CCN-S Systems Companion Guide

April 11, 2011

CCN-S Systems Companion Guide

DHH will provide maintenance of all documentation changes to this Guide using the Change Control Table as shown below.

Change Control Table

Author of Change	Sections Changed	Descriptions	Reason	DATE

CCN –S Systems Companion Guide

Contents

1

Overview

Introduction

Beginning November 2011, DHH will phase-in implementation of member enrollment services into Medicaid's Coordinated Care Network (CCN) Program. Member enrollment into the Coordinated Care Program will be phased in based on DHH's GSAs. Services will begin January 1, 2012 for GSA A; March 1, 2012 for GSA B; and May 1, 2012 for GSA C.

A Shared Savings CCN (CCN) differs from the current CommunityCARE 2.0 program in that the CCN is a primary care case manager that provides enhanced primary care case management in addition to being the entity contracting with primary care providers (PCP) for PCP care management. The CCN will expand the current roles and responsibilities of the primary care providers through the establishment of patient-centered medical homes and create a formal and distinct network of primary care providers to coordinate the full continuum of care while achieving budget and performance goals and benchmarks.

DHH, or its FI, shall make monthly enhanced primary care case management fee payments to the CCN and lump sum savings payments to the CCN, if eligible. The enhanced primary care case management fee shall be based on the enrollee's Medicaid eligibility category as specified in the RFP and paid on a PMPM basis. The enhanced primary care case management rate schedule is provided in the CCN-S RFP in Appendix E – Mercer Certification, Rate Development Methodology and Rates). In order to be eligible to receive these payments, the CCN must enter into a Contract with DHH and remain in compliance with all provisions contained in the Contract.

In accordance with the requirements set forth in the Contract, the CCN shall specify the timeframe in which a provider has to submit a clean claim with the CCN. The CCN must accept and pre-process claims within two (2) business days of receipt. Pre-processed approved claims will be paid on a fee-for-service (FFS) basis by DHH. DHH shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP program

pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with DHH.

The CCN shall notify providers to file all claims directly to the CCN for services provided to CCN members. Claims submitted directly to DHH's FI for a CCN member will be denied. The CCN shall specify the timeframe in which a provider has to submit a clean claim with the CCN. The CCN must accept and pre-process claims within two (2) business days of receipt. The CCN shall pre-process all claims and submit claims for payment on a fee-for-service basis to the FI.

DHH Responsibilities

DHH is responsible for administering the state's Coordinated Care Network Program. Administration includes data analysis, production of feedback and comparative reports to CCNs, data confidentiality, and the contents of this CCN Systems Companion Guide. Written questions or inquiries about the Guide must be directed to:

Ruth Kennedy	
Telephone	225 342 9240
Fax	225 342 9508
E-mail	Ruth.Kennedy@la.gov

DHH is responsible for the oversight of the Contract and CCN activities. DHH's claim responsibilities include production and dissemination of the Systems Companion Guide, the initiation and ongoing discussion of data quality improvement with each CCN, and CCN training. DHH is responsible for reimbursing providers for services rendered to CCN enrollees. DHH will update the Systems Companion Guide on a periodic basis.

Fiscal Intermediary (FI) Responsibilities

Molina is under contract with DHH to provide Louisiana Medicaid Management Information System (LMMIS) services including the acceptance of electronic claim reporting from the CCNs. DHH's FI will be responsible for accepting, editing and storing CCN 837 claims data. The FI will also provide technical assistance to the CCNs during the 837 testing process.

X12 Reporting

If the file contains syntactical errors, the segments and elements where the error occurred are reported in a 997 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship.

After claim adjudication, an ANSI ASC X12N 835 Remittance Advice (835) will be delivered to the CCN if requested by the CCN. The CCN must prearrange for receipt of 835 transactions.

Proprietary Reports

The FI will also provide CCNs with a monthly financial reconciliation report. The file layout can be found in Appendix D of this Guide.

Enrollment Broker Responsibilities

The Enrollment Broker shall make available to the CCN, via a daily and weekly 834 X12 transaction, updates on members newly enrolled, disenrolled or with demographic changes. At the end of each month, the Enrollment Broker shall reconcile enrollment/disenrollment with a full 834 X12 reconciliation file.

CCN Responsibilities

It is the CCN's responsibility to ensure accurate and complete claims reporting from their providers.

The CCN shall maintain an automated Management Information System (MIS), hereafter referred to as System, which accepts provider claims, verifies eligibility, validates prior authorization, pre-processes, and submits claims data to DHH's FI that complies with DHH and federal reporting requirements. The CCN shall ensure that its System meets the requirements of the RFP and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.

Claims Pre-processing

As it relates to the CCN Program, is the processing of all claims by a CCN for services provided to CCN members by Medicaid providers to verify service authorizations and ensure only clean claims are submitted to the FI for payment. Pre-processing will include, but not be limited to the following steps:

- Receipt of paper and EDI claims from providers
- Receipt of paper attachments necessary to substantiate a claim, if necessary
- Claims imaging, Image indexing, OCR and archiving
- Claims data capture
- Validation of eligibility
- Validation of prior authorization number
- Validation that visits do not exceed the number authorized or allowed by the CCN
- Generation of a claims internal control number (ICN)

Claims Submission

The CCN must accept and pre-process claims within two (2) business days of receipt. Preprocessed approved claims will be paid on a fee-for-service (FFS) basis by DHH. The ICN should reflect the Julian date that the claim was pre-processed.

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Transaction Set Supplemental Instructions

Introduction

The HIPAA transaction and code set regulation requires that covered entities exchanging specified transactions electronically must do so using the appropriate ANSI ASC X12 EDI formats. Further, HIPAA has defined how each of these transactions is to be implemented. Implementation instructions are contained in detailed instruction manuals known as implementation guides (IGs). The IGs provide specific instructions on how each loop, segment, and data element in the specified transaction set is used.

This Guide will not provide detailed instructions on how to map encounters from the Coordinated Care Networks' systems to the 837 transactions. The 837 IGs contain most of the information needed by the CCNs to complete this mapping.

CCNs shall create their 837 transactions for DHH using the HIPAA IG for Version 5010. On January 16, 2009, HHS published final rules to adopt updated HIPAA standards; these rules are available at the Federal Register.

In one rule, HHS is adopting X12 Version 5010 for HIPAA transactions. For Version 5010, the compliance date for all covered entities is January 1, 2012.

The ANSI ASC X12N 837 (Healthcare Claim Transactions – Institutional, Professional, and Dental) Companion Guide is intended for trading partner use in conjunction with the ANSI ASC X12N National Implementation Guide. The ANSI ASC X12N Implementation Guides can be accessed at http://www.wpc-edi.com/content.

File Transfer

The CCN shall be able to transmit, receive and process data in HIPAA compliant or DHH specific formats and/or methods, including but not limited to, secure File Transfer Protocol (FTP)

over a secure connection such as a Virtual Private Network (VPN), that are in use at the start of the Systems Readiness Review activities.

Prior Authorization

The CCN-S prior authorization number is to be populated in loop 2300, PRIOR AUTHORIZATION OR REFERRAL NUMBER, REF02, data element 127. The prior authorization number may not exceed 16 digits and must be in a numeric format. A reference identification qualifier value of G1 is to be used in REF01, data element 128.

Internal Control Number

The CCN ICN is to be populated in loop 2300, MEDICAL RECORD NUMBER, REF02, data element 127. A reference identification qualifier value of EA is to be used in REF01, data element 128.

Molina Companion Guides and Billing Instructions

Molina, as DHH's FI, provides Electronic Data Interchange (EDI) services. The EDI validates submission of ANSI X12 format(s). If the file contains syntactical error(s), the segments and elements where the error(s) occurred are reported in a 997 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship. The FI HIPAA Companion Guides can be found at www.lamedicaid.com or www.lmmis.com. Select HIPAA Billing Instructions and Companion Guides from the left hand menu.

Professional Identifiers

CCNs are required to submit the provider's NPI, Taxonomy Code and 9-digit zip code in each encounter.

Category II CPT Codes

DHH requires the use of applicable Category II CPT Codes or HCPCS Level II G-codes for performance measurement. These codes will facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures. In conjunction with the Category II CPT Codes, the PQRI quality-data codes (QDCs) codes follow current rules for reporting other CPT and HCPCS codes.

On the ASC X12N 837 professional health care claim transaction, Category II CPT and HCPCS Level II codes are submitted in the SV1 "Professional Service" Segment of the 2400 "Service Line" Loop. The data element for the procedure code is SV101-2 "Product/Service ID." Note that it is also necessary to identify in this segment that you are supplying a Category II CPT/HCPCS Level II G-code by submitting the "HC" code for data element SV101-1. Necessary data elements (or fields) include, but are not necessarily limited to, the following:

- Date of service;
- Place of service;
- PQRI QDC (s), along with modifier (if appropriate);

- Diagnosis pointer;
- Submitted charge ($0.00 shall be entered for PQRI codes);
- Rendering provider number (NPI).

The submitted charge field cannot be left blank. The amount of $0.00 shall be entered on the claim as the charge.

