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Revision History

VERSION NUMBER	UPDATE DATE	OWNER OF UPDATE	DESCRIPTION/LOCATION OF CHANGE
V1.1	1/14/19	Chris Pruett	• Added claim adjustment reason codes for capitation files: 101 Retroactive INF Adjustment 102 Retroactive Newborn Adjustment 103 Void Incarcerated Client • Changed description of Provider Type 317 to Nurses, Home Visiting – there was never any intention to have EPSDT Personal Care providers enroll with this type • Changed instruction re: reporting of interest payments on the encounter after finalizing testing of encounters with interest. • Added clarification to the 113 file that if the MCO did not receive the initial 112 for a client, the 113 does not need to include the LOC Seq Num • Added valid values for B-LCKN-CHNG-RSN-CD for CR and IN • Updated Pharmacy Encounter Denial and Pay & Report Edits
V1.2	3/1/2019	Chris Pruett	• Updated language in the NFLOC approval section (The MCO shall submit the initial NF LOC determination date spans via the ASPEN interface file within ~~60~~ 40 calendar days); clarified language re: Community Benefit reassessment; corrected # days for (The Reminder Notice shall advise the member that in ~~30~~ 60 calendar days) • Added to the Medicare claims rules clarification that the MCO must not require billing first to Medicare if the services are not covered by Medicare with a list of those Community Benefit and EPSDT services not covered by Medicare • Updated contact name for LTSSB on page 70 • Removed Copay Sections • Added clarification re: the 112/113/114 files for NFLOC • Added exception 4075 to the list of pharmacy denial exceptions.
V1.3	4/18/19	Chris Pruett	• Added clarification re: Ordering and Referring Provider for out of network • Updated list of Provider Type and Specialty– a number of new specialties have been added for provider types 203, 313, 363 • Removed incorrect statement that NFLOC redeterminations will not have a request date on the 112 • Added clarification re: not submitting 113 when a 112 has not been received
V1.4	7/26/19	Chris Pruett	• Added clarification re: submission of 113 records when denying a portion of the requested period. • Added information on MCO provider termination for cause • Added clarification re: reporting of Interest payments in the 2320 loop
V1.5	10/7/2019	Chris Pruett	• New Values for Care Coordination entered, with updates to file edits • Reporting of DD/MF Waiver authorizations reported as LTC spans
V1.6	11/15/19	Chris Pruett	• Revised Termination Reason Codes for MCO's termination for cause • Revised Payer Code for Interest payments • Updated Monthly Managed Care Roster Dates
V1.7	1/9/2020	Chris Pruett	• Added more information re: Interest payment encounter submission based on questions from an MCO • Revised section on NFLOC determinations re: submission of 113 file
V1.8	4/16/2020	Chris Pruett	• Revised Encounter Edit table to update to current settings • Added the bold: Only the conditions that meet pricing process code 00 and 04 will be allowed to reflect a $0 Paid Amount ***and must always reflect a $0 payment***.
V1.9	5/1/2020	Chris Pruett	• Revised List of MCO to HSD Errors to include two new ones that prevent acceptance of a NFL LTC span if a client has a non-NFL LTC span or DD/Med Frag Waiver Prior Auth with instructions re: who to contact when this happens

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V1.10	5/21/2020	Chris Pruett	• Removed the following statement from the instructions for submitting ASPEN NFLOC approvals on page 64: The NF LOC date should begin when the member was admitted to the facility, even if they were covered under Medicare Skilled (you just don't enter the SOC into Omnicaid) and add more explanation re: NF LOC and skilled care.
V1.11	6/20/2020	Chris Pruett	• Removed reference to the COBA FFS claims file distributed by the State to the MCOs. MCOs continue to get their COBA files directly from the COBC. • Added Section re: Supports Waiver to be effective 7/1/2020 • Added Type of Bill code 621 to Inpatient Claim Type Assignment
V1.12	7/7/2020	Chris Pruett	• Clarified definition of codes to use for Respite Nursing • Updated Provider Type and Specialty to add Specialties 260/261 to PT 216 and to Redefine PT 302 to Physician, DO & NA and add specialties 150 and 300 • Updated description of exception 0367 • Updated Roster description for B-PRIOR-CARD-ID1 and B-PRIOR-CARD-ID2 to show it will be populated by the Medicaid Card ID of the merged client.
V1.13	10/1/2020	Chris Pruett	• Added instruction for procedures in Fee Schedule with Factor Code 5 and value 0 and FC Y - OPPS All with a Source Code of J6 • Added New Provider Network Interface which MCOs are currently testing prior to implementation
V1.14	1/7/2021	Chris Pruett	• Added 3 fields to the MRPRPRT report to add specialties required • Added documentation re: the TPL file that the MCOs send to HSD to include instruction re: submission of terminations and voids • Updated the Community Benefit Codes to include G9012
V1.15	6/23/2021	Chris Pruett	• Added section for Care coordination Assessment and Level Data Requirements – HSD has added two new CC Assessment Types with rules for usage • Updated Non-Drug Exception Disposition Table • Updated 837 maximum file size to reflect 45 MG instead of 30 • Updated Duplicate processing to clarify that the Ux range modifiers cannot be used with Dental claims • Updated description of edit 0182 to correctly reflect how the edit is working.
V1.16	8/23/21	Chris Pruett	• Added H0045 to list of Community Benefit codes • Clarifications to the EPSDT services • Added to Exceptions for Encounter processing – note edit 0600 • Added MCO to HSD Errors 51 and 52 to the list of errors • Added 1 byte field to end of Provider Master File identified as Hi Fidelity WrapAround
V1.17	9/15/21	Chris Pruett	• Updated list of CYFD offices for MCOs to contact • Fixed previous error with entry of edit 600
V1.18	11/15/21	Chris Pruett	• Updated Monthly Roster Schedule • Included additional editing criteria for edits 0367 and 1361 for claim type O
V1.19	3/18/2022	Chris Pruett	• Added SSA COEs to section on Reporting Client Demographic Updates • Added clarification to Care Coordination Assessment in the MCO to HSD interface file and in Care Coordination Assessment and Level Data Requirements
V1.20	4/1/2022	Chris Pruett	• New contact person for retroactive exception requests submissions • Added instruction from LOD 49 re: MCOs not to recover claim payments from providers when they receive a client recoupment span on the Enrollment Roster file – added in 2 places: Page 19 and page 127

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V1.21	8/22/2022	Chris Pruett	• Added 4 sections in the Long Term Care Section: Short Term Stays in a Nursing Facility, Medicaid Pending, LTC Custodial Care, MCO Review Type and Requirement Chart • Added Prospective Medicare section to describe reporting on Enrollment Roster of Prospective Medicare spans to support Default Enrollment of Medicaid/Medicare Duals which will begin in April 2023 • Added to Incarcerated Individuals information related to new reporting of incarcerated individuals that starts August 2022 where ASPEN will be sending on the Daily Enrollment File records with a minor type '6' for Incarceration updates. • Added to Rate cohort Determination details about the ARP cohorts which are in place starting July, 2022 for DOS from July, 2021 thru June 2024.
V1.22	11/1/2022	Chris Pruett	Updated Monthly Roster Cutoff Schedule
V1.23	1/31/2023	Chris Pruett	• Added clarification re: billing for NF services, not using rev code 0022 for non-Medicare long term care • Added section in the Edits *Most Frequent Medicaid Exceptions* that provides clarification re: Rendering Provider Type Required Indicator • Added clarification re: Edit 0367 to add logic that references a system list bypass
V1.24	2/22/2023	Chris Pruett	• Added clarification re: Medical Care Credit • Added clarification to Daily Enrollment re: Incarceration Daily Files to only update incarceration fields • Updated the Provider Type and Specialty list
V1.25	6/27/2023	Chris Pruett	• Added a Section Changes to a Provider Record • Updated list of Provider type/Specialtyy list • Updated list of PDCS edits • Removed reference to Conduent Call Center and replaced with Consolidated Call Center • Added reinforcing language in LTC section that COE 096 doesn't prevent a member from being approved for NF or CB • Updated list of Community Benefit Services
V1.26	8/1/2023	Chris Pruett	• LTC Reconciliation Interface will now include DD and Med Frag Waiver authorizations so the MCOs can better coordinate for their members. • The EVV Stipend for EPSDT is to be billed with G9005. • High Fidelity Wrap members will no longer be sent with Care Coordination Level 9 by CareLink; the MCOs will be responsible for establishing the correct care coordination for these members.
V1.27	10/26/2023	Chris Pruett	• Updated Monthly Roster Calendar • Clarified When the EVV Sitpend is billed by the Home Health Agency, bill the G9005 with the revenue code 0569 MEDICAL SOCIAL (HOME HEALTH)- OTHER MEDICAL SOCIAL SERVICES
V1.28	11/8/2023	Chris Pruett	• Clarified the Revenue Code to use for Short Term Nursing Facility Care • LTC Custodial Care – clarified to use the LTC Reconciliation file to validate status for members with COE 095/096 • MCO Review Type and Requirement Chart - added Revenue Code column and hospice section

INTRODUCTION

The purpose of this manual is to summarize all the data and system requirements for an organization participating in New Mexico Medicaid as a Centennial Care 2.0 Managed Care Organization.

It is required that the MCO share the information included in this manual with its subcontractors if those contractors are responsible for any of the information exchanges described in this manual and provide technical assistance to ensure their systems and procedures are sufficient to enable the MCO to meet all its data and reporting obligations. Contained in this manual are the minimal MCO system requirements, file layouts (or links to file layouts) and descriptions for the data provided to the MCO's by the New Mexico Medicaid Management Information System (MMIS), also referred to as "Omnicaid", as well as the data requirements, file layouts (or links to file layouts), data definitions, and system edits for encounter and provider data the MCO's are to provide to the MMIS. As any changes are made in the managed care system, the Medical Assistance Division will provide the MCO's with updates to this manual.

MCO's are responsible to maintain management information systems sufficient to meet the system requirements outlined in this manual. MCO's are further responsible for ensuring that their subcontractors and major providers also have sufficient systems capability so that the MCO's ability to meet minimal system requirements is not impaired.

MCO's will receive data related to functions they are to provide for New Mexico Medicaid. Reports and files are downloaded to the CONDUENT Website https://nmmedicaid.Conduent.com/secure/login.jsp and or placed on the CONDUENT DMZ Moveit Server, https://grabit.Conduent.com.

The following is a summary of the files received by the MCO's . Each file is discussed in more detail in the following sections and at the end of this document is a table that summarizes the files and frequencies.

The following ***daily*** files are produced by the MMIS or Omnicaid system (Daily cycles do not run on the days that the monthly and update cycles run):

- ***Daily 834 Benefit Enrollment and Maintenance and Roster Supplement Files*** –will show clients who have been enrolled or terminated in the night's enrollment cycle. Clients may have chosen the MCO or have been auto-assigned. The Daily file will also include client's re-enrolled for the current or prior months and newborn clients newly enrolled for the current month. This file is run Monday thru Saturday.
- ***Provider Confirmation file*** – a file of any Provider who has been enrolled in NM Medicaid as either a FFS or MC provider and thus approved for participation with the MCO along with any changes to the provider's record. An initial file will be sent prior to implementation of all active FFS providers so that the MCOs will know which are already approved for participation.
- ***Long Term Care Interface file*** – a file that contains any updates to the client's nursing facility level and setting of care.

- ***Enrollment Informational File*** - Any time a Health Home, Care Coordination, or Patient Liability span is added, those records will appear on the Managed Care Enrollment Informational Records for the MCO to which the client was enrolled for dates covered by that span.
- ***ASPEN to MCO and MCO to ASPEN interface files*** – NFLOC and SOC assessment request and determination files
- ***RC070 & RC072 files*** – these are response files to Encounters submitted the previous day, showing whether encounters have been 'paid' (accepted) or 'denied' and why.

MCO's will receive the following ***weekly*** files:

- ***820 Payroll Deducted and Other Group Premium Payment for Insurance Products –*** the HIPAA payment file showing all capitations. The first weekly capitation file reflects all per member per month payments made for that enrollment month, any retroactive periods of enrollment, and any recoupments that occur as part of that week's cycle; successive weeks include any periodic recoupments made throughout the month.

MCO's will receive the following ***monthly*** files:

- ***834 Benefit Enrollment and Maintenance and Roster Supplement Files –*** the HIPAA transaction will report all clients enrolled for the upcoming month. This file is generated the 3rd working day before the end of the month. The Roster Supplement file contains supplemental information that the 834 transaction is not equipped to handle. These files are generated the 3rd working day before the end of the month.
- ***Provider Master File and Other Formulary/Reference files***
- ***TPL File –*** a full file of managed care program clients with Other Insurance.
- ***Carrier File –*** a full file of Third Party Carriers registered with Omnicaid
- ***Long Term Care Interface file*** – a file that contains all client's nursing facility level and setting of care.

MCO's must provide to the Medical Assistance Division (MAD) information related to their Managed Care Program. This information is:

- ***Encounters*** - must be submitted at least weekly using HIPAA compliant formats.
- ***Managed Care to HSD Omnicaid Interface file*** – a daily update file that contains enrollee information including care coordination level, level of care, setting of care (agency directed vs self- directed community benefit or Nursing Facility), PCP assignment, Health Home assignment, date of death, etc.
- ***TPL Notification file*** – the MCO is required to send monthly a file containing any new third party payer coverage discovered by the MCO that is not yet identified by Omnicaid on the TPL file sent to the MCO.

If the MCO does not have any updates to send, an empty file does not need to be sent. The MCO's should contact CONDUENT and the Medical Assistance Division Systems Bureau (SB) staff whenever there is a problem with the transmission or receipt of data or to report a problem with data validity. Most data will be exchanged via web site

or FTP server. All HIPAA formats are sent through Conduent's EDI Gateway. All non-HIPAA format files or reports are received/sent through the FTP site maintained by CONDUENT, Inc. the entity that designs and maintains the New Mexico MMIS. All the data provided to the MCOs and data coming from the MCOs goes through CONDUENT. Conduent has staff responsible for responding to EDI Gateway data issues. CONDUENT staff may be contacted directly to resolve a technical data issue via the following numbers:

1-800-705-4452 Eligibility Help Desk
1-800-246-0710 Provider Relations Local
1-800-299-7304 Provider Relations

I. MCO SYSTEM REQUIREMENTS

It is required that an MCO's Management Information System (MIS) be capable of accepting, processing, maintaining, and reporting specific information necessary to the administration of the managed care program. The MCO's MIS must meet the following requirements.

1. MCO System Hardware and Software Requirements

The MCO is required to maintain system hardware, software and information systems resources sufficient to provide the capability to:

a. Accept, transmit, process, maintain and report specific information necessary to the administration of the State's Centennial Care programs, including, but not limited to, data pertaining to providers, Members, Claims, Encounters, Grievance and Appeals, disenrollment for other than loss of Medicaid eligibility and HEDIS and other quality measures;

b. Comply with the most current federal standards for encryption of any data that is transmitted via the internet by the CONTRACTOR or its subcontractors;

c. Conduct automated Claims processing with current National Provider Identification Number (NPI) for health care providers and FEIN/SSN numbers for atypical providers in HIPAA compliant formats;

d. Accept and maintain the State's ten (10) digit Member Medicaid identification number to be used for all communication to HSD and be cross-walked to the CONTRACTOR's assigned universal Member number and which is used by the Member and providers for identification, eligibility verification, and Claims adjudication by the CONTRACTOR and all subcontractors;

e. Monitor the completeness of the encounter data being received to detect providers or subcontractors who are transmitting partial or no records;

f. Transmit data securely and electronically;

g. Maintain a website for dispersing information to providers and Members, and be able to receive comments electronically and respond when appropriate, including responding to practitioner transactions for eligibility and formulary information;

h. Disseminate enrollment information to providers and subcontractors/vendors within twenty-four (24) hours of receipt of the information or, at a minimum, ensure that current eligibility information is available to providers for eligibility verification within twenty-four (24) hours of receiving the information, via a website, automated voice response system, or other means. Providers must be able to verify eligibility on weekends, holidays and after normal business hours.

i. Receive data elements associated with identifying Members who are receiving ongoing services or from another contractor and using, where possible, the formats that HSD uses to transmit similar information to an MCO;

j. Transmit to HSD or another contractor, data elements associated with Members who have been receiving ongoing services within the CONTRACTOR's MCO; and

k. Have an automated access system for providers to obtain Member enrollment information that includes the cross-reference capability of the system to the

Member's ten (10) digit Medicaid identification number designated by HSD to the Member's Social Security number as a means of identifying the Member's most current benefits such as providing the Member's category of eligibility.

l. Have systems capability to transmit to HSD/MAD or another MCO data elements associated with their clients or assignees who have been receiving ongoing services within their organization and maintain a system backup and recovery plan.

m. Maintain a system backup and recovery plan.

2. MCO Provider Network Information Requirements

Every provider who participates with the MCO is required to be either enrolled with HSD as a FFS provider or as a Managed Care-Only provider under Centennial Care. The MCO is required to refer providers not already enrolled to HSD's fiscal agent, Conduent, for enrollment, and accept the Provider Master and Confirmation files (all discussed in the Provider section of this manual). The MCO's provider network capabilities must include, but not be limited to:

a. Maintenance of complete provider information for all providers contracted with the MCO and its subcontractors and any other non-contracted providers who have provided services to date.

b. MCO editing of the recommended taxonomies for each provider type and specialty reported back on the Provider Confirmation file from Omnicaid against claims prior to submission of the encounters to ensure the claims are appropriate to the provider and claim type being submitted (e.g., ensure physician provider types are submitting physician taxonomies and are not submitting dental claims, etc.),

c. Ability to provide automated access to clients and providers of a client's PCP assignment.

3. Client Information Requirements

The MCO is required to accept, maintain, and transmit Client information to include, but not be limited to:

a. Acceptance of client eligibility and demographic data as well as monthly enrollment information via electronic data transfer.

b. Monitoring of newborns whose mother was enrolled in Managed Care at the time of the newborn's birth to ensure minimal lapse in time between the infant's birth and their determination of Medicaid eligibility. After eligibility is approved, newborns of Medicaid eligible MCO enrolled mothers are eligible for a period of twelve (12) months starting with the month of birth. The newborn is enrolled retroactively to the date of birth with the same MCO the mother had during the birth month, as soon as the newborn's eligibility is approved. However, the parent or legal guardian may choose a different MCO for the newborn as early as the second month of life. In such a case, the MCO of the mother is only entitled to capitation for the birth month. If the newborn's mother is not a member of an MCO at the time of birth, the newborn is enrolled during the next applicable

enrollment cycle.

c. The ability to generate client information to providers within 24 hours of receipt of the Enrollment Roster from HSD.

d. Assign as the key Medicaid client ID number, the RECIP-MCD-CARD-ID-NO that is sent on the Enrollment Roster file. The MCO will cross-reference this ID to the member's social security number and any internal number used in the MCO's system to identify members The Medicaid Card ID number printed on the client's Medicaid card is either the Medicaid System ID number preceded by a '3' or the ASPEN MCI ID preceded by a '2'.

e. Meet Federal CMS standards for release of client information (applies to subcontractors as well). These standards specify that providers may access the Medicaid eligibility information only by entering the client's Medicaid identification number or two or more of the following data elements:

   - Client's full name, including middle initial;
   - Client's date of birth;
   - Client's Social Security Number

   AND by entering date(s) of service(s). If a span of service dates is entered, you determine the length of the span that is appropriate, not to exceed a maximum of 12 months prior to the query date. If a specific date of service is requested, the date cannot be more than 12 months prior to the query date.

   The MCO, and its subcontractors, are subject to HIPAA confidentiality/privacy laws, regulations, and contractual provisions (see 42 CFR 431.306(b).) This is in addition to the requirement that restricts the use or disclosure of information to purposes directly connected with the administration of the Medicaid program (see 42 CFR 431.301). The MCO and its subcontractors are responsible for establishing appropriate administrative, technical, and physical safeguards to insure the security and confidentiality of records.

f. Tracking of changes in the client's category of eligibility and co-pay max amount to ensure appropriate services are covered and appropriate application of co-pays.

g. Accurate maintenance of client eligibility and demographic data.

h. Ability to provide automated access to providers of client eligibility and PCP assignment. The MCO must provide an automated voice response system or Web-based solution for providers to verify eligibility and PCP assignment.

i. Make client enrollment and PCP assignment information available for electronic verification systems, including swipe card systems.

j. Ability to provide electronic transmission to HSD/MAD of client PCP assignment, Care Coordination level, level of care, community long term care arrangement, Health Home assignment, etc. as specified in the MCO to HSD Interface file.

