000001381 | 1000001020 | 09/21/2004 | 03/08/2005 | \$0.52 |
| 36 | 2003262300007 | JANET D SMITH | 000001832 | 200307329A | 09/06/2003 | 02/24/2005 | \$24.00 |
| 37 | 2004219300096 | SAM D ROSE | 000001834 | 200307329A | 02/05/2003 | 02/24/2005 | \$9.00 |
| 38 | 2005111300168 | ZELDA B WATERS | 000001346 | 1000000354 | 03/15/2005 | 04/22/2005 | \$17.63 |
| 39 | 2003262300008 | JANET D SMITH | 000001832 | 200307329A | 01/06/2003 | 02/24/2005 | \$24.00 |
| 40 | 2005104300057 | ANDY TYLER | 000041578 | 1000000354 | 11/30/2004 | 04/14/2005 | \$489.09 |
| 41 | 2005098300071 | SORROS GEORGE | 888800040 | 100714379 | 02/05/2005 | 04/08/2005 | \$47.88 |
| 42 | 2505069130008 | CINDY C BILLS | 000040247 | 1000000354 | 05/15/2004 | 03/10/2005 | \$1.35 |
| 43 | 2005109300049 | RICK C COX | 000040632 | 200307329A | 03/30/2005 | 04/19/2005 | \$0.35 |
| 44 | 2005137300062 | HUBERT HUBBLE | 000088830 | 1000000354 | 11/30/2004 | 05/19/2005 | \$489.09 |
| 45 | 2003183300003 | LYLE VINE | 000001380 | 200307329A | 03/06/2003 | 02/24/2005 | \$24.00 |
| 46 | 2004219300095 | PAM ROSE | 000001841 | 200307329A | 05/05/2003 | 02/24/2005 | \$231.74 |

6.1.10.10 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-------------------------|---|--------|-----------|-------------------|---|
| Adjudication Date | The date the claim adjudicated. | 10 | Date | T_RS_SELECT_RSLT | DTE_PAID |
| As of | The last date of the period for which the report was produced. | 10 | Date | T_RS_SELECT | DTE_HIST_TO |
| Beginning QC Number | The first QC number assigned to the first selected claim. | 9 | Number | T_RS_SELECT_RSLT | SEQ_RANDOM |
| Billing Provider Number | The billing provider number from the claim. | 15 | Char | T_RS_SELECT_RSLT | ID_PROV_BILL |
| Claims Universe | The total number of claim history records which met the criteria for the selection. | 9 | Number | T_RS_SELECT | NUM_POPULATION |
| Ending QC Number | The last QC number assigned to the last selected claim. | 9 | Number | T_RS_SELECT_RSLT | SEQ_RANDOM |
| First Date of Service | The first date of service from the claim. | 10 | Date | T_RS_SELECT_RSLT | DTE_FIRST_SVC |
| ICN | The transaction control number of the selected claim. | 13 | Char | T_RS_SELECT_RSLT | NUM_ICN |
| Member ID | The Medicaid identification number for the member. | 12 | Char | T_RS_SELECT_RECIP | ID_MEDICAID |
| Member Name | The full member name. | 29 | Char | T_RS_SELECT_RECIP | NAM_LAST, NAM_FIRST, NAM_MID_INIT |
| Paid Amount | The reimbursement amount from the claim. | 12 | Number | T_RS_SELECT_RSLT | AMT_PAID |
| QC Number | The QC number assigned to the randomly pulled claim by the system. | 9 | Char | T_RS_SELECT_RSLT | SEQ_RANDOM |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|----------------------|--|--------|-----------|-------------|---------------|
| Total Claims Sampled | The number of claims chosen for the selection. | 9 | Number | T_RS_SELECT | CNT_RESULT |

6.1.10.11 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.11.4 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|----------------|--|--------|-----------|--------------------|--|
| (Drug) Max Age | This is a number used to indicate the upper value in an age range. It is the maximum member age that is valid and is entered in number of years. | 4 | Number | T_DRUG_LIMITS | QTY_AGE_MAX |
| (Drug) Min Age | This is a number used to indicate the lower value in an age range. It is the minimum member age that is valid and is entered in number of years. | 4 | Number | T_DRUG_LIMITS | QTY_AGE_MIN |
| (Proc) Max Age | The maximum age a member may be to receive the procedure. | 4 | Number | T_PROC_LIMITS | QTY_AGE_MAX |
| (Proc) Min Age | The minimum age a member may be to receive the procedure. | 4 | Number | T_PROC_LIMITS | QTY_AGE_MIN |
| Abortion | Abortion | 1 | Char | T_PROC_GROU P | Derived - if proc sak type = 57, then 'Y' |
| Brand Name | This field is a combination of the drug name appearing on the package label, the strength description and the dosage form description. The field size is 30 Characters but is edited to fit within a maximum length of 27. | 30 | Char | T_DRUG_DN | DSC_NDC |
| DEA Ind | The Drug Enforcement Administration Code denotes the degree of potential abuse and Federal control of a drug. It is subject to change by Federal regulation. The current code list is: 0, 1, 2, 3, 4, 5 with 0 being the highest risk for abuse. | 1 | Char | T_DRUG_DN | CDE_DEA |
| Diag Data | Subtitle | 1 | Char | N/A | N/A |
| Dose Form | An abbreviated two-byte code (GCDF on NDDF update) is available for applications. Users may request the code in addition to or instead of the description. | 2 | Char | T_GENERIC_DR UG | CDE_DOSAGE_FOR M |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-----------|---|--------|-----------|------------------|---|
| Drg Mnt | This will indicate that the drug is required for "maintaining" health and as such provisions have been made to provide the drug in quantities greater than the standard 30-day or monthly supply. | 1 | Char | T_DRUG_LIMITS | IND_DRUG_MAINT |
| EPSDT | EPSDT Indicator | 1 | Char | T_PROC_GROU P | Derived - if proc sak type = 76, then 'Y' |
| Edit Type | Code that indicates whether and what type of editing is to be performed in claims processing on the procedure/diagnosis compatibility groupings. An 'N' indicates not editing is to be performed. An 'I' (Include) indicates only diagnosis codes on the diagnosis compatibility groups listed are acceptable. An 'E' (Exclude) indicates the diagnosis codes in the listed diagnosis compatibility groups cannot be billed with the procedure. | 1 | Char | T_PROC_LIMITS | CDE_DIAG_CMPT_E DIT |
| Fam Plan | Indicates that the Procedure code relates to Family Planning. | 1 | Char | T_PROC_GROU P | Derived - if proc sak type = 135, then 'Y' |
| Fam/Pln | Identifies classification type of the limits placed on a drug. These classifications may be Family Planning (F) or Vaccine (V), Insulin (I), Supply (S), Nutritional (N), Class 1A (1), Anorexic (A), Smoking Cessation (C), Fertility Enhancements (E) or Minoxidil (M). | 1 | Char | T_DRUG_LIMITS | CDE |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|--------------|--|--------|-----------|----------------|---|
| Generic Code | The Generic Code Number Sequence Number (GCN_SEQNO) is a unique number representing a generic formulation. Like the GCN, it is specific to the generic ingredient(s), route of administration, and drug strength. Both are the same across manufacturers and/or package sizes. Unlike the GCN, which in some cases may have the same value for different dosage forms, the GCN_SEQNO is specific to its dosage form. | 7 | Char | T_GENERIC_DRUG | NUM_FORMULATION |
| Generic Name | The first field (30 Characters) is the generic drug name, the next is the route description (10), the next is the dosage form (10) and the last is the drug strength description (10). These fields are each separated by a space, for a total of 3 spaces. | 30 | Char | T_GENERIC_DRUG | NAM_DRUG_GENERIC |
| HCFA Unit | CMS Units Per Package Size indicates the number of units per package as supplied on the Centers for Medicare and Medicaid Services' (CMS) quarterly update. This column must be used in conjunction with the CMS Unit Type Indicator to determine the appropriate number of units. Information in this column is provided by CMS and may vary from the First DataBank Package Size and Drug Form Code | 11 | Number | T_DRUG_DN | NUM_HCFA_PS |
| Hyster | This is an indicator that defines that a service is related to a hysterectomy. | 1 | Char | T_PROC_GROUP | Derived - if proc sak type = 58, then 'Y' |
| Innov | This field identifies the original innovator product for a particular generic code number. Values are: (0) =Default - non innovator drug; (1) =Innovator - held original patent. It is possible to have more than one product to appear to be the innovator. | 1 | Char | T_DRUG_DN | IND_DRUG_INNOV |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|--------------|--|--------|-----------|-------------------|-------------------|
| Legend | The Drug Source Code differentiates single source from multiple source drugs. The current codes are: 1 - Multiple sources & 2 - Single source. Note that this field does not distinguish between the "innovator" products and its substitutes. | 1 | Char | T_DRUG_DN | CDE_DRUG_SOURCE |
| Maid | The member Medical Assistance identification number. | 12 | Char | T_RS_SELECT_RECIP | ID_MEDICAID |
| Manufacturer | This is the name of the distributor as listed on the drug label or as indicated by the NDC code. It does not necessarily identify the actual drug fabricator. | 30 | Char | T_DRUG_MANUF | NAM_DRUG_MANUF |
| Max Days | The maximum number of days a prescribed drug should last a Medicaid member from the date it is dispensed. | 4 | Number | T_DRUG_LIMITS | QTY_DAYS_SPLY_MAX |
| Max Qty | The maximum quantity of the drug which can be dispensed. The default value is 100. | 5 | Number | T_DRUG_LIMITS | QTY_SUPPLY_MAX |
| Min Days | The minimum number of days a prescribed drug should last a Medicaid member from the date it is dispensed. | 4 | Number | T_DRUG_LIMITS | QTY_DAYS_SPLY_MIN |
| Min Qty | The minimum quantity of the drug which can be dispensed. The default value is 1. | 5 | Number | T_DRUG_LIMITS | QTY_SUPPLY_MIN |
| Once/Life | Indicates if a procedure can only occur once in the lifetime of a member. | 1 | Char | T_PROC_LIMITS | IND_LIFETIME |
| Pkg Qty: | This field contains the metric quantity used to derive a unit price. It is the usual labeled quantity from which the pharmacist dispenses, such as 100 tablets, 1000 capsules, 20 ml vial, etc. | 11 | Number | T_DRUG_DN | QTY_DRUG_PACK_SZ |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|--|---|--------|-----------|------------------|---|
| Post Op | This field represents the number of days before an E&M (visit) procedure can be paid, since it was included as part of the original surgery that was performed. This field is three bytes in length. | 1 | Char | T_PROC_LIMITS | QTY_FOLLOWUP |
| Proc Name | A short medical description of a specific, singular medical or dental service which is performed for the express purpose of identification or treatment of the patient's condition. | 40 | Char | T_PROC | DSC_PROCEDURE |
| Procedure Code | This field contains the procedure code or drug code billed on the Contract Monitoring audit claim. | 11 | Char | T_RS_SELECT_RSLT | CDE_PROC, CDE_NDC |
| Procedure/Drug Display For Sample *** -> | The QC number assigned to the claim. | 6 | Char | T_RS_SELECT_RSLT | SEQ_RANDOM |
| Route | The Route indicates the normal site or method by which a drug is administered. On the NDDF alternate forms of the route description are available in two codes: A one-byte route code (GCRT) is available for applications where the description is transparent to the user. A two-byte route code (GCRT2) is available as an abbreviation. This is the one-byte code (GCRT). | 2 | Char | T_GENERIC_DRUG | CDE_ROUTE_ADMIN |
| Steril | Sterilization | 1 | Char | T_PROC_GROUP | Derived - if proc sak type = 59, then 'Y' |
| Strength | The Drug Strength Description (STR) is a description of drug potency in units of grams, milligrams, percentage, and other terms. Strength is expressed in metric units. This field includes needle sizes, length of devices, and release rates of transdermal patches. | 10 | Char | T_GENERIC_DRUG | DSC_STRENGTH |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-------------|--|--------|-----------|---------------|-----------------|
| Unit Dose | Marks a drug as packaged in unit doses. Unit dose is defined by FDB as all products labeled as Unit Dose by the mfr. This indicator does not apply to injectable products, suppositories, or powder packets. Current codes are: 1=Unit Dose & 0=All other. | 1 | Char | T_DRUG_DN | IND_UNIT_DOSE |
| Unit Of Use | The Unit of Use (UU) field denotes those packages which are supplied with appropriate labeling and (usually) child resistant closures and are appropriate to dispense as a unit. Valid values are: 1 = Unit of Use, 0 = All Other Products. | 1 | Char | T_DRUG_DN | IND_UNIT_OF_USE |
| Valid Sex | Indicates restriction of gender for this procedure | 1 | Char | T_PROC_LIMITS | CDE_SEX |
| Valid Sex | Identifies the gender of a person that this drug is limited to. | 1 | Char | T_DRUG_LIMITS | CDE_SEX |

6.1.11.5 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.12 QAA Contract Monitoring Sample Summary

The QAA Contract Monitoring Sample Summary report lists all the claims pulled for each of the five Contract Monitoring review stratum in Internal Control Number (ICN) order.

6.1.12.1 Technical Name

QAA Contract Monitoring Sample Summary

6.1.12.2 Sort Order

QC Number

For readability, the layout displays on the next page.

6.1.12.3 QAA Contract Monitoring Sample Summary Layout

QAA Contract Monitoring Sample Summary Report Layout

| | | |
|---------------------|---|----------------------|
| Report : QAA-6001-M | COMMONWEALTH OF KENTUCKY | Run Date: 07/24/2006 |
| Process : QAAJM601 | MEDICAID MANAGEMENT INFORMATION SYSTEM | Run Time: 14:45:05 |
| Location: QAAP6001 | Contract Monitoring Sample Summary Report | Page: 1 |