Transaction Type

The following tables provide guidance on the use of 837s. Please note that this guidance is subject to change. At present, the following provider types use 837I:

Provider Type	Description
44	Home Health Agency
54	Ambulatory Surgical Center
55	Emergency Access Hospital
59	Neurological Rehabilitation Unit (Hospital)
60	Hospital
64	Mental Health Hospital (Free-Standing)
65	Rehabilitation Center
69	Hospital – Distinct Part Psychiatric Unit
76	Hemodialysis Center
77	Mental Health Rehabilitation
80	Nursing Facility

The following provider types use 837P:

Provider Type	Description
07	Case Mgmt - Infants & Toddlers
08	Case Mgmt - Elderly
09	Hospice Services
12	Multi-Systemic Therapy
13	Pre-Vocational Habilitation
19	Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group
20	Physician (MD) and Physician (MD) Group
23	Independent Lab
24	Personal Care Services (LTC/PCS/PAS)

Provider Type	Description
25	Mobile X-Ray/Radiation Therapy Center
28	Optometrist and Optometrist Group
29	Title V Part C Agency Services (EarlySteps)
30	Chiropractor and Chiropractor Group
31	Psychologist
32	Podiatrist and Podiatrist Group
34	Audiologist
35	Physical Therapist
37	Occupational Therapist
39	Speech Therapist
40	DME Provider
41	Registered Dietician
42	Non-Emergency Medical Transportation
43	Case Mgmt - Nurse Home Visit - 1st Time Mother
46	Case Mgmt – HIV
51	Ambulance Transportation
61	Venereal Disease Clinic
62	Tuberculosis Clinic
66	KIDMED Screening Clinic
67	Prenatal Health Care Clinic
68	Substance Abuse and Alcohol Abuse Center
69	Hospital - Distinct Part Psychiatric Unit
70	EPSDT Health Services
71	Family Planning Clinic
72	Federally Qualified Health Center
73	Social Worker
74	Mental Health Clinic
75	Optical Supplier
78	Nurse Practitioner
79	Rural Health Clinic (Provider Based)
81	Case Mgmt - Ventilator Assisted Care Program
87	Rural Health Clinic (Independent)

Provider Type	Description
88	ICF/DD - Group Home
90	Nurse-Midwife
91	CRNA or CRNA Group
93	Clinical Nurse Specialist
94	Physician Assistant
95	American Indian / Native Alaskan "638" Facilities
96	Psychiatric Residential Treatment Facility
97	Residential Care

The following table provides guidance on specialty and associated provider types. Please note that this guidance is subject to change. At present, DHH Provider Specialty and Provider Type Crosswalk:

Specialty	Description	Associated Provider Types
01	General Practice	19,20
02	General Surgery	19,20,93
03	Allergy	19,20
04	Otology, Laryngology, Rhinology	19,20
05	Anesthesiology	19,20,91
06	Cardiovascular Disease	19,20
07	Dermatology	19,20
08	Family Practice	19,20,78
09	Gynecology (DO only)	19
10	Gastroenterology	19,20
12	Manipulative Therapy (DO only)	19
13	Neurology	19,20
14	Neurological Surgery	19,20
15	Obstetrics (DO only)	19
16	OB/GYN	19,20,78,90
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	19
18	Ophthalmology	20
19	Orthodontist	19,20

Specialty	Description	Associated Provider Types
20	Orthopedic Surgery	19,20
21	Pathologic Anatomy; Clinical Pathology (DO only)	19
22	Pathology	20
23	Peripheral Vascular Disease or Surgery (DO only)	19
24	Plastic Surgery	19,20
25	Physical Medicine Rehabilitation	19,20
26	Psychiatry	19,20,93
27	Psychiatry; Neurology (DO only)	19
28	Proctology	19,20
29	Pulmonary Diseases	19,20
30	Radiology	19,20
31	Roentgenology, Radiology (DO only)	19
32	Radiation Therapy (DO only)	19
33	Thoracic Surgery	19,20
34	Urology	19,20
35	Chiropractor	30,35
36	Pre-Vocational Habilitation	13
37	Pediatrics	19,20,93
38	Geriatrics	19,20
39	Nephrology	19,20
40	Hand Surgery	19,20
41	Internal Medicine	19,20
42	Federally Qualified Health Centers	72
44	Public Health	66,70
45	NEMT - Non-profit	42
46	NEMT - Profit	42
47	NEMT - F+F	42
48	Podiatry - Surgical Chiropody	20,32
49	Miscellaneous (Admin.	20

Specialty	Description	Associated Provider Types
	Medicine)	
51	Med Supply / Certified Orthotist	40
52	Med Supply / Certified Prosthetist	40
53	Med Supply / Certified Prosthetist Orthotist	40
54	Med Supply / Not Included in 51, 52, 53	40
55	Indiv Certified Orthotist	40
56	Indiv Certified Protherist	40
57	Indiv Certified Protherist - Orthotist	40
58	Indiv Not Included in 55, 56, 57	40
59	Ambulance Service Supplier, Private	51
60	Public Health or Welfare Agencies & Clinics	61,62,66,67
62	Psychologist Crossovers only	29,31
63	Portable X-Ray Supplier (Billing Independently)	25
64	Audiologist (Billing Independently)	29,34
65	Indiv Physical Therapist	29,35
66	Dentist, DDS, DMS	27
67	Oral Surgeon - Dental	27
68	Pedodontist	27
69	Independent Laboratory (Billing Independently)	23
70	Clinic or Other Group Practice	19,20,68,74,76
71	Speech Therapy	29
72	Diagnostic Laboratory	23
73	Social Worker Enrollment	73
74	Occupational Therapy	29,37
75	Other Medical Care	65
76	Adult Day Care	85
77	Habilitation	85

Specialty	Description	Associated Provider Types
78	Mental Health Rehab	77
79	Nurse Practitioner	78
81	Case Management	07,08,43,46,81
83	Respite Care	83
85	Extended Care Hospital	60
86	Hospitals and Nursing Homes	55,59,60,64,69, 80,88
87	All Other	26,40,44
88	Optician / Optometrist	28,75
93	Hospice Service for Dual Elig.	09
94	Rural Health Clinic	79,87
95	Psychologist (PBS Program Only)	31
96	Psychologist (PBS Program and X-Overs)	31
97	Family Planning Clinic	71
1T	Emergency Medicine	19,20
2R	Physician Assistant	94
2T	American Indian/Native Alaskan	95
4R	Registered Dietician	41
5B	PCS-EPSDT	24
5C	PAS	24
5F	PCS-EPSDT, PAS	24
5H	Community Mental Health Center	18
5M	Multi-Systemic Therapy	12
6A	Psychologist -Clinical	31
6B	Psychologist-Counseling	31
6C	Psychologist - School	31
6D	Psychologist - Developmental	31
6E	Psychologist - Non-Declared	31
6F	Psychologist - All Other	31
6N	Endodontist	27
6P	Periodontist	27

Specialty	Description	Associated Provider Types
7A	SBHC - NP - Part Time - less than 20 hrs week	38
7B	SBHC - NP - Full Time - 20 or more hrs week	38
7C	SBHC - MD - Part Time - less than 20 hrs week	38
7D	SBHC - MD - Full Time - 20 or more hrs week	38
7E	SBHC - NP + MD - Part Time - combined less than 20 hrs week	38
7F	SBHC - NP + MD - Full Time - combined less than 20 hrs week	38
9B	Psychiatric Residential Treatment Facility	96
9D	Residential Care	97

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Repairable Denial Edit Codes and Descriptions

DHH has modified edits for claims processing. In order to ensure DHH has the most complete data for rate setting and data analysis, the provider and/or the CCN is to repair as many edit codes as possible. The table below represents the edit codes that must be corrected with assistance from the CCN.

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE UNDER LIMITED CIRCUMSTANCES) EDIT DESCRIPTION
110	REBILL OB/ABORT D&C
161	HOSP-STAY-REQUIRES-PRECERT
187	PA-THRU-CLAIM-THRU-NOT-SAME
191	PROC-REQUIRES-PRIOR-AUTH
265	SURG REQUIRES PA-0
468	JUSTIFY EYEGLASSES
469	EYEWEAR DENIED
512	VNS REPROGRAMMING
538	REVIEW-DIAG-MED
621	RESUBMIT-WITH-REPORTS
627	SEND MED NECESSITY
664	1 PAYABLE/180 DAYS
770	PERTINENT HIST/REQ
786	UNKNOWN ABBREVATION
950	OPERATIVE-REQUESTED

Claim Correction Process

DHH's FI will submit remittance advices to the providers the day after they are produced by the MMIS adjudication cycle via the web. The CCNs are to assist providers with obtaining the required or missing information and resubmitting the claims in accordance with an approved quality assurance plan.

4

Files and Reports

The following list of electronic files or reports are to be submitted by CCNs, DHH and the Enrollment Broker. The format and/or layout requirements for each file or report are located in either this Guide, the Quality Companion Guide, or are still at a developmental stage. As the following list may not be all inclusive, it is the CCNs responsibility to ensure that all required files or reports, as stated in the RFP, are submitted to DHH in a timely manner.

Unless otherwise specified, deadlines for submitting files and reports are as follows:

- Daily reports and files shall be submitted within one (1) business day following the due date;
- Weekly reports and files shall be submitted on the Wednesday following the reporting week;
- Monthly reports and files shall be submitted within fifteen (15) calendar days of the end of each month;
- Quarterly reports and files shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;
- Annual reports and files shall be submitted within thirty (30) calendar days following the twelfth (12th) month; and
- Ad Hoc reports shall be submitted within three (3) business days from the agreed upon date of delivery.

Responsible Party	Receiving Party	File/Report Name	Frequency
DHH-FI	EB	New Enrollee File	Daily
Enrollment Broker	CCN and DHH-FI	Member Linkage File	Daily
Enrollment Broker	CCN and DHH-FI	Member Disenrollment File	Daily
DHH-FI	CCN	CCN-S Monthly PMPM Reconciliation File	Monthly
CCN	DHH-FI	Network Provider and Subcontractor Registry	At Readiness Review and Monthly thereafter
DHH-FI	CCN	Claims Historical Data & Immunization Data	Prior to Readiness Review

5

Transaction Testing and EDI Certification

Introduction

CCNs are required to undergo Trading Partner testing with the FI prior to electronic submission of claims data. Testing is conducted to verify that the transmission is free of format errors. In order to simulate a production environment, CCNs are requested to send real transmission data. The FI does not define the number of claims in the transmission; however, DHH will require a minimum set of claims for each transaction type based on testing needs.

If a CCN rendering contracted provider has a valid NPI and taxonomy code, the CCN will submit those values in the 837. If the provider is an atypical provider, the CCN must follow 837 atypical provider guidelines.

Test Process

The Electronic Data Interchange (EDI) protocols are available at: http://www.lamedicaid.com/provweb1/billing_information/medicaid_billing_index.htm or www.lmmis.com/provweb1/default.htm and choosing Electronic Claims Submission (EMC). Below are the required steps of the testing process. Please refer to Appendix F for the testing process.

