



Service Prior Authorization Subsystem User Manual

Kentucky MMIS Project

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

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1 Introduction

This user manual is designed to cover the information necessary to perform the tasks of the Service Prior Authorization functional area.

This manual covers the following areas:

- Subsystem Overview;
- Getting Started;
- Procedures;
- Panels;
- Reports;
- Letters;
- Glossary of Terms;
- interChange Navigational Overview;
- Service Authorization How To Guide;
- Using the Audit Trail; and,
- Using the Help Functions.

1.1 User Manual Audience

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

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

1.2 Table of Contents Help Function

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."

2 Overview

The Service/Prior Authorization subsystem is a mechanism to review, assess, and approve or deny the Department for Medicaid Services (DMS) identified medical services prior to claims adjudication. It serves as a cost containment and utilization review mechanism for the Commonwealth, and enables the Medicaid Management Information System (MMIS) to approve payment for only those treatments and services that are medically necessary, appropriate, and cost effective.

HP Enterprise Services' subcontractor SHPS has responsibility for performing authorization screenings, medically necessary review approvals or denials, and managing all DMS identified approved services requiring Prior Authorization. The MMIS is responsible for the correct payment of authorized services.

2.1 Data Model

The Service/Prior Authorization subsystem maintains information on requested services for Medicaid members. The service requests are reviewed and updated with a determination of approved or denied and a reason is assigned for the decision. The requests are then available during claims processing to provide an authorization or denial for the payment of services. Service usage data is captured during claims processing and tracked to ensure that unit quantity and amounts do not exceed amounts approved on the service authorization request.

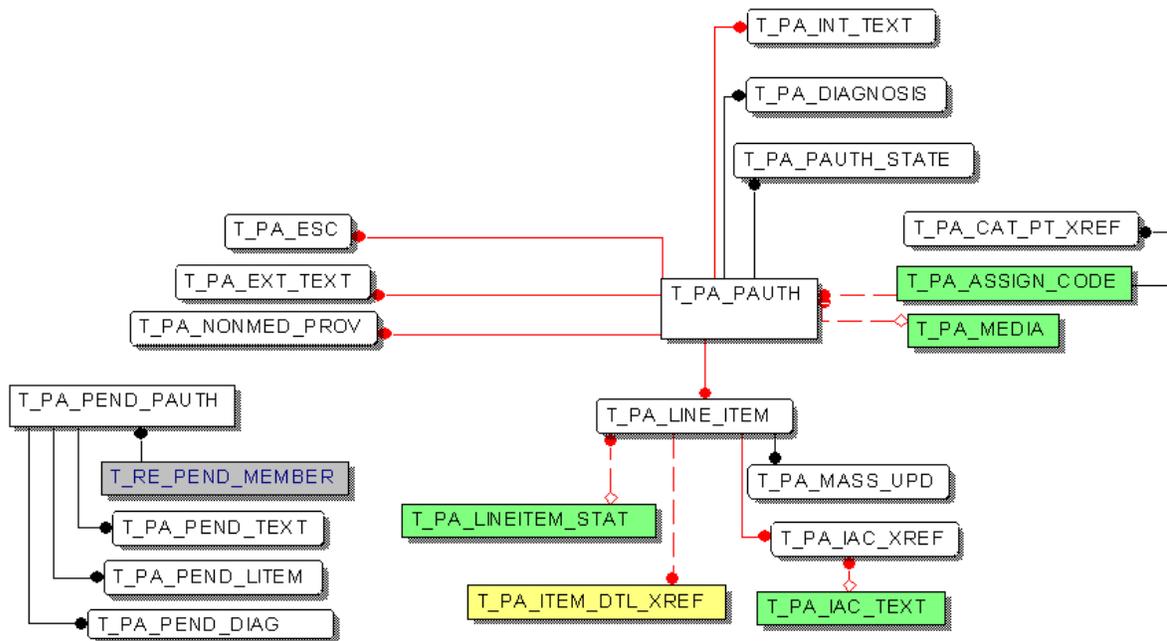
The Service/Prior Authorization subsystem also maintains prior authorization requests for pending eligibles. The requests may be submitted for in-patient and long term care type prior authorizations only. The requests reside in separate pending prior authorization tables awaiting assignment of a Medicaid ID to the pending eligible.

The Service/Prior Authorization process is supported by SHPS, which provides utilization management services. SHPS' role includes providing clinical, medical necessity reviews for various program areas, where prior authorization is required, as well as, providing supportive services, preparing case summaries, and providing testimony on behalf of the Commonwealth to support the rationale for the adverse determination that the member is challenging.

SHPS maintain the review information in maxMC. The data is available for reporting from the DSS.

2.1.1 Data Model Diagram

The following data model gives a view of the primary entities within the Prior Authorization Subsystem.



2.1.1.1 Data Model Legend

White- Prior Authorization Subsystem Entity

Green- Prior Authorization Code Table

Gray- Other Subsystem Entity

Yellow- Crosses PA and another subsystem

2.1.2 Subsystem Primary Entities

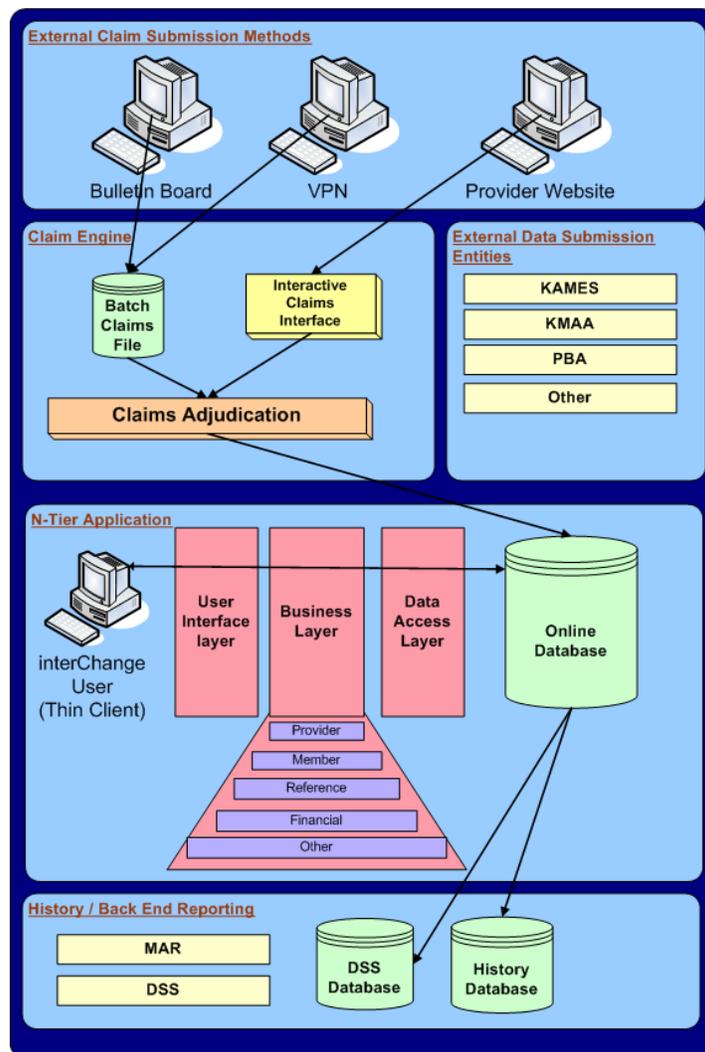
The following table provides a high level description of the primary entities that are used within the Service/Prior Authorization subsystem.

Entity	Description
T_PA_ASSIGN_CODE	This entity contains category codes and their descriptions. A category code is assigned to a PA as a way to group or classify requests. The category code is recorded on the PA header.
T_PA_EXT_TEXT	This entity contains free form text that may be entered by a reviewer. The text is displayed on the prior authorization notice to provide additional information regarding a decision.
T_PA_IAC_TEXT	This entity contains reason codes to document the reason for a decision on a service/prior authorization request.
T_PA_IAC_XREF	This entity associates one or more reason codes with a service/authorization request and is printed on the PA notice.
T_PA_INT_TEXT	This entity contains free form text that is entered for a service/authorization request. Internal text is intended for use within the Service/Prior Authorization unit. The text is not printed on the PA notice.
T_PA_ITEM_DTL_XREF	This entity contains units and amounts used on a service/prior authorization. The entity is accessed by claims processing to determine whether there are units or dollars available for a service that has been prior authorized. Entries are made into this table by claims processing when a PA is used to authorize payment of a claim.
T_PA_LINE_ITEM	This entity contains information about the requested services on a PA. It holds the requested service code, requested and authorized amounts, as well as the requested and authorized effective and end dates.
T_PA_LINITEM_STAT	This entity contains the status codes that may be associated with a PA line item.
T_PA_MEDIA	This entity contains the media code that represents the type of media that was used to submit a PA request. The media type for a PA is recorded on the PA header.
T_PA_PAUTH	This entity contains information about a service/prior authorization request such as the member for which the request was made, the requesting and servicing provider and the type or category of the request.
T_PA_PAUTH_STATE	This entity contains additional information about a service/prior authorization such as Case Number, Nursing Facility Indicator, and Admission and Discharge Dates.

Entity	Description
T_PA_PEND_DIAG	This entity contains information about diagnoses for a service/prior authorization that have been entered for a person that does not currently have Medicaid eligibility.
T_PA_PEND_LITEM	This entity contains information about requested services for a service/prior authorization that have been entered for a person that does not currently have Medicaid eligibility.
T_PA_PEND_PAUTH	This entity contains information about the service/prior authorization that has been entered for a person that does not currently have Medicaid eligibility.
T_PA_PEND_TEXT	This entity contains free form text associated with a service/prior authorization that has been entered for a person that does not currently have Medicaid eligibility.
T_RE_PEND_MEMBER	This entity contains information about the recipient that does not currently have Medicaid eligibility on the service/prior.

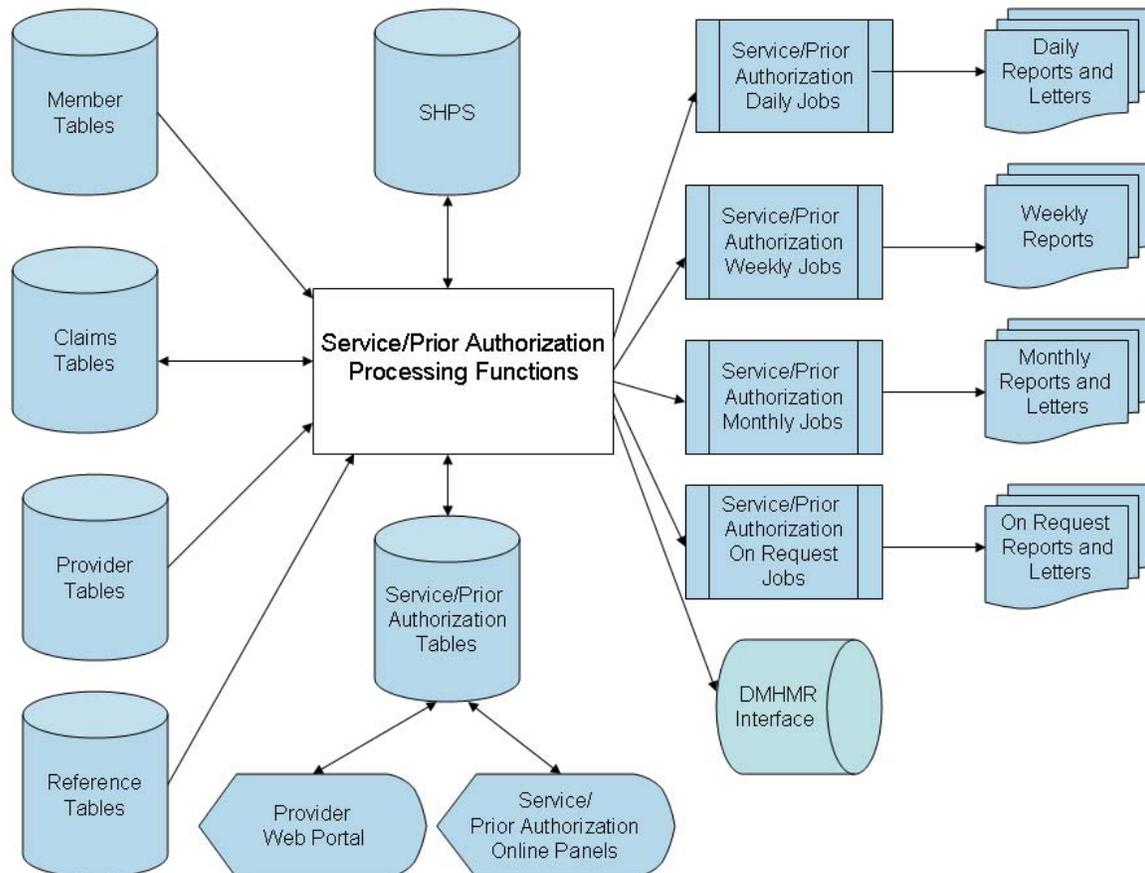
2.1.3 interChange System Architecture

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



2.1.4 System Flow

The following diagram represents Service/Prior Authorization input/output processing in a production context (job, jils, directories, and data).



2.1.4.1 How Service/Prior Authorization Requests/Records Reach interChange

There are four sources for entry of PAs into interChange: (School Based PAs Only)

2.1.4.1.1 Provider Internet Portal

Processing is near real-time

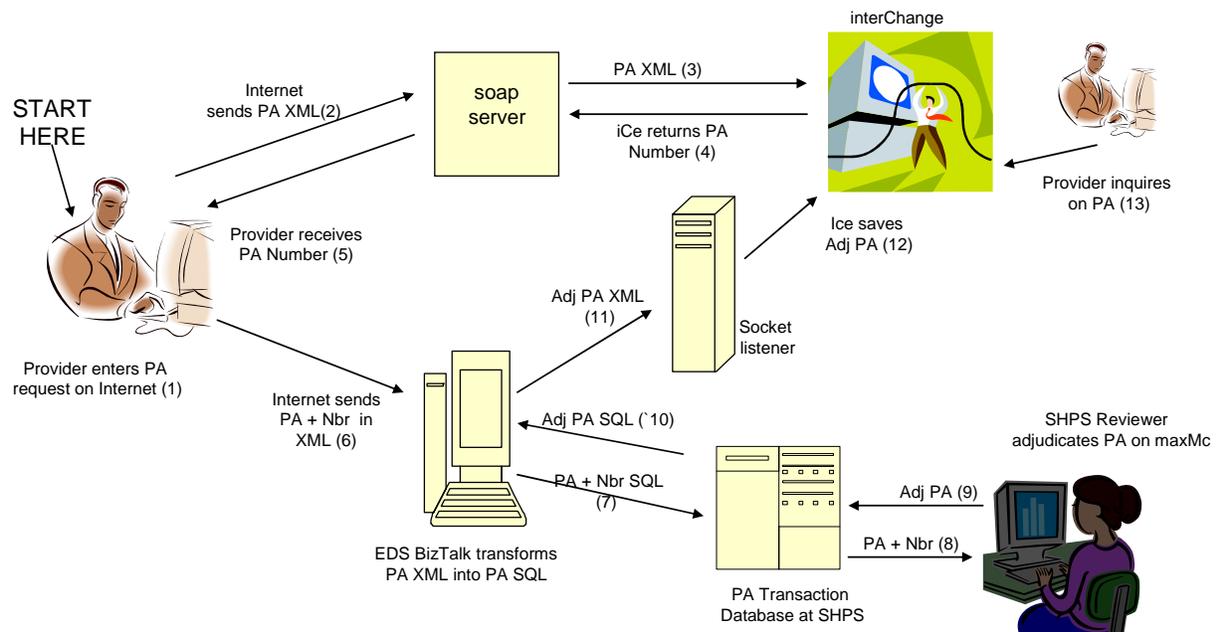
Only School Based PA category can be entered at this time.

Requested services are set to a pending status

PA receives PA number from iCe

School based PAs are added and updated on the Internet only.

2.1.4.1.2 PAs Entered Via Provider Internet Portal



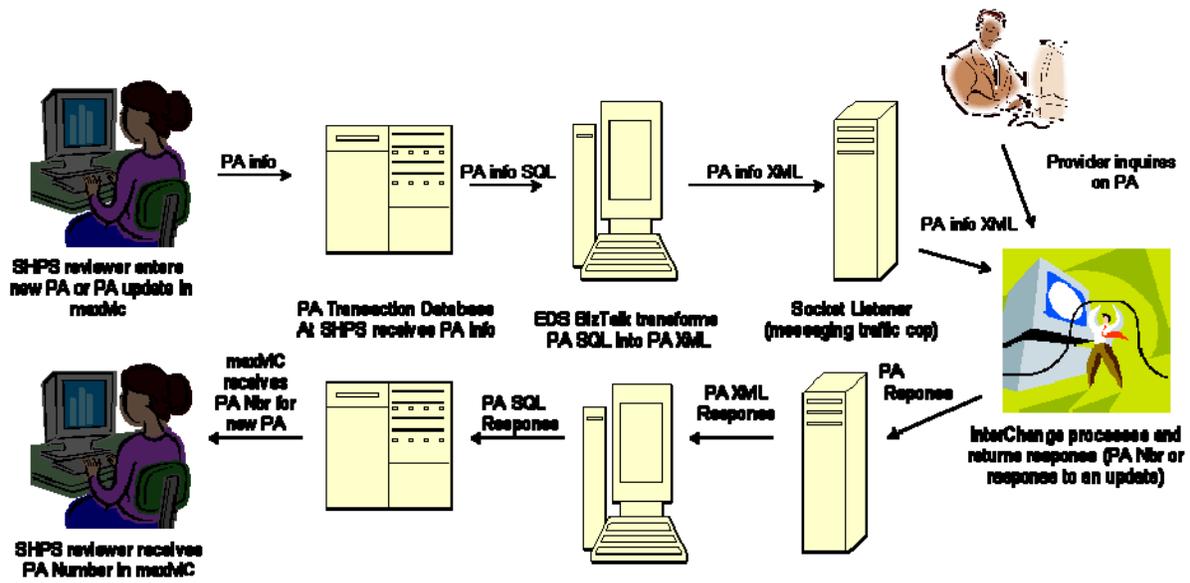
SHPS

- Processing is near real time;
- Pro Certs and regular PAs are kept on the same tables and display on the same panels in iCe;

iCe sends PA letter if requested service is approved;

- SHPS sends denial letter if requested service is denied; and,
- PA updates by SHPS travel the same path as PA adds

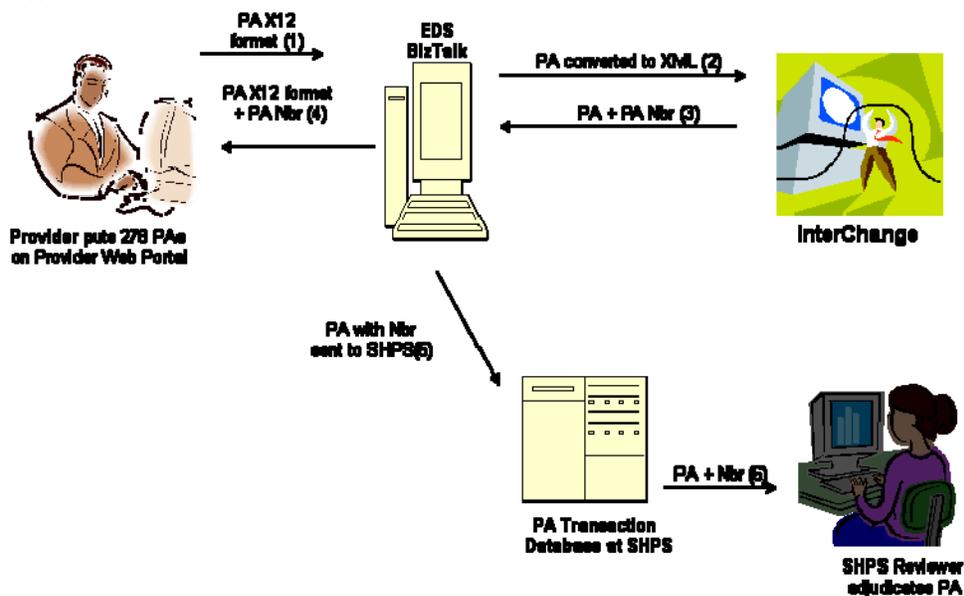
2.1.4.2 PAs Entered by SHPS



2.1.4.3 HIPAA 278 Transactions

- Provider drops off 278 files at Provider Internet Portal;
- Every 5 minutes process checks for new 278s;
- BizTalk picks up X12 format files and transforms to XML;
- BizTalk sends files to iCe;
- iCe processes PAs and returns results to BizTalk;
- BizTalk transforms XML back into X12 278 format and returns results to Provider;
- BizTalk sends PAs to SHPS; and,
- SHPS adjudicates the PA and sends interChange the update

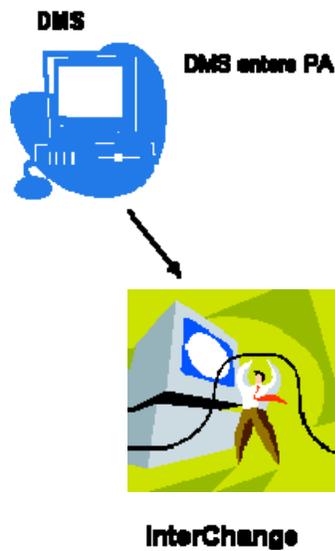
2.1.4.3.1 PAs Entered as HIPAA 278 Transactions



2.1.4.4 Online

- PAs entered into iCe are added directly to the PA tables;
- Periodically transactions are pulled off and sent to BizTalk;
- BizTalk puts transactions on SHPS PA Transaction database;
- maxMC picks up transactions and loads to the maxMC database;
- Reviewer adds Case Number;
- Case Number plus line item tracking number are sent back to iCe; and.
- Handshake transaction is sent from iCe to PA transaction database to say process is complete.

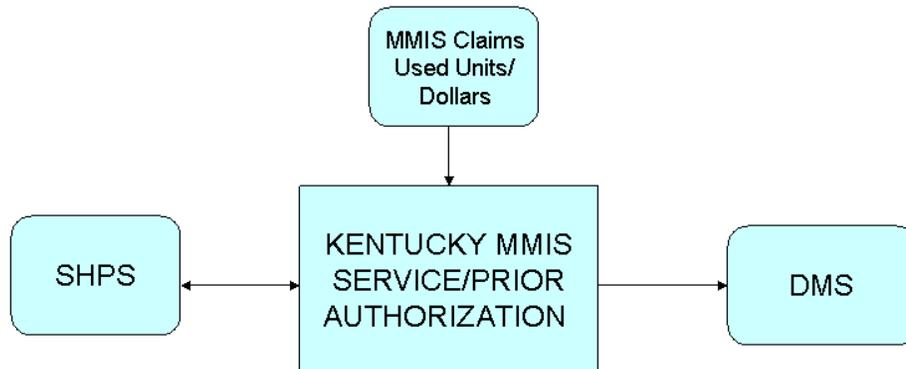
2.1.4.4.1 PAs Entered Online



2.2 External System Interfaces

2.2.1 External System Interfaces

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



2.3 Service/Prior Authorization Processes

2.3.1 Mass Updates

Some circumstances require a single change be made to a large number of Service Authorization records. For example, if a provider has a change of ownership, a new provider number is issued. All current PA records for the provider must be updated to reflect the new provider number. The Mass Update function allows all records to be updated at one time. The Mass Update Search function allows the User to set the criteria for locating the records to be changed.

2.3.2 Service Authorization Requests for “Pending Eligibles”

Service Authorization must be required prior to the provision of services. However, there are some cases which involve patients who are awaiting eligibility determination. If a member has applied for *KY Medicaid* benefits, but not yet been determined eligible, a provider may request Service Authorization before eligibility is determined. This allows a provider to provide the service, and submit a claim after eligibility is determined.

2.3.3 Prior Authorization “Line Items”

Each Service/Prior Authorization record contains one or more “line items.” These are the detail lines of the PA record. Line items include information such as (but not limited to) procedure code, modifier, and number of units.

2.3.4 Prior Authorization Diagnosis Codes

Diagnoses are used in the Prior Authorization approval process, but diagnoses on claims are not compared to diagnoses on corresponding PAs.

2.4 Service/Prior Authorization Process Descriptions

2.4.1 Maintain Service/Prior Authorization Data

Connected via	Connected to	Src	Dst
Soap Server	Provider Web Portal	X	
BizTalk	SHPS	X	
Biz Talk (HIPAA transactions)	Provider Web Portal	X	

2.4.1.1 Process Description

Service/prior authorization data is received from the Provider Internet and SHPS. The data is edited and valid data is added to the MMIS database making it available for Claims Processing.

Level of care is determined for enrolled Medicaid members as well as pending eligibles and sent to KAMES for the determination of financial eligibility.

2.4.1.2 interChange Narrative

Service/prior authorization data is received from the following sources: provider data entry on the Provider Web Portal, HIPAA 278 transactions, SHPS data entry into maxMC, and data entry into the interChange online panels. The data is edited and valid data is added to the MMIS database making it available for Claims Processing. SHPS sends pending eligibles and level of care for selected PA Categories which is sent on to KAMES by the Member subsystem.

2.4.1.2.1 PA Category Code

The PA Category code is used to group service/prior authorizations. It is also used to determine the type of PA letter to generate for the PA and the payment method to be used for pricing the PA. Below is the PA Category Table for a list of valid PA Categories used in interChange.

2.4.1.2.2 Provider Submits School Based PAs on the Web

Providers submit School Based PA requests on the MMIS Provider Web Portal. The PAs are sent to the MMIS Service/Prior Authorization subsystem where they are edited and valid PAs are added to the database. Line items are automatically set to an approved status. There are no approval letters generated for School Based PAs. The PAs reside only in the MMIS. SHPS has no responsibility for these PAs.

2.4.1.2.3 Maintain SCL and ABI Service/Prior Authorizations

SHPS determines the level of care and required services for a member for SCL and ABI PA Categories. SHPS performs direct data entry of service/prior authorizations into interChange panels for these PA Categories. LOC and pending eligible information is sent to KAMES in a manual process.

2.4.1.2.4 Provider submits PAs for Member or Pending Eligible to SHPS

A provider may submit a PA request to SHPS by telephone, fax, mail, e-mail or in person. The following describes PA processes when a PA is submitted for either a Member or a Pending Eligible.

PA Category Table

PA Category	PA Category Description	Payment Method	Level of Care	Primary Data Entry Method
02	In-Patient Hospital	system rate	no	SHPS Interface
03	Mental Hospital	system rate	yes	SHPS Interface
07	Model Waiver 2	system rate	yes	SHPS Interface
08	PRTF - Psychiatric Residential Treatment Facility	system rate	yes	SHPS Interface
12	Out-Patient Hospital	system rate	no	SHPS Interface
16	Impact Plus	price from PA	no	SHPS Interface
26	ICF/MR - Institutional Care Facility/Mental Retardation	system rate	yes	SHPS Interface
27	Nursing Facility	system rate	yes	SHPS Interface
32	EPSDT-Related Services	price from PA	no	SHPS Interface
36	Other Lab & X-Ray	system rate	no	SHPS Interface
40	DME Supplier	price from PA	no	SHPS Interface
41	Primary Care Center	system rate	no	SHPS Interface
43	Rural Health Clinic	system rate	no	SHPS Interface
46	Home Health	system rate	no	SHPS Interface
50	SCL-Support For Community Living	system rate/ audit cap amount	yes	SHPS entry into panels
52	Home & Community Base Waiver	system rate/ audit cap amount	yes	SHPS Interface
53	Home & Community Adult Day Care	system rate/ audit cap	yes	SHPS Interface

PA Category	PA Category Description	Payment Method	Level of Care	Primary Data Entry Method
		amount		
60	Acquired Brain Injury	system rate/ audit cap amount	yes	SHPS entry into panels
72	Dental	system rate	no	SHPS Interface
73	Orthodontia	capitated rate	no	SHPS Interface
74	Physician	system rate	no	SHPS Interface
76	IMD – Institute For Mental Disease	system rate	yes	SHPS Interface
77	School Based	system rate	no	Provider Web Portal
92	Psychiatric DPU	system rate	no	SHPS Interface
93	Rehab DPU	system rate	no	SHPS Interface

- **Provider submits PA request for Member to SHPS**

When SHPS receives the PA request the following occurs:

1. SHPS enters the PA into maxMC. SHPS also enters transactions with Level of Care updates for existing members;
2. SHPS reviewer adjudicates the PA;
3. PA transaction is sent to MMIS PA with a Case Number. LOC information for Long Term Care type PAs is also sent to MMIS PA. LOC information is forwarded to the MMIS Member subsystem for transmission to KAMES;
4. MMIS returns a PA number to maxMC; and,
5. A letter is generated by the MMIS for approved PAs and by SHPS for denied PAs.

- **Provider submits PA request for Pending Eligible to SHPS**

The following occurs when a provider submits a PA request for a Pending Eligible to SHPS:

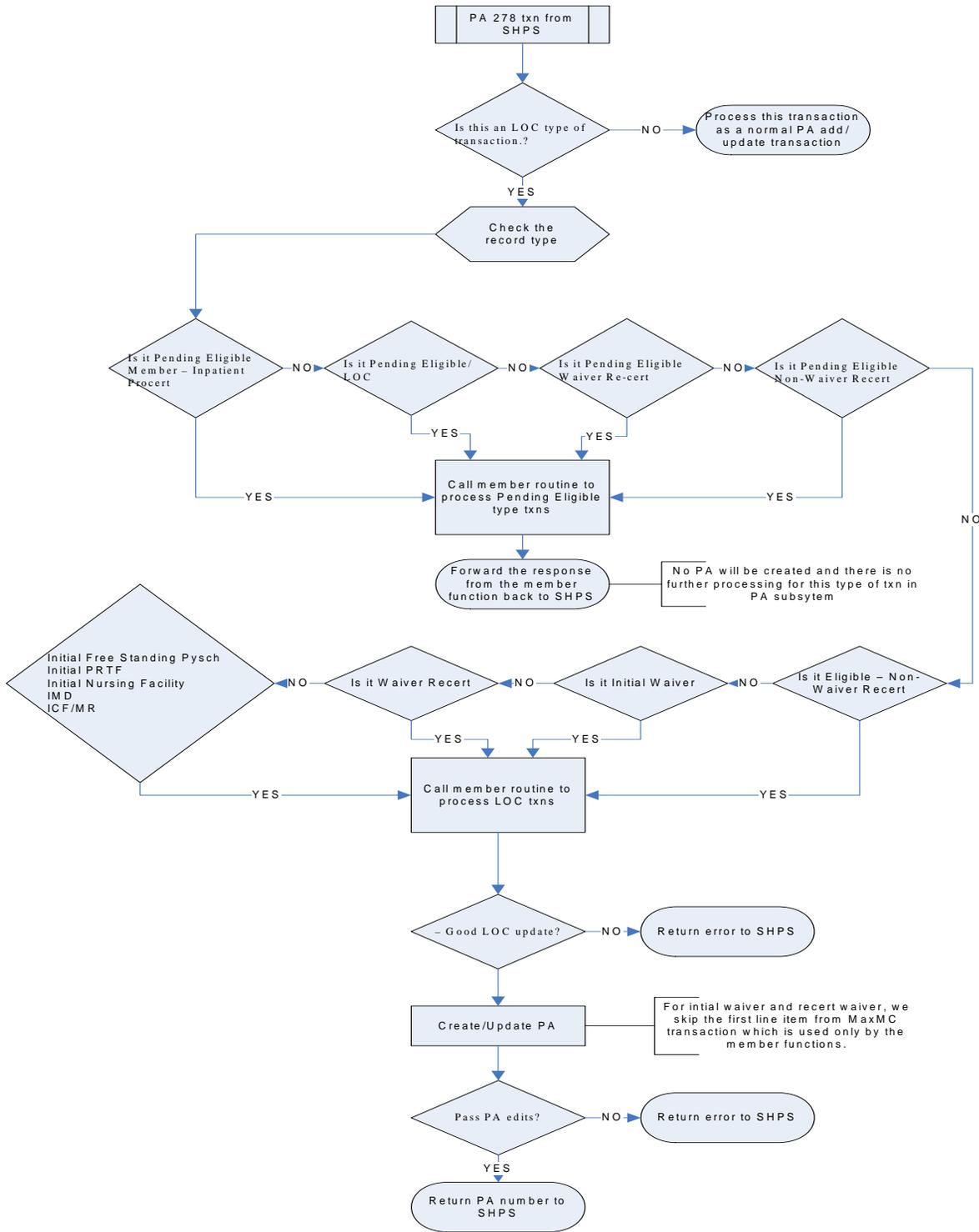
1. Demographic information for the Pending Eligible and the pending PA is entered into maxMC;
2. SHPS determines LOC if required and adjudicates PA;
3. SHPS sends pending eligible and LOC information for Long Term Care type PAs. This information is forwarded to the MMIS Member subsystem;
4. MMIS sends LTC pending eligible and LOC information to KAMES in nightly Member subsystem interface file;
5. KAMES sends MMIS Member subsystem Medicaid ID for pending eligible in nightly interface file;
6. MMIS Member subsystem sends maxMC Member updates in nightly interface file;
7. SHPS updates Pending Eligible's PA with a Medicaid ID and the PA is sent to the MMIS;
8. MMIS returns PA Number to maxMC; and,
9. A letter is generated by the MMIS for approved PAs and by SHPS for denied PAs.

- **SHPS Transaction Processing**

The MMIS processes an incoming SHPS transaction based on a "Process Status" and "Record Type" in the transaction. The table below lists the Process Status/Record Type combinations with how it processes (Transaction Description Column).

Process Status	Txn type	Record type	Description
P	Add/Update	Not Applicable	New PA or update existing PA
K	Add/Update	I	Pending Eligible Member – Inpatient Procert
		P	Pending Eligible/LOC
		A	Pending Eligible Waiver Recert
		B	Pending Eligible Non-Waiver Recert
		R	Eligible - Non-Waiver Recert
		L	<ul style="list-style-type: none"> • Initial Free Standing Pysch; • Initial PRTF; • Initial Nursing Facility; • IMD; and, • ICF/MR
		M	Initial Waiver
		W	Waiver Recert
A	Add/Update	Not Applicable	Resubmitting the pending eligible with a member ID

The following flowchart details the path of pending eligible and LOC transactions sent by SHPS in the PA interface.



2.4.2 Generate Prior Authorization Letters

2.4.2.1 Process Description

Prior Authorization approval letters are sent to members, providers and a member's local Department for Community Based Services (DCBS) office where appropriate.

2.4.2.2 interChange Narrative

When all requested services on a PA have been placed in a finalized status (Approved or Denied), an indicator is set to trigger printing of PA Notification letter(s). Batch job PAUJD001 creates letter requests for the letter generator and resets the letter indicator. The letter generator nightly batch job actually creates the letters sent to members, providers and DCBS. If changes are made to a service for authorized dates or amounts, the indicator is again set to print and a notification letter generated. PA letters and letter recipients are listed below. See the Letters section (Chapter 2.9) for specific letter formats.

PA Category	MMIS Letter Formats
Waivers - <ul style="list-style-type: none"> • SCL-Supports for Community Living; • Acquired Brain Injury; • Home & Community Based Waiver; • Home & Community Adult Day Care; and, • Model Waiver 2. 	Member – PAU-001A-D Provider – PAU-001B-D
Home Health	Provider – PAU-001D-D Member – PAU-001E-D
Impact Plus	Provider – PAU-001F-D

PA Category	MMIS Letter Formats
<p>Other - for remaining PA types e.g.</p> <ul style="list-style-type: none"> • Primary Care Center; • Rural Health Clinic; • Other Lab & X-Ray; • Out-Patient Hospital; • EPSDT; • Dental; • Orthodontics; • Physician; and, • DME. 	<p>Provider – PAU-001G-D</p>
<p>Inpatient /Nursing Facility</p> <ul style="list-style-type: none"> • In Patient Hospital; • Nursing Facility; • IMD – Institute for Mental Disease; • Mental Hospital; • PRTF – Psychiatric Residential Treatment Facility; and ICF/MR 	<p>Provider – PAU-001H-D</p>

The following letters are generated by SHPS:

- Medical Necessity Denial;
- Nursing Facility & Waiver Medical;
- Necessity Denial-Initial and CSR;
- Psych Freestanding & Psych PRTF Denial;
- Impact Plus Service Denial;
- Impact Plus Eligibility Approval;
- Impact Plus Service Approval;
- Impact Plus Eligibility Denial 915;

- Lack of Information Denial;
- Request for Information;
- Technical Denial;
- Durable Medical Equipment Technical Denial;
- Reconsideration Request Out of Timeframe Notice;
- Reconsideration Date Scheduled Notice;
- Reconsideration Denial Overturned;
- Psych Freestanding & Psych PRTF Approval (LO2); and,
- Physician Services Confirmation of Consent Part1

2.4.3 End Date PAs of Members going into Managed Care

2.4.3.1 Process Description

Members may enroll in Managed Care and still have open PAs for services that are provided by the managed care organization. Open PAs are end dated for services that will be provided by the MCO.

2.4.3.2 interChange Narrative

Monthly process (job PAUJM130) accesses Managed Care data looking for enrolled members. If a member with a PA is found to be enrolled in Managed Care, there is a check to see if the PA services are for services covered by the MCO. If the services are covered by the MCO, the PAs are end-dated.

2.4.4 Orthodontic Case Tracking Process

2.4.4.1 Process Description

Providers are required to submit documentation during the span of a member's orthodontic treatment. Reminder letters are set to providers when documentation is overdue. If the reminder letters do not generate a response from the provider, the PA authorizing treatment is included on reports tracking overdue documentation.

2.4.4.2 interChange Narrative

The Utilization Management Organization monitors timely submission of progress reports for orthodontia work authorized on service/prior authorizations. An Orthodontic Status Code on the service/prior authorization is maintained by the UMO indicating when documentation has been received. The status code, along with the authorized begin date for a service, is used to determine the generation of provider reminder letters and inclusion of the PA on overdue reports. The following reports and letters are created in quarterly job PAUJM220.

Reports:

- Prior Authorization Case Tracking Six Month Progress Report Not Received (PAU-0220-M1);
- Prior Authorization Case Tracking Final Case Submission Form Not Received (PAU-0220-M2); and,

- Ad hoc report is created in the Data Warehouse to aid in PA research for a specific provider. The DSS report is “Orthodontic Prior Authorization Case Tracking”.

Letters Sent To Providers:

- Prior Authorization Orthodontic Six Month Progress Report Letter (PAU-0220-1L);
- Prior Authorization Orthodontic Six Month Progress Report Follow Up Letter (PAU-0220-2L);
- Prior Authorization Orthodontic Final Case Letter (PAU-0220-3L); and,
- Prior Authorization Orthodontic Final Case Follow Up Letter (PAU-0220-4L).

2.4.5 Generate EPSDT First Time Letter**2.4.5.1 Process Description**

The EPSDT Special Services Program provides services for a member from birth through age 21. The first time a member requests an EPSDT service through a PA, a letter is sent to the member with notification that the services are no longer available when the member reaches 21 years of age.

2.4.5.2 interChange Narrative

Daily job PAUJD200 generates letter requests (PAU-0200-DL) for the letter generator. The letters are sent to members when an EPSDT service/prior authorization is requested for the first time. The letter notifies the member that EPSDT services are no longer available when the member reaches 21 years of age. Monthly process (PAUJM210) generates report PAU-210-M listing members with EPSDT prior authorization requests for the first time in the preceding month.

2.4.6 Automated Mass Update Process**2.4.6.1 Process Description**

There are situations that call for a mass update of a significant number of PAs. The updates come under two categories: 1) provider updates and 2) rate and service code updates. In the case of provider mass updates, the PAs are end dated for the original provider and outstanding services are transferred to the new provider on a new PA. For rate and service code mass updates, an override entry with a rate or service code is created for Claims to access during claims processing.

2.4.6.2 interChange Narrative

Mass updates are split into two automated processes: a provider mass update and a service/rate mass update. The processes are detailed below.

2.4.6.2.1 Automated Provider Mass Updates Solution

Mass update of providers is a two-step process. The first step end dates the old provider's PAs so that claims will not pay past the effective date for the new provider. The old provider is given time to submit claims for payment. The second step updates authorized units and amounts for the old provider with what has been used to date. PAs are then created for the new provider with the remaining authorized units and amounts from the original PA. Details of each step are given below.

Step1 (job PAUJD140):

- End-date the old provider's PAs with the effective date of the provider change less one day. The prior auth numbers are saved for later use in Step 2. The old provider submits claims for processing and payment within a specified amount of time;
- Create and send letter of notification to old provider;
- Send SHPS transactions of PA changes;
- Create report of PAs selected for mass change; and,
- Only end-date PAs where there are units left on a line item. Put the PA on the report with **** at the end of the report line.

Step 2 (job PAUJD141):

- After sufficient time has passed for the old provider to have claims submitted and processed, authorized units and amounts are updated on the old provider's PAs with total to date of used units and amounts. PAs for the old provider are now considered used up;
- PAs are now transferred to the new provider by creating a new PA for each of the end dated PAs. Authorized units and amounts are calculated based on original units and amounts less used units and amounts by the old provider. The authorized effective date is the effective date of the provider change and the authorized end date is the original end date of the PA. The new provider is now able to bill claims with the new PA and has authorized units and amounts available;
- Create and send PA letter to new provider;
- Send SHPS transactions of PA changes; and,
- Create report with old and new PA information.

2.4.6.2.2 Automated Rate Mass Change - (job PAUJD142)

Create and maintain new PA line item rates in the MMIS: Rate changes for a PA line item are created by an automated process and maintained on a new PA table in the MMIS. PA line items may be selected to receive a rate change based on PA category, service code and provider ID. Rate change information include the PA number, line item number, service code, the new rate, and effective begin end dates for the new rate. The effective begin date is the date the new rate is effective for claim payment. The end date for the rate is the end date of the PA line item;

Claims and the new rate: Claims processing will choose the rate to pay based on the service dates on the claim from either the line item or the override line item rate change, whichever is in effect at that time. Units and amounts paid will be recorded and tracked against the original line item units and amounts and provide an audit trail and an accounting of units and amounts used. If a rate is retroactive and a claim has already been paid, the claim must be manually adjusted to pay at the new rate;

Provider notification of the new rate: Letters are generated notifying providers of the new rate to be paid on a PA and the effective begin and end dates for the new rate;

Reporting affected line items: A report is created detailing line items where a rate change was generated; and

SHPS: Maintenance transactions are sent to SHPS with the rate change.

2.4.6.2.3 Automated Service Code Mass Change - (job PAUJD142)

Create and maintain new PA line item service codes in the MMIS: Service code changes for a PA are created by an automated process and maintained on a new PA table in the MMIS. PA line items will be selected to receive a service code change based on PA category and existing service code. Service code change information includes the PA number, line item number, the new service code, and effective begin end dates for the new service code. The effective begin date is the date the new service code is effective for claim payment. The end date for the new service code is the end date of the PA line item;

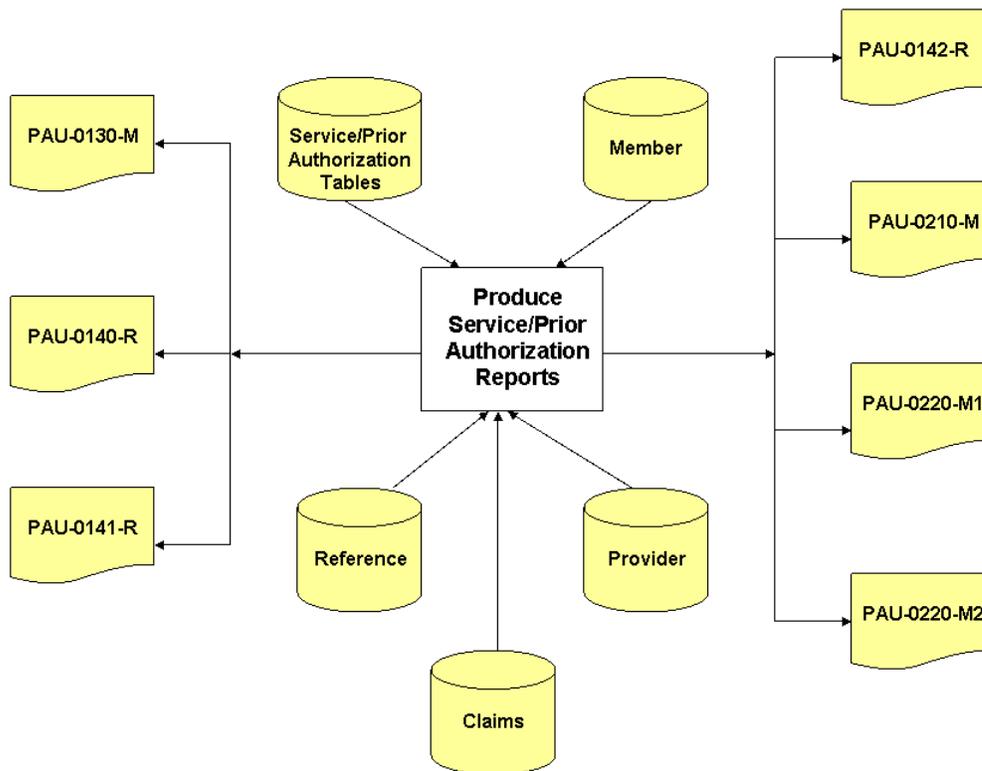
Claims and the new service code: Claims processing will choose the service code to pay based on the service dates on the claim from either the line item or the override line item service code change, whichever is in effect at that time. Units and amounts paid will be recorded and tracked against the original line item units and amounts and provide an audit trail and an accounting of units and amounts used. If a service code is retroactive and a claim has already been paid, the claim must be manually adjusted to pay with the new service code;

Provider notification of the new service code: Letters are generated notifying providers of the new service code to be paid on a PA and the effective begin and end dates for the new service code; and,

Reporting affected line items: A report is created detailing line items where a service code change was generated.

2.4.7 Produce Service/Prior Authorization Reports Flow Diagram

The Report Process Flow Diagram is displayed below.



2.4.7.1 Diagram Abstract

The process flow diagram provides a visual representation of how the Service/Prior Authorization processing area reports are generated. All reports are stored and accessible in COLD. The data for the Service/Prior Authorization reports is extracted from the Prior Authorization, Member, Reference, Claims and Provider Tables. A proposed layout of each report may be found in the report section of this DSD.

3 Service Prior Authorization Getting Started

3.1 System Access

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

3.2 Accessing the Prior Authorization Subsystem

To access the Service PA subsystem in interChange MMIS, click on the interChange icon which takes you to the home page and then click on Prior Authorization.

The screenshot shows the home page of the Kentucky interChange website. The browser address bar displays "change.kymmis.com/kentucky/Default.aspx". The page header includes the Kentucky logo with the tagline "UNBROKEN SPIRIT", the user email "mzwt9@eds.kyxix.edsmhg.com [window 5]", the date "Tuesday, November 13, 2007", and the site name "Site E KyHealth Choices". A navigation menu contains links for Home, Claims, Reference, Provider, Member, Financial, EPSDT, TPL, Managed Care, MAR, Prior Authorization, CTMS, and Site. A left sidebar titled "Contact Information" provides contact details for the Unicenter ServicePlus Service Desk, including the phone number 502-209-3221. The main content area features a "Welcome to the New Kentucky MMIS" message, identifying the site as "Production site E" and noting its installation on Tuesday, October 30, 2007.

3.2.1.1 Service Prior Authorization Panels Display

The screenshot shows the 'Prior Authorization Search' panel within the 'KyHealth Choices' application. The panel is titled 'Prior Authorization Search' and contains several search criteria fields:

- Prior Authorization Number
- Requesting Provider ID [Search]
- Clerk Keyed [Search]
- PA Category Code (dropdown menu)
- Member ID [Search]
- Servicing Provider ID [Search]
- Authorizer [Search]
- Primary Diagnosis Code [Search]
- Case Number

At the bottom of the search area, there is a 'Records' dropdown menu set to '20'. On the right side, there are four buttons: 'search', 'clear', 'adv search', and 'add'. The top of the page shows the date 'Thursday, January 25, 2007' and the 'KyHealth Choices' logo. A navigation menu includes 'Home', 'Claims', 'Reference', 'Provider', 'Member', 'Financial', 'EPSDT', 'TPL', 'Managed Care', 'MAR', 'Prior Authorization', 'CTMS', 'Security', 'Site', 'Admin', and 'Host'. Below the search panel, there is a copyright notice: 'Copyright 2005 Electronic Data Systems Corporation. All rights reserved.'

The Service Prior Authorization menu will display under the main menu. Select a menu item by clicking once on the menu title.

3.2.1.2 Service Prior Authorization Menu Selections

Menu Selection	Description
Search	Allows user to search for information using member's ID.
Information	Allows user to access abnormalities, member comments and notices.
Mass Update Search	Allows user to verify that updates to the PA were executed.
Pending PA Search	This panel displays information about a service/prior authorization request for a pending eligible entered through the Provider Web Portal
Related Data	Allows user to access category/provider type xref, pa category information, decision status, media type, and reason

4 Pages and Panels

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

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

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

Some information in this section is represented in table format. In order to fit information on the page, some data field information may wrap to the next line.

Note to users:

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

4.1 PAGE: Prior Authorization Search Page

4.1.1 Description:

Use the Prior Authorization Search Page to view service/prior authorizations that meet specified criteria. One or more criteria may be entered. Prior authorizations meeting all entered criteria display in the Search Results section. Click a Prior Authorization row in the Search Results frame to display the Information panel giving details about the selected service/prior authorization. Use the "adv search" button to display additional search criteria.

Navigation Path: [Prior Authorization] - [Search]

4.1.2 Technical Name:

PriorAuthSearch

4.1.3 Web Page Name:

PaSearch

For readability, the Prior Authorization Search Page Layout displays on the next page.

4.1.4 Prior Authorization Search Page Layout

Prior Authorization Search

Prior Authorization Number	<input type="text"/>	Member ID	<input type="text"/> [Search]	<input type="button" value="search"/> <input type="button" value="clear"/> <input type="button" value="adv search"/> <input type="button" value="add"/>
Requesting Provider ID	<input type="text"/> [Search]	Servicing Provider ID	<input type="text"/> [Search]	
Clerk Keyed	<input type="text"/> [Search]	Authorizer	<input type="text"/> [Search]	
PA Category Code	<input type="text"/> ▼	Primary Diagnosis Code	<input type="text"/> [Search]	
		Case Number	<input type="text"/>	
		Records	20 ▼	

Search Results												
PA Number	Line Item	Authorization Effective Date	Authorization End Date	PA Category Code	Requesting Provider ID	Servicing Provider ID	Servicing Code Number From	Servicing Code Number To	PA Status	Member ID	Case Number	Legacy PRO Cert Number
0102203001	01	01/10/2007	02/10/2007	Inpatient Hospital			D8210		Approved	000001261	TEST1234567890	00123
0102203001	02	02/20/2007	02/20/2007	Inpatient Hospital			204		Approved	000001261	TEST1234567890	00123
0102203001	03	03/30/2007	03/30/2007	Inpatient Hospital			D8210		Denied	000001261	TEST1234567890	00123
0102203001	04	04/14/2007	04/14/2007	Inpatient Hospital			204		Denied	000001261	TEST1234567890	00123
1005208001	01	07/27/2005	12/31/2005	Orthodontia			00009009403		Approved	000001261		00123
1005208001	02	0	0	Orthodontia			100	101	Pending	000001261		00123

To access this panel;

STEP 1. Click on **Prior Authorization** located in the subsystem header listing under the Commonwealth logo “Kentucky Unbridled Spirit.”

STEP 2. From the subsystem menu click **Search**.

4.1.5 PANEL: Prior Authorization Search

4.1.5.1 Description:

The Prior Authorization Search panel provides for PA searches by specific criteria. The panel first displays an abbreviated list of search criteria.

Navigation Path: [Prior Authorization] - [Search]

4.1.5.2 Technical Name:

PA.PaSearchPage.ascx (PA.PaSearchPanel.ascx)

4.1.5.3 Panel Name:

PA PrAuthSrch

For readability, the layout displays on the next page.

4.1.5.4 Prior Authorization Search Layout

Search Results												
PA Number	Line Item	Authorization			Requesting Provider ID	Servicing Provider ID	Servicing Code		PA Status	Member ID	Case Number	Legacy PRO Cert Number
		Effective Date	Authorization End Date	PA Category Code			Number From	Number To				
0102203001	01	01/10/2007	02/10/2007	Inpatient Hospital			D8210		Approved	000001261	TEST1234567890	00123
0102203001	02	02/20/2007	02/20/2007	Inpatient Hospital			204		Approved	000001261	TEST1234567890	00123
0102203001	03	03/30/2007	03/30/2007	Inpatient Hospital			D8210		Denied	000001261	TEST1234567890	00123
0102203001	04	04/14/2007	04/14/2007	Inpatient Hospital			204		Denied	000001261	TEST1234567890	00123
1005208001	01	07/27/2005	12/31/2005	Orthodontia			00009009403		Approved	000001261		00123
1005208001	02	0	0	Orthodontia			100	101	Pending	000001261		00123

To access the **Prior Authorization Search** panel:

- STEP 1. Click on **Prior Authorization** in the main search panel.
- STEP 2. Next, click on **search** in the submenu below **Prior Authorization**.

This panel allows for a search of a PA using specific criteria.

4.1.5.5 Extra Features

The Prior Authorization Search panel has no extra features.

4.1.5.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Prior Authorization Number	Prior Authorization number is a unique identifier for a PA.	Listview	Character	10	T_PA_PAUTH	PRIOR_AUTH_NUM
2	Member ID	Unique identifier for the member for whom services are requested on the PA.	Field	Character	12	T_RE_BASE	ID_MEDICAID
3	Requesting Provider ID	Unique identifier for the provider requesting services for a member on a PA.	Field	Character	15	T_PR_PROV	ID_PROVIDER
4	Servicing Provider ID	Unique identifier for the provider performing the services for a member specified on a PA.	Field	Character	15	T_PR_PROV	ID_PROVIDER
5	Clerk Keyed	Unique identifier for the clerk who entered the PA.	Field	Character	8	T_PA_PAUTH	ID_CLERK_ENTRY
6	Authorizer	Unique identifier for person authorizing services on the PA.	Field	Character	8	T_PA_PAUTH	ID_CLERK_REV
7	PA Category Code	Code that groups a PAs requested services under a type such as dental, inpatient, and physician.	Field	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
8	Primary Diagnosis Code	A member's primary diagnosis.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
9	Case Number	The Case Number used in maxMC is being brought over to interChange to group PAs by an episode of care.	Field	Character	25	T_PA_PAUTH_S TATE	ID_CASE
10	Records	The maximum number of records displayed on the panel when the search results are displayed.	Field	Number	0	N/A	N/A

4.1.5.7 Button Descriptions

Button No	Button	Description
11	Search	Clicking the Search button returns search results based on the search criteria.
12	Clear	Clicking the Clear button clears the field.
13	Adv Search	Clicking Advanced Search opens the main search panel.
14	Add	Clicking the Add button adds a new prior authorization.

4.1.5.8 Field Edits

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

4.1.6 PANEL: Prior Authorization Advanced Search

4.1.6.1 Description:

The Prior Authorization Advanced Search panel provides for PA searches by specific criteria. The panel first displays an abbreviated list of search criteria. Click the "adv search" button to expand the choice of criteria.

Navigation Path: [Prior Authorization] - [Search]

4.1.6.2 Technical Name:

PA.PaSearchPage.ascx (PA.PaSearchPanel.ascx)

4.1.6.3 Panel Name:

PA PrAuthSrch

4.1.6.4 Prior Authorization Advanced Search Layout

The screenshot shows the 'Prior Authorization Search' panel with the following fields and callouts:

- 1** Prior Authorization Number
- 2** Member ID [Search]
- 3** Requesting Provider ID [Search]
- 4** Servicing Provider ID [Search]
- 5** Clerk Keyed [Search]
- 6** Authorizer [Search]
- 7** PA Category Code
- 8** Primary Diagnosis Code [Search]
- 9** Case Number
- 10** Revenue Code From [Search]
- 11** Revenue Code To [Search]
- 12** Procedure Code From [Search]
- 13** Procedure Code To [Search]
- 14** NDC Code [Search]
- 15** PA Status
- 16** Authorization Effective Date
- 17** Authorization End Date
- 18** Records 20
- 19** search button
- 20** clear button
- 21** adv search button
- 22** add button

To access the **Prior Authorization Advanced Search** panel:

STEP 1. Click on **Prior Authorization** in the main search panel.

- STEP 2. Next, click on **search** in the submenu below **Prior Authorization**.
- STEP 3. For searching with additional criteria, click on the **adv search** button on the right side of the screen.
- STEP 4. The **Prior Authorization Advanced Search** panel should now be displayed.
- STEP 5. This panel allows for a search of a PA using specific criteria.

4.1.6.5 Extra Features

The Prior Authorization Search panel has no extra features.