4. Claims Processing Requirements

The MCO and any of its subcontractors or providers paying their own claims are required to maintain Claims processing capabilities to include, but not be limited to:

a. Accepting NPI and HIPAA-compliant formats for electronic Claims submission;

b. Assigning unique identifiers for all Claims received from providers;

c. Standardizing protocols for the transfer of Claims information between the CONTRACTOR and its subcontractors/providers, audit trail activities, and the communication of data transfer totals and dates;

d. Date stamping all Claims in a manner that will allow determination of the calendar date of receipt;

e. Running a payment cycle to include all submitted Claims to date at least weekly;

f. Paying Clean Claims in a timely manner as follows:

   - For Claims from I/T/Us, day activity providers, assisted living providers, Nursing Facilities and home care agencies including Community Benefit providers, ninety-five percent (95%) of Clean Claims must be adjudicated within a time period of no greater than fifteen (15) Calendar Days of receipt and ninety-nine percent (99%) or more of Clean Claims must be adjudicated within a time period of no greater than thirty (30) Calendar Days of receipt;

   - For all other Claims, ninety percent (90%) of all Clean Claims must be adjudicated within thirty (30) Calendar Days of receipt, and ninety-nine percent (99%) of all Clean Claims must be adjudicated within ninety (90) Calendar Days of receipt;

g. Paying contracted and non-contracted provider interest on the MCO's liability at the rate of one and one-half percent per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating provider and not paid within 30 calendar days of the date of receipt of an electronic claim and 45 calendar days of receipt of a paper claim. Interest shall accrue from the 31st calendar day for electronic claims and from the 46th calendar day for manual claims. The MCO shall not be required to pay any interest calculated to be less than two dollars ($2.00). The interest shall be paid within 30 days of the payment of the claim. The MCO shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HSD/MAD;

h. Meeting both State and federal standards for processing Claims;

i. Generating remittance advice and/or 835 to providers for all Claims submissions;

j. Participating on a committee or committees with HSD to discuss and resolve systems and data related issues, as required by HSD;

k. Accepting from providers and subcontractors only national HIPAA- compliant standard codes and editing to ensure that the standard measure of units is billed and paid for;

l. Editing Claims to ensure that services being billed are provided by providers licensed to render these services, that services are appropriate in scope and amount, that Members are eligible to receive the services, and that services are billed in a manner consistent with HSD defined editing criteria and national coding standards;

m. Using the Third Party Liability (TPL) file provided by HSD along with any TPL identified to the MCO outside of this file to coordinate benefits with other payers;

n. Capturing and reporting all TPL, interest, copay, or other financial adjustments on all Claims, using HSD defined editing criteria and HIPAA standard Claim adjustment reason codes and remark codes to identify the payments and adjustments;

o. Developing and maintaining a NPI HIPAA-compliant electronic billing system for all providers submitting bills directly to the CONTRACTOR and requiring all subcontractors to meet the same standards;

p. Accepting and accurately paying Medicare Claims coming either as Medicare claims sent to the CONTRACTOR from the CONTRACTOR's providers or as Medicaid crossover Claims submitted by the coordination of benefits agreement ("COBA") contractor or provider; ensuring the following:

    1) All information on the Medicare or crossover Claim for the client enrolled in the MCO must be accepted, adjudicated, and stored in the MCO's system; including the Medicare allowed and paid amounts and Medicaid allowed and paid amounts with all Claim adjustment reason codes on the Claim that allow the Claim to balance as per HIPAA 837 balancing rules;

    2) Any Medicare claims paid by the SNP for which there is no Medicaid obligation (no coinsurance or deductible) must be adjudicated and stored complete with all Claim adjustment reason codes explaining the difference between the provider's billed charges and the MCO's allowed and paid amounts.

q. Maintaining adequate data to the same standards of completeness and accuracy as required for proper adjudication of Fee-For-Service claims for all services, regardless of the method of payment for those services, to meet the Encounter Data requirements in the next section, including but not limited to:

    a. Services provided under subcapitation payment arrangements;

    b. Services provided as part of a bundled rate;

    c. Services performed by CONTRACTOR staff, even where no payment is made or identified for those services, such as care coordination activities;

r. Adhering to federal and State timely filing requirements as defined in HSD timely filing Claims exceptions detailed in the MCO Systems Manual; and

s. Configuring the CONTRACTOR's own system to meet HSD's editing criteria as detailed in the MCO Systems Manual.

t. acceptance from providers and subcontractors of national standard codes; using, standard definitions for services and unit definitions.

u. Systemic review and control systems, to include editing of claims to ensure services are being submitted by providers licensed to render the services being billed, that services are appropriate in scope and amount, and that enrollees are eligible to receive the service and that services are billed in a manner consistent with national coding criteria (e.g., discharge type of bill includes discharge date, rendering provider is always identified for facility and group practices, services provided in any inpatient/residential setting are coded with an inpatient type of bill, etc.);.

5. Encounter Reporting Requirements

The MCOs have a responsibility for the following Encounter File Submission and Reporting capabilities to include, but not be limited to:

a. Provide Encounter Data to HSD by electronic file transmission using the 837 and NCPDP formats according to HIPAA transaction and code sets and operating rules using HSD approved, standard protocols;

b. Comply with CMS and HIPAA standards for electronic transmission, security and privacy (also applies to subcontractors);

c. Submit to HSD all Encounters in accordance with the HIPAA Technical Guidance, NM's Companion Guides for Encounters, HIPAA Operating Rules, EDI guidelines for successful submission for files and any specific information included in the MCO Systems Manual;

d. Make changes or corrections to any systems, processes or data transmission formats as needed to comply with HSD data quality standards as originally defined or subsequently amended;

e. Submit to HSD Encounters for all Claims or services paid by the CONTRACTOR.;

f. Within five (5) Business Days of the end of a payment cycle the CONTRACTOR shall generate Encounter Data files for that payment cycle from its Claims management system(s) and/or other sources. If the CONTRACTOR has more than one (1) payment cycle within the same calendar week, the Encounter Data files may be merged and submitted within five (5) Business Days of the end of the last payment cycle during the calendar week;

g. Submit to HSD Encounters for all adjustment/void Claims of previously reported Encounters according to the same timeliness standards as required of paid original

Claims, applied to the adjustment date. Adjustment and voids of previously paid Claims must be identified as such according to instructions in the HIPAA Technical Requirements guide and NM Companion guides, including the HSD Transaction Control Number (TCN) of the previously paid Encounter that the adjustment/void modifies;

h. Submit corrections to any encounters that are rejected by the HIPAA EDI transaction processing within 5 working days of the notice of rejection.

i. Submit to HSD Encounters for any Medicare claims for a Medicaid client sent to the CONTRACTOR from the CONTRACTOR's providers as well as Medicaid crossover Claims submitted by the COBA contractor or provider; ensuring the following:

   (1) all information on the Medicare or Medicaid crossover Claim must be submitted as an Encounter to HSD including the Medicare allowed and paid amounts and Medicaid allowed and paid amounts with all Claim Adjustment reason codes on the Claim that allow the Claim to balance as per HIPAA 837 balancing rules. Instructions for the submission of Medicare Encounters will be included in the MCO Companion Guides;

   (2) any Medicaid crossover Claim where the CONTRACTOR either paid the Medicaid obligation or there was no payment made on the Medicaid obligation must be sent to HSD as a Medicaid crossover Encounter;

j. Have a formal monitoring and reporting system to reconcile submission and resubmission of Encounter Data between the CONTRACTOR and HSD to assure timeliness of submissions, resubmissions and corrections and the overall completeness and accuracy of data;

k. Have a formal monitoring and reporting system to reconcile submissions and resubmissions of Encounter Data between the CONTRACTOR and the subcontractors or providers who pay their own Claims to assure timeliness, completeness and accuracy of their submission of Encounter Data to the CONTRACTOR;

l. Meet HSD Encounter timeliness requirements by submitting to HSD at least ninety percent (90%) of its Claims, originals and adjustments within thirty (30) Calendar Days of the date of adjudication, and ninety-nine percent (99%) within sixty (60) Calendar Days of the date of adjudication in accord with the specifications included in HIPAA Technical Report, the NM Companion Guide and the MCO Systems Manual, regardless of whether the Encounter is from a subcontractor, subcapitated arrangement, or performed by the CONTRACTOR. CONTRACTOR may not withhold submission of Encounters for any reason;

m. Have written contractual requirements of subcontractors or providers that pay their own Claims to submit Encounters to the CONTRACTOR on a timely basis which

ensures that the CONTRACTOR can meet its timeliness requirements for Encounter submission;

n. Meet Encounter accuracy requirements by submitting CONTRACTOR paid Encounters with no more than a three percent (3%) error rate per invoice type (837I, 837P, 837D, NCPDP), calculated for a quarter's worth of submissions. HSD will monitor the CONTRACTOR corrections to New Mexico denied Encounters by random sampling. Seventy-five percent (75%) of the New Mexico denied Encounters included in the random sample must have been corrected and resubmitted by the CONTRACTOR within thirty (30) Calendar Days of denial.

o. Systematically edit Encounters prior to submission to prevent or decrease submission of duplicate Encounters and other types of Encounter errors. The edits used in the Omnicaid system for encounters are included in this manual and should be used to establish similar edits within the MCO's system for claims; and

p. Where the CONTRACTOR has entered into capitated reimbursement arrangements with providers, the CONTRACTOR shall require submission of all utilization or Encounter Data to the same standards of completeness and accuracy as required for proper adjudication of Fee-For-Service claims, as a condition of the capitation payment and shall make every effort to enforce this contract provision to ensure timely receipt of complete and accurate data.

q. Meet encounter completeness requirements by submitting to HSD/MAD a report of the number of denied claims by invoice type (Professional, Institutional, Pharmacy, Dental) by date of payment and date of service. This report will be compared to encounter data to evaluate the completeness of data submitted. A variance between the MCO's report and the record of encounters received cannot exceed 10% for months of payment greater than 90 days.

r. Report all data with specific attention to the following financial information that will be used to ensure accuracy of claims payment and to set future capitation rates:

- Actual MCO Paid Amount on all claims/lines paid by the MCO or subcontractor;
- An MCO Paid Amount equivalent for any claims/lines not paid as fee for service claim/line, with a pricing process code that indicates the amount shown is an equivalent amount (e.g., subcapitated providers/clients);
- Claim Adjustment reason codes (CAS codes) with Remark Codes as needed to designate the reasons any claim/line is not paid (e.g., bundling) and to describe any differences between billed charges and MCO payment amount;
- Any payments by any third party payer, copayments from the client, or adjustments to the claim/line's pricing reported with the appropriate claim adjustment reason and remark codes.
- Payment to IHS, FQHC, and RHC providers using institutional claim formats and including the encounter rate on one line of the claim, but including all services rendered as part of that encounter.

MCO's must define the subcontractors' system requirements in such a way as to ensure that HSD's MCO system requirements can be met.

II. ENROLLMENT DATA

Effective December 4, 2017, the system that determines eligibility for Medicaid, ASPEN, also enrolls clients to Centennial Care. ASPEN will send daily and monthly enrollment files to the MMIS which processes these files, appending additional information the ASPEN system doesn't maintain (i.e., cohorts, long term care, health home, care coordination, etc). From the daily and monthly processing, there are a number of files that are provided to the MCO's to expedite their enrollment of MCO eligibles. In addition to the routine Managed Care processing, the MMIS creates a number of files that are provided to assist MCO staff to manage transition and continuity of care. This section provides a description of these various files and the file layouts. Each file is designated according to the program for which it is generated. At the end of this manual is a list of all the files that are produced and a schedule for when files are placed on the DMZ Moveit Server.

Reporting Client Demographic Updates

The Enrollment data that HSD sends to the MCOs comes from eligibility determined by one of three possible sources, ISD, SSA, or CYFD. Because the Omnicaid system is not the originator of the data, any changes to the client information have to be made by ISD, SSA or CYFD, depending on where that eligibility originated. The majority of client eligibility is originated and maintained by ISD in the ASPEN system. When the MCO becomes aware of a change in a client's address and the client has any Category of Eligibility (COE) other than 006, 014, 017, 037, 046, 047, 066 or 086 (these all originate from CYFD) or 001, 003, 004 (these usually originate from SSA) this information should be communicated to the local ISD office that manages the client's case.

Please remember that the MCO's are reporting as third parties. ISD has to verify address change information thru SSA/MVD scans or contact with the client.

Daily Client Enrollment

When a client applies for Medicaid eligibility at the local county office or via the web portal Yes NM, ISD or Yes NM informs the client that they must choose an MCO for their Medicaid services. The MCO Choice made by the client is retained in ASPEN and is used to enroll the client once eligibility has been determined (using that choice if it doesn't conflict with re-enrollment requirements). ASPEN then sends the enrollment data on the daily file that comes to Omnicaid. In that night's managed care cycle, the enrollment roster file will be finalized and sent to the MCO.

If the client doesn't make a choice or the client's eligibility is initiated outside of the county ISD system (SSA or CYFD determines eligibility), the client will be auto-assigned to an MCO the night their eligibility is received. Regardless of whether assignment is by Choice or Auto-Assignment, the ASPEN system will send the enrolled clients an enrollment confirmation letter showing the MCO to whom they've been assigned and the effective dates of enrollment.

Clients who are eligible, and not currently enrolled, but have a prior enrollment within the last 180 days are automatically reenrolled with their prior Centennial Care health plan if

they are still eligible and have no lockout span in effect for the health plan. In the absence of a prior enrollment within the last 180 days, clients will be auto-assigned to the MCO that any other household member is assigned to and in the absence of that, clients are randomly assigned to an MCO.

Native Americans are not required to enroll in Centennial Care, unless the client is in need of long term care or is a Dual Eligible. Native American clients can enroll in Centennial Care using either the State's Web Portal, YesNM (www.yes.state.nm.us) or by calling the Consolidated Call Center (1-800-299-7304).

MCO's Responsibility for New Clients

Upon receipt of new enrollment for clients on the Daily roster file, the MCO is responsible for sending the client by mail or electronically a Member handbook within thirty (30) Calendar Days of receipt of notification of enrollment in the CONTRACTOR's MCO. Upon request of a Member or Recipient, the MCO must mail or send electronically a Provider Directory, Preferred Drug List, and/or Member handbook within ten (10) Calendar Days. The MCO must give the person requesting a provider directory, Preferred Drug List, and/or Member handbook the option to get the information from the MCO's website or to receive a printed document. Each Member shall be provided an identification card identifying the Member as a participant in the Centennial Care program within thirty (30) Calendar Days of notification of enrollment into the MCO. The MCO shall re-issue a Member ID card within ten (10) Calendar Days of notice if a Member reports a lost card or if information on the Member ID card needs to be changed.

HSD carries a number of different addresses for clients, including Authorized Rep, Payee, Mailing and Residential. The MCO is instructed to mail items to the client using the address in this hierarchy; however, if the client has a CYFD Category of Eligibility ('006','014','017','037','046','047','060','061','066','086'), the Payee address is always used if present:

1 Authorized Rep,
2 Payee,
3 Mailing
4 Residential

Initial MCO Switch

When a client is newly enrolled with a Managed Care Organization, the client has a 90 day period during which they can make a change. After exercising switching rights, a Member shall remain with the MCO until the annual choice period, unless the client is a Native American. Native American's can opt-out of Centennial Care at any time. This switch can be made using either the State's Web Portal, YesNM (www.yes.state.nm.us) or by calling the Consolidated Call Center (1-800-299-7304).communicated on the client's enrollment notification letter.

Monthly Reminder Letters

A client enrolled in Centennial Care is locked-in to that enrollment for a period of 12 months. The ASPEN system sends an open enrollment reminder letter to enrolled clients 90 days prior to the end of each of their 12-month lock-in periods. If the clients do not choose to enroll with another MCO before the end of the lock-in period, they will continue to be locked-in to the current MCO enrollment for another 12 months. If the client chooses another MCO during the open enrollment period, they will have one opportunity anytime during the ninety (90) Calendar Day period immediately following the effective date of enrollment in the newly selected MCO to request to change MCOs. Similar to the initial switch, the client wishing to switch using either the State's Web Portal, YesNM (www.yes.state.nm.us) or by calling the Consolidated Call Center (1-800-299-7304).

MCO's Responsibility for Client Transfers

The MCO is responsible for identifying clients who are transferring to a different MCO and clients transferring from another MCO and performing all the required transition of client data outlined in the Managed Care Transition Management Agreement. Client Transfers are identified in the Enrollment Roster by use of a Transfer ID. When a client is transferring from the MCO, the roster will include a termination record with the Transfer ID populated with the ID of the MCO the client is transferring to. When a client is transferring to the MCO the roster will include an enrollment record with the Transfer ID of the MCO the client is transferring from. The MCO is expected to reach out to the transfer MCO to coordinate the client s care.

Managed Care Enrollment and the Enrollment Roster Files

The managed care daily cycle identifies any client who is newly eligible or whose status has changed since the previous daily cycle and creates either an enrollment or termination/recoupment record for those clients.

All Medicaid clients will be in Centennial Care except for the following (this is primarily a list of COEs not included; where the COE is noted as not included, it is not meant to exclude clients who have one of these COEs in conjunction with an included COE):

1. Clients in ICF/MR facilities (newly named ICF/IID)
2. Children's Medical Services COE 007
3. General Assistance – COE 005
4. Out of State CYFD categories – COE's 046 and 047
5. Refugees – COE 014, 019, 049,
6. Undocumented aliens – COE 085 with fed match <> 8
7. COVID19 Uninsured – COE 085 with fed match = 8
8. Clients who have only eligibility as QMB/SLMBs , Qualified Individuals, LIS – COE's 041, 042, 044, 045, 048 , 050
9. PACE – not identified by COE but by lock-in type code 'PAC'
10. Medical Management client identified as the system does currently

Managed Care Services

The only services outside Centennial Care (carved out) will be:

- DD Waiver services,
- Medically Fragile Waiver
- Supports Waiver services
- School Based Services
- Early Intervention

These can be defined by excluding:

- provider type (PT 344, 345),
- claim type W with COE 096 and 095,
- and for Early Intervention, excluding the procedure code/modifier codes as follows:

  T2023/TL
  T1027/TL
  T1027/TLHQ
  T1027/TLTT
  T1027/TLTJ
  H2000/TL
  H2000/HA

Incarcerated Individuals

HSD will report when a client has been discharged from an incarceration facility to be enrolled with the MCO and when a client enrolled with an MCO is being terminated due

to incarceration. The rules governing incarceration are that if the client is enrolled in managed care during the month of incarceration, the client is disenrolled effective the end of that month; except if the incarceration begin date is exactly the first day of the month in which case the enrollment will be terminated as of the end of the prior month. And if the client is eligible for enrollment in managed care, upon their discharge, they will be enrolled into the MCO effective with the month of discharge, as long as the discharge date isn't exactly the last day of the month. So a client enrolled in managed care when they are incarcerated on 8/3/2019 will be terminated from enrollment effective 8/31/2019 and if they are discharged October 29, 2019, they will be re-enrolled effective 10/1/2019, assuming they still meet the criteria for required Centennial Care enrollment. And a client enrolled in managed care when they are incarcerated on 8/1/2019 will be terminated from enrollment effective 7/31/2019 and if they are discharged October 31, 2019, they will be re-enrolled effective 11/1/2019, assuming they still meet the criteria for required Centennial Care enrollment.

The monthly Supplemental Enrollment Roster file reports when a member has been incarcerated for 30 days or more at which point the client's benefits are considered suspended, and the enrollment to managed care is terminated. The monthly roster file includes the incarceration booking date, release date, and facility ID. This information is not provided timely enough for the MCOs to perform the monitoring and follow-up prescribed.

Effective August 21, 2022, ASPEN will begin providing incarceration data at the time it is received via the Daily Enrollment Roster file. Since the booking date doesn't affect the client's enrollment until 30 days after incarceration, there isn't necessarily any enrollment information that would trigger a record on the Daily enrollment roster file. The MCOs will need to recognize that a record on the Daily file with Minor Type '6' indicates an incarceration update and shall capture this information in their own system.

- ASPEN will send an 'E' record with the member's actual booking date and the incarceration facility ID when the member enrolled to the MCO is first incarcerated using a Minor Type value '6' to identify the record as an incarceration record.
    - If the member is transferred to another incarceration facility while still enrolled to that MCO another E record will be sent on the Daily file with Minor Type '6' showing the booking date as the date the member transferred to the new facility and the new facility ID.
- If the member remains incarcerated for 30 days, their Enrollment status is suspended, and ASPEN will send a 'T' record still showing the member's actual booking date and facility ID. This would be sent on the Daily roster but would not carry the Minor Type value '6' since there's no update to the client's incarceration period. The incarceration data would also be reflected on the Monthly Roster.
    - A 'T' record is sent on the Daily roster file with the Minor type '6' at any point during the member's incarceration when the member transfers from one incarceration facility to another; even though the client may have been disenrolled from that MCO for a month or more. When this happens,

ASPEN will send the last T record produced for the client reflecting the booking date of that transfer and the new facility ID.

- An 'E' record will be sent with the member's release date when the member is identified as released with the re-enrollment date to the MCO to which the member was previously enrolled; assuming the member hasn't chosen a new MCO while incarcerated.
- Depending on the notification timing of the incarceration, the MCO could get a daily record that contains both a change to enrollment as well as the incarceration data. For example, if ASPEN is not notified of an incarceration until 30 days has already passed, the MCO could get a T record that also contains the incarceration information, sent on the Daily with the Minor Type '6'.

HIPAA 834 Format

New Mexico will produce the 834 format for the Enrollment roster file. The 834 format is produced from the proprietary roster file. Refer to the NM Companion Guide on the HSD website at http://www.hsd.state.nm.us/mad/5010HIPAAforNMMedicaidProviders.html for any explanation of NM specific mapping that has been done to the 834 format fields.

The X12N 834 Health Care Enrollment and Maintenance standard transaction does not accommodate the full range of information currently provided in New Mexico's Enrollment Roster file interface. For that reason, New Mexico will continue to produce Supplemental Member file interface which will carry some of the same data as on the 834, plus the additional data not covered by the 834. The discussion in this section primarily addresses the enrollment process and the Supplemental Roster files that are produced.

Daily Enrollment

A daily (Monday thru Saturday) 834 Benefit Enrollment file and a daily Supplemental Roster file is generated for Centennial Care. The MCOs should not expect to receive a roster/834 file on the day after a State holiday.

The Daily 834 Benefit Enrollment and Supplemental Roster files contain a record for every new client that has been enrolled in the nightly cycle. A new client can be added with retroactive months of enrollment. This file will also include clients who've lost eligibility for a prior month or months and have been determined eligible for those lost months and any Retroactive Newborn enrollments. The daily file will also report any terminations or recoupments.