Electronic Data Interchange (EDI)

Enrollment as an EDI submitter is achieved through the completion of the DHH/FI approval process and the successful testing of provider claims of a particular claim type. The FI EDI Coordinator is available to assist in answering questions, but enrollment and participation proceed through the following steps:

- Upon request from an approved CCN, the FI will provide application and approval forms for completion by the submitter. When completed, these forms must be submitted to the FI Provider Enrollment Unit.
- During the authorization process, the prospective CCN can call the EDI Department to receive EDI specifications that contain the data and format requirements for creating EDI

claims. Using these specifications, the potential submitter develops and tests application software to create EDI claims.

- Molina requires CCNs to certify with a third-party vendor, EDIFECS, prior to submitting test claims to Molina.
- When the submitter is ready to submit a file of test claims, the test claims should be submitted to the FI EDI Coordinator using the submitter number: 4509999. The test submission is run through Louisiana Medicaid Management Information System (MMIS) programs that validate the data and formats. Reports produced from this testing are reviewed by the FI. The test results are verified and the submitter is contacted to review any problems with the submission. If necessary, additional test claims will be submitted until an acceptable test run is completed. **This test submitter number (4509999) should be used for submission of test claims only!**

When all forms have been received and approved by the FI's Provider Enrollment Unit, and the EDI Department has verified the test claims, the submitter will be notified that EDI claims may be submitted.

Once a CCN becomes an approved EDI submitter, the billing process will be as follows:

- Upon receipt of the submission, the FI's EDI Department logs the submission and verifies it for completeness. If the submission is not complete, the log is rejected and the submitter is notified about the reject reason(s) via electronic message or telephone call.
- If the certification form is complete, the EDI Department enters the submitted claims into a pre-processor production run. The pre-processor generates an claims data file and one report. The Claims Transmittal Summary report, which lists whether a provider's batch of claims has been accepted or rejected, is generated for each submission. If a provider's claims are rejected, the provider number, dollar amount and number of claims are listed on the report.

CCNs will submit to DHH and its FI a test plan with systematic plans for testing the ASC X12N 837 COB. The plan consists of three (3) tiers of testing, which are outlined in detail in Appendix F.

Timing

CCNs may initiate EDIFECS testing at any time. DHH's FI Business Support Analysts are ready to answer technical questions and to arrange testing schedules and EDIFECS enrollment. Please refer to the FI Companion Guides located at: www.lamedicaid.com/provweb1/HIPAABilling/HIPAAindex.htm for specific instructions.

Appendix A

Definition of Terms

The following terms shall be construed and interpreted as follows unless the context clearly requires otherwise.

837 Format	The file format used for electronic billing of professional services, institutional services or dental services. ANSI 837 is shorthand for the ASC X12N 837 (004010X098A1) file format.
997 Functional Acknowledgment	Transaction set-specific verification is accomplished using a 997 Functional Acknowledgement. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents.
Administrative Region	Louisiana Medicaid is divided into 9 geographically-defined regions according to the following coded values: 1=New Orleans 2=Baton Rouge 3=Houma/Thibodaux 4=Lafayette 5=Lake Charles 6=Alexandria 7=Shreveport 8=Monroe 9=Covington/Bogalusa
Agent	Any person or entity with delegated authority to obligate or act on behalf of another party.

Atypical providers	Individuals or businesses that bill Medicaid for services rendered, and do not meet the definition of a health care provider according to the NPI Final Rule 45 CFR 160.103 (e.g., carpenters, transportation providers, etc).
Benefits or Covered Services	Those health care services to which an eligible Medicaid recipient is entitled under the Louisiana Medicaid State Plan.
CAS Segment	Used to report claims or line level adjustments.
Case Management	Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's needs through communication and available resources, to promote high quality, cost-effective outcomes. Case Management services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Case Management services include an individual needs assessment and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and monitoring outcomes.
Centers for Medicare and Medicaid Services (CMS)	The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. Formerly known as Health Care Financing Administration (HCFA).
Claim adjustment	A reason why a claim or service line was paid differently than it was billed. Adjustments are communicated by adjustment reason codes.
Claim denial	When a claim does not meet the criteria of being complete or does not meet all of the criteria for payment under health plan rules.
Claims adjudication	In health insurance claims, adjudication refers to the determination of the insurer's payment or financial responsibility, after the member's insurance benefits are applied to a medical claim.

CommunityCARE 2.0	Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program, which links Medicaid enrollees to a primary care provider as their medical home.
Contract	As it pertains to the Louisiana Department of Health and Hospitals (DHH) and the CCNs, the contract signed by or on behalf of the CCN entity and those things established or provided for in R.S. 46:437.11 - 437.14 or by rule, which enrolls the entity in the Medical Assistance Program and grants to the entity provider number and the privilege to participate in the CCN program. It includes the signed Contract, together with any and all future addendums issued thereto by DHH.
Coordinated Care Network (CCN)	An entity designed to improve performance and health outcomes through the creation of cost effective integrated healthcare delivery system that provides a continuum of evidence-based, quality-driven healthcare services for Medicaid eligibles.
Coordinated Care Network – Prepaid (CCN-P)	The private entity that contracts with DHH to provide core benefits and services to Louisiana Medicaid CCN Program enrollees in exchange for a monthly prepaid capitated amount per member. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to Title 22 of the Louisiana Revised Statues, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid Program be regulated by the Louisiana Department of Health and Hospitals.
Coordinated Care Network – Shared Savings (CCN-S)	An entity that serves as a primary care case manager by providing enhanced primary care case management in addition to contracting with primary care providers (PCPs) for primary care management.
Coordination of Benefits (COB)	Refers to the activities involved in determining Medicaid benefits when a recipient has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.
Co-payment	Any cost sharing payment for which the Medicaid CCN member is responsible for in

	accordance with 42 CFR § 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.
Core Benefits and Services	A schedule of health care benefits and services required to be provided by the CCN to Medicaid CCN members as specified under the terms and conditions of the RFP and Louisiana Medicaid State Plan.
Corrective Action Plan (CAP)	A plan developed by the CCN that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency.
Corrupt data	Data corruption refers to errors in electronic data that occur during transmission, retrieval, or processing, introducing unintended changes to the original data. Computer storage and transmission systems use a number of measures to provide data integrity and the lack of errors. In general, when there is a Data Corruption, the file containing that data would be inaccessible, and the system or the related application will give an error. There are various causes of corruption.
Covered Services	Those health care services/benefits to which an individual eligible for Medicaid is entitled under the Louisiana Medicaid State Plan.
Data Certification	The Balanced Budget Act (BBA) requires that when State payments to a CCN are based on data that is submitted by the CCN, the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State.
Department (DHH)	The Louisiana Department of Health and Hospitals, referred to as DHH.
Department of Health and Human Services (DHHS; also HHS)	The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least

	able to help themselves. The DHHS includes more than 300 programs, covering a wide spectrum of activities, including medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; overseeing Medicare, Medicaid and CHIP; and providing financial assistance for low-income families.
Dispute	An expression of dissatisfaction about any matter other than an action, as action is defined. Examples of a Dispute include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee, and network administration practices. Administrative Disputes are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, or access to care issues.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A federally required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (CFR 440.40 (b)). EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of “medical assistance”.
Edit Code Report	A proprietary report prepared by the Fiscal Intermediary that includes all of the edit codes for each claim line and each claim header. Some edit codes indicate that the encounter has denied. Other edit codes are informational only.
EDI Certification	EDI Certification essentially provides a snapshot that asserts an entity is capable at that point in time of generating or receiving compliant files. It is based solely on the files that have been tested and submitted for certification. Specifically, it is based on the exact capabilities that are reflected within those files. Testing and certification are typically done through a third party vendor prior to encounters being submitted to the Fiscal Intermediary.

Eligible	An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under the Title XIX or Title XXI of the Social Security Act.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. Emergency care requires immediate face-to-face medical attention.
Enrollee	Louisiana Medicaid or CHIP recipient who is currently enrolled in a CCN or other managed care program.
Enrollment	The process conducted by the Enrollment Broker by which an eligible Medicaid recipient becomes a member of a CCN.
Enrollment Broker	The states contracted or designated agent that performs functions related to outreach, education, choice counseling, enrollment and disenrollment of potential enrollees and enrollees into a CCN.
Evidence-Based Practice	Clinical interventions that have demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, and other related activities as set forth in federal regulations, or both.
Federally Qualified Health Center (FQHC)	An entity that receives a grant under Section 330 of the Public Health Service Act, as amended, (also see Section 1905(1) (2) (B) of the Social Security Act), to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

Fee for Service (FFS)	A method of provider reimbursement based on payments for specific services rendered to an individual enrolled in Louisiana Medicaid.
File Transfer Protocol (FTP)	Software protocol for transferring data files from one computer to another with added encryption.
Fiscal Intermediary (FI)	DHH's designee or agent responsible in the current delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.
Fiscal Year (FY)	Refers to budget year – A Federal Fiscal Year is October 1 through September 30 (FFY); A State Fiscal Year is July 1 through June 30 (SFY).
Fraud	As it relates to the Medicaid Program Integrity; means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.
Health Care Professional	A physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law. Other health care practitioner includes any includes any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health Care Provider	A health care professional or entity who provides health care services or goods.
Healthcare Effectiveness Data and Information Set (HEDIS)	A set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures were designed to help health care purchasers understand the value of health care purchases and measure plan (i.e., CCN) performance.
HIPAA – Health Insurance Portability Administration Act	The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. As the industry has implemented these standards, and increased the use of electronic data interchange, the nation's health care system will become increasingly effective and efficient.
Immediate	In an immediate manner; instant; instantly or without delay, but not more than 24 hours.
Implementation Date	The date DHH notifies the CCN of on-site Readiness Review completion and approval. It differs from the service start-up or “go live” date (which should be roughly five months from the implementation date). At implementation, a CCN can begin the process of establishing all systems for the subsequent enrollment of Medicaid eligibles and service start-up date, and preparing for DHH’s on-site Readiness Review. Enrollment of members will not begin until the CCN has signed a Contract with DHH and passed the Readiness Review or at the “go live” date.
Information Systems (IS)	A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