4.1.6.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Prior Authorization Number	Prior Authorization number is a unique identifier for a PA.	Listview	Character	10	T_PA_PAUTH	PRIOR_AUTH_NUM
2	Member ID	Unique identifier for the member for whom services are requested on the PA.	Field	Character	12	T_RE_BASE	ID_MEDICAID
3	Requesting Provider ID	Unique identifier for the provider requesting services for a member on a PA.	Field	Character	15	T_PR_PROV	ID_PROVIDER
4	Servicing Provider ID	Unique identifier for the provider performing the services for a member specified on a PA.	Field	Character	15	T_PR_PROV	ID_PROVIDER
5	Clerk Keyed	Unique identifier for the clerk who entered the PA.	Field	Character	8	T_PA_PAUTH	ID_CLERK_ENTRY
6	Authorizer	Unique identifier for person authorizing services on the PA.	Field	Character	8	T_PA_PAUTH	ID_CLERK_REV

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
7	PA Category Code	Code that groups a PAs requested services under a type such as dental, inpatient, and physician.	Field	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
8	Primary Diagnosis Code	A member's primary diagnosis.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
9	Case Number	The Case Number used in maxMC is being brought over to interChange to group PAs by an episode of care.	Field	Character	25	T_PA_PAUTH_STATE	ID_CASE
10	Revenue Code From	Code identifying a specific accommodation or ancillary service.	Field	Character	6	T_REVENUE_CODE	CDE_REVENUE
11	Revenue Code To	The ending range of revenue codes specified on a PA line item.	Field	Character	6	T_REVENUE_CODE	CDE_REVENUE
12	Procedure Code From	Code that uniquely identifies a procedure.	Field	Character	6	T_PROC	CDE_PROC
13	Procedure Code To	The ending range of procedure codes specified on a PA line item.	Field	Character	6	T_PROC	CDE_PROC
14	NDC Code	National Drug Code used to uniquely identify a drug.	Field	Character	11	T_DRUG	CDE_NDC
15	PA Status	Status (e.g. pending) or decision (e.g. approved, denied) for a line item.	Field	Character	20	T_PA_LINEITEM_STAT	DSC_STATUS

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
16	Authorization Effective Date	Begin date of the date range for which the service is approved for use by a member.	Field	Date (MMDDCCYY)	8	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
17	Authorization End Date	Last date an authorized service can be used by a member.	Field	Date (MMDDCCYY)	8	T_PA_LINE_ITEM	DTE_PA_AUTH_END
18	Records	The maximum number of records displayed on the panel when the search results are displayed.	Field	Number	0	N/A	N/A

4.1.6.7 Button Descriptions

Button No	Button	Description
19	Search	Clicking the Search button returns search results based on the search criteria.
20	Clear	Clicking the Clear button clears the field.
21	Adv Search	Clicking Advanced Search opens the main search panel.
22	Add	Clicking the Add button adds content.

4.1.6.8 Field Edits

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

4.1.7 PANEL: Prior Authorization Mini Search

4.1.7.1 Description:

The Prior Authorization Mini Search panel provides searches by Prior Authorization number. Using the Mini Search, a PA is accessed directly rather than having to select a PA from a list as when using the Search panel.

Navigation Path: [Prior Authorization] - [Information]

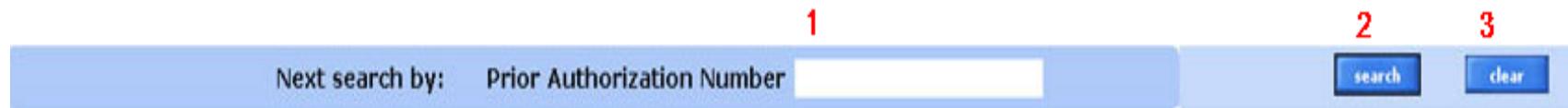
4.1.7.2 Technical Name:

PA.PaMiniSearchPanel.ascx

4.1.7.3 Panel Name:

Pa Mini Search

4.1.7.4 Prior Authorization Mini Search Layout



To access this panel:

- STEP 1. Click on **Prior Authorization** on the main search panel.
- STEP 2. Next, click on **Information** in the submenu below.
- STEP 3. Enter the Prior Authorization Number and click **Search** to access a new Prior Authorization Information page.

4.1.7.5 Extra Features

Global ERL

4.1.7.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Prior Authorization Number	Unique number assigned to a Prior Authorization request.	Field	Character	10	T_PA_PAUTH	PRIOR_AUTH_NUM

4.1.7.7 Button Descriptions

Button No	Button	Description
2	Search	Clicking the Search button returns search results based on the search criteria.
3	Clear	Clicking the Clear button clears the field.

4.1.7.8 Field Edits

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

4.1.8 PANEL: Prior Authorization Search Results

4.1.8.1 Description:

The Prior Authorization Search Results panel lists prior authorizations that meet the criteria specified in the Search panel fields. Click a row in the Search Results panel to display the Prior Authorization Information and Maintenance panels for viewing details of the selected prior authorization.

Navigation Path: [Prior Authorization] - [Search Panel] - [Search Button]

4.1.8.2 Technical Name:

PA.PaSearchPanel.ascx (results)

4.1.8.3 Panel Name:

PASearchResults

4.1.8.4 Prior Authorization Search Results Layout

1	2	3	4	5	6	7	8	9	10	11	12	13
» Search Results												
PA Number	Line Item	Authorization Effective Date	Authorization End Date	PA Category Code	Requesting Provider ID	Servicing Provider ID	Servicing Code Number From	Servicing Code Number To	PA Status	Member ID	Case Number	Legacy PRO Cert Number
0102203001	01	01/10/2007	02/10/2007	Inpatient Hospital			D8210		Approved	000001261	TEST1234567890	00123
0102203001	02	02/20/2007	02/20/2007	Inpatient Hospital			204		Approved	000001261	TEST1234567890	00123
0102203001	03	03/30/2007	03/30/2007	Inpatient Hospital			D8210		Denied	000001261	TEST1234567890	00123
0102203001	04	04/14/2007	04/14/2007	Inpatient Hospital			204		Denied	000001261	TEST1234567890	00123
1005208001	01	07/27/2005	12/31/2005	Orthodontia			00009009403		Approved	000001261		00123
1005208001	02	0	0	Orthodontia			100	101	Pending	000001261		00123

This panel is the result of the PA Search. The user can continue to view the data by selecting the "Next" link at the bottom right of the panel or return to previous data by selecting the "Prev" link. The user can also review additional results by selecting a page number at the bottom of the panel, if applicable. Clicking one of the hyperlinked items will bring up an additional browser window, displaying the corresponding information. Clicking anywhere else on the row (not on a hyperlinked item) selects the row.

To access the **Prior Authorization Search Results** panel:

- STEP 1. Click on **Prior Authorization** in the main search panel.
- STEP 2. Next, click on **search** in the submenu below **Prior Authorization**.
- STEP 3. From there, click on Prior Authorization Search Results.
- STEP 4. The Prior Authorization Search results panel should now be displayed.

STEP 5. This panel displays the results of the Prior Authorization Search. To display the information of a specific PA, click on the line item.

4.1.8.5 Extra Features

PriorAuthSearch_ERL.doc

4.1.8.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	PA Number	Prior Authorization number is a unique identifier for a PA.	Listview	Character	10	T_PA_PAUTH	PRIOR_AUTH_NUM
2	Line Item Number	Two characters that sequentially list the services included on a PA. The characters are 01 through 99. The Line item is automatically generated.	Listview	Character	2	T_PA_LINE_ITEM	NUM_PA_LINE_ITEM
3	Authorization Effective Date	Begin date of the date range for which the service is approved for use by a member.	Listview	Date (MMDDCCYY)	8	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
4	Authorization End Date	Date showing the last date an authorized service can be used by a member.	Listview	Date (MMDDCCYY)	8	T_PA_LINE_ITEM	DTE_PA_AUTH_END
5	PA Category Code	Code that groups a PAs requested services under a type such as dental, inpatient, PT, OT.	Listview	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
6	Requesting Provider ID	Unique identifier for the provider requesting services for a member.	Listview	Character	15	T_PR_PROV	ID_PROV
7	Servicing Provider ID	Unique identifier for the provider performing the services for a member.	Listview	Character	15	T_PR_PROV	ID_PROV
8	Code (Service Code Number From)	National Drug Code used to uniquely identify a drug.	Listview	Character	11	T_DRUG	CDE_NDC
9	Code (Service Code Number to)	Code that uniquely identifies a procedure.	Listview	Character	6	T_PROC	CDE_PROC
10	PA Status	Status (pending, void) or a decision (approved, denied) on a line item.	Listview	Character	20	T_PA_LINEITEM_STAT	DSC_STATUS
11	Member ID	Unique identifier for the member for whom services are requested on the PA.	Listview	Alphanumeric	12	T_RE_BASE	ID_MEDICAID
12	Case Number	This is the corresponding case number assigned by maxMC. This field will only be populated on new PAs or when a converted PA is updated	Listview	Character	25	CN_T_PA_PAUTH_STATE	ID_CASE

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
13	Legacy procert number	Legacy Peer Review Organization Certification Number	Listview	Character	8	T_PA_NBR_XREF	PRO_CERT_REF

4.1.8.7 Field Edits

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

4.2 PAGE: Prior Authorization Information Page

4.2.1 Description:

The Prior Authorization Information page displays a summary of information about a PA. The check boxes indicate if there are additional Diagnosis Codes or Internal Text for viewing. This information is accessed through links on the Prior Authorization Maintenance panel.

Navigation Path: [Prior Authorization] - [Information]

4.2.2 Technical Name:

PA.PaPauthInformation

4.2.3 Web Page Name:

Information Page

For readability, the layout displays on the next page.

4.2.3.1 Prior Authorization Information Page Layout

Next search by: **Prior Authorization Number**

Prior Authorization Information ? ^			
PA Number	Member ID	Requesting Provider Number	
Legacy PRO Cert Number	Member Last Name	Servicing Provider Number	
Authorizer	Member First Name	Service Provider Check	All Service Providers
Received Date	Member Date Of Birth	PA Category Code	
05/22/2007		Case Number	
Review Date	Clerk Keyed	Fund Code	
		Primary Diagnosis Code	
Update Received Date	Date Keyed	Case Management	NO
	05/22/2007	Disease Management	NO
Update Reviewed Date	Admission Date	Media Type	
		Print Option	NO PRINT
Date Mailed	Discharge Date		
Additional Diagnosis Codes	Accident		NO
<input type="checkbox"/>	Special Considerations		NO
Internal Text	Emergency		NO
<input type="checkbox"/>	Nursing Facility Type		
Super PA	Ortho Status Code		
<input type="checkbox"/>			

Prior Authorization Maintenance - Complete the Panels below then select Save to add the new Prior Authorization. Prefs Top Bot ? ^										
Prior Authorization	<table border="0"> <tr> <td>Additional Diagnosis Codes</td> <td>Base Information</td> <td>Internal Text</td> </tr> <tr> <td>Line Item</td> <td>Paid Claim List</td> <td>Related Documents</td> </tr> <tr> <td>Super PA</td> <td></td> <td></td> </tr> </table>	Additional Diagnosis Codes	Base Information	Internal Text	Line Item	Paid Claim List	Related Documents	Super PA		
	Additional Diagnosis Codes	Base Information	Internal Text							
Line Item	Paid Claim List	Related Documents								
Super PA										
<input type="button" value="save"/> <input type="button" value="cancel"/>										

To access the above page:

STEP 1. Click on **Prior Authorization** located in the subsystem header listing under the commonwealth logo “Kentucky Unbridled Spirit.”

STEP 2. Click on **Information** located under the subsystem header listing to display the following panel;

4.2.4 PANEL: Prior Authorization Information

4.2.4.1 Description:

The Prior Authorization Information panel displays Prior Authorization header data.

Navigation Path: [Prior Authorization] - [Information]

4.2.4.2 Technical Name:

PA.PaPauthInformation.ascx

4.2.4.3 Panel Name:

PaPauthPanel

4.2.4.4 Prior Authorization Information Layout

Prior Authorization Information					
PA Number	1	Member ID	2	Requesting Provider Number	3
Legacy PRO Cert Number	4	Member Last Name	5	Servicing Provider Number	6
Authorizer	7	Member First Name	8	Service Provider Check	All Service Providers 9
Date Received	05/17/2007 11	Member Date Of Birth	10	PA Category Code	13
Review Date	14	Clerk Keyed	12	Case Number	16
Update Received Date	17	Date Keyed	05/17/2007 15	Fund Code	18
Update Reviewed Date	19	Admission Date	20	Primary Diagnosis Code	21
Date Mailed	22	Discharge Date	23	Case Management	NO 25
Additional Diagnosis Codes	<input type="checkbox"/> 26	Accident	NO 24	Disease Management	NO 28
Internal Text	<input type="checkbox"/> 29	Special Considerations	NO 27	Media Type	33
Super PA	<input type="checkbox"/> 31	Emergency	NO 30	Print Option	NO PRINT 35
		Nursing Facility Type	32		
		Ortho Status Code	34		

To access this panel:

STEP 1. Click on **Prior Authorization** in the Main Menu. The **Prior Authorization Search** panel will open.

STEP 2. Enter your search criteria and then click the **Search** button on the right side of the screen.

STEP 3. Select a row from the **Search Results** panel. The record will populate into a **PA Information** panel.

4.2.4.5 Extra Features

Global ERL

4.2.4.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	PA Number	Prior authorization number is a unique identifier for a PA.	Field	Character	10	T_PA_PAUTH	PRIOR_AUTH_NUM
2	Member ID	Unique identifier for the member for whom services are requested on the PA.	Field	Character	12	T_RE_BASE	ID_MEDICAID
3	Requesting Provider Number	Unique identifier for the provider requesting services for a member on a PA request.	Field	Character	15	T_PR_PROV	ID_PROVIDER
4	Legacy PRO Cert Number	Legacy Peer Review Organization Certification Number	Field	Character	8	T_PA_NBR_XREF	PRO_CERT_REF
5	Member Last Name	Last name of the member for whom services are requested on the PA.	Field	Character	20	T_RE_BASE	NAM_LAST
6	Servicing Provider Number	Unique identifier for the provider performing the services for a member specified on a PA request.	Field	Character	15	T_PR_PROV	ID_PROVIDER
7	Authorizer	Unique identifier for person authorizing services on the PA.	Field	Character	8	T_PA_PAUTH	ID_CLERK_REV

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
8	Member First Name	First name of the member for whom services are requested on the PA.	Field	Character	15	T_RE_BASE	NAM_FIRST
9	Service Provider Check	Used to tell whether the service provider ID on the PA was entered as an NPI or Medicaid ID.	Field	Character	1	T_PA_PAUTH	CDE_SERV_PROV_CHK
10	Member Date of Birth	Date of birth of the member.	Field	Number	8	T_RE_BASE	DTE_BIRTH
11	Date Received	Date PA request was received by the Prior Authorization team.	Field	Number	8	T_PA_PAUTH	DTE_RECEIVED
12	Clerk Keyed	ID of the clerk who entered the PA.	Field	Character	8	T_ANALYST	ID_CLERK
13	PA Category Code	Code that groups a PAs requested services under a type such as dental, inpatient, PT, OT.	Field	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
14	Review Date	Review date of the PA.	Field	Number	8	T_PA_PAUTH	DTE_REVIEW
15	Date Keyed	Date the PA was entered.	Field	Number	8	T_PA_PAUTH	DTE_PA_KEYED
16	Case Number	The Case Number used in maxMC is being brought over to interChange to group PAs by an episode of care.	Field	Character	25	T_PA_PAUTH_ST ATE	ID_CASE

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
17	Update Received Date	Date SHPS received a PA update request from the provider.	Field	Number	8	T_PA_PAUTH	DTE_UPDATE_REC
18	Fund Code	Source of funds for payment of the authorized services.	Field	Character	3	T_PA_PAUTH	CDE_FIN_FUND
19	Update Reviewed Date	Date SHPS reviewed a PA update request from the provider.	Field	Number	8	T_PA_PAUTH	DTE_UPDATE_REV
20	Admission Date	Date a member was admitted to a facility.	Field	Date (MMDDCCY Y)	8	T_PA_PAUTH_ST ATE	DTE_ADMISSION
21	Primary Diagnosis Code	A member's primary diagnosis.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
22	Date Mailed	Date that a prior authorization letter is generated to send to the provider, member or DCBS for either an original PA request or a PA update.	Field	Number	8	T_PA_PAUTH	DTE_SENT
23	Discharge Date	Date a member was released from a facility.	Field	Date (MMDDCCY Y)	8	T_PA_PAUTH_ST ATE	DTE_DISCHARGE
24	Accident	A checked box indicates the PA is the result of the member's involvement in an accident.	Field	Character	1	T_PA_PAUTH	IND_ACCIDENT

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
25	Case Management	Field is set to "YES" if there is Case Management program information available in the Member subsystem for this member. If there is no information, the field is set to "NO".	Field	Character	3	T_RE_CSE_DIS_STATE	CDE_PROGRAM
26	Additional Diagnosis Codes	Additional diagnosis codes which appear on the PA request.	Check Box	Character	1	N/A	N/A
27	Special Considerations	Indicates if there are special considerations concerning the PA.	Field	Character	1	T_PA_PAUTH	IND_SPECIAL_CONSID
28	Disease Management	Field is set to "YES" if there is Disease Management program information available in the Member subsystem for this member. If there is no information, the field is set to "NO".	Field	Character	3	T_RE_CSE_DIS_STATE	CDE_PROGRAM_
29	Internal Text	A checked Internal Text box indicates there is internal text for the PA.	Check Box	Character	1	N/A	N/A
30	Emergency	Indicator is set to "Yes" when a member's condition requires an emergency or urgent service.	Field	Drop Down List Box	1	T_PA_PAUTH	IND_EMERG

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
31	Super PA	A checked Super PA box indicates there is Super PA data for the PA.	Check Box	Character	1	N/A	N/A
32	Nursing Facility Type	Code used for Nursing Facility PAs. Valid values are: H = Brain Injury, B = Bl Locked Unit, Y = Nursing Facility, V = Ventilator.	Field	Drop Down List Box	1	T_PA_PAUTH_ST ATE	CDE_TOS
33	Media Type	Description of the medium by which a PA request is received.	Field	Character	1	T_PA_MEDIA	DSC_MEDIA_TYPE
34	Ortho Status Code	The PA Orthodontic Status Code is used to track receipt of the documentation from the provider. Based on the code and the service begin date of the PA, reminder letters are sent to providers and reports created of PAs with overdue documentation.	Field	Drop Down List Box	1	T_PA_PAUTH_ST ATE	CDE_ORTHO
35	Print Option	Print option for the PA notice. Options are Batch (B), Internal (I), No Print (N), and Online (O).	Field	Character	1	T_PA_PAUTH	IND_LETTER

4.2.4.7 Field Edits

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

4.2.5 PANEL: Prior Authorization Maintenance

4.2.5.1 Description:

The Prior Authorization Maintenance panel has links to view all data associated with a specific PA.

Navigation Path: [Prior Authorization] - [Information]

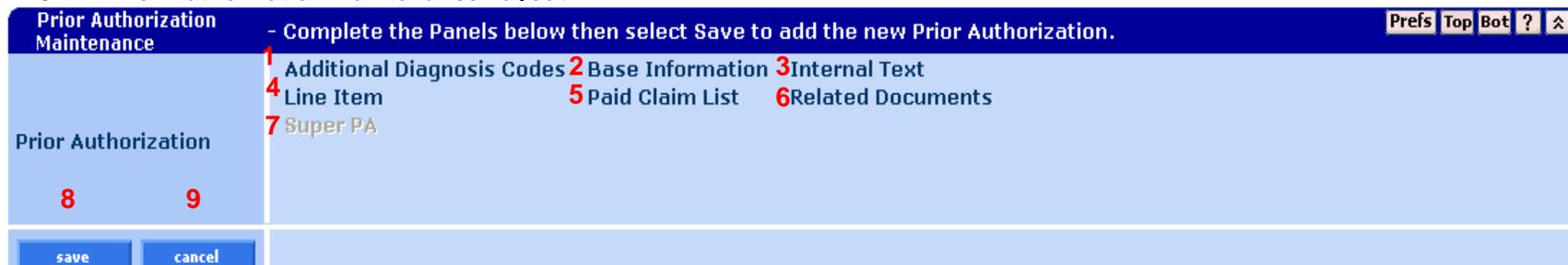
4.2.5.2 Technical Name:

PA.PaPauthInformation.ascx (Maintenance)

4.2.5.3 Panel Name:

Maintenance

4.2.5.4 Prior Authorization Maintenance Layout



This panel provides the user easy access to the Additional Diagnosis Codes, Line Item, Base Information, Paid Claim List, Internal Text and Related Documents by selecting the appropriate link.

NOTE: The "save" and "cancel" buttons are only used in conjunction with other panels.

To access this panel:

- STEP 1. Click on **Prior Authorization** on the main search panel.
- STEP 2. Next, click on **Search** in the submenu below **Prior Authorization**.
- STEP 3. Enter your search criteria and then click on the **Search** button on the right side of the screen.
- STEP 4. Select a row from the search results.
- STEP 5. The **Prior Authorization Maintenance** menu is located under the **Prior Authorization Information** window.

STEP 6. Click on a link to open the associated panel.

STEP 7. Click on **Save** to save changes (e.g. update records, add a new record, or delete an existing record) executed on the applicable panel(s).

STEP 8. Click on **Cancel** to cancel changes executed on the applicable panel(s).

4.2.5.5 Extra Features

Global ERL

4.2.5.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Additional Diagnosis Codes	Activates the Diagnosis Codes display.	Hyperlink	N/A	0	N/A	N/A
2	Base Information	Activates the Base Information display.	Hyperlink	N/A	0	N/A	N/A
3	Internal Text	Activates the Internal text display.	Hyperlink	N/A	0	N/A	N/A
4	Line Item	Activates the Line Item display.	Hyperlink	N/A	0	N/A	N/A
5	Paid Claim List	Activates the Paid Claim List display panel.	Hyperlink	N/A	0	N/A	N/A
6	Related Documents	Activates the Related Documents display panel.	Hyperlink	N/A	0	N/A	N/A
7	Super PA	Activates the Super PA display, and updates panel. NOTE: This is NOT used in KY>	Hyperlink	N/A	0	N/A	N/A

4.2.5.7 Button Descriptions

Button No	Button	Description
8	Save	Clicking the Save button saves the data.

Button No	Button	Description
9	Cancel	Clicking the Cancel button cancels the action.

4.2.5.8 Field Edits

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

4.2.6 PANEL: Additional Diagnosis Codes

4.2.6.1 About Prior Authorization Diagnosis Codes

Diagnoses are used in the Prior Authorization approval process, but diagnoses on claims are not compared to diagnoses on corresponding PAs.

4.2.6.2 Description:

The Additional Diagnosis Codes panel maintains any secondary, tertiary etc. diagnosis codes for a member. The Primary Diagnosis is entered on the Base Information panel. There may be up to 9,999 additional diagnoses entered. Diagnosis codes may be added, updated or deleted.

Navigation Path: [Prior Authorization] - [Additional Diagnosis Codes]

4.2.6.3 Technical Name:

PA.DiagnosisCodesPanel.ascx

4.2.6.4 Panel Name:

Diagnosis Codes

4.2.6.5 Additional Diagnosis Codes Layout

Diagnosis Sequence Number	Diagnosis Code	Diagnosis Code Description
0001	200	LYMPHOSARCOMA AND RETICULOSARCOMA
0002	2000	RETICULOSARCOMA
0003	20000	RETCLSRC UNSP XTRNDL ORG

Type data below for new record.

Diagnosis Sequence Number	<input type="text"/>		
Diagnosis Code	<input type="text"/> [Search]		
Diagnosis Code Description	<input type="text"/>		

4 5

To access this panel:

- STEP 1. Click on **Prior Authorization** on the main search panel.
- STEP 2. Next, click on **Search** in the submenu below **Prior Authorization**.
- STEP 3. Enter your search criteria and then click on the **Search** button on the right side of the screen.
- STEP 4. Select a row from the search results.
- STEP 5. Finally, click on **Additional Diagnosis Codes** from the **Prior Authorization Maintenance** menu under the **Prior Authorization Information** window.
- STEP 6. The user can select the applicable diagnosis code from the list to update, click on **Add** to add a new diagnosis code record or click on **Delete** to delete an existing diagnosis code record.
- STEP 7. Input the new information and click on **Save** in the **Prior Authorization Maintenance** menu to save the changes.

4.2.6.6 Extra Features

This panel has no extra features.

4.2.6.7 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Diagnosis Sequence Number	Unique number assigned to the diagnosis. There may be 1 - 9,999 additional diagnosis codes.	Field	Number	4	T_PA_DIAGNOSIS	NUM_SEQ
2	Diagnosis Code	A code designating a particular diagnosis.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
3	Diagnosis Code Description	Description of the diagnosis code.	Field	Character	40	T_DIAGNOSIS	DSC_25

4.2.6.8 Button Descriptions

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

4.2.6.9 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Diagnosis Sequence Number	Field	200	Diagnosis sequence number is invalid.	Enter a number between 1 and 9,999.
2	Diagnosis Code	Field	100	Diagnosis code is invalid.	Enter a valid diagnosis code or select valid code from the list.

4.2.7 PANEL - Prior Authorization Line Item

4.2.7.1 About Prior Authorization “Line Items”

Each Service/Prior Authorization record contains one or more “line items.” These are the detail lines of the PA record. Line items include information such as (but not limited to) procedure code, modifier, and number of units.

4.2.7.2 Description:

The Prior Authorization Line Item panel is used for viewing of line items on a Service/Prior Authorization request. There may be up to 99 services entered on a PA.

Navigation Path: [Prior Authorization] - [Information] - [Line Item]

4.2.7.3 Technical Name:

PA.PaLineItemPanel.ascx

4.2.7.4 Panel Name:

PaLineItem

For readability the layout displays on the next page.

4.2.7.5 Prior Authorization Line Item Layout

Line Item														Top	Nav	?	A	↕	X
Line Item Number	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Revenue Code From	Revenue Code To	Procedure Code From	Procedure Code To	Modifier 1	Modifier 2	Modifier 3	Modifier 4	NDC Code	Pa Line Item Status	Subcontractor Tax ID				
01	0	\$150.00	0	\$15.00			W4764							Pending					
02	1	\$1.00	1	\$0.00			W4764							Pending					
03	0	\$5.00	0	\$0.00	100									Pending					
04	0	\$15.00	0	\$0.00			W4764							Pending					

Type changes below.

1 Line Item Number

3 Service Type Code*

5 Revenue Code

8 Procedure Code From [Search]

11 Modifier 1 [Search]

Modifier 2 [Search]

Modifier 3 [Search]

Modifier 4 [Search]

20 PA Line Item Status*

6 Revenue Code To

9 Procedure Code To [Search]

12 Quad [Search]

14 Tooth [Search]

16 NDC Lock

18 NDC Code

21 Subcontractor Tax ID

Requested Effective Date* **2**

Requested End Date* **4**

Requested Frequency

Requested Frequency Units

7 Requested Units **10**

Requested Dollars **13**

Authorized Effective Date **15**

Authorized End Date **17**

Authorized Frequency

19 Authorized Frequency Units

22 Authorized Frequency Units

Authorized Units **23**

Authorized Dollars

Payment Method* **24**

Quantity Used Units **25**

Quantity Used Dollars

Balance Units

Balance Dollars **28**

31

-Reason Code- Select row below to update -or- type data below to add.

*** No rows found ***

29 Reason Code

Reason Description

30

32 **31**

4.2.7.6 Extra Features

PA Line Item ERL

To access this panel:

- STEP 1. Click on **Prior Authorization** on the main search panel.
- STEP 2. Next, click on **Search** in the submenu below **Prior Authorization**.
- STEP 3. Enter your search criteria and then click on the **Search** button on the right side of the screen.
- STEP 4. Select a row from the search results.
- STEP 5. Finally, click on **Line Item** from the **Prior Authorization Maintenance** menu under the **Prior Authorization Information** window.
- STEP 6. The user can view the applicable line item information in more detail by clicking on a line item record row. The information will populate in the fields below the record.
- STEP 7. In addition, the user can select the applicable line item from the list to update or click on **Add** to add a new line item record.
- STEP 8. Input the new information and click on **Save** in the **Prior Authorization Maintenance** menu to save the changes.

4.2.7.7 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Line Item Number	Two characters that sequentially list the items pertaining to the PA. The characters are 01 through 99. The line item is automatically generated.	2	Character	T_PA_LINE_ITEM	NUM_PA_LINE_ITEM
2	Requested Effective Date	Requested date the authorization is effective.	8	Date (MM/DD/CCYY)	T_PA_LINE_ITEM	DTE_PA_REQ_EFF
3	Service Type Code	Indicates the code set to use for validation of the requested service: procedure, revenue, or drug.	1	Character	T_PA_LINE_ITEM	CDE_SVC_TYPE

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
4	Requested End Date	Date requested that a service would end for a member.	8	Date (MM/DD/CCYY)	T_PA_LINE_ITEM	DTE_PA_REQ_END
5	Revenue Code	Code identifying a specific accommodation or ancillary service.	4	Character	T_REVENUE_CODE	CDE_REVENUE
6	Revenue Code To	Revenue code that ends the range of revenue code specified for a service.	4	Character	T_REVNUE_CODE	CDE_REVENUE
7	Requested Frequency Units	The field is used for waiver service/prior authorizations in conjunction with the Requested Frequency field to indicate rate of usage. The field is informational only and displays on waiver letters.	9	Number	T_PA_LINE_ITEM	QTY_FREQ_REQ
7	Requested Frequency	The field is used for waiver service/prior authorizations in conjunction with the Requested Quantity field to specify rate of usage. The field is informational only and displays on waiver letters. Valid values are M = Month and W = Week.	1	Character	T_PA_LINE_ITEM	CDE_FREQ_REQ
8	Procedure Code From	Code that uniquely identifies a procedure.	6	Character	T_PROC	CDE_PROC
9	Procedure Code To	Procedure code ending the procedure code range used at the line item level on a PA.	6	Character	T_PROC	CDE_PROC
10	Requested Units	Number of units requested of a product or service.	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_REQ

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
11	Modifier (1 - 4)	Four occurrences of codes used in combination with a procedure code to provide more information.	2	Character	T_MODIFIER	CDE_PROC_MOD
12	Quad	Tooth quadrant used in combination with a tooth number and procedure code to provide more information concerning the service.	2	Character	T_TOOTH_QUADRA NT	CDE_TOOTH_QUAD
13	Requested Dollars	Dollar amount requested for a service for a member.	9	Number	T_PA_LINE_ITEM	AMT_PA_REQ
14	Tooth	Tooth number used in combination with a procedure code to provide more information concerning the service.	2	Character	T_TOOTH	CDE_TOOTH_NBR
15	Authorized Effective Date	Begin date of the date range for which the service is approved for use by a member.	8	Date (MM/DD/CC YY)	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
16	NDC Lock	If 'Yes', the prior authorization is locked into to the NDC that is listed. If 'No', then the authorization is for the GCN sequence number represented by the NDC entered in the service code. This field is hidden unless the service code is an NDC.	1	Character	T_PA_LINE_ITEM	IND_NDC_LOCK
17	Authorized End Date	Date showing the last date an authorized service can be used by a member.	8	Date (MM/DD/CC YY)	T_PA_LINE_ITEM	DTE_PA_AUTH_END
18	NDC Code	National Drug Code used to uniquely identify a drug.	11	Character	T_DRUG	CDE_NDC

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
19	Authorized Frequency	The field is used for waiver service/prior authorizations in conjunction with the Authorized Quantity field to specify rate of usage. The field is informational only and displays on waiver letters. Valid values are M = Month and W = Week.	1	Character	T_PA_LINE_ITEM	CDE_FREQ_AUTH
20	PA Line Item Status	Status (e.g. pending) or decision (e.g. approved, denied) for a service.	20	Character	T_PA_LINEITEM_STAT	DSC_STATUS
21	Subcontractor Tax ID	Field used for PAs received before 11/1/2002 to designate actual Service Provider since all PAs were initially issued for providers '29000015' (DMHMR) or '29000023' (DCBS).	9	Character	T_PA_LINE_ITEM	ID_IMPACT_TAX
22	Authorized Frequency Units	The field is used for waiver service/prior authorizations in conjunction with the Authorized Frequency field to indicate rate of usage. The field is informational and displays on waiver letters.	9	N/A	T_PA_LINE_ITEM	QTY_FREQ_AUTH
23	Authorized Units	Units approved for payment for a service on a PA line item.	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
23	Authorized Dollars	Dollar amount authorized for a service.	9	Number	T_PA_LINE_ITEM	AMT_PA_AUTH

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
24	Payment Method	Payment method is used during claim adjudication to determine how a claim should be paid. Valid payment methods are: pay unit fee price specified on the service request, pay system price specified on a fee schedule, pay up to capitated amount specified on the service request, pay audit cap amount specified on an audit.	1	Character	T_PA_LINE_ITEM	CDE_PYMT_METHOD
25	Quantity Used Units	Number of units used by a member of an approved service.	9	Number	T_PA_ITEM_DTL_X REF	QTY_UNT_SVC_USD
26	Quantity Used Dollars	Dollar amount of an approved service used by a member.	9	Number	T_PA_ITEM_DTL_X REF	AMT_PA_USED
26	Balance Dollars	Remaining dollars of a service available for use by a member.	9	Character	CALCULATED FIELD	N/A
27	Balance Units	Number of units remaining on a PA line item.	9	Number	CALCULATED FIELD	N/A
28	Authorized Dollars	Dollar amount authorized for a service.	9	Number	T_PA_LINE_ITEM	AMT_PA_AUTH
29	Reason Code	Code indicating the reason the decision on the line item was chosen.	3	Character	T_PA_IAC_TEXT	CDE_IAC
30	Reason Description	Text describing a reason code.	500	Character	T_PA_IAC_TEXT	DSC_IAC

4.2.7.8 Button Descriptions

Button No	Button	Description
31	Add	Clicking the Add button adds content.

Button No	Button	Description
32	Delete	Clicking the Delete button deletes the contents.

4.2.7.9 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
	All Date Fields	Field	5501	Invalid date. Format is MM/DD/YYYY.	Enter date greater than or equal to 1/1/1900.
1	Line Item Number	Field	5001	Line Item is required.	Enter value or cancel transaction.
2	Requested Effective Date	Field	15503	Requested effective date is required	Enter appropriate date value
2	Requested Effective Date	Field	5015	Requested end date must be greater than or equal to 1/1/1900.	Enter date greater than or equal to 1/1/1900.
4	Requested End Date	Field	15504	Requested end date is required	Enter appropriate date value
4	Requested End Date	Field	5115	Requested end date must be greater than or equal to 1/1/1900.	Enter date greater than or equal to 1/1/1900.
5 or 25	Requested or Authorized Units	Field	5500	Enter a valid value.	Enter value for units.
8 or 28	Requested or Authorized Dollars	Field	5500	Enter a valid value.	Enter value greater than or equal to 0.01.
9	Procedure Code From	Field	15506	Invalid Procedure Code From	Enter a valid procedure code or check the Ignore check box
10	Procedure Code To	Field	15508	Invalid Procedure Code To	Enter a valid procedure code or check the ignore check box

Field No	Field	Field Type	Error Code	Error Message	To Correct
14	Modifier 1	Field	15507	Modifier required for this procedure code	Enter valid modifiers or tooth
15	Quad	Field	15508	Tooth quadrant or arch required for this procedure code.	Enter a valid tooth quadrant or arch
19	Authorized Effective Date	Field	5015	Authorized effective date must be greater than or equal to 1/1/1900.	Enter date greater than or equal to 1/1/1900.
19	Authorized Effective Date	Field	15501	Authorized effective date is required	Enter appropriate date value
19	Authorized Effective Date	Field	15519	Invalid authorized effective date - cannot exclude a paid claim	Enter a valid value
22	Authorized End Date	Field	5115	Authorized end date must be greater than or equal to 1/1/1900.	Enter date greater than or equal to 1/1/1900.
22	Authorized End Date	Field	15502	Authorized end date is required	Enter appropriate date value
22	Authorized End Date	Field	15520	Invalid authorized end date - cannot exclude a paid claim	Enter a valid value
25	Authorized Units	Field	15509	Authorized units must be present.	Enter a valid value for authorized units
25	Authorized Units	Field	15511	Authorized units must be 0.	Enter a valid value for authorized units
25	Authorized Units	Field	15516	Requested units must be present.	Enter a valid value for requested units.

Field No	Field	Field Type	Error Code	Error Message	To Correct
25	Authorized Units	Field	15517	Invalid authorized units - Units must be greater than units already used	Enter a valid value
25	Authorized Units	Field	2	Authorized units must be present.	Enter value for units.
25	Authorized Units	Field	4	Authorized units must be 0.	Enter value for units.
26	PA Line Item Status	Field	15505	A valid PA line item status is required	Choose a valid line item status
26	PA Line Item Status	Combo Box	5029	A valid status is required.	Select item from list.
28	Authorized Dollars	Field	15510	Authorized dollars must be present.	Enter a valid value for authorized dollars
28	Authorized Dollars	Field	15518	Invalid authorized dollars - Dollars must be greater than dollars already used	Enter a valid value
28	Authorized Dollars	Field	3	Authorized dollars must be present	Enter value for units.
28	Authorized Dollars	Field	5015	Authorized dollars must be greater than or equal to 0.01.	Enter value for units.
28	Requested Dollars	Field	5015	Requested dollars must be greater than or equal to 0.01.	Enter value greater than or equal to 0.01.
29	Payment Method	Combo Box	5001	Payment method is required.	Select item or cancel transaction.
34	Reason Code	Field	15513	Please specify a reason code	Enter a valid reason code

4.2.8 PANEL: Prior Authorization Base Information

4.2.8.1 Description:

The Base Information panel displays header information for a Prior Authorization. Data for this panel is maintained by a near real time interface with SHPS; service/prior authorizations entered online and for school based prior authorization by the provider on the internet.

Navigation Path: [Prior Authorization] [Base Information]

4.2.8.2 Technical Name:

PA.BaseInformationPanel.ascx

4.2.8.3 Panel Name:

PABaseInfo

4.2.8.4 Prior Authorization Base Information Layout

To access this panel:

- STEP 1. Click on **Prior Authorization** in the Main Menu. The **Prior Authorization Search** panel will open.
- STEP 2. Enter your search criteria and then click the **Search** button on the right side of the screen.
- STEP 3. The file will open in a **PA Information** panel.
- STEP 4. From there click on **Base Information** in the **Prior Authorization Maintenance** menu.

STEP 5. The **Prior Authorization Base Information** panel will be displayed.

STEP 6. This panel is for the entry of basic information about a Prior Authorization.

- a. To add a new Prior Authorization record, click on **Prior Authorization** in the Main Menu. The **Prior Authorization Search** panel will open.
- b. Click the **Add** button on the right side of the screen.
- c. Enter the Prior Authorization information in the new panels.
- d. Click the **Save** button located in the **Prior Authorization Maintenance** panel to save the new record.

4.2.8.5 Extra Features

PA Base Edit ERL

4.2.8.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	PA Category	Service/prior authorization category used to batch requests (for example, Waiver, Inpatient, DME, Physician).	Field	Character	30	T_FIN_FUND_CODE	T_FIN_FUND_CODE
1	Primary Diagnosis Code	Primary diagnosis code for the member's condition.	Field	Character	7	T_PA_PAUTH	CDE_DIAG
3	Requesting Provider Number	Identifier for the provider requesting the PA for a member.	Field	Character	15	T_PR_PROV	ID_PROVIDER
4	Authorizer	The ID of the person who authorized services on the prior authorization.	Field	Character	8	T_PA_PAUTH	ID_CLERK_REV

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Service Provider Check	Field indicates type of service provider validation required. S = Specified Service Loc, N = Any Service Loc, B = Any Service Loc with the same Base Provider, A = All Service Locations	Field	Character	1	T_PA_PAUTH	CDE_SERV_PROV
6	Servicing Provider Number	Identifier for the provider specified to perform the service on a service/prior authorization request.	Field	Character	15	T_PR_IDENTITY	ID_PROVIDER
7	Fund Code	Funding source assigned for payment of the authorized services. Fund Code is not used by the Kentucky MMIS. (Not used)	Combo Box	Character	30	T_FIN_FUND_CODE	T_FIN_FUND_CODE
8	Member ID	Unique Identifier for a member.	Field	Character	12	T_RE_BASE	ID_MEDICAID
9	Print Option	Print option for the PA notice. Options are only: batch, and no print (default). Since PA letters are maintained and generated by SHPS, the print option is set to no print.	Combo Box	Character	8	T_PA_PAUTH	IND_LETTER

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
10	Emergency	Indicator used to identify the authorization as an emergency 72-hour supply of drugs.	Field	Check Box	1	T_PA_PAUTH	IND_EMERG
11	Admission Date	First date of an institutional stay.	Field	Date (MMDDCCYY)	8	T_PA_PAUTH _STATE	DTE_ADMISSION
12	Accident	Indicator used to identify that the prior authorization services requested for a member are due to an accident and may need to seek recovery for costs through Third Party Liability (TPL).	Field	Check Box	1	T_PA_PAUTH	IND_ACCIDENT
13	Discharge Date	Last day of an institutional stay.	Field	Date (MMDDCCYY)	8	T_PA_PAUTH _STATE	DTE_DISCHARGE
14	Special Considerations	Indicator used to identify that the Prior Authorization should receive special consideration.	Field	Check Box	1	T_PA_PAUTH	IND_SPECIAL_CONSID
15	Update Received Date	Date that SHPS received a Prior Authorization update request from the provider.	Field	Date (MMDDCCYY)	8	T_PA_PAUTH	DTE_UPDATE_REC

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
16	Nursing Facility Type	Code used for Nursing Facility PAs. Valid values are: H = Brain Injury, B = BI Locked Unit, Y = Nursing Facility, V = Ventilator.	Field	Drop Down List Box	1	T_PA_PAUTH_STATE	CDE_TOS
17	Update Reviewed Date	Date that SHPS reviewed a Prior Authorization update request sent in by the provider.	Field	Date (MMDDCCYY)	8	T_PA_PAUTH	DTE_UPDATE_REV
18	Ortho Status Code	The PA Orthodontic Status Code is used to track receipt of the documentation from the provider. Based on the code and the service begin date of the PA, reminder letters are sent to providers and reports created of PAs with overdue documentation.	Field	Drop Down List Box	1	T_PA_PAUTH_STATE	CDE_ORTHO

4.2.8.7 Field Edits

Field No.	Field	Field Type	Error Code	Error Message	To Correct
1	PA Category	Combo Box	5	PA Assignment requires a service provider to be entered	Enter a valid provider number.
1	PA Category	Combo Box	5029	A valid PA Assignment is required.	Select a PA category from the drop down list.
9	Print Option	Combo Box	5001	Print Option is required.	Select item from list.

Field No.	Field	Field Type	Error Code	Error Message	To Correct
11	Admission Date	Field	10	Admission Date must be greater than or equal to 1/1/1900.	Invalid date. Format is MM/DD/YYYY. Verify date is greater than or equal to 1/1/1900.
11	Admission Date	Field	15	Invalid Date. Format is MM/DD/YYYY.	Invalid date. Format is MM/DD/YYYY.
13	Discharge Date	Field	10	Discharge Date must be greater than or equal Admission Date and greater than or equal to 1/1/1900.	Invalid date. Format is MM/DD/YYYY.
13	Discharge Date	Field	15	Invalid Date. Format is MM/DD/YYYY.	Invalid Date. Format is MM/DD/YYYY.
8	Member ID	Field	5029	A valid Member ID is required.	Enter valid ID or select one from search list.
8	Member ID	Field	5030	PA Line Item Number <num> is not allowed – member has Presumptive Eligibility	Member is of type PE and has overlapping dates for line item<num>. Discard line item or change authorized effective and end dates.
8	Member ID	Field	5031	PA not allowed – member is KCHIP III	Member is of type P7 or M7. Change member ID or discard PA.
8	Member ID	Field	5032	PA Line Item Number <num> is not allowed – member is in Managed Care	Member has overlapping line item dates with active managed care dates. Either discard line item or change authorized effective and end dates.

Field No.	Field	Field Type	Error Code	Error Message	To Correct
8	Member ID	Field	5033	PA Line Item Number has Procedure Code – member is in Managed Care	Member has overlapping line item dates with active managed care dates and the procedure code is not allowed to override the validation.
8	Member ID	Field	5034	PA Line Item Number has Revenue Code – member is in Managed Care	Member has overlapping line item dates with active managed care dates, and the revenue code is not allowed to override the validation.
16	Nursing Facility Type	Field	5000	Nursing Facility Type is required for Nursing Facility PA	Select nursing facility type from drop down list.
3	Requesting Provider Number	Field	5029	A valid Requesting Provider Number is required.	Enter a valid provider number or select one from search list.
3	Requesting Provider Number	Field	17001	A valid Servicing Provider Number is required.	Enter a valid provider number or select one from search list.
3	Requesting Provider Number	Field	17002	At least one Line Item must be added.	Add a line item before attempting to save the panel.
3	Requesting Provider Number	Field	17003	A valid Member ID is required	Enter ID or select one from search list.
3	Requesting Provider Number	Field	17004	A valid Authorizer is required	Enter ID or select one from search list. Authorizer must be present for finalized services.
3	Requesting Provider Number	Field	17005	A valid PA Category is required	Choose a value from the drop down list.

Field No.	Field	Field Type	Error Code	Error Message	To Correct
3	Requesting Provider Number	Field	17006	The PA Category requires a servicing provider to be entered!	Enter ID or select one from search list.
3	Requesting Provider Number	Field	17007	Cannot change Servicing Provider, a claim has been paid.	Undo changes or cancel.
6	Servicing Provider Number	Field	7001	A Servicing Provider Number is required	Enter a valid provider number or select one from search list.
6	Servicing Provider Number	Field	7002	Servicing Provider type is invalid for PA Category	Enter an acceptable service provider number.
15	Update Received Date	Field	5015	Update Received must be greater than or equal to 1/1/1900.	Verify date is greater than or equal to 1/1/1900.
15	Update Received Date	Field	5501	Invalid Date. Format is MM/DD/YYYY.	Verify date is greater than or equal to 1/1/1900.
17	Update Reviewed Date	Field	5015	Update Reviewed must be greater than or equal to 1/1/1900.	Verify date is greater than or equal to 1/1/1900.
17	Update Reviewed Date	Field	5501	Invalid Date. Format is MM/DD/YYYY.	Verify date is greater than or equal to 1/1/1900.

4.2.9 PANEL: Prior Authorization Paid Claim List

4.2.9.1 Description:

The Paid Claim List displays paid claims associated with a PA. Available information includes claim number, itemized claim line, PA line item number, paid units, paid dollar amount, and status. A status of "Active" indicates an adjudicated claim. A status of "Inactive" indicates an adjudicated claim that has been adjusted. The units and amounts for the "Inactive" claim are not counted toward used units and amounts for a PA.

Navigation Path: [Prior Authorization] - [Information] - [Claim List]

4.2.9.2 Technical Name:

PA.ClaimListPanel.ascx

4.2.9.3 Panel Name:

Paid Claim List

4.2.9.4 Prior Authorization Paid Claim List Layout

1 IGN	2 Claim Line Detail	3 PA Line Item Number	4 PA Units Paid	5 PA Amount Paid	6 Claim Status
2003142600313	0001	01	3	\$3.00	Active

- STEP 1. Click on **Prior Authorization** in the Main Menu. The **Prior Authorization Search** panel will open.
- STEP 2. Enter your search criteria and then click the **Search** button on the right side of the screen.
- STEP 3. The file will open in a **PA Information** panel and **Prior Authorization Maintenance** will open below it.
- STEP 4. Select the **Paid Claim List** link in the **Prior Authorization Maintenance** menu.
- STEP 5. This panel allows access to a specific claim that has been paid.

4.2.9.5 Extra Features

PA Claim List ERL

4.2.9.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	ICN	Internal Control Number is a unique identifier for a claim.	Listview	Number	13	T_HIST_DIRECT ORY	NUM_ICN_FL
2	Claim Line Detail	Number of claim detail that has paid units and dollars authorized by a PA line item.	Listview	Number	4	T_PA_ITEM_DTL _XREF	NUM_DTL
3	PA Line Item Number	Unique identifier for a PA line item. The number ranges from 01 through 99.	Listview	Character	2	T_PA_ITEM_DTL _XREF	NUM_PA_LINE_ ITEM
4	PA Units Paid	Number of units paid for by the claim detail, that were authorized by the PA line item.	Listview	Number	9	T_PA_ITEM_DTL _XREF	QTY_UNT_SVC _USD
5	PA Amount Paid	Dollar amount paid for by the claim detail and authorized by the PA line item.	Listview	Number	9	T_PA_ITEM_DTL _XREF	AMT_PA_USED
6	Claim Status	Indicates whether the record of paid units and amounts is active or inactive. A record is created with an active status when a claim is paid. The status is changed to inactive when a claim is adjusted. Records with a status of inactive are not included in the calculation of used units and amounts.	Listview	Character	1	T_PA_ITEM_DTL _XREF	CDE_STATUS1

4.2.9.7 Field Edits

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

4.2.10 PANEL: Prior Authorization Internal Text

4.2.10.1 Description:

The Prior Authorization Internal Text panel is used to enter free form text for prior authorizations. This pane can also be used to view internal text for all PAs.

Navigation Path: [Prior Authorization] - [Information] - [Internal Text]

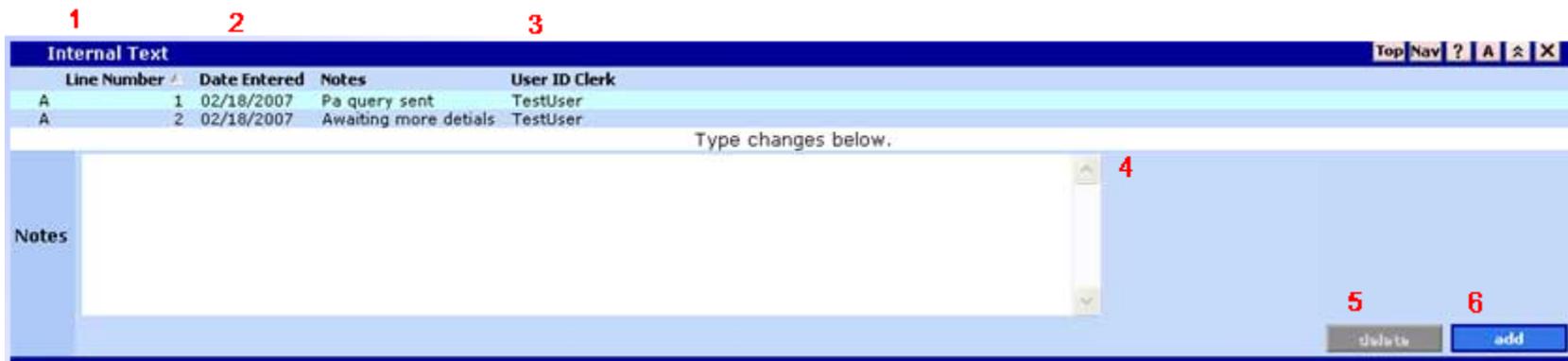
4.2.10.2 Technical Name:

WebUI.EntityMaintenancePanel.ascx (Int)

4.2.10.3 Panel Name:

PalntText

4.2.10.4 Prior Authorization Internal Text Layout



To access this panel:

1. Click on **Prior Authorization** in the Main Menu. The **Prior Authorization Search** panel will open.
2. Enter your search criteria and then click the **Search** button on the right side of the screen.
3. Select a row from the **Search Results** panel. The file will open in a **PA Information** panel.
4. **The Prior Authorization Maintenance** panel will open below the **PA Information** panel. Select the **Internal Text** link. The panel will open.

4.2.10.5 Extra Features

PA Internal Text ERL

4.2.10.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Line Number	Sequential number assigned to each 500 character block of text.	Listview	Number		T_PA_INT_TEXT	NUM_LINE_NUMBER
2	Date Entered	Date a row of text was entered for a Prior Authorization.	Listview	Number	8	T_PA_INT_TEXT	DTE_SENT
3	User ID Clerk	Identifier for the person entering the text.	Listview	Character	8	T_PA_INT_TEXT	ID_CLERK
4	Notes	Free form text entered to provide additional information about a PA.	Field	Character	500	T_PA_INT_TEXT	DSC_PA_TEXT

4.2.10.7 Button Descriptions

Button No	Button	Description
5	Delete	Clicking the Delete button deletes the contents.
6	Add	Clicking the Add button adds content.

4.2.10.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
4	Notes	Field	5001	Notes is required.	Enter up to 500 characters of text into the Notes field.

4.3 PAGE: Prior Authorization Mass Update Search Page

4.3.1 About Mass Updates

Some circumstances require a single change be made to a large number of Service Authorization records. For example, if a provider has a change of ownership, a new provider number is issued. All current PA records for the provider must be updated to reflect the new provider number. The Mass Update function allows all records to be updated at one time. The Mass Update Search function allows the User to set the criteria for locating the records to be changed.

4.3.2 Description:

The Prior Authorization Mass Update Search Page provides for the search of rate and service code mass updates by specific search criteria.

Navigation Path: [Prior Authorization] - [Mass Update Search]

4.3.3 Technical Name:

PriorAuthMassUpdateSearch

4.3.4 Web Page Name:

Prior Authorization Mass Update Search Page

For readability the layout displays on the next page.

4.3.4.1 Prior Authorization Mass Update Search Page Layout

Prior Authorization Mass Update Search
?

Provider	<input type="text"/>	[Search]	Begin Date	<input type="text"/>
Rate	<input type="text"/>		End Date	<input type="text"/>
Revenue Code	<input type="text"/>	[Search]		
Revenue Code Thru	<input type="text"/>	[Search]		
Procedure Code	<input type="text"/>	[Search]		
Procedure Code Thru	<input type="text"/>	[Search]		

Records

Search Results

PA Number	Line Item	Type Change	Rate	Service Code From	Service Code To	Begin Date	End Date
0102133002	A	Procedure		0002F		04/02/2002	04/02/2002
0102182013	A	Revenue	92			08/12/2001	08/12/2001

To access this panel:

- STEP 1. Click on **Prior Authorization** located in the subsystem header listing under the commonwealth logo “Kentucky Unbridled Spirit.”
- STEP 2. Click on **Mass Update Search** in the submenu below **Prior Authorization**.

4.3.5 PANEL: Prior Authorization Mass Update Search

4.3.5.1 About Mass Updates

Some circumstances require a single change be made to a large number of Service Authorization records. For example, if a provider has a change of ownership, a new provider number is issued. All current PA records for the provider must be updated to reflect the new provider number. The Mass Update function allows all records to be updated at one time. The Mass Update Search function allows the User to set the criteria for locating the records to be changed.

4.3.5.2 Description:

This panel provides for searches of service/prior authorization line item overrides created in a mass update process. The overrides may be for a service code or for a rate. A specific override for a line item is viewed on the subpanel of the line item.

4.3.5.3 Technical Name:

PA.PaMassUpdSearchPage.ascx

4.3.5.4 Panel Name:

PAMassUpdate

For readability the layout displays on the next page.

4.3.5.5 Prior Authorization Mass Update Search Layout

Prior Authorization Mass Update Search

Provider 1 [Search] Begin Date 2

Rate 3 End Date 4

Revenue Code [Search] 5

Revenue Code Thru [Search] 6

Procedure Code [Search] 7

Procedure Code Thru [Search] 8

Records 9

10 11

Search Results

PA Number	Line Item	Type Change	Rate	Service Code From	Service Code To	Begin Date	End Date
0102133002	A	Procedure		0002F		04/02/2002	04/02/2002
0102182013	A	Revenue	92			08/12/2001	08/12/2001

To access this panel:

- STEP 1. Click on **Prior Authorization** in the Main Menu.
- STEP 2. Select Prior **Authorization Mass Update** from the submenu.
- STEP 3. Enter your search criteria and then click the **Search** button on the right side of the screen. **Search Results** will appear in rows.
- STEP 4. A specific line item can be accessed by clicking on a line in the search results or entering information in the panel and clicking search.

4.3.5.6 Extra Features

This panel has no extra features.

4.3.5.7 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Provider	Field to search using the Service Provider Number as a search Criteria	Field	Character	10	T_PR_IDENTIFIER	ID_PROVIDER
2	Begin Date	The date the change begins	Field	Number	8	T_PA_MASS_UPD	DTE_EFFECTIVE
3	Rate	New replacement rate in a Mass Update	Field	Number	9	T_PA_MASS_UPD	AMT_NEW_RATE
4	End Date	The date the change terminates	Field	Number	8	T_PA_MASS_UPD	DTE_END
5	Revenue Code	The new revenue code from	Field	Number	9	T_PA_MASS_UPD	SAK_REVENUE
6	Revenue Code To	The new revenue code to	Field	Number	9	T_PA_MASS_UPD	SAK_REVENUE_THRU
7	Procedure Code	The new procedure code from	Field	Number	9	T_PA_MASS_UPD	SAK_PROCEDURE
8	Procedure Code Thru	The new procedure code to	Field	Number	9	T_PA_MASS_UPD	SAK_PROCEDURE_THRU
9	Records	The maximum number of records displayed on the panel when the search results are displayed.	Field	Number	0	N/A	N/A

4.3.5.8 Button Descriptions

Button No	Button	Description
10	Search	Clicking the Search button returns search results based on the search criteria.
11	Clear	Clicking the Clear button clears the field.

4.3.5.9 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Begin Date	Field	1	Revenue code from is required.	Enter a valid revenue code
2	Begin Date	Field	3	Begin date can not be less than end date	Check the dates
2	Begin Date	Field	4	Begin date is required	Enter a valid date
2 and 4	Begin and End Date	Field	6	Dates can not overlap	Dates overlap with another row for this line item number. Correct the dates
4	End Date	Field	5	End date is required	Enter a valid date
7	Procedure Code	Field	2	Procedure code from is required.	Enter a valid procedure code

4.4 PAGE: Prior Authorization Related Data

4.4.1 Description:

The Prior Authorization Related data page displays links to panels that perform maintenance on code tables. PA Category codes group Prior Authorizations. Decision Status codes indicate the status (e.g. approved, denied) of a line item. Reason codes indicate the reason for the line item decision. Media Type codes indicate the means (e.g. Web, online, SHPS) used to submit a Prior Authorization

Note: Media types of fax, mail or phone is not valid.