| QC Number | Medicaid Id | Warrant Number | Reimbursement Amount | Remittance Advice Number | Pay To Provider | ICN | Paid Date | Enter Date | Billed Amount |
|-----------|-------------|----------------|----------------------|--------------------------|-----------------|---------------|------------|------------|---------------|
| HOSP-1 | 000041487 | | \$99999999.99 | 0 | 200308710A | 2105106100001 | 04/18/2005 | 04/16/2005 | \$99999999.99 |
| HOSP-2 | 000002469 | | \$50.00 | 0 | 1000000335 | 2005080130019 | 03/22/2005 | 03/21/2005 | \$200.00 |
| HOSP-3 | 000001385 | | \$8127.35 | 0 | 1000000971 | 2005055100104 | 02/24/2005 | 02/24/2005 | \$15000.00 |
| HOSP-4 | 000001385 | | \$8127.35 | 0 | 1000000971 | 2205056100007 | 03/01/2005 | 02/25/2005 | \$15000.00 |
| HOSP-5 | 000040075 | | \$37.50 | 0 | 1000000515 | 5205119001020 | 04/29/2005 | 04/29/2005 | \$200.00 |
| HOSP-6 | 000002456 | | \$99.00 | 0 | 1000000069 | 2205115130002 | 04/25/2005 | 04/25/2005 | \$99.00 |
| HOSP-7 | 000002446 | | \$1.16 | 0 | 1000000515 | 2005104250042 | 04/14/2005 | 04/14/2005 | \$200.00 |
| HOSP-8 | 000002469 | | \$735.85 | 0 | 1000000971 | 2005091100025 | 04/04/2005 | 04/01/2005 | \$15000.00 |
| HOSP-9 | 000040344 | | \$3863.76 | 0 | 1000000971 | 2205068100046 | 03/10/2005 | 03/09/2005 | \$3000.00 |
| HOSP-10 | 000001261 | | \$184.80 | 0 | 1000000515 | 5205110001006 | 04/21/2005 | 04/20/2005 | \$200.00 |
| HOSP-11 | 000040632 | | \$24.88 | 0 | 1000000360 | 2005104130032 | 04/14/2005 | 04/14/2005 | \$200.00 |
| HOSP-12 | 000001297 | | \$4.95 | 0 | 200307489B | 2005112130108 | 04/22/2005 | 04/22/2005 | \$12.80 |
| HOSP-13 | 000039866 | | \$50.00 | 0 | 1000000971 | 2205111130001 | 04/21/2005 | 04/21/2005 | \$1200.00 |
| HOSP-14 | 000039888 | | \$7760.00 | 0 | 1000000981 | 2005081100004 | 03/22/2005 | 03/22/2005 | \$1200.00 |
| HOSP-15 | 000041423 | | \$8127.35 | 0 | 1000000971 | 2005091100034 | 04/04/2005 | 04/01/2005 | \$15000.00 |
| HOSP-16 | 000041423 | | \$50.00 | 0 | 1000000971 | 2005064130003 | 03/08/2005 | 03/05/2005 | \$400.00 |
| HOSP-17 | 000002431 | | \$7339.97 | 0 | 1000001297 | 2005110100140 | 04/21/2005 | 04/20/2005 | \$1100.00 |
| HOSP-18 | 000001308 | | \$6649.65 | 0 | 1000000971 | 2005069100127 | 03/15/2005 | 03/10/2005 | \$12000.00 |
| HOSP-19 | 000041348 | | \$708.00 | 0 | 1000001024 | 2205063250009 | 03/08/2005 | 03/04/2005 | \$15000.00 |
| HOSP-20 | 000041412 | | \$11779.70 | 0 | 1000000971 | 5205121001004 | 05/02/2005 | 05/01/2005 | \$13500.00 |
| HOSP-21 | 000002411 | | \$3694.25 | 0 | 1000000971 | 2005077100068 | 03/22/2005 | 03/18/2005 | \$13000.00 |
| HOSP-22 | 000002446 | | \$188.80 | 0 | 1000000515 | 2005103250069 | 04/14/2005 | 04/13/2005 | \$200.00 |
| HOSP-23 | 000002456 | | \$99.00 | 0 | 1000000069 | 2205115130001 | 04/25/2005 | 04/25/2005 | \$99.00 |
| HOSP-24 | 000039931 | | \$11779.70 | 0 | 1000000971 | 2005063100063 | 03/08/2005 | 03/04/2005 | \$13500.00 |
| HOSP-25 | 000039931 | | \$3394.90 | 0 | 1000000971 | 2005069100077 | 03/10/2005 | 03/10/2005 | \$20000.00 |
| HOSP-26 | 000041294 | | \$94.40 | 0 | 1000000358 | 2005056250036 | 03/01/2005 | 02/25/2005 | \$115.00 |
| HOSP-27 | 000001385 | | \$16185.18 | 0 | 1000000971 | 5205109001005 | 04/26/2005 | 04/19/2005 | \$8400.00 |
| HOSP-28 | 888800011 | | \$7.00 | 0 | 1000001027 | 2105108130135 | 04/19/2005 | 04/18/2005 | \$10.00 |
| HOSP-29 | 000001423 | | \$12.80 | 0 | 1000000069 | 2105055130004 | 02/24/2005 | 02/24/2005 | \$12.80 |
| HOSP-30 | 000001346 | | \$10.48 | 0 | 1000000360 | 2005108130029 | 04/18/2005 | 04/18/2005 | \$600.00 |
| HOSP-31 | 000040540 | | \$17.00 | 0 | 200305069A | 2105082130106 | 03/24/2005 | 03/23/2005 | \$20.00 |
| HOSP-32 | 000041590 | | \$18.37 | 0 | 1000000971 | 2005102130067 | 04/14/2005 | 04/12/2005 | \$72.80 |
| HOSP-33 | 000041444 | | \$2216.55 | 0 | 1000000971 | 2005113100169 | 04/25/2005 | 04/23/2005 | \$15000.00 |
| HOSP-34 | 000001384 | | \$4404.34 | 0 | 1000000971 | 2005060100056 | 03/01/2005 | 03/01/2005 | \$18000.00 |
| HOSP-35 | 000001865 | | \$10137.71 | 0 | 1000000971 | 2005116100040 | 04/26/2005 | 04/26/2005 | \$13500.00 |
| HOSP-36 | 000040014 | | \$581.69 | 0 | 1000001297 | 2005055100038 | 02/24/2005 | 02/24/2005 | \$629.69 |
| HOSP-37 | 000001297 | | \$4.95 | 0 | 1000001349 | 2005117130096 | 04/28/2005 | 04/27/2005 | \$52.80 |
| HOSP-38 | 000041493 | | \$6286.06 | 0 | 1000001037 | 2005112100010 | 04/22/2005 | 04/22/2005 | \$17000.00 |
| HOSP-39 | 000040075 | | \$197.00 | 0 | 1000000448 | 2005070130018 | 03/15/2005 | 03/11/2005 | \$200.00 |
| HOSP-40 | 000041221 | | \$735.85 | 0 | 1000000971 | 2005055100009 | 02/24/2005 | 02/24/2005 | \$1200.00 |
| HOSP-41 | 000040787 | | \$21.37 | 0 | 1000000360 | 2105105130117 | 04/15/2005 | 04/15/2005 | \$72.80 |
| HOSP-42 | 234567899 | | \$8105.13 | 0 | 1000001071 | 2005096100070 | 04/07/2005 | 04/06/2005 | \$2300.00 |
| HOSP-43 | 000002388 | | \$8094.35 | 0 | 1000000971 | 2005055100017 | 02/24/2005 | 02/24/2005 | \$15000.00 |
| HOSP-44 | 000040787 | | \$738.85 | 0 | 1000000971 | 2005102100107 | 04/12/2005 | 04/12/2005 | \$1245.00 |
| HOSP-45 | 000041444 | | \$2216.55 | 0 | 1000000971 | 2005111100093 | 04/21/2005 | 04/21/2005 | \$15000.00 |
| HOSP-46 | 000041487 | | \$13.11 | 0 | 200308710A | 2105106130091 | 04/18/2005 | 04/16/2005 | \$45.00 |
| HOSP-47 | 000002469 | | \$5876.66 | 0 | 1000000971 | 2005063100041 | 03/08/2005 | 03/04/2005 | \$16000.00 |
| HOSP-48 | 000001346 | | \$27.88 | 0 | 1000000360 | 2005111130118 | 04/22/2005 | 04/21/2005 | \$250.00 |

6.1.12.4 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|--------------------------|--|--------|-----------|------------------|----------------------|
| Billed Amount | The amount billed by the provider on the claim. | 12 | Number | T_RS_SELECT_RSLT | AMT_BILLED |
| Date Paid | The date the claim adjudicated. | 10 | Date | T_RS_SELECT_RSLT | DTE_PAID |
| Enter Date | The date the claim entered the system. | 10 | Date | T_CA_ICN | Derived from NUM_ICN |
| ICN | The transaction control number of the selected claim. | 13 | Char | T_RS_SELECT_RSLT | NUM_ICN |
| Member ID | The Medicaid identification number for the member. | 12 | Char | T_RS_SELECT_RSLT | ID_MEDICIAD |
| Pay to Provider Number | The billing provider number from the claim. | 15 | Char | T_RS_SELECT_RSLT | ID_PROV_BILL |
| QC Number | The QC number assigned to the randomly pulled claim by the system. | 9 | Char | T_RS_SELECT_RSLT | SEQ_RANDOM |
| Reimbursement Amount | The reimbursement amount from the claim. | 12 | Number | T_CA_ICN | AMT_REIMBURSED |
| Remittance Advice Number | The remittance advice number which posted final payment information to the provider. | 9 | Char | T_CA_ICN | NUM_RA |
| Warrant Number | The check number which included payment for the selected claim. | 9 | Number | T_CA_ICN | NUM_CHECK |

6.1.12.5 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.13 QAA Contract Monitoring UR Medical Criteria

The QAA Contract Monitoring Utilization Review (UR) Medical Criteria report prints the UR Criteria File parameter numbers which are associated with each procedure code billed on claims pulled for Contract Monitoring stratum 200 (Long Term Care Services) and 300 (Other Individual Practitioners, Clinics, Services and Supplies).

6.1.13.1 Technical Name

QAA Contract Monitoring UR Medical Criteria

6.1.13.2 Sort Order

For Sample Number

For readability, the layout displays on the next page.

6.1.13.3 QAA Contract Monitoring UR Medical Criteria Layout

QAA Contract Monitoring UR Medical Criteria Report Layout

| Proc Code | Diag Req | Eff Date | End Date | Life time | Fam Plan | Preg Ind | CLIA Ind | Att Ind | Sex Ind | Min Age | Max Age | Min Qty | Max Qty | Conf Ind | Follow up Qty | Prov Spec | From Thru | Diag Cmpt | |
|----------------------|----------|------------|--|--------------------|----------|----------|----------|---------|---------|---------|---------|---------|----------------------|----------|---------------|-----------|-----------|-----------|--|
| Report : QAA-7001-M | | | COMMONWEALTH OF KENTUCKY | | | | | | | | | | Run Date: 09/01/2006 | | | | | | |
| Process : QAAJM701 | | | MEDICAID MANAGEMENT INFORMATION SYSTEM | | | | | | | | | | Run Time: 14:02:51 | | | | | | |
| Location: QAAP7001 | | | Contract Monitoring UR Medical Criteria Report | | | | | | | | | | Page: 1 | | | | | | |
| | | | For Sample # LTC18 | | | | | | | | | | | | | | | | |
| Member Id: 000041397 | | | | ICN: 5205121001016 | | | | | | | | | | | | | | | |
| W3018 | Y | 01/01/1964 | 12/31/2299 | N | N | N | N | N | B | 0 | 999 | 1 | 4 | N | 0 | N | Y | N | |
| | | | For Sample # LTC19 | | | | | | | | | | | | | | | | |
| Member Id: 000041397 | | | ICN: 5205119001016 | | | | | | | | | | | | | | | | |
| W3018 | Y | 01/01/1964 | 12/31/2299 | N | N | N | N | N | B | 0 | 999 | 1 | 4 | N | 0 | N | Y | N | |
| | | | For Sample # LTC28 | | | | | | | | | | | | | | | | |
| Member Id: 000041397 | | | | ICN: 2005094150068 | | | | | | | | | | | | | | | |
| W3018 | Y | 01/01/1964 | 12/31/2299 | N | N | N | N | N | B | 0 | 999 | 1 | 4 | N | 0 | N | Y | N | |
| Report : QAA-7001-M | | | COMMONWEALTH OF KENTUCKY | | | | | | | | | | Run Date: 09/01/2006 | | | | | | |
| Process : QAAJM701 | | | MEDICAID MANAGEMENT INFORMATION SYSTEM | | | | | | | | | | Run Time: 14:02:51 | | | | | | |
| Location: QAAP7001 | | | Contract Monitoring UR Medical Criteria Report | | | | | | | | | | Page: 2 | | | | | | |
| | | | For Sample # OTHER1 | | | | | | | | | | | | | | | | |
| Member Id: 000001394 | | | | ICN: 2003161600715 | | | | | | | | | | | | | | | |
| W4539 | N | 01/01/1964 | 12/31/2299 | N | N | N | N | N | B | 0 | 999 | 1 | 1 | N | 0 | N | N | N | |
| | | | For Sample # OTHER2 | | | | | | | | | | | | | | | | |
| Member Id: 000002453 | | | | ICN: 2005055600029 | | | | | | | | | | | | | | | |
| 72240 | N | 01/01/1964 | 12/31/2299 | N | N | N | N | N | B | 0 | 999 | 1 | 7 | N | 0 | N | Y | N | |
| | | | For Sample # OTHER3 | | | | | | | | | | | | | | | | |
| Member Id: 000001346 | | | | ICN: 2005063050085 | | | | | | | | | | | | | | | |
| D2710 | N | 01/01/1964 | 12/31/2299 | N | N | N | N | N | B | 0 | 999 | 1 | 12 | N | 0 | N | N | N | |
| | | | For Sample # OTHER4 | | | | | | | | | | | | | | | | |
| Member Id: 000001419 | | | | ICN: 2003260600029 | | | | | | | | | | | | | | | |
| Proc Code | Diag Req | Eff Date | End Date | Life time | Fam Plan | Preg Ind | CLIA Ind | Att Ind | Sex Ind | Min Age | Max Age | Min Qty | Max Qty | Conf Ind | Follow up Qty | Prov Spec | From Thru | Diag Cmpt | |

6.1.13.4 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|------------------|---|--------|-----------|-----------------------|------------------------|
| Attachment Ind | Attachment required Indicator | 1 | Char | T_PROC_LIMITS | IND_ATTACHMENT |
| CLIA Ind | CLIA Indicator | 1 | Char | T_PROC_LIMITS | IND_CLIA |
| Confidential Ind | Confidential Indicator | 1 | Char | T_PROC_LIMITS | IND_CONFIDENTIAL |
| Diag code | Diag Edit | 1 | Char | T_PROC_LIMITS | CDE_DIAG_CMPT_E DIT |
| Eff Date | The date the reference values are effective | 10 | Char | T_PROC_LIMITS | DTE_EFFECTIVE |
| End Date | The end date of the reference values | 10 | Char | T_PROC_LIMITS | DTE_END |
| Family plan Ind | Family Planning Indicator | 1 | Char | T_PROC_LIMITS | IND_FAM_PLAN |
| Followup qty | Follow up Quantity | 4 | Number | T_PROC_LIMITS | QTY_FOLLOWUP |
| From thru | From Thru Indicator | 1 | Char | T_PROC_LIMITS | IND_FROM_THRU_ OK |
| ICN | The transaction control number of the selected claim. | 13 | Char | T_RS_SELECT_ RSLT | NUM_ICN |
| Life time Ind | Lifetime indicator | 1 | Char | T_PROC_LIMITS | IND_LIFETIME |
| Max Age | Maximum age | 4 | Number | T_PROC_LIMITS | QTY_AGE_MAX |
| Max Qty | Maximum Quantity | 9 | Number | T_PROC_LIMITS | QTY_UNITS_MAX |
| Member ID | The Medicaid identification number for the member. | 12 | Char | T_RS_SELECT_ RECIP | ID_MEDICAID |
| Min Age | Minimum age | 4 | Number | T_PROC_LIMITS | QTY_AGE_MIN |
| Min Qty | Minimum Quantity | 9 | Number | T_PROC_LIMITS | QTY_UNITS_MIN |
| Pregnancy Ind | Pregnancy indicator | 1 | Char | T_PROC_LIMITS | IND_PREGNANCY |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|----------------|--|--------|-----------|------------------|--------------------|
| Prov spec edit | Provider Specialty Code | 1 | Char | T_PROC_LIMITS | CDE_PROV_SPEC_EDIT |
| Sex Code | Sex code | 1 | Char | T_PROC_LIMITS | CDE_SEX |
| diag req. | The diagnosis-required indicator. | 1 | Char | T_PROC_LIMITS | IND_DIAG_REQ |
| proc code | The procedure code billed on the selected claim. | 6 | Char | T_RS_SELECT_RSLT | CDE_PROC |

6.1.13.5 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

6.1.14 QAA Provider Information Sheets

The QAA Provider Information Sheets report displays the data from each of the provider file information display panels for the claims that were pulled for each of the five Contract Monitoring stratum.