Interchange Envelope	Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Internal Control Number (ICN)	DHH's FI assigns each claim an Internal Control Number (ICN) systematically when it is received electronically or by mail. Processing or returning the claim constitutes the FI's final action on that claim. A resubmission of the same claim is considered a new claim. Each claim sent to the FI is assigned an ICN automatically, which is used to track the claim. The ICN is made up of 13 digits following a specific format. The format of the ICN enables you to determine when the FI actually received the claim.
KIDMED	Louisiana's screening component for Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program provided for Medicaid eligible children under the age of 21. Required by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89).
Louisiana Department of Health and Hospitals (DHH)	The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.
Medicaid	A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals.
Medicaid FFS Provider	An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, has been approved by DHH, and accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.
Medicaid Management Information System (MMIS)	A mechanized claims processing and

	information retrieval system, which all states Medicaid programs are required to have, and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Eligibles.
Medicaid Recipient	An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH may make payments under the Medicaid or CHIP Program, who may or may not be currently enrolled in the Medicaid or CHIP Program, and on whose behalf payment is made.
Medical Vendor Administration (MVA)	Refers to the name for the budget unit specified in the Louisiana state budget that contains the Bureau of Health Services Financing (Louisiana's single state Medicaid Agency).
Medically Necessary Services	Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the patient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, cosmetic, or intended primarily for the convenience of the recipient or the provider, are specifically excluded from Medicaid coverage and will be

	deemed "not medically necessary". The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing such a service in his discretion on a case-by-case basis.
Medicare	The federal medical assistance program in the United States authorized in 1965 by Title XVIII of the Social Security Act, to address the medical needs of older American citizens. Medicare is available to U.S. citizens 65 years of age and older and some people with disabilities under age 65.
Member	As it relates to the Louisiana Medicaid Program and the Contract, refers to a Medicaid eligible who enrolls in a CCN under the provisions of the Contract and also refers to "enrollee" as defined in 42 CFR 438.10(a).
National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
Network	As utilized in the Contract, "network" may be defined as a group of participating providers linked through contractual arrangements to a CCN to supply a range of primary and acute health care services. Also referred to as Provider Network.
Newborn	A live infant born to a CCN member.
Non-Contracting Provider	A person or entity that provides hospital or medical care, but does not have a contract, or agreement with the CCN.

Non-Covered Services	Services not covered under the Title XIX Louisiana State Medicaid Plan.
Non-Emergency	An encounter by a CCN member who has presentation of medical signs and symptoms, to a health care provider, and not requiring immediate medical attention.
Performance Measures	Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.
Policies	The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state and/or federal rules and regulations.
Primary Care Case Management (PCCM)	A system under which a PCCM contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.
Primary Care Provider (PCP)	An individual physician or other licensed nurse practitioner responsible for the management of a member's health care who is licensed and certified in one of the following general specialties; family practitioner, general practitioner, general pediatrician, general internal medicine, general internal medicine and pediatrics, or obstetrician/ gynecologist. The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.
Primary Care Services	Health care services and laboratory services customarily furnished by or through a primary care provider for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either through, direct service to the member when possible, or through appropriate referral to specialists and/or ancillary providers.
Prior Authorization	The process of determining medical necessity

	for specific services before they are rendered.
Prospective Review	Utilization review conducted prior to an admission or a course of treatment.
Protected Health Information (PHI)	Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 160 and 164.
Provider	Either (1) for the Fee-For-Service Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the CCN Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services.
Provider Specialty	A second-level qualification code, specific to Louisiana Medicaid, that designates the specialty classification of a provider according to Louisiana State Plan for Medicaid (for example, for physicians, some specialties are General Practice, Pediatrics, Family Medicine, etc.).
Provider Type	A high-level identification code, specific to Louisiana Medicaid, that designates the service classification of a provider according to Louisiana State Plan for Medicaid (for example, physician, dentist, pharmacy, hospital, etc.).
Quality	As it pertains to external quality, review means the degree to which a CCN increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.
Quality Assessment and Performance Improvement Program (QAPI Program)	Program that objectively and systematically defines, monitors, evaluates the quality and appropriateness of care and services, and promotes improved patient outcomes through performance improvement projects, medical record audits, performance measures, surveys, and related activities.
Quality Assessment and Performance Improvement	A written plan, required of all CCN-P entities,

Plan (QAIP Plan)	detailing quality management and committee structure, performance measures, monitoring and evaluation process and improvement activities measures that rely upon quality monitoring implemented to improve health care outcomes for enrollees.
Quality Management (QM)	The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.
Readiness Review	Refers to DHH's assessment of the CCN's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of CCN standards; and review of systems. The review may be done as a desk review, on-site review, or combination and may include interviews with pertinent personnel so that DHH can make an informed assessment of the CCN's ability and readiness to render services.
Recipient	An individual entitled to benefits under Title XIX of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid and on whose behalf a payment has been made for medical services rendered.
Reject	Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 997 (Functional Acknowledgement) will be returned to the submitter. The 997 contains ACCEPT or REJECT information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
Remittance Advice	An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the CCN, payments for maternity, and adjustments.
Repairable Edit Code	An encounter that denies for a reason that is repairable (shall be fixed and resubmitted) will have an accompanying "repairable edit code

	"code" to indicate that the encounter is repairable.
Representative	Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative.
Risk	The chance or possibility of loss. The member is at risk only for pharmacy co-payments as allowed in the Medicaid State Plan and the cost of non-covered services. The CCN, with its income fixed, is at risk for whatever volume of care is entailed, however costly it turns out to be. Risk is also defined in insurance terms as the possibility of loss associated with a given population.
Rural Health Clinic (RHC)	A clinic located in an area that has a healthcare provider shortage that provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services; and which must be reimbursed on a prospective payment system.
SE Segment	The 837 transaction set trailer.
Security Rule (45 CFR Parts 160 & 164)	Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.
Service Area	Referred to as geographic service area (GSA) in the Contract. The designated geographical service area(s) within which the CCN is authorized to furnish covered services to enrollees. A service area shall not be less than one GSA.
Service Line	A single claim line as opposed to the entire claim or the claim header.
Shall	Denotes a mandatory requirement.
Should	Denotes a preference but not a mandatory requirement.

Social Security Act	The current version of the Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).
Span of Control	Information systems and telecommunications capabilities that the CCN itself operates, or for which it is otherwise legally responsible according to the terms and conditions of the Contract with DHH. The span of control also includes systems and telecommunications capabilities outsourced by the CCN.
ST Transaction Set Header	Indicates the start of a transaction set and to assign a control number.
Start-Up Date	The date CCN providers begin providing medical care to their Medicaid members. Also referred to as “go-live date”.
State	The state of Louisiana.
Stratification	The process of partitioning data into distinct or non-overlapping groups.
Surveillance and Utilization Review Subsystems (SURS) Reporting	Surveillance and Utilization Review Subsystems is reporting as required in the subsection under Fraud, Abuse and Waste Prevention.
Syntactical Error	Syntax is the term associated with the "enveloping" of EDI messages into interchanges. Items included in Syntax Set maintenance include: "Delimiters" which separate individual elements and segments within the interchange; "Envelope segments" which denote the beginning and ending of messages, functional groups, and interchanges; and "Permitted Characters" which define the values allowed for a particular syntax set. Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 997 (Functional Acknowledgement) will be returned to the submitter. The 997 contains ACCEPT or REJECT information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.

System Function Response Time	Based on the specific sub function being performed: • Record Search Time-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor. • Record Retrieval Time-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor. • Print Initiation Time- the elapsed time from the command to print a screen or report until it appears in the appropriate queue. • On-line Claims Adjudication Response Time- the elapsed time from the receipt of the transaction by the CCN from the provider and/or switch vendor until the CCN hands-off a response to the provider and/or switch vendor.
System Unavailability	Measured within the CCN's information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key.
TA1	The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions. Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Taxonomy codes	These are national specialty codes used by providers to indicate their specialty at the

	claim level.
Trading Partners	Covered entities who are involved in Electronic Data Interchange involving HIPAA ANSI transactions.
Utilization Management (UM)	Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM is inclusive of utilization review and service authorization.
Validation	The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis.
Will	Denotes a mandatory requirement.

Appendix B

Frequently Asked Questions (FAQs)

What is Molina and what is their role with CCNs?

Molina is under contract as DHH's Fiscal Intermediary and responsible for providing functions and services to receive and send ANSI ASC X12N transactions on behalf of their clients.

Is there more than one 837 format? Which should I use?

There are three HIPAA-compliant 837 transactions — Institutional, Professional, and Dental services. The transactions CCNs will use will depend upon the type of service being reported.

Whom do I contact if I have a question regarding the EDI Information Sheet or need technical assistance concerning electronic claim submission?

You may contact the Molina EDI Support Unit Monday through Friday, from 8:00 a.m. to 5:00 p.m. CDT, at 225-216-6303.

I am preparing for testing with EDIFECS. Whom do I contact for more information?

For answers to questions regarding specifications and testing, please contact Molina's EDI Business Support Analysts at 225-216-6303.

Will DHH provide us with a paper or electronic remittance advice?

DHH's FI will provide CCNs with an electronic 835 Health Care Claim Payment/Advice (ERA), if requested and arranged in advance.

Where can I find HIPAA code lists, including the Claim Adjustment Reason Codes and Remittance Remark Codes, which appear in the 835 Health Care Claim?

The Claim Adjustment Reason Codes provide the "explanation" for the positive or negative financial adjustments specific to particular claims or services that are referenced in the 835.

The Remittance Remark Codes are used in the 835 to relay informational messages that cannot be expressed with a Claim Adjustment Reason Code. These codes are all nationally mandated codes that must be used by payers in conjunction with the 835.

Payers may no longer use the proprietary codes that they used prior to HIPAA, even if the proprietary codes give better details about how a claim was adjudicated.

HIPAA code lists can be found on the Washington Publishing Company's website at http://www.wpc-edi.com/codes/.

We understand that DHH will require the NPI, taxonomy code and 9-digit zip of the provider to process the 837 COB. Is this correct?