Navigation Path: [Prior Authorization] - [Related Data]

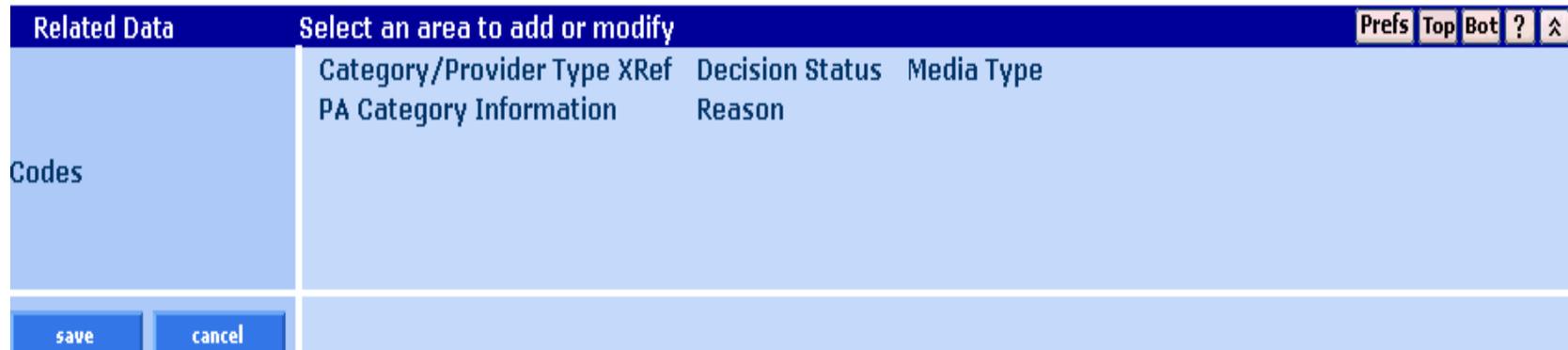
4.4.2 Technical Name:

PA.RelatedData

4.4.3 Web Page Name:

PARelatedData

4.4.4 Prior Authorization Related Data Layout



To access the above panel;

STEP 1. Click on **Prior Authorization** located in the subsystem header listing under the commonwealth logo “Kentucky Unbridled Spirit.

STEP 2. Then click on **Related Data**.

4.4.5 PANEL: Prior Authorization PA Category Information

4.4.5.1 Description:

The Category Information panel maintains codes that assign a PA type to a service/prior authorization such as Physician, Dental, Orthodontics, DME, Impact Plus or EPSDT. Codes may be added, modified or deleted.

The code is used in PA processing. For example, if a PA's category code is orthodontics, the PA is included for review in the Orthodontic Case Tracking process. If the PA category code is set to EPSDT, the PA is included for review in the EPSDT process that sends the member a letter at the first use of an EPSDT service. The category code is also used in determining which format to select for printing a PA letter.

Category code indicator "Servicing Provider Required" is used during Claims Processing. When the indicator is set to "Y", the service provider on the claim must match the service provider on the PA request. All PA categories are set to "Y" indicating a servicing provider is required on all service/prior authorization requests.

Navigation Path: [Prior Authorization] [Category Information]

4.4.5.2 Technical Name:

PA.PaAssignCodePanel.ascx

4.4.5.3 Panel Name:

PACategory

For readability the layout displays on the next page.

4.4.5.4 Prior Authorization PA Category Information Layout

PA Category Information			
PA Category Code	PA Category Description	PA Category Group	Servicing Provider Required
AA	TEST	01	Yes
01	HOMEHEALTH	01	Yes
02	HOSPITAL - INPATIENT	01	No
03	HOSPITAL - OUTPATIENT	01	No
04	PHYSICIAN	01	No
05	REHAB	01	No
06	TRANSPLANT	01	No
07	TRANSPORTATION	01	Yes
08	AUDIOLOGY	01	Yes
09	SPEECH	01	Yes

1 2 3 4 Next >

Select row above to update -or- click Add button below.

PA Category Code	<input type="text" value="1"/>	PA Category Group	<input type="text" value="2"/>
PA Category Description	<input type="text" value="3"/>	Servicing Provider Required	<input type="text" value="No"/> 4

5 delete 6 add

To access the **Prior Authorization Category Information** panel:

- STEP 1. Click on **Prior Authorization** in the main search panel.
- STEP 2. Next, click on **related data** in the submenu below **Prior Authorization**.
- STEP 3. From there, click on **PA Category Information**.
- STEP 4. The **Prior Authorization Category Information** panel should now be displayed.
- STEP 5. Codes may be added by clicking on the add button and entering the information at the bottom of the panel. Codes can be modified or deleted by selecting and clicking on a line item.

4.4.5.5 Extra Features

This panel has no extra features.

4.4.5.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	PA Category Code	Code signifying the type of PA request (e.g. dental, inpatient, home health, and transplant).	Field	Character	2	T_PA_ASSIGN_CODE	CDE_PA_ASSIGN
2	PA Category Group	Code describing group responsible to review PA request.	Field	Character	2	T_PA_ASSIGN_CODE	CDE_PA_GRP_ASSIGN
3	PA Category Description	Text describing the category code.	Field	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
4	Servicing Provider Required	Field indicates that for the PA category, in addition to a PA and claim matching on service code and date range, there must also be matching service providers.	Field	Character	1	T_PA_ASSIGN_CODE	IND_SERV_PROVID_REQ

4.4.5.7 Button Descriptions

Button No	Button	Description
5	Delete	Clicking the Delete button deletes the contents.
6	Add	Clicking the Add button adds content.

4.4.5.8 Field Edits

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

4.4.6 PANEL: Prior Authorization Media Type

4.4.6.1 Description:

The Media Type panel maintains codes describing how a service/prior authorization was submitted. Media Type codes may be added, modified or deleted.

Navigation Path: [Prior Authorization] - [Related Data] - [Media Type]

4.4.6.2 Technical Name:

WebUI.EntityMaintenanceSearchPanel.ascx (Media)

4.4.6.3 Panel Name:

PAMediaType

4.4.6.4 Prior Authorization Media Type Layout

Media Type Code	Media Type Description
1	ONLINE
2	WEB
3	SHPS
4	ELEC TXN
9	CONVERSN

Select row above to update -or- click Add button below.

Media Type Code

Media Type Description

To access this panel:

- STEP 1. Click on **Prior Authorization** in the main search panel.
- STEP 2. Next, click on **related data** in the submenu below **Prior Authorization**.
- STEP 3. From there, click on **Media Type**.
- STEP 4. The Prior Authorization Media type Panel should now be displayed

STEP 5. This panel displays the codes on how a service/prior authorization was submitted. Codes may be added by clicking on the add button and entering the information at the bottom of the panel. Codes may also be modified or deleted by clicking on the line item.

4.4.6.5 Extra Features

This panel has no extra features.

4.4.6.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Media Type Code	Code to signify a media type.	Field	Character	1	T_PA_MEDIA	CDE_MEDIA_TYPE
2	Media Type Description	Description of the type of media used to submit a PA.	Field	Character	9	T_PA_MEDIA	DSC_MEDIA_TYPE

4.4.6.7 Button Descriptions

Button No	Button	Description
3	Delete	Clicking the Delete button deletes the contents.
4	Add	Clicking the Add button adds content.

4.4.6.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Media Type Description	Field	111	Delete Error; Media Type is associated with a PA. Cannot delete.	Check Dependencies

4.4.7 PANEL: Prior Authorization Category Provider Xref

4.4.7.1 About the PA Category Provider Cross Reference

Each Prior Authorization type is limited to specific provider types. The Category Cross Reference maintains this information.

4.4.7.2 Description:

The Category Provider Xref panel creates a cross reference of a category code with a provider type for editing.

Navigation Path: [Prior Authorization] - [Prior Authorization Category/Provider Xref]

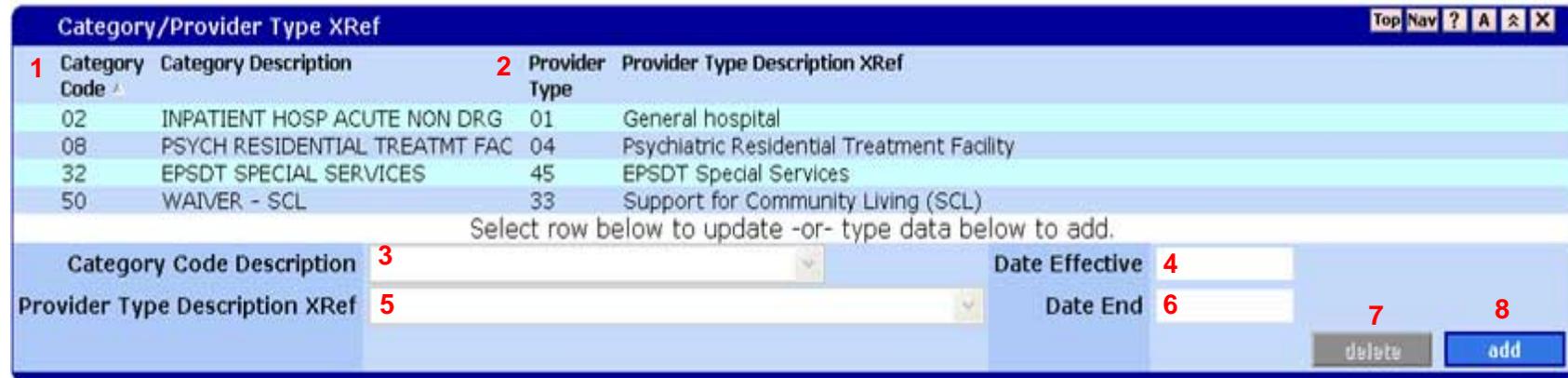
4.4.7.3 Technical Name:

PA.ProvTypeXrefPanel.ascx

4.4.7.4 Panel Name:

ProvTypeXrefPanel

4.4.7.5 Prior Authorization Category Provider Xref Layout



To access this panel:

- STEP 1. Click on **Prior Authorization** on the main search panel.
- STEP 2. Next, click on **Related Data** in the submenu below **Prior Authorization**.
- STEP 3. Click on **Category / Provider Type Xref** in the Related Data Maintenance panel.
- STEP 4. The user can select the applicable category code description from the list to update.

STEP 5. Also, the user can click on **Add** to add a new record or click on **Delete** to delete an existing record.

4.4.7.6 Extra Features

This panel has no extra features.

4.4.7.7 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Category Code	The category code	Field	Character	2	T_PA_CAT_PT_XREF	CDE_PA_ASSIGN
2	Provider Type	The provider type code cross-reference	Field	Character	2	T_PA_CAT_PT_XREF	CDE_PROV_TYPE
3	Category Code Description	The category code description	Field	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
4	Date Effective	The effective date of the cross-reference	Field	Number	8	T_PA_CAT_PT_XREF	DTE_EFFECTIVE
5	Provider Type Code Description Xref	The cross-reference description of the provider type code	Field	Character	50	T_PR_TYPE_CDE	DSC_PROV_TYPE
6	Date End	The end date of the cross-reference	Field	Number	8	T_PA_CAT_PT_XREF	DTE_END

4.4.7.8 Button Descriptions

Button No	Button	Description
7	Delete	Clicking the Delete button deletes the contents.
8	Add	Clicking the Add button adds content.

4.4.7.9 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	Category Code Description	Field	50765	A valid category code is required	Select a category code description from the drop down list

Field No	Field	Field Type	Error Code	Error Message	To Correct
4	Date Effective	Field	50767	Date effective is required	Enter a valid date
5	Provider Type Code Description Xref	Field	50766	A valid provider type code is required	Select a provider type description from the drop down list
6	Date End	Field	50768	Date end is required	Enter a valid date

4.4.8 PANEL: Prior Authorization Reason

4.4.8.1 Description:

The Reason panel maintains codes and descriptions that provide justification for a service/prior authorization decision. Reason codes may be added, updated or deleted.

Navigation Path: [Prior Authorization] - [Related Data] - [Reason]

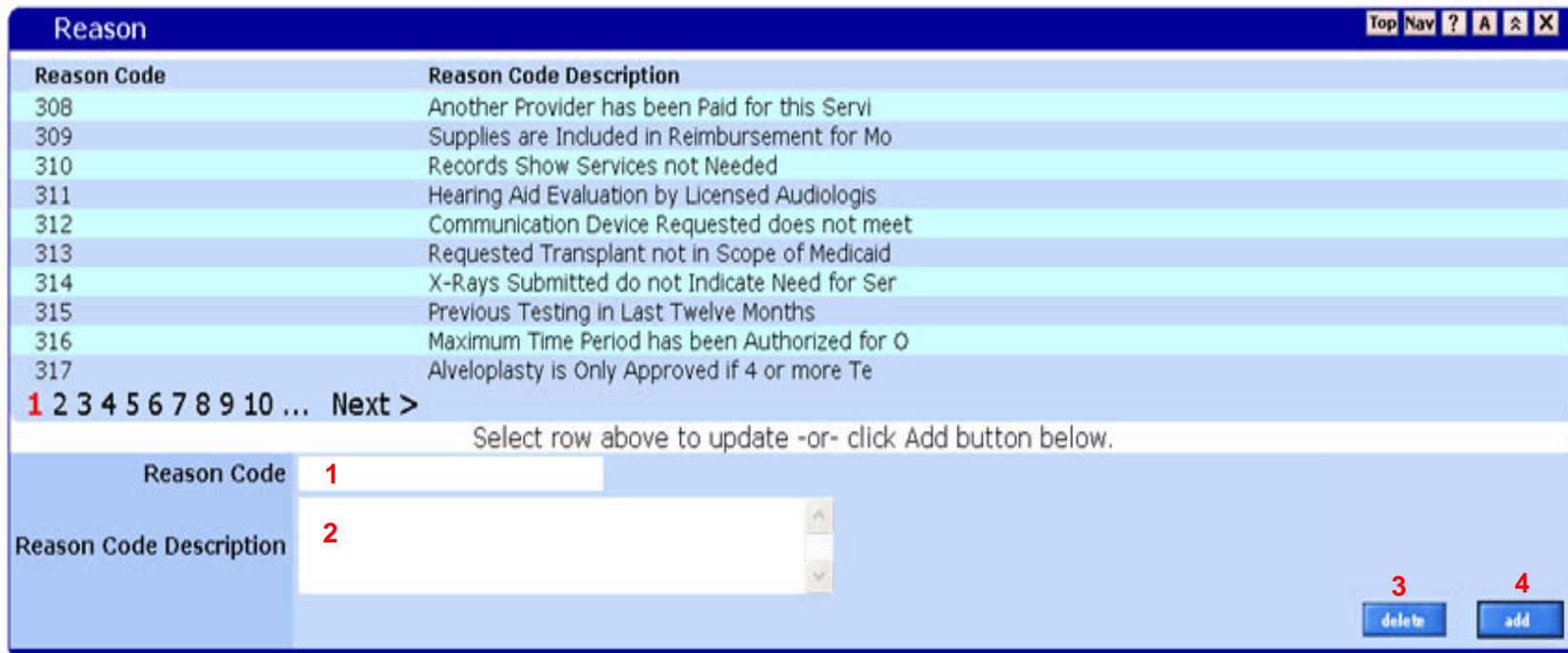
4.4.8.2 Technical Name:

WebUI.EntityMaintenanceSearchPanel.ascx (Reason)

4.4.8.3 Panel Name:

PARReason

4.4.8.4 Prior Authorization Reason Layout



To access the **Prior Authorization Reason Layout** panel:

- STEP 1. Click on **Prior Authorization** in the main search panel.
- STEP 2. Next, click on **related data** in the submenu below **Prior Authorization**.
- STEP 3. From there, click on **Reason**.
- STEP 4. The **Prior Authorization Reason** panel should now be displayed.
- STEP 5. These codes provide reason for a service/prior authorization decision. To add a code, click on the add button and enter the information at the bottom of the panel. To update, click on a line item.

4.4.8.5 Extra Features

This panel has no extra features.

4.4.8.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Reason Code	Code indicating reason for a decision by an authorizer on a Prior Authorization line item.	Field	Character	25	T_PA_IAC_TEXT	CDE_IAC
2	Reason Code Description	Text describing the reason for a decision.	Field	Character	500	T_PA_IAC_TEXT	DSC_IAC

4.4.8.7 Button Descriptions

Button No	Button	Description
3	Delete	Clicking the Delete button deletes the contents.
4	Add	Clicking the Add button adds content.

4.4.8.8 Field Edits

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

4.4.9 PANEL: Prior Authorization Decision Status

4.4.9.1 Description:

The Decision Status panel maintains codes describing the adjudication of a service request. A decision status may be added, modified or deleted. Valid statuses are: A=Approved, D=Denied, P=Pending, R=Inactive-Returned, S=Ready for Submission, V=Void, 4=Finished.

Navigation Path: [Prior Authorization] - [Related Data] - [Decision Status]

4.4.9.2 Technical Name:

WebUI.EntityMaintenanceSearchPanel.ascx (Decision)

4.4.9.3 Panel Name:

PADecisionStatus

4.4.9.4 Prior Authorization Decision Status Layout

Decision Status Code	Decision Status Description	Status Type
A	Approved	Finalized
D	Denied	Finalized
V	Void	Non-finalized
P	Pending	Non-finalized
R	Inactive - Returned	Non-finalized
S	Ready For Submission	Non-finalized
4	Finished	Finalized

Select row above to update -or- click Add button below.

Decision Status Code: **1**

Decision Status Description: **2**

Status Type:

3 delete **4** add

To access the **Prior Authorization Decision Status** panel:

- STEP 1. Click on **Prior Authorization** in the main search panel.
- STEP 2. Next, click on **related data** in the submenu below **Prior Authorization**.
- STEP 3. From there, click on **Decision Status**.

STEP 4. The **Prior Authorization Decision Status** panel should now be displayed.

STEP 5. Select a row by clicking on the line item, or to add, click on the add button and enter the information at the bottom of the panel.

4.4.9.5 Extra Features

This panel has no extra features.

4.4.9.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Decision Status Code	Code signifying the status of a PA request.	Field	Character	1	T_PA_LINEITEM_STAT	CDE_PA_STATUS
2	Decision Status Description	Text describing the status of the PA request.	Field	Character	20	T_PA_LINEITEM_STAT	DSC_STATUS

4.4.9.7 Button Descriptions

Button No	Button	Description
3	Delete	Clicking the Delete button deletes the contents.
4	Add	Clicking the Add button adds content.

4.4.9.8 Field Edits

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

4.5 PAGE: Prior Authorization Pending Information Page

This page is not currently used in Kentucky.

4.5.1 Description:

The Prior Authorization Information Page contains all information pertaining to a Pending PA.

Navigation Path: [Prior Authorization] - [Pending information]

4.5.2 Technical Name:

PriorAuthorizationPendingInformation

4.5.3 Web Page Name:

4.5.4 Prior Authorization Pending Information Page Layout

Prior Authorization Information - Pending					
Pending PA Number	000210008	SSN	999-99-9999	Requesting Provider ID	100674459A MCD
		Member Last Name	PRITCHARD	Servicing Provider ID	100674459A MCD
		Member First Name	HANK	Service Provider Check	Specified Service Provider
Admission Date	06/04/2001	Member Date Of Birth	01/01/1929	PA Category Code	ACUTE IN-PATIENT PSYCHIATRIC
Discharge Date	06/05/2001	Clerk Keyed		Primary Diagnosis Code	311
Accident	NO	Date Keyed	06/04/2001	Media Type	ONLINE
Special Considerations	NO	Time Keyed			
Emergency	NO				
Nursing Facility Type					

4.5.5 PANEL: Pending Prior Authorization Diagnosis Panel

This panel is not currently used in Kentucky.

4.5.5.1 Description:

Providers may enter PAs for Pending Eligibles through the Provider Web Portal. When a Medicaid ID is issued to a Pending Eligible, the Pending PA is available for submission by the provider for adjudication. This panel displays additional diagnosis codes for the Pending PA request. The panel is view only.

Navigation Path: [Prior Authorization] - [Pending Information]

4.5.5.2 Technical Name:

PA.PendingDiagnosisPanel.ascx

4.5.5.3 Panel Name:

Pending Diagnosis Codes

4.5.5.4 Pending Prior Authorization Diagnosis Panel Layout

Diagnosis Codes - Pending

Diagnosis Sequence Number	Diagnosis Code	Diagnosis Code Description
0001	200	LYMPHOSARCOMA AND RETICULOSARCOMA
0002	2000	RETICULOSARCOMA
0003	20000	RETCLSRC UNSP XTRNDL ORG

Diagnosis Sequence Number	0001	1
Diagnosis Code	200	2
Diagnosis Code Description	LYMPHOSARCOMA AND RETICULOSARCOMA	3

4.5.5.5 Extra Features

This panel has no extra features.

4.5.5.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Diagnosis Sequence Number	Unique number that may be used to indicate the order of importance of the diagnosis.	Field	Number	4	T_PA_PEND_D IAG	NUM_SEQ
2	Diagnosis Code	A list of diagnosis codes associated with a particular authorization.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
3	Diagnosis Code Description	Describes the diagnosis codes listed for a prior authorization.	Field	Character	40	T_DIAGNOSIS	DSC_25

4.5.5.7 Field Edits

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

4.5.6 PANEL: Pending Prior Authorization Information Panel

This panel is not currently used in Kentucky.

4.5.6.1 Description:

Providers may enter PAs for Pending Eligibles through the Provider Web Portal. When a Medicaid ID is issued to a Pending Eligible, the Pending PA is available for submission by the provider for adjudication. This panel displays the Information panel for the Pending PA request. The panel is view only.

4.5.6.2 Technical Name:

PA.PaPendingInformationPanel.ascx

4.5.6.3 Panel Name:

Pending Prior Authorization Information

4.5.6.4 Pending Prior Authorization Information Panel Layout

Prior Authorization Information - Pending			
1 Pending PA Number	000210008	SSN	999-99-9999 2
		4 Member Last Name	PRITCHARD
		6 Member First Name	HANK
8 Admission Date	06/04/2001	Member Date Of Birth	01/01/1929 9
10 Discharge Date	06/05/2001	Clerk Keyed	11
		13 Date Keyed	06/04/2001
		15 Time Keyed	
16 Accident	NO		
17 Special Considerations	NO		
18 Emergency	NO		
19 Nursing Facility Type			
		Requesting Provider ID	100674459A MCD 3
		Servicing Provider ID	100674459A MCD 5
		Service Provider Check	Specified Service Provider 7
		PA Category Code	ACUTE IN-PATIENT PSYCHIATRIC 12
		Primary Diagnosis Code	311 14
		Media Type	ONLINE 20

4.5.6.5 Extra Features

This panel has no extra features.

4.5.6.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Pending PA Number	The Pending Prior Authorization Number	Field	Character	10	T_PA_PEND_PAUTH	PRIOR_AUTH_NUM
2	Member SSN	Unique identifier for the member for whom services are requested on the PA.	Field	Character	9	T_RE_PEND_MEMBER	NUM_SSN
3	Requesting Provider Number	Unique identifier for the provider requesting services for a member on a PA request.	Field	Character	15	T_PR_PROV	ID_PROVIDER
4	Member Last Name	Last name of the member for whom services are requested on the PA.	Field	Character	20	T_RE_PEND_MEMBER	NAM_LAST
5	Servicing Provider ID	Unique identifier for the provider performing the services for a member specified on a PA request.	Field	Character	15	T_PR_PROV	ID_PROVIDER
6	Member First Name	First name of the member for whom services are requested on the PA.	Field	Character	15	T_RE_PEND_MEMBER	NAM_FIRST
8	Admission Date	Date a member was admitted to a facility.	Field	Date (MM/DD/CCYY)	8	T_PA_PEND_PAUTH	DTE_ADMISSION
9	Member Date of Birth	Date of birth of the member.	Field	Number	8	T_RE_PEND_MEMBER	DTE_BIRTH

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
10	Discharge Date	Date a member was released from a facility.	Field	Date (MM/DD/CCYY)	8	T_PA_PEND_PAUTH	DTE_DISCHARGE
11	Clerk Keyed	ID of the clerk who entered the PA.	Field	Character	8	T_PA_PEND_PAUTH	ID_CLERK_ENTRY
12	PA Category Code	Code that groups a PA's requested services under a type such as dental, inpatient, PT, OT.	Field	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
13	Date Keyed	Date the PA was entered.	Field	Number	8	T_PA_PEND_PAUTH	DTE_ENTERED
14	Primary Diagnosis Code	A checked Diagnosis box indicates there are additional diagnosis codes for the PA.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
14	Primary Diagnosis Code	A member's primary diagnosis.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
15	Time Keyed	Time the PA was entered.	Field	Number	8	T_PA_PEND_PAUTH	TME_ENTERED
16	Accident	A checked box indicates the PA is the result of the member's involvement in an accident.	Field	Character	1	T_PA_PEND_PAUTH	IND_ACCIDENT
17	Special Considerations	Indicates if there are special considerations concerning the PA.	Field	Character	1	T_PA_PEND_PAUTH	IND_SPECIAL_CONSID

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
18	Emergency	Manually checked and identifies the PA as an emergency 72-hour supply of drugs that does not count towards limitations.	Check Box	Character	1	T_PA_PEND_PAUTH	IND_EMERG
20	Media Type	Description of the medium by which a PA request is received.	Field	Character	1	T_PA_MEDIA	DSC_MEDIA_TYPE

4.5.6.7 Field Edits

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

4.5.7 PANEL: Pending Prior Authorization Line Item Panel

This panel is not currently used in Kentucky.

4.5.7.1 Description:

Providers may enter PAs for Pending Eligibles through the Provider Web Portal. When a Medicaid ID is issued to a Pending Eligible, the Pending PA is available for submission by the provider for adjudication. This panel displays the line item or service request information for a Pending PA request. The panel is view only.

4.5.7.2 Technical Name:

PA.PaPendingLineItemPanel.ascx

4.5.7.3 Panel Name:

Pending Line Item

4.5.7.4 Pending Prior Authorization Line Item Panel Layout

Line Item - Pending											
Line Item Number	Requested Units	Requested Dollars	Revenue Code From	Revenue Code To	Procedure Code From	Procedure Code To	Modifier 1	Modifier 2	Modifier 3	Modifier 4	
01	5	\$0.00			B4176						
02	1	\$0.00			B4172						

1	Line Item Number	01							2	Requested Effective Date*	06/08/2001
3	Service Type Code*	Procedure Code							4	Requested End Date*	06/09/2001
	5	Requested Units							5	Requested Units	5
6	Revenue Code			7	Revenue Code To				8	Requested Dollars	
9	Procedure Code From	B4176		10	Procedure Code To				11	Frequency	
	12	Modifier 1			13	Quad			14	Frequency Units*	
		Modifier 2			15	Tooth			16	Payment Method*	Pay System Price
		Modifier 3									
		Modifier 4									

4.5.7.5 Extra Features

This panel has no extra features.

4.5.7.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Line Item Number	Two characters that sequentially lists the items pertaining to the Pending PA.	Field	Character	2	T_PA_PEND_LITEM	NUM_PA_LINE_ITEM
2	Requested Effective Date	Requested date the authorization is effective.	Field	Date (MM/DD/CCYY)	8	T_PA_PEND_LITEM	DTE_PA_REQ_EFF
3	Service Type Code	Indicates the code set to use for validation of the requested service: procedure, revenue.	Combo Box	Character	1	T_PA_PEND_LITEM	CDE_SVC_TYPE
4	Requested End Date	Date requested that a service would end for a member.	Field	Date (MM/DD/CCYY)	8	T_PA_PEND_LITEM	DTE_PA_REQ_END
5	Requested Units	Number of units requested of a product or service.	Field	Number	9	T_PA_PEND_LITEM	QTY_UNT_SVC_REQ
6	Revenue Code	Code identifying a specific accommodation or ancillary service.	Field	Character	4	T_REVENUE_CODE	CDE_REVENUE
7	Revenue Code To	Revenue code that ends the range of revenue code specified for a service.	Field	Character	4	T_REVNUE_CODE	CDE_REVENUE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
8	Requested Dollars	Dollar amount requested for a service for a member.	Field	Number	9	T_PA_PEND_LITEM	AMT_PA_REQ
9	Procedure Code From	Code that uniquely identifies a procedure.	Field	Character	6	T_PROC	CDE_PROC
10	Procedure Code To	Procedure code ending the procedure code range used at the line item level on a Pending PA.	Field	Character	6	T_PROC	CDE_PROC
12	Modifier (1 - 4)	Four occurrences of codes used in combination with a procedure code to provide more information.	Field	Character	2	T_MODIFIER	CDE_PROC_MOD
13	Quad	Tooth quadrant used in combination with a tooth number and procedure code to provide more information concerning the service.	Field	Character	2	T_TOOTH_QUADRANT	CDE_TOOTH_QUADRANT
15	Tooth	Tooth number used in combination with a procedure code to provide more information concerning the service.	Field	Character	2	T_TOOTH	CDE_TOOTH_NBR

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
16	Payment Method	Payment method is used during claim adjudication to determine how a claim should be paid. Valid payment methods are: 2 = pay price specified on the service request, 1 = pay system price specified on a fee schedule, 3 = pay up to capitated amount specified on the service request.	Combo Box	Character	1	T_PA_PEND_LITEM	CDE_PYMT_METHOD

4.5.7.7 Field Edits

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

4.5.8 PANEL: Pending Prior Authorization Text Panel

This panel is not currently used in Kentucky.

4.5.8.1 Description:

Providers may enter PAs for Pending Eligibles through the Provider Web Portal. When a Medicaid ID is issued to a Pending Eligible, the Pending PA is available for submission by the provider for adjudication. This panel displays free form text for a Pending PA entered by the provider. The panel is view only.

4.5.8.2 Technical Name:

WebUI.EntityMaintenancePanel.ascx

4.5.8.3 Panel Name:

Pending Text

4.5.8.4 Pending Prior Authorization Text Panel Layout



4.5.8.5 Extra Features

This panel has no extra features.

4.5.8.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Text Line Number	Line number of the Prior Authorization free form text. It is generated automatically to identify a block of free form text.	Field	Number	4	T_PA_PEND_TEXT	NUM_TEXT_ENTRY

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
2	Text Description	Free form text.	Field	Character	500	T_PA_PEND_TEXT	DSC_TEXT

4.5.8.7 Field Edits

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

4.6 PAGE: Prior Authorization Pending Search Page

This page is not currently used in Kentucky.

4.6.1.1 Description:

The Prior Authorization Pending Search Page provides for searches of Pending PAs with specific criteria.

Navigation Path: [Prior Authorization] - [Pending Search]

4.6.1.2 Technical Name:

PriorAuthorizationPendingSearch

4.6.1.3 Web Page Name:

4.6.1.4 Prior Authorization Pending Search Page Layout

Pending - Prior Authorization Search

Prior Authorization Number

Requesting Provider ID [Search]

Clerk Keyed [Search]

PA Category Code ▼

Revenue Code From [Search]

Procedure Code From [Search]

Requested Effective Date

Requested End Date

Member SSN [Search]

Servicing Provider ID [Search]

Primary Diagnosis Code [Search]

Revenue Code To [Search]

Procedure Code To [Search]

Records 20 ▼

search
clear
adv search
add

Search Results										
PA Number	Line Item	Requested Effective Date	Requested End Date	PA Category Code	Requesting Provider ID	Servicing Provider ID	Servicing Code Number From	Servicing Code Number To	Member SSN	
00210008	01	06/08/2001	06/09/2001	Acute In-Patient	100674459A	100674459A	B4176		999999999	

4.6.2 PANEL: Pending Prior Authorization Search

This panel is not currently used in Kentucky.

4.6.2.1 Description:

Use this search panel to search pending PA's. This search Panel searches the Pending PA's which have not been assigned a Medicaid Member ID. The search is performed on the Prior Auth Pending Tables and results are based on the search criteria entered by the user.

Navigation Path: [Prior Authorization] - [Pending Search]

4.6.2.2 Technical Name:

PA.PaPendingSearchPage.aspx

4.6.2.3 Panel Name:

Pending Prior Authorization Search

4.6.2.4 Pending Prior Authorization Search Layout

The screenshot shows a web form titled "Pending - Prior Authorization Search". The form contains the following fields and controls, each with a red numbered callout:

- 1** Prior Authorization Number (text input)
- 2** Member SSN (text input with [Search] button)
- 3** Requesting Provider ID (text input with [Search] button)
- 4** Servicing Provider ID (text input with [Search] button)
- 5** Clerk Keyed (text input with [Search] button)
- 6** PA Category Code (dropdown menu)
- 7** Primary Diagnosis Code (text input with [Search] button)
- 8** Revenue Code From (text input with [Search] button)
- 9** Revenue Code To (text input with [Search] button)
- 10** Procedure Code From (text input with [Search] button)
- 11** Procedure Code To (text input with [Search] button)
- 12** Requested Effective Date (text input)
- 13** Requested End Date (text input)
- 14** Records (dropdown menu set to 20)
- 15** search (button)
- 16** clear (button)
- 17** adv search (button)
- 18** add (button)

4.6.2.5 Extra Features

The advanced search button expands the search criteria. Only Revenue Code or Procedure Code fields can be present for any given search. A validation check is done before presenting the results.

4.6.2.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Prior Authorization Number	The Pending Prior Authorization Number assigned to the record	Field	Character	9	T_PA_PEND_PAUTH	PA_NUM_PEND
2	Member SSN	The member SSN for whom services are requested on the Pending PA.	Field	Character	9	T_RE_PENDING_MEMBER	NUM_SSN
3	Requesting Provider ID	Unique identifier for the provider requesting services for a member on a Pending PA.	Field	Character	15	T_PR_PROV	ID_PROVIDER
4	Servicing Provider ID	Unique identifier for the provider performing the services for a member specified on a Pending PA.	Field	Character	15	T_PR_PROV	ID_PROVIDER
5	Clerk Keyed	Unique identifier for the clerk who entered the Pending PA.	Field	Character	8	T_PA_PEND_PAUTH	ID_CLERK_ENTRY
6	PA Category Code	Code that groups a Pending PA's requested services under a type such as dental, inpatient, and physician.	Field	Character	30	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
7	Primary Diagnosis Code	A member's primary diagnosis.	Field	Character	7	T_DIAGNOSIS	CDE_DIAG
8	Revenue Code From	Code identifying a specific accommodation or ancillary service	Field	Character	6	T_REVENUE_CODE	CDE_REVENUE

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
9	Revenue Code To	The ending range of revenue codes specified on a PA line item.	Field	Character	6	T_REVENUE_CODE	CDE_REVENUE
10	Procedure Code From	Code that uniquely identifies a procedure.	Field	Character	6	T_PROC	CDE_PROC
11	Procedure Code To	The ending range of procedure codes specified on a PA line item.	Field	Character	6	T_PROC	CDE_PROC
12	Requested Effective Date	Begin date of the date range for which the service is requested for use by a member.	Field	Date (CCYYMMDD)	8	T_PA_PEND_LITEM	DTE_PA_REQ_EFF
13	Requested End Date	Last date the requested service can be used by a member.	Field	Date (CCYYMMDD)	8	T_PA_PEND_LITEM	DTE_PA_REQ_END
14	Records	The maximum number of records displayed on the panel when the search results are displayed.	Field	Number	0	N/A	

4.6.2.7 Button Descriptions

Button No	Button	Description
15	Search	Clicking the Search button returns search results based on the search criteria.
16	Clear	Clicking the Clear button clears the field.
17	Adv Search	Clicking Advanced Search opens the main search panel.
18	Add	Clicking the Add button adds a new prior authorization.

4.6.2.8 Field Edits

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

5 Reports

5.1 Description

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

A	=	ANNUAL
D	=	DAILY
M	=	MONTHLY
Q	=	QUARTERLY
R	=	ON REQUEST
W	=	WEEKLY

The following section provides and a sample layout for each Report associated to the Member Data Maintenance subsystem.

Some information in this section is represented in table format. In order to fit information on the page, some data field information may wrap to the next line.

5.1.1 PAU-0130-M -- End Date PA for Member in MC

This report lists PAs end dated because a member has either entered into managed care and now receives services from the Managed Care Organization (MCO) or the PA was for EPSDT services and a member was placed in a status of "M7" or "P7".

PAs for members entering managed care are excluded from end dating if one of the following conditions exists:

1. The PA Category is for Impact Plus, In-patient or one of the Long Term Care PA types;
2. The service provider has an active specialty of "psychiatry"; or,
3. The PA is Category EPSDT and the requested services are for behavioral health.

All PAs are end-dated if the PA category is EPSDT and member is in a status of "M7" or "P7"

NOTE: The process that generates this report also end-dates the PAs.

5.1.1.1 Technical Name

PAU-0130-M

5.1.1.2 Sort Order

PA Type, Provider ID, Medicaid ID, PA Number, PA Line Item Number.

5.1.1.3 Distribution

OnBase

5.1.1.4 End Date PA for Member in MC

Report: PAU-0130-M
 Process: PAUJM130
 Location: PAUPM130

COMMONWEALTH OF KENTUCKY
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 PRIOR AUTHORIZATION END DATE REPORT
 MONTH OF XXXXXXXXXXXX 9999

Run Date: MM/DD/CCYY
 Run Time: 99:99:99
 Page: 999

PA CATEGORY: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

SERVICING PROVIDER NUMBER	MEMBER ID	PRIOR AUTH NUMBER	LINE NBR	MC/Elig BEGIN DATE	MC/Elig END DATE	SERVICE CODE	LINE ITEM STATUS	LINE ITEM REASON CODE
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	XXXXXXXXXX	XXX
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	XXXXXXXXXX	XXX
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	XXXXXXXXXX	XXX
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	XXXXXXXXXX	XXX

5.1.1.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Line Nbr	Unique number associated with a service on a PA.	2	Character	T_PA_LINE_ITEM	NUM_PA_LINE_ITEM
Line Reason Code	Reason code associated with a requested service on a PA.	3	Character	T_PA_IAC_TEXT	CDE_IAC
Line Status	Status of requested service on a PA.	20	Character	T_PA_LINEITEM_S TAT	DSC_STATUS
MC/Elig Begin Date	Date enrollment in a Managed Care Organization or status of M7 or P7 begins.	8	Date (MM/DD/CCYY)	T_RE_PMP_ASSIG N, T_RE_AID_ELIG	DTE_EFFECTIVE
MC/Elig End Date	Date enrollment in a Managed Care Organization or status of M7 or P7 ends.	8	Date (MM/DD/CCYY)	T_RE_PMP_ASSIG N, T_RE_AID_ELIG	DTE_END
Member ID	Member's Medicaid identification number.	10	Character	T_RE_BASE	ID_MEDICAID
Month of XXXXXXXXXXXX 9999	Reporting period	17	Character		Calculated
PA Category	Code describing the PA Category (e.g. in-patient, dental, or physician).	30	Character	T_PA_ASSIGN_CO DE	DSC_PA_ASSIGN
Prior Auth Number	Unique number assigned to a PA.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Service Code	Service requested on a PA.	5	Character	T_PA_LINE_ITEM T_REVENUE T_PROCT_DRUG	CDE_SVC_TYPE CDE_REVENUE CDE_PROC CDE_NDC
Servicing Provider Number	ID of the service provider on a PA.	10	Character	T_PR_PROV	ID_PROVIDER

5.1.1.6 Associated Programs

Program	Description
paupm130	End Date Prior Auths
copy2routedir	Copy Reports to Router

5.1.2 PAU-0140-R -- Mass Update Old Provider

5.1.2.1 About Mass Updates

Some circumstances require a single change be made to a large number of Service Authorization records. For example, if a provider has a change of ownership, a new provider number is issued. All current PA records for the provider must be updated to reflect the new provider number. The Mass Update function allows all records to be updated at one time. The Mass Update Search function allows the User to set the criteria for locating the records to be changed.

5.1.2.2 Report Description

Mass update of providers is a two-step process. The first step end-dates the old provider's PAs so that claims do not pay past the effective date for the new provider. The old provider is given time to submit claims for payment. The second step updates authorized units and amounts for the previous provider with what has been used to date. PAs are then created for the new provider with the remaining authorized units and amounts from the original PA. This report lists PAs that are end-dated for the previous provider.

There is an input parameter in the previous provider mass update process that indicates whether actual updates should be performed or the process should just report on PAs that would be affected by the process to end-date the previous provider's PAs. A heading of 'Preliminary Report' indicates the report is for a preliminary run to view the potential results of running the original provider mass update. No database updates are made or letters generated. A report heading of 'Final Report' indicates all updates were made and letters were generated.

5.1.2.3 Technical Name

PAU-0140-R

5.1.2.4 Sort Order

PA Number, PA Line Item Number.

5.1.2.5 Distribution

OnBase

For readability, the layout displays on the next page.

5.1.2.6 Mass Update Old Provider Layout

Report : PAU-0140-R
 Process : PAUJR140
 Location: PAUPR140

COMMONWEALTH OF KENTUCKY
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 OLD PROVIDER MASS UPDATE RESULTS

RUN DATE: MM/DD/CCYY
 RUN TIME: 99:99:99
 PAGE: 999

***** FINAL REPORT *****

PA NUMBER	LINE ITEM	SERVICE CODE FROM TO	UNITS AUTHORIZED	UNITS REMAINING	AMOUNT AUTHORIZED	AMOUNT REMAINING	DATES ORIGINAL BEGIN	DATES ORIGINAL END	DATES NEW BEGIN	DATES NEW END
XXXXXXXXXX	XX	XXXXX XXXXX	9,999,999	9,999,999	9,999,999.99	9,999,999.99	XX/XX/XX	XX/XX/XX	XX/XX/XX	XX/XX/XX
XXXXXXXXXX	XX	XXXXX XXXXX	9,999,999	9,999,999	9,999,999.99	9,999,999.99	XX/XX/XX	XX/XX/XX	XX/XX/XX	XX/XX/XX
XXXXXXXXXX	XX	XXXXX XXXXX	9,999,999	9,999,999	9,999,999.99	9,999,999.99	XX/XX/XX	XX/XX/XX	XX/XX/XX	XX/XX/XX
XXXXXXXXXX	XX	XXXXX XXXXX	9,999,999	9,999,999	9,999,999.99	9,999,999.99	XX/XX/XX	XX/XX/XX	XX/XX/XX	XX/XX/XX
XXXXXXXXXX	XX	XXXXX XXXXX	9,999,999	9,999,999	9,999,999.99	9,999,999.99	XX/XX/XX	XX/XX/XX	XX/XX/XX	XX/XX/XX
XXXXXXXXXX	XX	XXXXX XXXXX	9,999,999	9,999,999	9,999,999.99	9,999,999.99	XX/XX/XX	XX/XX/XX	XX/XX/XX	XX/XX/XX
XXXXXXXXXX	XX	XXXXX XXXXX	9,999,999	9,999,999	9,999,999.99	9,999,999.99	XX/XX/XX	XX/XX/XX	XX/XX/XX	XX/XX/XX
XXXXXXXXXX	XX	XXXXX XXXXX	9,999,999	9,999,999	9,999,999.99	9,999,999.99	XX/XX/XX	XX/XX/XX	XX/XX/XX	XX/XX/XX

*** END OF REPORT ***
 *** NO DATA THIS REPORT ***

5.1.2.7 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Amount Authorized	Dollar amount authorized for the prior authorization line item service.	9	Number (Decimal)	T_PA_LINE_ITEM	AMT_PA_AUTH
Amount Remaining	Dollar amount that remains to be used on the line item service. The field is calculated using used amounts on T_PA_ITEM_DTL_XREF.	9	Number (Decimal)	N/A	Calculated Field
Dates New Begin	Original authorization start date for the line item.	8	Character	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF

Field	Description	Length	Data Type	DB Table	DB Attributes
Dates New End	Mass update effective date less one day as new authorized end date for the line item.	8	Character	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Dates Original Begin	Original authorized prior authorization start date for the line item.	8	Character	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Dates Original End	Original authorized prior authorization end date for the line item.	8	Character	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Line Item	Line item associated with the PA number.	2	Character	T_PA_LINE_ITEM	NUM_PA_LINE_ITEM
PA Number	Prior authorization number associated with the member.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Service Code From	Service code for the authorization.	5	Character	T_PA_LINE_ITEM/ T_PROC/T_REVEN UE_CODE/T_DRUG	CDE_SVC_TYPE/CDE_ PROC/CDE_REVENUE/ CDE_DRUG
Service Code To	Ending range for a service code request.	5	Character	T_PA_LINE_ITEM/ T_PROC/T_REVEN UE_CODE/T_DRUG	CDE_SVC_TYPE/CDE_ PROC/CDE_REVENUE/ CDE_DRUG
Units Authorized	Number of units requested for the prior authorization line item service.	9	Number (Integer)	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
Units Remaining	Number of services that remain to be used on the line item. The field is calculated by subtracting used amounts on T_PA_ITEM_DTL_XREF from authorized units.	9	Number (Integer)		Calculated Field

5.1.2.8 Associated Programs

Program	Description
No associated Programs found.	

5.1.3 PAU-0141-R -- Mass Update New Provider

Mass update of providers is a two-step process. The first step end dates the previous provider's PAs so that claims do not pay past the effective date for the new provider. The previous provider is given time to submit claims for payment. The second step updates authorized units and amounts for the old provider with what has been used to date. PAs are then created for the new provider with the remaining authorized units and amounts from the original PA. This report lists PAs that are created for the new provider.

There is an input parameter in the new provider mass update process that indicates whether actual updates should be performed or the process should just report on PAs that would be created by the new provider mass update process. A heading of 'Preliminary Report' indicates the report is for a preliminary run and no database updates were made or letters created. A heading of 'Final Report' indicates all updates were made and letters created.

5.1.3.1 Technical Name

PAU-0141-R

5.1.3.2 Sort Order

PA Number, PA Line Item Number.

5.1.3.3 Distribution

OnBase

5.1.3.4 Mass Update New Provider Layout

Report : PAU-0141-R
 Process : PAUJR141
 Location : PAUPR141

COMMONWEALTH OF KENTUCKY
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 NEW PROVIDER MASS UPDATE RESULTS

RUN DATE : MM/DD/CCYY
 RUN TIME : 99:99:99
 PAGE : 999

***** FINAL REPORT *****

-----	NEW	PA NUMBER OLD	---- LINE ITEM	SERVICE CODE FROM TO	---TRANFERRED UNITS	----- AMOUNT	AUTHORIZED BEGIN	DATES END
	XXXXXXXXXX	XXXXXXXXXX	XX	XXXXX XXXXX	9,999,999	9,999,999.99	XX/XX/XX	XX/XX/XX
	XXXXXXXXXX	XXXXXXXXXX	XX	XXXXX XXXXX	9,999,999	9,999,999.99	XX/XX/XX	XX/XX/XX
	XXXXXXXXXX	XXXXXXXXXX	XX	XXXXX XXXXX	9,999,999	9,999,999.99	XX/XX/XX	XX/XX/XX
	XXXXXXXXXX	XXXXXXXXXX	XX	XXXXX XXXXX	9,999,999	9,999,999.99	XX/XX/XX	XX/XX/XX
	XXXXXXXXXX	XXXXXXXXXX	XX	XXXXX XXXXX	9,999,999	9,999,999.99	XX/XX/XX	XX/XX/X

END OF REPORT ***
 *** NO DATA THIS REPORT ***

5.1.3.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Authorized Dates Begin	Authorized prior authorization start date for the line item for the new provider.	8	Character	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Authorized Dates End	Authorized prior authorization end date for the line item for the new provider.	8	Character	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Line Item	Line item associated with the PA number.	2	Character	T_PA_LINE_ITEM	NUM_PA_LINE_ITEM
PA Number New	New prior authorization number associated with the member.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUMBER
PA Number Old	Old prior authorization number associated with the member.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUMBER
Service Code From	Beginning range for a service code on a PA.	5	Character	T_PA_LINE_ITEM / T_REVENUE_CODE / T_PROC	CDE_SVC_TYPE/ CDE_REVENUE / CDEPROC
Service Code To	Ending range for a service code on a PA.	5	Character	T_PA_LINE_ITEM / T_REVENUE_CODE / T_PROC	CDE_SVC_TYPE/ CDE_REVENUE / CDE_PROC
Transferred Amount	Dollar amount for the prior authorization line item service transferred to the new provider.	9	Number (Decimal)	T_PA_LINE_ITEM	AMT_PA_AUTH
Transferred Units	Number of units transferred for the prior authorization line item service transferred to the new provider.	9	Number (Integer)	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH

5.1.3.6 Associated Programs

Program	Description
paupr141	Mass update - new provider
copy2routedir	Copy Reports to Router

5.1.4 PAU-0142-R -- Mass Update Rate Service Code

Rate and service code changes for a PA line item may be made by an automated mass update process. The process generates this report, which lists overrides for either a rate or service code on a PA line item. Claims access the override when paying a claim using a PA.

A heading of 'Preliminary Report' indicates the report is for a preliminary run to verify the correct updates are being made. No database updates are made or letters generated on a preliminary run. A heading of 'Final Report' indicates all updates were made and letters were generated during the mass update process.

5.1.4.1 Technical Name

PAU-0142-R

5.1.4.2 Sort Order

PA Number, PA Line Item Number.

5.1.4.3 Distribution

OnBase

5.1.4.4 Mass Update Rate Service Code Layout

Report : PAU-0142-R	COMMONWEALTH OF KENTUCKY	RUN DATE: MM/DD/CCYY
Process : PAUJR142	MEDICAID MANAGEMENT INFORMATION SYSTEM	RUN TIME: 99:99:99
Location:: PAUPR142	RATE/SERVICE CODE MASS UPDATE	PAGE: 999

***** FINAL REPORT *****

PA NUMBER	LINE ITEM	----- OLD	RATE NEW	-----	- SERVICE CODE - OLD NEW	---	---EFFECTIVE DATES --- BEGIN END
XXXXXXXXXX	XX	9.999.999/99	9,999,999.99		XXXXX XXXXX		XX/XX/X XX/XX/XX
XXXXXXXXXX	XX	9.999.999/99	9,999,999.99		XXXXX XXXXX		XX/XX/X XX/XX/XX
XXXXXXXXXX	XX	9.999.999/99	9,999,999.99		XXXXX XXXXX		XX/XX/X XX/XX/XX
XXXXXXXXXX	XX	9.999.999/99	9,999,999.99		XXXXX XXXXX		XX/XX/X XX/XX/XX
XXXXXXXXXX	XX	9.999.999/99	9,999,999.99		XXXXX XXXXX		XX/XX/X XX/XX/XX

END OF REPORT ***

*** NO DATA THIS RUN ***

5.1.4.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Effective begin date	Start date for either the rate or service code change	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD	DTE_EFFECTIVE
Effective end date	Ending date for either the rate or service code change	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD	DTE_END
Line item	The line item associated with the PA number	2	Character	T_PA_LINE_ITEM	NUM_PA_LINE_ITEM
New rate	Current dollar amount authorized for the prior authorization line item service (Input Parameter)	9	Number (Decimal)	T_SYSTEM_PARMS	DSC_30 (INPUT PARM)
Old rate	Previous dollar amount authorized for the prior authorization line item service	9	Number (Decimal)	T_PA_LINE_ITEM	AMT_PA_AUTH
Pa number	Prior Authorization number	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Service code - new from	Line item service code that is the replacement service code for a service code mass update	5	Character	T_SYSTEM_PARMS	DSC_30 (INPUT PARM)
Service code - new thru	Ending range for the new service code. If there is no ending range, the default is -1.	5	Character	T_SYSTEM_PARMS	DSC_30 (INPUT PARM)
Service code - old from	Line item service code that matches the input parameter for either a rate or service code change	5	Character	T_SYSTEM_PARMS	DSC_30 (INPUT PARM)
Service code - old thru	Ending range that matches the input parameter for the original service code. If there is no ending range, the default is -1.	5	Character	T_SYSTEM_PARMS	DSC_30 (INPUT PARM)

5.1.4.6 Associated Programs

Program	Description
paupr142	Rate Service Code Mass Update Report.
copy2routedir	Copy Reports to Router.

5.1.5 PAU-0210-M -- EPSDT First Time Prior Authorizations

The report displays PAs of members with an approved EPSDT service/prior authorization request during the preceding month that had no previously approved EPSDT request.

5.1.5.1 Technical Name

PAU-0210-M

5.1.5.2 Sort Order

Medicaid ID

5.1.5.3 Distribution

OnBase

5.1.5.4 EPSDT First Time Prior Authorizations Layout

Report : PAU-0210-M
 Process : PAUJM210
 Location : PAUPM210

COMMONWEALTH OF KENTUCKY
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 EPSDT MEMBERS - 1ST TIME PRIOR AUTHORIZATIONS
 FOR THE MONTH OF XXXXXXXX CCYY

RUN DATE: MM/DD/CCYY
 RUN TIME: 99:99:99
 PAGE: 999

MEMBER ID	MEMBER Name	PA NUMBER	PROVIDER NUMBER	SERVICE CODE	APPROVED UNITS
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	9,999,999
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	9,999,999
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	9,999,999
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	9,999,999
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	9,999,999
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	9,999,999
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	9,999,999
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	9,999,999
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	9,999,999
XXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXX	9,999,999

TOTAL MEMBERS: 9,999,999

*** END OF REPORT ***
 *** NO DATA THIS REPORT ***

5.1.5.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Approved Units	Quantity of authorized service units.	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
Member ID	Member Identification number.	12	Number	T_RE_BASE	ID_MEDICAID
Member Name	Name of the member.	37	Character	T_RE_BASE	NAM_LAST, NAM_FIRST
Month of XXXXXXXXXXXX CCYY	Reporting period	17	Character	N/A	Calculated Field
PA Number	Prior Authorization number associated with the Member.	10	Number	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Number	Medicaid provider identification number.	10	Character	T_PR_IDENTIFIER	ID_PROVIDER
Service Code	Line Item service type code.	6	Character	T_PA_LINE_ITEM (T_REVENUE_CODE , T_PROC, T_DRUG)	CDE_SVC_TYPE (CDE_REVENUE, CDE_PROC, CDE_NDC)
Total Members	A count of unique members listed on the report.	9	Number	N/A	Calculated Field

5.1.5.6 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
paupm210	Create monthly first-time EPSDT services report

5.1.6 PAU-0220-M1 -- Orthodontic Six Month Progress Report Not Received

This report supports orthodontic case management as part of the PA orthodontic case tracking process. Providers are required to submit specific documentation during the span of a member’s orthodontic treatment. The PA orthodontic status code is used to track receipt of the documentation from the provider. Based on the code and the service begin date of the PA, reminder letters are sent to providers and reports created of PAs with overdue documentation. The combination of the PA orthodontic status code and the PA service begin date determine what letters are generated and what PAs are displayed on a report.

5.1.6.1 Technical Name

PAU-0220-M1

5.1.6.2 Sort Order

Provider ID, Medicaid ID, PA Number, First DOS, Ortho Status, Procedure Code.

5.1.6.3 Distribution

OnBase

5.1.6.4 Orthodontic Six Month Progress Report Not Received Layout

Report : PAU-0220-M1
 Process : PAUJM220
 Location: PAUP220

COMMONWEALTH OF KENTUCKY
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 ORTHODONTIC PRIOR AUTHORIZATION CASE TRACKING

Run Date: MM/DD/CCYY
 Run Time: HH:MM:SS
 Page : 9,999

SIX MONTH PROGRESS REPORT NOT RECEIVED

PROVIDER NUMBER	MEMBER NUMBER	PRIOR AUTH NUMBER	FIRST DATE OF SERVICE	CLAIM PAID AMOUNT
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	MM/DD/CCYY	9,999,999.99
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	MM/DD/CCYY	9,999,999.99
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	MM/DD/CCYY	9,999,999.99
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	MM/DD/CCYY	9,999,999.99

END OF REPORT ***
 NO DATA THIS REPORT ***

5.1.6.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Claim Paid Amount	Total amount of paid claims associated with a PA service.	9	Number (Decimal)	T_PA_ITEM_DTL_XREF	AMT_PA_USED
First Date of Service	Date of first service on a claim associated with a PA service.	10	Date (MM/DD/CCYY)	T_HIST_DIRECTORY	DTE_FIRST_SVC
Member Number	Member's Medicaid ID.	12	Character	T_RE_BASE	ID_MEDICAID
Prior Auth Number	Unique identifier assigned to a PA request.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Number	Unique identifier assigned to a provider.	10	Character	T_PR_IDENTIFIER	ID_PROVIDER

5.1.6.6 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router.
paupm220	PA Orthodontic Case Tracking Process Reports and Letters.

5.1.7 PAU-0220-M2 -- Orthodontic Final Case Tracking

This report supports orthodontic case management as part of the PA orthodontic case tracking process. Providers are required to submit specific documentation during the span of a member’s orthodontic treatment. The PA orthodontic status code is used to track receipt of the documentation from the provider. Based on the code and the service begin date of the PA, reminder letters are sent to providers and reports created of PAs with overdue documentation. The combination of the PA orthodontic status code and the PA service begin date determine what letters are generated and what PAs are displayed on a report.

5.1.7.1 Technical Name

PAU-0220-M2

5.1.7.2 Sort Order

PA Number, PA Line Item Number.

5.1.7.3 Distribution

OnBase

5.1.7.4 Orthodontic Final Case Tracking Layout

```

Report   : PAU-0220-M2
Process  : PAUJM220
Location : PAUPM220

COMMONWEALTH OF KENTUCKY
MEDICAID MANAGEMENT INFORMATION SYSTEM
ORTHODONTIC PRIOR AUTHORIZATION CASE TRACKING
FINAL CASE SUBMISSION FORM NOT RECEIVED

Run Date: MM/DD/CCYY
Run Time: HH:MM:SS
Page:    9,999

PROVIDER      MEMBER      PRIOR AUTH      FIRST DATE      CLAIM PAID
NUMBER        NUMBER        NUMBER          OF SERVICE     AMOUNT
XXXXXXXXXX    XXXXXXXXXXXX   XXXXXXXXXXXX    MM/DD/CCYY     9,999,999.99

*** END OF REPORT ***
*** NO DATA THIS REPORT ***
    
```

5.1.7.5 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Claim Paid Amount	Total of paid claim amounts associated with a PA service.	9	Number (Decimal)	T_PA_ITEM_DTL_XREF	AMT_PA_USED

Field	Description	Length	Data Type	DB Table	DB Attributes
First Date of Service	Date of first service on a claim associated with a PA service.	10	Date (MM/DD/CCYY)	T_HIST_DIRECTORY	DTE_FIRST_SVC
Member Number	Member's Medicaid ID.	12	Character	T_RE_BASE	ID_MEDICAID
Prior Auth Number	Unique identifier assigned to a PA request.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Number	Unique identifier assigned to a provider.	10	Character	T_PR_IDENTIFIER	ID_PROVIDER

5.1.7.6 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
paupm220	PA Orthodontic Case Tracking Process Reports and Letters

6 Letters

6.1 Description

Some information in this section is represented in table format. In order to fit on the page, some data field information may wrap to the next line." Documentation on each letter then follows this statement.