The Daily 834 Benefit Enrollment and Supplemental Member files contain a record for each retroactive month of managed care enrollment that has been added. The different types of records other than new enrollments are:

- *Retroactive Newborn enrollments* - During the daily and both monthly cycles, the system attempts to auto-enroll newborns who would otherwise be

candidates for notification of health plan eligibility. The system identifies newborns using the following criteria:

- The client is less than 12 months old.
- The client has no prior health plan enrollment or recoupment span.
- The client's mother is on file and enrolled in a health plan on the newborn's birth date.
- The client is eligible for health plan enrollment back to the date of birth with the health plan the client's mother was enrolled in on the birth date.

The system uses the following method to locate a newborn client's mother:
If the relationship-to-head-of-household indicator on the client's highest ranked COE span indicates a child, and there is only one female designated as the case head of household, auto enroll the infant. In all other cases, do not auto-enroll the infant.

Once the system identifies a newborn to auto-enroll, the system creates a health plan enrollment span for the health plan the newborn's mother was enrolled in on the birth date. If the newborn's eligibility is not open-ended, the system creates the enrollment with a closed end date. The enrollment span covers each month the newborn is eligible from the birth date through the end of the month where the first gap in the newborn's eligibility occurs.

If the system cannot link the non-Native American newborn to a mother using the criteria above, the system will auto-assign the newborn like any other Medicaid eligible client. If the newborn is Native American, the newborn will not be enrolled in Centennial Care and will show up on the MCO Notification file of Native Americans not enrolled in Centennial Care.
A daily record is sent for the following:

- *Terminations* - During the daily cycle, the system will terminate any clients who are not meeting enrollment criteria. If later in the month, the client's eligibility for enrollment is reestablished, a re-enrollment record will be sent.
- *Re-enrollments* – Clients who have been terminated and then re-enrolled.
- *Recoupments* – Clients whose termination is retroactive will be recorded as recoupment spans.
- *Voided Enrollment* - If the client was previously reported on a Daily 834 Benefit Enrollment and Supplemental Roster files as a new enrollment for the upcoming month and subsequently has that eligibility voided, the client will be shown on a subsequent Daily 834 Benefit Enrollment and Supplemental Roster files as a voided record.
- *Incarceration* – A minor type '6' will indicate an update to incarceration data. The **only** fields that will be updated on an Incarceration record with minor type 6 are the Facility Id and the Incarceration Booking and Release dates.

Other data included in this Incarceration record should not be allowed to update the MCO's member record.

Prospective Medicare Enrollment

Effective April, 2023 the MCOs will be sending default enrollment notices to clients who will become Medicare eligible. This is an initiative the State is undertaking to align enrollment for full benefit dually eligible individuals, thereby streamlining Medicare enrollment for newly Medicare eligible into their existing Medicaid MCO's D-SNP with the option to opt out in favor of Original Medicare.

To enable this default enrollment, the Supplemental Enrollment Roster file will begin sending the prospective Medicare dates for clients who have not previously been enrolled in Medicare. Prior to this time, the roster file only includes Medicare spans that overlap the current enrollment month. The State obtains future Medicare spans from CMS and starting in April, will report them on the roster. There is no change to the file layout, but will do the following:

- The change applies to Medicare Parts A and B only.
- Prospective Medicare dates will only be reported on current enrollment month major type E roster records.
- The Medicare coverage indicator on the roster will continue to be set only in the context of current Medicare coverage and will not be set if the client has only prospective Medicare coverage.

Upon implementation, the new process would call for the MCOs to ingest the future date spans and send default enrollment notices to their clients who have the future Medicare begin dates. Clients would have the right to opt-out, otherwise they'll be enrolled with the MCO for both their Medicaid and their D-SNP plans. The systems manual doesn't outline this process; only note that the prospective spans will be sent.

Monthly Enrollment Reporting

In the nightly cycle, 3 days before the end of the month, the system will generate a monthly 834 Benefit Enrollment and Supplemental Roster files. These files will show all the clients active or terminated as of the upcoming enrollment month, along with any retroactively enrolled eligible clients. It is also during this process that the system will produce open enrollment reminder letters for clients who are in the 9th month of a 12-month lock-in period.

Clients who have appeared on the Daily 834 Benefit Enrollment and Supplemental Roster files will appear again on the Monthly 834 Benefit Enrollment and Supplemental Roster files. There will be a separate record for each retro span record and ongoing span record.

Any clients added retroactively once the monthly processing is run will be reported on the next Daily 834 Benefit Enrollment and Supplemental Roster files and captured in the next monthly reporting.

Enrollment Roster File

The Daily Supplemental Roster file format is the same as the Monthly Supplemental Roster file. The file differentiates between new enrollees, ongoing enrollees and terminated enrollees by using a Major Enrollment Indicator as follows:

Major Enrollment Indicator	Values	Values
E	Enrolled	New Enrollee
E	Enrolled	Ongoing Enrollee
T	Terminated	Disenrolled
R	Retroactive	Retroactive Enrollment
X	Recoupment	Recoupment

Since retroactive enrollments are reported on the Supplemental Roster file, it is possible for the roster to have multiple entries for one client; one for each month of retroactive enrollment, and one for the current month enrollment.

Recoupment spans are created when a client was enrolled in the MCO for the enrollment month but ASPEN determines that a mistake in enrollment was made and either reassigns the client to Fee For Service Medicaid or determines the client as ineligible. The recoupment span notifies the MCO that the client is not considered enrolled in that MCO for the enrollment month indicated by X5 span, despite what may have been communicated on an earlier enrollment roster. If a recoupment spans multiple months, there will be an entry with X5 span for each month the recoupment is effective. This will typically only happen as a result of audit activity or retroactive date of death.

It is the nature of eligibility and enrollment that clients lose eligibility for enrollment which results in a recoupment span that is sent on the roster file; only to be added back retroactively at a later date. MCOs recovering paid claims from providers based on the roster recoupment span is a premature action that places an unnecessary burden on the providers and the MCO. HSD instructs the MCOs that they must not recover claim payments from providers upon receipt of the recoupment span on the Enrollment Roster file. MCOs must wait and only recoup from the providers if the capitation payment for the month of service that covers that claim's dates of service is voided by HSD. The capitation voids are reported on the 820, the electronic remittance.

It is possible that the enrollee's begin date shown on the enrollment roster may change, although the enrollee has been an ongoing enrollee with that plan. The MCO should rely on the combination of the Major Enrollment Indicator and the enrollee's begin date to identify the enrollee's status as new or ongoing. It may happen that a new enrollee will have both a begin date and an end date, due to their having chosen to transfer to another MCO at some point in the future or perhaps due to a future loss of eligibility for managed care. The enrollee with an end date will also show up as a Terminated Enrollee on the month in which the termination takes place.

The Monthly Supplemental Roster File contains both demographic information about the enrollees as well as the capitation amount to be paid for each enrollee and that enrollee's cohort number. The file is placed on the DMZ Movit server where it can be downloaded via the MCO's login and secure password.