6.1.14.1 Technical Name

QAA Provider Information Sheets

6.1.14.2 Sort Order

SMPL #

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

6.1.14.4 Field Descriptions

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|---------------------------------|--|--------|-----------------------|----------------------|---|
| ADDRESS | The home address of the Provider. Address type = H (home office). | 50 | Char | T_PR_ADR_DN | ADR_MAIL_STRT1, ADR_MAIL_CITY,ADR_ MAIL_STATE,ADR_MAIL_ _ZIP |
| CORRES ADDRESS | The provider's mail to address. Addr type = M. | 30 | Char | T_PR_ADR_DN | ADR_MAIL_STRT1, ADR_MAIL_CITY,ADR_ MAIL_STATE,ADR_MAIL_ _ZIP |
| CORRES:FAX | The provider's mail to telephone fax number. | 10 | Char | T_PR_ADR_DN | NUM_PHONE_FAX |
| CORRES:PHONE | The provider's mail to telephone number. | 10 | Char | T_PR_ADR_DN | NUM_PHONE |
| COUNTY | Provider's County | 3 | Char | T_RS_SELECT_P ROV | CDE_COUNTY |
| DATE | Date for which Specialty begins | 10 | Date (MM/DD/CCYY) | T_PR_SPEC | DTE_EFFECTIVE |
| ELEC FUNDS:ABA NUMBER | A unique number assigned to individual financial institutions for identification. | 9 | Char | T_PR_EFT_ACCT | NUM_ABA |
| ELEC FUNDS:ACCOUNT NUMBER | This is the bank account number for the provider in which the payments are electronically transferred. | 17 | Char | T_PR_EFT_ACCT | NUM_EFT_ACCT |
| ELEC FUNDS:EFFECTIVE DATE | Effective date for an object. Used to signify the start of a span or period. | 10 | Date (MM/DD/ CCYY) | T_PR_EFT_ACCT | DTE_EFFECTIVE |
| ELEC FUNDS:END DATE | The date that this EFT segment is no longer in effect. | 10 | Date (MM/DD/ CCYY) | T_PR_EFT_ACCT | DTE_END |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|-------------------|--|--------|-----------|-----------------|----------------|
| FEIN | This is the tax identification number assigned to a provider by the Internal Revenue Service. Federal Employer Identifier Number | 9 | Char | T_PR_SVC_LOC_DN | NUM_FEIN |
| HOLD/REV:EFF DATE | Effective date for an object. Used to signify the start of a span or period. | 10 | Char | T_PR_RST_SVC_DN | DTE_EFFECTIVE |
| HOLD/REV:END DATE | The date that something is no longer in effect. | 10 | Char | T_PR_RST_SVC_DN | DTE_END |
| HOLD/REV:HIGH | This field contains the high value in a range of drug, revenue, or procedure codes for which a restriction exists for a provider. | 9 | Char | T_PR_RST_SVC_DN | CDE_RANGE_HIGH |
| HOLD/REV:LOW | This field contains the low value in a range of generic drug, revenue, or procedure codes for which a restriction exists for a provider. | 9 | Char | T_PR_RST_SVC_DN | CDE_RANGE_LOW |
| HOLD/REV:STATUS | Code that represents the status of the restricted service. | 1 | Char | T_PR_RST_SVC_DN | CDE_STATUS1 |
| HOLD/REV:TYPE | This field indicates the type of restriction that is being enforced for the NDC, revenue code or procedure code. | 1 | Char | T_PR_RST_SVC_DN | CDE_RST_TYPE |
| LIC NUMBER | Commonwealth assigned License Number | 9 | Char | T_PR_APPLN | NUM_PROV_LIC |
| LIC TYPE | This identifies the licensure. The current valid values are: P = Prescriber H = Health Board. | 1 | Char | T_PR_SVC_LOC_DN | CDE_LIC_TYPE |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|------------------|---|--------|-------------------|----------------------|---|
| MEDICARE # | Medicare number assigned by the government to the provider. | 10 | Char | T_PR_SVC_LOC_DN | NUM_MEDICARE |
| OOS IND | Indicates whether or not the providers reside out of state. | 1 | Char | T_PR_SVC_LOC_DN | IND_OOS |
| PAY TO:ADDRESS | The provider's pay to address. Addr type = P. | 30 | Char | T_PR_ADR_DN | ADR_MAIL_STRT1, ADR_MAIL_CITY, ADR_MAIL_STATE, ADR_MAIL_ZIP |
| PAY TO:FAX | The provider's pay to fax number. | 10 | Char | T_PR_ADR_DN | NUM_PHONE_FAX |
| PAY TO:PHONE | The provider's pay to telephone number. | 10 | Char | T_PR_ADR_DN | NUM_PHONE |
| PHONE | Telephone number of the provider | 10 | Char | T_PR_ADR_DN | NUM_PHONE |
| PHYSICAL:ADDRESS | The provider's service location address; Addr type = S. | 30 | Char | T_PR_ADR_DN | ADR_MAIL_STRT1, ADR_MAIL_CITY, ADR_MAIL_STATE, ADR_MAIL_ZIP |
| PHYSICAL:FAX | The provider's service location telephone fax number. | 10 | Char | T_PR_ADR_DN | NUM_PHONE_FAX |
| PHYSICAL:PHONE | The provider's service location telephone number | 10 | Char | T_PR_ADR_DN | NUM_PHONE |
| PROVIDER NAME | The Name of the provider on the Claim | 35 | Char | T_RS_SELECT_P ROV | NAM_PROV |
| PROVIDER NUMBER | The Identification Number of the provider on the Claim | 9 | Char | T_RS_SELECT_R SLT | ID_PROV_BILL |
| PRV GRP:EFF DATE | Date that the provider is effective with this group. | 10 | Date (MM/DD/CCYY) | T_PR_GRP_MBR | DTE_EFFECTIVE |

| Field | Description | Length | Data Type | DB Table | DB Attributes |
|--------------------|---|--------|-------------------|-------------------------|-----------------------------|
| PRV GRP:END DATE | Date that the provider is no longer effective with this group. | 10 | Date (MM/DD/CCYY) | T_PR_GRP_MBR | DTE_END |
| PRV GRP:GROUP | The provider number and type. The type field is derived (NPI). | 18 | Char | T_PR_SVC_LOC_DN | ID_PROVIDER_NPI |
| RATE:CDE | Code used to identify the rate type to use in determining provider reimbursement. | 3 | Char | T_PR_LOC_RATE | CDE_RATE_TYPE |
| RATE:CHARGE FACTOR | A daily room rate or percentage of Charge value depending on the pricing indicator. | 7 | Number | T_PR_LOC_RATE | AMT_RATE_PERCENT |
| RATE:EFF DATE | The first date in which the level of care rate became active. | 10 | Date (MM/DD/CCYY) | T_PR_LOC_RATE | DTE_EFFECTIVE |
| RATE:END DATE | The date in which the level of care rate became inactive. | 10 | Date (MM/DD/CCYY) | T_PR_LOC_RATE | DTE_END |
| SAMPLE | The QC number assigned to the claim whose provider data follows. | 4 | Char | T_RS_SELECT_RSLT | SEQ_RANDOM |
| SPECIALTY | Provider Specialty and Description | 24 | Char | T_PR_SPEC,T_PR_SPEC_CDE | CDE_PROV_SPEC,DSC_PROV_SPEC |
| SSN | Social Security Number | 9 | Char | T_PR_SVC_LOC_DN | NUM_SSN |
| UPIN | Universal Provider Identification Number | 6 | Char | T_PR_SVC_LOC_DN | NUM_UPIN |

6.1.14.5 Associated Programs

| Program | Description |
|-------------------------------|-------------|
| No associated Programs found. | |

7 Letters

The Quality Assurance and Audits subsystem does not produce, send or receive any letters.

8 Glossary of Terms and Acronyms

8.1 Terms and Acronyms

- 270/271** **Eligibility/Benefit Inquiry/Response – The Eligibility and Benefit transactions are designed so that inquiry submitters (information receivers) can determine: a) whether an information source organization (e.g., payer, employer, HMO) has a particular subscriber or dependent on file, and b) the health care eligibility and/or benefit information about that subscriber and/or dependent(s). The data available through these transaction sets is used to verify an individual's eligibility and benefits, but cannot provide a history of benefit use. The information source organization may provide information about other organizations that may have third party liability for coordination of benefits. These are x-12 transactions mandated by HIPAA regulations.**
- 276/277** **Claim Status Request/Claim Status Response – The 276 and 277 transaction sets are intended to meet specific needs of the health care industry. The 276 is used to request the current status of a specified claim(s). The 277 transaction set can be used as the following: a) a solicited response to a health care claim status request (276), b) a notification about health care claim(s) status, including front end acknowledgments, or c) a request for additional information about a health care claim(s). The 276 is used only in conjunction with the 277 Health Care Claim Status Response. These are x-12 transactions mandated by HIPAA regulations.**
- 277** **Unsolicited Claim Status – The Unsolicited Claim Status (277) transaction set can be used to transmit an unsolicited notification about a health care claim status. This is an x-12 transaction mandated by HIPAA regulations.**

- 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.**
- 820** Premium Payment – The 820 can be used by premium remitters to report premium payment remittance information, as well as premium payment to a premium receiver. The premium remitter can be: a) an employer-operated internal department or an outside agency which performs payroll processing on behalf of an employer, b) a government agency paying health care premiums, or c) an employer paying group premiums. The premium receiver can be either an insurance company, a government agency, or a health care organization. The 820 can be sent from the premium remitter to the premium receiver either directly, through a VAN, or through a financial institution using an ACH (Automated Clearing House) Network to facilitate both the remittance and dollars movement. This is an x-12 transaction mandated by HIPAA regulations.
- 834** Enrollment/Maintenance – The 834 is used to transfer enrollment information from the sponsor, the party that ultimately pays for the coverage, benefit, or policy to a payer, the party that pays claims and/or administers the insurance coverage, benefit, or product. This is an x-12 transaction mandated by HIPAA regulations.
- 835** Payment Advice – The 835 contains information about the payee, the payer, the amount, and any identifying information of the payment. In addition, the 835 can authorize a payee to have a DFI (Depository Financial Institutions) take funds from the payer's account and transfer those funds to the payee's account. This is an x-12 transaction mandated by HIPAA regulations.

- 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.**
- 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.

8.1.1 A

ABANDONED CALL A call is considered abandoned if the caller is connected to the system but hangs up before being connected with an agent or informational announcement. Also known as a lost call.

ABR Automatic Backup and Recovery

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT A lump sum payment made upon the loss of life of an insured as a direct cause of an accident or upon the accidental loss of a limb or sight of an insured.

ACCOMMODATION A hospital room with one or more beds.

ACCOMMODATION CHARGE A Charge billed on inpatient hospital claims for bed, board, and nursing care (revenue codes 100-219).

ACCOUNTS RECEIVABLES (AR, A/R) Money owed to the State by a provider, beneficiary, insurance company, drug manufacturer, etc.

ACCRETION A process that occurs when a beneficiary is eligible for coverage under both Medicaid and Medicare. Medicaid pays the beneficiary's Medicare premium, thus buying into the Medicare Program.

ACG Ambulatory Care 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. |

8.1.2 B

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| 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)

8.1.3 C

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| 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. |

- CERTIFICATION** A review by the U.S. Department of Health and Human Services/CMS of an operational MMIS, in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system and the ensuing certification resulted from a favorable review.
- CERTIFICATION DATE** An effective date specified in a written approval notice from CMS to the State when 75 percent federal financial participation (FFP) is authorized for the administrative costs of an MMIS.
- CHANGE ORDER (CO)** The documentation of a modification to the transfer system. A change order is not a modification of a requirement; it is the modification of the base system to meet an existing requirement.
- CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)** A classification given to children who require special health services. The classification comes through the Title V program.
- CIVILIAN HEALTH AND MEDICAL PROGRAMS OF THE UNIFORMED SERVICES (CHAMPUS)** The medical benefit program for military personnel or retirees and their dependents who exercise their option to obtain civilian medical treatment. CHAMPUS can be considered as a possible source for third-party coverage.
- CLAIM** The form required for providers to bill their services. Each claim is formatted into three levels of information: Header, Detail, and Trailer or Footer.
- CLAIM ADJUSTMENT** A claim adjustment is a modification to some part of the data of a previously paid claim. All adjustments will maintain an audit trail to deny adjustments to a previously adjusted claim. A message is displayed stating that the claim has already been adjusted or denied. (See Adjusted Claim)
- CLAIM HISTORY** All claims processed in the MMIS are kept available in the system and are referred to as being "in history." The Kentucky MMIS adjustment process has access to 60 months of claims data plus a lifetime file.

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| CLAIM TYPE | Claim types indicate the classification of claims by origin or type of service provided to a beneficiary. In the MMIS, this is a user-defined data element that refers to the kind of service being billed. For example, common claim types are dental, pharmacy, transportation, nursing, EPSDT, physician, inpatient, etc. Outside of the MMIS, the term often refers to the invoice type, i.e., HCFA-1500, UB-92, etc. The invoice type could be the claim type in an MMIS, but because more than one type of service can be billed on an invoice, the term "claim type" is usually defined in more detail. |
| CLAIMS PROCESSING ASSESSMENT SYSTEM (CPAS) | A State-administered Medicaid quality-control program that serves as a management tool for examining and evaluating the accuracy of claims processing and payments. |
| CLERK ID | A code assigned to personnel involved with processing records in the MMIS claims processing system. |
| CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) | A certification process done by CMS to ensure the proficiency of medical laboratories. |
| COINSURANCE (also CO-INSURANCE) | The dollar amount or percentage of the cost of medical care that a patient pays. The coinsurance or a percentage amount that will be paid by KY Medicaid if the beneficiary is eligible for Medicaid. |
| COMMON BUSINESS-ORIENTED LANGUAGE (COBOL) | A third generation computer language developed by the Federal Government and adopted by computer manufacturers in the 1960s. It is the most utilized language on mainframe business computers |
| COMMON GATEWAY INTERFACE (CGI) | One of the most common ways to add programs or scripting languages that execute on the server to your Web-based applications. |
| COMMON PROCEDURAL TERMINOLOGY (CPT) | A unique structure scheme for all medical procedures approved by the American Medical Association. |

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| COMMUNITY MENTAL HEALTH CENTER (CMHC) | A center that provides many services necessary for treatment of mental health conditions. Services include diagnostic evaluations, psychological testing, therapy (family, group, and individual), and medication checks. |
| COMPACT DISK (CD) | A standard medium for storage of digital data in machine-readable form, accessible with a laser-based reader. CDs are 4-3/4 in diameter. CDs are faster and more accurate than magnetic tape for data storage: Faster, because even though data is generally written on a CD contiguously within each track, the tracks themselves are directly accessible. This means the tracks can be accessed and played back in any order. More accurate, because data is recorded directly into binary code; whereas magnetic tape requires data to be translated into analog form. In addition, extraneous noise (tape hiss) associated with magnetic tape is absent from CDs. |
| COMPACT DISK-READ ONLY MEMORY (CD-ROM) | A data storage system using CDs as the medium. CD-ROMs hold more than 600 megabytes of data. |
| COMPUTER OUTPUT TO LASER DISK (COLD) | A system that provides the ability to take output from a report program that often runs on a mainframe computer and makes the information useful without the use of paper. |
| CONSOLIDATION OF BENEFITS IN RETIREMENT ACT (COBRA) | Cobra is a law that makes an employer let an employee remain covered under the employer's group health plan for a period of time after: the death of your spouse, losing your job, work hours reduction, or getting a divorce. The employee may have to pay both their share and the employer's share of the premium. |
| CONTACT TRACKING NUMBER (CTN) | A unique number assigned in CTMS. |
| CONTRACTOR | Successful bidder under an RFP or ITB. A person or organization from which the State contracts for products or service. |
| CONTRACT START DATE | The date the Contract for Services requested by an RFP becomes effective. |

CONTROLLED DRUGS / SCHEDULED DRUGS /Drugs that have a high potential for abuse. These are drugs classified as narcotics. There are five schedules, with Schedule I drugs being the most dangerous.

CONVERSION FACTOR The factor used to convert units of service; applicable to drug claims being processed in Drug Rebate.

COORDINATION OF BENEFITS (COB) When Medicaid and other primary insurance companies coordinate their benefits to ensure that beneficiaries/providers do not receive duplicate payments for a service.

COPAY/COPAYMENT (also CO-PAY) A Charge the beneficiary is responsible for paying on selected procedures or services. It is the patient's responsibility to pay some fixed portion of the cost of the medical service received, while the insurer pays the remainder.