6.1.1 PAU-001A-D -- Waiver Member Letter

This letter is generated for Waiver service/prior authorizations. It is created and sent to a member when all requested services on the service/prior authorization are in a finalized status, Approved or Denied, or when an update is applied to the record.

6.1.1.1 Technical Name

PAU-001A-D

For readability, letter displays on the next page.

6.1.1.2 Waiver Member Letter Layout

Current Date

Provider Number

Member Name
Member Address Line1
Member Address Line2
City, State Zip-Zip4

Subject: Prior Authorization of waiver services
Recipient Name : XXXXXXXXXXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXX
Member ID : XXXXXXXXX
Level of Care From Effective Date To End Date

Dear Member Name:

The authorization for waiver services by Provider
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, Provider Number, has
been reviewed.

The following service units have been requested:

Table with 5 columns: Service Code, Service Name, Monthly # Units, Service Begin, Service End. Contains 2 rows of placeholder data.

The following service units have been requested and approved on PA# XXXXXXXXXX:

Table with 5 columns: Service Code, Service Name, Monthly # Units, Service Begin, Service End. Contains 2 rows of placeholder data.

The following service units have been requested and denied:

Table with 5 columns: Service Code, Service Name, Monthly # Units, Service Begin, Service End. Contains 1 row of placeholder data.

Reason:

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX

Table with 5 columns: Service Code, Service Name, Monthly # Units, Service Begin, Service End. Contains 1 row of placeholder data.

Reason:

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX

Notice Of Right To An Administrative Hearing

Should you as a Medicaid recipient, applicant or guardian disagree with this adverse determination,
you have the right to request an administrative hearing in accordance with 907 KAR 1:563.

You may request a hearing by filing with the Department for Medicaid services, a written statement
clearly indicating a desire for a hearing.

This written request must be postmarked or received within thirty(30) days of the date of adverse
action, notice of decreased services, or denial of services to the Department for Medicaid Services,
Division of Member and Provider Services, 6E-A, 275 East Main Street, Frankfort, Kentucky 40621-
0001.

At this hearing you as the Medicaid recipient, applicant or guardian may be represented by an

authorized representative such as legal counsel , a relative, a friend, or other spokesperson or you may represent yourself. You may contact the Department for Community Based Services located in your county of residence regarding the availability of free representation by legal aid services.

You have the right to review the case record relating to the issue; and submit additional information in support of your claim.

Sincerely,

KYMMIS Prior Authorization Unit

6.1.1.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
City	The member address city	18	Character	T_RE_MULTI_ADDRESS	ADR_CITY
Current Date	The date the letter was generated	8	Date (MMDDCCYY)	N/A	CALCULATED FIELD
Effective Date	The begin date of the level of care	8	Date (MM/DD/CCYY)	T_RE_ASSIGN_PLAN	DTE_EFFECTIVE
End Date	The end date of the level of care	8	Date (MM/DD/CCYY)	T_RE_ASSIGN_PLAN	DTE_END
Member Address Line1	The member address line 2	30	Character	T_RE_MULTI_ADDRESS	ADR_STREET_1
Member Address Line2	The member address line 2	30	Character	T_RE_MULTI_ADDRESS	ADR_STREET_2
Member ID	The member ID	12	Character	T_RE_BASE	ID_MEDICAID
Monthly Units	The number of units approved for the PA	9	Number	T_PA_PAUTH	QTY_UNT_SVC_ATH
PA #	The prior authorization associated with the letter	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Name	The provider name	50	Character	T_PR_NAM	Name
Provider Number	The provider ID	15	Character	T_PR_IDENTIFIER	ID_PROVIDER
Recipient Name	The member name	36	Character	T_RE_BASE	NAM_FIRST + NAME_MID_INIT + NAM_LAST
Service Begin	The date the service begins	8	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_PA_AUTH_EFF
Service Code	The service code	5	Character	T_PROC/T_REVENUE	CDE_PROC/CDE_REVENUE/
Service End	The date the service ends	8	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_PA_AUTH_END

Field	Description	Length	Data Type	DB Table	DB Attributes
Service Name	The service code description	40	Character	T_PROC/T_REVENUE/	DSC_PROCECURE/ DSC_REV_CODE
State	The member address state	2	Character	T_RE_MULTI_ADDRESS	ADR_STATE
Zip	The member address zip	5	Character	T_RE_MULTI_ADDRESS	ADR_ZIP_CODE
Zip 4	The member address zip 4	4	Character	T_RE_MULTI_ADDRESS	ADR_ZIP_CODE_4

6.1.1.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.2 PAU-001B-D -- Waiver Provider Letter

This letter is generated for Waiver service/prior authorizations. It is created and sent to a provider when all requested services on the service/prior authorization are in a finalized status, Approved or Denied or when an update is applied to the record.

6.1.2.1 Technical Name

PAU-001B-D

For readability, the letter displays on the next page.

6.1.2.2 Waiver Provider Letter Layout

Kentucky Department For Medicaid Services
Prior Authorization Notice

Current Date

Provider Name
Provider Address Line1
Provider Address Line2
City, State Zip-Zip4

Subject: Prior Authorization of waiver services
Recipient Name : XXXXXXXXXXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXXXXXX
Member ID : XXXXXXXXXX
Level of Care From Effective Date Through End Date

Dear Provider Name:

The authorization for waiver services by Provider XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX,
Provider Number, has been reviewed.

The following services units have been requested:

Table with 5 columns: Service Code, Service Name, Monthly # Units, Service Begin, Service End. Contains 2 rows of placeholder data.

The following service units have been requested and approved, PA# XXXXXXXXXX

Table with 5 columns: Service Code, Service Name, Monthly # Units, Service Begin, Service End. Contains 2 rows of placeholder data.

The following service units have been requested and denied:

Table with 5 columns: Service Code, Service Name, Monthly # Units, Service Begin, Service End. Contains 2 rows of placeholder data with 'Reason:' labels.

Notice Of Right To An Administrative Hearing

Should you as a Medicaid recipient, applicant or guardian disagree with this adverse determination, you
have the right to request an administrative hearing in accordance with 907 KAR 1:563.

1. You may request a hearing by filing with the Department for Medicaid Services, a written statement clearly indicating a desire for a hearing.
 2. This written request must be postmarked or received within thirty(30) days of the date of adverse action, notice of decreased services, or denial of services to the Department for Medicaid Services, Division of Member and Provider Services, 6E-A, 275 East Main Street, Frankfort, Kentucky 40621-0001.
 3. At this hearing you as the Medicaid recipient, applicant or guardian may be represented by an authorized representative such as legal counsel, a relative, a friend, or other spokesperson or you may represent yourself. You may contact the Department for Community Based Services located in your county of residence regarding the availability of free representation by legal aid services.
 4. You have the right to review the case record relating to the issue, and submit additional information in support of your claim.
- This prior authorization does not guarantee payment. In order for you to receive payment, the recipient must be eligible on the date of service. Always check the recipient's medical card to verify eligibility.

Sincerely,

KYMMIS Prior Authorization Unit

6.1.2.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
City	Provider address city	18	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	The date the letter was generated	8	Date (MMDDCCYY)		CALCULATED FIELD
Effective Date	The begin date of the level of care	8	Date (MM/DD/CCYY)	T_RE_ASSIGN_PLAN	DTE_EFFECTIVE
End Date	The end date of the level of care	8	Date (MM/DD/CCYY)	P_RE_ASSIGN_PLAN	DTE_END
Member ID	The member ID	9	Character	T_RE_BASE	ID_MEDICAID
Monthly Units	The number of units approved for the PA	9	Number	T_PA_LINE_ITEM	QTY_FREQ_AUTH
PA #	The prior authorization associated with the letter	9	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Address Line1	Provider address line 1	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Provider Address Line2	Provider address line 2	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Provider Name	The provider name	50	Character	T_PR_NAM	Name
Provider Number	The provider ID	15	Number	T_PR_IDENTIFIER	ID_PROVIDER
Reason	Denial reason code + description	509	Character	T_PA_IAC_XREF	CDE_IAC + DSC_IAC
Reason Code	Reason code for denial	9	Character	T_PA_IAC_XREF	CDE_IAC
Recipient Name	Member associated with the prior authorization letter	20	Character	T_RE_BASE	NAM_LAST + NAM_FIRST + NAM_MID_INIT
Service Begin	The date the service begins	8	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_PA_AUTH_EFF

Field	Description	Length	Data Type	DB Table	DB Attributes
Service Code	The service code	6	Character	T_PROC/T_REVENUE/T_DRUG	CDE_PROC/ CDE_REVENUE/ CDE_NDC
Service End	The date the service ends	8	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_PA_AUTH_END
Service Name	The service code description	40	Character	T_PROC/T_REVENUE/T_DRUG	DSC_PROCECURE/DSC_REV_CODE/ DSC_NDC
State	Provider address state	2	Character	T_PR_ADR	ADR_MAIL_STATE
Zip	Provider address zip code	5	Character	T_PR_ADR	ADR_MAIL_ZIP
Zip4	Provider address zip code 4	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

6.1.2.4 Associated Programs

Program

No associated Programs found.

6.1.3 PAU-001D-D -- Home Health Provider Letter

This letter is generated for service providers specified on Home Health service/prior authorizations. It is created and sent to the service provider when all requested services on the service/prior authorization are in a finalized status, Approved or Denied or when an update is applied to the record.

6.1.3.1 Technical Name PAU-001D-D

For readability, the letter displays on the next page.

6.1.3.2 Home Health Provider Letter Layout

Kentucky Department For Medicaid Services

Prior Authorization Notice

Current Date

Provider Name

Address 1

Address 2

City, State Zip Zip4

Subject: Prior Authorization of Home Health Services

Member Name: XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXX

Member Number: XXXXXXXXXXX

Dear Provider Name:

The authorization for Home Health Services has been reviewed.

The following service units have been requested and approved on PA # XXXXXXXXXX

Code	Procedure Name	#Units	Service Begin	Service End
1. XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX	9,999,999	MM/DD/YYYY	MM/DD/YYYY

Notice Of Right To An Administrative Hearing

Should you as a Medicaid recipient, applicant or guardian disagree with this adverse determination, you have a right to request an administrative hearing in accordance with 907 KAR 1:563.

- (1) You may request a hearing by filing with the Department for Medicaid Services, a written statement clearly indicating a desire for a hearing.
- (2) This written request must be postmarked or received within thirty (30) days of the date of adverse action, notice of decreased services, or denial of services to the Department for Medicaid Services, Division of Administration & Financial Management, Administrative Services Branch 6W-C, 275 East Main Street, Frankfort KY 40621-0001.
- (3) At this hearing you as the Medicaid recipient, applicant or guardian may be represented by an authorized representative such as legal counsel, a relative, a friend, or other spokesperson or you may represent yourself. You may contact the Department for Community Based Services located in your county of residence regarding the availability of free representation by Legal Aid Services.
- (4) You have the right to review the case record relating to the issue; and submit additional information in support of your claim.
- (5) If you have any questions, contact DMS, Division of Long Term Care.

Sincerely,

KYMMIS Prior Authorization Unit

6.1.3.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
#Units	The number of units approved for the PA	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
Address1	Provider address line 1	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Address2	Provider address line 2	30	Character	T_PR_ADR	ADR_MAIL_STRT2
City	Provider Address city	30	Character	T_PR_ADR	ADR_MAIL_CITY
Code	The service code	6	Character	T_PROC/T_REVENUE_CODE/T_DRUG	CDE_PROC/CDE_REVENUE/CDE_NDC
Current Date	The date the letter was generated	8	Date (MMDDCCYY)	N/A	CALCULATED FIELD
PA #	The prior authorization associated with the letter	9	Number	T_PA_PAUTH	PRIOR_AUTH_NUM
Procedure Name	The service code description	40	Character	T_PROC/T_REVENUE_CODE/T_DRUG	DSC_PROCEDURE/DSC_REV_CODE/DSC_NDC
Provider Name	The provider name	50	Character	T_PR_NAM	Name
Provider Number	The provider ID	15	Character	T_PR_IDENTIFIER	ID_PROVIDER
Recipient Name	Member associated with the prior authorization letter	20	Character	T_RE_BASE	NAM_FIRST+ NAM_MID_INIT + NAM_LAST
Service Begin	The date the service begins	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Service End	The date the service ends	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_END
State	Provider address state	2	Character	T_PR_ADR	ADR_MAIL_STATE
Zip	Provider address zip code	5	Character	T_PR_ADR	ADR_MAIL_ZIP

Field	Description	Length	Data Type	DB Table	DB Attributes
Zip4	Provider address zip code 4	4	Number	T_PR_ADR	ADR_MAIL_ZIP_4

6.1.3.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.4 PAU-001E-D -- Home Health Member Letter

This letter is generated for a member specified on a Home Health service/prior authorization. It is created and sent to the member when all requested services on the service/prior authorization are in a finalized status, Approved or Denied.

6.1.4.1 Technical Name

PAU-001E-D

For readability, the letter displays on the next page.

6.1.4.2 Home Health Member Letter Layout

Kentucky Department For Medicaid Services
Prior Authorization Notice

Current Date

Recipient Name
Address 1
Address 2
City, State Zip Zip4

Subject: Prior Authorization of Home Health Services

Dear Recipient Name:

The authorization for Home Health Services by Provider Name, Provider Number has been reviewed.

The following service units have been requested and approved on PA # XXXXXXXXXXX

Code	Procedure Name	#Units	Begin	End
1. XXXXX	XXXXXXXXXXXXXXXXXXXXXXX	9,999,999	MM/DD/YYYY	MM/DD/YYYY

Notice Of Right To An Administrative Hearing

Should you as a Medicaid recipient, applicant or guardian disagree with this adverse determination, you have a right to request an administrative hearing in accordance with 907 KAR 1:563.

- (1) You may request a hearing by filing with the Department for Medicaid Services, a written statement clearly indicating a desire for a hearing.
- (2) This written request must be postmarked or received within thirty (30) days of the date of adverse action, notice of decreased services, or denial of services to the Department for Medicaid Services, Division of Administration & Financial Management, Administrative Services Branch 6W-C, 275 East Main Street, Frankfort KY 40621-0001.
- (3) At this hearing you as the Medicaid recipient, applicant or guardian may be represented by an authorized representative such as legal counsel, a relative, a friend, or other spokesperson or you may represent yourself. You may contact the Department for Community Based Services located in your county of residence regarding the availability of free representation by Legal Aid Services.
- (4) You have the right to review the case record relating to the issue; and submit additional information in support of your claim.
- (5) If you have any questions, contact DMS, Division of Long Term Care.

Sincerely,

Kentucky Department for Medicaid Services
Prior Authorization Notice

6.1.4.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	The member's mailing address line 1	30	Character	T_RE_MULTI_ADDRESS	ADR_STREET_1
Address2	The member's mailing address line 2	30	Character	T_RE_MULTI_ADDRESS	ADR_STREET_2
City	The member's mailing address city	18	Character	T_RE_MULTI_ADDRESS	ADR_CITY
Code	The service code	6	Character	T_PROC/ T_REVENUE_ CODE/ T_DRUG	CDE_PROC/CDE_ REVENUE/ CDE.NDC
Current Date	The date the letter was generated	8	Date (MMDDCCY Y)		CALCULATED
PA #	The prior authorization associated with the letter	9	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Procedure Name	The service code description	40	Character	T_PROC/ T_REVENUE_ CODE/T_DRU G	DSC_PROCECUR E/DSC_REV_COD E/DSC_NDC
Provider Name	The provider name	50	Character	T_PR_NAM	Name
Provider Number	The provider ID	15	Character	T_PR_IDENTIFI ER	ID_PROVIDER
Recipient Name	Member associated with the prior authorization	20	Character	T_RE_BASE	NAM_FIRST + NAM_LAST
Service Begin	The date the service begins	8	Number	T_PA_LINE_IT EM	DTE_PA_AUTH_E FF
Service End	The date the service ends	8	Number	T_PA_LINE_IT EM	DTE_PA_AUTH_ END
State	The member's mailing address state	2	Character	T_RE_MULTI_ADDRESS	ADR_STATE
Units	The number of units approved for the PA	9	Number	T_PA_LINE_IT EM	QTY_UNT_SVC_A UTH
Zip	The member's mailing address zip	5	Number	T_RE_MULTI_ADDRESS	ADR_ZIP_CODE

Field	Description	Length	Data Type	DB Table	DB Attributes
Zip 4	The member's mailing address zip 4	4	Number	T_RE_MULTI_ADDRESS	ADR_ZIP_CODE_4

6.1.4.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.5 PAU-001F-D -- Impact Plus Provider Letter

This letter is generated for a service provider specified on an Impact Plus service/prior authorization. It is created and sent to the service provider when all requested services on the service/prior authorization are in a finalized status (Approved or Denied) or when an update is applied to the record.

6.1.5.1 Technical Name

PAU-001F-D

For readability, the letter displays on the next page.

6.1.5.2 Impact Plus Provider Letter Layout

Kentucky Department For Medicaid Services

Current Date

Provider Number

Provider Name

Address 1

Address 2

City, State Zip Zip4

Subject: Prior Authorization Approval/Denial

Dear Provider Name:

The authorization for Services submitted Received Date for Member Name, Member ID, has been reviewed. The service(s) requested are listed below:

Procedure	--- Mod ---	Tax ID
XXXXXX -	XXXXX	999999999 XX
XXXXXX -	XXXXX	999999999 XX
XXXXXX -	XXXXX	999999999 XX

The following item(s) have been approved:

Procedure	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX - XXXXX	XX XX XX XX	Approved	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY
XXXXX	XXXXX	Approved	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY

If approved your prior authorization number is XXXXXXXXXXXX.

The following item(s) have been denied.

Procedure	Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX -	XXXXX	Denied	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY
Reason Code: Reason code Description						
XXXXX	XXXXX	Denied	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY
Reason Code: Reason code Description						
XXXXX	XXXXX	Denied	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY
Reason Code: Reason code Description						

If additional information is available, please resubmit your request with the additional information attached.

For denied service(s), if the recipient you are serving disagrees with this determination, he/she has a right to appeal this decision by requesting a hearing. The above-referenced recipient will receive a letter stating his/her right to appeal and procedures to request a hearing.

This prior authorization does not guarantee payment. In order for you to receive payment, the recipient must be eligible on the date of service. Always check the recipient's Medicaid card to verify eligibility.

If you, as the provider, have any questions regarding this prior authorization approval/denial, contact KYMMIS Prior Authorization unit.

Sincerely,

KYMMIS Prior Authorization Unit

Note: If the case has been approved for treatment and the recipient is enrolled with a partnership prior to the date of service, the provider will need to contact the partnership for approval status.

6.1.5.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Amount	Amount authorized	9	Number	T_PA_LINE_ITEM	AMT_PA_AUTH
Begin Date	The date the service begins	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Current Date	The date the letter was generated	8	Date (MMDDCCYY)		CALCULATED FIELD
End Date	The date the service ends	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Member ID	The member ID	9	Character	T_RE_BASE	ID_MEDICAID
Member Name	Member associated with the prior authorization letter	20	Character	T_RE_BASE	NAM_LAST + NAM_FIRST + NAM_MID_INIT
Mod	The modifiers	8	Character	T_PA_LINE_ITEM	CDE_PROC_MOD + CDE_PROC_MOD2 + CDE_PROC_MOD3 + CDE_PROC_MOD4
Prior Authorization Number	The prior authorization associated with the letter	9	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Procedure	The service code	6	Character	T_PROC/T_REVENUE/T_DRUG	CDE_PROC/CDE_REVENUE/CDE.NDC
Provider Address1	Provider address line 1	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Provider Address2	Provider address line 2	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Provider City	Provider address city	30	Character	T_PR_ADR	ADR_MAIL_CITY
Provider Name	The provider name	50	Character	T_PR_NAM	Name
Provider Number	The provider ID	9	Number	T_PR_IDENTIFIER	ID_PROVIDER

Field	Description	Length	Data Type	DB Table	DB Attributes
Provider State	Provider address state	2	Character	T_PR_ADR	ADR_MAIL_STATE
Provider Zip	Provider address zip code	5	Number	T_PR_ADR	ADR_MAIL_ZIP
Provider Zip4	Provider address zip code 4	4	Number	T_PR_ADR	ADR_MAIL_ZIP_4
Quantity	The number of units approved for the PA	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_AUTH
Reason	Reason code and description of denial (if any)	509	Character	T_PA_IAC_XREF	CDE_IAC + DSC_IAC
Received Date	The date the Impact Plus was submitted	8	Number	T_PA_PAUTH	DTE_RECEIVED
Services	The description of the service	30	Character	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
Status	The line item status	20	Character	T_PA_LINEITEM_STAT	DSC_STATUS
Tax ID	The tax ID and sub ID - use the converted Tax and sub ID if available. If not, use the provider ID for "Vendor".	11	Character	T_PA_LINE_ITEM/T_PR_IDENTIFIER	ID_IMPACT_TAX + ID_IMPACT_SUB/ID_PROVIDER

6.1.5.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.6 PAU-001G-D -- Other PA Types Provider Letter

This letter is generated for a service provider specified on a service prior authorization for other PA Category types (e.g. Physician, EPSDT, or DME). It is created and sent to the service provider when all requested services on the service/prior authorization are in a finalized status (Approved or Denied) or when an update is applied to the record.

6.1.6.1 Technical Name

PAU-001G-D

For readability, the letter displays on the next page.

6.1.6.2 Other PA Types Provider Letter Layout

Kentucky Department For Medicaid Services

Current Date

Provider Number

Provider Name

Address 1

Address 2

City, State Zip Zip4

Subject: Prior Authorization Approval/Denial

Dear Provider Name:

The authorization for Services submitted Month Name DD, CCYY, for Member Name, Member ID, has been reviewed. The service(s) requested are listed below:

Procedure	Mod --	Quantity	Amount
XXXXX - XXXXX	XX XX XX XX	9,999,999	9.999.999.00
XXXXX - XXXXX	XX XX XX XX	9,999,999	9.999.999.00
XXXXX - XXXXX	XX XX XX XX	9,999,999	9.999.999.00

The following item(s) have been approved:

Procedure	Mod	Status	Quantity	Amount	Begin Date	End Date
XXXXX - XXXXX	XX XX XX	Approved	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY
XXXXX	XX XX XX	Approved	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY

If approved your prior authorization number is XXXXXXXXXXXX.

The following item(s) have been denied.

Procedure	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX	XX XX XX XX	Denied	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY
Reason Code: Reason code Description						
XXXXX	XX XX XX XX	Denied	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY
Reason Code: Reason code Description						
XXXXX	XX XX XX XX	Denied	9,999,999	9,999,999.00	MM/DD/CCYY	MM/DD/CCYY
Reason Code: Reason code Description						

If additional information is available, please resubmit your request with the additional information attached.

For denied service(s), if the recipient you are serving disagrees with this determination, he/she has a right to appeal this decision by requesting a hearing. The above-referenced recipient will receive a letter stating his/her right to appeal and procedures to request a hearing.

This prior authorization does not guarantee payment. In order for you to receive payment, the recipient must be eligible on the date of service. Always check the recipient's Medicaid card to verify eligibility.

If you, as the provider, have any questions regarding this prior authorization approval/denial, contact KYMMIS Prior Authorization unit.

Sincerely,

KYMMIS Prior Authorization Unit

Note: If the case has been approved for treatment and the recipient is enrolled with a partnership prior to the date of service, the provider will need to contact the partnership for approval status.

6.1.6.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Amount	Amount authorized	9	Number (Decimal)	T_PA_LINE_ITE M	AMT_PA_AUTH
Begin Date	The date the service begins	8	Number	T_PA_LINE_ITE M	DTE_PA_AUTH_ EFF
Current Date	The date the letter was generated	8	Date (MMDDCC YY)	N/A	CALCULATED FIELD
End Date	The date the service ends	8	Number	T_PA_LINE_ITE M	DTE_PA_AUTH_ END
Member ID	The member ID	9	Character	T_RE_BASE	ID_MEDICAID
Member Name	Member associated with the prior authorization letter	20	Character	T_RE_BASE	NAM_LAST +NAM_FIRST + NAM_MID_INIT
Mod	The modifiers	8	Character	T_PA_LINE_ITE M	CDE_PROC_MOD+ CDE_PROC_MOD2 +CDE_PROC_MOD 3+CDE_PROC_MO D4
Prior Authorization Number	The prior authorization associated with the letter	9	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Procedure	The service code	6	Character	T_PROC/T_REV ENUE/T_DRUG	CDE_PROC/ CDE_REVENUE/ CDE.NDC
Provider Address1	Provider address line 1	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Provider Address2	Provider address line 2	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Provider City	Provider address city	30	Character	T_PR_ADR	ADR_MAIL_CITY
Provider Name	The provider name	50	Character	T_PR_NAM	Name
Provider Number	The provider ID	9	Number	T_PR_IDENTIFIE R	ID_PROVIDER
Provider State	Provider address state	2	Character	T_PR_ADR	ADR_MAIL_STATE

Field	Description	Length	Data Type	DB Table	DB Attributes
Provider Zip	Provider address zip code	5	Number	T_PR_ADR	ADR_MAIL_ZIP
Provider Zip4	Provider Address zip code 4	4	Number	T_PR_ADR	ADR_MAIL_ZIP_4
Quantity	The number of units approved for the PA	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_ATTRH
Reason	Reason code + description of denial (if any)	503	Character	T_PA_IAC_XREF	CDE_IAC + DSC_IAC
Received Date	The date the EPSDT special services was submitted	8	Number	T_PA_PAUTH	DTE_RECEIVED
Services	The description of the service	30	Character	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
Status	The line item status	20	Character	T_PA_LINEITEM_STAT	DSC_STATUS

6.1.6.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.7 PAU-001H-D -- Inpatient NF Provider Letter

This letter is generated for the service provider specified on an Inpatient/Nursing Facility type of service/prior authorization. It is created and sent to the service provider when all requested services are in a finalized status or when an update is applied to the record.

6.1.7.1 Technical Name

PAU-001H-D

For readability, the letter displays on the next page.

6.1.7.2 Inpatient NF Provider Letter Layout

Kentucky Department For Medicaid Services
Prior Authorization Notice

Current Date

Service Provider Name;
Service Provider Address Line1
Service Provider Address Line2
Service City, State Zip-Zip4

Subject: Prior Authorization for (PA Category Description) stay
Prior Authorization Number: XXXXXXXXXX

Member Name : XXXXXXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXXXXXX
Member ID : XXXXXXXXX
Admit Date: XX/XX/XXXX
Stay authorized for 9,999 (authorized quantity) days from MM/DD/CCYY (authorized begin date) through
MM/DD/CCYY (authorized end date)

Requesting Provider: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Requesting Provider ID:
Requesting Provider Address Line1
Requesting Provider Address Line2
Requesting City, State Zip-Zip4

This prior authorization does not guarantee payment. In order for you to receive payment, the recipient must be eligible on the date of service. Always check the recipient's medical card to verify eligibility.

Sincerely,

KYMMIS Prior Authorization Unit

6.1.7.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Admit Date	Date member admitted to a facility.	8	Number	T_PA_PAUTH_STATE	DTE_ADMISSION
Authorized Begin Date	Authorized date for stay to begin in in-patient facility.	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Authorized Date End	In-patient stay is authorized through this date.	8	Number	T_PA_LINE_ITEM	DTE_PA_AUTH_END
Authorized Quantity	Authorized days for a stay in an in-patient facility.	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
Current Date	Date the letter was generated.	8	Date (MM/CC YY)		CALCULATED FIELD
Member ID	Member's Medicaid ID.	10	Character	T_RE_BASE	ID_MEDICAID
Member Name First	Member's name: first, middle initial and last name.	36	Character	T_RE_BASE	NAM_FIRST,NAM_MID_INIT,NAM_LAST
PA Category Description	Type of service/prior authorization being requested.	30	Character	T_PA_ASSIGN_CODE	DSC_PA_ASSIGN
Prior Authorization Number	Unique number identifying the service/prior authorization.	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Requesting Provider Address 1	Requesting provider address line 1.	50	Character	T_PR_ADR	ADR_MAIL_STR1
Requesting Provider Address 2	Requesting provider address 2.	50	Character	T_PR_ADR	ADR_MAIL_STR2
Requesting Provider City	Requesting provider address city.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Requesting Provider ID	Requesting Provider Medicaid identifier.	10	Character	T_PR_IDENTIFIER	ID_IDENTIFIER
Requesting Provider Name	Requesting provider's name.	50	Character	T_PR_NAME	Name

Field	Description	Length	Data Type	DB Table	DB Attributes
Requesting Provider State	Requesting provider state.	20	Character	T_PR_ADR	ADR_MAIL_STAT E
Requesting Provider Zip	Requesting provider zip code.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
Requesting Provider Zip 4	Requesting provider zip code +4.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4
Service Provider Address 2	Service provider address line 2.	30	Character	T_PR_ADR	ADR_MAIL_STR2
Service Provider Address1	Service provider address line 1.	30	Character	T_PR_ADR	ADR_MAIL_STR1
Service Provider City	Service provider city.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Service Provider Name	Name of the rendering provider.	50	Character	T_PR_NAM	Name
Service Provider State	Service provider state.	30	Character	T_PR_ADR	ADR_MAIL_STAT E
Service Provider Zip	Service provider zip code.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
Service Provider Zip 4	Service provider zip code + 4.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

6.1.7.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.8 PAU-0140-RL -- Mass Update Old Provider Letter

This letter is generated out of the first step in the service/prior authorization provider mass update process. The letter notifies the original service provider on the PA that the services have been end-dated effective the date of transfer less one day.

6.1.8.1 Technical Name

PAU-0140-RL

For readability, the letter displays on the next page.

6.1.8.2 Mass Update Old Provider Letter Layout

Current Date (Month DD, CCYY)

Provider Name
 Address 1
 Address 2
 City, State Zip-Zip4

Subject: Prior Authorization XXXXXXXXXXXX

Dear Provider Name:

Due to [Reason Code Description e.g. Provider transfer of ownership] previously authorized service(s) submitted Received Date MM DD, CCYY), for Member Name, Member ID, have been end dated as of (MMDD/CCYY). The service(s) affected are listed below:

The following item(s) were originally approved:

Service	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX	XX XX XX XX	Approved	XXXXXX	XXXXXXXXXX	MM/DD/YYYY	MM/DD/YYYY
XXXXX	XX XX XX XX	Approved	XXXXXX	XXXXXXXXXX	MM/DD/YYYY	MM/DD/YYYY

The following item(s) are currently approved:

Service	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX	XX XX XX XX	Approved	XXXXXX	XXXXXXXXXX	MM/DD/YYYY	MM/DD/YYYY
XXXXX	XX XX XX XX	Approved	XXXXXX	XXXXXXXXXX	MM/DD/YYYY	MM/DD/YYYY

The amounts shown above reflect amounts on the original approved prior authorization. They do not reflect amounts that have been billed and paid on claims.

This prior authorization does not guarantee payment. In order for you to receive payment, the recipient must be eligible on the date of service. Always check the recipient's Medicaid card to verify eligibility.

If you, as the provider, have any questions regarding this prior authorization approval/denial, contact KYMMIS Prior Authorization unit.

Sincerely,

KYMMIS Prior Authorization Unit

6.1.8.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Amount	Dollar amount authorized.	0	Number (Decimal)	T_PA_LINE_ITEM	AMT_PA_AUTH
City	Provider city	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Current date	8	Date (MMDDCCYY)		CALCULATED FIELD
Dates Begin (New)	New authorized prior authorization start date for the line item	8	Date (MM/DD/CCYY)	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Dates Begin (Original)	Authorized prior authorization start date for the line item	8	Date (MM/DD/CCYY)	T_PA_LINE_ITEM	DTE_PA_AUTH_EFF
Dates End (Original)	Authorized prior authorization end date for the line item	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD_PROV	DTE_ORIG_END
Dates End (New)	New authorized prior authorization end date for the line item	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD_PROV	DTE_EFF - 1
End dated	Date PA end dated.	8	Date (MM/DD/CCYY)	T_PA_TEMP_MASS_UPD	DTE_EFF -1
Member ID	Member Medicaid ID	12	Character	T_RE_BASE	ID_MEDICAID
Member first name	Member first name	15	Character	T_RE_BASE	NAM_FIRST
Member last name	Member last name	20	Character	T_RE_BASE	NAM_LAST
Member middle initial	Member middle initial	1	Character	T_RE_BASE	NAM_MID_INIT
Mod	Modifiers	8	Character	T_PA_LINE_ITEM	CDE_PROC_MODAL/CDE_PROC_MODAL2/CDE_PROC_MODAL3/CDE_PROC_MODAL4

Field	Description	Length	Data Type	DB Table	DB Attributes
Prior Authorization Number	The prior authorization number associated with the member	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider address 1	First line of provider address	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Provider address2	Second line of provider address	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Provider name	The provider name.	50	Character	T_PR_NAM	Name
Quantity	Quantity authorized	0	Number (Integer)	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
Reason Code	Reason PA was end dated.	500	Character	T_PA_IAC_TEXT	DSC_IAC
Received date	Date PA received.	17	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_RECEIVED
Service Code	The service code for the authorization	5	Character	T_PA_LINE_ITEM / T_REVENUE_CODE / T_PROC	CDE_SVC_TYPE / CDE_REVENUE / CDE_PROC
State	Provider state	2	Character	T_PR_ADR	ADR_MAIL_STATE
Status	PA status	20	Character	T_PA_LINE_ITEM	DSC_STATUS
Zip	Provider zip	5	Character	T_PR_ADR	ADR_MAIL_ZIP
Zip + 4	Provider zip +4	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

6.1.8.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.9 PAU-0141-RL -- Mass Update New Provider Letter

This letter is generated out of the second step in the service/prior authorization provider mass update process. The letter notifies the new service provider of the transferred services. The transferred services have an effective date of the date of transfer and calculated units and/or amounts (original units/amounts less used units/amounts).

6.1.9.1 Technical Name

PAU-0141-RL

For readability, the letter displays on the next page.

6.1.9.2 Mass Update New Provider Letter Layout

Current Date (Month DD, CCYY)

Provider Name
Address 1
Address 2
City, City, State Zip-Zip4

Subject: Prior Authorization XXXXXXXXXXXX

Dear Provider Name:

Due to [Reason Code Description] effective MM/DD/CCYY, services previously authorized on Prior Authorization XXXXXXXXXXXX for Provider XXXXXXXXXXXX and Member Name, Medicaid Number, have been transferred to you on this Prior Authorization. Approved units and amounts are the difference between the original authorized amounts and the balance that has not been paid to Provider XXXXXXXXXXXX.

The following item(s) are the remaining balance on the original approved prior authorization:

Service	---- Mod ----	Status	Quantity	Amount	Begin Date	End Date
XXXXX	XX XX XX XX	Approved	XXXXXXXX	XXXXXX.XX	MM/DD/CCYY	MM/DD/CCYY
XXXXX	XX XX XX XX	Approved	XXXXXXXX	XXXXXX.XX	MM/DD/CCYY	MM/DD/CCYY

This prior authorization does not guarantee payment. In order for you to receive payment, the recipient must be eligible on the date of service. Always check the recipient's Medicaid card to verify eligibility.

If you, as the provider, have any questions regarding this prior authorization approval/denial, contact KYMMIS Prior Authorization unit.

Sincerely,

KYMMIS Prior Authorization Unit

6.1.9.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Amount	Dollar amount authorized.	9	Number (Decimal)	T_PA_LINE_ITEM	AMT_PA_AUTH
Begin date	PA begin date per service for the new provider	8	Date (MM/DD/CCYY)	T_PA_MASS_UP D_PROV	DTE_EFF
City	Provider city	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Current date	8	Date (MMDDCCYY)	N/A	CALCULATED FIELD
Effective date	Effective Date	8	Date (MM/DD/CCYY)	T_PA_MASS_UP D_PROV	DTE_EFF
End date	PA end date per service for the new provider	8	Date (MM/DD/CCYY)	T_PA_MASS_UP D_PROV	DTE_ORIG_END
Medicaid Number	Member Medicaid ID	12	Character	T_RE_BASE	ID_MEDICAID
Member first name	Member first name	15	Character	T_RE_BASE	NAM_FIRST
Member last name	Member last name	20	Character	T_RE_BASE	NAM_LAST
Member middle initial	Member middle initial	1	Character	T_RE_BASE	NAM_MID_INIT
Mod	Modifiers	8	Character	T_PA_LINE_ITEM	CDE_PROC_MOD/CDE2/CDE_PROC_MOD3/CDE_PROC_MOD4
Prior Authorization Number	Prior Authorization number	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider address 1	First line of provider address	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Provider address 2	Second line of provider address	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Provider name	The provider name	50	Character	T_PR_NAM	Name
Quantity	Quantity authorized	0	Number (Integer)	T_PR_LINE_ITEM	QTY_UNT_SVC_AUTH

Field	Description	Length	Data Type	DB Table	DB Attributes
Reason Code	Reason PA was end dated.	500	Character	T_PA_IAC_TEXT	DSC_IAC
Service	The service code of the prior authorization line item	5	Character	T_PA_LINE_ITEM /T_PROC/T_REV ENUE_CODE/ T_DRUG	CDE_SVC_TYPE /CDE_PROC/CD E_REVENUE/CD E_DRUG
State	Provider state	20	Character	T_PR_ADR	ADR_MAIL_STATE
Status	PA status	20	Character	T_PA_LINE_ITEM	DSC_STATUS
Zip	Provider zip	5	Character	T_PR_ADR	ADR_MAIL_ZIP
Zip + 4	Provider zip +4	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

6.1.9.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.10 PAU-0142-RL -- Mass Update Rate Service Code Letter

This letter is generated out of the service/prior authorization mass update for rates and service codes. It notifies the service provider of a modified rate or service.

6.1.10.1 Technical Name

PAU-0142-RL

For readability, the letter displays on the next page.

6.1.10.2 Mass Update Rate Service Code Letter Layout

Current Date (Month DD, CCYY)

Provider Name

Address 1

Address 2

City, State Zip-Zip4

Subject: Prior Authorization XXXXXXXXXXXX

Dear Provider Name:

Due to [Reason Code Description] previously authorized service(s) submitted Received Date (MM/DD/CCYY), for Member Name, Medicaid Number, have been modified as of Effective Mass Update (MM/DD/CCYY). The service(s) affected are listed below:

The following item(s) were originally approved:

Service	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX	XX XXX	Approved	9,999,999	9,999,999.00	MM/DD/YYYY	MM/DD/YYYY
XXXXX	XX XXX	Approved	9,999,999	9,999,999.00	MM/DD/YYYY	MM/DD/YYYY

The following item(s) are currently approved:

Service	-- Mod --	Status	Quantity	Amount	Begin Date	End Date
XXXXX	XX XXX	Approved	9,999,999	9,999,999.00	MM/DD/YYYY	MM/DD/YYYY
XXXXX	XX XXX	Approved	9,999,999	9,999,999.00	MM/DD/YYYY	MM/DD/YYYY

The amounts shown above reflect amounts on the original approved prior authorization. They do not reflect amounts that have been billed and paid on claims.

This prior authorization does not guarantee payment. In order for you to receive payment, the recipient must be eligible on the date of service. Always check the recipient's Medicaid card to verify eligibility.

If you, as the provider, have any questions regarding this prior authorization approval, contact KYMMIS Prior Authorization unit.

Sincerely,

KYMMIS Prior Authorization Unit

6.1.10.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	The address street1 of the service provider	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Address2	The address street2 of the service provider	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Amount	Amount authorized for the prior authorization line-item service	9	Number	T_PA_LINE_ITEM	AMT_PA_AUTH
Begin Date	Authorized prior authorization new start date for the line-item	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD	DTE_EFFECTIVE
City / Town	The address city/town of the service provider	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Date letter was generated	8	Date (MMDDCCYY)		CALCULATED FIELD
Effective Mass Update	Date new rate or service code is effective.	8	Date (MM/DD/CCYY)	T_SYSTEM_PARMS	DTE_EFFECTIVE
End Date	Authorized prior authorization end date	8	Date (MM/DD/CCYY)	T_PA_MASS_UPD	DTE_END
Member Name	The member name	36	Character	T_RE_BASE	NAM_LAST / NAME_FIRST
Member Number	The Medicaid ID (Number) of the Member	12	Character	T_RE_BASE	ID_MEDICAID
Mod	Procedure code modifiers	5	Character	T_PA_LINE_ITEM	CDE_PROC_MOD,C DE_PROC_MOD2,C DE_PROC_MOD3,C DE_PROC_MOD4
Prior Authorization Number	The prior authorization number associated with the member	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM

Field	Description	Length	Data Type	DB Table	DB Attributes
Provider Name	The Name of the service provider	50	Character	T_PR_NAM	Name
Quantity	Number of units authorized for the prior authorization line-item service	9	Number	T_PA_LINE_ITEM	QTY_UNT_SVC_ATH
Reason Code Description	The reason code description	500	Character	T_PA_IAC_TEXT	DSC_IAC
Received Date	The submission date of the previously authorized service	8	Date (MMDDCCYY)	T_PA_PAUTH	DTE_RECEIVED
Service	The service code (procedure or revenue code)	5	Character	T_PROC/T_REVENUE_CODE	CDE_PROC/CDE_REVENUE
Status	Status indicating approval	8	Character	DSC_STATUS	T_PA_LINEITEM_STAT
ZIP Code	The address zip code of the service provider	5	Character	T_PR_ADR	ADR_MAIL_ZIP
ZIP Code 4	The address zip code last four digits of the service provider	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

6.1.10.4 Associated Programs

Program	Description
No associated Programs found.	

Program	Description
Paupr142	This program takes in parameters from the T_SYSTEM_PARAMS table and creates a mass update with overrides for rates and service codes on a PA line item that Claims accesses during processing.

6.1.11 PAU-0200-DL -- EPSDT First Time Prior Authorization Letter

The EPSDT Special Services Program provides services for a member from birth through age 21. This letter is generated the first time a member receives EPSDT services. It is notification that the services will no longer be available after the last day of the month in which the member becomes 21 years of age.

6.1.11.1 Technical Name

PAU-0200-DL

For readability, the letter displays on the next page.

6.1.11.2 EPSDT First Time Prior Authorization Letter Layout

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES

***** RECIPIENT NOTICE *****

Current Date (MMDDCCYY)

Member Name
Address 1
Address 2
City, State Zip-Zip4

Dear Parent/Guardian,

Based on our records, Member Name is receiving services through Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Special Services Program. The Kentucky Medicaid program is pleased to provide coverage for these services. Please be aware that services through the EPSDT Special Services Program are covered for children from birth up to 21 years of age. These services will be covered when medically necessary and appropriate until the last day of the month during Member Name becomes twenty-one (21) years of age.

A few months before Member Name twenty-first (21st) birthday, you may need information about other services that may be available. At that time you may want to contact the Division of Medical Management and Quality Assurance at 502-564-9444.

Member Name may or may not lose Medicaid eligibility at any time prior to his/her 21st birthday. If you have any questions about Medicaid eligibility, please contact your local Department for Community Based Services office.

Sincerely,

Department for Medicaid Services

6.1.11.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	Member Address Line 1	30	Character	T_RE_BASE	ADR_STREET1
Address2	Member Address Line 2	30	Character	T_RE_BASE	ADR_STREET2
Current Date	The Current Date	8	Date (MMDDCCYY)	N/A	Calculated Field
Member Name	The Member Name	36	Character	T_RE_BASE	NAM_FIRST/NAM_LAST
State	Member state	2	Character	T_RE_BASE	ADR_STATE
ZIP4	Member Zip 4	4	Character	T_RE_BASE	ADR_ZIP_CODE_4
Zip	Member Zip	5	Character	T_RE_BASE	ADR_ZIP_CODE

6.1.11.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.12 PAU-0220-1L -- Orthodontic Six Month Progress Report Letter

This letter is sent to providers as notification that required documentation of progress on approved orthodontic services has not been received by the Orthodontic Program Department. The letter is generated eight months from the service begin date if the Orthodontic Status Code = spaces or after 14 months if the Ortho Status Code = "I". A Code of "I" indicates the provider has notified the department that treatment is still in progress.

6.1.12.1 Technical Name

PAU-0220-1L

For readability, the letter displays on the next page.

6.1.12.2 Orthodontic Six Month Progress Report Letter Layout

Provider Number

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, KENTUCKY 40621

Current Date (Month DD, CCYY)

Dear Dr. Provider Name
Provider Address Line1
Provider Address Line2
City, State Zip-Zip4

The submission of a six (6) month orthodontic progress report (MAP-559) accompanied by a prior authorization form (MAP-9) is necessary to receive prior authorization for your final third payment for fixed appliance therapy. This documentation is due when six (6) monthly visits have been completed and no more than twelve (12) months after the banding date or placement of appliances. One third of the total fee for fixed appliance therapy (D8670) listed on your original prior authorization form (MAP-9) should be listed as your final third payment. The procedure code for this should reflect the treatment progress from the initial visit through the present time. Providers who fail to comply with this policy may receive a request for recoupment of funds on each unaccounted case.

If the patient's treatment status has changed, please notify the staff of the KYMMIS Orthodontic Program immediately. Otherwise, please submit the above mentioned documentation (MAP-559 and MAP-9). If treatment has ceased, please submit a letter outlining 1) dates seen, 2) treatment given, and 3) progress made with prorated fee. If treatment is progressing as scheduled, please indicate with a brief notation beside the patient's name.

The information on each case must be received by the KYMMIS Orthodontic Program, 9200 Shelbyville Road Suite 100, Louisville, KY 40222 within thirty (30) days of the date of this letter. Claims or request for prior authorization for dates of service over a year old can no longer be overridden by the Medicaid program.

If the patient is enrolled with a managed care partnership on the date of banding or when case is finalized, please submit records to the appropriate partnership. Beside the patient's name please note the date and name of partnership where records were submitted.

We appreciate your cooperation with the Kentucky Medicaid Orthodontic Program. If you have questions regarding this matter, please contact KYMMIS Orthodontic Staff at 1-800-805-6465 MON-FRI, 8:00 AM THROUGH 6:00 PM EST. If you have questions regarding policy issues please contact the Physician and Specialty Services Branch at 502-564-2687.

MEDICAID NUMBER	MEMBER Name	PA NUMBER	RECEIPT DATE
XXXXXXXXXX	FIRST LAST	XXXXXXXXXX	MM/DD/CCYY
XXXXXXXXXX	FIRST LAST	XXXXXXXXXX	MM/DD/CCYY

6.1.12.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	Mailing address street 1 for a service provider	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Address2	Mailing address street 2 for a service provider	30	Character	T_PR_ADR	ADR_MAIL_STRT2
City	Mailing address city for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Date letter was generated	8	Date (MM/DD/CCYY)		CALCULATED FIELD
Medicaid Number	The Medicaid ID of the member	12	Character	T_RE_BASE	ID_MEDICAID
Member Name	The member name	36	Character	T_RE_BASE	NAM_FIRST/NAME_LAST
Prior Authorization Number	The prior authorization number	10	Character	T_PA-PAUTH	PRIOR_AUTH_NUM
Provider Name	The name of the service provider	50	Character	T_PR_NAM	Name
Provider Number	The unique identifier for a service provider	10	Character	T_PR_IDENTIFIER	ID_PROVIDER
Receipt Date	The date a prior authorization request was received.	8	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_RECEIVED
State	Mailing address state for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_STATE
ZIP Code	Mailing address zip code for a service Provider.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
ZIP Code 4	Mailing address zip code + 4 last four digits of a zip code.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

6.1.12.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.13 PAU-0220-2L -- Orthodontic Six Month Progress Report Follow Up Letter

This letter is sent to providers as notification that required documentation of progress on approved orthodontic services has not been received by the Orthodontic Program department. The letter is generated 11 months from the service begin date if the Orthodontic Status Code = spaces or after 17 months if the Ortho Status Code = "I". A Code of "I" indicates the provider has notified the department that treatment is still in progress.

6.1.13.1 Technical Name

PAU-0220-2L

For readability, the letter displays on the next page.

6.1.13.2 Orthodontic Six Month Progress Report Follow Up Letter Layout

FOLLOW UP

Provider Number

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, KENTUCKY 40621

Current Date (Month DD, CCYY)

Dear Dr. Provider Name
Provider Address Line1
Provider Address Line2
City, State Zip-Zip4

A letter was previously sent requesting a six (6) month orthodontic progress report. This is the final notice, and if no response is received within thirty (30) days, the orthodontic cases(s) will be closed and any monies paid for treatment will be recouped.

The submission of a six (6) month orthodontic progress report (MAP-559) accompanied by a prior authorization form (MAP-9) is necessary to receive prior authorization for your final third payment for fixed appliance therapy. This documentation is due when six (6) monthly visits have been completed and no more than twelve (12) months after the banding date or placement of appliances. One third of the total fee for fixed appliance therapy (D8670) listed on your original prior authorization form (MAP-9) should be listed as your final third payment. The procedure code for this should reflect the treatment progress from the initial visit through the present time. Providers who fail to comply with this policy may receive a request for recoupment of funds on each unaccounted case.

If the patient's treatment status has changed, please notify the staff of the KYMMIS Orthodontic Program immediately. Otherwise, please submit the above mentioned documentation (MAP-559 and MAP-9). If treatment has ceased, please submit a letter outlining 1) dates seen, 2) treatment given, and 3) progress made with prorated fee. If treatment is progressing as scheduled, please indicate with a brief notation beside the patient's name.

The information on each case must be received by the KYMMIS Orthodontic Program, 9200 Shelbyville Road Suite 100, Louisville, KY 40222 within thirty (30) days of the date of this letter. Claims or request for prior authorization for dates of service over a year old can no longer be overridden by the Medicaid program.

If the patient is enrolled with a managed care partnership on the date of banding or when case is finalized, please submit records to the appropriate partnership. Beside the patient's name please note the date and name of partnership where records were submitted.

We appreciate your cooperation with the Kentucky Medicaid Orthodontic Program. If you have questions regarding this matter, please contact KYMMIS Orthodontic Staff at 1-800-805-6465 MON-FRI, 8:00 AM through 6:00 PM EST. If you have questions regarding policy issues please contact the Physician and Specialty Services Branch at 502-564-2687.

MEDICAID NUMBER	MEMBER Name	PA NUMBER	RECEIPT DATE
XXXXXXXXXX	FIRST LAST	XXXXXXXXXX	MM/DD/CCYY
XXXXXXXXXX	FIRST LAST	XXXXXXXXXX	MM/DD/CCYY

6.1.13.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	Mailing address street 1 for a service provider	30	Character	T_PR_ADR	ADR_MAIL_STR1
Address2	Mailing address street 2 for a service provider	30	Character	T_PR_ADR	ADR_MAIL_STR2
City	Mailing address city for a service provider	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Date letter was generated	8	Date (MMDDCCYY)	N/A	CALCULATED FIELD
Medicaid Number	The Medicaid ID of the member	12	Character	T_RE_BASE	ID_MEDICAID
Member Name	The member(recipient) name	36	Character	T_RE_BASE	NAM_FIRST/NAM_LAST
Prior Authorization Number	The prior authorization number	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Name	The name of the service provider	50	Character	T_PR_NAM	Name
Provider Number	Unique identifier for the service provider	10	Character	T_PR_IDENTITY	ID_PROVIDER
Receipt Date	The date a prior authorization request was received.	8	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_RECEIVED
State	Mailing address state for a service provider	30	Character	T_PR_ADR	ADR_MAIL_STATE
ZIP Code	Mailing address zip code for a service Provider.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
ZIP Code 4	Mailing address zip code + 4 last four digits of a zip code.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

6.1.13.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.14 PAU-0220-3L -- Orthodontic Final Case Letter

This letter is sent to providers as notification that required documentation of progress on approved orthodontic services has not been received by the Orthodontic Program department. The letter is generated 14 months from the service begin date if the Orthodontic Status Code = spaces or 'L', and after 24 months if the Ortho Status Code = "I". An Orthodontic Status Code of 'I' indicates the provider has notified the department that treatment is still in progress. A Status Code of 'L' indicates one lump sum payment was made to the provider rather than the usual split of one third and two thirds payment.

6.1.14.1 Technical Name

PAU-0220-3L

For readability, the letter displays on the next page.

6.1.14.2 Orthodontic Final Case Letter Layout

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, KENTUCKY 40621

Current Date (MMDDCCYY)

DEAR DR. Provider Name

Address 1

Address 2

City, State Zip-Zip4

The submission of an orthodontic final case form (MAP-700) accompanied by a prior authorization form (MAP-9) is necessary to receive prior authorization for your final case submission and payment for your final records (D8660). This documentation is due when the case has been completed and no more than twenty-four (24) months after the six (6) month orthodontic progress report has been submitted. The orthodontic final case submission form (MAP-700) should reflect the treatment progress from the initial visit through the present time. Providers who fail to comply with this policy may receive a request for recoupment of funds on each unaccounted case.

If the patient's treatment status has changed, please notify the staff of the KYMMIS Orthodontic Program immediately otherwise, please submit a letter outlining 1) dates seen, 2) treatment given, and 3) progress made with prorated fee. If treatment is progressing on schedule, please indicate with a brief notation beside the patient's name.

The information on each case must be received by the KYMMIS Orthodontic Program, 9200 Shelbyville Road Suite 100, Louisville, KY 40222 within thirty (30) days of the date of this letter. Claims or request for prior authorization for dates of service over a year old can no longer be overridden by the Medicaid program.

If the patient is enrolled with a managed care partnership on the date of banding or when case is finalized, please submit records to the appropriate partnership. Beside the patient's name please note the date and name of partnership where records were submitted.

We appreciate your cooperation with the Kentucky Medicaid Orthodontic Program. If you have questions regarding this matter, please contact KYMMIS Orthodontic Staff at 1-800-805-6465 MON-FRI, 8:00 AM through 6:00 PM EST. If you have questions regarding policy issues please contact the Physician and Specialty Services Branch at 502-564-2687.

MEDICAID NUMBER	MEMBER Name	PA NUMBER	RECEIPT DATE
XXXXXXXXXX	FIRST LAST	XXXXXXXXXX	MM/DD/CCYY
XXXXXXXXXX	FIRST LAST	XXXXXXXXXX	MM/DD/CCYY

6.1.14.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	Mailing address street 1 for a service provider	30	Character	T_PR_ADR	ADR_MAIL_STR1
Address2	Mailing address street 2 for a service provider	30	Character	T_PR_ADR	ADR_MAIL_STR2
City	Mailing address city for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Date letter was generated	8	Date (MM/DD/CCYY)		CALCULATED FIELD
Medicaid Number	The Medicaid ID of the member	12	Character	T_RE_BASE	ID_MEDICAID
Member Name	The member name	36	Character	T_RE_BASE	NAM_FIRST/NAME_LAST
Prior Authorization Number	The prior authorization number associated with the member	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Name	The name of the service provider	50	Character	T_PR_NAM	Name
Provider Number	Unique identifier for the service provider	10	Character	T_PR_PROVIDER	ID_PROVIDER
Receipt Date	The date a prior authorization request was received.	10	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_RECEIVED
State	Mailing address state for a service provider.	30	Character	T_PR_ADR	ADR_MAIL_STATE
ZIP Code	Mailing address Zip code for a service provider.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
ZIP Code	Mailing address zip code + 4 last 4 digits of a zip code.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

6.1.14.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.15 PAU-0220-4L -- Orthodontic Final Case Follow Up Letter

This letter is sent to providers as notification that required documentation of progress on approved orthodontic services has not been received by the Orthodontic Program department. The letter is generated 17 months from the service begin date if the Orthodontic Status Code = spaces or 'L', and after 27 months if the Ortho Status Code = "I". An Orthodontic Status Code of 'I' indicates the provider has notified the department that treatment is still in progress. A Status Code of 'L' indicates one lump sum payment was made to the provider rather than the usual split of one third and two thirds payment.

6.1.15.1 Technical Name

PAU-0220-4L

For readability, the letter displays on the next page.

6.1.15.2 Orthodontic Final Case Follow Up Letter Layout

F O L L O W U P

Provider Number

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, KENTUCKY 40621

Current Date (MMDDCCYY)

Dear DR. Provider Name
Address 1
Address 2
City, State Zip-Zip4

A letter was previously sent requesting final case submission. This is the final notice, and if no response is received within thirty (30) days, the orthodontic cases(s) will be closed and any monies paid for treatment will be recouped.

The submission of an orthodontic final case form (MAP-700) accompanied by a prior authorization form (MAP-9) is necessary to receive prior authorization for your final case submission and payment for your final records (D8660). This documentation is due when the case has been completed and no more than twenty-four (24) months after the six (6) month orthodontic progress report has been submitted. The orthodontic final case submission form (MAP-700) should reflect the treatment progress from the initial visit through the present time. Providers who fail to comply with this policy may receive a request for recoupment of funds on each unaccounted case.

If the patient's treatment status has changed, please notify the staff of the KYMMIS Orthodontic Program immediately otherwise, please submit a letter outlining 1) dates seen, 2) treatment given, and 3) progress made with prorated fee. If treatment is progressing on schedule, please indicate with a brief notation beside the patient's name.

The information on each case must be received by the KYMMIS Orthodontic Program, 9200 Shelbyville Road Suite 100, Louisville, KY 40222 within thirty (30) days of the date of this letter. Claims or request for prior authorization for dates of service over a year old can no longer be overridden by the Medicaid program.

If the patient is enrolled with a managed care partnership on the date of banding or when case is finalized, please submit records to the appropriate partnership. Beside the patient's name please note the date and name of partnership where records were submitted.

We appreciate your cooperation with the Kentucky Medicaid Orthodontic Program. If you have questions regarding this matter, please contact KYMMIS Orthodontic Staff at 1-800-805-6465 MON-FRI, 8:00 AM through 6:00 PM EST. If you have questions regarding policy issues please contact the Physician and Specialty Services Branch at 502-564-2687.