Yes, that is correct. Effective with claims and claim submissions after May 23, 2008, all providers are required to have an NPI and taxonomy. DHH will also require that a 9-digit zip code be placed on the claim.

Does Molina have any payer-specific instructions for 837 COB transactions?

Yes, the Molina Companion Guides contain a number of payer-specific instructions for 837 transactions. The FI Companion Guides can be found at www.lamedicaid.com. Once on the DHH website, choose HIPAA Billing Instructions & Companion Guides from the left hand menu. There are separate companion guides for each of the 837 transactions.

What is a Trading Partner ID?

The Trading Partner ID is a number assigned by the FI for each submitter of claim data. You are assigned this ID prior to testing.

Appendix C

Code Sets

The use of standard code sets will improve the effectiveness and efficiency of Medicaid, Federal, and other private health programs through system administration simplification and efficient electronic transmission of certain health information. Code set means any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A code set includes the codes and the descriptors of the codes.

When conducting 837 transactions, DHH requires CCNs to adhere to HIPAA standards governing Medical data code sets. Specifically, CCNs must use the applicable medical data code sets described in §162.1002, as specified in the IGs that are valid at the time the health care is furnished. CCNs are also required to use the non-medical data code sets, as described in the IGs that are valid at the time the transaction is initiated.

DHH requires CCNs to adopt the following standards, or their successor standards, for Medical code sets:

A. International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9- CM), Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following conditions:

- Diseases;
- Injuries;
- Impairments;
- Other health problems and their manifestations; and
- Causes of injury, disease, impairment, or other health problems.

B. ICD-9-CM, Volume 3 Procedures (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following procedures or other actions taken for diseases, injuries, and impairments on inpatients reported by hospitals:
   - Prevention,

- Diagnosis,
- Treatment, and
- Management.

C. National Drug codes (NDC), as maintained and distributed by DHHS, in collaboration with drug manufacturers, for the following:

- Drugs and
- Biologics.

D. Current Dental Terminology (CDT) Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association (ADA) for dental services.

E. The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by DHHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association (AMA), for physician services and other health care services. Category I CPT codes describe a procedure or service identified with a five-digit CPT code and descriptor nomenclature. The inclusion of a descriptor and its associated specific five-digit identifying G-code number in this category of CPT codes is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations. Services described by Category I CPT codes include, but are not limited to, the following:

- Physician services,
- Physical and occupational therapy services,
- Radiological procedures,
- Clinical laboratory tests,
- Other medical diagnostic procedures,
- Hearing and vision services, and
- Transportation services, including ambulance.

In addition to the Category I codes described above, DHH requires that CCNs submit CPT Category II codes. CPT Category II codes are supplemental tracking G-codes that can be used for performance measurement. The use of the tracking G-codes for performance measurement will decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. Some codes in this category may relate to compliance by the health care professional with state or federal law.

F. The HCPCS, as maintained and distributed by DHHS, for all other substances, equipment, supplies, or other items used in health care services. These items include, but are not limited to, the following:

- Medical supplies,
- Orthotic and prosthetic devices, and
- Durable medical equipment.

Appendix D

System Generated Reports

Claims Summary — Molina FILE CCN-W-001

This report will serve as the high-level error report for the CCNs as a summarization of the errors incurred. The format, as depicted below, is by claim type. This report **will be distributed as a delimited text file** and it will produce the overall claim count with the disposition of MMIS paid or denied status occurrence and overall percentage. The number and percent to be denied represent all denials.

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "**CCN-W-001**"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Report Date	Date that the report was created by Molina.	8	Numeric, format YYYYMMDD
22	Delimiter		1	Uses the ^ character value
23-72	Report Description	Value is "**Claims**	50	Character

Column(s)	Item	Notes	Length	Format
		Summary"		
73	Delimiter		1	Uses the ^ character value
74-80	CCN Provider ID	Medicaid Provider ID associated with the CCN.	7	Numeric
81	Delimiter		1	Uses the ^ character value
DETAIL RECORD		There may be multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "**CCN-W-001**"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record. The detail portion of the file is sorted by this number	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Claim Type	Will have one of these values: 01=Inpatient 02=LTC/NH 03=Outpatient 04=Professional 05=Rehab 06=Home Health Outpatient 07=Emergency Medical Transportation 08=Non-emergency Medical	2	Numeric

Column(s)	Item	Notes	Length	Format
		Transportation 09=DME 10=Dental 11=Dental 12=Pharmacy 13=EPSDT Services. 14=Medicare Crossover Instit. 15=Medicare Crossover Prof		
25	Delimiter		1	Uses the ^ character value
26-33	Number of claim records accepted		8	Numeric, no commas, decimal points.
34	Delimiter		1	Uses the ^ character value
35-42	Number of claim records denied		8	Numeric, no commas, decimal points.
43	Delimiter		1	Uses the ^ character value
44-51	Percentage of Denied Claims		8	Numeric, with decimal point. For example, 00015.99 represents 15.99%
52	Delimiter		1	Uses the ^ character value
53-81	End of Record		29	Value is spaces.
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Character
2	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
3-12	Report ID	Value is "**CCN-W-001**"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Not Used		8	Character value is spaces.
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^ character value
26-33	Total Number of Claim records accepted		8	Numeric, no commas, decimal points.
34	Delimiter		1	Uses the ^ character value
35-42	Total Number of Claim records denied		8	Numeric, no commas, decimal points.
43	Delimiter		1	Uses the ^ character value
44-51	Overall Percentage of Denied Claims		8	Numeric, with decimal point. For example, 00015.99 represents 15.99%
52	Delimiter		1	Uses the ^ character value
53-81	End of Record		29	Value is spaces.

Claim EDIT Disposition Summary — Molina Report CCN-W-005

This report will serve as the high-level edit report for the CCNs as a summarization of the edit codes incurred. The format, as depicted below, is by claim type. This report **will be distributed as a delimited text file** and it will produce the overall edit code disposition, edit code, and the number of edit codes from the submission.

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "**CCN-W-005**"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Report Date	Date that the report was created by Molina.	8	Numeric, format YYYYMMDD
22	Delimiter		1	Uses the ^ character value
23-72	Report Description	Value is "**EDIT Disposition Summary**"	50	Character
73	Delimiter		1	Uses the ^ character value
74-80	CCN Provider ID	Medicaid Provider ID associated with the CCN.	7	Numeric
81	Delimiter		1	Uses the ^ character value
DETAIL RECORD		There may be multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^

Column(s)	Item	Notes	Length	Format
				character value
3-12	Report ID	Value is "**CCN-W-005**"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record. The detail portion of the file is sorted by this number.	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Claim Type	Will have one of these values: 01=Inpatient 02=LTC/NH 03=Outpatient 04=Professional 05=Rehab 06=Home Health Outpatient 07=Emergency Medical Transportation 08=Non-emergency Medical Transportation 09=DME 10=Dental 11=Dental 12=Pharmacy 13=EPSDT Services 14=Medicare Crossover Instit. 15=Medicare Crossover Prof.	2	Numeric
25	Delimiter		1	Uses the ^ character value
26-29	Error Code		4	Numeric

Column(s)	Item	Notes	Length	Format
30	Delimiter		1	Uses the ^ character value
31-38	Number of claim records having this error code		8	Numeric
39	Delimiter		1	Uses the ^ character value
40-81	End of Record		42	Value is spaces.
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "**CCN-W-005**"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Total Detail Lines in the file	This is a number that represents the total detail lines submitted in the file.	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^ character value
26-29	Unused		4	Value is spaces
30	Delimiter		1	Uses the ^ character value
31-38	Total Number of Claim	This value should match that of the CCN-	8	Numeric

Column(s)	Item	Notes	Length	Format
	records denied	W-001 file. It may not equal the total of all detail lines in the CCN-W-005 file because one claim may have several edits.		
39	Delimiter		1	Uses the ^ character value
40-81	End of Record		42	Value is spaces.

Claim detail — Molina file CCN-W-010

This report lists claims detail as adjudicated in the MMIS. **This report will be distributed as a delimited text file** and it is a detailed listing by header and line item of the edits applied to the claim data.

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "**CCN-W-010**"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Report Date	Date that the report was created by Molina.	8	Numeric, format YYYYMMDD
22	Delimiter		1	Uses the ^ character value
23-72	Report Description	Value is "**Claim Detail**"	50	Character
73	Delimiter		1	Uses the ^ character

Column(s)	Item	Notes	Length	Format
				value
74-80	CCN Provider ID	Medicaid Provider ID associated with the CCN.	7	Numeric
81	Delimiter		1	Uses the ^ character value
82-321	End of Record		240	Value is spaces.
DETAIL RECORD		There may be multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "**CCN-W-010**"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record. The detail portion of the file is sorted by this number	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-35	Claim ICN	Internal Claim Number, assigned by Molina. Unique per claim line.	13	Numeric
36	Delimiter		1	Uses the ^ character value
37-66	Medical Record Number	Submitted on the claim by the CCN.	30	Character
67	Delimiter		1	Uses the ^ character value
68-87	Patient	Submitted on	20	Character

Column(s)	Item	Notes	Length	Format
	Control Number	the claim by the CCN		
88	Delimiter		1	Uses the ^ character value
89-118	Line Control Number	Submitted on the claim by the CCN	30	Character
119	Delimiter		1	Uses the ^ character value
120-128	Remittance Advice Number	Assigned by Molina	9	Numeric
129	Delimiter		1	Uses the ^ character value
130-133	Error Code 1	First error code, if claim was denied.	4	Numeric
134	Delimiter		1	Uses the ^ character value
135-138	Error Code 2 (if necessary)	2nd error code, if claim was denied and if available.	4	Numeric
139	Delimiter		1	Uses the ^ character value
140-143	Error Code 3 (if necessary)	3rd error code, if claim was denied and if available.	4	Numeric
144	Delimiter		1	Uses the ^ character value
145-148	Error Code 4 (if necessary)	4th error code, if claim was denied and if available.	4	Numeric
149	Delimiter		1	Uses the ^ character value
150-153	Error Code 5	5th error code,	4	Numeric