CONTACT TRACKING MAINTENANCE SYSTEM (CTMS) This ancillary application provides a means of access and storage for all information associated with a customer service contact. All contact information is associated with an assigned CTN. This information includes contact type, demographic information, questions, resolutions, and contact reasons. HP Enterprise Services and DMS staff enter information for each contact through online windows. Search windows allow users to sort and access contacts based on a variety of criteria. Reports are available based on open dates, status, clerk IDs and department.

COS Category of Service

COST AVOIDANCE A claim may be denied when coverage exists and there is no indication that the carrier has been billed (cost avoided).

COST SHARING Provisions of an insurance policy requiring the covered individual to pay some portion of covered medical expenses. Premium amounts are not included in cost sharing. Deductibles (a set amount paid before payment of benefits occurs), co-payments (a fixed amount paid for each service), and coinsurance (payment of a set portion of the cost per service), are forms of cost sharing.

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| COVERAGE CODE | A system of letters or numbers assigned to the type of coverage provided by the third party carrier policy. |
| CLAIM CREDIT | A financial transaction that reverses a previously paid claim to zero amount. A credit is entered in the MMIS just like a claim. A provider can request a credit if he has been paid for a service he did not perform. The State agency can also request a credit. It is one type of adjustment. Also known as Credit-Only Adjustment. |
| CRNA | Certified Registered Nurse Anesthetist |
| CROSSOVER CLAIM | If a beneficiary is eligible for both Medicare and Medicaid, the Medicare claim is automatically sent to Medicaid after the Medicare carrier processes it. The claim, in effect, crosses over from one system to the other via tapes or disks. It is important to know that Medicaid is considered the payer of last resort. Therefore, claims must always be sent to Medicare first when a beneficiary is eligible for both programs. |
| CROSS WALK | A table used to relate one code to another code |
| CURRENT PROCEDURAL TERMINOLOGY, FOURTH EDITION (CPT-4) | Contains procedure codes that are used by medical practitioners in billing for services rendered to Medicaid beneficiaries. The book is published by the American Medical Association. The CPT codes are also included as the Level One codes in the HCPCS list of codes. |
| CURSOR | A highlighted mark on the screen that shows where the next Character you enter will appear. |
| CUSTOMARY CHARGE | A dollar amount that represents the median Charge for a given service by an individual physician or supplier. |

**CUSTOMER
INFORMATION
CONTROL SYSTEM
(CICS)**

An IBM software system that provides the on-line user interface to MMIS data. This is the “front” end of the mainframe-based MMIS online system. CICS was originally developed to provide transaction processing for IBM mainframes. It controls the interaction between applications and users and lets programmers develop screen displays without detailed knowledge of the terminals used. It provides terminal routing, password security, transaction logging for error recovery and activity journals for performance analysis. CICS commands are written along with and into the source code of the applications, typically COBOL.

CUTBACK

A reduction in quantity or rate.

8.1.4 D

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| 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 |

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| 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. |

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| 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. |

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| DISABILITY | A physical or mental condition that makes an insured incapable of performing one or more duties of his occupation or any occupation. |
| DISABILITY BENEFIT | A payment that arises because of the total and/or permanent disability of an insured; a provision added to a policy that provides for a waiver of premium in case of total and permanent disability. |
| DISABILITY DETERMINATION SERVICES (DDS) | A division of SRS that contracts with the Social Security Administration to determine the disability status of Social Security Disability applicants. |
| DISABILITY INCOME INSURANCE | A form of health insurance that provides periodic payments when the insured is unable to work as a result of illness, disease, or injury. |
| DISASTER RECOVERY (DR) | Facilities, plans, tests, etc. for the recovery of the MMIS from a total loss. |
| DISENROLLMENT | Removal of assignment or from the Managed Care program. |
| DISPOSITION | The actual status of a claim. The result of processing a claim is the assignment of a status or disposition. The disposition of a claim is determined by the Exception Control File. |
| DISPROPORTIONATE SHARE HOSPITAL (DSH) | Qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income persons. |
| DMS | Department for Medicaid Services |
| DO | Doctor of Osteopathy |
| DOB | Date of Birth |

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| 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. |

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| 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. |

8.1.5 E**E&M** **Evaluation and Management****E-DOS** Ending Date of Service**EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)** As described in Title XIX of the Social Security Act.**EDIT** As applied to MMIS, an edit is a set of parameters against which a claim transaction is "edited." These edits can stop payment and/or generate reports.

The verification and validation of claims data for detection of errors or potential error situations. Logic placed in the MMIS programming to cause claims that have specific errors to be placed in a suspend or deny mode due to not having successfully passed these edits.**EDP** Electronic Data Processing**EFT** Electronic Fund Transfer**ELECTRONIC BENEFITS TRANSFER (EBT)** EBT capabilities allow the State to issue food stamps and benefit checks electronically by utilizing the plastic Beneficiary ID Cards. Conforms to the ANSI Uniform Health Care ID Card Standards.**ELECTRONIC CLAIMS SUBMISSION (ECS)** See EDI.

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 (EDS) The Fiscal Agent for the Commonwealth of Kentucky.

ELECTRONIC FUNDS TRANSFER (EFT) An electronic deposit system for provider remittance amounts, and the process of authorizing a computer system to transfer funds between accounts.

ELECTRONIC MEDIA CLAIMS (EMC) Claims that are electronically transmitted to the MMIS through media such as telephone lines, diskettes, or tapes. This term is no longer used.

ELECTRONIC REMITTANCE ADVICE (ERA) Generally, RAs are submitted to the provider using the same media that the provider uses when submitting a claim. If the claim is submitted using a particular standard format, the RA is returned in the same format. See RA, NCPDP.

ELIG Eligibility

ELIGIBLE PROVIDER An institute, facility, agency, person, partnership, corporation, or association as enrolled and approved by the State that accepts, as payment in full for providing eligible services, reimbursement provisions, regulations, and schedules.

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| 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. |

8.1.6 F

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| FAIR HEARING (FH) | A formal meeting where a Hearings Officer listens to all the facts and then makes a decision based on the law. |
| FAMILY PLANNING (FP) | A medically approved treatment, counseling, drugs, supplies, or devices that are prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children. |
| FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN) | Number assigned to a business entity for tax purposes. This number might be of value in identifying all the businesses owned by a corporation. |
| FEDERAL INSURANCE CONTRIBUTIONS ACT (FICA) | Social Security taxes deducted by the employer. |
| FEDERAL POVERTY LEVEL (FPL) | The poverty threshold is a statistical measure used to indicate the level of cash income needed by a family to purchase a “minimally adequate” market basket of goods and services. The threshold is adjusted for family size and updated every February for inflation. It is a nationwide standard of poverty. |
| FEDERAL REGISTER (FR) | The Federal Register is the official daily publication for Rules, Proposed Rules, and Notices of Federal agencies and organizations, as well as Executive Orders and other Presidential Documents. |
| FEDERALLY QUALIFIED HEALTH CENTER (FQHC) | A federally funded agency that provides medical services on a sliding fee schedule to the general public. |
| FEE FOR SERVICE (FFS) | The payment method by which KY Medicaid reimburses providers on a service-by-service basis. |

- FEE SCHEDULE** A listing of acceptable Charges or established allowances, normally representative of either standard or maximum Charges, for the listed medical or dental procedures.
- FIELD** An on-screen area used for entering specific information, such as a name or extension number, within the telephone system. A field prompt identifies the type of information that belongs in each field.
- FILE MAINTENANCE** The periodic updating of master files. For example, adding or deleting employees and customers, making address changes and changing product prices. It does not refer to daily transaction processing and batch processing.
- FILE TRANSFER
PROTOCOL/PROGRAM (FTP)** A method of transferring files between heterogeneous computing platforms. Since most large scale computing systems interface between mainframes, mini, PC's, and the Internet, a method is needed to transfer data between these different platforms. (See TCP/IP)
- FIREWALL** Security protection for a Web site (see proxy server), LAN, and Intranet. May check incoming and outgoing messages.
- FISCAL AGENT (FA)** The contractor retained by the State for operation of the MMIS and for the performance of claims processing and other related Medicaid functions in KY Medicaid.
- FISCAL
INTERMEDIARY (FI)** Similar to a fiscal agent. A corporation is designated to have complete responsibility for a government health program, including all data processing functions, program administration, professional relations, and clerical staffing for claims processing.
- FISCAL YEAR (FY)** Any twelve-month period for which manual accounts are retained. The fiscal year may, but need not, correspond to the calendar year. The federal Fiscal Year starts October 1 and ends September 30 of the following year. States usually operate on July 1 through June 30 of the following year.

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| FLAT FILE | A database consisting of one table. It is a stand-alone data file that does not have any predefined linkages or pointers to locations of data in other files. This is the type of file used in a relational database; however, the term is often used to refer to a type of file that has no relational capability, which is exactly the opposite. |
| FOOD AND DRUG ADMINISTRATION (FEDERAL DRUG AGENCY, FDA) | A federal agency responsible for the monitoring and regulation of foods and drugs distributed in the United States. |
| FORMULARY | A listing of drugs and the regulations that govern payment. |
| FPA | Family Planning Agency |
| FROM DATE OF SERVICE (FDOS) | Date used in the claim. |
| FRAUD AND ABUSE (F&A) | Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by KMAP. This is not the same as fraud. |
| FTE | Full-Time Equivalent |
| FULL TEXT SEARCH | The ability to search text files for occurrences of certain words, digits, sentences, or patterns of Characters. Generally, a scanned document cannot be full text searched. To do that, the document would have to be retyped or scanned with an OCR to create a text file. (Imaging) |
| FUNCTIONAL ACKNOWLEDGEMENT | An EDI message that is sent in response to the receipt of an EDI message or packet of messages to notify the sender of the original message that it was received. It acknowledges only the receipt of the message or message packet, and does not imply agreement with or understanding of its content. |

8.1.7 G

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| 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

8.1.8 H

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| 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 (HIPP) A program where Medicaid-eligible beneficiaries may receive insurance premium assistance using Medicaid funds when it is determined cost-effective to purchase group health insurance.

HEALTH MAINTENANCE ORGANIZATION (HMO) A prepaid cost-effective health plan that provides a range of preventative and maintenance services in return for a fixed monthly premium that entitles the enrollees to a predetermined set of basic and supplemental services. A health care providing organization, which Charges a flat fee per month (Capitation) per person, enrolled. The services provided are defined by contract and generally are comprehensive. HMO enrollment is an alternative form of health care delivery that is offered to Medicaid beneficiaries.

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS) Used to measure a plan's performance. Utilized in Quality Assurance for Managed Care. HEDIS and HEDIS and Compliance Audit are registered trademarks of the National Committee for Quality Assurance (NCQA). NCQA encourages and promotes the use of performance measures that comprise HEDIS. HEDIS Compliance Audit is a rigorous process for evaluating the accuracy and validity of plan-reported performance results.

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET STANDARD (HEDIS STANDARD) A Federal standard for Electronic Data Interchange (EDI) for Medicaid Managed Care programs.

**HEALTHCARE
COMMON
PROCEDURE
CODING SYSTEM
(HCPCS)**

A uniform health care procedural coding system approved by CMS. It describes the physician and non-physician patient services covered by the Medicaid and Medicare programs. It is used primarily to report reimbursable services provided to patients.

There are three types of HCPCS codes.

Level 1 includes the CPT-4 codes.

Level 2 includes the alphanumeric codes A through V which CMS maintains for a wide range of services from ambulance trips to hearing aids which are not addressed by the CPT-4 coding.

Level 3 includes the alphanumeric codes W through Z, which are assigned for use by the state agencies.

**HOME AND
COMMUNITY BASED
SERVICES (HCBS)**

Home and Community Based services are for persons with mental retardation or other developmental disabilities are made possible through Medicaid waivers. These services are intended as an alternative to institutional services. Each waiver offers services for a specific group: Head Injury, Technology Assistance, Physical Disability, Frail and Elderly, Developmental Disabilities, and Children with Severe Emotional Disturbance.

**HOME HEALTH
AGENCY (HHA)**

An agency that provides home health care services such as home health aide visits, LPN and RN visits, and therapy services.

HOSPICE

A program that provides an integrated program of appropriate hospital and home care for the terminally ill patient. A hospice is a public agency or private organization that provides services for terminally ill people. It is usually affiliated with a hospital. Hospice care may be home care, inpatient care, or respite care. Respite care is inpatient care provided for the beneficiary to give the family temporary relief from the strain of caring for a loved one at home.

HOSPITAL

A health care institution whose primary function is to provide inpatient services for a variety of surgical and non-surgical medical conditions. Hospitals are classified by length of stay, teaching or non-teaching, major type of services, and by control.

HOSPITAL INSURANCE PROGRAM (PART A) The compulsory portion of Medicare that automatically enrolls all persons 65 years of age or older, entitled to railroad retirement and eligible for disability for over two years, and insured workers and their dependents requiring dialysis or kidney transplants.

HOST Computer in which an application or database resides or to which a user is connected. Sometimes used generically as synonym for computer. (Imaging)

HYPertext MARKUP LANGUAGE (HTML) Programming language used to develop and maintain web pages on the Internet.

HYPertext TRANSFER 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.

8.1.9 I

ICD-10-CM **International Classification of Diseases, Tenth Revision**

iCE interChange Enhanced

ICF/MR Intermediate Care Facility/Mental Retardation

ICN Internal Control Number.

ICON The basis of a graphical user interface, an icon is a picture or drawing of a device or program that is activated, usually with a mouse, to access the device or run the program.

IMAGE The computerized representation of a picture or graphic. (Imaging)

IMAGING A method of electronically capturing a representation of a form, whether it is a claim or other piece of correspondence, to allow rapid retrieval and processing of the source document copy.

IMAGING SYSTEM Collection of units that work together to capture and recreate images. At its simplest, it has an acquisition device (scanner, camera), an image processor and an imaging device (printer, microfilm, computer). (Imaging)

INCOME MAINTENANCE (IM) A division within the Commission of Income Maintenance/Employment Preparation Services of SRS. The division is responsible for administration and oversight of programs relating to eligibility for Public Assistance programs, including AFDC, Medicaid, and food stamps.

INFORMATION TECHNOLOGY (IT) A broad term referring to the entire field – computers, communications, Internet, imaging, etc.

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| 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

8.1.10 J

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| 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. |

8.1.11 K

KAPER **Kentucky Application for Provider Evaluation and Re-evaluation**

KenPAC Kentucky Patient Access and Care program.

KEY Keys are indexed columns in tables, often used to join tables. Keys uniquely identify each record, or row, in a table. Examples would be Cust-ID or Provider Number.

A word, number or phrase associated with a document to aid in its retrieval from storage. Sometimes called descriptors. There are often many keys used together to fully locate a document; together they are called an index. Also called a retrieval key. (Imaging)

KILOBYTE One thousand bytes. To a computer, its actually 1,024. So, 16 kbytes, or 16K, is actually 16,384 bytes; 64K is 65,536 bytes, etc. (Imaging)

KMAA Kentucky Medicaid Administrative Agent

8.1.12 L

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| 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 |

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| 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> |

8.1.13 M

MAGNETIC DISK AND TAPE The primary computer storage media. The choice depends on accessing requirements. Disk is direct access; tape is sequential access. Locating a program or data on disk can take a fraction of a second. On tape, it can take seconds or minutes.

MAGNETIC RESONANCE IMAGING (MRI) A noninvasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves.

MAINFRAME A large, powerful computer, often serving several connected terminals.

MANAGED CARE (MC) Comprehensive health care integrating clinic/admin for cost effective care (HMO). Managed Care includes Capitated HMO, PCCM, and Fee-For-Service managed care.

MANAGED CARE ORGANIZATION (MCO) An organization paid to provide services to a select group of beneficiaries assigned to them for a given time period.

MANAGEMENT ADMINISTRATIVE REPORTING SUBSYSTEM (MAR, MARS) The MMIS subsystem that produces the management data required for financial, benefit, provider and beneficiary reporting.