MEDICAID NUMBER	MEMBER Name	PA NUMBER	RECEIPT DATE
XXXXXXXXXX	FIRST LAST	XXXXXXXXXX	MM/DD/CCYY
XXXXXXXXXX	FIRST LAST	XXXXXXXXXX	MM/DD/CCYY

6.1.15.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	Mailing address street 1 for a service provider	30	Character	T_PR_ADR	ADR_MAIL_STR1
Address2	Mailing address street 2 for a service provider	30	Character	T_PR_ADR	ADR_MAIL_STR2
City	Mailing address city for a service provider	30	Character	T_PR_ADR	ADR_MAIL_CITY
Current Date	Date letter was generated	8	Date (MM/DD/CCYY)	N/A	CALCULATED FIELD
Medicaid Number	The Medicaid ID of the member	12	Character	T_RE_BASE	ID_MEDICAID
Member Name	The member name(recipient name)	36	Character	T_RE_BASE	NAM_FIRST/NAM_LAST
Prior Authorization Number	The prior authorization number associated with the member	10	Character	T_PA_PAUTH	PRIOR_AUTH_NUM
Provider Name	The name of the service provider	50	Character	T_PR_NAM	Name
Provider Number	The unique identifier for a service provider	10	Character	T_PR_PROVIDER	ID_PROVIDER
Receipt Date	The date a prior authorization request was received.	8	Date (MM/DD/CCYY)	T_PA_PAUTH	DTE_RECEIVED
State	Mailing address state for a service provider	30	Character	T_PR_ADR	ADR_MAIL_STATE
ZIP Code	Mailing address zip code for a service provider.	5	Character	T_PR_ADR	ADR_MAIL_ZIP
ZIP Code	Mailing address zip code + 4 last four digits of a zip code.	4	Character	T_PR_ADR	ADR_MAIL_ZIP_4

Program	Description
No associated Programs found.	

6.1.16 Transplant Letters



4/09/2007

JEFFERY W NEMEC, MD
350 PARK ST SUITE 203
BOWLING GREEN, KY 42101

Dear Dr. Nemeec:

Kentucky Health Choices has approved the medical necessity for a bilateral lung transplant for Felicia West, Medicaid # 4012369155. This authorization is valid for 180 days and is for the purpose of establishing medical necessity for the aforementioned procedure. After 180 days, if the procedure has not been performed, you are requested to provide clinical information with reference to the patient's current clinical status to Kentucky Health Choices. This information will be utilized by the Kentucky Health Choices physician reviewer in establishing the ongoing medical necessity for the transplant.

This authorization is contingent upon the Medicaid recipient's eligibility for the Kentucky Medicaid program. This letter is considered an eligibility disclaimer. Medicaid's reimbursement to University Hospital will be 80% of billed inpatient charges not to exceed \$75,000.00 which is consistent with 907 KAR 1:350. Any requests for exception to this maximum payment must be made to the Department for Medicaid Services. All other services will be subject to normal coverage limitations.

Claims must be submitted for payment with twelve (12) months from the date of service. Claims received by the Kentucky Medicaid program after that date will not be payable unless documentation is attached showing timely receipt by the Medicaid program and subsequent billing efforts. To ensure proper handling, please send all claims for this procedure to the following address:

9200 Shelbyville Rd, Suite 800
Louisville, Kentucky 40222
1-800-292-2392



Page 2

JEFFERY W NEMEC, MD
4/09/2007

Department for Medicaid Services
Division of Hospital & Outpatient Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Please contact Mary Ann Hacker of Hospital & Outpatient Facilities at 502-564-6511, if you need further assistance.

Sincerely,
Kentucky Health Choices
Transplant Precertification

Cc: Transplant Coordinator
Patient
Mary Ann Hacker, Dept. for Medicaid Services

9200 Shelbyville Rd, Suite 800
Louisville, Kentucky 40222
1-800-292-2392



4/09/2007

JEFFERY W NEMEC, MD
350 PARK ST SUITE 203
BOWLING GREEN, KY 42101

Dear Dr. Nemec:

Kentucky Health Choices has approved the medical necessity for a bilateral lung transplant for Judy Carrender, Medicaid # 4025843394. This authorization is valid for 180 days and is for the purpose of establishing medical necessity for the aforementioned procedure. After 180 days, if the procedure has not been performed, you are requested to provide clinical information with reference to the patient's current clinical status to Kentucky Health Choices. This information will be utilized by the Kentucky Health Choices physician reviewer in establishing the ongoing medical necessity for the transplant.

This authorization is contingent upon the Medicaid recipient's eligibility for the Kentucky Medicaid program. This letter is considered an eligibility disclaimer. Medicaid's reimbursement to University Hospital will be 80% of billed inpatient charges not to exceed \$75,000.00 which is consistent with 907 KAR 1:350. Any requests for exception to this maximum payment must be made to the Department for Medicaid Services. All other services will be subject to normal coverage limitations.

Claims must be submitted for payment with twelve (12) months from the date of service. Claims received by the Kentucky Medicaid program after that date will not be payable unless documentation is attached showing timely receipt by the Medicaid program and subsequent billing efforts. To ensure proper handling, please send all claims for this procedure to the following address:

9200 Shelbyville Rd, Suite 800
Louisville, Kentucky 40222
1-800-292-2392

Page 2



JEFFERY W NEMEC, MD
4/09/2007

Department for Medicaid Services
Division of Hospital & Outpatient Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Please contact Mary Ann Hacker of Hospital & Outpatient Facilities at 502-564-6511, if you need further assistance.

Sincerely,
Kentucky Health Choices
Transplant Precertification

Cc: Transplant Coordinator
Patient
Mary Ann Hacker, Dept. for Medicaid Services

9200 Shelbyville Rd, Suite 800
Louisville, Kentucky 40222
1-800-292-2392



August 3, 2006

Stella Davies, M.D.
Cincinnati Children's Hospital Medical Center
Division of Hematology/Oncology
3333 Burnet Avenue
Cincinnati, OH 45229-3039

Dear Dr. Davies:

Kentucky Health Choices has approved the medical necessity for a bone marrow transplant for Maleek Kattara, Medicaid # 4066333925. This authorization is valid for 180 days and is for the purpose of establishing medical necessity for the aforementioned procedure. After 180 days, if the procedure has not been performed, you are requested to provide clinical information with reference to the patient's current clinical status to Kentucky Health Choices. This information will be utilized by the Kentucky Health Choices physician reviewer in establishing the ongoing medical necessity for the transplant.

This authorization is contingent upon the Medicaid recipient's eligibility for the Kentucky Medicaid program. This letter is considered an eligibility disclaimer. Medicaid's reimbursement to Cincinnati Children's Hospital Medical Center will be 80% of billed inpatient charges not to exceed \$75,000.00 which is consistent with 907 KAR 1:350. Any requests for exception to this maximum payment must be made to the Department for Medicaid Services. All other services will be subject to normal coverage limitations.

Claims must be submitted for payment with twelve (12) months from the date of service. Claims received by the Kentucky Medicaid program after that date will not be payable unless documentation is attached showing timely receipt by the Medicaid program and subsequent billing efforts. To ensure proper handling, please send all claims for this procedure to the following address:

9200 Shelbyville Rd, Suite 800
Louisville, Kentucky 40222
1-800-292-2392



Page 2
Stella Davies, MD
August 3, 2006

Department for Medicaid Services
Division of Hospital & Outpatient Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Please contact Mary Ann Hacker of Hospital & Outpatient Facilities at 502-564-6511, if you need further assistance.

Sincerely,
Kentucky Health Choices
Transplant Precertification

Cc: Transplant Coordinator
Patient
Mary Ann Hacker, Dept. for Medicaid Services



March 1, 2007

Haydar Frangoul, MD
Monroe Carell, JR Childrens Hospital
at Vanderbilt
2220 Pierce Avenue, 397 PRB
Nashville, TN 37232-6310

Dear Dr. Frangoul:

Kentucky Health Choices has approved the medical necessity for a bone marrow transplant for Logan Miller, Medicaid#4055373858. This authorization is valid for 180 days and is for the purpose of establishing medical necessity for the aforementioned procedure. After 180 days, if the procedure has not been performed, you are requested to provide clinical information with reference to the patient's current clinical status to Kentucky Health Choices. This information will be utilized by the Kentucky Health Choices physician reviewer in establishing the ongoing medical necessity for the transplant.

This authorization is contingent upon the Medicaid recipient's eligibility for the Kentucky Medicaid program. This letter is considered an eligibility disclaimer. Medicaid's reimbursement to Monroe Carell, JR Childrens Hospital at Vanderbilt will be 80% of billed inpatient charges not to exceed \$75,000.00 which is consistent with 907 KAR 1:350. Any requests for exception to this maximum payment must be made to the Department for Medicaid Services. All other services will be subject to normal coverage limitations.

Claims must be submitted for payment within twelve (12) months from the date of service. Claims received by the Kentucky Medicaid program after that date will not be payable unless documentation is attached showing timely receipt by the Medicaid program and subsequent billing efforts. To ensure proper handling, please send all claims for this procedure to the following address:

9200 Shelbyville Road, Suite 800
Louisville, Kentucky 40222
1-800-292-2392



Page 2
March 1, 2007
Haydar Frangoul M.D.

Department for Medicaid Services
Division of Hospital & Outpatient Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Please contact Mary Ann Hacker of Hospital & Outpatient Facilities at 502-564-6511, if you need further assistance.

Sincerely,
Kentucky Health Choices
Transplant Precertification

Cc: Transplant Coordinator
Patient
Mary Ann Hacker, Dept. for Medicaid Services

9200 Shelbyville Road, Suite 800
Louisville, Kentucky 40222
1-800-292-2392

February 4, 2007

Dinesh Ranjan, M.D.
UK Chandler Medical Center
Transplant Center
800 Rose Street
Room-C416
Lexington, KY 40536-0293

Dear Dr. Ranjan:

Kentucky Health Choices has determined that Stephen Fields, Medicaid # 2659883223, continues to meet medical necessity criteria for a liver transplant. This authorization is valid for 180 days and is for the purpose of establishing medical necessity for the aforementioned procedure. After 180 days, if the procedure has not been performed, you are requested to provide clinical information with reference to the patient's current clinical status to Kentucky Health Choices. This information will be utilized by the Kentucky Health Choices physician reviewer in establishing the ongoing medical necessity for the transplant.

This authorization is contingent upon the Medicaid recipient's eligibility for the Kentucky Medicaid program. This letter is considered an eligibility disclaimer. Medicaid's reimbursement to University of Kentucky Chandler Medical Center will be 80% of billed inpatient charges not to exceed \$75,000.00 which is consistent with 907 KAR 1:350. Any requests for exception to this maximum payment must be made to the Department for Medicaid Services. All other services will be subject to normal coverage limitations.

Claims must be submitted for payment with twelve (12) months from the date of service. Claims received by the Kentucky Medicaid program after that date will not be payable unless documentation is attached showing timely receipt by the Medicaid program and subsequent billing efforts. To ensure proper handling, please send all claims for this procedure to the following address:

9200 Shelbyville Road, Suite 800
Louisville, Kentucky 40222
1-800-292-2392



Page 2
Dinesh Ranjan, M.D.
February 4, 2007

Department for Medicaid Services
Division of Hospital & Outpatient Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Please contact Mary Ann Hacker of Hospital & Outpatient Facilities at 502-564-6511, if you need further assistance.

Sincerely,
Kentucky Health Choices
Transplant Precertification

Cc: Transplant Coordinator
Patient
Mary Ann Hacker, Dept. for Medicaid Services

9200 Shelbyville Road, Suite 800
Louisville, Kentucky 40222
1-800-292-2392



February 1, 2007

Dinesh Ranjan, MD
UK Chandler Medical Center
800 Rose Street, Room C416
Lexington, KY 40536-0293

Dear Dr. Ranjan:

Kentucky Health Choices has approved the medical necessity for a liver transplant for Karen Stambaugh, Medicaid # 4009004898. This authorization is valid for 180 days and is for the purpose of establishing medical necessity for the aforementioned procedure. After 180 days, if the procedure has not been performed, you are requested to provide clinical information with reference to the patient's current clinical status to Kentucky Health Choices. This information will be utilized by the Kentucky Health Choices physician reviewer in establishing the ongoing medical necessity for the transplant.

This authorization is contingent upon the Medicaid recipient's eligibility for the Kentucky Medicaid program. This letter is considered an eligibility disclaimer. Medicaid's reimbursement to University of Kentucky Chandler Medical Center will be 80% of billed inpatient charges not to exceed \$75,000.00 which is consistent with 907 KAR 1:350. Any requests for exception to this maximum payment must be made to the Department for Medicaid Services. All other services will be subject to normal coverage limitations.

Claims must be submitted for payment with twelve (12) months from the date of service. Claims received by the Kentucky Medicaid program after that date will not be payable unless documentation is attached showing timely receipt by the Medicaid program and subsequent billing efforts. To ensure proper handling, please send all claims for this procedure to the following address:

9200 Shelbyville Rd, Suite 800
Louisville, Kentucky 40222
1-800-292-2392



Page 2
Dinesh Ranjan, MD
February 1, 2007

Department for Medicaid Services
Division of Hospital & Outpatient Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Please contact Mary Ann Hacker of Hospital & Outpatient Facilities at 502-564-6511, if you need further assistance.

Sincerely,
Kentucky Health Choices
Transplant Precertification

Cc: Transplant Coordinator
Patient
Mary Ann Hacker, Dept. for Medicaid Services

9200 Shelbyville Rd, Suite 800
Louisville, Kentucky 40222
1-800-292-2392



January 20, 2007

Apurva Mehta, MD
James Brown Cancer Center
529 S. Jackson Street
Suite 230
Louisville, KY 40203

Dear Dr. Mehta:

Kentucky Health Choices has approved the medical necessity for a bone marrow transplant for Richard Tharp, Medicaid # 3135229668. This authorization is valid for 180 days and is for the purpose of establishing medical necessity for the aforementioned procedure. After 180 days, if the procedure has not been performed, you are requested to provide clinical information with reference to the patient's current clinical status to Kentucky Health Choices. This information will be utilized by the Kentucky Health Choices physician reviewer in establishing the ongoing medical necessity for the transplant.

This authorization is contingent upon the Medicaid recipient's eligibility for the Kentucky Medicaid program. This letter is considered an eligibility disclaimer. Medicaid's reimbursement to James Brown Cancer Center will be 80% of billed inpatient charges not to exceed \$75,000.00 which is consistent with 907 KAR 1:350. Any requests for exception to this maximum payment must be made to the Department for Medicaid Services. All other services will be subject to normal coverage limitations.

Claims must be submitted for payment with twelve (12) months from the date of service. Claims received by the Kentucky Medicaid program after that date will not be payable unless documentation is attached showing timely receipt by the Medicaid program and subsequent billing efforts. To ensure proper handling, please send all claims for this procedure to the following address:

9200 Shelbyville Rd, Suite 800
Louisville, Kentucky 40222
1-800-292-2392



Page 2
Apurva Mehta, MD
January 20, 2007

Department for Medicaid Services
Division of Hospital & Outpatient Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Please contact Mary Ann Hacker of Hospital & Outpatient Facilities at 502-564-6511, if you need further assistance.

Sincerely,
Kentucky Health Choices
Transplant Precertification

Cc: Transplant Coordinator
Patient
Mary Ann Hacker, Dept. for Medicaid Services

9200 Shelbyville Rd, Suite 800
Louisville, Kentucky 40222
1-800-292-2392



January 26, 2007

Dianna S. Howard, MD
UK Chandler Medical Center
Markey Cancer Center
800 Rose St., Room CC301
Lexington, KY 40536-0093

Dear Dr. Howard:

Kentucky Health Choices has approved the medical necessity for a bone marrow transplant for Jackie Francis, Medicaid # 407313237. This authorization is valid for 180 days and is for the purpose of establishing medical necessity for the aforementioned procedure. After 180 days, if the procedure has not been performed, you are requested to provide clinical information with reference to the patient's current clinical status to Kentucky Health Choices. This information will be utilized by the Kentucky Health Choices physician reviewer in establishing the ongoing medical necessity for the transplant.

This authorization is contingent upon the Medicaid recipient's eligibility for the Kentucky Medicaid program. This letter is considered an eligibility disclaimer. Medicaid's reimbursement to University of Kentucky Chandler Medical Center will be 80% of billed inpatient charges not to exceed \$75,000.00 which is consistent with 907 KAR 1:350. Any requests for exception to this maximum payment must be made to the Department for Medicaid Services. All other services will be subject to normal coverage limitations.

Claims must be submitted for payment within twelve (12) months from the date of service. Claims received by the Kentucky Medicaid program after that date will not be payable unless documentation is attached showing timely receipt by the Medicaid program and subsequent billing efforts. To ensure proper handling, please send all claims for this procedure to the following address:

9200 Shelbyville Road, Suite 800
Louisville, Kentucky 40222
1-800-292-7392



Page 2
January 26, 2007
Dianna S. Howard, MD

Department for Medicaid Services
Division of Hospital & Outpatient Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Please contact Mary Ann Hacker of Hospital & Outpatient Facilities at 502-564-6511, if you need further assistance.

Sincerely,
Kentucky Health Choices
Transplant Precertification

Cc: Transplant Coordinator
Patient
Mary Ann Hacker, Dept. for Medicaid Services

9200 Shelbyville Road, Suite 800
Louisville, Kentucky 40222
1-800-292-2392

7 Glossary of Terms and Acronyms

7.1 Terms and Acronyms

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

- 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.

7.1.1 A

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

ABR Automatic Backup and Recovery

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

ACCOMMODATION A hospital room with one or more beds.

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

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

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

ACG Ambulatory Care 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).
ARCHIVE	A copy of data on disks, CD-ROM, magnetic tape, etc., for long-term storage and later possible access. Archived files are often compressed to save storage space (Imaging).
AS OF DATE	Based on parameters entered, the date of the cycle run.
ASC	Ambulatory Surgical Center
ASSIGNED CLAIM	A claim for which the provider of service has agreed to accept the program allowed Charge as payment in full without recourse to the patient, except for coinsurance or deductible amounts.

ASSIGNMENT	When a provider accepts the maximum allowable Charge offered for a given procedure under the Medicare Program, it is said that this person accepts assignment. The provider has waived the right to bill the beneficiary for the difference between what Medicare pays and what the provider usually Charges for a fee. The term assignment is not related to the administration of the Medicaid Program except that some Medicaid agencies treat crossover claims differently depending upon whether or not the provider accepts assignment.
ATTACHMENT	Attachments may accompany claims to provide additional claim-related information for which no field is specified on the corresponding claim form, or when the specified field is not adequate to submit the required information.
AUDIT	Limitations applied to specific procedures, diagnoses or other data elements after editing and validation of the claim to ensure conformity and consistency of claim payment.
AUTHENTICATION	A query method that ensures that both the sender and receiver of an electronic message are valid and are authorized to transmit and receive messages.
AUTO ASSIGNMENT	An automated process used to make 'intelligent' Managed Care assignments for beneficiaries who do not make a selection of a Primary Medical Provider of their own accord.
AUTOMATED VOICE RESPONSE SYSTEM (AVRS)	This is the machine and the application that enable users to access KY Medicaid information by using a touch-tone telephone.
AUTOMATIC RECOUPMENT	Automatic recoupment occurs when an A/R with a credit balance has recoupments applied to it by adjustments or new-day claims. Money is recouped only through the payment process, which is automatic, and cannot be posted online with a refund.

7.1.2 B

BACKUP	Duplicate copy of data placed in a separate, safe place - electronic storage, on a tape, on a disk, in a vault - to guard against total loss in the event the original data somehow become inaccessible. Generally for short-term safety. Contrast with archive, which is a filed-away record of data meant to be maintained a long time, in the event of future reference. (Imaging)
BALANCED BUDGET ACT OF 1997 (BBA)	Federal legislation enacted in 1997 that gave beneficiaries certain rights related to Managed Care enrollment and disenrollment. Most significant changes in the Medicaid/Medicare Program since their inception. Provides for state option to use Managed Care. Provides that an MMIS must be compatible with Medicare claims processing and must, after January 1, 1999, transmit data in a format consistent with the Medicaid Statistical Information System (MSIS).
BATCH	A set of claims.
BENEFICIARY DATA EXCHANGE SYSTEM (BENDEX)	An interface system between the Commonwealth of Kentucky and Social Security Administration that provides Social Security beneficiary information. Information includes eligibility for benefits as well as Medicare Part A and Part B entitlement and eligibility information.
BENEFIT PERIOD	The period of time a health plan will pay for covered benefits.
BENEFIT PLAN	A group of covered services (benefits) that are granted to a beneficiary who is deemed eligible for the program the benefit plan represents.
BENEFITS	A schedule of health care service coverage that an eligible KY Medicaid member receives for the treatment of illness, injury, or other conditions allowed under the State Plan.
BILLED AMOUNT	The billed amount is the dollar figure submitted by a provider for medical services rendered.

BILLING PROVIDER	The provider who will receive payment (if a group/clinic number is present, it would be the “Billing Provider”)
BIN	Bank Identification Number
BITMAP	Representation of Characters or graphics by individual pixels, or points of light, dark or color, arranged in row (horizontal) and column (vertical) order. Each pixel is represented by either one bit (simple black and white) or up to 32 bits (fancy high definition color). (Imaging)
BLS	Basic Life Support
BUNDLED CHARGES	Charges that are combined together or represent a flat rate such as in capitated reimbursed where there would be a specified fee for a service. In an example of a surgery procedure, the bundled Charges would include supplies, surgery Charges, anesthesia Charges, recovery, etc. In contrast, unbundled Charges would be separate Charges for each entity.
BUY-IN	Procedure whereby states pay a monthly premium to the Social Security Administration on behalf of Medicaid beneficiaries, enrolling them in Medicare Title XVIII Part A, Part B and/or Part D program.
BUY-IN DATA MAINTENANCE	Medicaid beneficiaries who are entitled to receive Medicare benefits may have Medicare premiums paid by the State. This is known as Medicare buy-in. Automated data exchanges between HP Enterprise Services and the Centers for Medicare and Medicaid Services (CMS), are conducted monthly to identify, update, resolve differences, and monitor new and ongoing Medicare buy-in cases. The State is responsible for initiating Medicare buy-in for eligible members. Because Medicare is usually primary to the State, payment of Medicare premiums, coinsurance, and deductibles costs the State less than paying the entire cost of medical care for a beneficiary. In addition, the State receives Federal Financial Participation (FFP) for premiums paid on behalf of members eligible as Qualified Medicare Beneficiaries (QMB), Qualified Disabled Working Individual (QWSI), Specified Low Income Medicare Beneficiaries (SLMB), and Cash Assistance beneficiaries (Supplemental Security Income (SSI) and cash assistance from Temporary Assistance for Families (TAF).

BYTE

Common unit of computer storage. A byte is eight bits of information, one of which may be a parity bit. Generally, eight bits equals one Character. Also called 'octet'. (Imaging)

7.1.3 C

CACHE	(Pronounced “cash”) Small portion of high-speed memory used for temporary storage of frequently used data. Reduces the time it would take to access that data, since it no longer has to be retrieved from the disk. (Imaging)
CAPITATION	A specified amount paid periodically to a health care provider for a group of specified health care services regardless of quantity rendered. A fee is paid per person. Capitation fees are paid for each enrollee, regardless of whether an enrollee actually received a service. The use of capitation separated the payment process from the claims submission process. Encounter claims are submitted for historical data, not for payment. Also known as capitation payment or rate.
CAPITATION RATE	The payment of a fixed dollar amount, per person, for the provision of a defined set of health services to a defined population for a specified period of time (e.g. one month). Capitation is a fixed revenue system that pays the same amount each month no matter how many or how few services are actually provided.
CARRIER	A carrier refers to a private insurance company.
CASE	A file opened at the DCBS office when an individual applies for government assistance.
CASE MANAGEMENT/MANAGER	Method designed to accommodate the specific health services needed by an individual through a coordinated effort to achieve the desired health outcome in a cost-effective manner.
CASE MIX INDEX	A numeric score with a specific range that identifies the relative resources used by a particular group of residents and represents the average resource consumption across a population or sample.
CASE NUMBER	The number assigned to each Medicaid case opened by DCBS.

CASH CONTROL NUMBER (CCN)	This is the unique number assigned to a Cash Receipt.
CATEGORICALLY NEEDY	Individuals certified by the state welfare agency as being low income and thus being eligible for Medicaid benefits. A person is categorically needy and may receive assistance if that person's income and resources do not exceed the categorically needy maximums and they fit into one of six categories: Age 65, Blind, Disabled, Families with dependent children (TANF), Pregnant, Incapacitated. A person must still meet various other criteria (categorical relationship, citizenship etc.) before receiving Medicaid payments from the Commonwealth of Kentucky. This applies to all cases. Individuals whose income and resources are in excess of the maximums but still cannot pay their medical expenses are considered medically needy. However, to receive aid, the client must still fall into one of the six) categories.
CATEGORY OF SERVICE (CAT OF SRVC, COS)	The type of service that a provider renders. An indication of the general classification of the procedures performed. Examples include: inpatient hospital, outpatient hospital, skilled nursing facility, hospice, prescribed drugs, physician care, dental care, transportation, family planning services, therapy services, and crossover.
CCN	Cash Control Number
CDC	Centers for Disease Control
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	The agency within the U.S. Department of Health and Human Services responsible for administering Title XIX and Title XXI of the Social Security Act. With the help of Health Resources and Services Admin, CMS also runs the Child Health Insurance program.
CENTRAL PROCESSING UNITY (CPU)	The computing part of the computer. Also called the processor, it is made up of the control unit and ALU.

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

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

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

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

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

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

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

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

COS Category of Service

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

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

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

**CUSTOMER
INFORMATION
CONTROL SYSTEM
(CICS)**

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

CUTBACK

A reduction in quantity or rate.

7.1.4 D

DATA ELEMENT DICTIONARY (DED)	Describes the fields (data elements) within a database.
DATA ENTRY	Entering data into the computer, which includes keyboard entry, scanning and voice recognition. When transactions are entered after the fact (batch data entry), they are just stacks of source documents to the keyboard operator. Deciphering poor handwriting from a source document is a judgment call that is often error prone.
DATA WAREHOUSE	The architecture that serves as the secondary storage area for a collection of data, both at a detailed and aggregated level. The EIS/DSS Data Warehouse is a collection of ORACLE tables that contain the data extracted from flat files generated from the Kentucky MMIS on a monthly basis.
DATABASE (DB)	Data that has been organized and structured in a disciplined fashion, so that access to information of interest is as quick as possible. Database management programs form the foundation for most document storage indexing systems. (Imaging)
DATABASE ADMINISTRATOR (DBA)	The person responsible for maintaining the database system: managing data, designing database objects, database performance and data recovery and integrity at a physical level. This person is not an applications programmer.
DATABASE TABLE	A collection of similar records in a database.
DATE OF SERVICE (DOS)	The date of service on a claim; the date the beneficiary received medical service.
DC	Doctor of Chiropractic
DD	Developmentally Disabled

DDE	Direct Data Entry
DDI	Design, development, and implementation.
DDS	Doctor of Dentistry
DECISION SUPPORT SYSTEM (DSS)	The Decision Support System (DSS) function provides access to the MMIS data and various external data sources. The data is stored in an Oracle RDBMS and is accessed through the Business Objects application. A computer program application that analyzes and presents business data in a form that assists users in making business decisions more easily. It is an informational ad-hoc reporting application, not an operational one. A DSS may present information graphically and may include an expert system or artificial intelligence.
DECOMPRESS	To reverse the procedure conducted by compression software, and thereby return compressed data to its original size and condition. (Imaging)
DEDUCTIBLE	The out-of-pocket expense a beneficiary must pay before other third party will begin payment for covered medical expenses, usually based on a calendar year. This amount, or a percentage thereof, is paid by Medicaid for beneficiaries also eligible for Medicaid.
DEFAULT	An automated process used to make random Managed Care assignments for beneficiaries who do not make a selection of a Primary Medical Provider of their own accord or were not assigned through auto assignment.
DEFENSE ENROLLMENT AND ELIGIBILITY REPORTING SYSTEM (DEERS)	A system that contains eligibility information on CHAMPUS, the insurance company for military dependents.
DELIMITER	A special Character used to separate fields of data. The three used in an EDI file are the segment delimiter, the element delimiter, and the sub-element delimiter.

DENIED CLAIM	Claim for services not paid by KY Medicaid, including services provided to an ineligible member, services provided by an ineligible provider, or services not billed in the correct manner.
DENY	Claim denial.
DETAIL (DTL)	A term that refers to the actual health care service provided to a member, billed on a claim form as the only service or possibly as one of several services provided. This is frequently called a line item or detail line.
DETAILED SYSTEM DESIGN (DSD)	Document created by the Fiscal Agent as a detailed guide to developing a new system or subsystem.
DIAGNOSIS CODE (DIAG, DX)	<p>The medical classification of a disease or condition according to ICD-9-CM or HCPCS.</p> <p>A numeric code that identifies the patient's condition as determined by the provider of the performed service.</p>
DIAGNOSIS-RELATED GROUP (DRG)	DRGs are the basis for one type of hospital reimbursement. A hospital specific fee is calculated for each diagnosis group for each hospital. Factors of age, sex, length of stay data, and historical costs for each hospital are taken into consideration in calculating the reimbursement amount. Usually, mental institutions and pediatric hospitals are excluded from DRG reimbursement due to the abnormal length of stay experienced by most patients.
DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS, THIRD EDITION, REVISED (DSM III)	A publication of the American Psychiatric Association establishing a coding system for mental diagnoses.
DISABILITY	A physical or mental condition that makes an insured incapable of performing one or more duties of his occupation or any occupation.

DISABILITY BENEFIT	A payment that arises because of the total and/or permanent disability of an insured; a provision added to a policy that provides for a waiver of premium in case of total and permanent disability.
DISABILITY DETERMINATION SERVICES (DDS)	A division of SRS that contracts with the Social Security Administration to determine the disability status of Social Security Disability applicants.
DISABILITY INCOME INSURANCE	A form of health insurance that provides periodic payments when the insured is unable to work as a result of illness, disease, or injury.
DISASTER RECOVERY (DR)	Facilities, plans, tests, etc. for the recovery of the MMIS from a total loss.
DISENGAGEMENT	Removal of assignment or from the Managed Care program.
DISPOSITION	The actual status of a claim. The result of processing a claim is the assignment of a status or disposition. The disposition of a claim is determined by the Exception Control File.
DISPROPORTIONATE SHARE HOSPITAL (DSH)	Qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income persons.
DO	Doctor of Osteopathy
DOB	Date of Birth
DOCTOR	Specifically, any person with a doctoral degree. In common usage, a synonym for physician; a person with a doctor of medicine degree.
DOCUMENT	Structured file sent to a trading partner. In ASC X12 usage, a document is synonymous with a transaction set.

DOCUMENT IMAGES	A computerized representation of a picture or graphic. (Imaging)
DOCUMENT RETRIEVAL	The ability to search for, select and display a document or its facsimile from storage. (Imaging)
DOD	Date of Death
DOING BUSINESS AS (DBA)	Refers to a type of Provider Name and Address.
DOT	Department of Transportation
DP	Data Processing
DPM	Doctor of Podiatric Medicine
DRILLDOWN	Applies additional criteria to an existing subset of data displayed on the DSS.
DROP DOWN DATAWINDOW (DDDW)	This is a tabular presentation of data that is used as a drop-down list on a window.
DRUG	Any substance or its components recognized in one of the official drug compendia for use in the diagnosis, cure, mitigation, treatment or prevention of disease, or intended to affect the structure or function of the body.
DRUG FORMULARY	A listing of drugs covered by a state Medicaid Program, which includes the drug code, description, strength and manufacturer.

DRUG REBATE SYSTEM (DR, DRS) Federal regulations provide for drug manufacturers, with whom CMS has a formal agreement and whose drug products are covered by Medicaid, to give financial rebates to Medicaid based upon the volume of the manufacturer's products dispensed by Medicaid. The Kentucky Drug Rebate Subsystem maintains the information to carry out the federal mandates related to drug rebate processing.

DSS Decision Support System

DUPLICATE PAYMENT A payment to a provider for services provided to a beneficiary resulting from the processing of a duplicate or near-duplicate claim by the contractor.

DURABLE MEDICAL EQUIPMENT (DME) Equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, such as crutches, wheelchairs, and walkers.

DX Diagnosis Code, Diagnosis.

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

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

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.

ENCOUNTER	A record of a medically related service rendered to a beneficiary who is enrolled in a participating health plan (HMO) or in a PCCM plan during date of service. It includes (but is not limited to) all services for which the plan incurred any financial responsibility. Encounters are priced at the Medicaid value of a similar claim, but the reimbursement amount is zero (see STOP-LOSS). If a service is not covered under the HMO/PCCM plan, the claim will be billed by the provider as a FFS claim. Encounters are sometimes referred to as Shadow Claims as no money is paid out.
ER	Emergency Room
ESC	Error Status Code
EXCEPTION	The phrase “posts an exception” is commonly used when discussing claims processing to indicate there is data on the claim that fails an edit; therefore, an exception is posted to the claim.
EXCEPTION CODE	This code indicates that there is data on a claim that has caused the claim to fail an edit. An exception is then posted to the claim in question. Depending on the disposition of the edit on the Claim Edit Disposition Listing, the claim may pay, even with edits posted to it. An exception code can have different dispositions dependent upon media type.
EXPENDITURES (EXP)	The issuance of checks, disbursement of cash, or electronic transfer of funds as reported by the State.
EXPLANATION OF BENEFITS (EOB)	A notice issued to a provider that explains in detail the payment or nonpayment of a specific claim processed. Also a three-digit code that prints on the remittance advice to explain why a claim was either denied or suspended.
EXTENSIBLE MARKUP LANGUAGE (XML)	Universal format for structured documents and data on the Web.

7.1.6 F

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

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

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

7.1.7 G

GARNISHMENT	A court-ordered attachment, or withholding, of a provider's earnings to pay a debt.
GATEWAY	The interconnection between public or private networks that allow the transmission of documents in X12 format across multiple networks. Also called interconnect.
GB	Gigabyte
GENERAL PRACTITIONER	A doctor of medicine who generally performs a wide range of medical services as opposed to one who specializes only in certain areas of practice.
GENERIC	A term used in reference to drugs that meet the following criteria: <ol style="list-style-type: none">1) The product is available from more than one source.2) The Average Wholesale Price of the product is significantly lower than the non-generic.3) The product is not under patent.
GENERIC CODE NUMBER (GCN)	The standard generic code for drugs.
GLOBAL POSITIONING SOFTWARE (GPS)	This software is incorporated into the MMIS interChange allowing default and auto assignment of beneficiaries to providers. It utilizes longitude and latitude for assignment purposes.
GRAPHICAL USER INTERFACE (GUI)	A "windows" based computer interface that allows for consistency of this application with other applications used by the operators. The device drivers associated with these GUIs optimize the painting of snippets and the rendering of fonts to take full advantage of the high-performance graphic cards installed in PCs. (Imaging)

GRAY SCALE The spectrum, or range, of shades of black an image has. Scanners and terminals gray scales are determined by the number of gray shades, or steps, they can recognize and reproduce. A scanner that can only see a gray scale of 16 will not produce as accurate an image as one that distinguishes a gray scale of 256. (Imaging)

GROUP PRACTICE A medical practice where more than one provider render and bill for services under a single provider number.

GSD General System Design

7.1.8 H

HARD DISK	A storage device that uses a magnetic recording material. Generally, hard disks are fixed inside a PC, but there are removable cartridge versions. Hard disks store anywhere from five to hundreds of megabytes. (Imaging)
HCFA-1500	CMS-approved uniform claim form that is required for most professional providers to bill for most non-institutional services. The form is mandated for use in billing both Medicare and Medicaid programs for medically related services.
HEADER (HDR)	This term refers to data on a claim that is not line item specific, but applies to the entire claim. An example of header information would be the provider's name, address and SSN.
HEALTH AND HUMAN SERVICES (HHS)	The executive department of the federal government responsible for social and economic security, educational opportunity, national health and child welfare. Specifically, the department is responsible for Medicaid and Medicare Programs. Formerly DHEW.
HEALTH CARE FINANCING ADMINISTRATION (HCFA)	See CMS.
HEALTH INSURANCE	A contract under which a company guarantees payment for specified loss by disease or accidental bodily injury normally by covering a portion of the associated medical costs.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) A Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191. Accountability Act of 1996.

HIPAA Health Insurance Portability and Accountability Act of 1996

HEALTH INSURANCE PREMIUM PAYMENT SYSTEM (HIPPS) A program where Medicaid-eligible beneficiaries may receive insurance premium assistance using Medicaid funds when it is determined cost-effective to purchase group health insurance.

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

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

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

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

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

There are three types of HCPCS codes.

Level 1 includes the CPT-4 codes.

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

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

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

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

**HOME HEALTH
AGENCY (HHA)**

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

HOSPICE

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

HOSPITAL

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

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

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

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

HYPertext TRANSFER PROTOcol (HTTP) The underlying protocol used by the World Wide Web. HTTP defines how messages are formatted and transmitted, and what actions Web servers and browsers should take in response to various commands.

HYPertext TRANSFER PROTOcol SECURE (HTTPS) Protocol to provide encrypted transmission of data between Web browsers and Web servers.

7.1.9 I**ICD-10-CM** **International Classification of Diseases, Tenth Revision****iCE** interChange Enhanced**ICF/MR** Intermediate Care Facility/Mental Retardation**ICN** Internal Control Number.**ICON** The basis of a graphical user interface, an icon is a picture or drawing of a device or program that is activated, usually with a mouse, to access the device or run the program.**IMAGE** The computerized representation of a picture or graphic. (Imaging)**IMAGING** A method of electronically capturing a representation of a form, whether it is a claim or other piece of correspondence, to allow rapid retrieval and processing of the source document copy.**IMAGING SYSTEM** Collection of units that work together to capture and recreate images. At its simplest, it has an acquisition device (scanner, camera), an image processor and an imaging device (printer, microfilm, computer). (Imaging)**INCOME MAINTENANCE (IM)** A division within the Commission of Income Maintenance/Employment Preparation Services of SRS. The division is responsible for administration and oversight of programs relating to eligibility for Public Assistance programs, including AFDC, Medicaid, and food stamps.**INFORMATION TECHNOLOGY (IT)** A broad term referring to the entire field – computers, communications, Internet, imaging, etc.

INPATIENT (IN, INP, IP)	A patient who has been admitted, at least overnight, to a health care facility. A patient who is literally in residence or in bed in the facility.
INQUIRY MODE	An window mode where the user is viewing data as the result of an inquiry rather than having accessed the specific window in order to add, change or delete data from certain financial records and/or claims. Inquiry Mode allows flow between the various parts of the system but does not allow changes to the data being viewed.
INSURANCE	Health insurance.
INTEGRATED TEST FACILITY (ITF)	Copy of MMIS production system used for testing changes and enhancements to the MMIS.
INTENSIVE CARE UNIT (ICU)	The level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.
INTERACTIVE	Back-and-forth dialog between the user and a computer.
INTERMEDIARY	A public or private insurance organization under contract with the government to handle claims from hospitals, skilled nursing facilities and home health agencies (Part A Medicare).
INTERMEDIATE CARE FACILITY (ICF)	Any facility that provides room, board, and all routine services and supplies.
INTERMEDIATE CARE FACILITY FOR MENTAL RETARDATION (ICF/MR)	Facilities that have met state licensure standards and that provide habilitation-related care and services, prescribed by a physician, in conjunction with active treatment programming for beneficiaries who are mentally retarded and who have related health and physical conditions.

INTERNAL CONTROL NUMBER (ICN) A unique 13-digit identification number assigned to every KMAP claim in order to distinguish it from all other claims received by the system. The ICN consists of: 2-byte Region, which represents claim media and claim type; a 5-byte Date of Receipt, which consists of the YY – year and JJJ – Julian; and a 6-byte Sequence number.

INTERNATIONAL CLASSIFICATION OF DISEASES (ICD) A classification and coding structure of diseases used by the health care community to describe patients' conditions and illness, and to facilitate the collection of statistical and historical data.

INTERNATIONAL CLASSIFICATION OF DISEASES, NINTH REVISION (ICD-9-CM) A three-volume coding manual that contains the diagnosis codes used in coding claims, as well as the procedure codes used in billing for services performed in a hospital setting.

INTERNATIONAL STANDARDS ORGANIZATION (ISO) An international organization, working with the United Nations that maintains the standards for all applications of technology and mechanics for global industry.

INTERNET CONTROL MESSAGE PROTOCOL (ICMP) Extension to IP supporting packets containing error and control information. For example. The PING command uses ICMP to test an Internet connection. (See IP, TCP/IP.)

INTERNET PROTOCOL (IP) Works like the postal system. There is no direct connection – just the packet address to send messages to, and the address for returned messages.

INTERNET SERVICE PROVIDER (ISP) Commercial provider of Internet services; e.g., AOL, Sprynet, Flashnet, etc. To use the Internet a user must have a commercial ISP that maintains a computer system through which the user accesses the Internet.

IP Inpatient

7.1.10 J

JCAHO	Joint Commission On The Accreditation Of Health Care Organizations
JCODE	A five-digit procedure code that begins with the letter J.
JOB CONTROL LANGUAGE (JCL)	A language designed to express statements in a computer job that are used to identify the job or describe its requirements to an operating system.
JOINT APPLICATION DESIGN (JAD)	The process where the system user and designer meet together to define the application. Generally, requirements are reviewed, validated, and clarified.
JULIAN DATE	The representation of month and day by a consecutive number starting with January 1. For example, February 1 is Julian 032. Dates are converted into Julian dates for calculation.

7.1.11 K

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)

7.1.12 L

LASER DISC	An optical disc with the same technology as a Compact Disc, except laser discs are 12 inches in diameter. (Imaging)
LEGACY	Term used to refer to the prior MMIS used in Kentucky
LENGTH OF STAY/SERVICE (LOS)	A designation generally correlated to the patient's diagnosis that refers to the number of days that a patient is confined to an inpatient facility.
LIFETIME RESERVE DAYS	A nonrenewable sixty-day period of additional hospital days awarded to Medicare beneficiaries.
LINE ITEM	A term used in reference to a level of detail on a claim. Line item details are services billed using a procedure code, a quantity, and a date of service for a specific fee. Claims may have multiple line items or detail lines.
LKN	Lock-In
LMB	Low-Income Medicare Beneficiary
LOC	Level of Care

LOCAL AREA NETWORK (LAN)	<p>A communications network that serves users within a confined geographical area. It is made up of servers, workstations, a network operating system and a communications link.</p> <p>Servers are high-speed machines that hold programs and data shared by all network users. The workstations, or clients, are the users' personal computers, which perform stand-alone processing and access the network servers as required.</p> <p>The controlling software in a LAN is the network operating system, such as NetWare, UNIX, and Appletalk, which resides in the server. A component part of the software resides in each client and allows the application to read and write data from the server as if it were on the local machine.</p> <p>The message transfer is managed by a transport protocol such as IPX, SPX, and TCP/IP. The physical transmission of data is performed by the access method (Ethernet, Token Ring, etc.), which is implemented in the network adapters that plug into the machines. The actual communications path is the cable (twisted pair, coax, optical fiber) that interconnects each network adapter.</p>
LOCAL CODES	<p>A generic term for code values that are defined for a state or other political subdivision, or for a specific payer. This term is most commonly used to describe HCPCS Level III Codes, but also applies to state-assigned Institutional Revenue Codes, Condition Codes, Occurrence Codes, Value Codes, etc.</p>
LOCAL OFFICE	<p>The DCBS office in an individual county. Local county offices are grouped into a management area for administrative efficiency.</p>
LOCK-IN	<p>The punitive restriction of a Medicaid beneficiary to a particular provider for a period of time as determined by the State.</p>
LONG TERM CARE (LTC)	<p>Beneficiary care that includes room, board, and all routine services and supplies. The LTC program includes the SNF, ICF and ICF/MR services.</p>
LPN	<p>Licensed Practical Nurse</p>

7.1.13 M

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

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

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

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

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

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

MANUAL CHECKS Checks written outside the automated check writing cycle.

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

**MASS
ADJUSTMENTS**

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

MB

Megabyte

MEDICAID (MCD)

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

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

**MEDICAID
STATISTICAL
INFORMATION
SYSTEM (MSIS)**

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

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

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

MEDICAL NECESSITY (MN)	A documented decision by a medical practitioner that a therapy, treatment, drug, item, or service prescribed or provided is essential to treat or diagnose a specific physical or psychiatric condition.
MEDICALLY NEEDY (MN)	<p>Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.</p> <p>Beneficiary who has a catastrophic illness and cannot pay the incurred costs. (See “CATEGORICAL NEEDY”). Must still fall into one of the six categories.</p>
MEDICAL REVIEW (MR)	Analysis of Medicaid claims to ensure that the service was necessary and appropriate.
MEDICARE	The federal medical assistance program that is described in Title XVIII of the Social Security Act for people 65 years of age or older, for persons eligible for Social Security disability payments, and for certain workers of their dependents who require kidney dialysis or transplantation. A health insurance program for individuals over 65 years of age, as well as certain disabled persons. Medicare is 100 percent federally funded. The Medicare Program is administered by the Health Care Financing Administration (HCFA). Applications for Medicare benefits are processed by the Social Security Administration. Medicare has two distinct plans: Part A is hospital insurance covering inpatient, hospice, home health, and skilled nursing facility care; and Part B is medical insurance covering physicians’ services, outpatient care, diagnostic tests, durable medical equipment, and ambulance services. Refer to Title XVIII.
MEDICARE PART A	Part A of Title XVIII of the Social Security amendments of 1965 that provided benefits principally for hospital and hospital-related services. The formal designation is “Hospital Insurance Benefits for the Aged”.
MEDICARE PART B	Part B of Title XVIII of the Social Security amendments of 1965 that provided benefits principally for physician’s services. The formal designation is “Supplementary Medical Insurance Benefits for the Aged”.

MEDIGAP	In relation to Medicare, this private health insurance pays most of the health care service Charges not covered by Parts A or B of Medicare. These policies, which must meet federally imposed standards, are offered by many commercial health insurance companies.
MEGABYTE	Approximately one million bytes. Precisely, 1,024 kilobytes or 1,048,576 bytes. (Imaging)
MENTAL RETARDATION (MR)	Significantly sub-average intellectual functioning, evidenced by an IQ rating of 70 or below on any standardized measure of intelligence, concurrently existing deficits in adaptive behavior as listed in the Other Development Disability definition.
MICROMEDIA	For the purpose of this document, micromedia refers to microfilm, microfiche, or the ability to access online those documents residing on the State's imaging database.
MSIS	Medicaid Statistical Information System
MSW	Master of Social Work
MTD	Month to Date
MULTIMEDIA	Combining more than one media for the dissemination of information, i.e., using text, audio, graphics, animation and full-motion video all together. Requires enormous amounts of bandwidth and processing power. (Imaging)

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

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

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

NATIONAL DATA CORPORATION/NATIONAL DRUG CODE (NDC)

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

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

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

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

NATIONAL PROVIDER FILE (NPF)

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

NATIONAL PROVIDER IDENTIFIER (NPI)

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

NATIONAL STANDARD FORMAT (NSF)	The NSF was designed to standardize and increase the submission of electronic claims and coordination of benefits exchange. The NSF is used to electronically submit health care claims and encounter information from providers of health care services to payers. It is also used to exchange health care claims and payment information between payers with different payment responsibility.
NEMT	Non Emergency Transportation
NH	Nursing Home
NON-COVERED SERVICES (NC)	The service does not meet the requirements of a Medicaid benefit category, or the service is excluded from coverage or is not reasonable and necessary.
NON EMERGENT MEDICAL TRANSPORTATION (NEMT)	Non-commercial medical transportation provided to beneficiaries in private vehicles, including their own.
NURSE PRACTITIONER (NP)	A registered nurse who has advanced training in a specialized nursing field such as geriatrics or pediatrics.

NURSING FACILITY (NF)

Any facility that provides room, board, and all routine services and supplies. All NFs are required to be licensed by the secretary of the state Department of Health.

An institution or a distinct part of an institution which is primarily engaged in providing to residents: nursing care and related services, rehabilitation services or health related care, and services (above the level of room and board) which can be made available only in an institutional facility. The facility must have in effect a transfer agreement with one or more hospitals and must meet Medicaid participation requirements.

Any place or facility operating for not less than twenty-four (24) hours in any day and caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves, and for whom reception, accommodation, board and skilled nursing care and treatment is provided, and which place or facility is staffed to provide 24-hour-a-day, licensed, nursing personnel plus additional staff, and is maintained and equipped primarily for the accommodation of individuals who are not acutely ill and are not in need of hospital care but who require skilled nursing care.

7.1.15 O**OCC Occurrence Codes (Inpatient claims)**

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

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

OD Doctor of Optometry

OIG Office of Inspector General

OMNIBUS BUDGET RECONCILIATION ACT (OBRA) See PASARR. OBRA-90 establishes the Drug Rebate program.

OMNIBUS BUDGET AND RECONCILIATION ACT OF 1990 (OBRA-90) Establishes the Drug Rebate program.

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

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

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

7.1.16 P

PA	Physician's Assistant Prior Authorization
PAID CLAIM	A claim that has been processed through the adjudication and payment cycles. In the MMIS, the term “paid” refers to a claim with a payment status of either “paid” or “denied”. A paid claim can result in the provider being reimbursed for some dollar amount or a zero paid amount.
PARAMETER	Any value passed to a program by the user or by another program in order to customize the program for a particular purpose. A parameter may be anything; for example, a file name, a coordinate, a range of values, a money amount or a code of some kind. Parameters may be required as in parameter-driven software or they may be optional. Parameters are often entered as a series of values following the program name when the program is loaded.
PASSPORT	Managed care organization which serves Medicaid members in Jefferson and surrounding counties.
PASSWORD	Confidential code used in conjunction with the User ID to gain access to a system.
PATIENT	A person receiving treatment or care from a physician or other health professional.
PATIENT LIABILITY (PAT LIAB)	A beneficiary's monetary obligation to a nursing facility that is determined by his or her income level.
PAY AND CHASE	Under certain circumstances, the claims are initially paid by the Claims processing system and then the claims must accumulate to a pre-determined threshold prior to payment by the third party insurance. In this situation, a claim is paid, despite coverage, and the carrier is billed (pay and chase).

PAYER OF LAST RESORT	The insurance program that pays after all of a patient's other insurance programs have paid for a service. Medicaid is usually the payer of last resort.
PAYMENT CYCLE	The processing of adjudicated claims to a paid or denied status. Users determine the frequency of running payment cycles. Most state agencies pay providers weekly.
PAY-TO PROVIDER	The provider who will receive payment (if a group/clinic number is present, it would be the "Pay-to Provider"
PAYOUT (PAY)	Non-claim specific payment to a provider or other entity (i.e.: insurance company).
PDD	Procedure, Drug, Diagnosis
PE	Presumptive Eligibility
PEER	A person or committee in the same profession as the provider whose claim is being reviewed.
PEER REVIEW	An activity performed by a group or groups of practitioners or other providers to review the medical practices of their peers for conformance to generally accepted standards.
PEER REVIEW ORGANIZATION (PRO)	A quality assurance or peer review program that reviews Medicare, Medicaid and Maternal and Child Health program claims. Mandated by the federal government to review the necessity and appropriateness of admissions to hospitals and continued stay in hospitals. PROs have the authority to deny payment or recoup payment for services that are deemed unnecessary.
PER DIEM	A daily rate usually associated with payment to an institution such as a hospital or a skilled nursing facility assigned to institutional providers.

PERSONAL COMPUTER (PC)	Although the term "PC" is sometimes used to refer to any kind of personal computer, PC refers to computers that conform to the PC standard originally developed by IBM. PCs are used as stand-alone personal computers or as workstations and file servers in a LAN (local area network). They are predominantly used as single-user systems under DOS; however, they are occasionally used as a central computer in a multi-user environment under UNIX and other operating systems.
PERSONAL IDENTIFICATION NUMBER (PIN)	A number used to provide a password into the system for security purposes.
PF KEY	The function keys at the top of a computer keyboard which serve as commands (for example, F1, F2, F3, etc.).
PHARMACIST	A professional qualified by education and authorized by law to prepare, preserve, compound, dispense and give appropriate instruction in the use of drugs.
PHARMACY BENEFIT MANAGEMENT (PBM)	Pharmacy Benefit Management (PBM) applies managed care principles to prescription drug programs, with the goal of optimal and cost-effective drug prescribing and use. PBM functions include (1) claims processing and adjudication, (2) data management, reporting, and trending (3) formulary management and clinical review services, (4) prospective Drug Utilization Review (ProDUR), and (5) drug rebate management.
PHARMACY POINT-OF-SERVICE (RX-POS, POS)	The Pharmacy POS system enables Medicaid providers to submit electronic pharmacy claims in an on-line, real-time environment. The electronic claim submission will verify beneficiary eligibility; including other health insurance coverage, and monitor Medicaid drug policies. Claims will also be screened against beneficiary medical and prescription history within the Medicaid system. Once these processes are complete, the provider will receive an electronic response indicating payment or denial within seconds of submitting the electronic claim. Also referred to Point of Sale.
PHD	Doctorate of Philosophy.

PHYSICAL THERAPY (PT)	Rehabilitation concerned with the restoration of function and prevention of disability following disease, injury, or loss of a body part.
PHYSICIAN (PHY, PHYS)	A professional qualified by education and authorized by law to practice medicine.
PHYSICIANS DESK REFERENCE (PDR)	PDR is considered the standard prescription drug reference.
POS	Place Of Service The location at which a service was rendered, such as office, home, emergency room, etc.
POS	Point Of Sale
PLAN OF CARE	A document completed following the determination of long-term care eligibility and the individual elects home and community based services instead of nursing facility services. This document must include: the services to be provided, the frequency of each service, who will provide each service, and the cost of each service.
PM	Project Manager
PMP	Primary Medical Provider
POD	Podiatrist
POVERTY LEVEL	The poverty threshold is a statistical measure used to indicate the level of cash income needed by a family to purchase a “minimally adequate” market basket of goods and services. The threshold is adjusted for family size and updated every February for inflation. It is a nationwide standard of poverty.
PPO	Preferred Provider Organization

PRE-CERTIFICATION (PRE-CERT)	Serves as an entry and approval process PA requests. It interfaces with the PA subsystem to provide automated update to the PA files.
PREMIUM	The periodic payment (e.g. monthly, quarterly) made to an insurance company to keep an insurance policy in force.
PRICING INDICATOR CODE (PIC)	An indicator that determines the reimbursement restrictions for drug and procedure codes.
PRIMARY CARE	Basic level of health care rendered by general practitioners.
PRIMARY CARE PROVIDER (PCP)	A professional, which could be a physician, ARNP, health department, or clinic, who manages a beneficiary's health care needs.
PRIMARY CARE SERVICES	Those services provided by a duly licensed medical practitioner who has contracted with SRS to initiate or approve specified medical services for participating Medicaid beneficiaries.
PRIMARY MEDICAL PROVIDER	An individual provider or organization assigned to a beneficiary with the responsibility of providing the majority of a beneficiary's medical services.
PRIOR AUTHORIZATION (PA)	Authorization granted by SRS staff, or its designated representative, to a provider to render specified services to a designated beneficiary. Acknowledgement, given before payment may occur, that certain specified services meet an established criterion. Acquiring permission before performing a service. Prior authorization is a condition for payment for many services reimbursed by Medicaid.
PROCEDURE (PROC)	A numeric or alphanumeric code used to describe the specific service rendered to a patient by a provider.
PROCEDURE, DRUG, AND DIAGNOSIS FILE (PDDF FILE)	A file within the Reference Subsystem that contains records on all billable codes. The file also contains information on provider restrictions, beneficiary eligibility, and service limitations.

PROCESSED CLAIM	A claim that has been adjudicated, properly paid or denied, and the remittance has been sent.
PROFESSIONAL COMPONENT (PC)	Charges associated with a physician's expert reading of and interpreting some x-ray, lab, and diagnostic procedures.
PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO)	A quality assurance or peer review program that reviews Medicare, Medicaid and Maternal and Child Health program claims.
PROJECT WORKBOOK (PWB)	HP Enterprise Services proprietary WEB application that serves as a repository of HP Enterprise Services interChange information. The Project Workbook contains administrative, application, and project information.
PROMPT	To request input from the user by displaying a message on the computer screen or by playing an audio message on the telephone.
PROTOCOL	In information technology, it is a set of rules describing the contents of an electronic communication. To communicate, both the sender and receiver must adhere to the protocol. See TCP/IP, HTTP, and FTP.
PROVIDER	An eligible institution, facility, agency, managed care organization, administrative service organization, person, partnership, corporation, or association as enrolled and approved by the State which accepts, as payment in full for providing eligible services, reimbursement provisions, regulations, and schedules.
PROVIDER CATEGORY OF SERVICE	A code that indicates on a claim the type of service given by the provider in question. This code indicates the specific categories of service a provider may bill for.
PROVIDER SPECIALITY (PS)	A code that specifies the type of service a provider renders.
PROVIDER TYPE	A general code that indicates the type of service a provider can perform.

PROXY SERVER	A firewall security for a web site. A server that acts as an intermediary between a workstation user and the Internet and is associated with the gateway server that separates the enterprise network from outside intrusion.
PSY	Psychologist
PSYCHIATRIC HOSPITAL	An institution that is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons.
PURGE	Refers to moving data from the master files to the archive files. For example, beneficiary eligibility records may be purged if there is no activity within a three-year period.