Column(s)	Item	Notes	Length	Format
	(if necessary)	if claim was denied and if available.		
154	Delimiter		1	Uses the ^ character value
155-158	Error Code 6 (if necessary)	6th error code, if claim was denied and if available.	4	Numeric
159	Delimiter		1	Uses the ^ character value
160-163	Error Code 7 (if necessary)	7th error code, if claim was denied and if available.	4	Numeric
164	Delimiter		1	Uses the ^ character value
165-168	Error Code 8 (if necessary)	8th error code, if claim was denied and if available.	4	Numeric
169	Delimiter		1	Uses the ^ character value
170-173	Error Code 9 (if necessary)	9th error code, if claim was denied and if available.		
174	Delimiter		1	Uses the ^ character value
175-178	Error Code 10 (if necessary)	10th error code, if claim was denied and if available.		
179	Delimiter		1	Uses the ^ character value
180	Not used		1	Character
181	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
182-195	Not used		14	Numeric with decimal point, left zero-fill.
196	Delimiter		1	Uses the ^ character value.
197-204	DOS-From		8	Numeric, YYYYMMDD
205	Delimiter		1	Uses the ^ character value.
206-213	DOS-Through		8	Numeric, YYYYMMDD
214	Delimiter		1	Uses the ^ character value.
215-227	Medicaid Recipient ID	Recipient's current Medicaid ID number	13	Character
228	Delimiter		1	Uses the ^ character value.
229-242	Provider Billed Charges	Billed charges from provider as submitted by CCN on claim	14	Numeric with decimal point, left zero-fill.
243	Delimiter		1	Uses the ^ character value.
244-248	Procedure Code	As submitted by CCN on claim, for all claim types except inpatient hospital.		Character
249	Delimiter		1	Uses the ^ character value.
250-259	Provider Billed Units	As submitted by CCN on claim	10	Numeric with decimal point, left zero-fill.
260	Delimiter		1	Uses the ^ character

Column(s)	Item	Notes	Length	Format
				value.
261-274	Medicaid Payment	Amount Louisiana Medicaid paid on the claim	14	Numeric with decimal point, left zero-fill.
275	Delimiter		1	Uses the ^ character value.
276-286	NDC	If Rx claim, then this is the NDC on the claim	11	
287	Delimiter		1	Uses the ^ character value.
288-290	Therapeutic Class	If Rx claim	3	
291	Delimiter		1	Uses the ^ character value.
292	Rx refill code	If Rx claim: 0=1st script, 1-5=refill number	1	
293	Delimiter		1	Uses the ^ character value.
		ICD-9-CM diag code, if available	5	Character, does not include the decimal.
299	Delimiter		1	Uses the ^ character value.
300	Admit Date		8	Numeric, YYYYMMDD For inpatient hospital claims
308	Delimiter		1	Uses the ^ character value.
309	Discharge Date		8	Numeric, YYYYMMDD For inpatient hospital claims

Column(s)	Item	Notes	Length	Format
317	Delimiter		1	Uses the ^ character value.
318,319	Servicing Provider Specialty		2	Numeric with leading zero if necessary.
320	Delimiter		1	Uses the ^ character value.
321	End of Record		1	Character, value is space.
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "**CCN-W-010**"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Total Detail Lines in the file	This is a number that represents the total detail lines submitted in the file. It is equivalent to the total number of claim lines that denied.	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^ character value
26-33	Total Number of claim records denied.	This value represents the count of unique claim lines that appear in the	8	Numeric

Column(s)	Item	Notes	Length	Format
		detail portion of this file and have been denied.		
34	Delimiter		1	Uses the ^ character value
35-321	End of Record		287	Value is spaces.

Appendix E

Provider Directory/Network Provider and Subcontractor Registry

At the onset of the CCN Contract and periodically as changes are necessary, DHH shall publish a list of NPIs of Medicaid providers that will include provider types, specialty, and sub-specialty coding schemes to the CCN and or its contractor. The CCN and/or its contractor shall utilize these codes within their provider file record. The objective is to coordinate the provider enrollment records of the CCN with the same provider type, specialty and sub-specialty codes as those used by DHH and the Enrollment Broker.

The CCN-S program requires claims to be paid through the MMIS on a FFS basis. Network providers must be enrolled as a Louisiana Medicaid provider.

CCNs will be required to provide DHH with a list of contracted primary care providers. DHH shall be provided advance copies of all updates not less than ten (10) working days in advance of distribution. Any providers no longer taking patients must be clearly identified.

The provider directory must include the following information:

- NPI
- Entity Type Code (1-Individual or 2-Organization)
- Replacement NPI
- Provider Name (First Name, Middle Name, Last Name, Prefix, Suffix, Credential(s), or the Legal Business Name for Organizations)
- Provider Other Name (First Name, Middle Name, Last Name, or 'Doing Business As' Name, Former Legal Business Name, Other Name. for Organizations)
- Provider Business Mailing Address (First line address, Second line address, City, State, Postal Code[1], and Country Code if outside U.S., Telephone Number, Fax Number)

[1] 9-digit Postal Code

- Provider Business Location Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Healthcare Provider Taxonomy Code(s)
- Other Provider Identifier(s)
- Other Provider Identifier Type Code
- Provider Enumeration Date
- Last Update Date
- NPI Deactivation Reason Code
- NPI Deactivation Date
- NPI Reactivation Date
- Provider Gender Code
- Provider License Number
- Provider License Number State Code
- Authorized Official Contact Information (First Name, Middle Name, Last Name, Title or Position, Telephone Number)
- Panel Open (Y/N)
- Language
- Age Restriction
- PCP Linkage Maximum
- PCP Linkages with Others
- CCN Enrollment Indicator
- CCN Enrollment Indicator Effective Date
- Family Only Indicator
- Provider Sub-Specialty
- CCN Contract Name or Number
- CCN Contract Begin Date
- CCN Contract Termination Date
- Provider Parish

CCNs are required to populate the Other Provider Type Code to a DHH valid provider type code as shown in the list below:

Provider Type	Description
07	Case Mgmt - Infants & Toddlers
08	Case Mgmt - Elderly
09	Hospice Services
12	Multi-Systemic Therapy
13	Pre-Vocational Habilitation
19	Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group
20	Physician (MD) and Physician (MD) Group
23	Independent Lab
24	Personal Care Services (LTC/PCS/PAS)
25	Mobile X-Ray/Radiation Therapy Center
28	Optometrist and Optometrist Group
29	Title V Part C Agency Services(EarlySteps)
30	Chiropractor and Chiropractor Group
31	Psychologist
32	Podiatrist and Podiatrist Group
34	Audiologist
35	Physical Therapist
37	Occupational Therapist
39	Speech Therapist
40	DME Provider
41	Registered Dietician
42	Non-Emergency Medical Transportation
43	Case Mgmt - Nurse Home Visit - 1st Time Mother
44	Home Health Agency
46	Case Mgmt - HIV

Provider Type	Description
51	Ambulance Transportation
54	Ambulatory Surgery Center
55	Emergency Access Hospital
59	Neurological Rehabilitation Unit (Hospital)
60	Hospital
61	Venereal Disease Clinic
62	Tuberculosis Clinic
64	Mental Health Hospital Freestanding
65	Rehabilitation Center
66	KIDMED Screening Clinic
67	Prenatal Health Care Clinic
68	Substance Abuse and Alcohol Abuse Center
69	Hospital – Distinct Part Psychiatric
69	Hospital - Distinct Part Psychiatric Unit
70	EPSDT Health Services
71	Family Planning Clinic
72	Federally Qualified Health Center
73	Social Worker
74	Mental Health Clinic
75	Optical Supplier
76	Hemodialysis Center
77	Mental Health Rehabilitation
78	Nurse Practitioner
79	Rural Health Clinic (Provider Based)
80	Nursing Facility
81	Case Mgmt - Ventilator Assisted Care Program
87	Rural Health Clinic (Independent)
88	ICF/DD - Group Home
90	Nurse-Midwife
91	CRNA or CRNA Group

Provider Type	Description
93	Clinical Nurse Specialist
94	Physician Assistant
95	American Indian / Native Alaskan "638" Facilities
96	Psychiatric Residential Treatment Facility
97	Residential Care

For providers registered as individual practitioners, DHH will also require the CCN to assign a DHH provider specialty code from the DHH valid list of specialties found below:

Provider Specialty	Description	Associated Provider Types
01	General Practice	19,20
02	General Surgery	19,20,93
03	Allergy	19,20
04	Otology, Laryngology, Rhinology	19,20
05	Anesthesiology	19,20,91
06	Cardiovascular Disease	19,20
07	Dermatology	19,20
08	Family Practice	19,20,78
09	Gynecology (DO only)	19
10	Gastroenterology	19,20
12	Manipulative Therapy (DO only)	19
13	Neurology	19,20
14	Neurological Surgery	19,20
15	Obstetrics (DO only)	19
16	OB/GYN	19,20,78,90
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	19
18	Ophthalmology	20
19	Orthodontist	19,20
20	Orthopedic Surgery	19,20
21	Pathologic Anatomy; Clinical Pathology (DO only)	19
22	Pathology	20

Provider Specialty	Description	Associated Provider Types
23	Peripheral Vascular Disease or Surgery (DO only)	19
24	Plastic Surgery	19,20
25	Physical Medicine Rehabilitation	19,20
26	Psychiatry	19,20,93
27	Psychiatry; Neurology (DO only)	19
28	Proctology	19,20
29	Pulmonary Diseases	19,20
30	Radiology	19,20
31	Roentgenology, Radiology (DO only)	19
32	Radiation Therapy (DO only)	19
33	Thoracic Surgery	19,20
34	Urology	19,20
35	Chiropractor	30,35
36	Pre-Vocational Habilitation	13
37	Pediatrics	19,20,93
38	Geriatrics	19,20
39	Nephrology	19,20
40	Hand Surgery	19,20
41	Internal Medicine	19,20
42	Federally Qualified Health Centers	72
44	Public Health	66,70
45	NEMT - Non-profit	42
46	NEMT - Profit	42
47	NEMT - F+F	42
48	Podiatry - Surgical Chiropody	20,32
49	Miscellaneous (Admin. Medicine)	20
51	Med Supply / Certified Orthotist	40
52	Med Supply / Certified Prosthetist	40