MANUAL CHECKS Checks written outside the automated check writing cycle.

MAPPING The act of determining what pieces of information in the company's database should be placed into each data element of an EDI message or transaction set, or in reverse, what data elements of an EDI message or transaction set should be placed into the company's database.

**MASS
ADJUSTMENTS**

The systematic adjustment of more than one claim at the same time for the same reason. Multiple adjustments entered at one time. Mass adjustments are requested on line and they are particularly useful when it is necessary to reprocess hundreds or thousands of claims. Mass adjustment requests are submitted for a specific population of claims. In other words, claims that have something in common. They may be all of the drug claims processed after a certain date; they may be a subset of claims for a specific provider, or they may be all of the claims processed for a specific beneficiary. The criterion for claims selection is highly variable.

MB

Megabyte

MEDICAID (MCD)

The joint federal and state medical assistance program that is described in Title XIX of the Social Security Act, designed to provide health benefits assistance to medically needy young persons (less than 21 years of age) and to the aged (more than 65 years of age). A health insurance program for the poor which is jointly funded by the state and federal governments. Also, referred to as Title XIX of the Social Security Act. The Medicaid Program is administered by the states under the management of the Centers for Medicare and Medicaid (CMS).

Federal/State partnership of medical assistance for low income (title XIX, SS act) persons. There are 33 million people eligible. Includes ABD, low-income with children, low-income pregnant, and people with very high medical bills. In order to receive medical assistance a client must qualify into one of six categories: age 65, Blind, disabled, families with dependent children (TANF), pregnant, incapacitated (= categorically needy).

**MEDICAID
STATISTICAL
INFORMATION
SYSTEM (MSIS)**

Reporting required by CMS in standard formats. MSIS reports are required by each state and combined by CMS.

**MEDICAID
MANAGEMENT
INFORMATION
SYSTEM (MMIS,
MMIS
INTERCHANGE)**

Computer application that makes up the Medical Assistance Program system. A system composed of at least six subsystems for the general design of Title XIX systems as defined, outlined, and documented by the Department of Health and Human Services. All states with Medicaid Programs are required to have an MMIS. The MMIS processes medical claims and produces reports which track expenditures by aid category, claim type, category of service, or some other parameter.

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| 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". |

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| 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) |

8.1.14 N**NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP)**

An ANSI-accredited council developed to review and define national standards for the billing of prescription drug services for reimbursement by private insurance as well as state and federal agencies. Some of the standard formats are included in the HIPAA mandates.

Provides standards for data interchange and standards for processing pharmacy services in the health care industry. The NCPDP Telecommunications Standard defines the record layout for interactive prescription drug claim transactions between providers and adjudicators. Version 5 of this standard is currently in draft form.

NATIONAL DATA CORPORATION/NATIONAL DRUG CODE (NDC)

Provider of communication software/hardware for pharmacies. (See ENVOY.) or

A generally accepted system for drug identification that is the primary drug ID used.

(1) A standard coding scheme of eleven digits that assigns a unique numeric code to all drugs on the market. (The first five digits indicate the drug manufacturer; the next four digits specify the particular drug and the last two digits refer to the package size.)

(2) A 10-Character code assigned to all prescription drug products by the labeler/distributor of the product under FDA regulation. Each NDC is composed of three sub-codes, which can assume different configurations. The NDC codes are impractical to use for data processing applications such as sorting, searching, etc., because of the variable structure of the sub-codes. The National Drug Data File (NDDF) Code therefore is always eleven digits in length and each of its sub-codes always contains the same number of Characters (5-4-2). This is achieved by inserting a leading zero in one of the three sub-codes in the NDC.

NATIONAL PROVIDER FILE (NPF)

A national repository of provider identification data to support assignment of a national provider identifier.

NATIONAL PROVIDER IDENTIFIER (NPI)

A national system of provider identification that is used nationally by all providers starting in 1997.

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| 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.

8.1.15 O**OCC****Occurrence Codes (Inpatient claims)****OCCUPATIONAL
THERAPY (OT)**

The use of life related activities to restore and evaluate motor skills so that disabled persons may attain health, social, or economic independence.

**OCR DATA
RECOGNITION (OCR)**

Images passed to the OCR subsystem are fed to the recognition engines one claim at a time. The recognition engines interpret each Character or mark sense field based on the form definition used. All recognized data is placed in an ASCII data file. (Imaging)

OD

Doctor of Optometry

OIG

Office of Inspector General

**OMNIBUS BUDGET
RECONCILIATION
ACT (OBRA)**

See PASARR. OBRA-90 establishes the Drug Rebate program.

**OMNIBUS BUDGET
AND
RECONCILIATION
ACT OF 1990 (OBRA-
90)**

Establishes the Drug Rebate program.

ONBASE

OnBase processes the print output of application programs, extracts index fields from the data, stores the index information in a relational database, and stores one or more copies of the data in the system so that the user can archive newly created and frequently accessed reports or images on high speed, disk storage volumes and automatically migrate them to other types of storage volumes as they age.

- ONLINE** The use of a computer terminal to display computer data interactively.
- Available for immediate use. If your data is on disk attached to your computer, the data is online. If it is on a disk in your desk drawer, it is offline.
- A peripheral device (terminal, printer, etc.) that is turned on and connected to the computer is said to be online. However, a printer can be taken offline by simply pressing the ONLINE or SEL button. It is still attached and connected, but is internally cut off from receiving data from the computer. Pressing the ONLINE or SEL button will turn it back on-line.
- Systems are designed as either online or batch. Online means terminals are connected to a central computer, and batch means entering batches of transactions on a second or third shift. Other terms, such as real-time and transaction processing evolved from online processing.
- OPERATING SYSTEM (OS)** The master control program that runs the computer. It is the first program loaded when the computer is turned on, and its main part, called the kernel, resides in memory at all times. It may be developed by the vendor of the computer it's running in or by a third party. It is an important component of the computer system, because it sets the standards for the application programs that run in it. All programs must "talk to" the operating system. See API, JCL.
- ORACLE** The Corporation that provides the ORACLE software which is the major Relational Database software for minicomputers and PCs.
- OTHER INSURANCE (OI)** A term used to describe primary insurance payers. Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.
- OUTPATIENT (OPT)** A patient who is receiving care at a hospital or other health facility without being admitted. Outpatient normally does not include patients receiving services from a facility that does not also give inpatient care.
- OUTPATIENT CARE** Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.

OVER THE COUNTER (OTC) A drug classification used to describe pharmaceuticals that do not require a prescription.

8.1.16 P

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| 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). |

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| 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. |

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| 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. |

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| 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 |

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| 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. |

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| 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. |

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| 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. |

8.1.17 Q**QA Quality Assurance**

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| 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> |

8.1.18 R**RA** **Remittance Advice****RAILROAD RETIREMENT BOARD (RRB)** A separate insurance program that covers some aged people who would otherwise be covered by Medicare.**RANDOM ACCESS** An accessing process that finds any record in a database quickly by using two logical reads; the first read being the accessing of the index pointing to that data, the second read accessing the actual record or data. This process is the opposite of sequential accessing.**RANDOM ACCESS MEMORY (RAM)** The primary memory in a computer. Memory that can be overwritten with new information. The random access part of its name comes from the fact that all information in RAM can be located -- no matter where it is -- in an equal amount of time. This means that access to and from RAM memory is extraordinarily fast. By contrast, other storage media -- like magnetic tape -- require searching for the information, and therefore take longer. (Imaging)**RD** Registered Dietitian**REALTIME SYSTEM** A computer system that responds to input signals fast enough to keep an operation moving at its required speed.**RECORD** A set of related fields used to enter and store information in the telephone system. A table is a set of records.**RECOUPMENT (REC)** Money withheld from a provider's payment due to overpayment of claims during adjudication cycles. Recoupments may be established 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.

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| 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. |

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| 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. |

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| 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> |

8.1.19 S

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| SAK | System Assigned Key |
| SCALING | Process of uniformly changing the size of Characters or graphics. (Imaging) |
| SCAN | To convert human-readable images into bitmapped or ASCII machine-readable code. (Imaging) |
| SCAN RATE | Number, measured in times per second, a scanner samples an image. (Imaging) |
| SCANNER | A device that reads text, images and bar codes. Text and bar code scanners recognize printed fonts and bar codes and convert them into a digital code. Graphics scanners convert a printed image into a video image without recognizing the actual content of the text or pictures. |
| SCHOOL-BASED SERVICES | Medicaid reimbursable services provided to Medicaid eligible children in local education agencies (LEAs) by enrolled providers. |
| SCL | Supports for Community Living |
| SCU | Storage Control Unit |
| SKILLED NURSING FACILITY (SNF) | Any facility that provides room, board, and all routine services and supplies. A nursing home facility requiring qualified professional personnel to remain on site twenty-four hours a day. |
| SOBRA | Sixth Omnibus Budget Reconciliation Act |

- SOCIAL SECURITY ADMINISTRATION (SSA)** Branch of the Department of Health and Human Services which administers the Medicare and Medicaid Programs.
- SOCIAL SECURITY INCOME (SSI)** A program of income support administered by the Social Security Administration that replaces the previously stated administered programs for low-income aged, blind and disabled individuals. Federal dollars paid to aged, blind, or disabled individuals to help pay their living expenses.
- SOCIAL SECURITY NUMBER (SSN)** An account number issued and used by the SSA to identify an individual on whose earnings SSA benefits are being paid. It is a Social Security account number followed by a three-digit suffix designating the type of beneficiary.
- SOCIAL SERVICES (SS)** Services that seek to improve the quality of life for individuals and families (i.e., public assistance, medical assistance, food stamps, etc.).
- SPECIALIST** A physician, dentist, or other health professional who works primarily in a certain field of medicine, related to specific services, certain categories of patients or types of diseases.
- SPECIALTY** The specialized area of practice of a provider, such as general practice, surgery, endocrinology, pathology.
- SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLMB)** Medicare beneficiaries who would meet the QMB requirements, except for having income in excess of the QMB limit but less than 110 percent of the federal poverty level in 1994 and less than 120 percent of the federal poverty level in 1995. The state Medicaid Program must pay the Medicare Part B premium for these individuals.

SPENDDOWN (SPN) A type of Medicaid insurance deductible. The dollar amount of medical bills the beneficiary is responsible for taking care of before Medicaid can help the beneficiary pay his or her medical bills. Spenddown is the difference between the beneficiary's income and the Medicaid income limit. A qualifying county nurse may assign this dollar amount to a beneficiary (based on the beneficiary's income, etc.), which must be spent on medical needs prior to Medicaid benefits being available.

A process whereby an otherwise Medicaid-eligible person, but for excess income, may become eligible through obligation of the excess amount of incurred medical expenses. A requirement that certain beneficiaries, in order to be eligible for Medicaid, must spend money on their medical bills to offset their excess income. This is a requirement for the Medically Needy category of eligible beneficiaries. In cases of short-term spenddown, the spenddown amount is defined as being the amount that should be used for a beneficiary's provided services prior to Medicaid being involved.

SQL SERVER Relational DataBase Management Software which uses Structured Query Language.

SSDI Social Security Disability Income

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) A program providing medical benefits for beneficiaries under the age of 19 who are between 150 and 200 percent of poverty. Also referred to as Title XX. In Kentucky, this is referred to as K-CHIP.

STD Sexually Transmitted Diseases

STOP-LOSS Portion of a claim that exceeds the Stop-Loss cap. Provides protection for a managed care provider (as agreed to in the HCA/HMO contract) from catastrophic expenses (losses). For example, if the HMO refers a beneficiary to a specialist whose fee ends up to be greater than the Stop-Loss amount and the HCA/HMO contract provides for Stop-Loss, then the excess will be paid at a percentage factor (70% or 90%) contained on the Plan File for this Plan and Service Class. PCP/CM claims are paid at 100% when the cap is reached.

STRUCTURED QUERY LANGUAGE (SQL) The programming language used to access data in relational databases.

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| SUBCONTRACTOR | The entity contracting with the prime Contractor to perform services. |
| SUBJECT MATTER EXPERT (SME) | A person who is an expert for a particular subject matter and becomes the contact for information in that area. |
| SURVEILLANCE AND UTILIZATION REVIEW (SUR) | The processes and procedures by which the quality, quantity, appropriateness, cost of care, and services provided are evaluated against established standards. |
| SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (SURS) | A subsystem within the KMMIS that reports on benefit usage, profiles beneficiaries and providers, and reports on anomalies in payment or services. |
| SUSPENDED | When a claim is being processed, it is considered a “suspended” claim. The claim has neither paid nor denied. |
| SUSPENDED ADJUSTMENT | An adjustment that cannot pay or deny until data is corrected. |
| SUSPENDED CLAIM | A claim that cannot pay or deny until data is supplied or corrected. Claims which could not be processed during an initial or previous submission cycle. |
| SUSPENSE FILE LIST | A list containing all ICNs that should remain in cache is provided by the mainframe and transferred to the PC imaging network. (Imaging) |
| SYSTEM | This term refers to all of the subsystems within the MMIS collectively. |
| SYSTEM GENERATED | Information not input from another source (e.g., a data file, data transmission or keyed by the user). Examples are date, time, calculated numbers, etc. |

8.1.20 T

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| 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 |

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| 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). |
| TITLE XVI (16) | The Supplemental Security Income program (SSI). Grants to states for ABD—Supplemental Security Income for ABD – SS Act. |

- TITLE XVIII (18)** ABD Health Insurance Program as part of SS Act. The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B) of the Social Security Act. See Medicare.
- TITLE XIX (T19)** Medicaid law as part of the Social Security Act (Medicaid). Federal law authorizing federal payments to states that have elected to provide Medicaid services to residents. See Medicaid.
- TITLE XXI (T21)** Child Health Insurance Program as part of SS Act. A program providing medical benefits for beneficiaries under the age of 19 who are between 150 and 200 percent of poverty. Also referred to as SCHIP. Refer to HealthWave.
- TOB** Type of Bill
- TOC** Table of Contents
- TOC** Type of Coverage
- TOOLBAR** Icons that work as short cuts to many system functions are located on the top or side of the screen within a toolbar.
- TRANSACTION PROCESSING** Processing transactions as they are received by the computer. Also called online or real-time systems, transaction processing means that master files are updated as soon as transactions are entered at terminals or received over communications lines.
- TRANSACTION SET** A block of information in EDI, making up a business transaction or part of a business transaction.
- TRANSACTION SET STANDARDS** The system of syntax, data elements, segments, and transaction sets (messages) with which EDI will be conducted.

TRANSLATOR A program used to convert information from flat file to EDI format or from EDI format to flat file.

TRANSMISSION CONTROL PROTOCOL/INTERNET PROTOCOL (TCP/IP) A set of protocols developed to allow cooperating computers to share resources across a network. This methodology is used to communicate on the Internet and the Wide Area Network. Also used to transfer data between a web site (Internet or Intranet) and other computing platforms. The IP portion refers to the addressing scheme used to address the Internet Network, hence the IP address for a packet. And while the IP does not establish a direct link (just to/from address), the TCP enables two computers to have a connection and exchange streams of data. See IP, ICMP.

TREATMENT Any type of medical care and services recognized under state law to prevent, correct or ameliorate disease or abnormalities detected by screening and diagnostic procedures.

TRUNK A telephone line used to make and/or receive calls within the telephone system.

Txn Transaction

TYPE OF SERVICES (TOS) A code indicating a general category of service, such as medical, surgical, consultation, laboratory or x-ray. A broad classification of services used in conjunction with a procedure code to uniquely define a service.

8.1.21 U**UAT** **User Acceptance Testing**

UB-92 A standard claim form used to bill hospitals, home-health, and LTC services. (HCFA) Uniform Billing Form for all hospital services used by all payers (HCFA 1450) – Universal Billing form that was revised in 1992. Previously it was UB-16, then UB-82. This form is in use nationally for billing hospital-based services. In some states, it is also used for billing home health, rural health, hospice, and nursing home services.