7.1.17 Q**QA Quality Assurance**

QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI)	<p>A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level.</p> <p>Certain formerly disabled persons who lost Medicare benefits because of their return to work are allowed to purchase Medicare Part A coverage. The State Medicaid Program must pay the Part A premium for those individuals entitled to enroll in Part A if their income does not exceed twice the SSI limit and they are not otherwise eligible for Medicaid benefits.</p>
QUALIFIED MEDICARE BENEFICIARY (QMB)	<p>A State program that pays for a beneficiary's Medicare premiums, coinsurance, and deductible amounts within limits.</p>
QUALIFIED WORKING DISABLED (QWD)	<p>See QDWI. A special program authorized by the Social Security Administration that allows certain individuals to work and still collect their disability payments for a period of time. SRS allows these individuals to remain on Medicaid while in QWD status.</p>
QUARTER	<p>Calendar quarter unless otherwise specified.</p>
QUEUE DIRECTORY	<p>A directory on a hard drive into which batch requests to unit storage are placed. (Imaging)</p>

7.1.18 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.

REFERENCE DATA MAINTENANCE SUBSYSTEM	The Reference Data Maintenance subsystem maintains a consolidated source of reference information that is accessed by the MMIS during performance of claims and adjustment processing functions, prior authorization functions, and Third Party Liability (TPL) processing. The Reference Data Maintenance function also supports MMIS reporting functions.
REFERRING PROVIDER	Provider who gives referral (such as the KenPAC provider)
REFORMAT	To change the record layout of a file or database. To initialize a disk over again.
REGULATION	A federal or state agency legal statement of general or specific applicability designed to implement or interpret law.
REHABILITATION THERAPIES	Services designed to improve the skills and adjustment of the head injured individual, integrating prevocational, educational, and independent living goals, in order to return, or maintain the individual at their most optimum level of functioning at the least restrictive level of care. Services include occupational therapy, physical therapy, speech-language therapy, cognitive therapy, behavioral therapies, and drug and alcohol abuse counseling.
REJECTED CLAIM	A claim that contains errors such as missing data, incorrect claim form, or missing provider signature and is returned to the responsible provider without being adjudicated.
RELATIONAL DATABASE	A database or collection of data organized into related tables comprised of rows and columns. The tables define relationships between the records.

RELATIVE VALUE SCALE	A type of fee schedule which uses unit values (multiplied times a dollar conversion factor) to price procedures, instead of using a flat fee. The methodology establishes value relationships between procedures. For example, a limited office visit might be valued at five units and an extended office visit (which is more complex) at 8 units. RVS based fee schedules have the advantage of being easier to revise because it is not necessary to change the units, only the conversion factors. These are carried as system parameters in the MMIS.
RELEASE	The release is associated with a specific version of a product being made available to the client. Also known as system release or version.
REMITTANCE ADVICE (RA)	The statement mailed to a provider detailing Charges pending, paid, denied.
REMITTANCE ADV	A document sent to providers to explain the payment status of claims. The statement mailed to the provider detailing the outcome of the claims processed in the most recent payment cycle. The claims are listed by claim type and then disposition, i.e., paid, denied, suspense, and History only. RAs are generated in the financial system in accordance with the providers' RA media type indicator. Only those providers sending the majority of their claims electronically will be allowed a choice of media. All providers will be allowed only one type of media for RAs.
REMOTE ACCESS SERVICES (RAS)	A feature built into Windows NT that enables users to log into an NT-based LAN using a modem, X.25 connection or WAN link. RAS works with several major network protocols, including TCP/IP, IPX, and Netbeui.
RENDERING PROVIDER	Provider who actual provides the service (for example, an individual physician)
REQUEST FOR PROPOSAL (RFP)	The bidding mechanism used to purchase goods and services.

RESOLUTION	<p>Usually used in context as claims resolution, pending resolution, or suspense resolution. It refers to the process of working or correcting errors on a claim, forcing edits, updating or modifying inaccurate data such as a provider number or category of service, or any other activity necessary to complete the adjudication of the claim.</p> <p>Measure of imager output capability, usually expressed in dots per inch (DPI).</p> <p>Measure of halftone quality, usually expressed in lines per inch (LPI). (Imaging)</p>
RETRIEVE	<p>To call up data that has been stored in a computer system. When a user queries a database, the data is retrieved into the computer first and then transmitted to the screen.</p>
RETURN TO PROVIDER (RTP)	<p>Request for additional information from the provider in the form of a letter.</p>
REVENUE CODES	<p>The three-digit accounting codes used on hospital claims to designate the service which generated the income, e.g., room and board = 110, laboratory pathology = 300, and physical therapy = 420. Revenue codes are used in billing both inpatient and outpatient services. These codes are essential to the hospital cost reporting process.</p>
RN	<p>Registered Nurse</p>
RN BSN	<p>Registered Nurse with Bachelor of Science Degree in Nursing</p>
ROUTE TABLE	<p>A database table that specifies resources, such as agent groups or trunks, that calls can be routed to within the telephone system.</p>
RULES BASED PROCESS	<p>Rules Based Processing, or Table Driven System, or Parameter Based Processing are terms that refer to systems that store data element variables in user-alterable tables rather than storing them inside a fixed computer program.</p>

7.1.19 S

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

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

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

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

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

SSDI Social Security Disability Income

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

STD Sexually Transmitted Diseases

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

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

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

7.1.20 T

T-1 CONNECTION	A high-speed connection to the Internet. Required in organizations having a large number of employees accessing the Internet.
TAGGED IMAGE FILE FORMAT (TIFF)	A bit map file format for describing and storing color and gray scale images. (Imaging)
TB	Tuberculosis
TCN	Transaction Control Number
TDOS	To Date of Service - Date used in the claim.
TECHNICAL COMPONENT (TC)	The technician's services used in some x-ray, lab, and diagnostic procedures.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)	<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

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

7.1.21 U**UAT** **User Acceptance Testing**

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

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

UPIN Universal Provider Identification Number

USER A data processing system customer.

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

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

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

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

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

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

7.1.22 V

VACCINE FOR CHILDREN (VFC)	A federally funded program that provides immunization serum for qualified children.
VALUE-ADDED NETWORK (VAN)	A vendor of EDI data communications and translation services. (Switched network provider).
VDT	Video Display Terminal (Screen)
VENDOR	An institution, agency, organization, or an individual practitioner who provides health care services.
VIRTUAL PRIVATE NETWORK (VPN)	Internet software for the client desktop. This allows two users to communicate via the Internet and for security purposes, it is a closed network between the two sites. Along with this technique is "tunneling" which allows data to be sent through a private tunnel rather than over the Internet connection.
VIRTUAL STORAGE ACCESS METHOD (VSAM)	An IBM access method for storing data, widely used in IBM mainframes.

7.1.23 W

WAIVER	A CMS-approved process that allows states to customize specific rules and regulations to their medical assistance programs to provide more cost-effective services.
WAN	Wide Area Network. See LAN.
WARRANT	An order for payment/reimbursement. After adjudication, a claim is marked for payment or denial. For the ones marked for payment, a warrant is issued for State finance to issue a check.
WARRANT NUMBER	The actual check number issued for claims payments to providers.
WARRANT TYPE	The type of warrant that is issued to Medicaid providers, be it a value of E (electronic funds transfer) or P (paper).
WIC	Women, Infants, and Children
WINDOWS	A graphics-based windows environment from Microsoft that integrates with and interacts with DOS. It provides a desktop environment similar to the Macintosh, in which applications are displayed in re-sizable, movable windows on screen.
WITHHOLD	An amount which SRS instructs the Fiscal Agent to withhold from the monthly capitation of an HMO.
WORKERS' COMPENSATION	A type of third party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which the employer's insurance company may be obligated under the Workers' Compensation Act.

WORKSTATION A single-user microcomputer or terminal, usually one that is dedicated to a single type of task (graphics, CAD, scientific applications, etc.).
(Imaging)

7.1.24 X

X12	An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards mandated or proposed under HIPAA are X12 standards.
X.25	A CCITT protocol that defines a standard way of arranging data in packets to be shipped over transmission lines. (Standard for packet switched networks). See CCITT.
X.400	A CCITT mail and messaging standard.
X.500	A CCITT directory services standard.
XA	Extended Architecture
XOVER	Cross Over
XREF	Cross-Reference

7.1.25 Y

**YEARLY
ENROLLMENT**

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

YTD

Year to Date

8 Appendix A – interChange Navigational Overview

8.1 System Navigation Introduction

8.1.1 Introduction

The new Kentucky Medicaid Management Information System (MMIS), currently based upon an HP Enterprise Services proprietary system called interChange, is designed according to a set of development standards. This document is designed to introduce users to standard system navigation features within interChange.

8.1.2 Screen Display Features

The interChange system is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

8.1.2.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log in to interChange.	The Home page opens.
2	In the Web browser menu bar, click View.	The View menu options appear.
3	Highlight Text Size, and then click Smaller.	The default Text Size is set to medium; however, after the user selects smaller, the system objects appear smaller.

8.2 System Wide Common Terminology and Layouts

The following section identifies common system terminology and features, and where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team members, training specialists, and help desk staff when discussing, or more importantly documenting, aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms which are described within this document:

- Page;
- Page Header;
- Page Footer;
- Sub Menu;
- Main Menu bar;
- Panel;
- Advanced Search;
- Mini Search panel;
- Hot Link;
- Information panel;
- Navigation panel;
- Task List panel;
- Title Bar Icons;
- Related Data; and,
- Personal Settings.

8.2.1 Home Page Layout



Figure 1 interChange Home Page

Menu Selection	Description
Home	Home Page, includes links to other applications
Claims	Link to Claims subsystem
Reference	Link to Reference subsystem
Provider	Link to Provider subsystem
Member	Link to Member subsystem
Financial	Link to Financial subsystem
EPSDT	Link to EPSDT subsystem
TPL	Link to TPL subsystem
Managed Care	Link to Managed Care subsystem
MAR	Link to MAR subsystem
Prior Authorization	Link to Prior Authorization subsystem
CTMS	Link to CTMS subsystem
Security	Link to Security settings
Site	Link to activate or modify personal settings

Menu Selection	Description
Admin	Link to log in as administrator and set up site settings
Host	Link to log in as host and set up host settings

8.2.2 Page Layout

A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed, a Main Menu bar, a Sub Menu, and any associated panels. The bottom of the page contains the Page Footer with the HP Enterprise Services copyright text displayed.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

Beneath the Main Menu bar is the Sub Menu of horizontal links that opens an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.

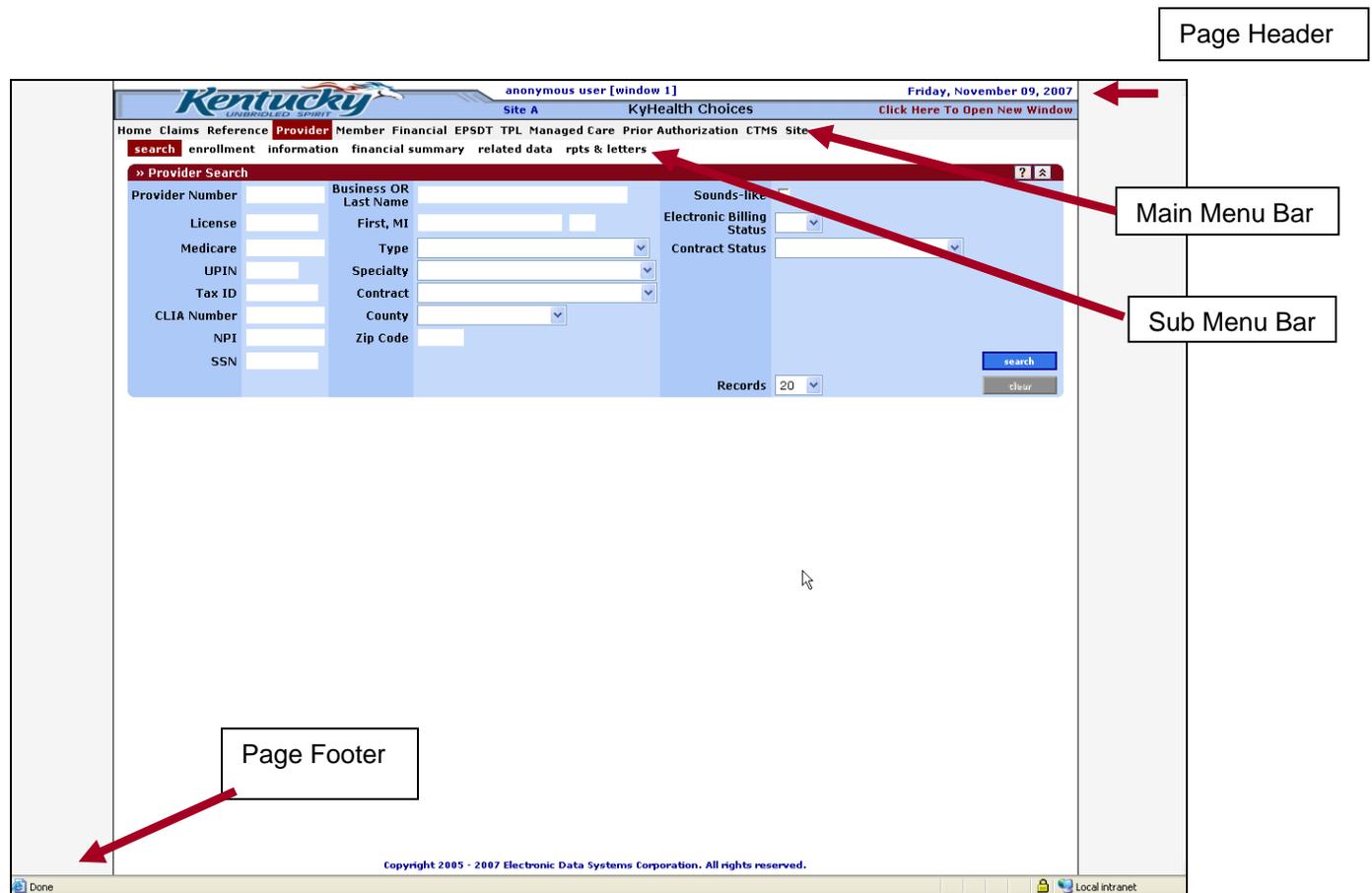


Figure 2 Provider Search Page

In general, when navigating a page, the vertical scroll bar should be the only scroll bar needed to view panels stacked in a vertical manner.

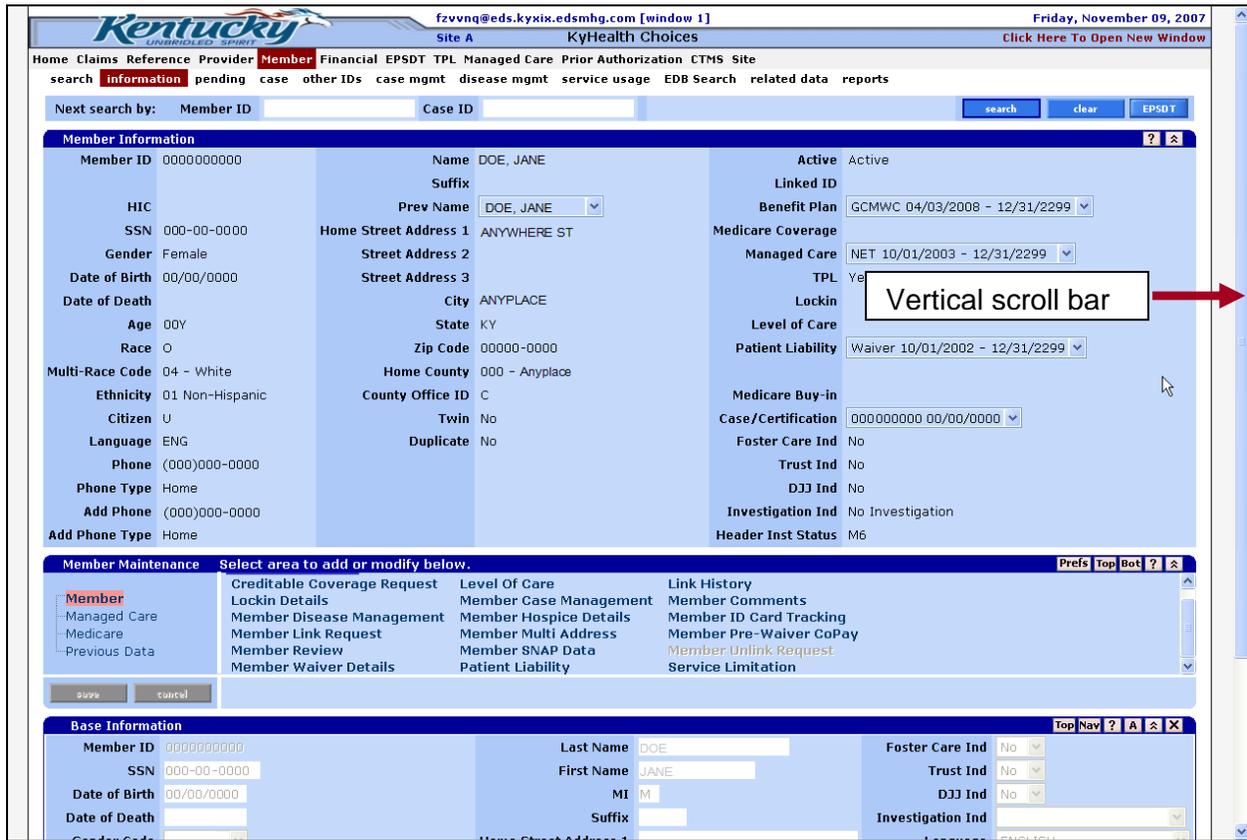


Figure 3 Member Information Page

If a user attempts to add, update, or delete information within the page, then prior to navigating away from the page, the system prompts the user with a pop-up modal window message. When the system generates the message, the detail panels are locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.



Figure 4 System Message

8.2.3 Search Options

There are several search options available within interChange.

8.2.3.1 Search Panels

The system contains more than one type of search panel: Search and Advanced Search.

Some subsystems such as the Provider Data Maintenance subsystem contain a search panel without an advanced search button included on the panel.



Figure 5 Provider Search Panel

Some subsystems such as the Claims subsystem contain a search panel with an advanced search button included for displaying an additional, advanced search panel.

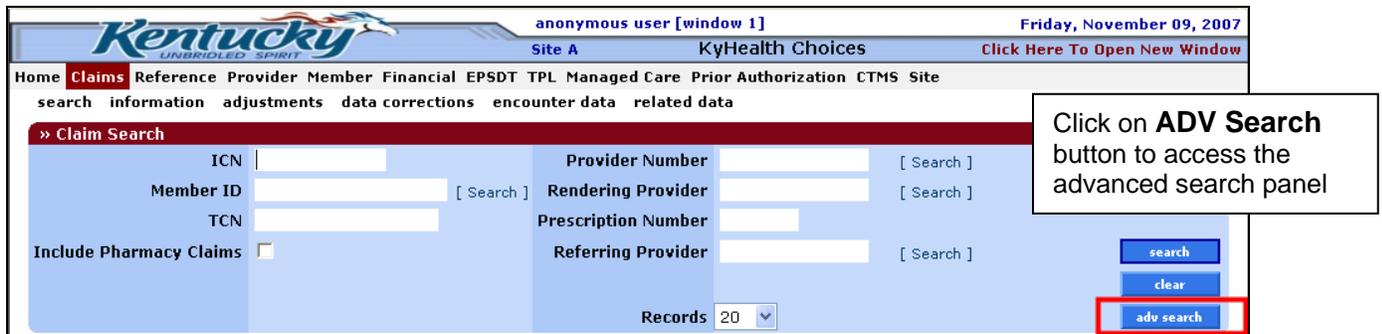


Figure 6 Claim Search Panel

Notice the white line – at least one field above the line must be entered to search for a claim. Fields below the line are optional.

Figure 7 Advanced Claim Search Panel

ICN	Member ID	Provider Number	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid	Prescription Number
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTP XOVER CLAIMS	PAID	11/02/2007	\$160.81	\$0.00
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTP XOVER CLAIMS	DENIED	11/02/2007	\$857.27	\$0.00
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/12/2007	\$2,890.35	\$0.00
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/19/2007	\$1,211.93	\$0.00
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	0	\$275.25	\$0.00
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/12/2007	\$127.71	\$44.25
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$746.63	\$177.00
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$109.21	\$12.80
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/19/2007	\$401.78	\$0.00
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/12/2007	\$896.25	\$177.00
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$233.84	\$62.67
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	0	\$836.18	\$191.25
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/19/2007	\$981.92	\$0.00
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	0	\$60.09	\$0.00
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$500.11	\$96.01
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$2,194.38	\$743.00
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/26/2007	\$572.73	\$138.42
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/19/2007	\$1,058.59	\$0.00
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$991.08	\$351.29
000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	0	\$787.41	\$288.34

To specify maximum number of records to be returned on single page – use drop down menu to change number

Indicates there are additional pages of results. To go to additional page, click on page number or click on "Next".

Figure 8 Claim Search Results Panel

The search results can be sorted in ascending  or descending  order by clicking the column name in the Search Results panel. All search results are resorted, not just the search results displayed on the current search result panel.

In Figure 9, the search results are sorted in descending order by Member ID.

Search Results											
ICN	Member ID	Provider Number	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid	Prescription Number	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$991.08	\$351.29	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/19/2007	\$259.26	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$233.84	\$62.67	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	0	\$2,044.89	\$756.62	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$363.31	\$164.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/26/2007	\$1,550.02	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	0	\$285.61	\$177.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/19/2007	\$101.92	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	0	\$450.68	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	0	\$6,755.78	\$2,375.12	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$2,373.70	\$834.13	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$363.31	\$164.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/19/2007	\$429.99	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/12/2007	\$2,890.35	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$386.27	\$39.51	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	0	\$566.36	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	11/02/2007	\$363.31	\$164.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/12/2007	\$1,131.55	\$347.63	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/19/2007	\$981.92	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$2,781.05	\$264.00	
Claim Count: 198			Total Billed: \$207,691.30			Total Paid: \$37,816.79					
1 2 3 4 5 6 7 8 9 10 Next >											

Figure 9 Search Results Page Sorted by Member ID

8.2.3.2 Selecting a Search Result Row

If the user clicks once on a search result row, the associated information panel opens. In Figure 10, the user clicks the third row of the Claim Search Results panel and the Paid Outpatient Claim for the associated ICN displays.

» Search Results											
ICN	Member ID	Provider Number	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid	Prescription Number	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$991.08	\$351.29	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/19/2007	\$259.26	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$233.84	\$62.67	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	0	\$2,044.89	\$756.62	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$363.31	\$164.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/26/2007	\$1,550.02	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	0	\$285.61	\$177.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/19/2007	\$101.92	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	0	\$450.68	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	0	\$6,755.78	\$2,375.12	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$2,373.70	\$834.13	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$363.31	\$164.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/19/2007	\$429.99	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/12/2007	\$2,890.35	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$386.27	\$39.51	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	0	\$566.36	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	11/02/2007	\$363.31	\$164.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/12/2007	\$1,131.55	\$347.63	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	DENIED	10/19/2007	\$981.92	\$0.00	
00000000000000	0000000000	00000000	MCD	10/01/2007	10/01/2007	OUTPATIENT CLAIMS	PAID	10/19/2007	\$2,781.05	\$264.00	
Claim Count: 198			Total Billed: \$207,691.30			Total Paid: \$37,816.79					
1 2 3 4 5 6 7 8 9 10 Next >											

Figure 10 Selecting a Search Result Row

8.2.3.4 Mini Search

After the user has viewed at least one search result in an information panel, another search can be completed by using the primary search fields within the Mini Search panel located above the information panel containing the search result.

Mini Search panels contain one or two primary search fields related to the business process.

The screenshot displays the 'KyHealth Choices' web interface. At the top, there are navigation links for Home, Claims, Reference, Provider, Member, Financial, EPSDT, TPL, Managed Care, Prior Authorization, CTMS, and Site. Below this is a search bar with 'Next Search By: ICN' and buttons for 'search', 'clear', and 'adv search'. The main content area is titled 'UB92 Claim' and contains a form with various fields for claim information, including ICN, Member ID, Last Name, First Name, DOB, Claim Diagnosis, Submitter ID, Admit Source, Admit Type, Discharge Hour, Type Of Bill, PAN, Claim Type, Status, FDOS, TDOS, Date Billed, Date Paid, Provider Number, Attending Provider, Other Provider 1, Other Provider 2, Facility ID, Admit Date, Admit Time, Patient Status, Certification Nbr., MRN, and financial details like Billed, Spenddown, Reimbursed, Paid, TPL, Total Patient Liability, Total Days, Covered Days, Days Not Covered, RA Number, and MCO Paid Amount. A red arrow points from the 'search' button to a box labeled 'Mini Search Panel'. Below the main panel is a 'Claim Detail' section with a table of claim details and a 'Next Search By' section at the bottom with search buttons.

Detail Number	Procedure	Revenue Code	Other Provider 2	Rate Type	Patient Liability	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	FDOS	TDOS	Units Billed	Units Allowed	Billed Amt	Allowed Amt	TPL Amt	System	Non-Covered Charges
77413	333				0	PAID					10/01/2007	10/01/2007	1.00	1.00	\$638.99	\$236.43	\$0.00	No	\$0.00

Figure 12 Claim Mini Search Panel

8.2.3.5 Pop Up Search

A Pop Up Search allows the user to search for field data without leaving the page. By clicking on the (Search) link, the user accesses the search panel that is associated with that particular field.

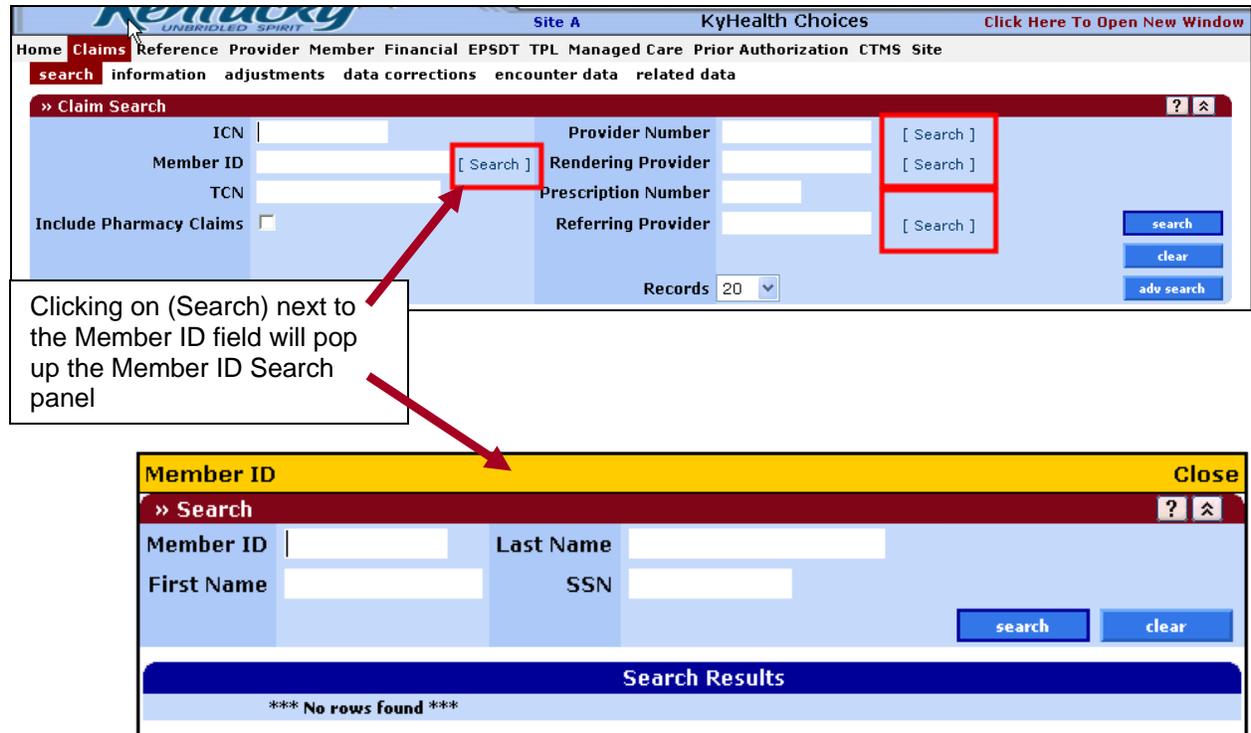


Figure 13 Claim Search Page

8.2.4 Panel Layout

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

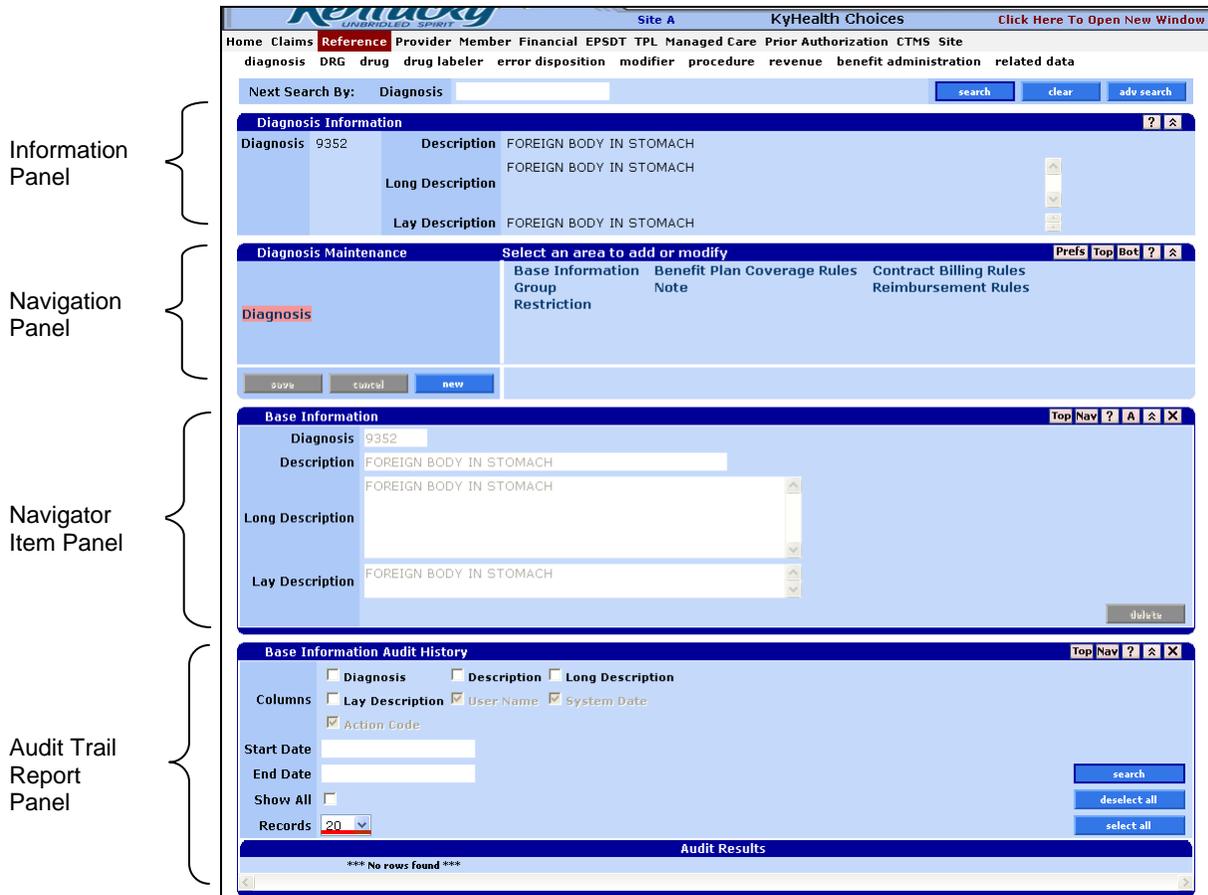
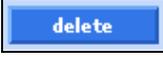


Figure 14 Diagnosis Code Base Information and Audit Panel

8.2.4.1 Panel Types and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on one or more types of panels:

Button/Icon	Description
Add Button 	Allows the user to insert a new data record on a panel. Click “Add” to open a record with blank fields. Fill in the applicable information. Click the “Save” button located on the Navigation panel to save the new record.
Delete Button 	Allows the user to delete a selected data record on a panel. Click on the record that needs deletion, which will highlight the record. Click on “Delete”. Click the “Save” button located on the Navigation panel to save the deletion.

Button/Icon	Description
Cancel Button 	Cancels all unsaved changes applied to all panels on the page. Can be found on the navigation panel.
Save Button 	If a new record is added to a panel, clicking “Save” will save the new record. If changes are made to an existing record on a panel, clicking “Save” will save the changes. If validation errors occur, an error message displays in the Task List panel. Can be found on the Navigation panel.
Asterisk 	Displayed next to a required field. Fields indicated with an asterisk are required to contain data.
Preferences Button 	Displays a checkmark box next to each Navigator Item link. By checking the box, the link automatically opens whenever the user browses the page. To hide the boxes, click on the button a second time. Can be found only on the Navigation panel.
Top Button 	Allows user to jump to the top of the page.
Bottom Button 	Allows user to jump to the bottom of the page.
Help Button 	Opens a window that displays the panel help page.
Maximize Button 	Expands a panel to display all of its content.
Minimize Button 	Collapses a panel.
Navigation Button 	To jump to the Navigation panel.
Audit History Button 	Opens the Audit History Panel for a specific panel.
X Button 	Closes a panel.
Green Information Button 	Opens information file for the associated field.

Among the panel types are the following:

- Navigation panel;
- Task List panel;
- Navigator Item Panel; and,
- Audit panel.

8.2.4.2 Navigation Panel

A navigation panel is a special control panel that uses links to open or close panels on a Web page. By clicking on a Navigator Group Link, the associated Navigator Item panels are displayed. Changes to Navigator Items displayed on the page are saved or cancelled by clicking the Save or Cancel buttons on the Navigator panel.

The navigation panel is used to navigate within a page, never to leave the page.

Figure 15 demonstrates Navigator Group Links (Provider and Service Location) and the associated Navigator Item links. By clicking on an Item Link (such as Comment), the associated panel opens.

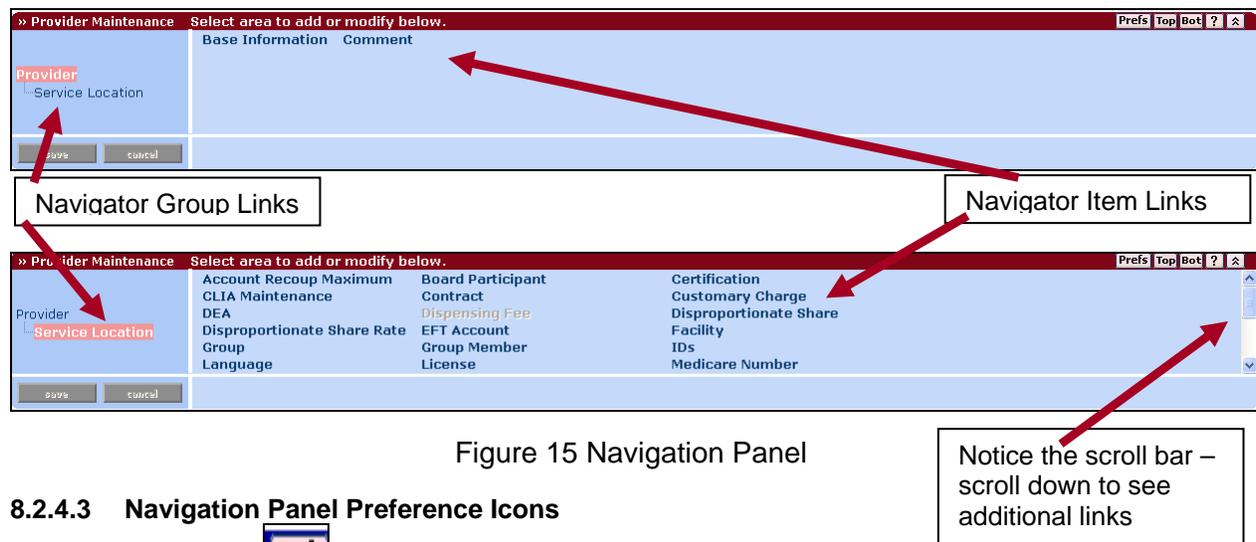


Figure 15 Navigation Panel

8.2.4.3 Navigation Panel Preference Icons

Users can click the  icon in the upper right-hand area of the navigation panel title bar to pre-set which panels automatically opens each time the user accesses that particular navigation page.

When the user clicks a link in the right-hand side of the navigation panel, the associated panel displays beneath the navigation panel.

In Figure 16, the Provider Maintenance navigation panel is open. If the user checks the Certification and Customary Charge check boxes, then the associated panels automatically displays directly beneath the navigation panel each time the user accesses this page.



Figure 16 Preference Feature for Provider Navigation Panel

The opening of multiple panels results in the display of the panels vertically down the page.

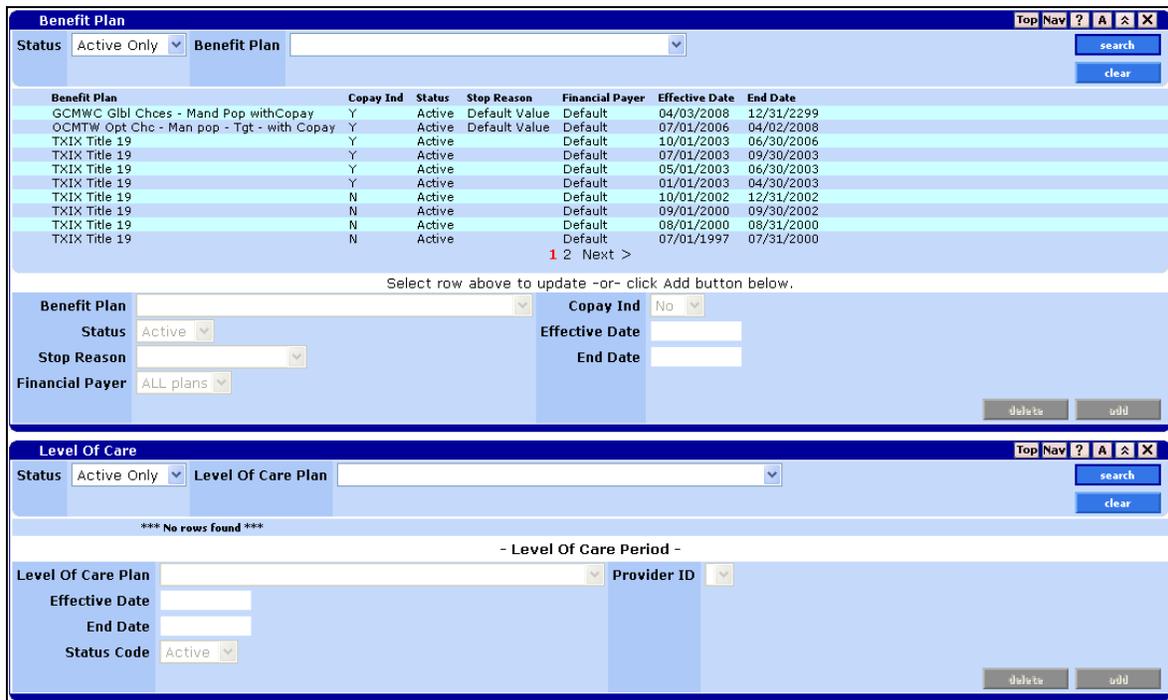


Figure 17 User Preference Panel Display

8.2.4.4 Task List Panel

Task List panels appear within navigation panels and provide messages to the user regarding whether the data was successfully saved, or if errors occurred to prevent the data from being successfully saved, or warning messages which may or may not include a radio button selection for the user to activate prior to completing the task.

Detail panels are locked open and navigation away from the page is not permitted until changes are saved or cancelled.

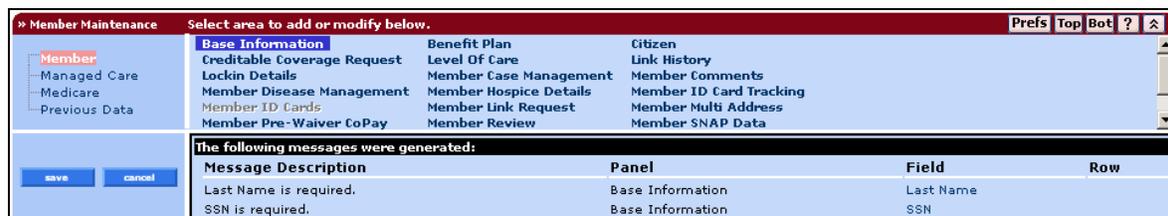


Figure 18 Task List Panel

The task list contains both the name of the panel where the error occurred, and the field name or row in order to help users quickly identify key areas to correct prior to attempting another save action.

Warning messages provide users with a warning about the data they are trying to update, delete, add, or save. For example, if the user attempts to add duplicate record, the system generates a warning message.

An error message can also contain additional information which is accessed by clicking on a square node icon in the lower left side of the Task List panel.



Figure 19 Warning Message

The task list can also be used to display messages that require a response. The user answers the question by completing an action within the message area, then click on the Continue link at the center bottom of the Task List panel to indicate the answer is ready for processing.



Figure 20 Response Message

The user answers the question posed by the message and then the user clicks the Continue link to indicate the answer is ready for processing.

8.2.4.5 Navigator Item Panel

A Navigator Item panel is opened by clicking a link on a Navigation panel. Navigator Items allow detail data to be viewed and updated. Usually a Navigator Item has a list of data records and a panel to perform data updates. Click the Add button to enter a new data record. Or click a data record from the list to perform field updates or to delete the record. Once selected, a data record is deleted by clicking the Delete button. All adds, deletes and updates must be followed by a Save before the transaction is permanent.

Prior Authorization Maintenance - Select Prior Authorization area to add or modify below.

Additional Diagnosis Codes | **Base Information** | Normal Text
 Line Item | Paid Claim List | Related Documents

Prior Authorization: Super P.A.

save | cancel | new

Base Information

PA Category*: INPATIENT HOSPITAL | Primary Diagnosis Code: [Search]

Requesting Provider Number: 00000000 | MCD [Search] | Authorizer: 99999999 | [Search]

Service Provider Check*: Specified Service Provider

Servicing Provider Number: 00000000 | MCD [Search] | Fund Code: []

Member ID*: 3333333333 | [Search] | Print Option*: No Print

Emergency*: No | Admission Date: 03/13/200:

Accident*: No | Discharge Date: 05/01/200:

Special Considerations*: No | Received Date: 05/01/200:

Nursing Facility Type: [] | Update Received Date: 05/01/200:

Ortho Status Code: [] | Update Reviewed Date: 05/01/200:

Line Item

Line Item Number	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Revenue Code From	Revenue Code To	Procedure Code From	Procedure Code To	Modifier 1	Modifier 2	Modifier 3	Modifier 4	NDC Code	Pa Line Item Status	Subcontractor Tax ID
01	2	\$0.00	2	\$0.00	100	219								Approved	

Select row above to update -or- click Add button below.

Line Item Number: [] | Requested Effective Date: []

Service Type Code: [] | Requested End Date: []

Revenue Code: [] | Revenue Code To: [] | Requested Frequency: []

Procedure Code From: [] | Procedure Code To: [] | Requested Frequency Units: []

Modifier 1: [] | Quad: [] | Requested Units: []

Modifier 2: [] | Tooth: [] | Requested Dollars: []

Modifier 3: [] | NDC Lock: [] | Authorized Effective Date: []

Modifier 4: [] | NDC Code: [] | Authorized End Date: []

PA Line Item Status: A - Approved | Subcontractor Tax ID: [] | Authorized Frequency: []

Authorized Frequency Units: []

Authorized Units: []

Authorized Dollars: []

Payment Method: Pay Audit Cap Amount

Quantity Used Units: []

Quantity Used Dollars: []

Balance Units: []

Balance Dollars: []

add

-Reason Code- Select row below to update -or- type data below to add.
 *** No rows found ***

-Mass Update Change- Select row below to update -or- type data below to add.
 *** No rows found ***

Figure 21 Base Information and Line Item Panels

By clicking on a data record, the fields below auto-populates. This allows the user to view detailed information about the data record, or, modify or delete the data record.

The screenshot displays the 'Prior Authorization Maintenance' interface. At the top, there are navigation buttons: 'save', 'cancel', and 'new'. Below this is the 'Base Information' panel, which contains various fields for patient and provider information, including 'PA Category*', 'Requesting Provider Number', 'Service Provider Check*', 'Servicing Provider Number', 'Member ID*', 'Emergency*', 'Accident*', 'Special Considerations*', 'Nursing Facility Type', and 'Ortho Status Code'. It also includes 'Primary Diagnosis Code', 'Authorizer', 'Fund Code', 'Print Option*', 'Admission Date', 'Discharge Date', 'Received Date', 'Update Received Date', and 'Update Reviewed Date'. A callout box with a red arrow points to the date fields, stating: 'Notice the date. Date formats on all pages and panels are the same: MM/DD/CCYY.'

Below the 'Base Information' panel is the 'Line Item' panel, which features a table with columns: 'Line Item Number', 'Requested Units', 'Requested Dollars', 'Authorized Units', 'Authorized Dollars', 'Revenue Code From', 'Revenue Code To', 'Procedure Code From', 'Procedure Code To', 'Modifier 1', 'Modifier 2', 'Modifier 3', 'Modifier 4', 'NDC Code', 'Pa Line Item Status', and 'Subcontractor Tax ID'. The table shows a single row for Line Item Number 01. Below the table, there are fields for 'Line Item Number', 'Service Type Code*', 'Revenue Code', 'Procedure Code From', 'Modifier 1', 'Modifier 2', 'Modifier 3', 'Modifier 4', 'PA Line Item Status*', 'Revenue Code To', 'Procedure Code To', 'Quad', 'Tooth', 'NDC Lock', 'NDC Code', 'Subcontractor Tax ID', 'Requested Effective Date', 'Requested End Date', 'Requested Frequency', 'Requested Frequency Units', 'Requested Units', 'Requested Dollars', 'Authorized Effective Date', 'Authorized End Date', 'Authorized Frequency', 'Authorized Frequency Units', 'Authorized Units', 'Authorized Dollars', 'Payment Method*', 'Quantity Used Units', 'Quantity Used Dollars', 'Balance Units', and 'Balance Dollars'. A red box highlights the 'Requested Effective Date' field, which contains the date '13/13/2002', with a red arrow pointing to it from the callout box.

Figure 22 Row Selection in Navigator Item Panel

8.2.4.6 Audit Panel

Audit panels display data change history for a given Navigator Item panel. Every insert, update or delete that is performed (on an auditable panel) in the system causes a "before" image of the data to be saved to the audit table. Users can then use the audit panel to display this information.

Audit panels are opened by clicking the  button in the Navigator Item panel.

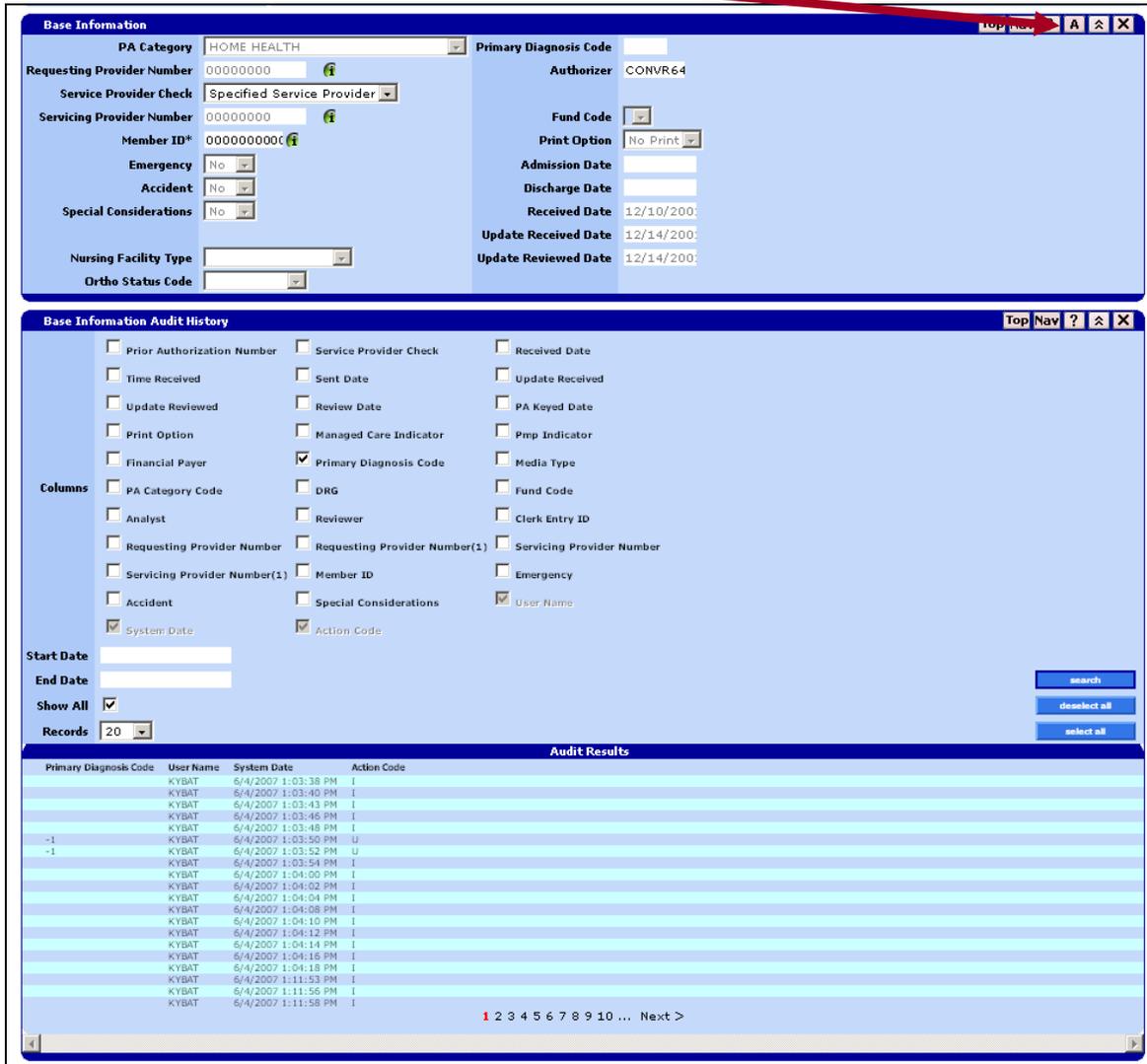


Figure 23 Audit History Panel

Field Name	Field Description
Columns	A check box for each editable field on the main panel displays. Allows the user to display select fields only.
Start Date	User can optionally limit Audit Results to matches where the system date of the change is equal to or greater than this date.

Field Name	Field Description
End Date	User can optionally limit Audit Results to matches where the system date of the change is equal to or less than this date.
Show All	If not checked, the audit result displays changes to only the single data row selected in the main panel. If checked, the audit results reports changes to all data rows contained in the list of the main panel.
Records	Number of records to display per page in the Audit Results.
Search	Displays Audit Results based on search criteria entered on the panel.
Deselect All	Removes all column checkboxes.
Select All	Checks all column checkboxes.
System Date	The date of the change.
Action Code	The type of change performed (delete, insert, update).

8.2.5 Related Data

Each subsystem, with the exception of MAR, contains Related Data. Related Data is a Sub Menu that contains codes, cross-reference tables, and other information for each associated subsystem.

8.2.5.1 Related Data Codes Page

The Related Data Codes page allows the user to access the various code tables not otherwise defined within the associated subsystem area.

The following subsystems contain a Related Data Codes page: Reference, Provider, Member, Financial, TPL, Managed Care, and Prior Authorization. Listed below are examples of “Codes” that can be found in Related Data.

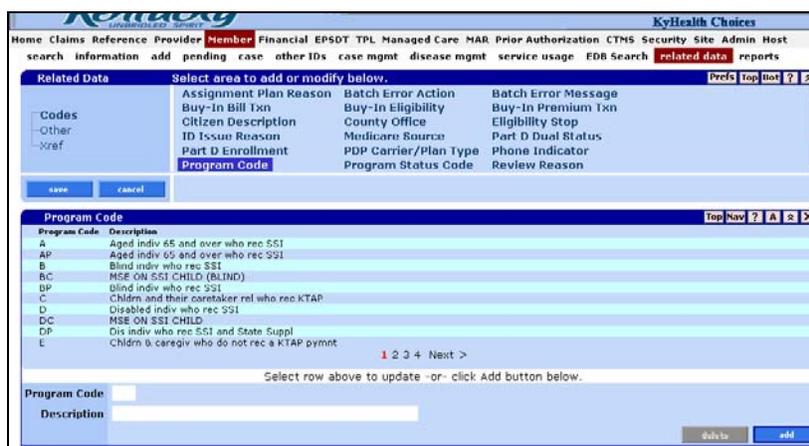


Figure 24 Program Codes (located in Member)

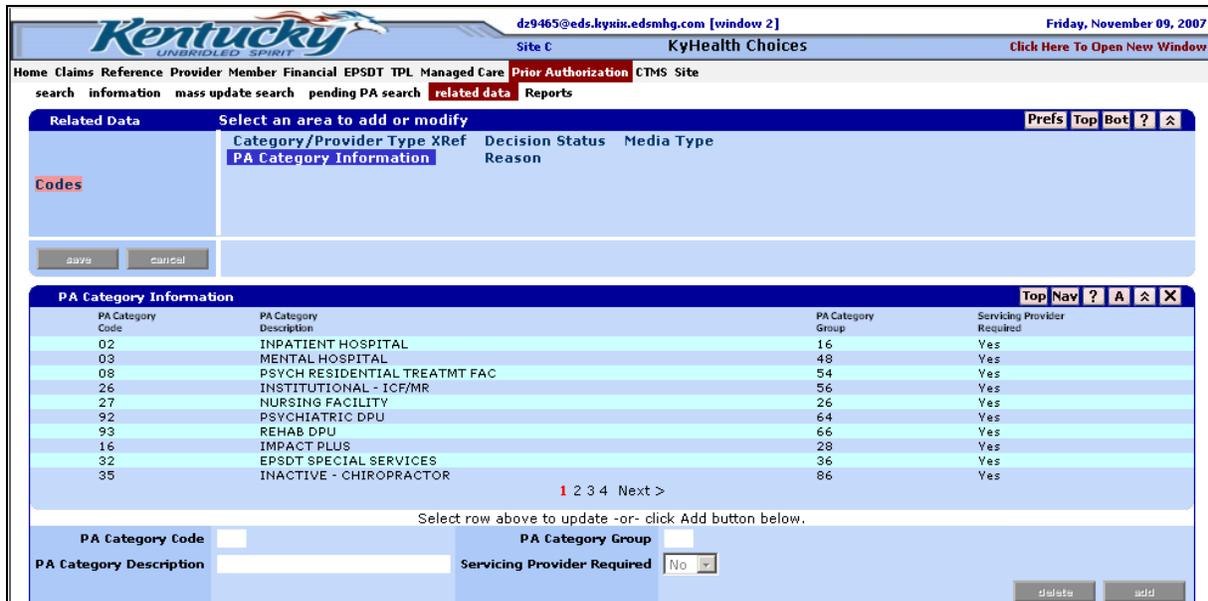


Figure 25 PA Category Information (located in Prior Authorization)

8.2.5.2 Related Data Other Page

The Related Data Other page allows the user to access the various miscellaneous data maintained within the associated subsystem area.

The following subsystems contain a Related Data Other page: Claims, Reference, Provider, Member, Financial, EPSDT, TPL, and Managed Care. Listed below are examples of “Other” panels that can be found in Related Data:

Click on "Other" to access these links.

The screenshot shows the 'Reference' section of the application. Under 'Related Data', the 'Other' link is highlighted in red. Below this, there is a search results table for EOB entries. The table has columns for EOB #, Type, Description, Effective Date, HIPAA Claim Status Code, and HIPAA Entity ID. Below the table is a form to add or update an EOB entry, with fields for Type, Description, Effective Date, HIPAA Claim Status Code, and HIPAA Entity ID.

EOB #	Type	Description	Effective Date	HIPAA Claim Status Code	HIPAA Entity ID
0057	INVALID	TYPE OF BILL FOR CORF/ORF PROVIDER SPECIALTY.	01/01/1990		
0204	INVALID	DIAGNOSIS CODE, CONTACT THE DEPARTMENT FOR MEDICAID SERVICES.	01/01/1990		
0409	INVALID	PROVIDER TYPE BILLED ON CLAIM FORM.	01/01/1990		
0753	INVALID	REVENUE CODE, CHARGES NOT ALLOWED.	01/01/1990		
0773	INVALID	DUR CONFLICT CODE.	01/01/1990		
0774	INVALID	DUR INTERVENTION CODE.	01/01/1990		
0775	INVALID	DUR OUTCOME CODE.	01/01/1990		
1643	INVALID	OTHER COVERAGE CODE.	01/01/2005		
2104	INVALID	PROVIDER SPECIALTY FOR PROCEDURE	01/01/1990	145	1P
2105	INVALID	DIAGNOSIS FOR PROCEDURE	01/01/1990	255	

Figure 26 EOB (located in Reference)

The screenshot shows the 'EPSDT' section of the application. Under 'Related Data', the 'Other' link is highlighted in red. Below this, there is a table of dental services with columns for Description, M6-12, M12-24, Y2-6, Y6-12, and Y12-21. Below the table is a form to add or update a dental schedule entry, with fields for Description, M6-12, M12-24, Y2-6, and Y12-21.

Description	M6-12	M12-24	Y2-6	Y6-12	Y12-21
Oral Hygiene Counseling (2)	P	P	P	P	P
Injury Prevention Counseling (3)	P	P	P	P	P
Dietary Counseling (4)	P	P	P	P	P
Counseling for Non-nutritive H	P	P	P	P	P
Fluoride Supplementation (6)	P	P	P	P	P
Assess Oral Growth & Developme	P	P	P	P	P
Clinical Oral Exam	P	P	P	P	P
Prophylaxis and Topical Fluori	-	-	P	P	P
Radiographic Assessment (9)	-	P	P	P	P
Treatment of Dental Diijury	P	P	P	P	P
Assessment & Treatment of Deve	-	-	P	P	P
Substance Abuse Counseling	-	-	-	P	P
Referral for regular and Perio	-	-	-	-	P
Anticipatory Guidance (10)	P	P	P	P	P

Figure 27 Dental Schedule (located in EPSDT)

8.2.5.3 Related Data Cross-Reference (Xref) Page

The Related Data Xref page allows the user to access the various cross-reference data tables maintained within the associated subsystem area.