Provider Specialty	Description	Associated Provider Types
53	Med Supply / Certified Prosthetist Orthotist	40
54	Med Supply / Not Included in 51, 52, 53	40
55	Indiv Certified Orthotist	40
56	Indiv Certified Protherist	40
57	Indiv Certified Protherist - Orthotist	40
58	Indiv Not Included in 55, 56, 57	40
59	Ambulance Service Supplier, Private	51
60	Public Health or Welfare Agencies & Clinics	61,62,66,67
62	Psychologist Crossovers only	29,31
63	Portable X-Ray Supplier (Billing Independently)	25
64	Audiologist (Billing Independently)	29,34
65	Indiv Physical Therapist	29,35
66	Dentist, DDS, DMS	27
67	Oral Surgeon - Dental	27
68	Pedodontist	27
69	Independent Laboratory (Billing Independently)	23
70	Clinic or Other Group Practice	19,20,68,74,76
71	Speech Therapy	29
72	Diagnostic Laboratory	23
73	Social Worker Enrollment	73
74	Occupational Therapy	29,37
75	Other Medical Care	65
76	Adult Day Care	85
77	Habilitation	85
78	Mental Health Rehab	77
79	Nurse Practitioner	78
81	Case Management	07,08,43,46,81
83	Respite Care	83

Provider Specialty	Description	Associated Provider Types
85	Extended Care Hospital	60
86	Hospitals and Nursing Homes	55,59,60,64,69, 80,88
87	All Other	26,40,44
88	Optician / Optometrist	28,75
93	Hospice Service for Dual Elig.	09
94	Rural Health Clinic	79,87
95	Psychologist (PBS Program Only)	31
96	Psychologist (PBS Program and X-Overs)	31
97	Family Planning Clinic	71
1T	Emergency Medicine	19,20
2R	Physician Assistant	94
2T	American Indian/Native Alaskan	95
4R	Registered Dietician	41
5B	PCS-EPSDT	24
5C	PAS	24
5F	PCS-EPSDT, PAS	24
5H	Community Mental Health Center	18
5M	Multi-Systemic Therapy	12
6A	Psychologist -Clinical	31
6B	Psychologist-Counseling	31
6C	Psychologist - School	31
6D	Psychologist - Developmental	31
6E	Psychologist - Non-Declared	31
6F	Psychologist - All Other	31
6N	Endodontist	27
6P	Periodontist	27
7A	SBHC - NP - Part Time - less than 20 hrs week	38
7B	SBHC - NP - Full Time - 20 or more hrs week	38
7C	SBHC - MD - Part Time -	38

Provider Specialty	Description	Associated Provider Types
	less than 20 hrs week	
7D	SBHC - MD - Full Time - 20 or more hrs week	38
7E	SBHC - NP + MD - Part Time - combined less than 20 hrs week	38
7F	SBHC - NP + MD - Full Time - combined less than 20 hrs week	38
9B	Psychiatric Residential Treatment Facility	96
9D	Residential Care	97

CCNs must submit this information in a file layout shown below.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
NOTE: This record format describes a fixed-format layout. The record size is fixed at 750 bytes. If a field is listed as Optional (O), and the CCN elects not to populate the field, then it should be filled with blanks or zeros as appropriate to the Length and Format definition (character or numeric, respectively).					
1-20	NPI	National Provider ID number	20	First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to include them.	R
21	Delimiter		1	Character, use the ^ character value	
22	Entity Type code	**1**=Individual, **2**=Organization	1		R
23	Delimiter		1	Character, use the ^ character value	
24-43	Replacement NPI	DO NOT USE AT THIS TIME. FOR FUTURE USE.	20	First 10 characters should represent the	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to use them.	
44	Delimiter		1	Character, use the ^ character value	
45-74	Provider Name (First Name, Middle Name, Last Name, Prefix, Suffix, Credential(s), OR the Legal Business Name for Organizations)		30	Character	R
75	Delimiter		1	Character, use the ^ character value	
76-105	Provider Business Mailing Address (First line address)		30	Character	R
106	Delimiter		1	Character, use the ^ character value	
107-136	Provider Business Mailing Address (Second line address)		30	Character	O
137	Delimiter		1	Character, use the ^ character value	
138-167	Provider Business Mailing Address (City,)		30	Character	R
168	Delimiter		1	Character, use the ^ character value	
169-170	Provider Business Mailing	USPS state code abbreviation	2	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Address (State)				
171	Delimiter		1	Character, use the ^ character value	
172-181	Provider Business Mailing Address (9-Digit Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
182	Delimiter		1	Character, use the ^ character value	
183-192	Provider Business Mailing Address (Country Code if outside U.S.)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
193	Delimiter		1	Character, use the ^ character value	
194-203	Provider Business Mailing Address (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
204	Delimiter		1	Character, use the ^ character value	
205-214	Provider Business Mailing Address (Fax Number)	Do not enter dashes or parentheses.	10	Numeric	O
215	Delimiter		1	Character, use the ^ character value	
216-245	Provider Business Location Address (First line address)	No P.O. Box here, please use a physical address.	30	Character	R
246	Delimiter		1	Character, use the ^ character value	
247-276	Provider Business Location		30	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Address (Second line address)				
277	Delimiter		1	Character, use the ^ character value	
278-307	Provider Business Location Address (City,)		30	Character	R
308	Delimiter		1	Character, use the ^ character value	
309-310	Provider Business Location Address (State)		2	USPS state code abbreviation	R
311	Delimiter		1	Character, use the ^ character value	
312-321	Provider Business Location Address (Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
322	Delimiter		1	Character, use the ^ character value	
323-332	Provider Business Location Address (Country Code if outside U.S)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
333	Delimiter		1	Character, use the ^ character value	
334-343	Provider Business Location Address (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
344	Delimiter		1	Character, use the ^ character value	
345-354	Provider Business Location Address (Fax	Do not enter dashes or parentheses.	10	Numeric	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Number)				
355	Delimiter		1	Character, use the ^ character value	
356-365	Healthcare Provider Taxonomy Code 1		10	Character	R Note: if a single NPI is used for multiple entities then we require at least 1 taxonomy per NPI. For example, if a single NPI is used for an acute care hospital as well as a DPPU in the hospital, then we need taxonomy for both units… each sent in a separate record.
366	Delimiter		1	Character, use the ^ character value	
367-376	Healthcare Provider Taxonomy Code 2	Use if necessary; otherwise leave blank.	10	Character	O
377	Delimiter		1	Character, use the ^ character value	
378-387	Healthcare Provider Taxonomy Code 3	Use if necessary; otherwise leave blank.	10	Character	O
388	Delimiter		1	Character, use the ^ character value	
389-395	Other Provider Identifier	If available, enter the provider's Louisiana Medicaid Provider ID	7	Numeric, left-fill with zeroes.	R, if provider is already enrolled with Medicaid; otherwise, optional.
396	Delimiter		1	Character, use the ^ character value	
397-400	Other Provider Identifier Type	Provider Type and Provider	4	1st 2 characters are	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Code	Specialty		provider type; last 2 characters (3-4) are provider specialty. See CCN Companion Guide for list of applicable provider types and specialties.	
401	Delimiter		1	Character, use the ^ character value	
402-409	Provider Enumeration Date	NPPES enumeration date.	8	Numeric, format YYYYMMDD	R
410	Delimiter		1	Character, use the ^ character value	
411-418	Last Update Date	NPPES last update date; leave all zeros if not available.	8	Numeric, format YYYYMMDD	O
419	Delimiter		1	Character, use the ^ character value	
420-439	NPI Deactivation Reason Code	NPPES deactivation reason; leave blank if appropriate.	20	Left justify, right-fill with spaces.	O
440	Delimiter		1	Character, use the ^ character value	
441-448	NPI Deactivation Date	NPPES deactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
449	Delimiter		1	Character, use the ^ character value	
450-457	NPI Reactivation Date	NPPES reactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
458	Delimiter		1	Character, use the ^ character value	
459	Provider Gender Code	**M**=Male, **F**=Female, **N**=Not applicable	1	Character .	R
460	Delimiter		1	Character, use the ^ character value	
461-480	Provider License Number		20	Character, left-justified, right-fill with spaces.	R
481	Delimiter		1	Character, use the ^ character value	
482-483	Provider License Number State Code	2-character USPS state code value	2	Character	R
484	Delimiter		1	Character, use the ^ character value	
485-534	Authorized Official Contact Information (First Name, Middle Name, Last Name)		50	Character, left-justified, right-fill with spaces.	R
535	Delimiter		1	Character, use the ^ character value	
536-565	Authorized Official Contact Information (Title or Position)		30	Character, left-justified, right-fill with spaces.	O
566	Delimiter		1	Character, use the ^ character value	
567-576	Authorized Official Contact Information (Telephone	Do not enter dashes or parentheses.	10	Numeric	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Number)				
577	Delimiter		1	Character, use the ^ character value	
578	Panel Open Indicator	**Y**=Yes, panel is open. **N**=No, panel is not open.	1	Character	R for PCPs; otherwise optional.
579	Delimiter		1	Character, use the ^ character value	
580	Language Indicator 1 (this is the primary language indicator)	1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
581	Delimiter		1	Character, use the ^ character value	
582	Language Indicator 2 (this is a secondary language indicator)	0=no other language supported 1= Accepts English-speaking patients 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients	1	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		5=Accepts Cambodian-speaking patients			
583	Delimiter		1	Character, use the ^ character value	
584	Language Indicator 3 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
585	Delimiter		1	Character, use the ^ character value	
586	Language Indicator 4 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-	1	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		speaking patients			
587	Delimiter		1	Character, use the ^ character value	
588	Language Indicator 5 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
589	Delimiter		1	Character, use the ^ character value	
590	Age Restriction Indicator	**0**=no age restrictions **1**=adult only **2**=pediatric only	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
591	Delimiter		1	Character, use the ^ character value	
592-596	PCP Linkage Maximum	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of patients that can be linked to the PCP. It should be left all zeroes if the provider is not a	R for PCPs; otherwise optional.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				PCP/specialist.	
597	Delimiter		1	Character, use the ^ character value	
598-602	PCP Linkages with CCN	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of CCN enrollees that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
603	Delimiter		1	Character, use the ^ character value	
604-608	PCP Linkages with Others	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of enrollees in other plans (not CCN) that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
609	Delimiter		1	Character, use the ^ character value	
610	CCN Enrollment Indicator	**N**=New enrollment **C**=Change to existing enrollment **D**=Disenrollment	1	Use this field to identify new providers, changes to existing providers, and disenrolled providers	R
611	Delimiter		1	Character, use the ^ character value	
612-619	CCN	Effective date of	8	Numeric,	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Enrollment Indicator Effective Date	Enrollment Indicator above.		format YYYYMMDD	
620	Delimiter		1	Character, use the ^ character value	
621	Family Only Indicator	**0**=no restrictions **1**=family members only	1		R for PCPs; otherwise optional.
622	Delimiter		1	Character, use the ^ character value	
623-624	Provider Sub-Specialty 1	Value set is determined by DHH and is available in CCN Companion Guide	2		R for PCPs; otherwise optional
625	Delimiter		1	Character, use the ^ character value	
626-627	Provider Sub-Specialty 2	If necessary, Value set is determined by DHH and is available in CCN Companion Guide	2		O
628	Delimiter		1	Character, use the ^ character value	
629-630	Provider Sub-Specialty 3	If necessary, Value set is determined by DHH and is available in CCN Companion Guide	2		O
631	Delimiter		1	Character, use the ^ character value	
632-661	CCN Contract Name or Number	This should represent the contract name/number that is established between the CCN and the Provider	30	Character	R
662	Delimiter		1	Character, use	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				the ^ character value	
663-670	CCN Contract Begin Date	Date that the contract between the CCN and the provider started	8	Numeric date value in the form YYYYMMDD	R
671	Delimiter		1	Character, use the ^ character value	
672-679	CCN Contract Term Date	Date that the contract between the CCN and the provider was terminated.	8	Numeric date value in the form YYYYMMDD	O
680	Delimiter		1	Character, use the ^ character value	
681-682	Provider Parish served – 1st or primary	Parish code value that represents the primary parish that the provider serves	2	2-digit parish code value. See the CCN Companion Guide.	R
683	Delimiter		1	Character, use the ^ character value	
684-685	Provider Parish served – 2nd	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the CCN Companion Guide.	O
686	Delimiter		1	Character, use the ^ character value	
687-688	Provider Parish served – 3rd	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter	2	2-digit parish code value. See the CCN Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		00.			
689	Delimiter		1	Character, use the ^ character value	
690-691	Provider Parish served – 4th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the CCN Companion Guide.	O
692	Delimiter		1	Character, use the ^ character value	
693-694	Provider Parish served – 5th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the CCN Companion Guide.	O
695	Delimiter		1	Character, use the ^ character value	
696-697	Provider Parish served – 6th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the CCN Companion Guide.	O
698	Delimiter		1	Character, use the ^ character value	
699-700	Provider Parish served – 7th	Parish code value that represents a secondary or other parish that the provider	2	2-digit parish code value. See the CCN Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		serves. Use only if necessary; otherwise enter 00.			
701	Delimiter		1	Character, use the ^ character value	
702-703	Provider Parish served – 8th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the CCN Companion Guide.	O
704	Delimiter		1	Character, use the ^ character value	
705-706	Provider Parish served – 9th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the CCN Companion Guide.	O
707	Delimiter		1	Character, use the ^ character value	
708-709	Provider Parish served – 10th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the CCN Companion Guide.	O
710	Delimiter		1	Character, use the ^ character value	
711-712	Provider	Parish code	2	2-digit parish	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Parish served – 11th	value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.		code value. See the CCN Companion Guide.	
713	Delimiter		1	Character, use the ^ character value	
714-715	Provider Parish served – 12th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the CCN Companion Guide.	O
716	Delimiter		1	Character, use the ^ character value	
717-718	Provider Parish served – 13th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the CCN Companion Guide.	O
719	Delimiter		1	Character, use the ^ character value	
720-721	Provider Parish served – 14th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the CCN Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
722	Delimiter		1	Character, use the ^ character value	
723-724	Provider Parish served – 15th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the CCN Companion Guide.	O
725	Delimiter		1	Character, use the ^ character value	
726-749	Spaces	End of record filler	24	Enter all spaces	
750	End of record delimiter		1	Character, use the ^ character value	