Supplemental Roster File Layout

The file layout for the Supplemental Roster file is provided below. The file layout is the same regardless of whether the file is produced from the Daily or Monthly Cycle.

```
01  HEADER-RECORD.
    05 HEADER-REC-IND             VALUE 'HD'PIC X(02).
    05 FILLER       VALUE SPACE PIC X(01).
    05 HEADER-FILE-NAME   PIC X(32).
    05 FILLER       VALUE SPACE PIC X(01).
    05 HEADER-DATE.
       10 HDR-DTE-MM              VALUE ZEROS PIC 9(02).
       10 FILLER    VALUE '/' PIC X(01).
       10 HDR-DTE-DD              VALUE ZEROS PIC 9(02).
       10 FILLER    VALUE '/' PIC X(01).
       10 HDR-DTE-YY              VALUE ZEROS PIC 9(02).
    05 FILLER                                VALUE SPACE PIC X(01).
    05 HEADER-FILE-TYPE-ID                   VALUE 'XXX' PIC X(03).
    05 FILLER       VALUE SPACE PIC X(1332).

01  W1H65521-H-SUPLM-ROSTER-DTL.
    05 W1H65521-B-LCKN-TY-CD                      PIC X(03).
    05 W1H65521-H-MO-SVC-DT                       PIC X(06).
    05 W1H65521-H-REC-MAJ-TY-CD                   PIC X(01).
    05 W1H65521-H-REC-MIN-TY-CD                    PIC X(01).
    05 W1H65521-P-ID                              PIC X(08).
    05 W1H65521 -FILLER                           PIC X(04).
    05 W1H65521-H-PLN-NAM                         PIC X(30).
    05 W1H65521-RECIP-MCD-CARD-ID-NO              PIC X(10).
    05 W1H65521-B-PRIOR-CARD-ID1                  PIC X(10).
    05 W1H65521-B-PRIOR-CARD-ID2                  PIC X(10).
    05 W1H65521-B-ASPEN-MCI-ID                    PIC X(09).
    05 W1H65521-B-SSN-NUM                         PIC X(09).
    05 W1H65521-B-MEDICARE-ID-NO                  PIC X(13).
    05 W1H65521-H-CVRG-MCARE-CD                   PIC X(01).
    05 W1H65521-B-LAST-NAM                        PIC X(21).
    05 W1H65521-B-FST-NAM                         PIC X(15).
    05 W1H65521-B-MI-NAM                          PIC X(01).
    05 W1H65521-B-MAIL-LINE1-AD                   PIC X(25).
    05 W1H65521-B-MAIL-LINE2-AD                   PIC X(25).
    05 W1H65521-B-MAIL-CITY-NAM                   PIC X(20).
    05 W1H65521-B-MAIL-ST-CD                      PIC X(02).
    05 W1H65521-B-MAIL-ZIP5                       PIC X(05).
    05 W1H65521-B-MAIL-ZIP4                       PIC X(04).
    05 W1H65521-B-RES-LINE1-AD                    PIC X(25).
    05 W1H65521-B-RES-LINE2-AD                    PIC X(25).
    05 W1H65521-B-RES-CITY-NAM                    PIC X(20).
    05 W1H65521-B-RES-ST-CD                       PIC X(02).
    05 W1H65521-B-RES-ZIP5                        PIC X(05).
    05 W1H65521-B-RES-ZIP4                        PIC X(04).
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05 W1H65521-B-RES-PHON-NUM                  PIC X(10).
05 W1H65521-B-GEO-CNTY-CD                   PIC X(02).
05 W1H65521-B-ADMIN-OFC-CD                  PIC X(05).
05 W1H65521-C-HDR-CLNT-AGE                  PIC 9(03).
05 W1H65521-B-DOB-DT                        PIC X(10).
05 W1H65521-B-DOD-DT                        PIC X(10).
05 W1H65521-B-GENDER-CD                     PIC X(01).
05 W1H65521-B-RACE-CD                       PIC X(02).
05 W1H65521-B-ETH-CD                        PIC X(02).
05 W1H65521-B-TRIBAL-AFFL-CD                PIC X(02).
05 W1H65521-B-PRIM-LANG-CD                  PIC X(02).
05 W1H65521-B-DISA-TY-CD                    PIC X(03).
05 W1H65521-B-CERT-DT                       PIC X(10).
05 W1H65521-B-PREG-DUE-DT                   PIC X(10).
05 W1H65521-B-PCP-NPI-ID                    PIC X(10).
05 W1H65521-B-CASE-HH-NUM                   PIC X(09).
05 W1H65521-B-HH-LAST-NAM                   PIC X(21).
05 W1H65521-B-HH-FST-NAM                    PIC X(15).
05 W1H65521-B-HH-MI-NAM                     PIC X(01).
05 W1H65521-B-COE-CD                        PIC X(03).
05 W1H65521-B-COE-TERM-RSN-CD               PIC X(03).
05 W1H65521-B-FED-MTCH-CD                   PIC X(01).
05 FILLER                                   PIC X(17).
05 W1H65521-B-NEW-TO-MCAID-IND              PIC X(01).
05 W1H65521-B-CC-LVL-CD                     PIC X(01).
05 W1H65521-B-CC-ASSESS-DT                  PIC X(10).
05 W1H65521-B-CC-ASSESS-TY-CD               PIC X(01).
05 W1H65521-B-CC-BEG-DT                     PIC X(10).
05 W1H65521-B-CC-END-DT                     PIC X(10).
05 W1H65521-B-HHM-NPI-ID                    PIC X(10).
05 W1H65521-B-HHM-BEG-DT                    PIC X(10).
05 W1H65521-B-HHM-END-DT                    PIC X(10).
05 W1H65521-B-HHM-LVL-CD                    PIC X(01).
05 W1H65521-B-LTC-SPN-BEG-DT                PIC X(10).
05 W1H65521-B-LTC-SPN-END-DT                PIC X(10).
05 W1H65521-B-LEVEL-OF-CARE-CD              PIC X(03).
05 W1H65521-B-LAST-ASSESS-DT                PIC X(10).
05 W1H65521-B-SETNG-OF-CARE-CD              PIC X(03).
05 W1H65521-B-LTC-NPI-PROV-ID               PIC X(10).
05 FILLER                                   PIC X(17).
05 W1H65521-B-COPAY-MAX-AMT                 PIC 9(05)V99.
05 W1H65521-B-FPL-PCT                       PIC 9(04).
05 W1H65521-B-LIAB-CURR-BEG-DT              PIC X(10).
05 W1H65521-B-LIAB-CURR-END-DT              PIC X(10).
05 W1H65521-B-LIAB-CURR-AMT                 PIC 9(05)V99.
05 W1H65521-B-LIAB-PREV-BEG-DT              PIC X(10).
05 W1H65521-B-LIAB-PREV-END-DT              PIC X(10).
05 W1H65521-B-LIAB-PREV-AMT                 PIC 9(05)V99.
05 W1H65521-B-DISA-BEG-DT                   PIC X(10).
05 W1H65521-B-DISA-END-DT                   PIC X(10).
05 W1H65521-B-MCARE-PT-A-BEG-DT             PIC X(10).
05 W1H65521-B-MCARE-PT-A-END-DT             PIC X(10).
05 W1H65521-B-MCARE-PT-B-BEG-DT             PIC X(10).
05 W1H65521-B-MCARE-PT-B-END-DT             PIC X(10).
05 W1H65521-B-MCARE-PT-C-BEG-DT             PIC X(10).
05 W1H65521-B-MCARE-PT-C-END-DT             PIC X(10).
05 W1H65521-B-MCARC-PBP-CNTRCT-ID           PIC X(05).
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05 W1H65521-B-MCARC-PBP-ORG-NAM              PIC X(30).
05 W1H65521-B-MCARC-PBP-PLN-NAM              PIC X(30).
05 W1H65521-B-MCARE-PT-D-BEG-DT              PIC X(10).
05 W1H65521-B-MCARE-PT-D-END-DT              PIC X(10).
05 W1H65521-B-MCARD-OPT-OUT-IND              PIC X(01).
05 W1H65521-B-MCARD-PBP-CNTRCT-ID            PIC X(05).
05 W1H65521-B-MCARD-PBP-PLN-ID               PIC X(03).
05 FILLER                                    PIC X(20).
05 W1H65521-B-CASE-MGMT-NAM                  PIC X(40).
05 W1H65521-B-CASE-MGMT-LINE1-AD             PIC X(25).
05 W1H65521-B-CASE-MGMT-LINE2-AD             PIC X(25).
05 W1H65521-B-CASE-MGMT-CITY-NAM             PIC X(20).
05 W1H65521-B-CASE-MGMT-ST-CD                PIC X(02).
05 W1H65521-B-CASE-MGMT-ZIP5                 PIC X(05).
05 W1H65521-B-CASE-MGMT-ZIP4                 PIC X(04).
05 W1H65521-B-CASE-MGMT-PHON-NUM             PIC X(10).
05 W1H65521-B-AUTHD-REP-LAST-NAM             PIC X(21).
05 W1H65521-B-AUTHD-REP-FST-NAM              PIC X(15).
05 W1H65521-B-AUTHD-REP-MI-NAM               PIC X(01).
05 W1H65521-B-AUTHD-REP-LINE1-AD             PIC X(25).
05 W1H65521-B-AUTHD-REP-LINE2-AD             PIC X(25).
05 W1H65521-B-AUTHD-REP-CITY-NAM             PIC X(20).
05 W1H65521-B-AUTHD-REP-ST-CD                PIC X(02).
05 W1H65521-B-AUTHD-REP-ZIP5                 PIC X(05).
05 W1H65521-B-AUTHD-REP-ZIP4                 PIC X(04).
05 W1H65521-B-AUTHD-REP-PHON-NUM             PIC X(10).
05 W1H65521-B-PAYEE-LAST-NAM                 PIC X(21).
05 W1H65521-B-PAYEE-FST-NAM                  PIC X(15).
05 W1H65521-B-PAYEE-MI-NAM                   PIC X(01).
05 W1H65521-B-PAYEE-LINE1-AD                 PIC X(25).
05 W1H65521-B-PAYEE-LINE2-AD                 PIC X(25).
05 W1H65521-B-PAYEE-CITY-NAM                 PIC X(20).
05 W1H65521-B-PAYEE-ST-CD                    PIC X(02).
05 W1H65521-B-PAYEE-ZIP5                     PIC X(05).
05 W1H65521-B-PAYEE-ZIP4                     PIC X(04).
05 W1H65521-B-PAYEE-PHON-NUM                 PIC X(10).
05 W1H65521-B-LCKN-BEG-DT                    PIC X(10).
05 W1H65521-B-LCKN-END-DT                    PIC X(10).
05 W1H65521-B-LCKN-ASGN-RSN-CD               PIC X(02).
05 W1H65521-B-LCKN-CHNG-RSN-CD               PIC X(02).
05 W1H65521-H-COHRT-NUM                      PIC X(03).
05 W1H65521-H-PLN-RATE-AMT                   PIC 9(05)V99.
05 W1H65521-H-BH-COHRT-NUM                   PIC X(03).
05 W1H65521-H-BH-RATE-AMT                    PIC 9(05)V99.
05 W1H65521-H-TOT-RATE-AMT                   PIC 9(05)V99.
05 W1H65521-H-TRNSF-P-ID                     PIC X(08).
05 W1H65521-FILLER                           PIC X(04).
05 FILLER                                    PIC X(09).
05 W1H65521-B-FACILITY-ID                    PIC X(04).
05 W1H65521-B-INCAR-BOOKING-DT               PIC X(10).
05 W1H65521-B-INCAR-RELEASE-DT               PIC X(10).
05 W1H65521-B-LIAB-PREV2-BEG-DT              PIC X(10).
05 W1H65521-B-LIAB-PREV2-END-DT              PIC X(10).
05 W1H65521-B-LIAB-PREV2-AMT                 PIC 9(05)V99.
05 W1H65521-G-AUD-DT                         PIC X(10).
05 W1H65521-G-AUD-TM                         PIC X(08).
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01  TRAILER-RECORD.
    05 TRAILER-REC-IND              VALUE 'TR'  PIC X(02).
    05 FILLER       VALUE SPACE PIC X(01).
    05 RECORD-COUNT                 VALUE ZEROS PIC 9(09).
    05 FILLER       VALUE SPACE PIC X(1368).
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Supplemental Roster**RECORD – HEADER**

Source Table	Source Column	Target Field	Req	Def	Specifications	Note Ref
N/A	N/A	HEADER-REC-IND	A	HD		
N/A	N/A	HEADER-FILE-NAME	A	N/A	This value is hard coded depending on the MCO:	
N/A	N/A	HEADER-DATE	A	N/A	Current date.	
N/A	N/A	HEADER-FILE-TYPE-ID	A	N/A	Hard coded values: "ROS"	

LEGEND: For Req: A = Always For Def: HD = Header
C = Conditionally
N = Never

Source Table or File	Source Column	Target Field	Req	Def	Specifications	Note Ref
ASPEN Roster Extract File.	WFH31050-B-LCKN-TY-CD	W1H65521-B-LCKN-TY-CD	A	N/A		
ASPEN Roster Extract File.	WFH31050-H-MO-SVC-DT	W1H65521-H-MO-SVC-DT	A	N/A	Current enrollment year and month. Format is YYYYMM.	1
MCO	WFH31050-H-REC-MAJ-TY-CD	W1H65521-H-REC-MAJ-TY-CD	A	N/A	Enrolled = "E Retroactive Enrollment = "R" Terminated = "T" Recoupment = "X"	5
ASPEN Roster Extract File.	N/A	W1H65521-H-REC-MINOR-TY-CD	A	N/A	Effective August 22, 2022 incarceration data will be sent on Daily files showing a minor type '6' to indicate the presence of some incarceration data. For the 834 processing we have to determine the minor type for enrollment by checking if the enrollment is ongoing or new. If there is an enrollment for the same provider ending within the past 3 months it should be ongoing otherwise it is considered to a new enrollment. New Enrollment = "1" Ongoing Enrollment = "2" Disenrolled = "3" Retroactive Enrollment = "4" Recoupment = "5"	
ASPEN Roster Extract File	WFH31050-P-ID	W1H65521-P-ID	A	N/A		
H_PLN_DETAIL_TB	H_PLN_NUM	W1H65521-H-PLN-NUM	A	N/A	From span that covers the upcoming enrollment month.	
ASPEN Roster Extract File	WFH31050-H-PLN-NAM	W1H65521-H-PLN-NAM	A	N/A		

Source Table or File	Source Column	Target Field	Req	Def	Specifications	Note Ref
ASPEN Roster Extract File	WFH31050-RECIP-MCD-CARD-ID-NO	W1H65521-RECIP-MCD-CARD-ID-NO	A	N/A	This field contains either the Omnicaid 9 digit system id formatted with a "3" in the first position (like the swipe card id) or the ASPEN swipe card formatted with a "2" in the first position and the MCI ID.	
ASPEN Roster Extract File	WFH31050-B-PRIOR-CARD-ID1	W1H65521-B-PRIOR-CARD-ID1	C	spaces	Contains Medicaid Card ID of the client merged into the Medicaid Card Id on this record	
ASPEN Roster Extract File	WFH31050-B-PRIOR-CARD-ID2	W1H65521-B-PRIOR-CARD-ID2	C	spaces	Contains the second Medicaid Card ID of the client merged into the Medicaid Card Id on this record (only happens rarely if more than 1 duplicate client record)	
ASPEN Roster Extract File	WFH31050-B-ASPEN-MCI-ID	W1H65521-B-ASPEN-MCI-ID	C	spaces	Only provided for ASPEN clients	
ASPEN Roster Extract File	WFH31050-B-SSN-NUM	W1H65521-B-SSN-NUM	A	N/A		2
B_DETAIL_TB	B_MCARE_ID	W1H65521-B-MEDICARE-ID-NO	C	spaces	The Omnicaid Medicare ID is used in this field instead of the ASPEN Medicare ID.	
B_MCARE_SPN_TB	B_BUYIN_MCARE_CD	W1H65521-H-CVRG-MCARE-CD	C	spaces	Not populated for terminations. This code is set based on the client's Medicare coverage status for the current enrollment month as follows (it will not be reported for prospective Medicare data spans): • If the client's B_BUYIN_MCARE_CD is A or C, this field is set to A (Part A or Part A HMO • If the client's B_BUYIN_MCARE_CD is B or D, this field is set to B (Part B or Part B HMO) • If the client has more than one Medicare span in effect for the current enrollment month, this field is set to C (Both Part A and Part B) • Otherwise, the field is set to blank (No Medicare coverage).	2
ASPEN Roster Extract File B	WFH31050-B-LAST-NAM	W1H65521-B-LAST-NAM	A	N/A		
ASPEN Roster Extract File	WFH31050-B-FST-NAM	W1H65521-B-FST-NAM	A	N/A		
ASPEN Roster Extract File	WFH31050-B-MI-NAM	W1H65521-B-MI-NAM	C	N/A		

Source Table or File	Source Column	Target Field	Req	Def	Specifications	Note Ref
ASPEN Roster Extract File	WFH31050-B-MAIL-LINE1-AD	W1H65521-B-MAIL-LINE1-AD	C	spaces	B_ADDRESS_TYPE_CD = 'M'	
ASPEN Roster Extract File	WFH31050-B-MAIL-LINE2-AD	W1H65521-B-MAIL-LINE2-AD	C	spaces		
ASPEN Roster Extract File	WFH31050-B-MAIL-CITY-NAM	W1H65521-B-MAIL-CITY-NAM	C	spaces		
ASPEN Roster Extract File	WFH31050-B-MAIL-ST-CD	W1H65521-B-MAIL-ST-CD	C	spaces		
ASPEN Roster Extract File	WFH31050-B-MAIL-ZIP5	W1H65521-B-MAIL-ZIP5	C	spaces		
ASPEN Roster Extract File	WFH31050-B-MAIL-ZIP4	W1H65521-B-MAIL-ZIP4	N	spaces		
ASPEN Roster Extract File	WFH31050-B-RES-LINE1-AD	W1H65521-B-RES-LINE1-AD	A	N/A	B_ADDRESS_TYPE_CD = 'R'	
ASPEN Roster Extract File	WFH31050-B-RES-LINE2-AD	W1H65521-B-RES-LINE2-AD	A	N/A		
ASPEN Roster Extract File	WFH31050-B-RES-CITY-NAM	W1H65521-B-RES-CITY-NAM	A	N/A		
ASPEN Roster Extract File	WFH31050-B-RES-ST-CD	W1H65521-B-RES-ST-CD	A	N/A		
ASPEN Roster Extract File	WFH31050-B-RES-ZIP5	W1H65521-B-RES-ZIP5	A	N/A		
ASPEN Roster Extract File	WFH31050-B-RES-ZIP4	W1H65521-B-RES-ZIP4	N	spaces		
ASPEN Roster Extract File	WFH31050-B-RES-PHON-NUM	W1H65521-B-RES-PHON-NUM	N	spaces		
ASPEN Roster Extract File	WFH31050-B-GEO-CNTY-CD	W1H65521-B-GEO-CNTY-CD	A	N/A	2	
ASPEN Roster Extract File	WFH31050-B-ADMIN-OFC-CD	W1H65521-B-ADMIN-OFC-CD	C	Spaces	This field is required in ASPEN if the source is non-SDX – not populated for Terminations or Recoupments.	
ASPEN Roster Extract File	WFH31050-C-HDR-CLNT-AGE	W1H65521-C-HDR-CLNT-AGE	A	N/A	For current enrollments this should be the age on first day of the current enrollment month. For retro enrollments this should be the age on first day of the applicable retroactive enrollment month.	2
ASPEN Roster Extract File	WFH31050-B-DOB-DT	W1H65521-B-DOB-DT	A	N/A		
B_DETAIL_TB	B_DOD_DT	W1H65521-B-DOD-DT	C	spaces	The Omnicaid DOD is used in this field instead of the ASPEN DOD in order to reduce capitation cohort determination errors.	

Source Table or File	Source Column	Target Field	Req	Def	Specifications	Note Ref
B_DETAIL_TB	B_GENDER_CD	W1H65521-B-GENDER-CD	A	N/A	The Omnicaid gender code is used in this field instead of the ASPEN gender code in order to reduce capitation cohort determination errors.	
ASPEN Roster Extract File	WFH31050-B-RACE-CD	W1H65521-B-RACE-CD	A	N/A		
ASPEN Roster Extract File	WFH31050-B-ETH-CD	W1H65521-B-ETH-CD	A	N/A		2
ASPEN Roster Extract File	WFH31050-B-TRIBAL-AFFL-CD	W1H65521-B-TRIBAL-AFFL-CD	C	spaces		
ASPEN Roster Extract File	WFH31050-B-PRIM-LANG-CD	W1H65521-B-PRIM-LANG-CD	C	spaces		
B_DISA_TY_TB	B_DISA_TY_CD	W1H65521-B-DISA-TY-CD	C	spaces		
ASPEN Roster Extract File	WFH31050-B-CERT-DT	W1H65521-B-CERT-DT	C	spaces		
ASPEN Roster Extract File	WFH31050-B-PREG-DUE-DT	W1H65521-B-PREG-DUE-DT	C	spaces		
B_AUX_DAT_TB	B_PCP_NPI_ID	W1H65521-B-PCP-NPI-ID	C	spaces		
B_COE_SPN_TB	B_CASE_HH_NUM	W1H65521-B-CASE-HH-NUM	A	N/A	Only populated for enrollments	
ASPEN Roster Extract File	WFH31050-B-HH-LAST-NAM	W1H65521-B-HH-LAST-NAM	A	N/A		
ASPEN Roster Extract File	WFH31050-B-HH-FST-NAM	W1H65521-B-HH-FST-NAM	A	N/A		
ASPEN Roster Extract File	WFH31050-B-HH-MI-NAM	W1H65521-B-HH-MI-NAM	C	spaces		
ASPEN Roster Extract File	WFH31050-B-COE-CD	W1H65521-B-COE-CD	A	N/A	Only populated for enrollments	
ASPEN Roster Extract File	WFH31050-B-COE-TERM-RSN-CD	W1H65521-B-COE-TERM-RSN-CD	C	spaces	Required if COE span end date is populated	
ASPEN Roster Extract File	WFH31050-B-FED-MTCH-CD	W1H65521-B-FED-MTCH-CD	A	N/A		
ASPEN Roster Extract File	WFH31050-B-NEW-TO-MCAID-IND	W1H65521-B-NEW-TO-MCAID-IND	C	spaces	Set to "Y" if client's Medicaid eligibility span has been inactive for at least 6 months prior to the enrollment month OR if client is a new enrollee. Set only on E1 (new enrollment) and R4(retroactive enrollment) roster records. Defaults to spaces on other roster records.	
B_CARE_COORD_TB	B_CC_LVL_CD	W1H65521-B-CC-LVL-CD	C	spaces		2

Source Table or File	Source Column	Target Field	Req	Def	Specifications	Note Ref
B_CARE_COORD_TB	B_CC_ASSESS_DT	W1H65521-B-CC-ASSESS-DT	C	spaces		2
B_CARE_COORD_TB	B_CC_BEG_DT	W1H65521-B-CC-BEG-DT	C	spaces		2
B_CARE_COORD_TB	B_CC_END_DT	W1H65521-B-CC-END-DT	C	spaces		2
B_HEALTH_HOME_TB	B_HHM_NPI_ID	W1H65521-B-HHM-NPI-ID	C	spaces		2
B_HEALTH_HOME_TB	B_HHM_BEG_DT	W1H65521-B-HHM-BEG-DT	C	spaces		2
B_HEALTH_HOME_TB	B_HHM_END_DT	W1H65521-B-HHM-END-DT	C	spaces		2
B_HEALTH_HOME_TB	B_HHM_LVL_CD	W1H65521-B-HHM-LVL-CD	C	spaces		2
B_LTC_SPN_TB	B_LTC_SPN_BEG_DT	W1H65521-B-LTC-SPN-BEG-DT	C	spaces		2
B_LTC_SPN_TB	B_LTC_SPN_END_DT	W1H65521-B-LTC-SPN-END-DT	C	spaces		2
B_LTC_SPN_TB	B_LEVEL_OF_CARE_CD	W1H65521-B-LTC-LVL-CARE-CD	C	spaces	The roster file will contain LOC/SOC as reported by the MCOs for their LTC clients which always will be LOC = 'NFL'. The roster file will also, starting with December, 2019 roster, contain the LOC/SOC for clients in the DD/Med Frag waiver programs whose services are carved out of managed care. These spans will contain LOC = MR0- and SOC MIV (Mi Via). Effective July, 2020 clients approved for Supports Waiver will be reported with LOC/SOC MR0/SWA or SWD. All MR0 spans are included so the MCO is aware when LTC is authorized for these clients, in case the MCO has implemented community benefit while waiting for the client's waiver approval.	2
B_LTC_SPN_TB	B_LAST_ASSESS_DT	W1H65521-B-LAST-ASSESS-DT	C	spaces		2
B_LTC_SPN_TB	B_SETNG_OF_CARE_CD	W1H65521-B-SETNG-OF-CARE-CD	C	spaces		2
B_LTC_SPN_TB, P_NPI_XMTCH_TB	P_ID, P_NPI_ID	W1H65521-B-LTC-NPI-PROV-ID	C	spaces	The NPI number is looked up in the Provider NPI Cross Match table using the LTC P_ID . If the NPI cannot be found for the Medicaid provider id, the Medicaid provider is reported.	

Source Table or File	Source Column	Target Field	Req	Def	Specifications	Note Ref
ASPEN Roster Extract File	WFH31050-B-COPAY-MAX-AMT	W1H65521-B-COPAY-MAX-AMT	C	spaces	This is the monthly copay maximum for the clients in a household (identified by members who share the same Case Number)	2
ASPEN Roster Extract File	WFH31050-B-FPL-PCT	W1H65521-B-FPL-PCT	C	spaces		2
ASPEN Roster Extract File	WFH31050-B-LIAB-CURR-BEG-DT	W1H65521-B-LIAB-CURR-BEG-DT	C	spaces		2
ASPEN Roster Extract File	WFH31050-B-LIAB-CURR-END-DT	W1H65521-B-LIAB-CURR-END-DT	C	spaces		2
ASPEN Roster Extract File	WFH31050-B-LIAB-CURR-AMT	W1H65521-B-LIAB-CURR-AMT	C	zeroes		2