The following subsystems contain a Related Data Xref page: Reference, Member, TPL, and Managed Care. Listed below are examples of “Xref” panels that can be found in Related Data:

Click on “Xref” to access these links.

The screenshot shows the 'Managed Care' subsystem interface. The 'Related Data' section is active, and the 'Xref' link is highlighted. Below it, the 'MC Program Code Group/Program Code Xref' table is displayed with columns for Program Code Group, Description, Effective Date, End Date, and MC Program.

Program Code Group	Description	Effective Date	End Date	MC Program
OWL	C,W,L,N,E,T	01/01/1964	12/31/2399	PARTNERSHIP
IP	I,P	01/01/1964	12/31/2399	PARTNERSHIP
IYP	I,Y,PE	01/01/1964	12/31/2399	PARTNERSHIP
PSK	P,S,X,KC	01/01/1964	12/31/2399	PARTNERSHIP
AAP	A,AP,B,BP,D,DP,F,FP,H,HP,G,GP,J,K,M	01/01/1964	12/31/2399	PARTNERSHIP
IY	I,Y	01/01/1964	12/31/2399	PARTNERSHIP
PE	PE	01/01/1964	12/31/2399	PARTNERSHIP
ALL	ALL	01/01/1964	12/31/2399	KENPAC
ALL	ALL	01/01/1964	12/31/2399	LOCK-IN (MEDICAL)
ALL	ALL	01/01/1964	12/31/2399	NON-EMERGENCY MEDICAL TRANSPORTATION

Below the table, a section titled '--Program Code Group Breakdown--' provides further details for the selected group.

Program Code / Description	Effective Date	End Date
C / Childn and their caretaker rel who rec KTAP	01/01/1964	12/31/2399
E / Childn & caregiv who do not rec a KTAP pymnt	01/01/1964	12/31/2399
L / Childn and their caretaker rel	01/01/1964	12/31/2399
N / Indiv who meet all the req for pgm code L	01/01/1964	12/31/2399
T / Fams and childn who are the same as pgm code W	01/01/1964	12/31/2399
W / Childn and their caretaker rel who rec KTAP	01/01/1964	12/31/2399

Figure 28 MC Program Code Group/Program Code Xref (located in Managed Care)

The screenshot shows the 'TPL' subsystem interface. The 'Related Data' section is active, and the 'HIPAA Relationship' link is highlighted. Below it, the 'HIPAA Relationship' table is displayed with columns for HIPAA Relationship and Description.

HIPAA Relationship	Description
1	SPOUSE
10	FOSTER CHILD
15	WARD
17	STEPSON OR STEPDAUGHTER
18	SELF
19	CHILD
20	EMPLOYEE
21	UNKNOWN
22	HANDICAPPED DEPENDENT
23	SPONSORED DEPENDENT

Below the table, a form titled 'HIPAA Relationship' allows for adding or updating a relationship. It includes a 'Description' field and 'delete' and 'add' buttons.

Figure 29 Local/HIPAA Relationship Code (located in TPL)

8.2.5.4 Related Data Report Distribution Page

The Reference subsystem contains a Related Data Report Distribution page. Listed below is an example of a Report Distribution panel:

Click on "Rpt Dist" to access these links.

The screenshot displays the 'Report Route' page. At the top, there is a navigation menu with 'Reference' selected. Below the menu, there are tabs for 'Report', 'Report Control', and 'Report Destination'. The 'Report' tab is active, showing a 'Report Route' section with a search bar and a 'Search Results' table. The table lists various report routes with columns for Environment, Report Name, Hold, Output Name, and Destination. Below the table, there are input fields for 'Report Name', 'Output Name', 'Control File Name', 'Hold', and 'Report Destination'. A 'Report Distribution' section is also visible at the bottom of the page.

Figure 30 Report Route (located in Reference)

8.2.5.5 Related Data Payee Page

The Financial subsystem contains a Related Data Payee page. This page contains the link for one panel – EFT Account.

Click on "Payee" to access the EFT Account link.

The screenshot shows the 'EFT Account' page with a table of 'EFT Account Information' and a form for adding or updating an account.

Payee	Payee Name	Payee Type	Financial Cycle	Financial Institution	Account Type	EFT Status
00000000	WOODS	Provider	PRIMARY FIN CYCLE	EASTERN BANK	Checking	Prenotification
00000000	ORTHOPAEDIC CTR	Provider	PRIMARY FIN CYCLE	EASTERN BANK	Checking	Prenotification
00000000	WRIGHT STATE PH	Provider	PRIMARY FIN CYCLE	EASTERN BANK	Checking	Prenotification
00000000	PO	Provider	PRIMARY FIN CYCLE	EASTERN BANK	Checking	Prenotification
00000000	TOUSSAINT	Provider	PRIMARY FIN CYCLE	EASTERN BANK	Checking	Prenotification
00000000	ANDERSON III	Provider	PRIMARY FIN CYCLE	EASTERN BANK	Checking	Prenotification
00000000	GOLDBLATT	Provider	PRIMARY FIN CYCLE	EASTERN BANK	Checking	Prenotification
00000000	ALBERT	Provider	PRIMARY FIN CYCLE	EASTERN BANK	Checking	Prenotification
00000000	BURDETTE	Provider	PRIMARY FIN CYCLE	EASTERN BANK	Checking	Prenotification
00000000	BIOSCRIP PHARMA	Provider	PRIMARY FIN CYCLE	BANK OF AMERICA, N.A.	Checking	Prenotification

Form fields for adding/updating an account:

- Payee Type: [Dropdown]
- Payee ID: [Text] [Search]
- Financial Institution: [Text] [Search]
- Account Type: [Dropdown]
- EFT Status: [Dropdown]
- EFT Begin Date: [Text]
- EFT End Date: [Text]
- Last Change Date: [Text]

Figure 31 EFT Account (located in Financial)

8.2.6 Personal Settings

The Site subsystem allows the user to activate or modify personal settings. Click on the Site link and the following page will be displayed:

The screenshot shows the 'Personal Settings' page with various checkboxes and a dropdown menu.

- Activate Dropdown Menus
- Activate Popup Searches
- Activate Row Selection Links
- Open Information Panel in Different Browser
- Activate Keyboard Accessible Field Help
- Activate Linearized Tables
- Activate Focus Return
- Activate Shortcut Keys
- Shortcut Key Display Mode: ADA Mode [Dropdown]

[update]

Field	Description
Activate Dropdown Menus	<p>If enabled, a drop down menu will display when scroll the mouse over the subsystem menu.</p> <p>If disabled, a drop down menu will not display.</p>
Activate Popup Searches	<p>If enabled, popup searches will be accessible by clicking the “[Search]” link next to some fields.</p> <p>If disabled, popup searches will not be available.</p>
Activate Row Selection Links	<p>If enabled, a link will be added at the beginning of each row in a list. To select a row, the user will click on the link.</p> <p>If disabled, there will not be a link and the user will click on the row itself to select a row.</p>
Open Information Panel in Different Browser	<p>If enabled, when a record is selected from search results, a different browser window will open, displaying the record selected.</p> <p>If disabled, a different browser window will not open. The selected record will be displayed in the same browser window as the search result panel.</p>
Activate Keyboard Accessible Field Help	<p>If enabled, the help feature for a field will be accessible by pressing ENTER on the keyboard.</p> <p>If disabled, the help feature will be accessible by clicking on the field name with the mouse.</p>
Activate Linearized Tables	<p>If enabled, the fields on a page and panel will be displayed in one column.</p> <p>If disabled, the fields on a page and panel will be displayed in two or more columns.</p>
Activate Focus Return	<p>If enabled, the cursor placement will be handled automatically, which will eliminate the need for the user to scroll and click on fields after a page navigation or refresh.</p> <p>If disabled, the cursor will not automatically return to the last field.</p>
Activate Shortcut Keys	<p>If activated, the system will enable shortcut keys and display shortcut key indicators on buttons and menu links.</p> <p>If disabled, the user will navigate the system by clicking on menu links and buttons with the mouse.</p>

Field	Description
Shortcut Key Display Mode	The mode in which the shortcut key is displayed: ADA Mode or Underlined.
Update	Updates changes to the Personal Settings fields.
Last Update	Indicates date and time of most recent update to personal settings.

To activate a personal setting, click to insert a check mark in the associated box, and then click the “Update” button.

To disable a personal setting, click to remove the check mark in the associated box and click the “Update” button.

The following personal setting functions are demonstrated in the next sections: Popup Searches, Row Selection Links, Linearized Tables, and Shortcut Keys.

8.2.6.1 Pop Up Searches

If the user activates the pop up searches function, the [Search] link located next to certain fields will become accessible.

If the pop up search function is not enabled, the [Search] link will not be displayed, as shown in Figure 32.

The screenshot displays the 'Claim Search' page in the KyHealth Choices system. The page header includes the Kentucky logo and navigation links like Home, Claims, Reference, Provider, Member, Financial, EPSDT, TPL, Managed Care, MAR, Prior Authorization, CTMS, Security, Site, Admin, and Host. The search form contains several input fields: ICN, Member ID, TCN, Provider Number, Rendering Provider, Prescription Number, and Referring Provider. There is also an unchecked checkbox for 'Include Pharmacy Claims' and a 'Records' dropdown menu currently set to 20. On the right side of the form, there are three buttons: 'search', 'clear', and 'adv search'. The page also shows the user is an 'anonymous user' and the date is 'Friday, November 09, 2007'.

Figure 32 Claims Search Page without Pop Up Searches

To activate the pop up searches, click on the Site link, check “Activate Popup Searches”, and click the “Update” button.

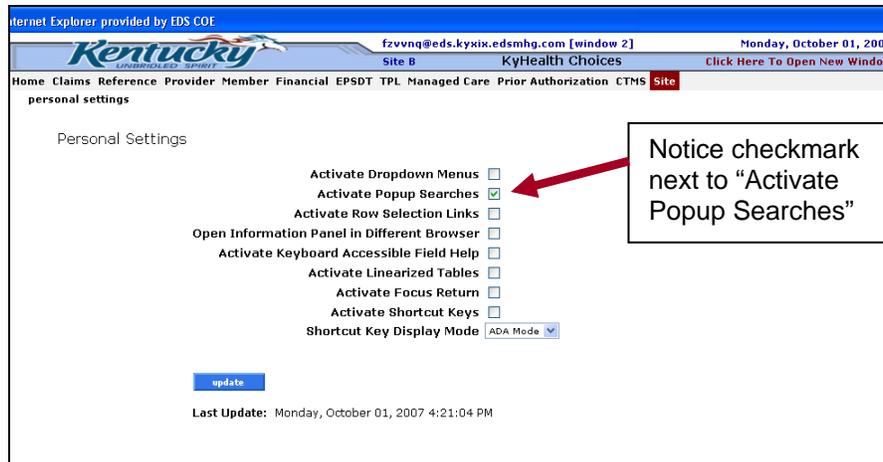


Figure 33 Personal Settings Page – Activate Popup Searches

The pop up search links are now accessible.

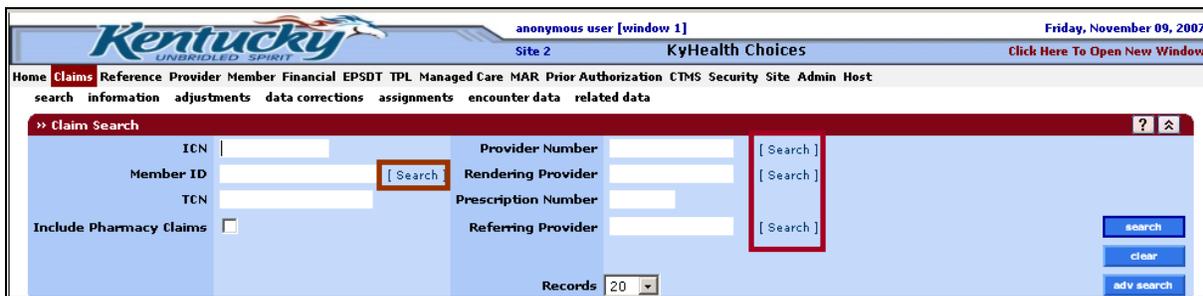


Figure 34 Claims Search Page with Pop Up Searches

8.2.6.2 Row Selection Links

The “Activate Row Selection Links” field determines how a user will select a row of records.

To activate the row selection links, click on the Site link, check “Activate Row Selection Links”, and click the blue “Update” button.

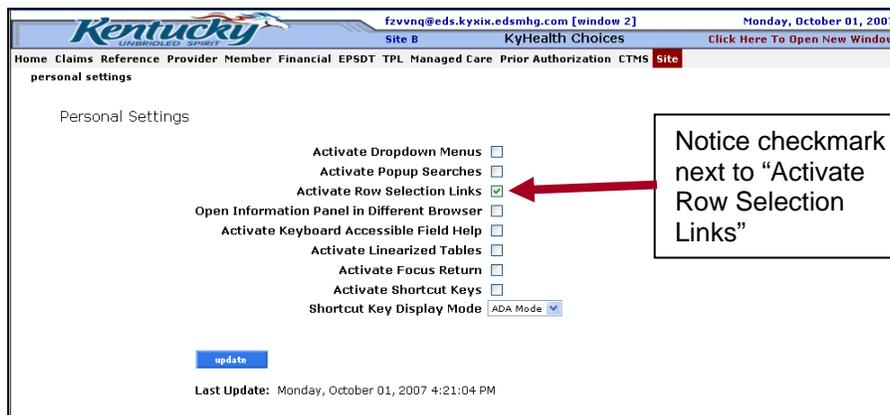
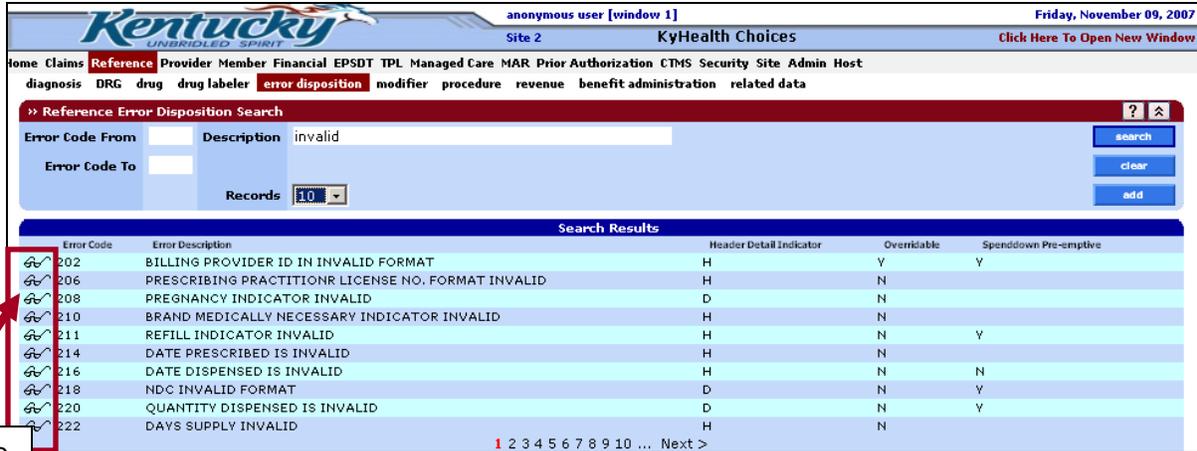


Figure 35 Personal Settings Page – Activate Row Selection Links

When activated, the user will select a row by clicking on the link next to the row.



Click on link to select a row.

Figure 36 Row Selection Link

If the Row Selection Links is disabled, the link next to the row will not be available. The user will select a row by clicking once anywhere within the row itself (except on a Hot Link, as discussed in a previous section).

8.2.6.3 Linearized Tables

The “Activate Linearized Tables” function determines how fields are displayed on a pages and panels.

To activate the linearized table function, click on the Site link, check “Activate Linearized Tables”, and click the blue “Update” button.

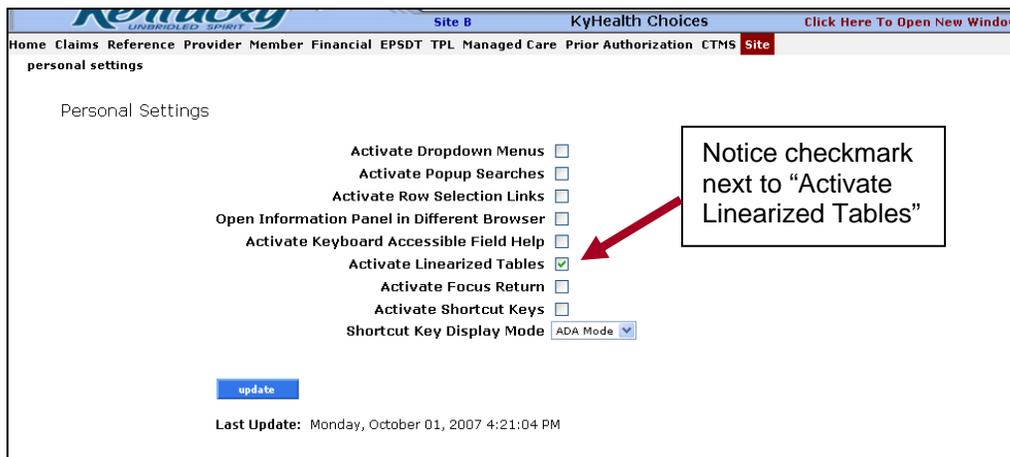


Figure 37 Personal Settings Page – Activate Linearized Tables

When activated, the linearized table function will display the fields in one column on a page and panel.

The screenshot shows the 'Provider Search' panel in the 'KyHealth Choices' system. The search criteria are listed in a single column on the left side of the panel, including: Provider Number, License, Medicare, UPIN, Tax ID, CLIA Number, NPI, SSN, Business OR Last Name, First, MI, Type, Specialty, Contract, County, Zip Code, Sounds-like, Electronic Billing Status, and Contract Status. There are search and clear buttons at the bottom right, and a 'Records' dropdown set to 20 at the bottom left.

Figure 38 Provider Search Panel with a Linearized Table

If the linearized table function is disabled, the fields will be displayed in two or more columns.

The screenshot shows the 'Provider Search' panel in the 'KyHealth Choices' system. The search criteria are displayed in two or more columns. The criteria include: Provider Number, License, Medicare, UPIN, Tax ID, CLIA Number, NPI, SSN, Business OR Last Name, First, MI, Type, Specialty, Contract, County, Zip Code, Sounds-like, Electronic Billing Status, and Contract Status. There are search and clear buttons at the bottom right, and a 'Records' dropdown set to 20 at the bottom left.

Figure 39 Provider Search Panel without a Linearized Table

8.2.6.4 Shortcut Keys

If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + focus key) to quickly open the associated page.

To activate the shortcut key, click on the Site link, check “Activate Shortcut Keys”, and select the Shortcut Key Display Mode (either “Underline” or “ADA Mode”). Click the blue “Update” button.

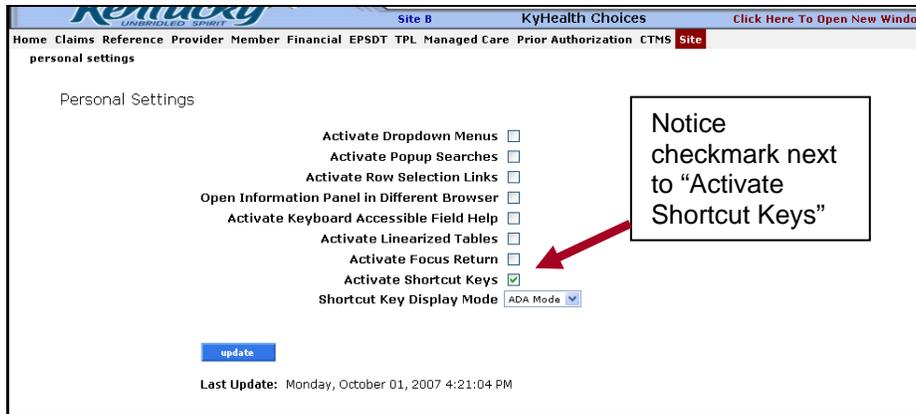
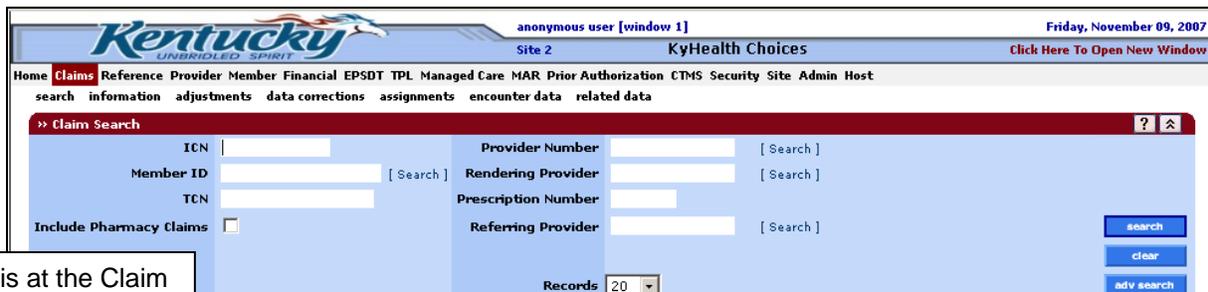


Figure 40 Personal Settings Page – Shortcut Key Activated

To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name.

If the “Underline” display mode is selected, the shortcut key will be displayed within the sub menu name. Within the name, the letter that has a horizontal bar above and below it is the shortcut key letter.

Figure 41 demonstrates how the user can use the shortcut keys to quickly navigate from the Claims Search panel to the Data Corrections panel by using the following shortcut key combination: (Ctrl + Alt + O) since the letter “O” is found within the horizontal bars on the Sub Menu adjustment link.



To jump to the Data Corrections Panel, (shows underline mode) the user presses Ctrl+Alt+O

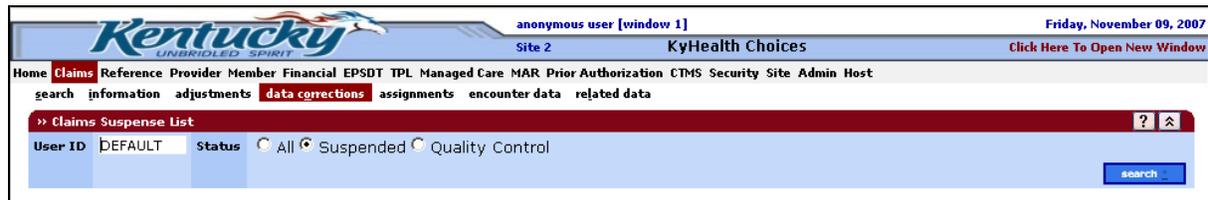


Figure 41 Shortcut Key – Jump from Search Page to Data Corrections Page

If the “ADA Mode” is selected as the display mode, the shortcut key will be displayed to the right of the sub menu name in brackets [].

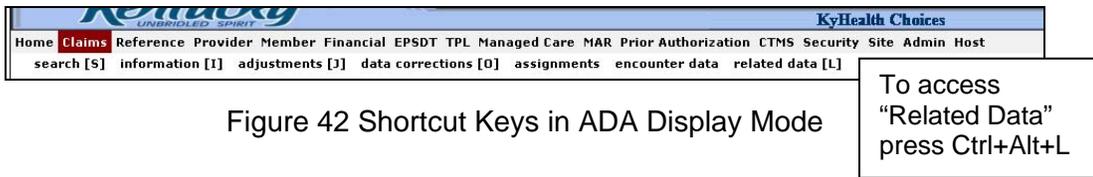


Figure 42 Shortcut Keys in ADA Display Mode

8.2.6.5 Drop Down Menus

If the user activates the drop down menu function, a drop down menu will display when the mouse is scrolled over the subsystem menus. Each submenu within the subsystem will display.

If the drop down function is not enabled, then the menu is displayed horizontally across the page.

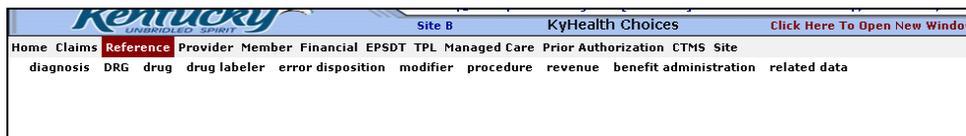


Figure 43 Subsystem Menu Without the Drop Down Menu Function

To active the shortcut key, click on the Site link, check “Activate Dropdown Menus”. Click the blue “Update” button.

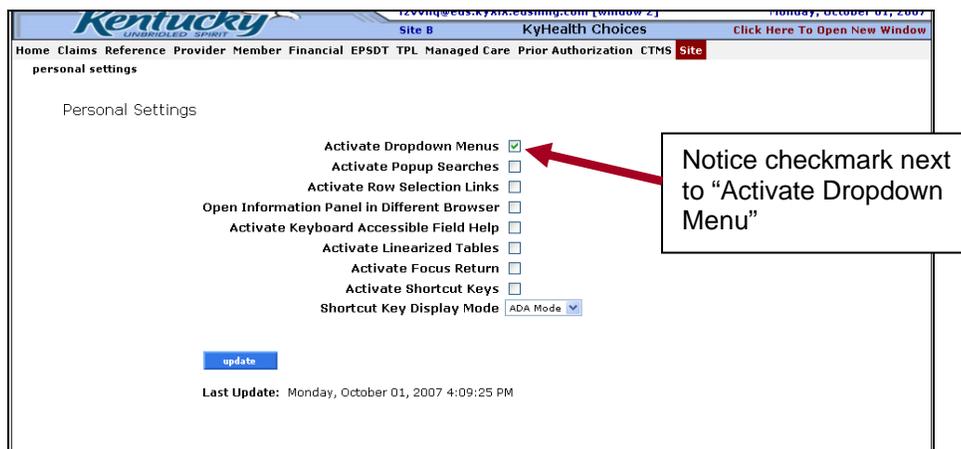


Figure 44 Personal Settings Page – Dropdown Menu Activated

If the dropdown menu is activated, the submenu will be displayed in the dropdown menu when the mouse is scrolled over the subsystem menu.



Figure 45 Dropdown Menu Displayed

8.2.6.6 Opening the Information Panel in a Different Browser Window

If the user activates the different browser window function, the user can select a search result from the search panel, and the selected record will open in a different browser window. Then the user will have two different browser windows open.

If the user does not activate this function, then only one browser window will be open. When a record is selected from the search results panel, the record will display in the same browser window as the search panel.

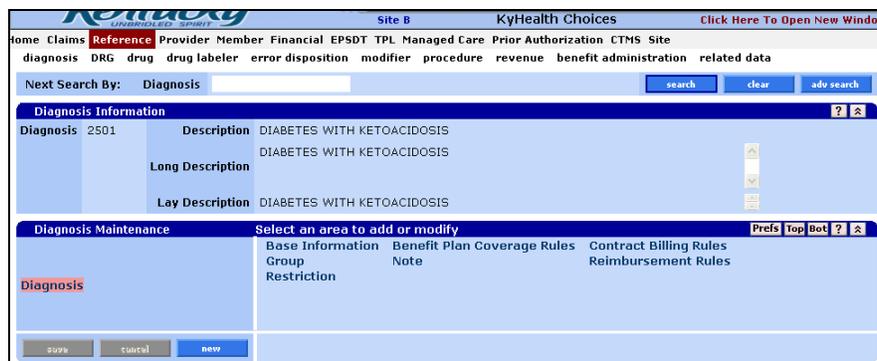


Figure 46 Diagnosis Information Panel (One Browser Window)

To active the shortcut key, click on the Site link, check “Open Information Panel in Different Window”. Click the blue “Update” button.

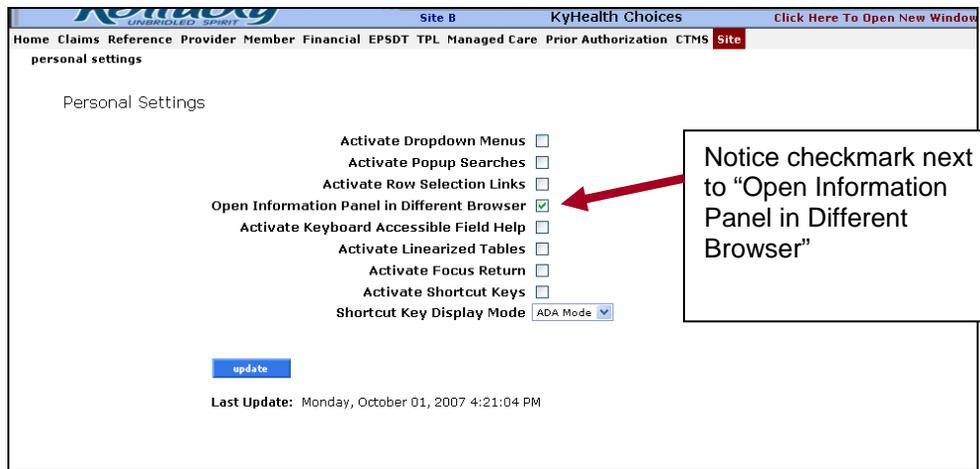


Figure 47 Personal Settings Page – Different Browser Function Activated

If the different browser function is activated, two browser windows will display. One window displayed the search results panel and the other window will display the record.

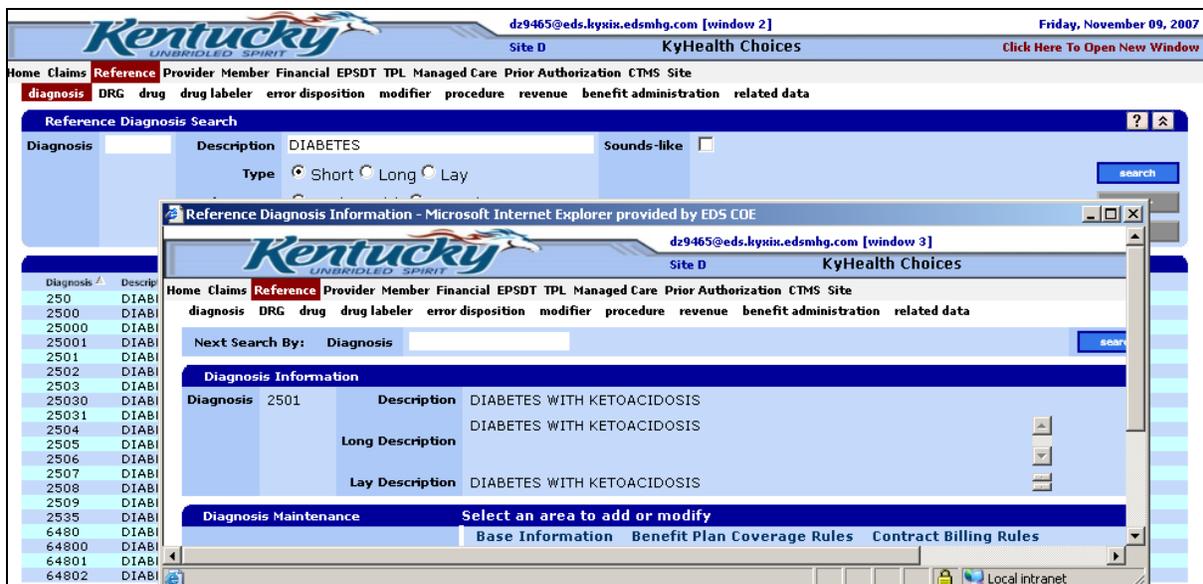


Figure 48 Two Browser Windows Displayed

Diagnosis Search Panel and Diagnosis Information Panel

9 Appendix B - Service Authorization How To Guide

9.1 Searching for Prior Authorization Information

9.1.1 How to Search for a Prior Authorization (PA)

STEP 1. Access interchange

STEP 2. Select Prior Authorization from the Main Menu.



STEP 3. The Prior Authorization Search panel will open. Enter the search criteria.

PA Search Panel

9.1.1.1 Prior Authorization Search Panel Field Descriptions

Field Selection	Description
Prior Authorization Number	Prior Authorization Number is the unique identifier for PA.
Requesting Provider ID	Unique identifier for provider requesting services for member on PA.
Clerk Keyed	Unique identifier for clerk who entered PA.
PA Category Code	Code that groups a PA's requested services under a type such as dental, inpatient, and physician.
Member ID	The member's 10-digit KY Medicaid ID number. Field is numeric only.
Servicing Provider ID	Unique identifier for provider performing services for member specified on PA.
Authorizer	Unique identifier for person authorizing services on PA.
Primary Diagnosis Code	Main reason service is being authorized.
Case Number	To group PAs for a member that are a result of a specific episode of care. maxMC issues a Case Number for this purpose.
Records	Maximum number of records displayed on panel when search results are displayed.

9.1.1.2 Prior Authorization Search Panel Button Descriptions

Button	Descriptions
Search	Activates search of MMIS for any information matching data in search criteria.
Clear	Clears all fields in search criteria.
Adv Search	Expands search criteria to include more options.
Add	Adds information entered to MMIS.

STEP 4. Click on “Search” in the bottom right corner of the panel.

STEP 5. The results will be displayed in rows. If the search returns multiple results, select the record by clicking on the eyeglass icon one time.

Search Results												
PA Number	Line Item	Authorization Effective Date	Authorization End Date	PA Category Code	Requesting Provider ID	Servicing Provider ID	Servicing Code Number From	Servicing Code Number To	PA Status	Member ID	Case Number	Legacy PRO Cert Number
	0000000000	01	12/07/2001	01/05/2002	Home Health	00000000	00000000	570	Approved	0000000000		
	0000000000	01	12/14/2001	01/12/2002	Home Health	00000000	00000000	570	Approved	0000000000		
	0000000000	02	12/14/2001	01/12/2002	Home Health	00000000	00000000	270	Approved	0000000000		
	0000000000	01	12/20/2001	01/18/2002	Home Health	00000000	00000000	570	Approved	0000000000		
	0000000000	01	12/21/2001	01/20/2002	Home Health	00000000	00000000	570	Approved	0000000000		
	0000000000	01	12/23/2001	01/21/2002	Home Health	00000000	00000000	570	Approved	0000000000		
	0000000000	02	12/23/2001	01/21/2002	Home Health	00000000	00000000	279	Approved	0000000000		
	0000000000	03	12/23/2001	01/21/2002	Home Health	00000000	00000000	270	Approved	0000000000		
	0000000000	01	12/27/2001	01/25/2002	Home Health	00000000	00000000	570	Approved	0000000000		
	0000000000	02	12/27/2001	01/25/2002	Home Health	00000000	00000000	279	Approved	0000000000		
	0000000000	03	12/27/2001	01/25/2002	Home Health	00000000	00000000	270	Approved	0000000000		
	0000000000	01	12/18/2001	12/31/2001	Home Health	00000000	00000000	550	Approved	0000000000		
	0000000000	02	12/18/2001	01/16/2002	Home Health	00000000	00000000	270	Approved	0000000000		
	0000000000	03	12/18/2001	01/16/2002	Home Health	00000000	00000000	570	Approved	0000000000		
	0000000000	01	12/19/2001	01/17/2002	Home Health	00000000	00000000	550	Approved	0000000000		
	0000000000	02	12/19/2001	01/17/2002	Home Health	00000000	00000000	570	Approved	0000000000		
	0000000000	03	12/19/2001	01/17/2002	Home Health	00000000	00000000	270	Approved	0000000000		
	0000000000	01	12/22/2001	01/20/2002	Home Health	00000000	00000000	430	Approved	0000000000		
	0000000000	02	12/22/2001	01/20/2002	Home Health	00000000	00000000	420	Approved	0000000000		
	0000000000	03	12/22/2001	01/20/2002	Home Health	00000000	00000000	270	Approved	0000000000		

PA Search Results Panel

9.1.1.3 Prior Authorization Search Results Panel Field Descriptions

Field	Descriptions
PA Number	Prior Authorization Number is a unique identifier for a PA.
Line Item	Two characters that sequentially lists the services included on a PA. The characters are 01 through 99. The Line item is automatically generated.
Authorization Effective Date	Begin date of the date range for which the service is approved for use by a member.
Authorization End Date	Date showing the last date an authorized service can be used by a member.

PA Category Code	Code that groups a PA's requested services under a type such as dental, inpatient, PT, and OT.
Requesting Provider ID	Unique identifier for the provider requesting services for a member.
Servicing Provider ID	Unique identifier for the provider performing the services for a member.
Servicing Code Number From	Code identifying a specific accommodation or ancillary service.
Servicing Code Number to	Ending revenue code for a range of revenue service codes.
PA Status	Status (pending, void) or a decision (approved, denied) on a line item.
Member ID	The member's 10-digit <i>KY Medicaid</i> ID number. Field is numeric only.
Case Number	To group PAs for a member that are a result of a specific episode of care. maxMC issues a Case Number for this purpose.
PRO Cert Legacy Number	The Legacy Peer Review Organization Certification Number.

The PA Information panel will open.

The screenshot displays two panels from the software interface. The top panel, titled "Prior Authorization Information", is a data entry form with a blue header and a light blue background. It is organized into three columns. The first column contains fields for PA Number, Legacy PRO Cert Number, Authorizer, Date Received (05/17/2007), Review Date, Update Received Date, Update Reviewed Date, Date Mailed, Additional Diagnosis Codes (checkbox), Internal Text (checkbox), and Super PA (checkbox). The second column contains fields for Member ID, Member Last Name, Member First Name, Member Date Of Birth, Clerk Keyed, Date Keyed (05/17/2007), Admission Date, Discharge Date, Accident (NO), Special Considerations (NO), Emergency (NO), Nursing Facility Type, and Ortho Status Code. The third column contains fields for Requesting Provider Number, Servicing Provider Number, Service Provider Check (All Service Providers), PA Category Code, Case Number, Fund Code, Primary Diagnosis Code, Case Management (NO), Disease Management (NO), Media Type, and Print Option (NO PRINT). The bottom panel, titled "Prior Authorization Maintenance", has a blue header with the instruction "Complete the Panels below then select Save to add the new Prior Authorization." and a "Prefs Top Bot ?" menu. It features a "Prior Authorization" section with a "Line Item" field containing "Super PA" and a "save" button next to a "cancel" button.

PA Information and Maintenance Panels

9.1.1.4 Prior Authorization Information Panel Field Descriptions

Field	Description
PA Number	Prior Authorization Number is unique identifier for PA.
Legacy PRO Cert Number	The Legacy Peer Review Organization Certification Number.
Authorizer	Unique identifier for person authorizing services on PA.
Date Received	Date PA request was received on site.
Review Date	Date PA was reviewed.
Update Received Date	Date update was received on site.
Update Reviewed Date	Day update was reviewed.
Date Mailed	Date mailed to provider.
Additional Diagnosis Codes	Any more relevant diagnosis codes besides primary diagnosis.
Internal text	Checked Internal Text box indicates there is internal text for PA.
Super PA	Checked Super PA box indicates there is Super PA data for PA.
Member ID	The member's 10-digit KY Medicaid ID number. Field is numeric only.
Member Last Name	Last name of member as shown on MMIS.
Member First Name	First name of member as shown on MMIS.
Member Date of Birth	Date of birth of member as shown on MMIS.
Clerk Keyed	ID of the clerk who entered the PA.
Date Keyed	Date PA was Typed into system.
Admission Date	Date member was admitted to facility.
Discharge Date	Date member was discharged from facility.
Accident	Checked box indicates PA is result of member's involvement in an accident.
Special Considerations	Indicates if there are special considerations concerning PA.
Emergency	Indicator is set to "Yes" when a member's condition requires an emergency or urgent service.

Field	Description
Nursing Facility Type	The valid values for Nursing Facility Type of service are Brain Injury, BI Locked Unit, Nursing facility, Infectious Disease, Ventilator.
Ortho Status Code	The PA Orthodontic Status Code is used to track receipt of the documentation from the provider.
Requesting Provider Number	Unique identifier for provider requesting services for member on PA request.
Servicing Provider Number	Unique identifier for provider performing services for member specified on PA request.
Service Provider Check	An indicator specifying the type of provider validation required.
PA Category Code	Code that groups a PA's requested services under a type such as Dental, In-patient, and Nursing Facility.
Case Number	The Case Number used in maxMC to group PAs by an episode of care.
Fund Code	Source of funds for payment of authorized services.
Primary Diagnosis Code	Member's primary diagnosis.
Case Management	Case Management indicators be displayed in Service/Prior Authorization. The Member Subsystem Case and Disease Management indicators will be checked to see if there are any in effect for the Member.
Disease Management	Disease Management indicators be displayed in Service/Prior Authorization. The Member Subsystem Case and Disease Management indicators will be checked to see if there are any in effect for the Member.
Media type	Description of medium by which PA request is received.
Print Option	Print option for PA notice. Options are Batch (B), Internal (I), No Print (N), and Online (O).

9.2 How to Add/Update Prior Authorization (PA) Information

9.2.1 How to Add a Prior Authorization File

- STEP 1. Access interchange
- STEP 2. Select Prior Authorization from the Main Menu.



InterChange Home Page

The PA Search panel will open.

STEP 3 Select the “Add” button by clicking on it one time.

Prior Authorization Search Panel

9.2.2 Prior Authorization/Search Panel Field Descriptions

Field	Description
Prior Authorization Number	Prior Authorization Number is the unique identifier for PA.
Requesting Provider ID	Unique identifier for provider requesting services for member on PA.
Clerk Typed	Unique identifier for clerk who entered PA.
PA Category Code	Code groups PAs requested services under type such as dental, inpatient, and physician.
Member ID	Member's unique 10 digit Medicaid ID.
Servicing Provider ID	Unique identifier for provider performing services for member specified on PA.
Authorizer	Unique identifier for person authorizing services on PA.
Primary Diagnosis Code	Main reason service is being authorized.
Records	Maximum number of records displayed on panel when search results are displayed.

Field	Description
Case Number	Case Number.

9.2.3 Prior Authorization/Search Panel Button Descriptions

Button	Descriptions
Search	Activates search of MMIS for any information matching data in search criteria.
Clear	Clears all fields in search criteria.
Adv Search	Expands search criteria to include more options.
Add	Adds information entered to MMIS.

The Information, Base Information, Maintenance, and Line Item panels will open.

STEP 4 Enter the new file information into the fields of the Base Information panel.

The screenshot shows a web-based form titled "Base Information". The form is organized into two columns. The left column contains fields for: PA Category (HOME HEALTH), Requesting Provider Number (00000000), Service Provider Check (Specified Service Provider), Servicing Provider Number (00000000), Member ID* (000000000), Emergency (No), Accident (No), Special Considerations (No), Nursing Facility Type, and Ortho Status Code. The right column contains: Primary Diagnosis Code, Authorizer (CONVR64), Fund Code, Print Option (No Print), Admission Date, Discharge Date, Received Date (12/10/200), Update Received Date (12/14/200), and Update Reviewed Date (12/14/200). The form has a blue background and a red border.

Base Information Panel

9.2.4 PA/Information/Maintenance/Base Information Panel Field Descriptions

Field	Description
PA Category	Prior Authorization category used to batch PA requests (e.g. Waiver, Inpatient, DME, Physician).
Requesting Provider Number	Unique identifier for provider requesting services for member on PA request.
Service Provider Check	An indicator specifying the type of provider validation required.
Servicing Provider Number	Unique identifier for provider performing services for member specified on PA request.
Member ID	Member's unique 10 digit Medicaid ID.

Field	Description
Emergency	Indicator used to identify authorization as an emergency 72-hour supply of drugs.
Accident	Indicator used to identify that Prior Authorization services requested for the member are due to an accident; as a result, costs may need to be recovered through Third Party Liability (TPL).
Special Considerations	Indicator used to identify Prior Authorization should receive special consideration.
Nursing Facility Type	The valid values for Nursing Facility Type of service are Brain Injury, BI Locked Unit, Nursing facility, Infectious Disease, Ventilator.
Ortho Status Code	The PA Orthodontic Status Code is used to track receipt of the documentation from the provider. Based on the code and the service begin date of the PA, reminder letters are sent to providers and reports created of PAs with overdue documentation.
Primary Diagnosis Code	A member's primary diagnosis.
Authorizer	ID of person who authorized services on Prior Authorization.
Fund Code	Funding source assigned for payment of authorized services. Fund Code is not used by Kentucky MMIS.
Print Option	Print option for PA notice. Options are batch, internal, online, or no print (default). Since PA letters are maintained and generated by KMAA, print option is set to no print.
Admission Date	First date of an institutional stay.
Discharge Date	Last day of an institutional stay.
Received Date	Date KMAA received Prior Authorization request from provider.
Update Received Date	Date KMAA received Prior Authorization update request from provider.
Update Reviewed Date	Date KMAA reviewed Prior Authorization update request sent in by provider.

STEP 5 Go to the Line Item panel and click the “Add” button to activate the fields. A new row is highlighted with an “A” at the beginning. This is a visual clue that the new file has been opened.

Line Item Panel

9.2.5 Prior Authorization/Information/Maintenance /Line Item Panel Field Descriptions

Field	Description
Line Item number	Two characters sequentially list items pertaining to PA. Characters are 01 through 99. Line item is automatically generated.
Service Type Code	Indicates code set to use for validation of requested service: procedure, revenue, or drug.
Revenue Code	Code identifying specific accommodation or ancillary service.
Procedure Code From	Beginning code for service being provided.
Modifier 1	First modifier of procedure code.
Modifier 2	Second modifier of procedure code.
Modifier 3	Third modifier of procedure code.
Modifier 4	Fourth modifier of procedure code.
PA Line Item Status	Status (for example, pending) or decision (for example, approved, denied) for service.

Field	Description
Revenue Code To	Revenue code ends range of revenue code specified for service.
Procedure Code To	Ending code for services being provided.
Quad	Tooth quadrant used in combination with tooth number and procedure code to provide more information concerning service. Valid values are: 10 20 30 40
Tooth	Tooth number used in combination with procedure code to provide more information concerning service.
NDC Lock	If 'Yes', prior authorization is locked into to NDC that is listed. If 'No', then authorization is for GCN sequence number represented by NDC entered in service code. Field is hidden unless service code is an NDC.
NDC Code	National Drug Code used to uniquely identify drug.
Subcontractor Tax ID	Field used for PAs received before 11/1/2002 to designate actual Service Provider since all PAs were initially issued for providers '29000015' (DMHMR) or '29000023' (DCBS).
Requester Effective Date	Requested date authorization is effective.
Requester End Date	Date requested service would end for member.
Requested Frequency	The field is used in conjunction with the Frequency Quantity field to specify requested rate of usage. The field is informational only. Valid values are M = Month and W = Week
Requested Frequency Units	The field is used in conjunction with the Frequency field to indicate requested rate of usage. The field is informational only.
Requested Units	Number of units requested of product or service.
Requested Dollars	Dollar amount requested for service for member.
Authorized Effective Date	Begin date of date range for which service is approved for use by member.
Authorized End Date	Date showing last date an authorized service can be used by member.
Authorized Frequency	The field is used in conjunction with the Frequency Quantity field to specify authorized rate of usage. The field is informational only. Valid values are M = Month and W = Week

Field	Description
Authorized Frequency Units	The field is used in conjunction with the Frequency field to indicate authorized rate of usage. The field is informational only.
Authorized Units	Unit amount authorized for service.
Authorized Dollars	Dollar amount authorized for service.
Payment Method	Payment method is used during claim adjudication to determine how claim should be paid. Valid payment methods are: pay unit fee price specified on service request, pay system price specified on fee schedule, pay up to capitation amount specified on service request.
Quantity Used Units	Number of units used by member of an approved service.
Quantity Used Dollars	Dollar amount of an approved service used by member.
Balance Units	Number of units remaining on PA line item.
Balance Dollars	Remaining dollars of service available for use by member.

9.2.6 Prior Authorization/Information/Maintenance /Line Item Panel Button Descriptions

Button	Descriptions
Add	Adds information entered to MMIS.

STEP 6 Enter new file information into the fields of the Line Item panel.

STEP 7 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

Message Description	Panel	Field	Row
A valid Reason Code is required	Line Item	Reason Code	1

STEP 8 (Reason Code was omitted) Correct errors and save. Message Description will show “Save was Successful” after a successful save.

Message Description	Panel	Field	Row
Save was Successful. All panels were saved.	Base Information		1

Save was successful. A PA Number has been assigned to the file automatically. This can be seen in the PA Information panel.

Prior Authorization Information			
PA Number	1000000000	Member ID	0000000000
Legacy PRD Cert Number		Member Last Name	B
Authorizer	CONVR64	Member First Name	DOROTHY
Received Date	12/10/2000	Member Date Of Birth	12/28/1920
Review Date	12/14/2000	Clerk Keyed	CONVR64
Update Received Date	12/14/2000	Date Keyed	12/14/2000
Update Reviewed Date	12/14/2000	Admission Date	
Date Mailed		Discharge Date	
Additional Diagnosis Codes	<input type="checkbox"/>	Accident	NO
Internal Text	<input type="checkbox"/>	Special Considerations	NO
Super PA	<input type="checkbox"/>	Emergency	NO
		Nursing Facility Type	
		Ortho Status Code	
		Requesting Provider Number	00000000 MCD
		Servicing Provider Number	00000000 MCD
		Service Provider Check	Specified Service Provide
		PA Category Code	HOME HEALTH
		Case Number	
		Fund Code	
		Primary Diagnosis Code	
		Case Management	NO
		Disease Management	NO
		Media Type	CONVERS
		Print Option	NO PRINT

9.3 How to Update A Line Item

STEP 1 Access a PA file.

STEP 2 Select “Line Item” link from the PA Maintenance panel by clicking on it one time.

Prior Authorization Maintenance Panel

9.3.1 Prior Authorization/Information/Maintenance Panel Field Descriptions

Field	Description
Additional Diagnosis Codes	Activates the Diagnosis Codes display and update panel.
Line Item	Activates the Line Item display, and update panel.
Base Information	Activates the Base Information display, and update panel.
Paid Claim List	Activates the Paid Claim List display panel.
Internal text	Activates the Internal text display, and update panel.
Related Documents	

9.3.2 Prior Authorization/Information/Maintenance Panel Button Descriptions

Button	Description
Save	Saves changes made to panel(s).
Cancel	Cancel all pending changes.

The Line Item panel will open.

STEP 3 Select a row to update by clicking on the eyeglass icon one time. The information will populate into the fields of the panel.

STEP 4 Update information in the fields.

Line Item Panel

9.3.2.1 Prior Authorization/Information/Maintenance /Line Item Panel Field Descriptions

Field	Description
Line Item number	Two characters sequentially list items pertaining to PA. Characters are 01 through 99. Line item is automatically generated.
Service Type Code	Indicates code set to use for validation of requested service: procedure, revenue, or drug.
Revenue Code	Code identifying specific accommodation or ancillary service.
Procedure Code From	Beginning code for service being provided.
Modifier 1	First modifier of procedure code.
Modifier 2	Second modifier of procedure code.
Modifier 3	Third modifier of procedure code.
Modifier 4	Fourth modifier of procedure code.
PA Line Item Status	Status (for example, pending) or decision (for example, approved, denied) for service.
Revenue Code To	Revenue code ends range of revenue code specified for service.

Field	Description
Procedure Code To	Ending code for services being provided.
Quad	Tooth quadrant used in combination with tooth number and procedure code to provide more information concerning service. Valid values are: 10 20 30 40
Tooth	Tooth number used in combination with procedure code to provide more information concerning service.
NDC Lock	If 'Yes', prior authorization is locked into to NDC that is listed. If 'No', then authorization is for GCN sequence number represented by NDC entered in service code. Field is hidden unless service code is an NDC.
NDC Code	National Drug Code used to uniquely identify drug.
Subcontractor Tax ID	Field used for PAs received before 11/1/2002 to designate actual Service Provider since all PAs were initially issued for providers '29000015' (DMHMR) or '29000023' (DCBS).
Requester Effective Date	Requested date authorization is effective.
Requester End Date	Date requested service would end for member.
Requested Frequency	The field is used in conjunction with the Frequency Quantity field to specify requested rate of usage. The field is informational only. Valid values are M = Month and W = Week
Requested Frequency Units	The field is used in conjunction with the Frequency field to indicate requested rate of usage. The field is informational only.
Requested Units	Number of units requested of product or service.
Requested Dollars	Dollar amount requested for service for member.
Authorized Effective Date	Begin date of date range for which service is approved for use by member.
Authorized End Date	Date showing last date an authorized service can be used by member.
Authorized Frequency	The field is used in conjunction with the Frequency Quantity field to specify authorized rate of usage. The field is informational only. Valid values are M = Month and W = Week
Authorized Frequency Units	The field is used in conjunction with the Frequency field to indicate authorized rate of usage. The field is informational only.
Authorized Units	Unit amount authorized for service.

Field	Description
Authorized Dollars	Dollar amount authorized for service.
Payment Method	Payment method is used during claim adjudication to determine how claim should be paid. Valid payment methods are: pay unit fee price specified on service request, pay system price specified on fee schedule, pay up to capitation amount specified on service request.
Quantity Used Units	Number of units used by member of an approved service.
Quantity Used Dollars	Dollar amount of an approved service used by member.
Balance Units	Number of units remaining on PA line item.
Balance Dollars	Remaining dollars of service available for use by member.

9.3.2.2 Prior Authorization/Information/Maintenance /Line Item Panel Button Descriptions

Button	Descriptions
Add	Adds information entered to MMIS.

STEP 5 Select the “Add” button in the “Reason” section of the panel to activate the fields.

STEP 6 Enter the Reason Code by selecting it from the pull-down menu and clicking on the correct code number.

» Line Item

Line Item Number	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Revenue Code From	Revenue Code To	Procedure Code From	Procedure Code To	Modifier 1	Modifier 2	Modifier 3	Modifier 4	NDC Code	PA Line Item Status	Subcontractor Tax ID
01	20	\$0.00	20	\$0,00570										Approved	

Type changes below.

Line Item Number: 01
 Service Type Code: Revenue Code
 Revenue Code: 570
 Revenue Code To:
 Procedure Code From:
 Modifier 1:
 Modifier 2:
 Modifier 3:
 Modifier 4:
 PA Line Item Status: A - Approved
 Subcontractor Tax ID:
 Requested Effective Date: 12/07/2001
 Requested End Date: 01/05/2001
 Requested Frequency:
 Requested Frequency Units:
 Requested Units: 20
 Requested Dollars:
 Authorized Effective Date: 12/07/2001
 Authorized End Date: 01/05/2001
 Authorized Frequency:
 Authorized Frequency Units: 20
 Authorized Units:
 Authorized Dollars:
 Payment Method: Pay System Price
 Quantity Used Units: 0
 Quantity Used Dollars:
 Balance Units: 20
 Balance Dollars:
 Reason Code: 742
 Reason Description: Converted PA
 Reason Code dropdown: 105, 106, 107, 110, 111, 112, 115, 116, 118, 119
 Type Of Mass Update:
 Begin Date:
 End Date:
 Procedure Code:
 Revenue Code From:
 Revenue Code To:
 Buttons: delete, add, save

STEP 7 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

STEP 8 (Incorrect Reason Code) Correct field error and save again.

Prior Authorization Maintenance - Select Prior Authorization area to add or modify below.

Additional Diagnosis Codes | Base Information | Internal Text
 Line Item | Paid Claim List | Related Documents
 Super PA

save | cancel | new

The following messages were generated:

Message Description	Panel	Field	Row
Reason Code is required.	Line Item		1

Save was successful.

Prior Authorization Maintenance - Select Prior Authorization area to add or modify below.

Additional Diagnosis Codes | Base Information | Internal Text
 Line Item | Paid Claim List | Related Documents
 Super PA

save | cancel | new

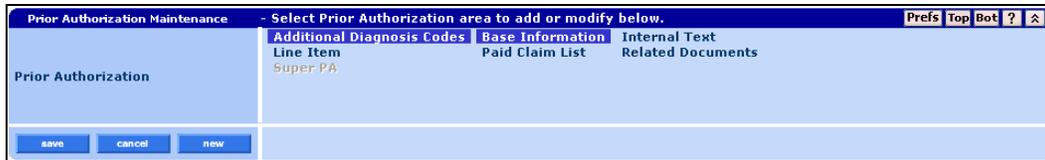
The following messages were generated:

Message Description	Panel	Field	Row
Save was Successful. All panels were saved.	Base Information		1

9.4 How to Add Additional Diagnosis Codes

STEP 1 Access a Prior Authorization file.

STEP 2 Select “Additional Diagnosis Codes” link from the PA Maintenance panel.



Prior Authorization Maintenance Panel

9.4.1 Prior Authorization/Information/Maintenance Panel Field Descriptions

Field	Description
Additional Diagnosis Codes	Activates the Diagnosis Codes display and update panel.
Line Item	Activates the Line Item display, and update panel.
Base Information	Activates the Base Information display, and update panel.
Paid Claim List	Activates the Paid Claim List display panel.
Internal text	Activates the Internal text display, and update panel.

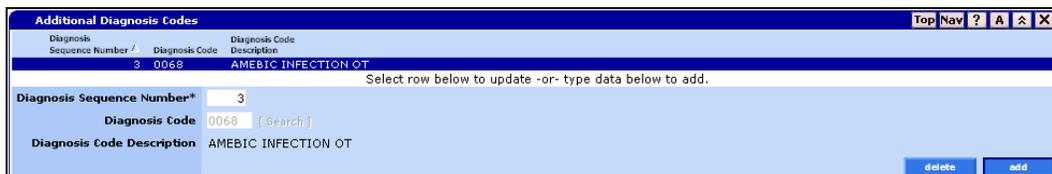
9.4.2 Prior Authorization/Information/Maintenance Panel Button Descriptions

Button	Description
Save	Saves changes made to panel(s).
Cancel	Cancel all pending changes.

The Additional Diagnosis Codes panel will open.

STEP 3 To add a new file click on the “Add” button. A new row is highlighted with an “A” at the beginning. This is a visual clue that the new file has been opened.