Appendix F

Test Plan

This appendix provides a step-by-step account of the FI's plan for testing the ASC X12N 837 COB and 835 electronic transaction sets for use in submitting claim data for storage in the MMIS claims history file. The plan consists of three (3) tiers of testing, which are outlined in detail below.

Testing Tier I

The first step in submitter testing is enrollment performed via Molina Electronic Data Interchange (EDI) Services, Inc. Each CCN must enroll with EDI to receive a Trading Partner ID in order to submit electronic claim data. In most cases, the CCNs will already have an ID, but are only permitted to receive electronic transactions; e.g. 834, 820, not to submit them. In this step, permission is granted for the CCNs to be able to both transmit and receive.

The second step performed concurrently with the enrollment, is EDIFECS testing. A partnership exists between EDIFECS and Molina Electronic Data Interchange (EDI) Services, Inc. to assist in compliance testing and tracking submitter test files prior to submission through the Molina Electronic Data Interchange (EDI). There are certain errors that will occur while testing with EDIFECS that should not be considered when determining whether a CCN has passed or failed the EDIFECS portion of testing.

EDI must certify each CCN prior to the MMIS receipt of claims via EDI. The objective is to ensure that the submitter can generate a valid X12 transaction, submit the transaction to the Molina Electronic Data Interchange (EDI), and that the transaction can be processed successfully with the resultant IRL, 997 Acceptance, or return transaction. X12 837 transactions (837I and 837P) must be in the 4010A (Addenda) format, not in the 4010 format. This phase of testing was designed to do the following:

- test connectivity with the Clearinghouse;
- validate Trading Partner IDs;
- validate the ability of the submitter to create and transmit X12 transactions with all required loops, segments, and data elements;
- validate the test submission with 997 Acceptance transactions; and

- generate IRL or paired transaction.

Once EDIFECS testing is complete, the CCN is certified that the X12 transaction is properly formatted to submit to the MMIS. The claim claims data from the CCNs are identified by the value 'RP' being present in X12 field TX-TYPE-CODE field. The CCNs must ensure that their Medicaid IDs are in loop 2330B segment NM1 in 'Other Payer Primary Identification Number'. If line item CCN paid amount is submitted, they also need to populate the 'Other Payer Primary Identifier' in loop 2430 segment SVD with their Medicaid provider number. These fields are used in the MMIS pre-processors to indicate that the amount in the accompanying prior paid field is the CCN's paid amount and not TPL or any other COB amount. For more details, please refer to the Molina Electronic Data Interchange (EDI) Services, Inc. *Submitter Testing Report* for the DHH.

Testing Tier II

Once each CCN has successfully passed more than 50% of their claim data claims through the pre-processors, Molina will process the claims through the MMIS Adjudication cycle and the Payment cycle. The Payment cycle will create an 835 transaction to be retrieved by the CCNs via IDEX. Each CCN is required to examine the returned 835s and compare them to the claim data claims (837s) they submitted to insure all claims that were submitted are accounted for in the data collection. Molina will send the new edit code reports to the CCNs and DHH/Mercer for evaluation as well as a MMIS edit code explanation document which details the conditions under which each edit code will post to an claim data claim in order to assist them with their research. Molina is available to answer any questions that any CCN may have concerning the edit codes.

Testing Tier III

Once satisfactory test results are documented, Molina will move the CCN into production. Molina anticipates receiving files from each of the CCNs in production mode at least once monthly.

Appendix G

Websites

The following websites are provided as references for useful information not only for CCN entities, but also for consumers, health care providers, health care organizations, and other impacted entities.

Website Address	Website Contents
http://aspe.hhs.gov/admnsimp/	This links to the **Department of Health and Human Services website regarding the Administrative Simplification provisions of HIPAA**. This site contains downloadable versions of the proposed and final rules, general information about the administrative simplification portion of the HIPAA law, an explanation of the Notice of Proposed Rulemaking (NPRM) process, update on when HIPAA standards may be implemented, and presentations made by parties regarding HIPAA.
http://www.cms.gov	This is the **CMS home page**.
http://www.wedi.org/snip/	This is the **Workgroup for Electronic Data Interchange website**. This site includes information on EDI in the health care industry, documents explaining the Privacy Rule, lists of conferences, and the availability of

Website Address	Website Contents
	resources for standard transactions.
http://www.ansi.org	This is the **American National Standards Institute website** that allows one to download ANSI documents. You may download a copy of ANSI Procedures for the Development and Coordination of American National Standards, or a copy of ANSI Appeals Process.
http://www.x12.org	This is the **Data Interchange Standards Association website**. This site contains information on ASC X12, information on X12N subcommittees, task groups, and workgroups, including their meeting minutes. This site will contain the test conditions and results of HIPAA transactions tested at the workgroup level.
http://www.nubc.org	This is the **National Uniform Billing Committee website**. This site contains NUBC meeting minutes, activities, materials, and deliberations.
http://www.nucc.org	This is the **National Uniform Claims Committee website**. This site includes a data set identified by the NUCC for submitting non-institutional claims, claims, and coordination of benefits. This site also includes information regarding purpose, membership, participants, and recommendations.
http://HL7.org	This site contains information on Logical Observation Identifier Names and Codes (LOINC) - **Health Level Seven (HL7)**. HL7 is being considered for requests for attachment information.

Website Address	Website Contents
http://www.cms.hhs.gov/home/medicare.asp	This is the **Medicare EDI website**. At this site, you will find information regarding Medicare EDI, advantages to using Medicare EDI, Medicare EDI formats and instructions, news and events, frequently asked questions about Medicare EDI, and information regarding Medicare paper forms and instructions.