UNIX A computer operating system used primarily in mini computers. The IBM 390 mainframe platform provides this OS as a sub-operating system to OS 390.

UPIN Universal Provider Identification Number

USER A data processing system customer.

USER ID The code unique to an individual which allows the user to sign-on to the computer system and defines the user's security status.

USUAL AND CUSTOMARY CHARGE (UCC, U&C) Those Charges most commonly billed for a service by each provider. The price the provider Charges his patients for a given service.

USUAL AND CUSTOMARY RATE (UCR) A method of calculating a reasonable Charge based on profiles generated from historical billed Charges.

UTILIZATION MANAGEMENT (UM) A unit of the fiscal agent that promotes cost-effective, quality health care through research, thorough reviews, and networks with agencies and committees.

**UTILIZATION
REVIEW
(UR/UTLIZATION
REV)**

Methods and procedures related to the utilization of covered care and services necessary to safeguard against unnecessary or inappropriate use of care and services.

8.1.22 V

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| 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. |

8.1.23 W

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| 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)

8.1.24 X

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| 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 |

8.1.25 Y

**YEARLY
ENROLLMENT**

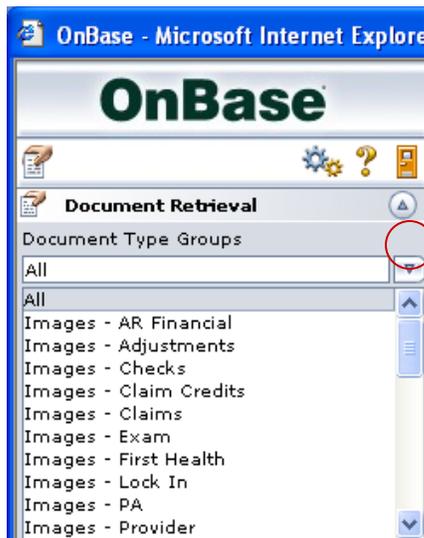
Managed Care re-enrollment opportunity that includes formal education on enrollment for all members annually after the actual county conversion.

YTD

Year to Date

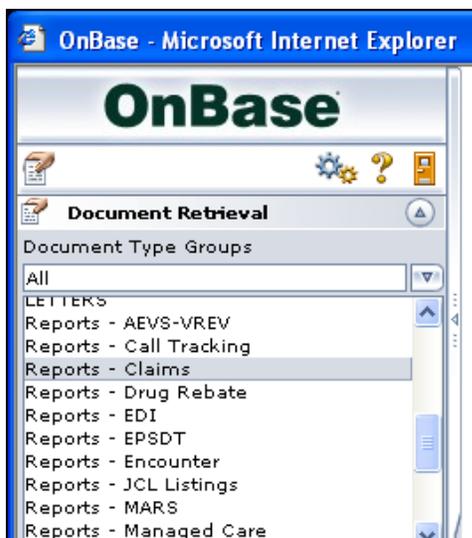
9 Appendix A- Searching for and Viewing Reports in OnBase

9.1 Searching for reports in OnBase



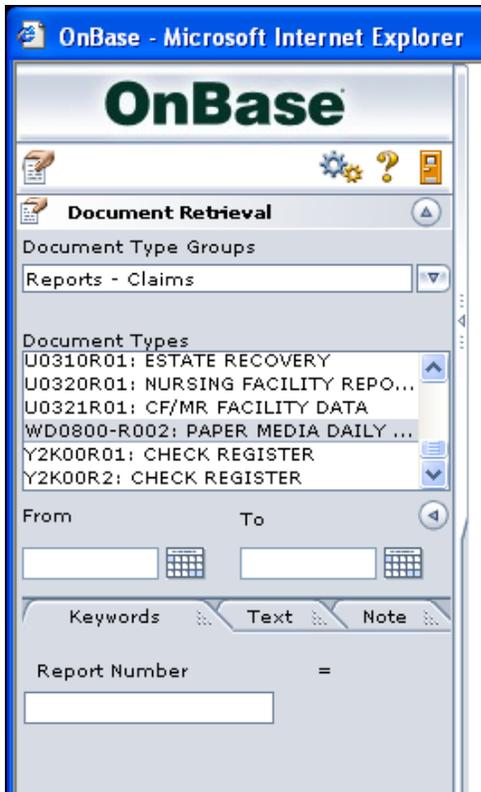
“DOCUMENT TYPE GROUP” is a drop down menu.

STEP 1. Click on the arrow at the right.

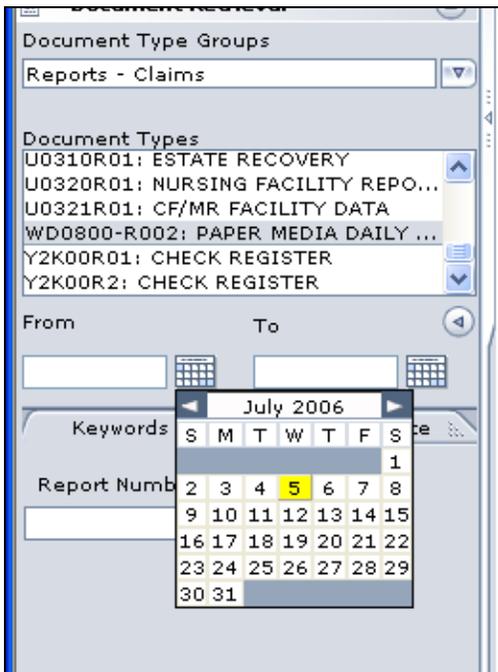


STEP 2. Under “DOCUMENT TYPE GROUP” select the type of report you wish to view.

NOTE: Reports are grouped as Mainframe Reports or iCE reports. Reports generated in the legacy MMIS will appear in “Mainframe” report groups. Reports generated in interchange will appear in “iCE” report groups.



STEP 3. Under “DOCUMENT TYPE” select the report you wish to view.



If you wish to limit your search to certain dates, you may do so by setting date parameters. Remember these are document dates, not dates of service or payment dates, etc.

STEP 4. Click on the calendar to the right of the “FROM” field.

The "FROM" and "TO" fields should look like this when you have entered date selections.

The search options on the "Keywords" tab may differ, depending on the Document Type selected. For example, when "ICE-Remittance Advice" is the selected Document Type, the search fields are "RA Number" and "Provider ID."

STEP 5. You may enter information in either or both fields. Note that the = sign appears in the example at the left. This indicates that you are searching for a value that "equals" your search criteria.

From: 01/01/2007 To: 01/15/2007

Keywords | **Text** | Note

RA Number =

Provider ID =

STEP 6. You may add additional values to search criteria by clicking on the field label (note the label "Provider ID" is highlighted in the example at the left).

From: 01/01/2007 To: 01/15/2007

Keywords | **Text** | Note

RA Number =

Provider ID =

AND

Provider ID =

An additional field will appear, allowing you to enter another value. For example, you could search for two providers' remittance advice statements in the same search.

Binoculars | Clock | Key | Refresh

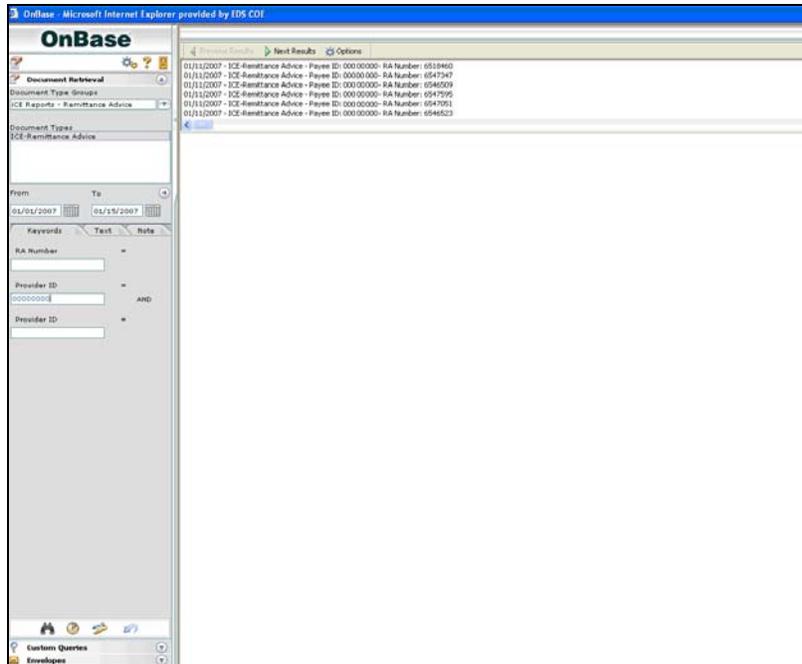
Custom Queries

Envelopes

STEP 7. After the search criteria have been entered, click the Binoculars on the left side of the bottom toolbar.

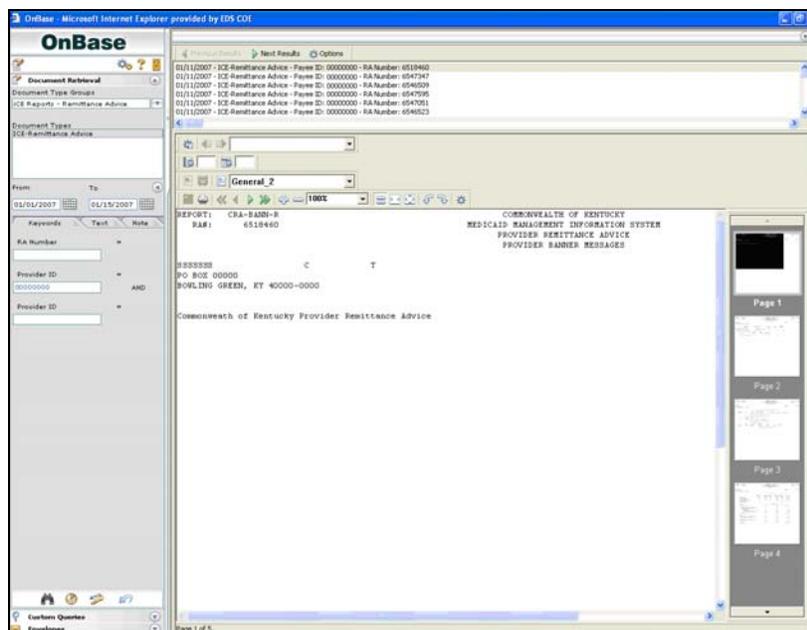
9.2 Selecting the report from search results

After your search is executed, you will see a screen that looks like this:



STEP 8. Select the desired report by double-clicking on the row in the results window.

The report will be displayed like this:



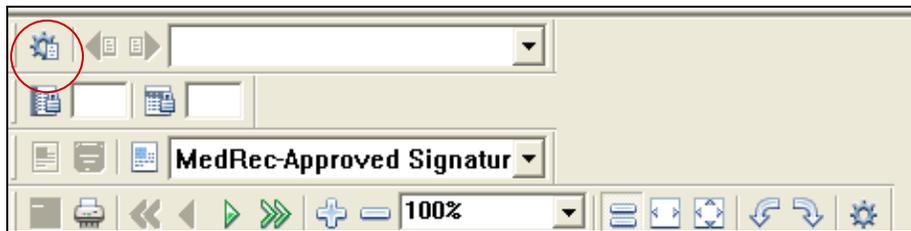
9.3 Viewing Reports in OnBase

Four tool bars appear above the report. They allow you to manipulate the document, and perform search and annotation functions.

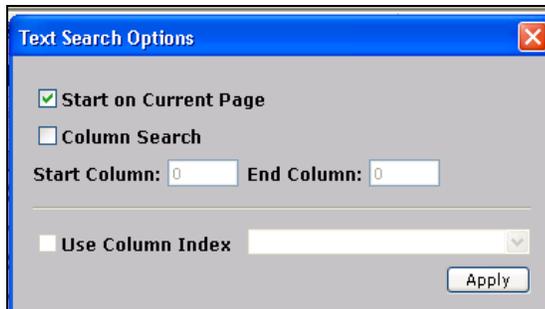
| TOOL BARS | |
|-----------|---|
| | <p>Scroll over the tool bar icons to see the pop-up labels.</p> |
| | <p>TOOL BAR 1 TEXT SEARCH OPTIONS icon</p> |
| | <p>Click the TEXT SEARCH OPTIONS button for Text Search Options box to be displayed.</p> |
| | <p>When you fill in the search criteria, the FIND NEXT button becomes active.</p> |
| | <p>After you have located the first occurrence of your search, the FIND PREVIOUS button becomes active.</p> |

| | | | | | |
|--|---|---|------------------|---|--------------------------|
|  | | <p>TOOL BAR 2</p> <p>LOCK COLUMNS icon</p> <p>LOCK ROWS icon</p> | | | |
|  | | <p>TOOL BAR 3</p> <p>TOGGLE ANNOTATION</p> | | | |
| <p>TOOL BAR 4</p> | | | | | |
|  | | | | | |
| <p>PRINT, ↑ OPTIONS</p> | <p>PAGE ↑ FORWARD, BACK, END, BEGINNING</p> | <p>ZOOM IN, ↑ OUT</p> | <p>ZOOM BY %</p> | <p>ACTUAL ↑ SIZE, FIT WINDOW, FIT WIDTH</p> | <p>ROTATE ↑ PAGE</p> |

9.3.1 Using the Text Search Option Within a Report



STEP 1. Click the TEXT SEARCH OPTIONS icon on the top tool bar.



STEP 2. When the TEXT SEARCH OPTIONS box pops up, select “Start on Current Page” and click apply.

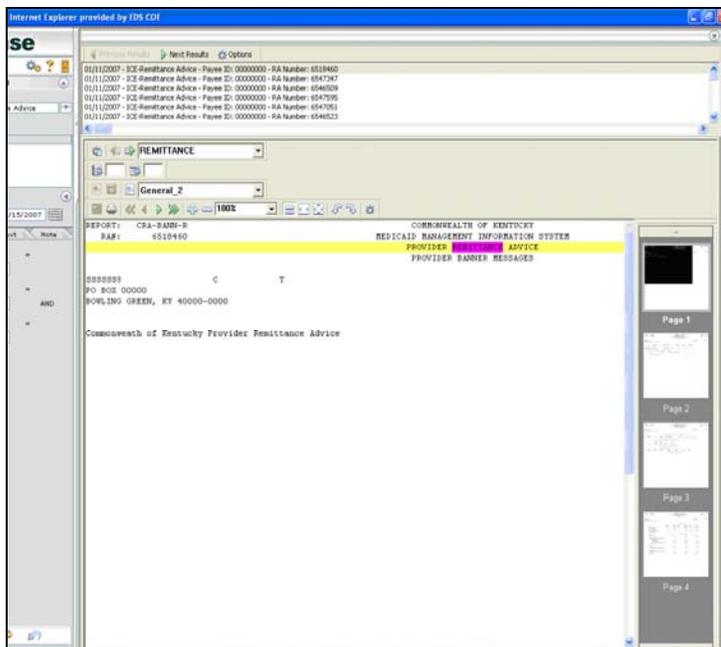


STEP 3. Enter search criteria in the search field. For best results, use ALL CAPS.