STEP 4 Enter new file information into fields.



Additional Diagnosis Codes Panel

9.4.2.1 Prior Authorization/Information/Maintenance /Additional Diagnosis Codes Panel Field Descriptions

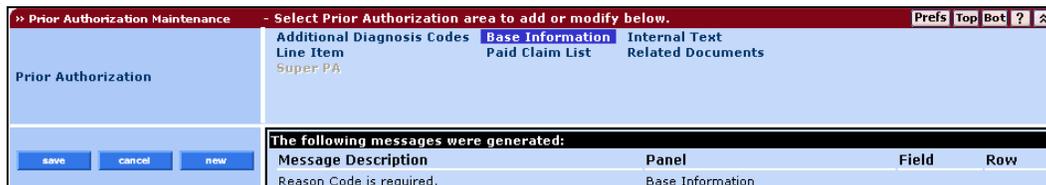
Field	Description
Diagnosis Sequence Number	Unique number assigned to the diagnosis. There may be 1 - 9,999 additional diagnosis codes.
Diagnosis Code	A code designating a particular diagnosis.
Diagnosis Code Description	Brief description of diagnosis code.

9.4.2.2 Prior Authorization/Information/Maintenance /Additional Diagnosis Codes Panel Button Descriptions

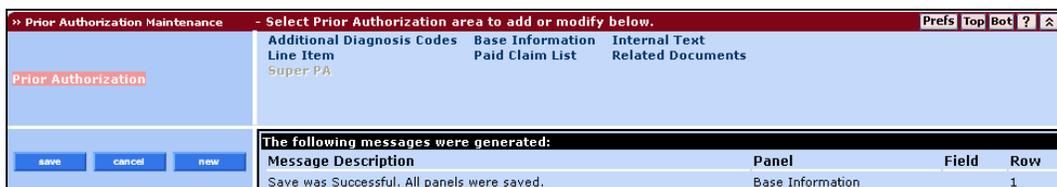
Button	Descriptions
Add	Adds information entered to MMIS.
Delete	Delete information from MMIS.

STEP 5 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

STEP 6 (Reason Code was omitted) Correct field error in Line Item panel and save again.



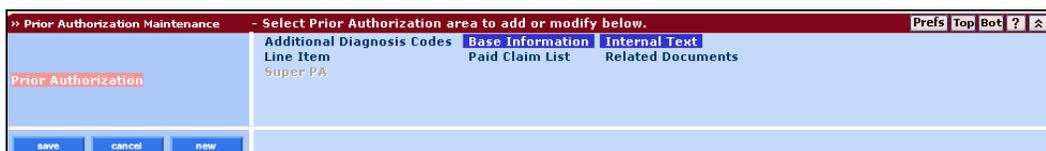
Save was successful.



9.5 How to Add Internal Text

STEP 1 Access a Prior Authorization file.

STEP 2 Access the “Internal Text” link in the PA Maintenance panel by clicking on it one time.



PA Maintenance Panel

9.5.1 Prior Authorization/Information/Maintenance Panel Field Descriptions

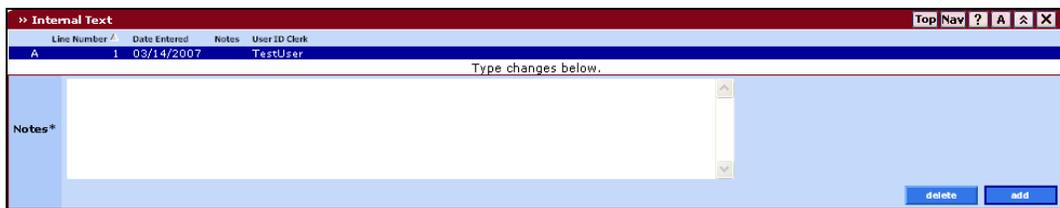
Field	Description
Additional Diagnosis Codes	Activates the Diagnosis Codes display and update panel.
Line Item	Activates the Line Item display, and update panel.
Base Information	Activates the Base Information display, and update panel.
Paid Claim List	Activates the Paid Claim List display panel.
Internal text	Activates the Internal text display, and update panel.

9.5.2 Prior Authorization/Information/Maintenance Panel Button Descriptions

Button	Description
Save	Saves changes made to panel(s).
Cancel	Cancel all pending changes.

The Internal Text panel will open.

STEP 3 To add a new file click on the “Add” button. A new row is highlighted with an “A” at the beginning. This is a visual clue that the new file has been opened.



Internal Text Panel

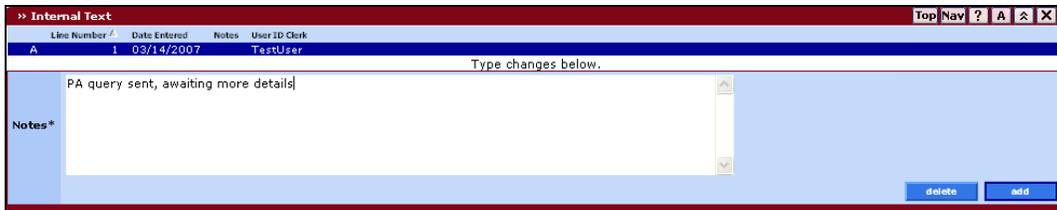
9.5.2.1 Prior Authorization/Information/Maintenance /Internal Text Panel Field Descriptions

Field	Description
Description	Description of external text.

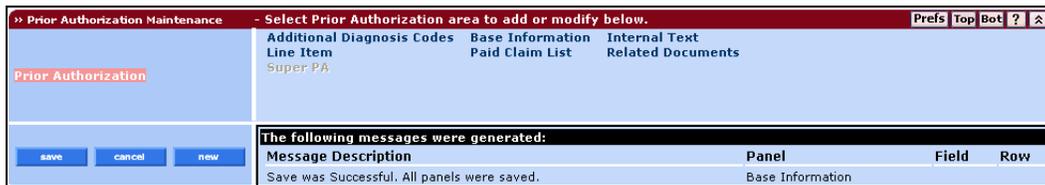
9.5.2.2 Prior Authorization/Information/Maintenance /Internal Text Panel Button Descriptions

Button	Descriptions
Add	Adds information entered to MMIS.
Delete	Delete information from MMIS.

STEP 4 Enter a free form note concerning information on the PA file.



STEP 5 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.



9.6 Other Information

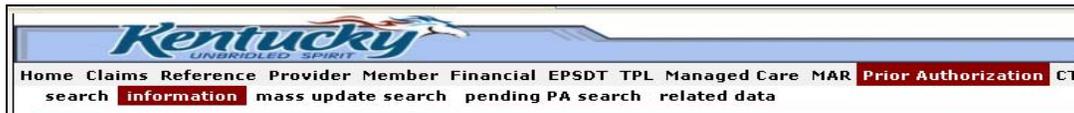
9.6.1 Searching for Claims Paid on a Prior Authorization

STEP 1. Access interChange.

STEP 2. Select Prior Authorization from the Main Menu.



STEP 3. Access Information in the PA submenu.



STEP 4. A mini-search panel will open. Enter the PA number.



9.6.1.1 PA/Information/Mini-Search Panel Field Descriptions

Field	Description
Prior Authorization Number	Unique number assigned to a Prior Authorization request.

9.6.1.2 PA/Information/Mini-Search Panel Button Descriptions

Button	Description
Search	Initiates search based on selected criteria.
Clear	Clears fields so new search may be conducted.

STEP 5. Click "Search".

The screenshot shows the top navigation bar of the KyHealth Choices system. The 'Prior Authorization' menu item is highlighted in red. Below the navigation bar, there is a search bar with the text 'Next search by: Prior Authorization Number' and the value '0000000000'. There are 'search' and 'clear' buttons to the right of the search bar.

STEP 6. The following panels will open: PA Information and PA Maintenance.

The screenshot displays two panels. The top panel is titled 'Prior Authorization Information' and contains the following data:

PA Number	0000000000	Member ID	0000000000	Requesting Provider Number	00000000 MCD
Legacy PRO Cert Number		Member Last Name	B	Servicing Provider Number	00000000 MCD
Authorizer	CONVR64	Member First Name	DOROTHY	Service Provider Check	Specified Service Provide
Received Date	12/10/2000	Member Date Of Birth	12/28/1920	PA Category Code	HOME HEALTH
Review Date	12/14/2000	Clerk Keyed	CONVR64	Case Number	
Update Received Date	12/14/2000	Date Keyed	12/14/2000	Fund Code	
Update Reviewed Date	12/14/2000	Admission Date		Primary Diagnosis Code	
Date Mailed		Discharge Date		Case Management	NO
Additional Diagnosis Codes	<input type="checkbox"/>	Accident	NO	Disease Management	NO
Internal Text	<input type="checkbox"/>	Special Considerations	NO	Media Type	CONVERS
Super PA	<input type="checkbox"/>	Emergency	NO	Print Option	NO PRINT
		Nursing Facility Type			
		Ortho Status Code			

The bottom panel is titled 'Prior Authorization Maintenance' and contains the following options:

Additional Diagnosis Codes	Base Information	Internal Text
Line Item	Paid Claim List	Related Documents
Super PA		

Buttons for 'save', 'cancel', and 'new' are visible at the bottom of the maintenance panel.

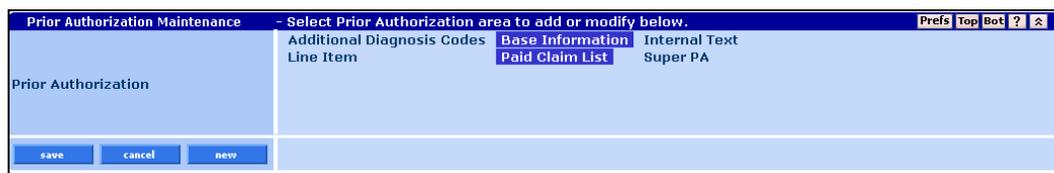
PA Information Panel

9.6.1.3 Prior Authorization Information Panel Field Descriptions

Field	Description
PA Number	Prior Authorization Number is unique identifier for PA.
Legacy PRO Cert Number	The Legacy Peer Review Organization Certification Number.
Authorizer	Unique identifier for person authorizing services on PA.

Field	Description
Date Received	Date PA request was received on site.
Review Date	Date PA was reviewed.
Update Received Date	Date update was received on site.
Update Reviewed Date	Day update was reviewed.
Date Mailed	Date mailed to provider.
Additional Diagnosis Codes	Any more relevant diagnosis codes besides primary diagnosis.
Internal text	Checked Internal Text box indicates there is internal text for PA.
Super PA	Checked Super PA box indicates there is Super PA data for PA.
Member ID	The member's 10-digit KY Medicaid ID number. Field is numeric only.
Member Last Name	Last name of member as shown on MMIS.
Member First Name	First name of member as shown on MMIS.
Member Date of Birth	Date of birth of member as shown on MMIS.
Clerk Keyed	ID of the clerk who entered the PA.
Date Keyed	Date PA was Typed into system.
Admission Date	Date member was admitted to facility.
Discharge Date	Date member was discharged from facility.
Accident	Checked box indicates PA is result of member's involvement in an accident.
Special Considerations	Indicates if there are special considerations concerning PA.
Emergency Supply	Field is used for pharmacy PAs only (which are not processed in interChange) and identifies the PA as an emergency 72-hour supply of drugs that does not count towards limitations.
Nursing Facility Type	The valid values for Nursing Facility Type of service are Brain Injury, BI Locked Unit, Nursing facility, Infectious Disease, Ventilator.
Ortho Status Code	The PA Orthodontic Status Code is used to track receipt of the documentation from the provider.

Field	Description
Requesting Provider ID	Unique identifier for provider requesting services for member on PA request.
Servicing Provider ID	Unique identifier for provider performing services for member specified on PA request.
Service Provider Check	An indicator specifying the type of provider validation required.
PA Category Code	Code that groups a PA's requested services under a type such as Dental, In-patient, and Nursing Facility.
Case Number	The Case Number used in maxMC to group PAs by an episode of care.
Fund Code	Source of funds for payment of authorized services.
Primary Diagnosis Code	Member's primary diagnosis.
Case Management	Case Management indicators be displayed in Service/Prior Authorization. The Member Subsystem Case and Disease Management indicators will be checked to see if there are any in effect for the Member.
Disease Management	Disease Management indicators be displayed in Service/Prior Authorization. The Member Subsystem Case and Disease Management indicators will be checked to see if there are any in effect for the Member.
Media type	Description of medium by which PA request is received.
Print Option	Print option for PA notice. Options are Batch (B), Internal (I), No Print (N), and Online (O).



PA Maintenance Panel

9.6.1.4 Prior Authorization Maintenance Panel Field Descriptions

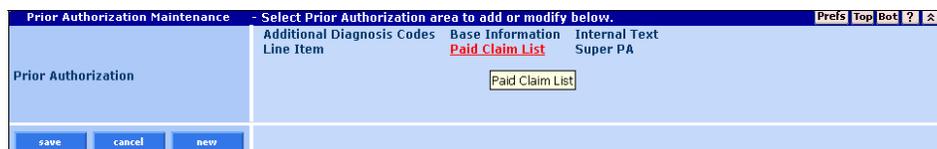
Field	Description
Additional Diagnosis Codes	Opens the Additional Diagnosis Codes panel.
Line Item	Opens the Line Item panel.
Base Information	Opens the Base Information panel.

Field	Description
Paid Claim List	Opens the Paid Claim List panel.
Internal Text	Opens the Internal Text panel.
Super PA	Opens the Super PA panel.

9.6.1.5 Prior Authorization Maintenance Panel Button Descriptions

Button	Description
Save	Saves changes made to panel(s).
Cancel	Cancels changes made to panel(s).
New	Activates panels so user may add new record.

STEP 6 Access the PA Maintenance Panel. Select the “Paid Claim List” link.



The Paid Claim List panel will open. It displays claims paid for that particular Prior Authorization number.

ICN	Claim Line Detail	PA Line Item Number	PA Units Paid	PA Amount Paid	Claim Status
2006000000000	1	01	20	\$17.11	Active

Paid Claim List Panel

9.6.1.6 Prior Authorization/Information/Paid Claim List Panel Field Descriptions

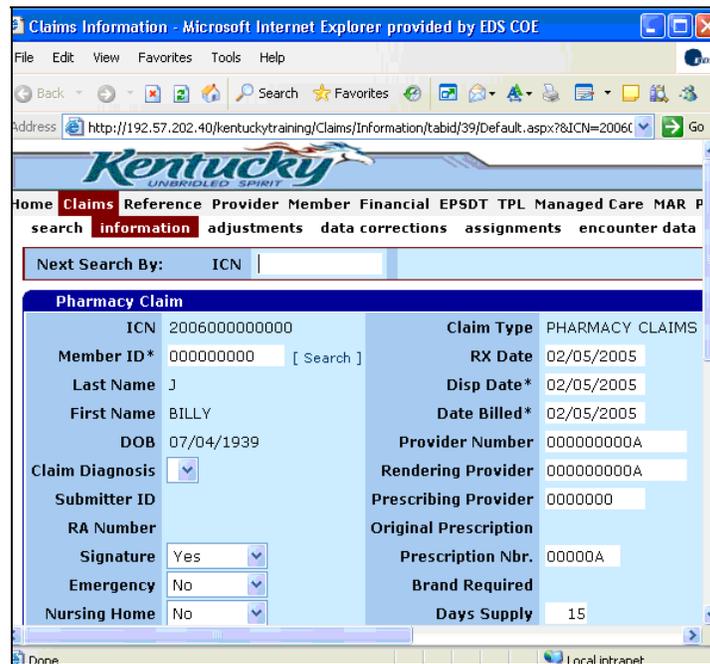
Field	Description
ICN	Internal Control Number is a unique identifier for a claim.
Claim Line Detail	Number of claim detail that has paid units and dollars authorized by a PA line item.
PA Line Item Number	Unique identifier for a PA line item. The number ranges from 01 through 99.
PA Units Paid	Number of units paid for by the claim detail that was authorized by the PA line item.
PA Amount Paid	Dollar amount paid for by the claim detail and authorized by the PA line item.

Field	Description
Claim Status	Indicates whether the record of paid units and amounts is active or inactive. A record is created with an active status when a claim is paid. The status is changed to inactive when a claim is adjusted. Records with a status of inactive are not included in the calculation of used units and amounts.

STEP 7. To view the claim information, click on the claim record one time.

Paid Claim List					
ICN #	Claim Line Detail	PA Line Item Number	PA Units Paid	PA Amount Paid	Claim Status
0000000000000	1	01	20	\$17.11	Active

A pop-up window will appear, which is a link to the related Claim Information Page.



9.6.2 Verifying Mass Updates

STEP 1. Access interChange

STEP 2. Select Prior Authorization from the main menu.



STEP 3. Select "Mass Update Search" from the submenu.



STEP 4. The PA Mass Update Search panel will open.

The screenshot shows the 'Prior Authorization Mass Update Search' panel. The panel has a blue background and contains the following search criteria fields:

- Provider: [Search]
- Rate: 0
- Revenue Code: [Search]
- Revenue Code Thru: [Search]
- Procedure Code: [Search]
- Procedure Code Thru: [Search]
- Begin Date:
- End Date:

At the bottom right, there is a 'Records' dropdown menu set to '20' and two buttons: 'search' and 'clear'.

9.6.2.1 Prior Authorization/Mass Update Search Panel Field Descriptions

Field	Description
Provider	Field to search using Service Provider as search Criteria.
Rate	New replacement rate in a Mass Update.
Revenue Code	New replacement Revenue Code in a Mass Update.
Revenue Code Thru	New replacement Revenue Code Thru Field in a Mass Update.
Procedure Code	New replacement Procedure Code in a Mass Update.
Procedure Code Thru	New replacement Procedure Code Thru Field in a Mass Update.
Begin Date	The date the override begins.
End Date	The date the override ends.
Records	The maximum number of records to display per page.

9.6.2.2 Prior Authorization/Mass Update Search Panel Button Descriptions

Button	Description
Search	Initiates search based upon selected criteria.
Clear	Clears fields so a new search may be conducted.

STEP 5. Enter the search criteria. Click on the “Search” button.



STEP 6. The results will display in rows. Select a PA by clicking on the record one time.

» Search Results							
PA Number	Line Item	Type Change	Rate	Service Code From	Service Code To	Begin Date	End Date
0000000000	01	Procedure		0001F	0003T	01/01/2006	12/31/2006
0000000000	02	Procedure		0001F		11/01/2006	12/31/2007
0000000000	01	Rate (Procedure)	343			11/01/2006	12/31/2006
0000000000	01	Rate (Procedure)				06/01/2006	12/31/2006
0000000000	01	Procedure		0001F		10/01/2006	08/30/2007
0000000000	01	Procedure		0002T		01/01/2007	12/31/2007
0000000000	01	Rate (Procedure)	720			11/01/2006	09/30/2007
0000000000	01	Rate (Procedure)	125			10/01/2006	12/30/2006

PA Mass Update Search Results Panel

9.6.2.3 Prior Authorization Mass Update Search Results Panel Field Descriptions

Field	Description
PA Number	Prior Authorization Number is a unique identifier for a PA.
Line Item	Two characters that sequentially list the services included on a PA. The characters are 01 through 99. The Line item is automatically generated.
Type Change	Indicates the type of Mass Update that generated the entry for the PA Line Item. Mass Update types are: Revenue Code, Rate Change for a Revenue Code, Procedure Code, Rate Change for a Procedure Code.
Rate	New replacement rate in a Mass Update.
Service Code From	The beginning range of procedure / revenue codes.
Service Code To	The ending range of procedure / revenue codes.
Begin Date	Date the override begins.
End Date	Date the override ends.

STEP 7. The following panels will open: PA Information and PA Maintenance.

Prior Authorization Information			
PA Number	000000000	Member ID	000000000
Legacy PRD Cert Number		Member Last Name	B
Authorizer	CONVR64	Member First Name	DOROTHY
Received Date	12/10/200:	Member Date Of Birth	12/28/192:
Review Date	12/14/200:	Clerk Keyed	CONVR64
Update Received Date	12/14/200:	Date Keyed	12/14/200:
Update Reviewed Date	12/14/200:	Admission Date	
Date Mailed		Discharge Date	
Additional Diagnosis Codes	<input type="checkbox"/>	Accident	NO
Internal Text	<input type="checkbox"/>	Special Considerations	NO
Super PA	<input type="checkbox"/>	Emergency	NO
		Nursing Facility Type	
		Ortho Status Code	
		Requesting Provider Number	00000000 MCD
		Servicing Provider Number	00000000 MCD
		Service Provider Check	Specified Service Provide
		PA Category Code	HOME HEALTH
		Case Number	
		Fund Code	
		Primary Diagnosis Code	
		Case Management	NO
		Disease Management	NO
		Media Type	CONVERS
		Print Option	NO PRINT

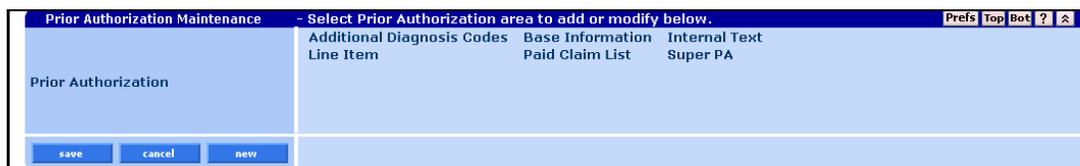
PA Information Panel

9.6.2.4 Prior Authorization Information Panel Field Descriptions

Field	Description
PA Number	Prior Authorization Number is unique identifier for PA.
Authorizer	Unique identifier for person authorizing services on PA.
Date Received	Date PA request was received on site.

Field	Description
Review Date	Date PA was reviewed.
Update Received Date	Date update was received on site.
Update Reviewed Date	Day update was reviewed.
Date Mailed	Date mailed to provider.
Additional Diagnosis Codes	Any more relevant diagnosis codes besides primary diagnosis.
Internal text	Checked Internal Text box indicates there is internal text for PA.
Super PA	Checked Super PA box indicates there is Super PA data for PA.
Member ID	The member's 10-digit KY Medicaid ID number. Field is numeric only.
Member Last Name	Last name of member as shown on MMIS.
Member First Name	First name of member as shown on MMIS.
Member Date of Birth	Date of birth of member as shown on MMIS.
Clerk Keyed	ID of the clerk who entered the PA.
Date Keyed	Date PA was Typed into system.
Admission Date	Date member was admitted to facility.
Discharge Date	Date member was discharged from facility.
Accident	Checked box indicates PA is result of member's involvement in an accident.
Special Considerations	Indicates if there are special considerations concerning PA.
Emergency Supply	Field is used for pharmacy PAs only (which are not processed in interChange) and identifies the PA as an emergency 72-hour supply of drugs that does not count towards limitations.
Nursing Facility Type	The valid values for Nursing Facility Type of service are Brain Injury, BI Locked Unit, Nursing facility, Infectious Disease, Ventilator.
Ortho Status Code	The PA Orthodontic Status Code is used to track receipt of the documentation from the provider.

Field	Description
Requesting Provider ID	Unique identifier for provider requesting services for member on PA request.
Servicing Provider ID	Unique identifier for provider performing services for member specified on PA request.
Service Provider Check	An indicator specifying the type of provider validation required.
PA Category Code	Code that groups a PA's requested services under a type such as Dental, In-patient, and Nursing Facility.
Case Number	The Case Number used in maxMC to group PAs by an episode of care.
Fund Code	Source of funds for payment of authorized services.
Primary Diagnosis Code	Member's primary diagnosis.
Case Management	Case Management indicators be displayed in Service/Prior Authorization. The Member Subsystem Case and Disease Management indicators will be checked to see if there are any in effect for the Member.
Disease Management	Disease Management indicators be displayed in Service/Prior Authorization. The Member Subsystem Case and Disease Management indicators will be checked to see if there are any in effect for the Member.
Media type	Description of medium by which PA request is received.
Print Option	Print option for PA notice. Options are Batch (B), Internal (I), No Print (N), and Online (O).



PA Maintenance Panel

9.6.2.5 Prior Authorization Maintenance Panel Field Descriptions

Field	Description
Additional Diagnosis Codes	Opens the Additional Diagnosis Codes panel.
Line Item	Opens the Line Item panel.

Field	Description
Base Information	Opens the Base Information panel.
Paid Claim List	Opens the Paid Claim List panel.
Internal Text	Opens the Internal Text panel.
Super PA	Opens the Super PA panel.

9.6.2.6 Prior Authorization Maintenance Panel Button Descriptions

Button	Description
Save	Saves changes made to panel(s).
Cancel	Cancels changes made to panel(s).
New	Activates panels so user may add new record.

9.6.3 Checking Units Used

STEP 1. Access interchange

STEP 2. Select Prior Authorization from the main menu.



STEP 3. Select "Information" from the submenu.



STEP 4. A mini search panel will open. Enter the PA number.



STEP 5. Click the "Search" button.



The PA Information and Maintenance panels will open.

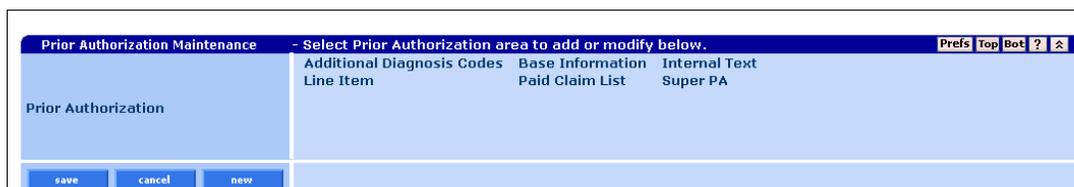
PA Information Panel

9.6.3.1 Prior Authorization Information Panel Field Descriptions

Field	Description
PA Number	Prior Authorization Number is unique identifier for PA.
Authorizer	Unique identifier for person authorizing services on PA.
Date Received	Date PA request was received on site.
Review Date	Date PA was reviewed.
Update Received Date	Date update was received on site.
Update Reviewed Date	Day update was reviewed.
Date Mailed	Date mailed to provider.
Additional Diagnosis Codes	Any more relevant diagnosis codes besides primary diagnosis.
Internal text	Checked Internal Text box indicates there is internal text for PA.
Super PA	Checked Super PA box indicates there is Super PA data for PA.

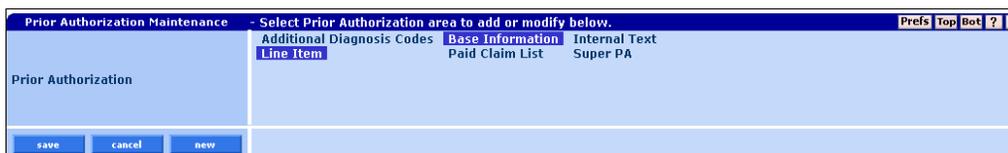
Field	Description
Member ID	The member's 10-digit KY Medicaid ID number. Field is numeric only.
Member Last Name	Last name of member as shown on MMIS.
Member First Name	First name of member as shown on MMIS.
Member Date of Birth	Date of birth of member as shown on MMIS.
Clerk Keyed	ID of the clerk who entered the PA.
Date Keyed	Date PA was Typed into system.
Admission Date	Date member was admitted to facility.
Discharge Date	Date member was discharged from facility.
Accident	Checked box indicates PA is result of member's involvement in an accident.
Special Considerations	Indicates if there are special considerations concerning PA.
Emergency Supply	Field is used for pharmacy PAs only (which are not processed in interChange) and identifies the PA as an emergency 72-hour supply of drugs that does not count towards limitations.
Nursing Facility Type	The valid values for Nursing Facility Type of service are Brain Injury, BI Locked Unit, Nursing facility, Infectious Disease, Ventilator.
Ortho Status Code	The PA Orthodontic Status Code is used to track receipt of the documentation from the provider.
Requesting Provider ID	Unique identifier for provider requesting services for member on PA request.
Servicing Provider ID	Unique identifier for provider performing services for member specified on PA request.
Service Provider Check	An indicator specifying the type of provider validation required.
PA Category Code	Code that groups a PA's requested services under a type such as Dental, In-patient, and Nursing Facility.
Case Number	The Case Number used in maxMC to group PAs by an episode of care.
Fund Code	Source of funds for payment of authorized services.
Primary Diagnosis Code	Member's primary diagnosis.

Field	Description
Case Management	Case Management indicators be displayed in Service/Prior Authorization. The Member Subsystem Case and Disease Management indicators will be checked to see if there are any in effect for the Member.
Disease Management	Disease Management indicators be displayed in Service/Prior Authorization. The Member Subsystem Case and Disease Management indicators will be checked to see if there are any in effect for the Member.
Media type	Description of medium by which PA request is received.
Print Option	Print option for PA notice. Options are Batch (B), Internal (I), No Print (N), and Online (O).



PA Maintenance Panel

STEP 6. Access the PA Maintenance panel. Select the “Line Item” link.



PA Maintenance Panel

9.6.3.2 Prior Authorization Maintenance Panel Field Descriptions

Field	Description
Additional Diagnosis Codes	Opens the Additional Diagnosis Codes panel.
Line Item	Opens the Line Item panel.
Base Information	Opens the Base Information panel.
Paid Claim List	Opens the Paid Claim List panel.
Internal Text	Opens the Internal Text panel.
Super PA	Opens the Super PA panel.

9.6.3.3 Prior Authorization Maintenance Panel Button Descriptions

Button	Description
Save	Saves changes made to panel(s).
Cancel	Cancel changes made to panel(s).
New	Activates panels so user may add new record.

The Line Item panel will open.

The screenshot shows a software interface titled "Line Item". At the top, there is a table with columns: Line Item Number, Requested Units, Requested Dollars, Authorized Units, Authorized Dollars, Revenue Code From, Revenue Code To, Procedure Code From, Procedure Code To, Modifier 1, Modifier 2, Modifier 3, Modifier 4, NDC Code, Pa Line Item Status, and Subcontractor Tax ID. The first row contains the values: 01, 2, \$200.00, 2, \$200.00, [blank], [blank], 7800, [blank], [blank], [blank], [blank], [blank], [blank], [blank], [blank]. Below the table is a form with various fields for editing or adding a new record, including dropdown menus for Service Type Code, PA Line Item Status, and NDC Lock, and search boxes for Revenue Code, Procedure Code, and various Modifiers. There are also fields for Requested/Authorized dates, units, dollars, and frequency. At the bottom, there are sections for Reason Code and Mass Update Change, both showing "No rows found".

Line Item Panel

9.6.3.4 Prior Authorization/Information/Maintenance /Line Item Panel Field Descriptions

Field	Description
Line Item number	Two characters sequentially list items pertaining to PA. Characters are 01 through 99. Line item is automatically generated.
Service Type Code	Indicates code set to use for validation of requested service: procedure, revenue, or drug.
Revenue Code	Code identifying specific accommodation or ancillary service.
Procedure Code From	Beginning code for service being provided.
Modifier 1	First modifier of procedure code.
Modifier 2	Second modifier of procedure code.

Field	Description
Modifier 3	Third modifier of procedure code.
Modifier 4	Fourth modifier of procedure code.
PA Line Item Status	Status (for example, pending) or decision (for example, approved, denied) for service.
Revenue Code To	Revenue code ends range of revenue code specified for service.
Procedure Code To	Ending code for services being provided.
Quad	Tooth quadrant used in combination with tooth number and procedure code to provide more information concerning service. Valid values are: 10 20 30 40
Tooth	Tooth number used in combination with procedure code to provide more information concerning service.
NDC Lock	If 'Yes', prior authorization is locked into to NDC that is listed. If 'No', then authorization is for GCN sequence number represented by NDC entered in service code. Field is hidden unless service code is an NDC.
NDC Code	National Drug Code used to uniquely identify drug.
Subcontractor Tax ID	Field used for PAs received before 11/1/2002 to designate actual Service Provider since all IMPACT Plus PAs were initially issued for providers '29000015' (DMHMR) or '29000023' (DCBS).
Requester Effective Date	Requested date authorization is effective.
Requester End Date	Date requested service would end for member.
Requested Frequency	The field is used for Waiver PAs in conjunction with the Requested Quantity field to specify rate of usage. The field is informational only and displays on Waiver letters. Valid values are M = Month and W = Week.
Requested Frequency Units	The field is used for Waiver PAs in conjunction with the Requested Frequency field to indicate rate of usage. The field is informational only and displays on Waiver letters.
Requested Units	Number of units requested of product or service.
Requested Dollars	Dollar amount requested for service for member.
Authorized Effective Date	Begin date of date range for which service is approved for use by member.

Field	Description
Authorized End Date	Date showing last date an authorized service can be used by member.
Authorized Frequency	The field is used for Waiver PAs in conjunction with the Authorized Quantity field to specify rate of usage. The field is informational only and displays on Waiver letters. Valid values are M = Month and W = Week.
Authorized Frequency Units	The field is used for Waiver PAs in conjunction with the Authorized Frequency field to indicate rate of usage. The field is informational and displays on Waiver letters.
Authorized Units	Unit amount authorized for service.
Authorized Dollars	Dollar amount authorized for service.
Payment Method	Payment method is used during claim adjudication to determine how claim should be paid. Valid payment methods are: pay unit fee price specified on service request, pay system price specified on fee schedule, pay up to capitation amount specified on service request.
Quantity Used Units	Number of units used by member of an approved service.
Quantity Used Dollars	Dollar amount of an approved service used by member.
Balance Units	Number of units remaining on PA line item.
Balance Dollars	Remaining dollars of service available for use by member.

9.6.3.5 Prior Authorization/Information/Maintenance /Line Item Panel Button Descriptions

Button	Description
Add	Add a new record.

STEP 7. To view the line item information, click on the record one time. The information will auto-populate in the fields below. The units used is located in the “Quantity Used Units” field.

» Line Item														Top	Nav	?	A	↕	X
Line Item Number	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Revenue Code From	Revenue Code To	Procedure Code From	Procedure Code To	Modifier 1	Modifier 2	Modifier 3	Modifier 4	NDC Code	Pa Line Item Status	Subcontractor Tax ID				
01	2	\$200.00	2	\$200.00			78000							Approved					
Type changes below.																			
Line Item Number	01												Requested Effective Date*		01/01/2005				
Service Type Code*													Requested End Date*		12/31/2006				
Revenue Code			[Search]		Revenue Code To								Requested Frequency						
Procedure Code From	78000		[Search]		Procedure Code To								Requested Frequency Units						
Modifier 1			[Search]		Quad								Requested Units		2				
Modifier 2			[Search]		Tooth								Requested Dollars		\$200.00				
Modifier 3			[Search]		NDC Lock								Authorized Effective Date		01/01/2005				
Modifier 4			[Search]		NDC Code								Authorized End Date		12/31/2006				
PA Line Item Status*	A - Approved				Subcontractor Tax ID								Authorized Frequency						
														Authorized Frequency Units					
														Authorized Units		2			
														Authorized Dollars					
														Payment Method*		Pay System Price			
														Quantity Used Units		0			
														Quantity Used Dollars					
														Balance Units					
														Balance Dollars					

10 Appendix C – Using the Audit Trail

The Audit Trail provides information about changes and updates to the MMIS. Each panel which has add/update functionality has an audit trail. This is accessed via the “A” button in the top right corner of the panel.

STEP 1. Click the “A” button on the panel.

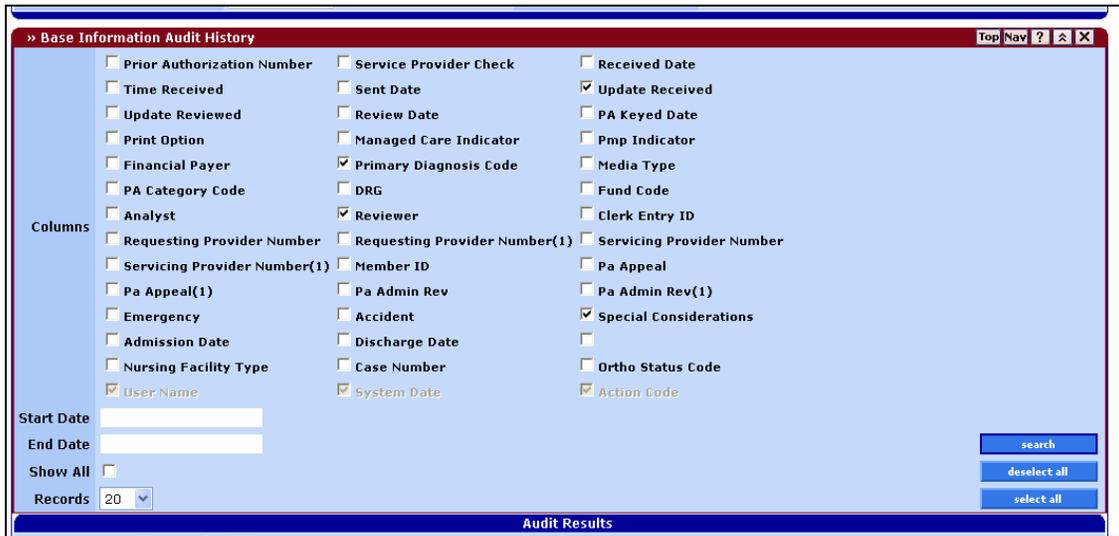
The Audit History panel will open.

Audit History Panel

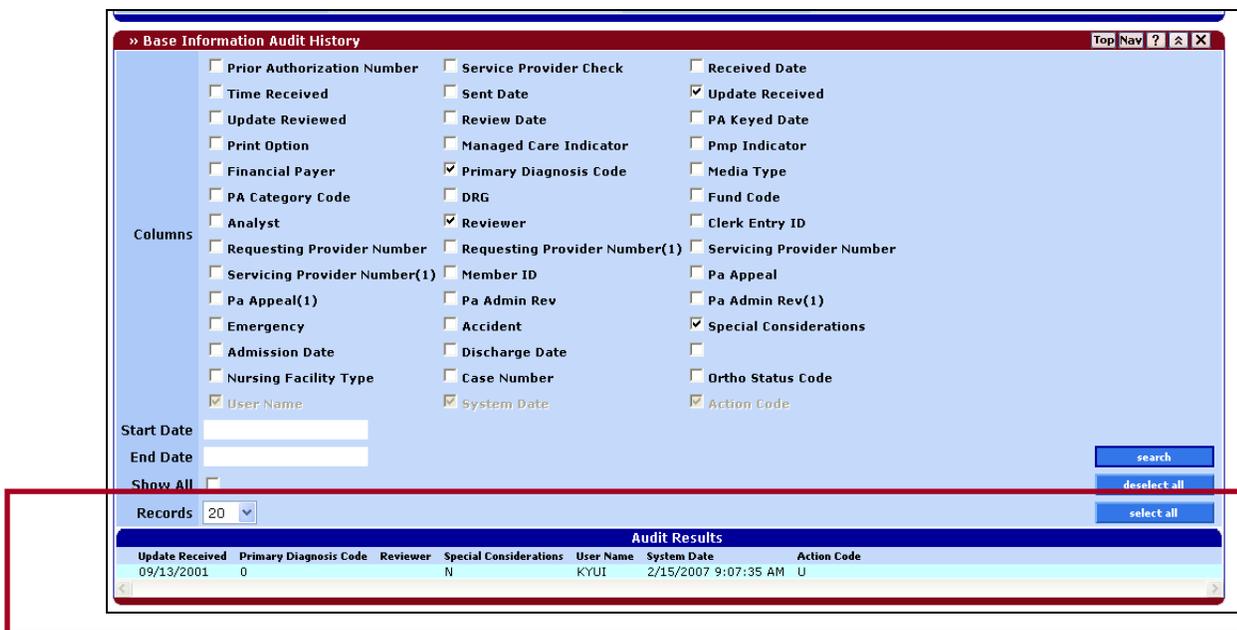
The Audit History panel will show a “check box” for each updatable field on the panel. Clicking a box instructs interChange to display the update/change record for that field. You may limit the time frame of your search by entering “Start Date” and “End Date,” or, you may click “Show All” to see all change records for the fields in question.

EXAMPLE: If you wanted to see if a change was made in the PA Category Code after a claim paid in June 2005, but before a claim paid in October 2005, you would click the box to the right of “PA Category Code” and enter a Start Date after June 2005, and an end date before October 2005.

STEP 2. Select the fields and enter a date range, if applicable.



Search results will be displayed at the bottom of the Audit History panel.



Audit Results

10.1 Audit Results Field Descriptions

Field	Description
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.

Field	Description
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.
User Name	The User who made the change/update.
System Date	Date the change/update was made.
Action Code	What type of change was made; U= Update, D= Delete, A= Add.

11 Appendix D – Using the Help Functions

interChange includes built in “Help” functions on each panel.

Each field label displays a question mark on mouse-over, alerting the user that help is available.

The screenshot shows a web form titled "Provider Information" with a blue header. The form is divided into three main sections: Provider Information, Service Location, and Organization. The SSN field label in the Provider Information section is circled in red and has a question mark icon next to it. The form contains the following data:

Field	Value
Provider Identifier	500010499
UPIN	
Ownership	No
Restriction	No
Gender	N/A
Date of Birth	
SSN	363709861
Service Location	01013978 - UNIVERSITY HOSPITAL
Provider Numbers	01013978 MCD 01/01/1978-12/31/2299
Address Type	Service Location
Address	800 ROSE ST
City	LEXINGTON
County	Fayette
State/Zip	KY 40536-0000
Phone	010-139-7800
Fax	010-139-7800
Managed Care	No
Organization	Individual
Provider Type	01 - General hospital
License	
Specialties	Acute Care 01/01/1978-12/31/2299
Taxonomies	
Tax ID	616001218 01/01/1978-12/31/2299
Contract	Hospital (Inpatient)01/01/1978-10/14/2237
Medicare	180067 12/14/1995-10/14/2237
Certification Board	

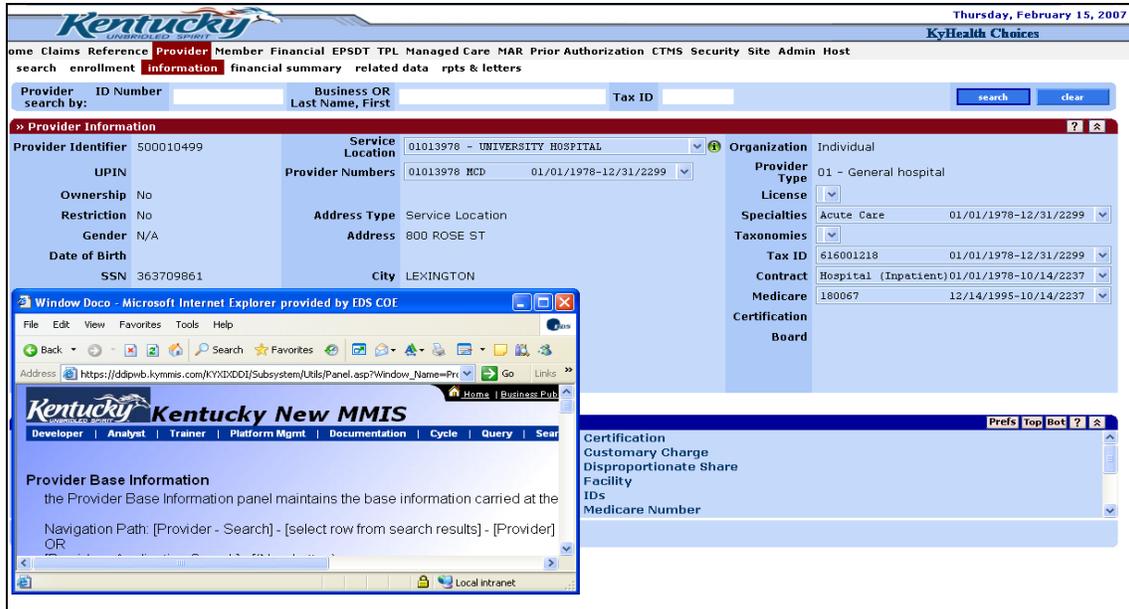
An alt tag will appear if the mouse “hovers” over a field label. The alt tag alerts the user that clicking the field label will go to “Help.”

The screenshot shows the same "Provider Information" form as above. The SSN field label is circled in red, and a small yellow box with the text "Help For SSN" is visible next to it, indicating that the alt tag is active when the mouse hovers over the field label.

11.1 Accessing Help for a Field

STEP 1. Click the field label.

A new browser will open. The Project Workbook page for the panel will be displayed.

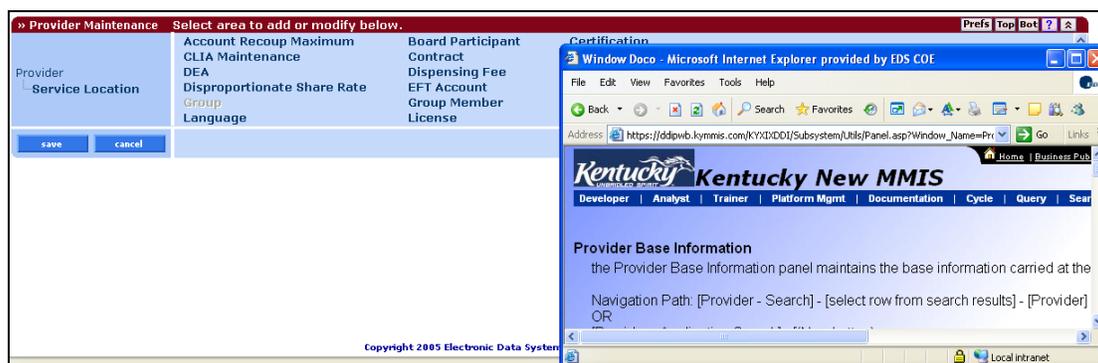


11.2 Accessing Help for a Panel

STEP 1. Click the question mark button in the upper right corner of the panel.



A new browser will open. The Project Workbook page for the panel will be displayed.



12 Appendix E- Service/Prior Authorization Letters Generated in MaxMC

Durable Medical Equipment Technical Denial

ImpactPlusEligibility Approval

ImpactPlusEligibility Denial

ImpactPlusEligibility Denial 915

ImpactPlusService Denial

Medical Necessity Denial

Lack of Information Denial

NursingFacility&Waiver Medical Necessity Denial-Initial and CSR

Physician Services Confirmation of Consent Part1

Psych Freestanding&Psych PRTF Approval (LO2)

Psych Freestanding&Psych PRTF Denial (LO5)

Reconsideration DateScheduled Notice

Reconsideration Denial Overturned

Reconsideration Denial Upheld

Reconsideration Request Out of Timeframe Notice

Request for Information

Technical Denial

13 Appendix C – Using the Audit Trail

The Audit Trail provides information about changes and updates to the MMIS. Each panel which has add/update functionality has an audit trail. This is accessed via the “A” button in the top right corner of the panel.

STEP 1. Click the “A” button on the panel.

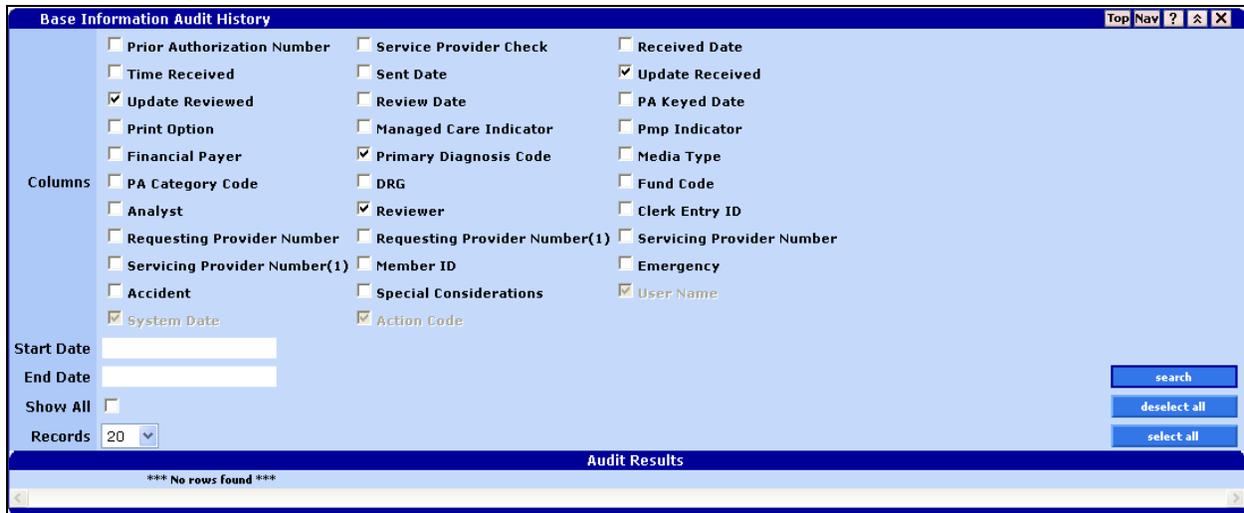
The Audit History panel will open.

Audit History Panel

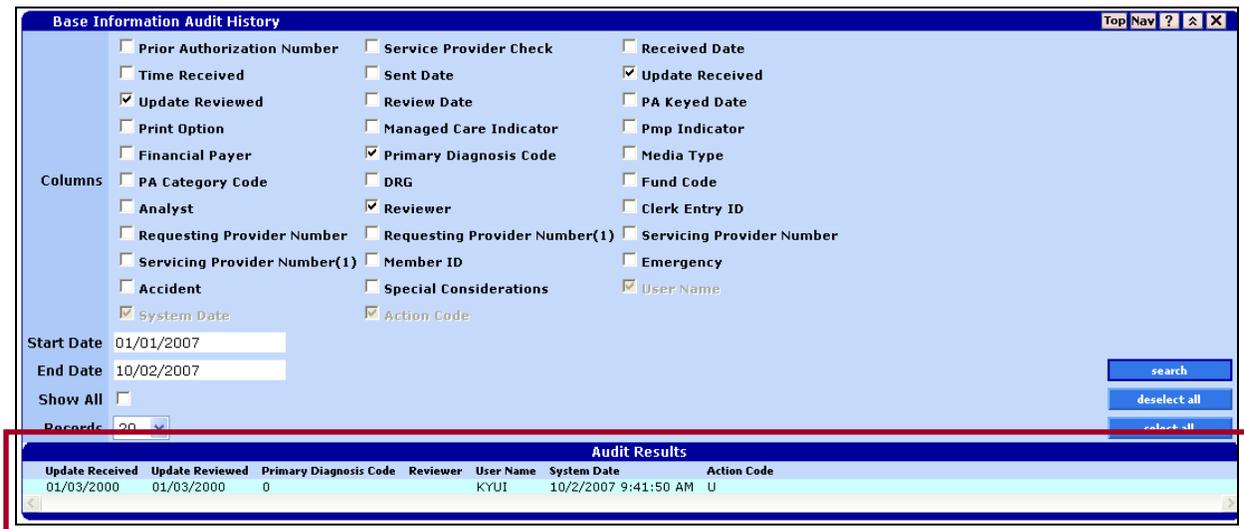
The Audit History panel will show a “check box” for each updatable field on the panel. Clicking a box instructs interChange to display the update/change record for that field. You may limit the time frame of your search by entering “Start Date” and “End Date,” or, you may click “Show All” to see all change records for the fields in question.

EXAMPLE: If you wanted to see if a change was made in the PA Category Code after a claim paid in June 2005, but before a claim paid in October 2005, you would click the box to the right of “PA Category Code” and enter a Start Date after June 2005, and an end date before October 2005.

STEP 2. Select the fields and enter a date range, if applicable.



Search results will be displayed at the bottom of the Audit History panel.



Audit Results

13.1 Audit Results Field Descriptions

Field	Description
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.

Field	Description
User Name	The User who made the change/update.
System Date	Date the change/update was made.
Action Code	What type of change was made; U= Update, D= Delete, A= Add.

14 Appendix D – Using the Help Functions

interChange includes built in “Help” functions on each panel.

Each field label displays a question mark on mouse-over, alerting the user that help is available.



The screenshot shows a web-based form titled "Provider Information". The form is divided into three main sections: Provider Information, Service Location, and Organization. The "Date of Birth" field is circled in red, and a red circle with a question mark is overlaid on the label. The "SSN" field is also circled in red.

Field	Value
Provider Identifier	500010499
U PIN	
Ownership	No
Restriction	No
Gender	N/A
Date of Birth	
SSN	363709861
Service Location	01013978 - UNIVERSITY HOSPITAL
Provider Numbers	01013978 MCD 01/01/1978-12/31/2299
Address Type	Service Location
Address	800 ROSE ST
City	LEXINGTON
County	Fayette
State/Zip	KY 40536-0000
Phone	010-139-7800
Fax	010-139-7800
Managed Care	No
Organization	Individual
Provider Type	01 - General hospital
License	
Specialties	Acute Care 01/01/1978-12/31/2299
Taxonomies	
Tax ID	616001218 01/01/1978-12/31/2299
Contract	Hospital (Inpatient) 01/01/1978-10/14/2237
Medicare	180067 12/14/1995-10/14/2237
Certification Board	

An alt tag will appear if the mouse “hovers” over a field label. The alt tag alerts the user that clicking the field label will go to “Help.”



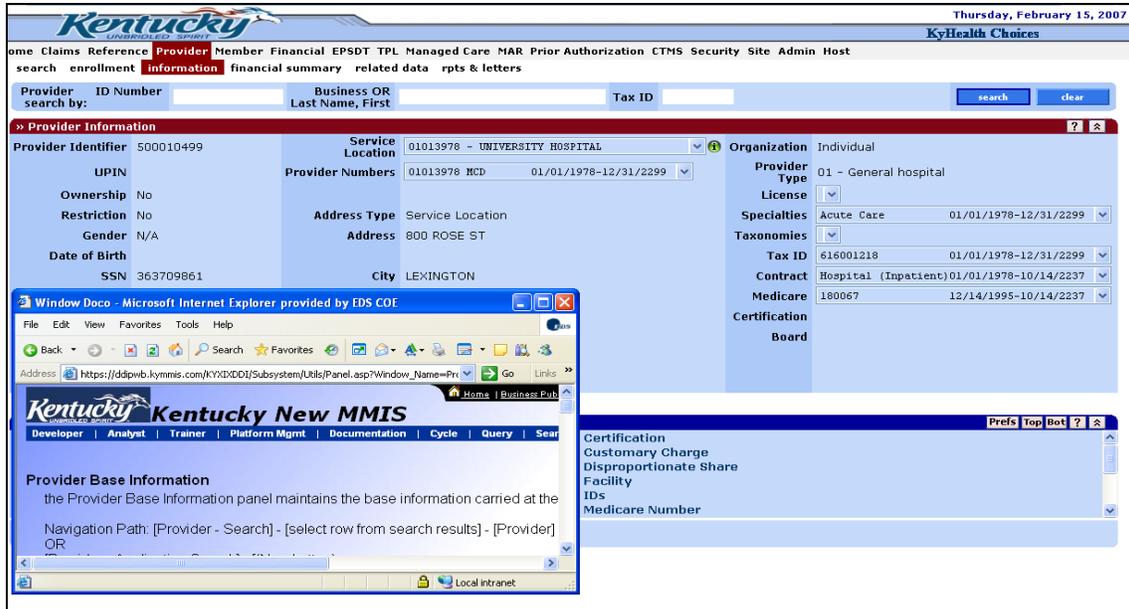
The screenshot shows the same "Provider Information" form as above. The "Date of Birth" label is circled in red, and a red circle with the text "Help For SSN" is overlaid on the label. The "SSN" field is also circled in red.

Field	Value
Provider Identifier	500010499
U PIN	
Ownership	No
Restriction	No
Gender	N/A
Date of Birth	
SSN	363709861
Service Location	01013978 - UNIVERSITY HOSPITAL
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Phone	010-139-7800
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Managed Care	No
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Provider Type	01 - General hospital
License	
Specialties	Acute Care 01/01/1978-12/31/2299
Taxonomies	
Tax ID	616001218 01/01/1978-12/31/2299
Contract	Hospital (Inpatient) 01/01/1978-10/14/2237
Medicare	180067 12/14/1995-10/14/2237
Certification Board	

14.1 Accessing Help for a Field

STEP 1. Click the field label.

A new browser will open. The Project Workbook page for the panel will be displayed.

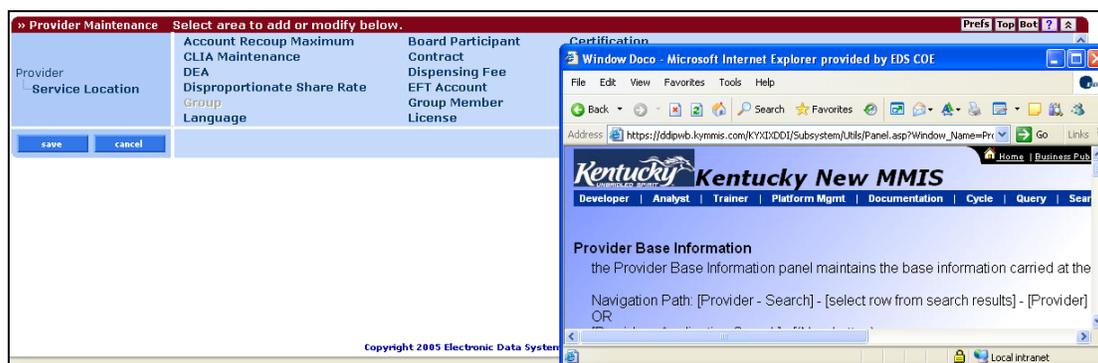


14.2 Accessing Help for a Panel

STEP 1. Click the question mark button in the upper right corner of the panel.



A new browser will open. The Project Workbook page for the panel will be displayed.



15 Appendix E- Service/Prior Authorization Letters Generated in MaxMC

Durable Medical Equipment Technical Denial

ImpactPlusEligibility Approval

ImpactPlusEligibility Denial

ImpactPlusEligibility Denial 915

ImpactPlusService Denial

Medical Necessity Denial

Lack of Information Denial

NursingFacility&Waiver Medical Necessity Denial-Initial and CSR

Physician Services Confirmation of Consent Part1

Psych Freestanding&Psych PRTF Approval (LO2)

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