ASPEN Roster Extract File	WFH31050-B-LIAB-PREV-BEG-DT	W1H65521-B-LIAB-PREV-BEG-DT	C	spaces	Span previous to current span	2
ASPEN Roster Extract File	WFH31050-B-LIAB-PREV-END-DT	W1H65521-B-LIAB-PREV-END-DT	C	spaces	Span previous to current span	2
ASPEN Roster Extract File	WFH31050-B-LIAB-PREV-AMT	W1H65521-B-LIAB-PREV-AMT	C	zeroes	Amount previous to current span amount	2
B_DISA_TY_TB	B_DISA_BEG_DT	W1H65521-B-DISA-BEG-DT	C	spaces		2
B_DISA_TY_TB	B_DISA_END_DT	W1H65521-B-DISA-END-DT	C	spaces		2
B_MCARE_SPN_TB	B_BUYIN_SPN_BEG_DT	W1H65521-B-MCARE-PT-A-BEG-DT	C	spaces	Not populated for terminations. B_BUYIN_MCARE_CD = “A” or “C”	2
B_MCARE_SPN_TB	B_BUYIN_SPN_END_DT	W1H65521-B-MCARE-PT-A-END-DT	C	spaces	Not populated for Terminations; B_BUYIN_MCARE_CD = “A” or “C”	2
B_MCARE_SPN_TB	B_BUYIN_SPN_BEG_DT	W1H65521-B-MCARE-PT-B-BEG-DT	C	spaces	Not populated for Terminations; B_BUYIN_MCARE_CD = “B” or “D”	2
B_MCARE_SPN_TB	B_BUYIN_SPN_END_DT	W1H65521-B-MCARE-PT-B-END-DT	C	spaces	Not populated for Terminations; B_BUYIN_MCARE_CD = “B” or “D”	2
B_MCARE_C_SPN_TB	B_PBP_SPN_BEG_DT	W1H65521-B-MCARE-PT-C-BEG-DT	C	spaces		2
B_MCARE_C_SPN_TB	B_PBP_SPN_END_DT	W1H65521-B-MCARE-PT-C-END-DT	C	spaces		2
B_MCARE_C_SPN_TB	B_PBP_CNTRCT_ID	W1H65521-B-MCARC-PBP-CNTRCT-ID	C	spaces		2
B_MCARE_C_SPN_TB	P_PBP_ORG_NAM	W1H65521-B-MCARC-PBP-ORG-NAM	C	spaces		2
B_MCARE_C_SPN_TB	P_PBP_PLN_NAM	W1H65521-B-MCARC-PBP-PLN-NAM	C	spaces		2
B_MCARE_D_SPN_TB	B_PBP_SPN_BEG_DT	W1H65521-B-MCARE-PT-D-BEG-DT	C	spaces		2

Source Table or File	Source Column	Target Field	Req	Def	Specifications	Note Ref
B_MCARE_D_SPN_TB	B_PBP_SPN_END_DT	W1H65521-B-MCARE-PT-D-END-DT	C	spaces		2
B_AUX_DAT_TB	B_PRTD_OPT_OUT_IND	W1H65521-B-MCARD-OPT-OUT-IND	C	spaces		2
B_MCARE_D_SPN_TB	B_PBP_CNTRCT_ID	W1H65521-B-MCARD-PBP-CNTRCT-ID	C	spaces		2
B_MCARE_D_SPN_TB	B_PBP_PLN_ID	W1H65521-B-MCARD-PBP-PLN-ID	C	spaces		2
ASPEN Roster Extract File	WFH31050-B-CASE-MGMT-NAM	W1H65521-B-CASE-MGMT-NAM	C	spaces		
ASPEN Roster Extract File	WFH31050-B-CASE-MGMT-LINE1-AD	W1H65521-B-CASE-MGMT-LINE1-AD	C	spaces	B_ADDRESS_TYPE_CD = "C"	
ASPEN Roster Extract File	WFH31050-B-CASE-MGMT-LINE2-AD	W1H65521-B-CASE-MGMT-LINE2-AD	C	spaces		
ASPEN Roster Extract File	WFH31050-B-CASE-MGMT-CITY-NAM	W1H65521-B-CASE-MGMT-CITY-NAM	C	spaces		
ASPEN Roster Extract File	WFH31050-B-CASE-MGMT-ST-CD	W1H65521-B-CASE-MGMT-ST-CD	C	spaces		
ASPEN Roster Extract File	WFH31050-B-CASE-MGMT-ZIP5	W1H65521-B-CASE-MGMT-ZIP5	C	spaces		
ASPEN Roster Extract File	WFH31050-B-CASE-MGMT-ZIP4	W1H65521-B-CASE-MGMT-ZIP4	C	spaces		
ASPEN Roster Extract File	WFH31050-B-CASE-MGMT-PHON-NUM	W1H65521-B-CASE-MGMT-PHON-NUM	C	spaces		
ASPEN Roster Extract File	WFH31050-B-AUTHD-REP-LAST-NAM	W1H65521-B-AUTHD-REP-LAST-NAM	C	spaces	B_ADDRESS_TYPE_CD = "A"	
ASPEN Roster Extract File	WFH31050-B-AUTHD-REP-FST-NAM	W1H65521-B-AUTHD-REP-FST-NAM	C	spaces		
ASPEN Roster Extract File	WFH31050-B-AUTHD-REP-MI-NAM	W1H65521-B-AUTHD-REP-MI-NAM	C	spaces		
ASPEN Roster Extract File	WFH31050-B-AUTHD-REP-LINE1-AD	W1H65521-B-AUTHD-REP-LINE1-AD	C	spaces		
ASPEN Roster Extract File	WFH31050-B-AUTHD-REP-LINE2-AD	W1H65521-B-AUTHD-REP-LINE2-AD	C	spaces		
ASPEN Roster Extract File	WFH31050-B-AUTHD-REP-CITY-NAM	W1H65521-B-AUTHD-REP-CITY-NAM	C	spaces		
ASPEN Roster Extract File	WFH31050-B-AUTHD-REP-ST-CD	W1H65521-B-AUTHD-REP-ST-CD	C	spaces		
ASPEN Roster Extract File	WFH31050-B-AUTHD-REP-ZIP5	W1H65521-B-AUTHD-REP-ZIP5	C	spaces		
ASPEN Roster Extract File	WFH31050-B-AUTHD-REP-ZIP4	W1H65521-B-AUTHD-REP-ZIP4	C	spaces		
ASPEN Roster Extract File	WFH31050-B-AUTHD-REP-PHON-NUM	W1H65521-B-AUTHD-REP-PHON-NUM	C	spaces		
ASPEN Roster Extract File	WFH31050-B-PAYEE-LAST-NAM	W1H65521-B-PAYEE-LAST-NAM	C	spaces	B_ADDRESS_TYPE_CD = "E"	10

Source Table or File	Source Column	Target Field	Req	Def	Specifications	Note Ref
ASPEN Roster Extract File	WFH31050-B-PAYEE-FST-NAM	W1H65521-B-PAYEE-FST-NAM	C	spaces		
ASPEN Roster Extract File	WFH31050-B-PAYEE-MI-NAM	W1H65521-B-PAYEE-MI-NAM	C	spaces		
ASPEN Roster Extract File	WFH31050-B-PAYEE-LINE1-AD	W1H65521-B-PAYEE-LINE1-AD	C	spaces		
ASPEN Roster Extract File	WFH31050-B-PAYEE-LINE2-AD	W1H65521-B-PAYEE-LINE2-AD	C	spaces		
ASPEN Roster Extract File	WFH31050-B-PAYEE-CITY-NAM	W1H65521-B-PAYEE-CITY-NAM	C	spaces		
ASPEN Roster Extract File	WFH31050-B-PAYEE-ST-CD	W1H65521-B-PAYEE-ST-CD	C	spaces		
ASPEN Roster Extract File	WFH31050-B-PAYEE-ZIP5	W1H65521-B-PAYEE-ZIP5	C	spaces		
ASPEN Roster Extract File	WFH31050-B-PAYEE-ZIP4	W1H65521-B-PAYEE-ZIP4	C	spaces		
ASPEN Roster Extract File	WFH31050-B-PAYEE-PHON-NUM	W1H65521-B-PAYEE-PHON-NUM	C	spaces		
ASPEN Roster Extract File	WFH31050-B-LCKN-BEG-DT	W1H65521-B-LCKN-BEG-DT	A	N/A		3
ASPEN Roster Extract File	WFH31050-B-LCKN-END-DT	W1H65521-B-LCKN-END-DT	A	N/A		3
ASPEN Roster Extract File	WFH31050-B-LCKN-ASGN-RSN-CD	W1H65521-B-LCKN-ASGN-RSN-CD	C	spaces		2
ASPEN Roster Extract File	WFH31050-B-LCKN-CHNG-RSN-CD	W1H65521-B-LCKN-CHNG-RSN-CD	C	spaces	Applies to terminations only	
H_PLN_RATE_TB	H_COHRT_NUM	W1H65521-H-COHRT-NUM	C	spaces	Blank for terminations and recoupments. The physical health rate cohort in effect for the current or retroactive capitation month.	2,6,8
H_PLN_RATE_TB	H_PLN_RATE_AMT	W1H65521-H-PLN-RATE-AMT	C	N/A	Blank for terminations and recoupments. The rate amount for the physical health rate cohort in effect for the current or retroactive capitation month.	2,6,8
H_PLN_RATE_TB	H_COHRT_NUM	W1H65521-H-BH-COHRT-NUM	C	N/A	Blank for terminations and recoupments. The behavioral health rate cohort in effect for the current or retroactive capitation month.	2,6,8

Source Table or File	Source Column	Target Field	Req	Def	Specifications	Note Ref
H_PLN_RATE_TB	H_PLN_RATE_AMT	W1H65521-H-BH-RATE-AMT	C	N/A	Blank for terminations and recoupments The rate amount for the behavioral health rate cohort in effect for the current or retroactive capitation month.	2,6,8
System generated	N/A	W1H65521-H-TOT-RATE-AMT	C/A	N/A	Total capitation payment including both physical and behavioral health rate amounts.	2,6
ASPEN Roster Extract File	WFH31050-H-TRNSF-P-ID	W1H65521-H-TRNSF-P-ID	C	N/A		4
N/A		W1H65521-H-TRNSF-PLN-NUM	N/A	spaces	This field is spaced out.	
ASPEN Roster Extract File	WFH31050-B-FACILITY-ID	W1H65521-B-FACILITY-ID	C	spaces	Populated only when W1H65521-B-INCAR-BOOKING-DT and W1H65521-B-INCAR-RELEASE-DT are populated.	9
ASPEN Roster Extract File	WFH31050-B-INCAR-BOOKING-DT	W1H65521-B-INCAR-BOOKING-DT	C	spaces		
ASPEN Roster Extract File	WFH31050-B-INCAR-RELEASE-DT	W1H65521-B-INCAR-RELEASE-DT	C	zeroes		
ASPEN Roster Extract File	WFH31050-B-LIAB-PREV2-BEG-DT	W1H65521-B-LIAB-PREV2-BEG-DT	C	spaces	Second previous span	2,7
ASPEN Roster Extract File	WFH31050-B-LIAB-PREV2-END-DT	W1H65521-B-LIAB-PREV2-END-DT	C	spaces	Second previous span	2,7
ASPEN Roster Extract File	WFH31050-B-LIAB-PREV2-AMT-2	W1H65521-B-LIAB-PREV2-AMT	C	zeroes	Second previous span	2,7
System generated	N/A	W1H65521-G-AUD-DT	A	N/A	Cycle date - – this information appears only on the combined roster file for all MCOS. It is spaces on the MCO-specific roster files that are posted to DMZ for each MCO.	
System generated	N/A	W1H65521-G-AUD-TM	A	N/A	Cycle time - – this information appears only on the combined roster file for all MCOS. It is spaces on the MCO-specific roster files that are posted to DMZ for each MCO.	

Notes:

1. All dates are formatted CCYY-MM-DD except for the month of service which is formatted YYYYYMM.
2. Some fields are not required/populated for Terminations. Cohort numbers and rate types are not generated for terminations or recoupments.
3. Unless otherwise stated, information for enrollment spans and the highest ranked health plan COE span for new or ongoing enrollees is taken from the span in effect for the current enrollment month. Information from

enrollment spans and the highest ranked health plan COE span for terminations is taken from the span in effect for the prior enrollment month.

4. For new plan enrollees, the transfer MCO and plan information is the plan in which the client was enrolled in the month immediately prior to the current enrollment month; otherwise, it is blank. For terminations, the transfer MCO and plan information is the plan to which the client has switched. For retro enrollments, the transfer MCO and plan number is the plan in which the client was enrolled in the month prior to the retro enrollment (if any enrollments exist and the provider/plan number is different than the retro enrollment - otherwise it contains spaces).

5. For retro enrollments and recoupments there is a separate roster record for each retroactive enrollment or recouped month. The enrollment begin and end dates (W1H65521-B-LCKN-BEG-DT, W1H65521-B-LCKN-END-DT) reflect the first and last day of the month to which the retroactive enrollment or recoupment applies. The roster record's major type (W1H65521-H-REC-MAJ-TY-CD) is always within the context of the current capitation month (W1H29051-H-MO-SVC-DT). In July 2016 (RAT 3124), the State requested that we change "R" (retro enrollment rosters) to "E" (ongoing enrollments) if there was an enrollment lockin span within the past three months preceding the begin date of the retroactive enrollment span for the same MCO provider. If there was no prior enrollment within the previous three months or the MCO provider was not the same, then the "R" is not changed and will remain an "R". The intent of this change is to insure that the definition of the "R" record is consistent with Mercer's definition. This record type conversion activity is done after the roster has been created but before it is sent out to the MCO's and before the electronic 834's have been generated.

6. For retroactive enrollments this is the rate cohort number used to determine the physical health or behavioral health cohort capitation rate that applied during the month covered by the enrollment begin and end dates. For ongoing enrollments this is the rate cohort number used to determine the the physical health or behavioral health cohort capitation rate that applies to the current enrollment month.

7. The patient liability amounts are also referred to as the medical care credit amounts.These fields are not populated for recoupment and/or termination rosters. Patient liability information is sent from ASPEN on the roster extract.

8. Cohort rates and amounts are calculated using the rate type returned from the managed care eligibility subroutine along with demographic data. If the cohort number shown is '999', this means that the system could not assign a cohort. These are considered errors and are worked by the state and will result in either a cohort assignment which will be seen on the MCO's 820, or a recoupment of the enrollment span that was sent.

9. For current month enrollment and termination roster records (record major type codes E and T), the incarceration booking date, release date, and facility ID are populated from the non-voided COE/FM 054/3 span with the most recent booking date that overlaps the current enrollment month. For retro enrollment month and recoupment roster records (record major type codes R and X), the incarceration booking date, release date, and facility ID are populated from the non-voided COE/FM 054/3 span with the most recent booking date that overlaps the retro enrollment or recoupment month. Incarceration COE spans with contiguous end and begin dates are combined.

The Incarceration Facility IDs are as follows:

100 Bernalillo County Juvenile Detention Center	111 Curry County Detention Center
101 Bernalillo County Detention Center	112 Curry County Juvenile Detention Center
102 Catron County Detention Center	113 DeBaca County Detention Center
103 Chaves County Adult Detention Center	114 Dona Ana County Detention Center
104 Chaves Juvenile Detention Center	115 Dona Ana Juvenile Detention Center
105 CYFD - Camino Nuevo Youth Center	116 Eddy County Detention Center
106 CYFD - John Paul Taylor Center	117 Grant County NM Detention Center
107 CYFD - San Juan Juvenile Facility	118 Hidalgo County NM Detention Center
108 CYFD - Youth Diagnostic and Development Center	119 Lea County Juvenile Detention Center
109 Cibola County NM Detention Center	120 Lea County NM Detention Center
110 Colfax County Detention Center	121 Lincoln County Detention Center

122 Los Alamos County Detention Center
123 Luna County Juvenile Detention Center
124 Luna County NM Detention Center
125 McKinley County Adult Detention Center
126 McKinley County Juvenile Detention Center
127 (CNMCF) Central New Mexico Correctional Facility - Level 1
128 (CNMCF) Central New Mexico Correctional Facility
129 (GCCF) Guadalupe County Correctional Facility
130 (LCCF) Lea County Correctional Facility
131 (NMWCF) New Mexico Women's Correctional Facility
132 (NENMDF) New Mexico Detention Facility
133 (OCPF) Otero County Prison Facility
134 (PNM) Penitentiary of New Mexico
135 (RCC) Roswell Correctional Center
136 (SNMCF) Southern New Mexico Correctional Facility
137 (SCC) Springer Correctional Facility
138 (WNMCF) Western New Mexico Correctional Facility
139 Otero County Detention Center
140 Quay County Detention Center
141 Rio Arriba County Adult Detention Center
142 Roosevelt County Detention Center
143 San Juan County NM Adult Detention
144 San Juan Juvenile Detention Center
145 San Miguel County Detention Center
146 Sandoval County Detention Center
147 Santa Fe County Detention Center
148 Santa Fe County Juvenile Detention Center
149 Sierra County Detention Center
150 Socorro County NM Detention Center
151 Taos County Adult Detention Center
152 Taos Juvenile Detention Center
153 Torrance County Detention Facility
154 Valencia County Adult Detention Center

10 CYFD Offices are sent in the Payee Address fields. The offices are:

County	*Office Manager*	*Address*	*Phone #*	*Fax #*
JENNIFER ARCHULETA-EARP, JenniferA.Earp@state.nm.us, NW Regional Manager, Phone: (505) 867-2373				
Cibola	Rebecca Sandoval rebecca.sandoval@state.nm.us	1019 E. Roosevelt Ave, Ste. A Grants, NM 87020	(505) 285-6673	(505) 287-7603
McKinley	Charles Reado Charles.Reado@state.nm.us	1720 East Aztec, Gallup, NM 87301	(505) 863-9556	(505) 722-6976
San Juan	Deborah Yost DeborahA.Yost@state.nm.us	2800 Farmington Ave., Farmington, NM 87401	(505) 327-5316	(505) 599-9680
Sandoval	Cantrell Mosley cantrell.mosley@state.nm.us	4359 Jager Dr., NE, Suite D, Rio Rancho, NM 87144	(505) 771-5990	(505) 867-7671
Torrance	Vacant	214 S. 5th Street, P.O. Box 348, Estancia, NM 87016	(505) 384-2745	(505) 384-2891
Valencia	Kimberly Chavez-Buie kim.chavez-buie@state.nm.us	750 Morris Road, SW, Los Lunas, NM 87031	(505) 866-2300	(505) 866-2319
NATIVIDAD POSDA, Natividad.Posada@state.nm.us, NE Regional Manager, Phone: (505) 426-1020				
Colfax/Union	April Jolley April.Jolley@state.nm.us	1900 Hospital Drive, Raton, NM 87740	(575) 445-2358	(575) 445-2410
Rio Arriba/Los Alamos	Marylina Tanuz Marylina.Tanuz@state.nm.us	912 North Railroad, Española, NM 87532	(505) 753-7191	(505) 753-0433
San Miguel/Mora/ Guadalupe	Georgia Baca GeorgiaM.Baca@state.nm.us	2518 Ridge Runner Rd., Las Vegas, NM 87701	(505) 426-1020	(505) 425-5049
Santa Fe	Matthew Esquibel matthewa.esquibel@state.nm.us	1920 5th Street, Santa Fe, NM 87505	(505) 827-7450	(505) 827-7440
Taos	Melissa Montoya MelissaD.Montoya@state.nm.us	1308 Gusdorf Rd., Taos, NM 87571	(575) 758-8871	(575) 751-0719
LARRY WISECUP, charles.wisecup@state.nm.us, SW Regional Manager, Phone: (575) 434-5950				
Dona Ana Perm Plan & Placement	Theresa Gonzales theresa.gonzales@state.nm.us	2805 Roadrunner Parkway, Las Cruces, NM 88007 945 Anthony Drive, Anthony, NM 88021	(575) 373-6490 (575) 882-7900	(575) 373-6415 (575) 882-7850
Dona Ana Invest & I-HS	Marianne Hernandez marianne.hernandez@state.nm.us	2805 Roadrunner Parkway, Las Cruces, NM 88007 945 Anthony Drive, Anthony, NM 88021	(575) 373-6490 (575) 882-7900	(575) 373-6415 (575) 882-7850
Grant & So. Catron	Melissa Marquez-Gonzales Melissa.Marquez-Gon@state.nm.us	3082 32nd Bypass Rd. Ste. A, Silver City, NM 88061	(575) 538-2945	(575) 388-5498
Luna/Hidalgo	Debbie Orona debbie.orona@state.nm.us	918 E. Pear, Deming, NM 88030	(575) 546-6557	(575) 546-7114
Otero	Jacquelyn Carter Jacquelyn.Carter@state.nm.us	2200 Indian Wells Rd., Alamogordo, NM 88310	(575) 434-5950	(575) 437-3084

Lincoln	Jacquelyn Carter Jacquelyn.Carter@state.nm.us	26387 US Highway 70, Ruidoso Downs, NM 88346	(575) 378-0045	(505) 841-9199
Sierra	Tina VanWinkle tina.vanwinkle@state.nm.us	161 New School Rd., T or C, NM 87901	(575) 894-3414	(575) 894-1044
Socorro/No. Catron	Tina VanWinkle	104 S. 6th Street, Socorro, NM 87801	(575) 835-2716	(575) 835-2257
GEORGE ARGUELLO, george.arguello@state.nm.us, SE Regional Manager, Phone: (575) 461-0110				
Chaves	Matthew Rael matthew.rael@state.nm.us	#4 Grand Ave. Plaza, Suite A, Roswell, NM 88201	(575) 624-6071	(575) 624-6190
Curry	Tamara Letcher Tamara.Letcher@state.nm.us	221 W. Llano Estacado, Clovis, NM 88101	(575) 763-0014	(575) 763-0041
Roosevelt	Tamara Letcher Tamara.Letcher@state.nm.us	1500 South Avenue D, Portales, NM 88130	(505) 841-9150	(575) 356-2601
Eddy/Carlsbad	Maria Calderon maria.calderon@state.nm.us	901 DeBaca, Carlsbad, NM 88220	(575) 887-3576	(575) 887-6437
Eddy/Artesia	Maria Calderon	2215 W. Main, Artesia, NM 88210	(575) 748-1221	(575) 748-3789
Lea/Hobbs	Trish Garza Patricia.Garza@state.nm.us	907 West Calle Sur, Hobbs, NM 88240	(575) 397-3450	(575) 397-3472
Quay/Harding/ DeBaca	Molly Clement Molly.Clement@state.nm.us	107 West Aber, Tucumcari, NM 88401	(575) 461-0110	(575) 461-4173
MICHELLE THREADGILL, michelle.threadgill@state.nm.us, Metro Regional Manager, Phone: (505) 841-7800				
Metro Reg Off #1	Christina Nuanes christina.nuanes@state.nm.us	4501 Indian School Rd., NE, Bldg. 3, Alb, NM 87110	(505) 841-7800	(505) 841-7867
Metro Reg Off #2	Lisa Moore Lisa.Moore@state.nm.us	1031 Lamberton Place, NE, Albuq NM 87107	(505) 841-2911	(505) 841-2919
Metro Reg Off #3	Joaquin Morales Joaquin.Morales@state.nm.us	1031 Lamberton Place, NE, Albuq NM 87107	(505) 841-7800	(505) 841-7932
Metro Reg Off #4	Vacant	4501 Indian School Rd., NE, Bldg., 3, Suite 310, Alb NM 87110	(505) 841-2911	(505) 841-6699
Metro Reg Off #5	Anastacia VanOrman Anastacia.Rivera@state.nm.us	1031 Lamberton Place, NE, Albuq NM 87107	(505)841-7800	(505) 841-7982
LETICIA SALINAS, LeticiaR.Salinas@state.nm.us, SCI & REC CTR Regional Manager, Phone: (505) 841-6100				
SCI Office #1	Paul Williams paul.williams@state.nm.us	4665 Indian School Rd., NE, Bldg. 1, Alb, NM 87110	(505) 841-6100	(505) 841-6691
SCI Office #2	Jeffrey Bowerman Jeffrey.Bowerman@state.nm.us	4665 Indian School Rd., NE, Bldg. 1, Alb, NM 87110	(505) 841-6100	(505) 841-6691
Receiving Center	Dorothy Trujillo-Fierro DorothyM.Trujillo-Fi@state.nm.us	4665 Indian School Rd., NE, Bldg. 1, Alb, NM 87110	(505) 841-6100	(505) 841-6691
Statewide Central Intake Toll Free Line 1-855-333-7233 (855-333-SAFE)				

W1H29051-B-GEO-CNTY-CD Valid Values are:

County Code	County Code Description
01	Bernalillo
02	Catron
03	Chaves
04	Colfax
05	Curry
06	DeBaca
07	DonaAna
08	Eddy
09	Grant
10	Guadalupe
11	Harding
12	Hidalgo
13	Lea

14	Lincoln
15	LosAlamos
16	Luna
17	McKinley
18	Mora
19	Otero
20	Quay
21	RioArriba
22	Roosevelt
23	Sandoval
24	SanJuan

25	SanMiguel
26	SantaFe
27	Sierra
28	Socorro
29	Taos
30	Torrance
31	Union
32	Valencia
33	Cibola
88	OutofCountry
99	OutofState

W1H29051-B-ADM-OFFICE-CD Valid Values are:

01	ISD office Albuquerque
03	ISD field office Roswell
04	ISD office Raton
05	ISD field office Clovis
07	ISD field office Las Cruces
08	ISD field office Carlsbad
09	ISD field office Silver City
10	ISD field office Santa Rosa
12	ISD field office Lordsburg
13	ISD field office Hobbs
14	ISD field office Ruidoso
16	ISD field office Deming
17	ISD field office Gallup
18	ISD field office Las Vegas
19	ISD field office Alamogordo
20	ISD field office Tucumcari
21	ISD field office Espanola
22	ISD field office Portales
23	ISD field office Rio Rancho
24	ISD field office Farmington
25	ISD field office Las Vegas
26	ISD field office Santa Fe
27	ISD field office T or C
28	ISD field office Socorro
29	ISD field office Taos
30	ISD field office Moriarty
32	ISD field office Belen
33	ISD field Grants
34	ISD field office Artesia
35	ISD field office Albuquerque
36	ISD field office SW Bernalillo county
37	ISD field office Las Cruces
38	ISD field office Anthony
39	ISD field office NE Bernalillo county
40	Admin office Santa Fe
42	ISD field office Los Lunas
45	SCI North, Bernalillo
47	SCI South Las Cruces
49	Centralized units Bernalillo

ISD COUNTY OFFICES

County Office	Geo/Adm County Code	Main Phone #	Toll Free #	Fax #	Address	Manager	Phone
NE Bernalillo 7:30-5:00	01 39	222-9600		222-9652	4330 Cutler Ave., NE P.O. Box 36090 Albuquerque, NM 87176	Dennis Davis	222-9603
NW Bernalillon 7:30-5:00	01 35	841-7700		841-7757	1041 Lamberton Place NE P.O. Box 25287 Albuquerque, NM 87125	Juli A. Lindsey	841-7775
SE Bernalillo 7:30-5:00	01 01	383-2600	1-800-432-6217 **COM Fax**	383-2105 **383-2151**	1711 Randolph Rd, SE. Po Box 19310 Albuquerque, NM 87109	Rochelle Radloff	383-2661

County Office	Geo/Adm County Code	Main Phone #	Toll Free #	Fax #	Address	Manager	Phone
SW Bernalillo 7:30-5:00	01 36	841-2300	**COM Fax**	841-2381 **841-2395**	3280 Bridge Blvd. SW P.O. Box 12355 Albuquerque, NM 87195	David Otero	841-2339
Catron	02	Contact Socorro County ISD Office					
Chaves 8:00-5:00	03 03	625-3000	1-800-824-8971	625-3099	1701 S. Sunset Roswell, NM 88203	Lorraine Gutierrez	625-3019
Cibola 7:00-5:00	33 33	287-8836		285-6278	900 Mount Taylor Ave. Po Box 1390 Grants, NM 87020	David Klumpenhower	287-1305
Colfax 8:00-5:00	04 04	445-2308		445-2218	1233 Whittier St. Raton, NM 87740	Phillip Rodriguez Cell	Ext. 108
Curry 8:00-5:00	05 05	762-4751	**COM Fax**	763-0493 **742-1978**	3316 North Main Suit A Clovis, NM 88101	Olga Aldaz Cell	762-6222
DeBaca	06	Contact Guadalupe County ISD Office					
W. Dona Ana 8:00-5:00	07 07	524-6500		524-6509	655 Utah Ave. Las Cruces, NM 88001	Dorothy Fisher	Ext: 1110
S. Dona Ana 8:00-5:00	07 38	882-5781		882-4728	220 Crosset Lane P.O. Box 4130 Anthony, NM 88021	Juan Ramos	Ext. 230
E. Dona Ana 8:00-5:00	07 37	524-6568		524-6510	2121 Summit Ct. Las Cruces, NM 88011	Richard Gil	Ext. 204
Eddy /Artesia 8:00-5:00	08 34	748-3361		746-6123	108 N. 16th St. Artesia, NM 88210	Sarah McArthur	Ext. 1008
Eddy/Carlsbad 8:00-5:00	08 08	885-8815		887-0550	3604 San Jose Blvd Carlsbad, NM 88220	Jerry Barnes **Cell (Staff)**	Ext. 1006 **361-0319**
Grant 8:00-5:00	09 09	538-2948	1-800-331-7311 **COM Fax**	538-0241 **534-3422**	3088 32nd Street Bypass Suite A Silver City, NM 88061	Corina Rivera	Ext.1023
Guadalupe 8:00-5:00	10 10	472-3459	1-800-523-6643	472-3425	620 Historic Route 66 Santa Rosa, NM 88435	Rita Romero	Ext: 124
Harding	11	Contact San Miguel County ISD Office					
Hidalgo 8:00-5:00	12 09	542-3562	**COM Fax**	542-3226 **534-3422**	109 Poplar St. Lordsburg, NM 88045	Corina Rivera	538-2948 Ext. 1023
Lea 8:00-5:00	13 13	397-3400	**COM Fax**	393-2529	2120 N. Alto-Suite D Hobbs, NM 88240	Paul Harms	397-3423

County Office	Geo/Adm County Code	Main Phone #	Toll Free #	Fax #	Address	Manager	Phone
Lincoln 8:00-5:00	14 14	378-1762		378-2204	26387 Hwy-70 PO Box 606 Ruidoso Downs, NM 88346	James K McCleland	Ext.41202
Lovington	37	Contact Lea County ISD Office					
Luna 8:00-5:00	16 16	546-0467	**COM Fax**	**546-9326**	910 E. Pear P.O. Box 818 Deming, NM 88030	Rebecca Joe	Ext. 103
McKinley 8:00-5:00	17 17	863-9545	1-800-825-7422	722-0991	2907 E. Aztec Avenue Gallup, NM 87301	Edna Ashley	Ext. 152
Mora	18	Contact San Miguel County ISD Office					
Otero 8:00-5:00	19 19	437-9260	1-800-826-4468	437-3098	2000 Juniper Drive Alamogordo, NM 88310	Rebeca Schuyler-Avila	Ext: 104
Quay 8:00-5:00	20 20	461-4627		461-2983	421 W. Tucumcari Blvd. Tucumcari, NM 88401	Rita Romero	Ext. 109
Rio Arriba 8:00-5:00	21 21	753-2271	1-800-231-2835	753-5826	228 Paseo de Onate Street Espanola, NM 87532	Antonette Cordova	Ext: 1001
Roosevelt 8:00-5:00	22 22	356-4473		359-2142	1028 Community Way P.O. Box 1090 Portales, NM 88130	Sherry Molder	Ext. 1027
Sandoval 7:30-5:00	23 23	383-6300	1-800-926-9425	383-6307	4363 Jager Drive Rio Rancho, NM 87144	Vacant	383-6305
San Juan 8:00-5:00	24 24	566-9600	1-800-231-6667	566-9655	101 W. Animas P.O. Box 5250 Farmington, NM 87499	Roger Burton	566-9605
San Miguel 8:00-5:00	25 25	425-6741		454-0256	3112 Hot Springs Blvd. P.O. Box 1348 Las Vegas, NM 87701	Seth Conkle	Ext. 113
Santa Fe 8:00-5:00	26 26	827-1932	1-800-231-8081	827-1940	2542 Cerrillos Road Santa Fe, NM 87505	Cathy Sisneros OIC	827-1911
Sierra 8:00-5:00	27 27	894-3011	1-800-560-3011	894-1021	102 Barton Street T or C, NM 87901	Lorie Medina	Ext.110
Socorro 8:00-5:00	28 28	838-8700	1-800-245-9571	835-9478	1014 N. California Str P.O. Box LL Socorro, NM 87801	Joseph Mascarena	838-8723
Taos 8:00-5:00	29 29	758-8804		758-1012	145 Roy RD Taos, NM 87571	Delfino "Del" Torres	Ext. 1002
Torrance 8:00-5:00	30 30	832-5026	1-866-335-7293	832-4882	109 Tulane Ave. P.O. Box 400 Moriarity, NM 87035	Belinda Garland	Ext. 1006

County Office	Geo/Adm County Code	Main Phone #	Toll Free #	Fax #	Address	Manager	Phone
Union 8:00-5:00	31 04	374-9401		374-2853	834 Main Street Clayton, NM 88415	Phillip Rodriguez	445-2308 Ext. 108
Valencia 8:00-5:00	32 32	864-5200		864-5247	620 E. Reinken Rd P.O. Box 259 Belen, NM 87002	Dennis Salas	864-5242
Valencia North 8:00-5:00	32 42	222-0800		222-0888	445 Camino Del Rey Los Lunas, NM 87031	Robert Chavez	222-0844
Tierra Amarillo 8:00-5:00	21 21	588-7103		588-7369	17345 Chama Highway P.O. Box 816 Tierra Amarillo, NM 87575	OIC Antonette Cordova	753-2271 Ext: 1001

W1H29051-B-COE-CD Valid Values are:

COE Cd	COE Code Description
001	SSIAgedorMedicaidExt-Aged
003	SSIBlindorMedicaidExt-Blind
004	SSIDisbldorMedicaidExt-Disabled
006	FosterCareChildProtectiveSvc
014	RefugeesFosterCare
017	SubsidyAdoptionOtherStates
018	Repatriates(Cash&MedAssist)
019	Refugee(Cash&MedAssist)
027	PostClosure-Eligible4Months
028	TransitionalMedicaid
029	FamilyPlanning
030	MedicalAssist-PregnantWomen
031	Newborns
032	133%ofPovertyKids
033	AFDC-DeemedIncomeDisregard
034	SSI-DeemedIncomeDisregard
035	PregnantWomen-with Fed Match =1
036	185%ofPovertyKids
037	TitleIV-EsubsidyAdoption
041	QMB-Age65andOver
044	QMB-UnderAge65
046	FCChildOutofNMTitleIV-E
047	SubsidyAdoptOutofNMTitleIV-E
048	Repatriates-(MedicalAssistOnly)
049	Refugee-(MedicalAssistanceOnly)
051	SpecialMedicalNeeds-Aged
052	Breast or Cervical Cancer
053	Special Medical Needs-Blind
059	Refugee-(MedicalAsstSpend-down)
060	Juvenile Justice NonIV-E

COE Cd	COE Code Description
061	Juvenile Justice TitleIV-E
066	Foster Care TitleIV-E
071	CHIP-235%PvtyKids with Fed Match = 1
072	Non-TANF(AFDC) with Fed Match = 1
073	12MonthExtension
074	QualifiedWorkingDisabled(QWD)
081	InstitutionalCare-Aged
083	InstitutionalCare-Blind
084	InstitutionalCare-Disabled
085	EMCforUndocumentedAliens
086	FosterChildFromAnotherState
090	HCBW-AIDS
091	HCBW-Handicapped&Elderly
092	HCBW-VentilatorDependent
093	HCBW-Hndicapped&Elderly(Blind)
094	HCBW-MedHandicapped(Disabled)
095	HCBW-MedicallyFragile
096	HCBW-DevelopmentallyDisabled
097	HCBW-Non-MedicaidElderly
098	HCBW-Non-MedicaidBlind
099	HCBW-Non-MedicaidHandicapped
100	Other Adults (133% FPL)
200	Parents/Caretaker Relatives
300	Full Medicaid for Pregnant Women (0% up to 133%)
301	Pregnancy-Related Medicaid (133% up to 185%)
400	Children's Medicaid (0% to 133% FPL)/0-5
401	Children's Medicaid (0% to 133% FPL)/6-19
402	Children's Medicaid (133% to 185% FPL)/0-5
403	Children's Medicaid (133% to 185% FPL)/6-19
420	CHIP Medicaid (185% to 235% FPL/CHIP kids)/0-5

COE Cd	COE Code Description	COE Cd	COE Code Description
421	CHIP Medicaid (185% to 235% FPL/CHIP kids)/6-19		

W1H29051-B-LCKN-ASGN-RSN-CD Valid Values are:

Value	Long		
AA	Auto Assignment	RD	Recoupment - Duplicate Client
AE	Administrative Assignment	RE	Reenroll With Previous Prov
CC	Client Choice	RI	Recoupment - Ineligibility
CF	Client Choice - County funded	RM	Recoupment - Medicare
CK	Clnt Choice PAK	RN	Retroactive Newborn
FC	Family Continuity	RO	Recoupment - Other
MA	Manual Assignment	RP	Retroactive Enrollment
MT	Mass Transfer	RX	Recoupment - Death

B DISABILITY TYPE CD

Value	Definition		
BL	Blind	OT	Other
DF	Deaf	PH	Physical
ME	Mental	UN	Unknown

B-RACE-CD

1	Caucasion	A	Native Hawaiin or Other Pacific Islander
2	Hispanic	B	African American and White
3	American Indian	C	Asian and White
4	Asian/Pacific islander	D	American Indian or Alaska Native and White
5	Black/African American	E	American Indian Or Alaska Native and African
6	Other	American	
9	Unknown		

B-LCKN-CHNG-RSN-CD Valid Values are:

Value	Long	Value	Long
AC	Administrative Closure	DH	Disenroll – Enroll In Mc
CC	Client Choice	DL	Disenroll – Med Mgmt, Hspc,Lck
CL	Disenroll-COLTS	DM	Disenroll – Medicare
CM	Disenroll - County Move	DN	Disenroll – Not With Employer
CN	Cancelled	DO	Disenroll – SCI Other
CO	Reassign - County Move	DP	Disenroll -Emplyee Prem Not Pd
CR	Disenroll - Client Request	DR	Disenroll -Emplyer Prem Not Pd
DC	Disenroll – Temp Exempt	DT	Disenroll – TPL
DD	Disenroll – Death	EC	Exclusion
DE	Disenroll – Dept Exempt		
EX	Exemption	OV	Override 12 Mo MCO Lockin
IN	Disenroll - Incarcerated	PC	Provider Request
JJ	Disenroll - Juvenile Justice	RC	RAC Audit
LE	Loss Of Eligibility	RD	Recoupment - Duplicate Client
LO	Lockout	RG	Recoupment - OIG
LT	Disenroll - Res In LTC/MH Fac	RI	Recoupment - Loss of Eligibili
MB	Disenroll - Max Benefit	RM	Recoupment - Medicare
ME	Disenroll - Medicaid Eligible	RN	Disenroll - No Recertification
MT	Standard Mass Transfer	RO	Recoupment – Other
NF	Disenroll - NMMIP Referral	RS	Recoupment Incarcerated
NP	Disenroll - No Plan Available	RX	Recoupment - Death
NR	Unable To Determine Cap Rate	SD	Disenroll - MCO Switch
OS	Disenroll - Moved out of State	XT	Mass Termination

B-TRIBAL-AFFL-CD – Client Tribal Code
This code designates the tribe to which a Native American client belongs.

Value	Long	Value	Long
	none	1M	San Juan
1A	Cochiti	1N	Acoma
1B	Jemez	1O	Laguna
1C	Sandia	1P	Picturis
1D	San Felipe	1Q	Taos
1E	Santa Ana	1R	Isleta
1F	Santo Domingo	1S	Zuni
1G	Zia	1T	Jicarilla Apache
1H	Nambe	1U	Mescalero Apache
1I	Pojoaque	1V	Alamo Navajo
1J	San Ildefanso	1W	Canoncito Navajo
1K	Tesuque	1X	Ramah Navajo
1L	Santa Clara	1Y	Main Reservation Navajo
99	**Other**	1Z	Checkerboard Navajo

B-ETH-CD **Ethnicity Code**

HS	Hispanic
NH	Not of Hispanic or Latino or Spanish origin
UK	Ethnicity Unknown

B-PRIM-LANG-CD **Primary Language Code**

Value	Long	Value	Long	Value	Long
00	English	30	Polish	63	Fijian
01	Spanish	31	Portuguese	64	Finnish
02	Vietnamese	32	Punjabi	65	Fukienese
03	Chinese Mandarin	34	Serbian	66	Gujarati
04	Chinese-Cantonese	35	Slovak	67	Hausa
05	Arabic	36	Slovanian	68	Hmong
06	Korean	37	Swahili	69	Icelandic
07	Hindi	38	Tagalog	70	Ilocano
08	Farsi	39	Taiwanese	71	Lithuanian
09	Urdu	40	Thai	72	Macedonian
10	Russian	41	Tigrinya	73	Malay
11	Bosnian	42	Turkish	74	Malayalam
12	Albanian	45	Khmer	75	Mien
13	Somali	46	Greek	76	Navaho
14	French	47	Italian	77	Tewa
15	German	48	Portuguese-Creole	78	Towa
16	Czech	49	Aklan	79	Apache
17	Sing Language	50	Assyrian	80	Zuni
18	Amharic	51	Bambara	81	Nepali
19	Armenian	52	Basque	82	Norwegian
20	Bengali	53	Bhojpuri	83	Pashto
21	Croatian	54	Bulgarian	84	Romanian
22	Haitian-Creole	55	Burmese	85	Shanghai
23	Hebrew	56	Cambodian	86	Somoan
24	Hungarian	Campuchean		87	Swedish
25	Indonesian	57	Catalan	88	Toishanese
26	Japanese	58	Chaochow	89	Tongan
27	Kurdish	59	Danish	90	Ukranian
28	Laotian	60	Dari	91	Wolof
29	Maltese	61	Dutch	92	Yiddish
		62	Estonian	93	Yoruba

94	Keresan	UK	Unknown

B-COE-TERM-RSN-CD COE Termination Reason Code

101	The individual(s) listed above did not verify their social security number(s).
102	The date of birth has not been verified for the individual(s) listed above.
103	The individual(s) listed above did not verify their living arrangements.
104	The individual(s) listed above did not verify their student status.
105	The individual(s) listed above did not verify citizenship.
106	The individual(s) listed above did not verify relationship.
107	The individual(s) listed above did not provide information to verify a disability
109	The individual(s) listed above did not verify their SSI status.
113	The individual(s) listed above did not verify identity.
116	The individual(s) listed above did not verify their earnings.
130	The individual(s) listed above did not verify their unearned income.
131	The individual(s) listed above did not verify their checking account(s) amounts.
132	The individual(s) listed above did not verify their savings account(s) amounts.
133	The individual(s) listed above did not verify their resources.
134	The individual(s) listed above did not verify their life insurance.
135	The individual(s) listed above did not verify their vehicle value.
149	The individual(s) listed above did not verify New Mexico residency.
150	The date of death has not been verified for the individual(s) listed above.
202	The individual(s) listed above is not eligible to participate in the program because the individual(s) is not a U.S. citizen, a legal immigrant, or has not declared U.S. citizenship/legal immigrant status.
206	The individual(s) listed above do not meet program age requirements.
207	The individual(s) listed above did not meet the <PROGRAM NAME> school attendance requirements.
208	The individual(s) listed above did not apply for or provide a social security number(s).
209	The individual(s) listed above do not meet the definition of refugee as defined by program policy.
210	The individual(s) listed above failed the New Mexico residency requirement.
212	The individual(s) listed above do not meet the program relationship requirements
213	Your pregnancy has not been medically verified.
217	The individual(s) listed above are participating in a strike.
219	The principal wage earner in your assistance group voluntarily quit a job without good cause. Therefore, the individual listed above is not eligible for a period of 3 months.
220	The individual(s) listed above do not meet the program definition of disability.
222	The individual(s) listed above do not meet the department's definition of blindness.
226	The individual(s) listed above is NOT institutionalized.
228	You did not cooperate with Child Support Enforcement Division requirements.
232	The individual(s) listed above have been disqualified for intentional violation of program rules.
239	The individual(s) listed above voluntarily quit a job or reduced their earnings.
242	The individual(s) listed above are ineligible students.
243	You are a minor unmarried parent and not living under adult supervision.
254	You have not yet been institutionalized for 30 consecutive days.
257	The member(s) listed above are ineligible for or are not receiving Medicare Part A.
257	The member(s) listed above are ineligible for or are not receiving Medicare Part A.
258	The set term General Assistance (GA) benefits have expired for the individual(s) listed above.
261	The individual(s) listed above received SNAP benefits for three months and did not meet the 20-hour-a-week work requirement.
268	Your child was born or your pregnancy ended.
301	The total countable income of your assistance group exceeds program limits.
305	The financial assistance benefits received by your assistance group have changed.
320	The gross income of your assistance group exceeds program limits.
401	The value of your countable personal and/or real property exceeds resource limits.
402	Your assistance group knowingly transferred resources to qualify for benefits.
544	The individual(s) listed above has passed away.
557	The head of household for your assistance group has passed away.
558	The whereabouts of your assistance group is unknown.
560	The member listed above is not the primary caretaker for the assistance group member(s).
563	The individual(s) listed above walked out of the interview before it was completed.
564	The individual(s) listed above did not provide necessary information to determine elibility.
565	You have voluntarily withdrawn your application.
566	The application was not signed.
567	The member(s) listed above did not cooperate with the Quality Assurance review.
570	The individual(s) listed above do not live in the household.
571	The individual(s) listed above requested closure of your case.
580	Your State Coverage Insurance (SCI) application has been received and you have been placed on a waiting list for the program.
585	The individual(s) listed above refused to be available for employment.
611	The individual(s) listed above have applied for SNAP benefits in another household.
707	The individual(s) listed above is included in another assistance program.

914	The Incapacity Review Unit (IRU) does not have enough information to support the disability claim.
CO1	The individual(s) listed above missed their scheduled appointment.
CO2	The individual(s) listed above did not reapply for benefits.
CO3	The individual(s) listed above did not complete the periodic review process or recertification process.
CO4	The individual(s) listed above received Cash Assistance out of state.
CO5	Your tribe has a LIHEAP program. You must apply for LIHEAP at your tribal offices.
MRG	Client Merge
UK	Unknown
SYS	Span Terminated by Omnicaid during Cut/Paste Processing

Monthly Cutoff Schedule

Enrollment Month	Monthly Roster Reconciliation Cycle Date
Dec-23	2023-11-23
Jan-24	2023-12-25
Feb-24	2024-01-26
Mar-24	2024-02-26
Apr-24	2024-03-26
May-24	2024-04-25
Jun-24	2024-05-27
Jul-24	2024-06-25
Aug-24	2024-07-26
Sep-24	2024-08-27
Oct-24	2024-09-25
Nov-24	2024-10-28
Dec-24	2024-11-26
Jan-24	2024-12-25

Enrollment Informational File

Any time a Health Home, Care Coordination, or Patient Liability span is added, those records will appear on the daily Enrollment Informational file for the MCO to which the client was enrolled for dates covered by that span. The Informational record could thus be generated for a client the MCO doesn't have currently enrolled. Unlike the Enrollment Roster file which produces data that is in effect only for the upcoming enrollment month, this Informational file reports any spans that have been added since the prior daily cycle. Since Health Home and Care Coordination levels can be assigned for some clients by an external vendor, the MCO will need to update their files with this information to ensure the MCO doesn't erroneously assign their own care coordination or health home to these clients. Patient Liability can change during the month, so its important for the MCO to update their records when this data is sent so that nursing facility claims can be paid correctly, deducting the correct patient liability amounts. This file will be a daily file, produced 7 days a week, and the file layout is:

WFH45450 - Managed Care Informational Record Layout