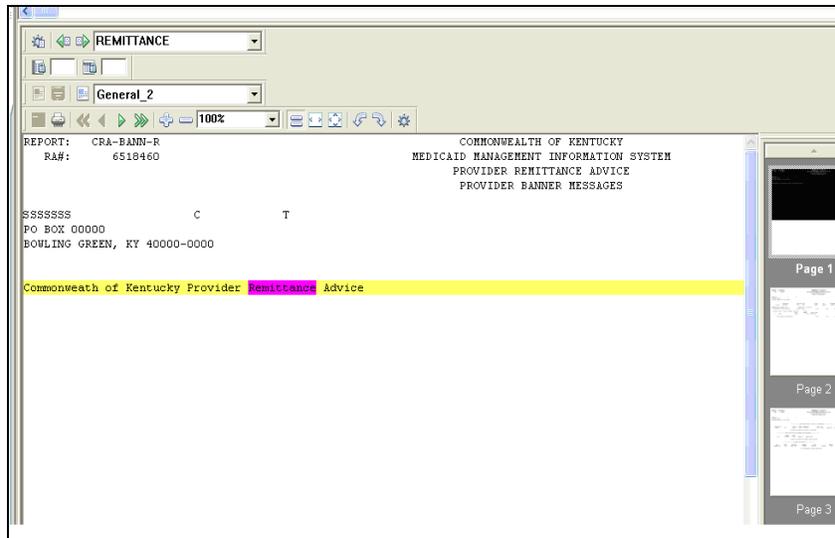
“REMITTANCE” is shown in the example.

The second icon, “FIND NEXT” will become active.

STEP 4. Click the FIND NEXT icon.



The first occurrence of the search criteria will be highlighted.



STEP 5. Click “FIND NEXT” again. The “FIND PREVIOUS” icon will become active, and the second occurrence of the search word will be highlighted. Clicking “FIND PREVIOUS” will return you to the previous occurrence.

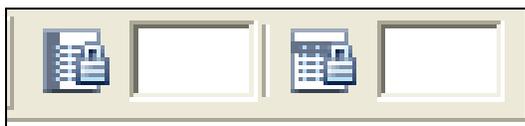
9.3.2 Locking Columns and Rows

If the document you are viewing is formatted as a text report, you can lock columns or rows of text into position to create easy reference points when you scroll through a page.

- Locking text columns locks the specified number of Character positions at the far left of the page.
- Locking text rows locks the specified number of lines at the top of the page.

When you lock rows or columns, the system inverts the colors in the locked area to make reference even easier. If the Pages toolbar is open, the colors in the locked areas of the thumbnails are also inverted.

Locks apply to the complete current document and only the current document and they apply only as long as it remains the current document. If you leave the document and return, all the text will be unlocked.



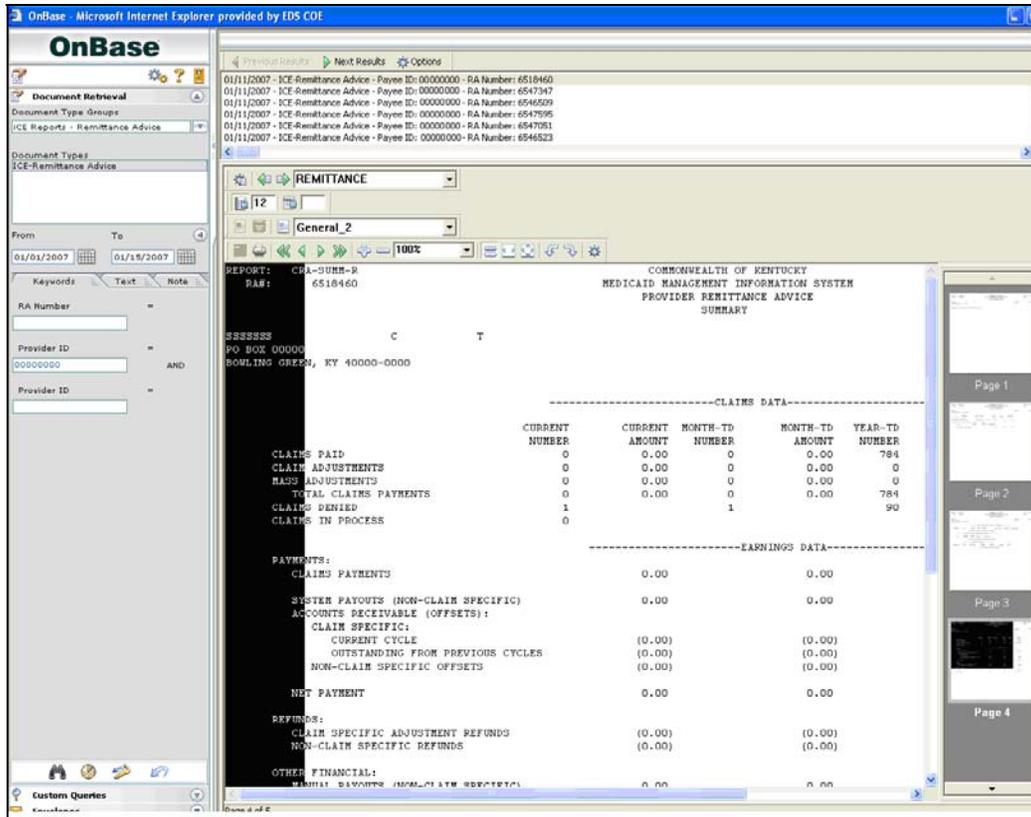
The “LOCKS COLUMNS” and “LOCK ROWS” icons are on the second toolbar.



The first icon is the “LOCK COLUMNS” icon. Enter a number in the box to the right of the “LOCK COLUMNS” icon.

STEP 1. Click the “LOCK COLUMNS” icon.

Your screen should look like this; the locked columns are black.



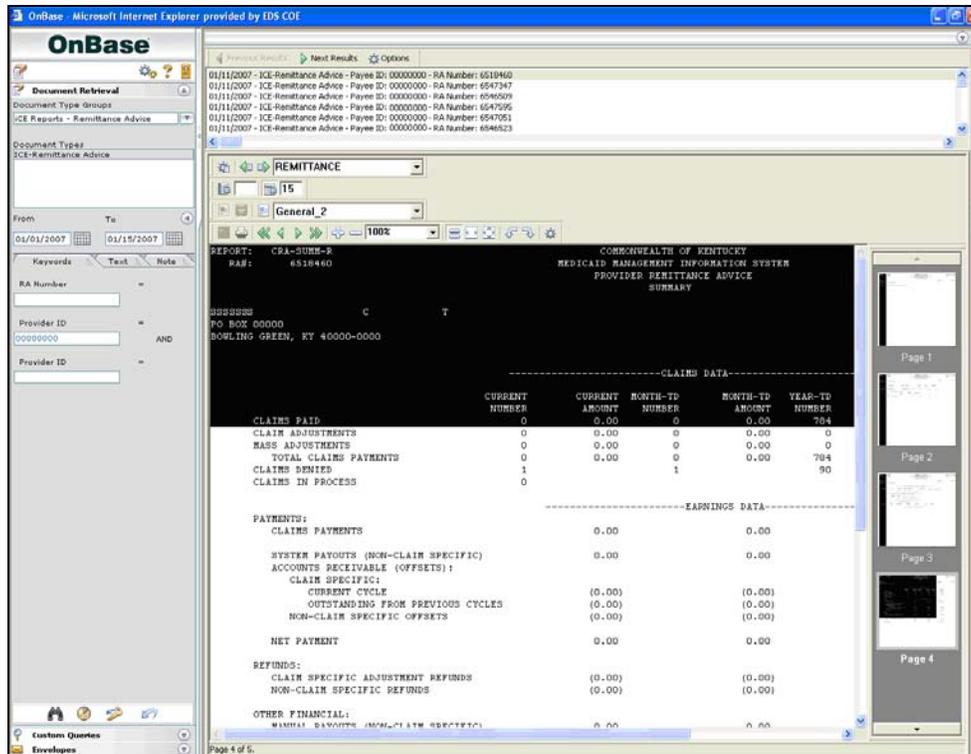
STEP 2. Click the “LOCK COLUMNS” icon again to unlock.



STEP 3. Delete the entry in the box next to the “LOCK COLUMNS” icon and enter a number in the box to the right of the “LOCK ROWS” icon.

STEP 4. Click the “LOCK ROWS” icon.

Your screen should look like this; the locked rows are black.



STEP 5. Click the "LOCK ROWS" icon again to unlock.

9.3.3 Adding an Annotation

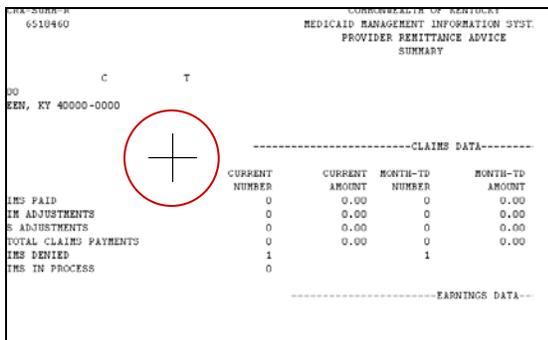


STEP 1. Click the arrow for the Annotation drop-down menu and select the Annotation Type.

*The only choice at this time is "MedRec-Approved Signatur"



STEP 2. Click on the TOGGLE ANNOTATION icon.



STEP 3. When you put your mouse in the document window, click and hold it. Crosshairs will appear.

GREEN, KY 40000-0000

| | CURRENT NUMBER | CURRENT AMOUNT |
|-----------------------|----------------|----------------|
| CLAIMS PAID | 0 | 0.00 |
| CLAIM ADJUSTMENTS | 0 | 0.00 |
| MASS ADJUSTMENTS | 0 | 0.00 |
| TOTAL CLAIMS PAYMENTS | 0 | 0.00 |
| CLAIMS DENIED | 1 | |
| CLAIMS IN PROCESS | 0 | |

PAYMENTS:

| | |
|-------------------------------------|--------|
| CLAIMS PAYMENTS | 0.00 |
| SYSTEM PAYOUTS (NON-CLAIM SPECIFIC) | 0.00 |
| ACCOUNTS RECEIVABLE (OFFSETS): | |
| CLAIM SPECIFIC: | |
| CURRENT CYCLE | (0.00) |
| OUTSTANDING FROM PREVIOUS CYCLES | (0.00) |

STEP 4. Left-click the mouse button and hold. Drag the mouse to create a box around the desired area of the report.

GREEN, KY 40000-0000

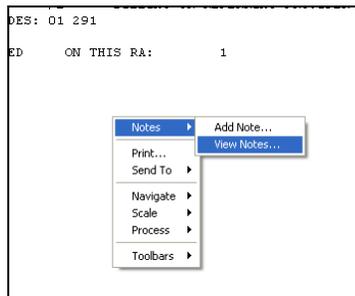
| | CURRENT NUMBER | CURRENT AMOUNT | MONTH-TD NUMBER |
|-----------------------|----------------|----------------|-----------------|
| CLAIMS PAID | 0 | 0.00 | 0 |
| CLAIM ADJUSTMENTS | 0 | 0.00 | 0 |
| MASS ADJUSTMENTS | 0 | 0.00 | 0 |
| TOTAL CLAIMS PAYMENTS | 0 | 0.00 | 0 |
| CLAIMS DENIED | 1 | | 1 |
| CLAIMS IN PROCESS | 0 | | |

PAYMENTS:

| | |
|-------------------------------------|------|
| CLAIMS PAYMENTS | 0.00 |
| SYSTEM PAYOUTS (NON-CLAIM SPECIFIC) | 0.00 |
| ACCOUNTS RECEIVABLE (OFFSETS): | |

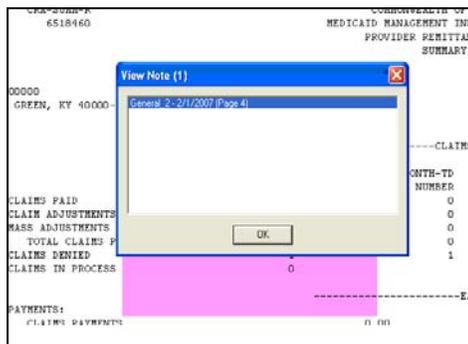
When you let go, a pink-shaded box will appear over the area marked.

STEP 5. Click the TOGGLE ANNOTATION icon again when you have placed your annotation.

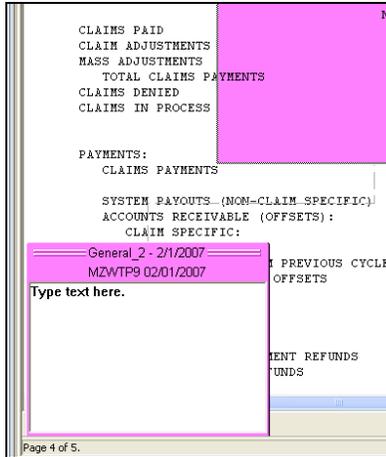


You must now open the note attached to the annotation to add your text.

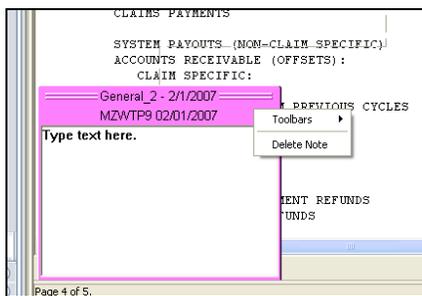
STEP 6. Right-click anywhere on the document. Select "Notes" and "View Notes."



STEP 7. Select the Annotation you wish to view and click "OK." Each annotation has a date, to help you identify it.



STEP 8. Click in the white area of the note and add text. Note the User's ID appears on the note.



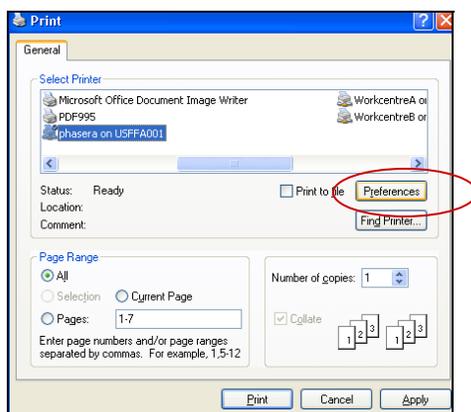
STEP 9. To delete the annotation, right-click in the header portion of the note and select "Delete Note."

NOTE: An annotation is visible to any user, and may be deleted by other users. It will remain until deleted.

9.3.4 Printing a Report

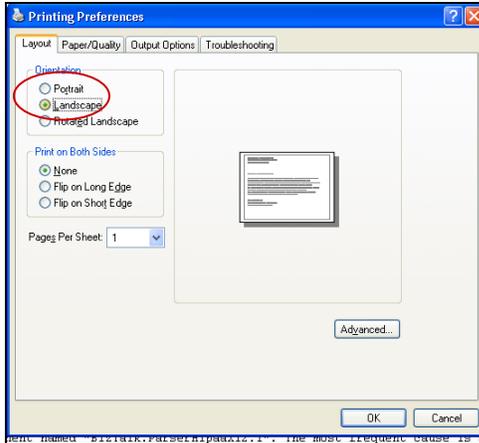


STEP 1. Click the Print icon on the toolbar.



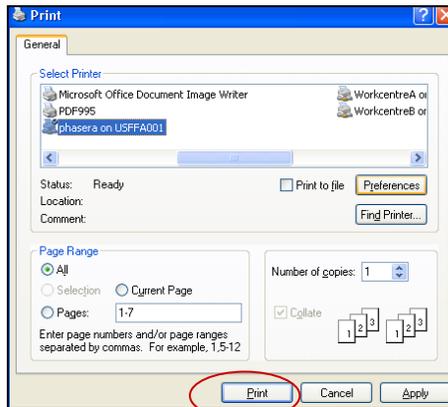
A Print dialog box appears.

STEP 2. Click "Preferences."



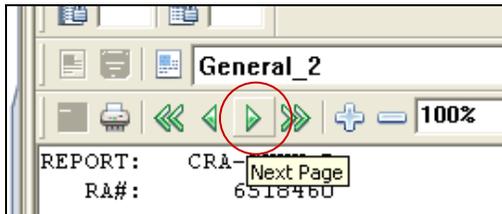
STEP 3. Select the Layout tab and click “Landscape” under Orientation.

STEP 4. Click OK.