```
001900 01  WFH45450-MC-INFO-INFO-HDR.
002000     05 WFH45450-HDR-REC-IND                  PIC X(02). ← 'HD'
002100     05 FILLER                                PIC X(01).
002200     05 WFH45450-HDR-FILE-NAME                PIC X(32). ← '<MCO Name>
CENTENNIAL CARE'
002300     05 FILLER                                PIC X(01).
002400     05 WFH45450-HDR-DATE.
002500        10 HDR-DTE-MM                         PIC 9(02).
002600        10 FILLER                             PIC X(01). ← '/'
002700        10 HDR-DTE-DD                         PIC 9(02).
002800        10 FILLER                             PIC X(01). ← '/'
002900        10 HDR-DTE-YY                         PIC 9(02).
003000     05 FILLER                                PIC X(01).
003100     05 WFH45450-HDR-FILE-TYPE-ID             PIC X(04). ← 'INFO'
003200     05 FILLER                                PIC X(654).
003300*
003400 01  WFH45450-MC-INFO-INFO-DTL.
003500     05 WFH45450-P-ID                         PIC X(08).
003600     05 WFH45450-H-PLN-NUM                    PIC X(04).
003700     05 WFH45450-H-PLN-NAM                    PIC X(30).
003800     05 WFH45450-RECIP-MCD-CARD-ID-NO         PIC X(10).
003900     05 WFH45450-B-ASPEN-MCI-ID               PIC X(09).
004000     05 WFH45450-B-SSN-NUM                    PIC X(09).
004100     05 WFH45450-B-MEDICARE-ID-NO             PIC X(13).
004200     05 WFH45450-B-LAST-NAM                   PIC X(21).
004300     05 WFH45450-B-FST-NAM                    PIC X(15).
004400     05 WFH45450-B-MI-NAM                     PIC X(01).
004500     05 WFH45450-B-DOB-DT                     PIC X(10).
004600     05 WFH45450-B-DOD-DT                     PIC X(10).
004700     05 WFH45450-B-GENDER-CD                  PIC X(01).
004800     05 WFH45450-B-RACE-CD                    PIC X(02).
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004900     05 FILLER                                  PIC X(25).
005000     05 WFH45450-HEALTH-HOME-INFO
005100                OCCURS 5 TIMES.
005200        10 WFH45450-B-HHM-BEG-DT                 PIC X(10).
005300        10 WFH45450-B-HHM-END-DT                 PIC X(10).
005400        10 WFH45450-B-HHM-LVL-CD                 PIC X(01).
005500        10 WFH45450-B-HHM-NPI-ID                 PIC X(10).
005600        10 WFH45450-B-HHM-VOID-IND               PIC X(01).
005700     05 FILLER                                   PIC X(25).
005800     05 WFH45450-CARE-COORD-INFO
005900                OCCURS 5 TIMES.
006000        10 WFH45450-B-CC-BEG-DT                  PIC X(10).
006100        10 WFH45450-B-CC-END-DT                  PIC X(10).
006200        10 WFH45450-B-CC-LVL-CD                  PIC X(01).
006300        10 WFH45450-B-CC-ASSESS-TY-CD            PIC X(01).
006400        10 WFH45450-B-CC-ASSESS-DT               PIC X(10).
006500        10 WFH45450-B-CC-VOID-IND                PIC X(01).
006600     05 FILLER                                   PIC X(25).
006700     05 WFH45450-LTC-LIAB-INFO
006800                OCCURS 5 TIMES.
006900        10 WFH45450-B-LIAB-SPAN-BEG-DT           PIC X(10).
007000        10 WFH45450-B-LIAB-SPAN-END-DT           PIC X(10).
007100        10 WFH45450-B-LTC-LIAB-AMT               PIC 9(05)V99.
007200     05 FILLER                                   PIC X(25).
007300*
007400 01  WFH45450-MC-INFO-INFO-TRL.
007500     05 WFH45450-TRL-REC-IND                     PIC X(02). ← 'TR'
007600     05 FILLER                                   PIC X(01).
007700     05 WFH45450-TRL-RECORD-COUNT                PIC 9(09).
007800     05 FILLER                                   PIC X(691).
```

Target Field	Req	Def	Specifications	Note Ref
HEADER-REC-IND	A	HD		
HEADER-FILE-NAME	A	N/A	This value is hard coded depending on the MCO: BCBS CENTENNIAL CARE PRESBYTERIAN CENTENNIAL CARE WESTERN SKY COMMUNITY CARE	
HEADER-DATE	A	N/A	Current date.	
HEADER-FILE-TYPE-ID	A	N/A	Hard coded values: "INFO"	

LEGEND: For Req: A = Always For Def: HD = Header
C = Conditionally
N = Never

MANAGED CARE INFORMATIONAL RECORD - DETAIL

Target Field	Req	Def	Specifications	Note Ref
WFH45450-P-ID	A	N/A	From Centennial Care (CCO) lock-in span that overlaps the added or updated span.	
WFH45450-H-PLN-NUM	A	N/A	From Centennial Care (CCO) lock-in span that overlaps the added or updated span.	
WFH45450-H-PLN-NAM	A	N/A	From matching plan detail record in effect for the current enrollment month on MC system parameter 0006.	
WFH45450-RECIP-MCD-CARD-ID-NO	A	N/A	This field contains the 9 digit system id formatted with a "3" in the first position (like the swipe card id)	
WFH45450-B-ASPEN-MCI-ID	C	spaces	Only provided for ASPEN clients	
WFH45450-B-SSN-NUM	A	N/A		
WFH45450-B-MEDICARE-ID-NO	C	spaces		
WFH45450-B-LAST-NAM	A	N/A		
WFH45450-B-FST-NAM	A	N/A		
WFH45450-B-MI-NAM	C	N/A		
WFH45450-B-DOB-DT	A	N/A	Date format CCYY-MM-DD	
WFH45450-B-DOD-DT	C	spaces	If present, date format is CCYY-MM-DD.	
WFH45450-B-GENDER-CD	A	N/A		
WFH45450-B-RACE-CD	A	N/A		
WFH45450-HEALTH-HOME -INFO			Occurs up to 5 times.	1
WFH45450-B-HHM-BEG-DT	C	spaces	If present, date format is CCYY-MM-DD.	
WFH45450-B-HHM-END-DT	C	spaces	If present, date format is CCYY-MM-DD.	
WFH45450-B-HHM-LVL-CD	C	spaces		
WFH45450-B-HHM-NPI-ID	C	spaces		
WFH45450-B-HHM-VOID-IND	C	spaces		
WFH45450-CARE-COORD-INFO			Occurs up to 5 times.	1
WFH45450-B-CC-BEG-DT	C	spaces	If present, date format is CCYY-MM-DD.	
WFH45450-B-CC-END-DT	C	spaces	If present, date format is CCYY-MM-DD.	
WFH45450-B-CC-LVL-CD	C	spaces		
WFH45450-B-CC-ASSESS-TY-CD	C	spaces		
WFH45450-B-CC-ASSESS-DT	C	spaces		
WFH45450-B-CC-VOID-IND	C	spaces		

Target Field	Req	Def	Specifications	Note Ref
WFH45450-LTC-LIAB-INFO			Occurs up to 5 times.	2
WFH45450-B-LIAB-SPAN-BEG-DT	C	spaces	If present, date format is CCYY-MM-DD.	
WFH45450-B-LIAB-SPAN-END-DT	C	spaces	If present, date format is CCYY-MM-DD.	
WFH45450-B-LTC- LIAB-AMT	C	zeroes	The field defaults to zeros for all 5 spans even if WFH45450-B-LIAB-SPAN-BEG-DT is not populated.	

Notes:

1. For Health Home and Care Coordination spans, the 5 most recently added or updated spans since the prior daily run of this interface are reported. Any non-voided spans are reported before voided spans. Spans are reported by descending end date, then by descending begin date.

2. If the LTC patient liability span dates are contiguous and have the same amounts they are consolidated into one span so that the three most recently updated amounts can be reported on the record. Added or updated spans with zero amount are only reported if the most recent prior span had a non-zero amount. If there is a gap between the date spans but the amounts are the same, then both spans would be reported up to 5 spans total. The 5 occurrences of patient liability data are displayed in descending date order so that the most recent amount is reported first.

III. SPECIALSERVICES - LONG TERM CARE, CARE COORDINATION & SUPPORT BROKER

MCOs are responsible for certain administrative tasks that require performing client assessments and reporting the determinations from these assessments and, for long term care services, any resulting plans of care. This section deals with the interfaces and rules regarding these special services.

Long Term Care

MCOs are responsible for determining level of care for nursing facility and community benefit services for clients already enrolled in the MCO and for clients applying for Medicaid benefits who are not otherwise Medicaid eligible (NOME) unless they meet the nursing facility level of care (NFLOC) criteria. The NOME clients who are applying for Medicaid and require NFLOC assessments are communicated by ASPEN to the MCOs, who must complete a timely NFLOC assessment and then report their determination back to ASPEN. If the client meets NFLOC and financial eligibility criteria, the client is approved for Medicaid. ASPEN sends the eligibility for the client and also sends the managed care enrollment to the MCO that did the assessment on the same day eligibility is approved. The eligibility and enrollment records sent to Omnicaid from ASPEN do not include any long term care information.

MCOs must communicate within 5 days of receiving the client Enrollment Roster file the client's long term care service delivery model. This is sent on the MCO to HSD Omnicaid interface file shown earlier in this manual as a Setting of Care span that includes the begin and end dates of the SOC span, usually a maximum 12 month period. The SOC span may change based on a change in the service delivery model or periodic absences due to hospitalization or change in condition, but unless the client meets the following criteria, it must always fall within the current 12 month NFLOC period.

Continuous NFLOC

A continuous NF LOC is intended to eliminate the requirement for annual NF LOC assessment and determination for Community Benefit Members whose chronic condition is not expected to improve. Continuous NF LOC does not change any comprehensive needs assessment (CNA) requirements.

The Community Benefit Member (NOME and full Medicaid) must meet the following requirements:

1. The Member must have had an approved NF LOC for the prior three years.

2. The approved NF LOC must be related to the Member's primary diagnosis.

3. A continuous NF LOC status must be approved by the MCO Medical Director and documented in the Member's file.

4. The Member's PCP must annually complete and sign a form that documents the Member's ongoing ADL deficits related to the Member's primary diagnosis. The MCO must maintain this form in the Member's file.

5. The MCOs are to use the following list of conditions as a guide to determine appropriate primary diagnosis to be considered for a continuous NFLOC.

   •Cerebral Palsy
   •Chronic Obstructive Pulmonary Disease (end stage)
   •Cystic Fibrosis
   •Dementias (such as Alzheimer's, Multi-Infarct, Lewy Body)
   •Developmental Disability (such as microcephaly and severe chromosomal abnormalities)
   •Neurodegenerative Diseases (such as ALS, muscular dystrophy, multiple sclerosis,)
   •Paralysis secondary to Cerebral Vascular Accident
   •Parkinson's Disease
   •Paraplegia
   •Quadriplegia
   •Spina Bifida
   •Paralysis secondary to severe spinal cord injury
   •Ventilator Dependent

6. The MCOs will be required to regularly report to HSD the number of Members with approved continuing NF LOC status and other related information as directed by HSD through the Community Benefit Report #4.

Continuous NFLOC is to be reported on the MCO to HSD interface by sending and end date of 12/31/9999.

Short Term Stays in a Nursing Facility
The MCO shall authorize a payable authorization/bed days (revenue code 0190) for a Member residing in a Nursing Facility that is not requesting Long Term Care (LTC) Custodial Care. The MCO shall not complete a NFLOC determination or transmit a Setting of Care (SOC) for Short Term Stays (less than 120 days). The Member will receive their skilled care through their Medicare benefit and if the Member is approved for Medicaid and appears on the MCO Enrollment Roster and the MCO determines the Member does require long-term care placement, the MCO shall submit the NFLOC SOC via the MCO to HSD interface file. The NFLOC SOC shall begin the day after the Member has exhausted their Medicare skilled care benefits (generally the first 100 days).

Medicaid Pending
The MCO will conduct a NFLOC determination once and only if the Member is admitted under LTC Custodial Care. The Nursing Facility must notify Income Support Division

(ISD) once the Member reverts to LTC Custodial Care. ISD/HSD shall not submit an ASPEN 112 notification to the MCO while the Member is receiving skilled/acute care through a short-term stay/skilled nursing through a Skilled Nursing Facility (SNF)/Nursing Facility. ISD/HSD will send the MCO an ASPEN 112 notification upon receipt of NFLOC packet for a Member applying for Institutional Medicaid.

The MCO will receive notification via ASPEN 112 and will have 30 calendar days to complete a NFLOC determination upon receipt of a complete NFLOC packet from the Nursing Facility. The MCO will submit a response with the NFLOC determination on the ASPEN 113 file. If an incomplete packet is received and the MCO is unable to make a NFLOC determination, the MCO should follow the Request for Information (RFI) process in order to obtain complete documentation. If after failed attempts the documentation is not received, an Administrative Denial can be transmitted on the ASPEN 113 file.

If the Member's NFLOC determination is approved and the Member qualifies both for financial and medical eligibility, the Member will be assigned an MCO. Once the MCO receives notification of eligibility via the Enrollment file, the MCO will determine the payable authorization and assign/transmit the Institutional Nursing Facility (INF) SOC to HSD via the MCO-to-HSD interface file within five (5) business days.

LTC Custodial Care

The MCO will conduct a NFLOC determination for Members with Full or Institutional Medicaid that are residing in a Nursing Facility and accessing services through LTC Custodial Care. The MCO will assign/transmit the Institutional INF SOC to HSD via the MCO-to-HSD interface file within five (5) business days in alignment with the payable authorization dates.

If the Member is under Institutional Medicaid (COE 081-084), the MCO will transmit the NFLOC determination on the ASPEN 113 file. ISD will send ASPEN 112 notification to the assigned MCO at 90, 45 and 30 calendar days prior to the current NFLOC expiration date.

If in the event a Member leaves the facility Against Medical Advice (AMA), prior to a Community Reintegration (CRI), or passes away prior to the 90th calendar day in an LTC Custodial Care facility, the MCO shall truncate the payable authorization and INF SOC span with the end date reflecting the discharge date/last date of the facility.

For Members that have a Community Benefit COE (090-094), the Member does not qualify for LTC Custodial Care. The Member or facility must notify ISD and/or apply for Institutional Medicaid to qualify for LTC Custodial Care. A Community Benefit Member can still access services through a short-term stay and/or through a Skilled Nursing Facility. The member should apply for Institutional Medicaid if transitioning from the community to a Nursing Facility. If the LOC is current for COE 090-094, ASPEN would not send a 112 notification for IC Medicaid, and would use the current LOC in ASPEN

for eligibility.

Members admitted to the Nursing Facility who are on the Medically Fragile (COE 095) Developmentally Disabilities (COE 096) and Supports Waiver (COE 096) should not be transitioned to Institutional Medicaid unless the Member plans to remain in the facility long-term. If the member is transitioned to Institutional Medicaid, their Waiver eligibility and access to Home and Community Based Services will be terminated. A Member who is under a Medically Fragile, Developmentally Disabled or Supports Waiver COE can still access skilled/acute care through a short-term stay/skilled nursing through a Skilled Nursing Facility/Nursing Facility. The member can also be approved for LTC in the Nursing Facility or Community Benefit even though they have the COE 095 or 096, but the Waiver Authorization has to be end dated 1 day prior to the start of the MCO's LTC span. This data can be validated by the LTC Reconciliation file that has the TPA Waiver Authorization information.

MCO Review Type and Requirement Chart

Review Type	Nursing Facility Level of Care (NFLOC)	Setting of Care (SOC)	Payable Authorization	Revenue Code
Skilled Nursing Facility	*Not required*	*Not required*	*Payable authorization will be issued upon Member meeting medical criteria*	*Dependent on the Nursing Facility and MCO contract*
Short Term Stay	*Not required*	*Not required*	*Payable authorization will be issued upon Member meeting medical criteria*	*Short Term Stay: 0191- Subacute Care Level 1*

Commented [SS1]: Updated grid to include Revenue Code and Hospice.

Long Term Custodial Care	*NFLOC must be submitted with an approval or denial*	*SOC must be transmitted with an approved NFLOC and payable authorization*	*Payable authorization will be issued upon Member meeting NFLOC criteria and bed days/authorization dates will be issued to align with HSD Criteria/NFLOC timelines and is dependent on Medicaid eligibility.*	*Low Nursing Facility Level of Care: 0190- Subacute Care/LNF* *High Nursing Facility Level of Care: 0199- Subacute Care/HNF* **Reserve Bed Days (Home)-Revenue Code 0182* **Reserve Bed Days (Hospital)-Revenue Code 0185*
Hospice Care in Nursing Facility	*NFLOC must be authorized for Hospice Care in a Nursing Facility*	*SOC must be transmitted with an approved NFLOC and payable authorization. The dates of service billed must align with the Institutional Nursing Facility (INF) SOC.*	*Payable authorization will be issued upon Member meeting NFLOC criteria and bed days/authorization dates will be issued to align with HSD Criteria/NFLOC timelines and is dependent on Medicaid eligibility.*	*Hospice: 0658- Hospice Room and Board* *Hospice: 0659- Other Hospice Room and Board*

Clients with IC Restricted Coverage

Sometimes, a member may be approved for Medicaid under a restricted IC category. A client with restricted IC category is eligible for all Medicaid benefits except for long term care benefits. The restricted coverage is identified by the client having a COE 081, 083, or 084 with a fed match code of '4'. The COE and Fed match are on the MCO's enrollment roster. Only once the client's restricted coverage is closed and ongoing Medicaid is established will the client have long term care benefits included in their Medicaid coverage.

The MCOs should always submit NF LOC determinations via the ASPEN interface. However, if the MCO receives enrollment for a member who is on IC restricted coverage "fed match code '4', even though the MCO has already determined the client to meet the NFLOC criteria, the client is not eligible for long term care benefits and the NF LOC/SOC must not be submitted via the MCO to HSD Omnicaid interface until the

"fed match '4' has been removed. The MCO should provide all other non-long term care benefits the client needs during this period of IC Restricted coverage.

Completing & Reporting NF LOC and SOC Determinations
When a client who is not enrolled with an MCO applies for Medicaid for long term care benefits, the eligibility system, ASPEN, will initiate a referral to an MCO to initiate a level of care assessment. These level of care assessment requests are randomly generated unless the client has chosen the MCO as part of their eligibility application. This file will be a daily file that the MCO is expected to process and schedule a Nursing Facility level of care assessment as soon as possible for any clients on the file, not to exceed 45 days from the date of the request for assessment. These clients will not be on the MCO's Enrollment Roster file at the time the request for assessment is made.

Clients who are already enrolled with the MCO with a full Medicaid category may also request or be referred for a level of care assessment. These clients will already have Medicaid so communicating the NFLOC determination to ASPEN is not needed. If determined to meet level of care criteria, the MCO will communicate the determination of NFLOC on the MCO to HSD interface file as a Setting of Care span.

Once the nursing facility determination is made for a client not enrolled with the MCO, the MCO will return information about the determination to ASPEN on the MCO to ASPEN Omnicaid interface file. If the client is determined eligible for nursing facility level of care and financially eligible for Medicaid, the client will be sent by ASPEN to Omnicaid with their eligibility data showing the MCO Choice as the MCO who completed the NF LOC determination. Omnicaid will then enroll the client to the MCO reflected in the MCO Choice field and send client data on the Enrollment Roster file.

The MCO will then submit updates to the client information via the MCO to HSD Omnicaid interface to reflect the nursing facility level of care and the Setting of Care effective dates and provider information.

Sometimes, the client may request with their Medicaid application a different MCO than the one performing the NFLOC determination. When this happens, it is critical that the MCO receiving the enrollment recognize the need for submitting the long term care SOC span to Omnicaid. If the MCO receives a new client on its enrollment file who has a Category of Eligibility in an IC (081, 083, 084) or Waiver category (090 through 094), these clients should be flagged for submission of the long term care SOC span. If the MCO has not completed a long term care assessment, this probably means that another MCO performed the assessment and the client is either in a nursing facility or should be receiving Community Benefit services. The MCO is instructed to immediately contact *Medical Assistance Division Allocations Manager 505-476-7258* to receive the MCO NFLOC assignment information. The MCO can then contact that MCO to obtain the NFLOC determination information. If the client is in an 081, 083, 084 category and in a nursing home, the MCO must submit a long term care span on the MCO to HSD interface within 10 business days of receiving the client on their

enrollment roster. If the client is in a waiver category, the MCO must develop a plan of care and submit that long term care SOC span on the MCO to HSD interface within 10 business days.

The timelines for reporting NF LOC and SOC date spans for clients for whom the MCO performed the NFLOC assessment via the ASPEN and MCO to HSD Omnicaid interface files are outlined based on the member's:

- Medicaid eligibility status;
- Service authorization level; and
- Long-term care (LTC) service model

Member Not Otherwise Medicaid Eligible (NOME)

Category Of Eligibility (COE) 090, 091, 092, 093, 094:

I. Initial approvals

A. The MCO shall submit the Initial NF LOC determination date spans via the ASPEN interface file within 40 calendar days of receiving the Primary Freedom of Choice (PFOC) in order for HSD to make a final Medicaid eligibility determination.

B. The MCO shall submit the NF LOC effective dates and applicable Setting of Care (SOC) date spans (ADB, SDB or INF) via the Omnicaid MCO to HSD interface file within 5 business days of receiving the member's initial enrollment on the Enrollment Roster file.

II. Initial NF LOC denials

A. The MCO shall submit the denial of a NF LOC via the ASPEN interface file within 5 business days of the NF LOC denial. The date span is reported as one day.

Example: NF LOC denial was completed on 10/12/16. No later than 10/19/16, the MCO must submit the NF LOC date span as: 10/12/16 – 10/12/16 with disposition reason: Medical Denial – does not meet medical necessity.

B. The Income Support Division (ISD) will issue a Notice of Case Action (NOCA) with denial of Medicaid eligibility.

C. Member may request a Fair Hearing by contacting the HSD Fair Hearings Bureau (FHB) or ISD. The member is not eligible to request continuation of benefits (COB). The MCO must adhere to the New Mexico Administrative Code (NMAC) 8.308.15 and the Managed Care Policy Manual Section 16 requirements related to Appeals and Fair Hearings.

D. The MCO shall not issue Appeal rights.

E. If the member requests a Fair Hearing, the MCO will be notified via the Fair Hearing Acknowledgement notice from the HSD/FHB.

F. The ISD office will be the primary lead during the Fair Hearing process. The MCO is responsible for the development of the Summary of Evidence (SOE) and distribution to all interested parties. The MCO is also responsible for providing testimony during the Fair Hearing.

G. The MCO will receive a copy of the final Fair Hearing decision letter from the HSD/ISD.
   1. If the Fair Hearing is found in favor of the Claimant, the MCO will comply with the final Fair Hearing decision letter and implement necessary steps to uphold the decision within three business days of receipt of the decision letter.

      EXAMPLE:Member does not have an existing NF LOC date span. The MCO will make the effective date of the Initial NF LOC date, the date the Primary Freedom of Choice (PFoC) is received by the MCO and the span shall cover a 12 month period. If the PFoC is received on February 14, 2017 the NF LOC date spans would be 02/14/17 – 02/13/18.
      - The MCO shall submit the NF LOC date spans via the ASPEN interface file
      - The MCO shall submit the NF LOC date spans and applicable SOC date span via the Omnicaid MCO to HSD interface file within five business days of receiving the member's initial enrollment on the enrollment roster file.

   2. If the Fair Hearing decision is in favor of the Department, the MCO does not have any entry/submission requirements.

III. Annual Recertification

The MCO shall submit the upcoming NF LOC effective date spans via the ASPEN Interface AND the MCO must submit the NF LOC effective dates and SOC applicable date spans (ADB, SDB or INF) via the Omnicaid MCO to HSD interface file no later than 60 calendar days prior to the expiration of the existing NF LOC and SOC date spans, including denials. The MCO may begin planning for the Community Benefit reassessment as much as 120 calendar days prior to and must complete the reassessment no less than 60 days prior to the expiration of the existing NFLOC span. For SOC INF, the MCO can only request the packet required for reassessment from the nursing facility 60 days in advance. A 45 and 30 day reminder file is generated from the Income Support Division (ISD) to the MCOs if ISD has not received the next year's NF LOC determination 60 days prior to expiration.

IV. Annual Renewal of NF LOC-denials – MCO Appeal

A. If the MCO has determined that an annual NOME member no longer meets NF LOC at annual renewal, the MCO shall send the Notice of Action (NOA) to the member with the denial of the NF LOC within five business days from the NF LOC determination and will include Appeal and Fair Hearing rights.