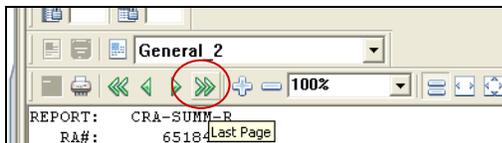


STEP 5. Click “Print.”

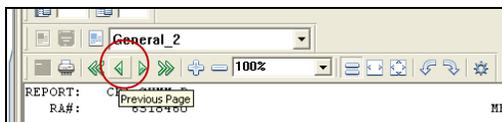
9.3.5 Navigating Multiple Report Pages



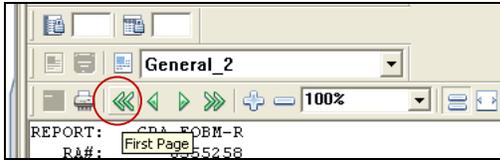
Click the right-pointing triangle to page forward one page.



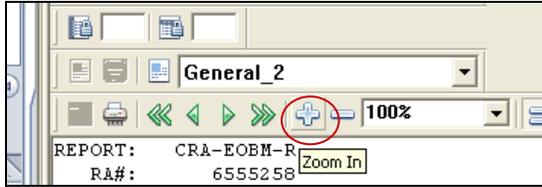
Click the right-pointing double arrows to go to the last page of the report.



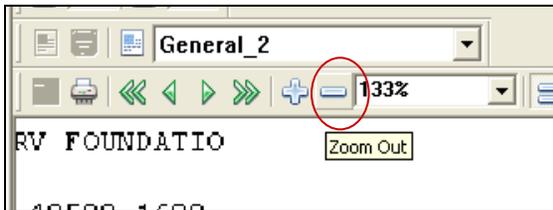
Click the left-pointing triangle to page back one page.



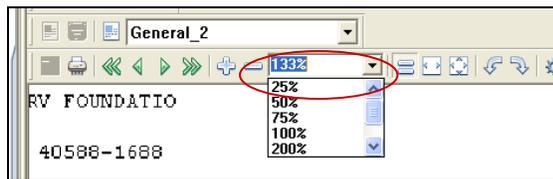
Click the left-pointing double arrows to go to the first page of the report.



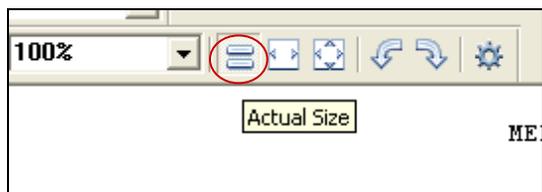
Click the plus sign to zoom in, or magnify the report page.



Click the minus sign to zoom out, or reduce the report page.



Use the drop-down menu or enter a percentage amount to set the magnification amount numerically.



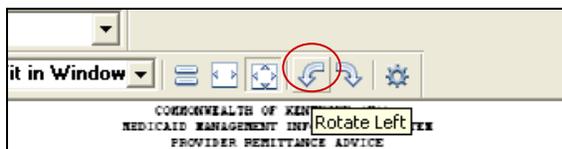
Click the equal sign button to display the report page in "actual size."



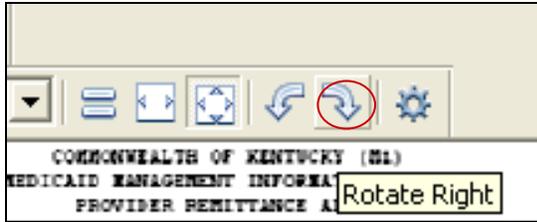
Click the button with two arrows to fit the report to the width of the document window.



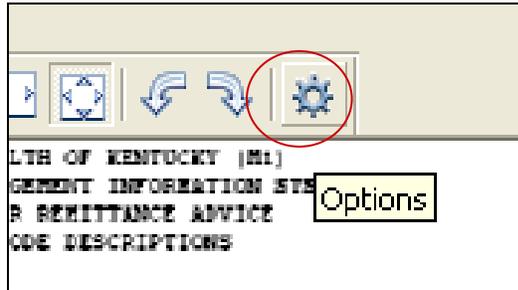
Click the button with four arrows to fit the report page to the size of the document window.



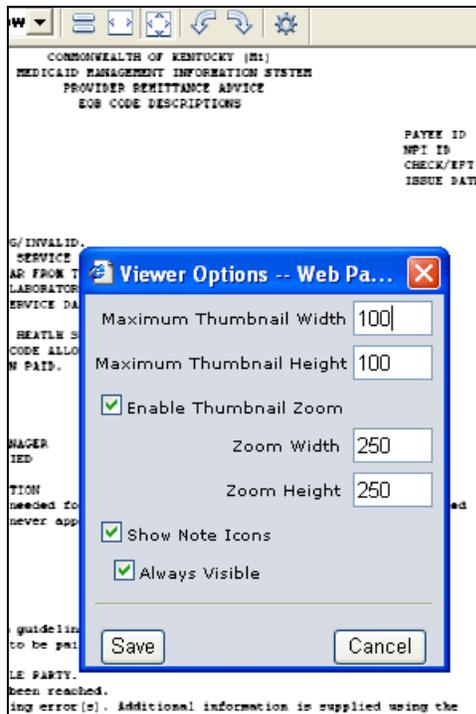
Click the left arrow to rotate the page to the left 90 degrees.



Click the right arrow to rotate the page to the right 90 degrees.



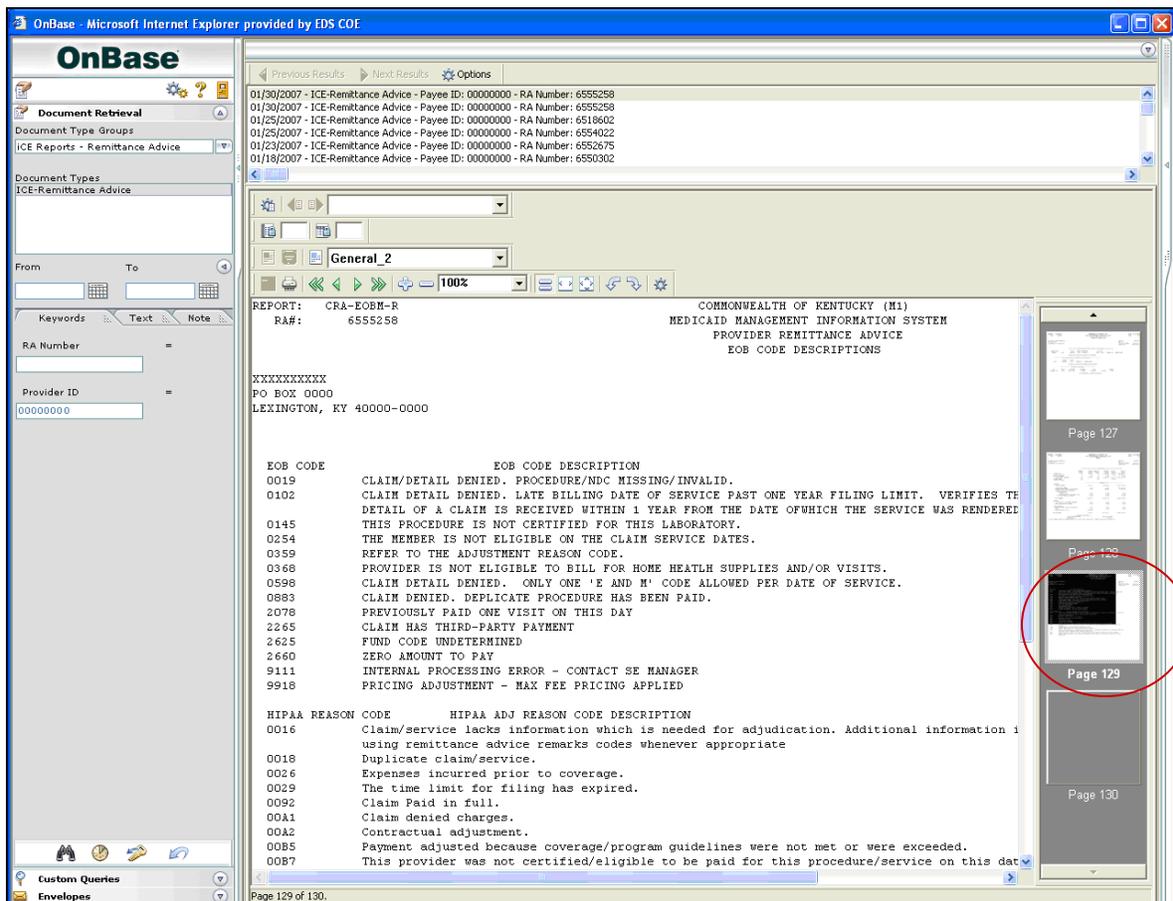
Click the "cog" button to set display options.



The Viewer Options box will open.

Setting changes will apply any time you are logged into OnBase.

9.3.6 Navigating with Document Thumbnails



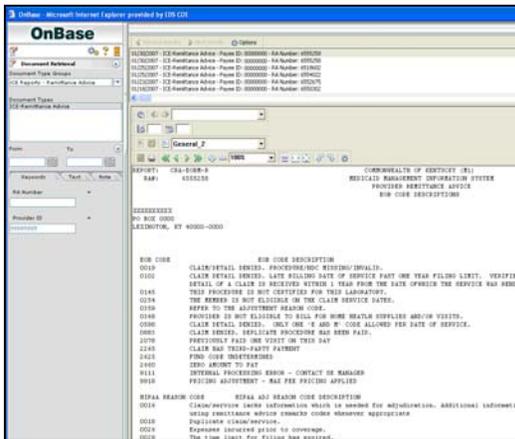
Look at the document thumbnails on the right side. Note that on Page 129, the upper left side of the thumbnail is black. That indicates the portion of the page you are viewing in the document window.

Use the light blue scroll bars to move to the left and down.

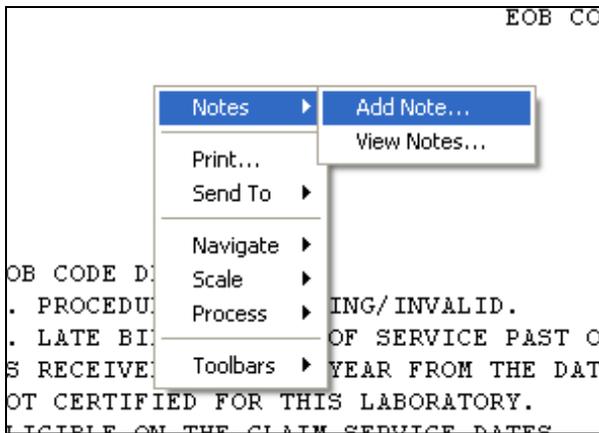
Note that the black box on the thumbnail moves as you scroll.

You may also place your cursor on the black box, left-click and drag. Note the page display changes as you move the black box.

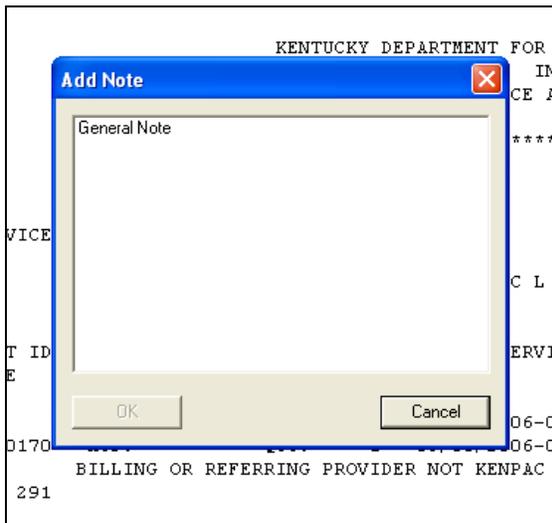
9.3.7 Adding Notes



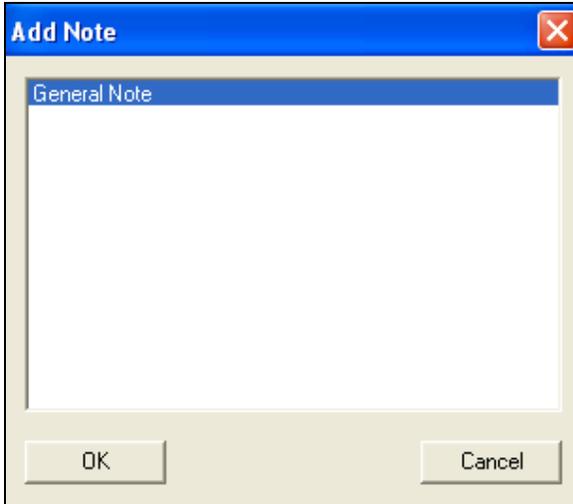
STEP 1. Right-click anywhere on the document within the document window.



STEP 2. Select “Notes” and “Add Note.”

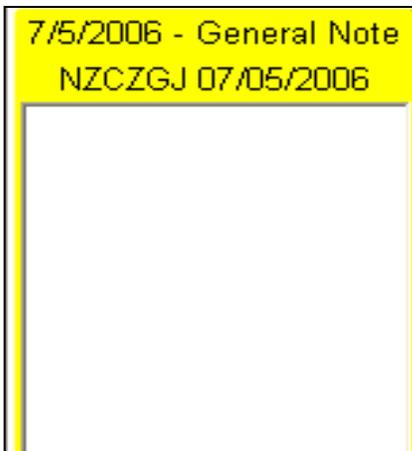


STEP 3. An “Add Note” dialog box will appear.

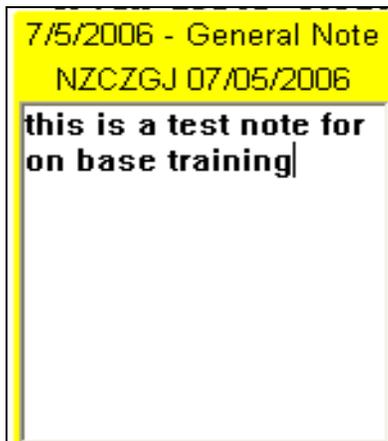


STEP 4. Highlight the NOTE TYPE and click "OK."

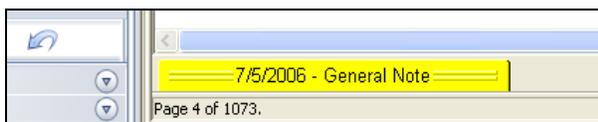
**"General Note" is the only type currently in use.



A "sticky note" box will appear.

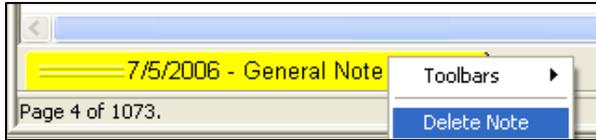


STEP 5. Enter the content of your note.



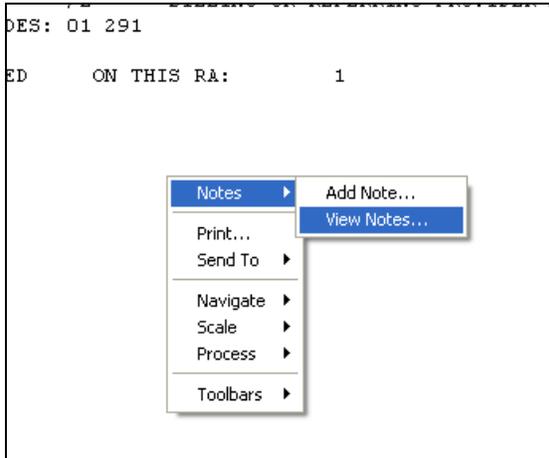
STEP 6. Click one time anywhere on the yellow bar to close the note window.

STEP 7. Another click will re-open it.



STEP 8. Right-clicking on the top bar of the Note will allow you to delete it.

9.3.8 Viewing Notes



STEP 1. To view Notes, right-click anywhere on the document window. Select "Notes" and "View Notes."



A menu pops up.

STEP 2. Select the Note you wish to view and click "OK."