B. The MCO shall wait 10 business days, from the date of the NOA, to submit the ASPEN interface file denial, to allow the member opportunity to request COB from the MCO.
C. If the member **requests COB** within 10 business days:
   1. The MCO shall send an ASPEN interface file with 120 temporary authorization days; and

2. The MCO shall also send the MCO to HSD Omnicaid interface file reflecting the same time period as the 120 temporary authorization days and applicable SOC, ADB or SDB.

D. If the member **does not request COB** within 10 business days, the MCO shall submit the denial of the NF LOC via the ASPEN interface file. The disposition reason is Medical Denial and the NF LOC date is reported as one day.

E. After the Appeal process has been exhausted:
   1. If the MCO overturns the NF LOC denial decision and the member:
      a. **Requested COB**, the MCO shall send the new annual NF LOC dates via the ASPEN interface file. The new annual NF LOC dates should cover a 12 month period. The MCO shall **also** send the MCO to HSD Omnicaid interface file reflecting the same NF LOC dates span and applicable SOC, ADB or SDB.
      Example: Current NF LOC dates are: 04/01/15 – 03/31/16. 120 temporary authorization days had previously been submitted to cover 04/01/16 – 07/31/16. The MCO submits the remaining months to cover a 12 month period (08/01/16 – 03/31/17). There should be no gaps in the NF LOC dates from the previous year.
      b. **Did not request COB**, the MCO shall send the new annual NF LOC dates via the ASPEN interface file and ISD will re-open and approve the Waiver COE. The new annual NF LOC dates must cover the entire 12 month period (04/01/16 – 03/31/17). The MCO shall **also** send the MCO to HSD Omnicaid interface file reflecting the same NF LOC dates span and applicable SOC, ADB or SDB.
   2. If the MCO does not overturn the NF LOC denial decision and the member:
      a. **Requested COB**, the MCO shall NOT submit a Medical Denial via the ASPEN interface file because the 120 temporary authorization days are already in ASPEN.
      b. **Did not request COB**, the MCO shall NOT submit a Medical Denial via the ASPEN interface file as this was completed in D above.

V. Annual NF LOC Fair Hearings & NF LOC/ SOC Timelines

A. If the member has exhausted the MCO Appeals process and had **requested COB** he/she is eligible to request a Fair Hearing through HSD/FHB. If the member requests a Fair Hearing, the MCO will be notified via the Fair Hearing Acknowledgement notice from the HSD/FHB. If the member **did not request COB**, go to letter F of this section.

B. **ASPEN INTERFACE:** The MCO shall review existing NF LOC temporary date spans to determine if enough days have been authorized for COB during the Fair Hearing process. If not, an additional 120 day temporary NF LOC date span must be submitted within 5 business days of receipt of the Fair Hearing acknowledgement notice.
   1. The ISD will keep the Waiver COE active to allow continuation of eligibility during the Fair Hearing process.

2. Prior to the 90th day, the MCO shall review the Fair Hearing case status to determine if the Fair Hearing is delayed and will continue beyond the temporary NF LOC span.
3. If the Fair Hearing is delayed, an additional 120 day temporary NF LOC span must be submitted via the ASPEN interface file by the MCO.

C. **OMNICAID INTERFACE:** The MCO shall send a 120 day temporary NF LOC span via the MCO to HSD Omnicaid interface file, with the applicable SOC, ADB or SDB, for COB during the Fair Hearing process.
1. Prior to the 90th day, the MCO shall review the Fair Hearing case status to determine if the Fair Hearing is delayed and will continue beyond the temporary NF LOC span.
2. If the Fair Hearing is delayed, an additional 120 day temporary NF LOC span and applicable SOC must be submitted via the MCO to HSD Omnicaid interface file by the MCO.

D. For members who are Agency Based Community Benefit (ABCB), a continued Prior Authorization (PA) must be sent to the appropriate provider(s) to continue service(s) for the 120 day period and for each subsequent temporary extension submitted during the Fair Hearing.

E. For members who are Self-Directed Community Benefit (SDCB), a partial budget and care plan for 120 days must be entered in the FOCoS System for COB during the Fair Hearing process and for each subsequent temporary extension submitted during the Fair Hearing.

F. The ISD office will be the primary lead during the Fair Hearing process. The MCO is responsible for the development of the Summary of Evidence (SOE) and distribution to all interested parties. The MCO is also responsible for providing testimony during the Fair Hearing.

G. The MCO will receive a copy of the final Fair Hearing decision letter from the HSD/ISD.
1. If the Fair Hearing is found <u>in favor of the Claimant</u>, **and requested COB**, the MCO will comply with the final Fair Hearing decision letter and uphold the decision within three business days of receipt of the decision letter.

Example:

- Member's original NF LOC date spans were 04/01/15 to 03/31/16. MCO previously sent a temporary NF LOC span via the ASPEN interface file for 04/01/16 – 07/31/16 AND **<u>also</u>** submitted a MCO to HSD Omnicaid interface file with NF LOC and SOC date spans 04/01/16 – 07/31/16.
- Decision letter was received by MCO on 07/06/16 indicating decision is in favor of Claimant. A NF LOC span of 08/01/16 – 03/31/17 must be sent via the ASPEN interface file extending the NF LOC to the original end date so that ISD can reinstate the Waiver COE.
- A MCO to HSD Omnicaid interface file submission is also required for NF LOC and SOC for 08/01/16 – 03/31/17.

- For an ABCB case, a PA must be sent to the appropriate provider(s) to continue service(s) through 03/31/17.
- For an SDCB case, the partial budget and care plan must be extended in FOCoS to 03/31/17.

2. If the Fair Hearing is found in favor of the Claimant, **and did not request COB**, the MCO will comply with the final Fair Hearing decision letter and uphold the decision within three business days of receipt of the decision letter.
   - The MCO shall send the new annual NF LOC dates via the ASPEN interface file and ISD will re-open and approve the Waiver COE. **Example:** The new annual NF LOC dates must cover the entire 12 month period (04/01/16 – 03/31/17). The MCO shall **also** send the MCO to HSD Omnicaid interface file reflecting the same NF LOC dates span and applicable SOC, ADB or SDB.
3. If the Fair Hearing decision is in favor of the Department:
   a. The MCO will end the NF LOC and SOC via the MCO to HSD Omnicaid interface file effective the date the final Fair Hearing decision letter was received by the MCO (on 07/06/16 per the previous example in G.1. above).
   b. If the MCO has submitted multiple temporary NF LOC date spans, the MCO shall submit the time frame span(s) that need to be voided to Linda Gonzales at Linda.Gonzales@state.nm.us and to John Padilla at JohnH.Padilla@state.nm.us for processing.
   c. The MCO will terminate the PA(s) issued to the appropriate provider(s) effective 14 calendar days (07/20/16) from the date the decision letter was received by the MCO (07/06/16) to provide adequate notice to the providers.
   d. The MCO will develop a close out budget and care plan in FOCoS (effective 7/20/16) and inform the EOR of the close out so the EOR can notify employees.

Members with Full Medicaid

COEs 001, 003, 004, 100, etc:

I. Initial approvals

A. The MCO shall submit the NF LOC effective date spans and applicable SOC (ANW, SNW or INF) date spans via the Omnicaid MCO to HSD interface file within 5 business days of the NF LOC determination.

II. Initial NF LOC Denials

A. The MCO shall send the NOA to the member with the denial of NF LOC and Community Benefits (CB) within five business days from the NF LOC determination and will include Appeal and Fair Hearing rights.

B. Member may request an Appeal by contacting his/her MCO. The MCO must adhere to the New Mexico Administrative Code (NMAC) 8.308.15 and the Managed Care Policy Manual Section 16 requirements related to Appeals and Fair Hearings.

C. Member is not eligible to request COB.
D. After the Appeal process has been exhausted, the MCO shall notify the MAD/PPB of the MCO Appeal decision via the CIU and include a copy of the Appeal decision letter sent to the member.
   1. If the MCO overturns the NF LOC denial decision the MCO shall send the new annual NF LOC dates via the MCO to HSD Omnicaid interface file. The new annual NF LOC dates should cover a 12 month period.
      Example: Current NF LOC dates are: 04/01/15 – 03/31/16. 120 day temporary authorization days had previously been submitted to cover 04/01/16 – 07/31/16. The MCO submits the remaining months to cover a 12 month period (08/01/16 – 03/31/17). There should be no gaps in the NF LOC dates from the previous year.

   2. If the MCO does not overturn the NF LOC denial decision the MCO shall notify PPB via the CIU.
E. If the member requests a Fair Hearing, the MCO will be notified via the Fair Hearing Acknowledgement notice from the HSD/FHB.
F. The MAD/Program Policy Bureau (PPB) will work with the MCO during the Fair Hearing process and the MCO is responsible for completion of the SOE and for providing testimony during the Fair Hearing. The MCO will follow the already established process and submit the SOE via the DMZ to MAD/PPB. MAD/PPB will distribute the SOE to all interested parties.
G. The MCO will receive a copy of the Fair Hearing decision from the HSD/MAD.

III. Annual Recertification

A. If the client has a 12 month NFLOC determination, the MCO shall submit the NF LOC effective date spans and applicable SOC (ANW, SNW or INF) date spans via the Omnicaid MCO to HSD interface file no later than 60 calendar days prior to the expiration of the existing NF LOC and SOC date spans. The MCO may begin planning for the Community Benefit reassessment as much as 120 calendar days prior to and must complete the reassessment no less than 60 days prior to the expiration of the existing NFLOC span. For SOC INF, the MCO can only request the packet required for reassessment from the nursing facility 60 days in advance. A 45 and 30 day reminder file is generated from the Income Support Division (ISD) to the MCOs if ISD has not received the next year's NF LOC determination 60 days prior to expiration.

IV. Annual NF LOC Denials

A. The MCO shall send the NOA to the member with the denial of NF LOC and CB 60 calendar days prior to the expiration of the existing NF LOC and will include Appeal and Fair Hearing rights.
B. If the member does not request COB, the MCO does not have any entry/submission requirements until the MCO Appeal or Fair Hearing process has been completed. Please go to letter F of the below section.
C. If the member files a Fair Hearing after the Appeals process has been

exhausted, the MAD/Program Policy Bureau (PPB) will work with the MCO during the Fair Hearing process and the MCO is responsible for completion of the SOE and for providing testimony during the Fair Hearing. The MCO will follow the already established process and submit the SOE via the DMZ to MAD/PPB. MAD/PPB will distribute the SOE to all interested parties.

D. The MCO will receive a copy of the Fair Hearing decision from the HSD/PPB.

V. Annual NF LOC Fair Hearings & NF LOC/SOC Timelines

A. If the member requests COB within 10 calendar days of the NOA, the MCO will complete the following steps:

B. **ASPEN INTERFACE:** The MCO does not send any information via the MCO to ASPEN interface.

C. **OMNICAID INTERFACE:** The MCO shall send a 120 day temporary NF LOC span via the MCO to HSD Omnicaid interface file, with the applicable SOC ANW or SNW, for COB during the MCO Appeal and Fair Hearing process.
   1. Prior to the 90th day, the MCO shall review the Fair Hearing case status to determine if Fair Hearing is delayed and will continue beyond the COB temporary NF LOC span.
   2. If delayed, an additional 120 day temporary NF LOC span and applicable SOC must be submitted via the MCO to HSD Omnicaid interface file by the MCO.

D. For members who are ABCB, a continued PA must be sent to the appropriate provider(s) to continue service(s) for the 120 day period and for each subsequent temporary extension submitted during the Fair Hearing.

E. For members who are SDCB, a partial budget and care plan for 120 days must be entered in FOCoS for COB during the Fair Hearing process and for each subsequent temporary extension submitted during the Fair Hearing.

F. The MAD/Program Policy Bureau (PPB) will work with the MCO during the Fair Hearing process and the MCO is responsible for completion of the SOE and for providing testimony during the Fair Hearing. The MCO will follow the already established process and submit the SOE via the DMZ to MAD/PPB. MAD/PPB will distribute the SOE to all interested parties.

G. The MCO will receive a copy of the Fair Hearing decision from the HSD/MAD.
   1. If the Fair Hearing decision is <u>in favor of the Claimant</u>, the MCO will comply with the decision and uphold the decision within three business days of receipt of the decision letter.
      Example: Member's current NF LOC date spans are 04/01/16 to 03/31/17. MCO sent a temporary NF LOC and SOC span from 04/01/16 – 07/31/16 via the MCO to HSD Omnicaid interface file.
      - A Decision letter is received by the MCO on 07/06/16 indicating decision is in favor of Claimant.
      - An MCO to HSD Omnicaid interface submission for NF LOC and SOC is 08/01/16 – 03/31/17 is required.
      - For an ABCB case, a PA must be sent to the appropriate provider(s) to continue service(s) through 03/31/17.
      - For an SDCB case, the partial budget must be extended in FOCoS

to 03/31/17.

2. If the Fair Hearing is found in favor of the Department, the MCO will:
   a. End the NF LOC and SOC via the MCO to HSD Omnicaid interface file effective the date the final Fair Hearing decision letter was received by the MCO (on 07/06/16 per the previous example in G.1. above).
   b. Determine if multiple temporary NF LOC date spans were submitted and need to be voided. The MCO shall submit the time frame span(s) that need to be voided to John Padilla at JohnH.Padilla@state.nm.us for processing.
   c. Terminate the PA(s) issued to the appropriate provider(s) effective 14 calendar days (07/20/16) from the date the decision letter was received by the MCO (07/06/16) to provide adequate notice to the providers.
   d. Develop a close out budget and care plan (effective 7/20/16) and inform the EOR of the close out so the EOR can notify employees.

Medicaid Pending and Institutional Care (IC)

COE 081, 083, 084

I.Approvals and Denials for Medicaid Pending and Institutional Care cases should be processed as:

A. Initial Approvals shall be submitted with the NF LOC determination date spans via the ASPEN interface file within 30 calendar days of receiving the NF LOC packet from the nursing facility.
B. Initial denials for Medicaid Pending cases should be followed as outlined in ***Section I Initial NF LOC denials*** above.
C. IC annual denials should be followed as outlined in ***Section II Annual NF LOC denials*** and ***Section III Annual NF LOC Fair Hearing & NF LOC/SOC Timelines*****.**
D. Initial and annual denials for residents in a NF with a Full Medicaid COE (i.e., 001, 003, 004, 100, etc) should be followed as outlined in ***Members with Full Medicaid*** section.

Annual Comprehensive Needs Assessment and NFLOC Reassessment

The MCO is required to complete a Comprehensive Needs Assessment (CNA) annually. For a waiver client who has been approved for NFLOC, but does not meet Continuous NFLOC criteria, the MCO must complete the CNA and NFLOC reassessment no earlier than 90 calendar days and no less than 60 calendar days prior to the end of the NFLOC period in order for the client to continue long term care services uninterrupted. If the client continues to meet NFLOC, the reassessment should trigger a new 12 month NFLOC period and a new SOC span. We refer to the NFLOC period and SOC span separately because a client's NFLOC period is expected to remain on the original 12 month schedule whereas the client's SOC spans may open and close over time. However, SOC spans must always fit within the 12 month NFLOC period and the LTC assessment date must always be prior to the begin date of the SOC

span.

For example: a client approved on 3/23/18 to begin community benefit starting 4/1/18 has a NFLOC period that runs 4/1/18-3/31/19. That client's SOC span may initially be entered with that same span. Subsequent changes have caused that span to be split into 4/1/18-6/30/18; 7/1/18-9/30/18 and the client now wishes to switch to a different SOC. The MCO must reassess the client's needs and plan of care but a new LTC determination is not needed. That span would be entered as 10/1/18 but cannot exceed the current NFLOC end date of 3/31/19.

A NFLOC reassessment must be performed any time a change in the client's condition or service delivery model warrants it , but the NFLOC period will remain on its 12 month schedule.

Refusal and/or Non-Compliance with the Annual CNA Requirement

I. Members who do not comply with CNA requirement

1. The MCO shall make reasonable efforts to contact the member to conduct the CNA and shall document at least three attempts to contact the member.
    1. Reasonable efforts shall include at least one attempt to contact the member at the phone number most recently reported by the Member and use of the member's last reported residential address.
    2. Documentation of the three attempts shall be included in the member's file.
    3. Such attempts shall occur on not less than three different calendar days, at different hours of the day, including day and evening hours and after business hours.
2. A Reminder Notice shall be sent to the member's most recently reported address indicating that the NF LOC will end and CB will not be accessible without the completion of the CNA.
    - If the member has a waiver COE, the Reminder Notice shall inform the member that not completing the CNA will result in loss of Medicaid Eligibility, and shall provide information about how to contact his/her care coordinator to obtain a CNA.

C. If the member has still refused to complete the CNA within 30 days of the expiration of the existing NF LOC span, the MCO shall issue a NOA indicating that due to refusal and/or non-compliance with the annual CNA requirements, the member's services will end (include end date in NOA). The NOA shall include Appeal and Fair Hearing Rights.

D. If the member is a NOME, the MCO is required to submit an Administative Denial (DA) via the ASPEN interface file to report the denial of the NF LOC to ISD.
    - The ISD will close the Waiver COE and issue a NOCA to the member offering Fair Hearing rights.

E. The MCO will allow the NF LOC to expire in ASPEN and/or Omnicaid unless

the member requests COB within 10 calendar days of the NOA. If the member requests COB, the MCO shall follow the above outlined steps for annual NOMEs and full Medicaid members who request COB. The MCO must adhere to the New Mexico Administrative Code (NMAC) 8.308.15 and the Managed Care Policy Manual Section 16 requirements related to Appeals and Fair Hearings.

ASPEN to MCO NF LOC Request file (ASPEN 112)
ASPEN runs the 112, 113, and 114 files Monday thru Friday, excluding holidays. ASPEN will send a file daily, regardless of whether there are any requests for NF LOC for that day or not. The interface files are transmitted directly between ASPEN and the MCOs using secure FTP. A client will only appear on the file once. If the MCO does not send a response for the client who is pending, that client will remain pending and a reminder record is not sent on a future file. However, for a pending client, any time that the client's eligibility is touched by the worker, this may trigger a record on the 112 file. So the MCO may receive the same client NFLOC request multiple times on the 112 file.

Each time a record for a Medicaid pending client is sent it will have a Sequence Number and a request date. If the same client is sent multiple times, the MCO will have multiple sequence numbers and may have different Request Dates. The MCO is instructed to submit their 113 with the sequence number that matches the Request Date being sent. If all the Request Dates are the same, ASPEN will accept any Sequence Number submitted.

The ASPEN to MCO Level of Care interface file will contain clients applying for or being redetermined for COEs 90/91/92/93/94 or 81/83/84 where the facility type is a nursing facility or Long Term Care.

If an individual has an approved open-ended NF LOC span, ASPEN shall not send a renewal NF LOC request to MCOs unless the individual changes to a COE not in 90, 91, 92, 93, 94. If an individual has an End-Dated NF LOC span, ASPEN shall continue to send renewal NF LOC requests to the MCOs 90 days from LOC expiration and on the day of LOC Expiration as well as the 30 and 45 day LOC Renewal Requests. After an LOC has expired (and case remains approved), another LOC Request shall be sent to the MCO every time Mass Update on the Case or Eligibility is run and certified by a caseworker.

ASPEN shall send an LOC request every 30 days for individuals in ASPEN who meet the following conditions:

a. There is no LOC response received from the MCO that received the most recent LOC Request (and)
b. The individual's eligibility is pending (and)
c. The most recent LOC request was sent 30 days ago.

File names are as follows:

MCO	File Transfer Location	File Name
BCBS	BCBS Server	ABCS015
Presbyterian	PRESB Server	APRS015
Western Sky	WSCC Server	AWSK01S

The file layout for the 112 file ASPEN sends to the MCOs to assign a client for NLFOC assessment is as follows:

Data Element	Position	Type & Size	Mandatory / Optional	Description
HDR_RECORD_IND		PIC X(2)	Mandatory	HD'
HDR_FILE_NAME		PIC X(5)	Mandatory	ASPEN'
HDR_SEND_TO_FILE_NAME		PIC X(5)	Mandatory	BCBS/PRESB/TPA/WEST
HDR_DATE		PIC X(8)	Mandatory	CCYYMMDD
ASPEN_CLIENT_ID	1-9	AN, 9	Mandatory	ASPEN individual (MCI) ID.
SSN	10-18	AN, 9	Mandatory	Individual SSN.
FIRST_NAME	19-48	AN, 30	Mandatory	
LAST_NAME	49-78	AN, 30	Mandatory	
MIDDLE_NAME	79-108	AN, 30	Optional	
DOB	109-116	AN 8	Mandatory	Individual date of birth. Format: MMDDYYYY
GROUP HEADER - CLIENT MAILING ADDRESS			Optional	GROUP HEADER For the 80s categories, the resident address is the facility address of an individual in a nursing home. Address will only be sent for the 80s categories (does not apply to the 90s).
MAILING_ADDR_ST_NAME	117-216	AN, 100	Optional	Mailing address street name of the client.
MAILING_ADDR_CITY	217-241	AN, 25	Optional	Mailing address city of the client.
MAILING_ADDR_STATE	242-243	AN, 2	Optional	Mailing address state of the client.
MAILING_ADDR_ZIP5	244-248	AN, 5	Optional	Mailing address zip5 of the client.
MAILING_ADDR_ZIP4	249-252	AN, 4	Optional	Mailing address zip4 of the client.
GROUP HEADER - CLIENT_RESIDENTIAL_ADDRESS				GROUP HEADER For the 80s categories, the resident address is the facility address of an individual in a nursing home. Address will only be sent for the 80s categories (does not apply to the 90s).
RESIDENTIAL_ADDR_ST_NAME	253-352	AN, 100	Optional	Residential address street name of the client.
RESIDENTIAL_ADDR_CITY	353-377	AN, 25	Optional	Residential address city of the client.
RESIDENTIAL_ADDR_STATE	378-379	AN, 2	Optional	Residential address state of the client.
RESIDENTIAL_ADDR_ZIP5	380-384	AN, 5	Optional	Residential address zip5 of the client.
RESIDENTIAL_ADDR_ZIP4	385-388	AN, 4	Optional	Residential address zip4 of the client.

Data Element	Position	Type & Size	Mandatory / Optional	Description
COE	389-391	AN, 3	Mandatory	Represents the category of eligibility. COES to be transmitted: COEs 081, 083, 084, 090, 091, 092, 093, 094, 095, and/or 096. Reference the EDTOA tab for a list of values and translations.
COE_DISPOSITION	392-393	AN, 2	Mandatory	Represents the status of the EDG. Reference the EDEDGSTATUS tab for a list of values.
LOC_END_DT	394-401	AN, 8	Optional	Date is only populated if LOC is 30 days from expiration for the following categories of eligibility: 81, 83, 84, 90, 91, 92, 93, 94, 95, or 96. Format: MMDDYYYY
FACILITY_NAME	402-351	AN, 50	Optional	Name of the facility giving care to the individual.
FACILITY_TYPE	452-453	AN, 2	Optional	Type of facility the individual is being cared for in. Reference the DCFACILITYTYPE tab for a list of values.
N/A	454-461	AN,8	Optional	N/A
N/A	462-469	AN,8	Optional	N/A
ADMIN_COUNTY_CODE	470-471	AN, 2	Optional	Administrative county of the client. This is the county for which the client is being worked. Reference the COUNTY tab for a list of values.
REQUEST_DATE	472-479	AN, 8	Mandatory	MCOs must return an LOC determination starting during the month of or before the 'Request Date'. The purpose of the 'Request Date' field is to ensure that the MCOs are informed of the date from when ASPEN requires an LOC determination made. The MCOs are expected to return an LOC determination with the LOC Begin Date starting from on or before the month of the 'Request Date
LOC_SEQ_NUM	480-488	AN, 9	Mandatory	▪ The 'LOC Sequence Number' shall be different for every LOC Request that ASPEN sends. ○Example: If ASPEN sends a 45 day and a 30 day LOC renewal reminder to an MCO, the LOC Sequence Number shall be different for these two LOC Requests. If the MCO has received more than one LOC request for an Individual, the MCO can return the LOC Sequence Number from either LOC request that has the 'Request Date' from when the MCO has determined LOC If the MCO did not receive the initial 112 for a client (e.g., client transfer), the 113 can be sent without the LOC Seq Num populated
TRLR_RECORD_IND	PIC X(2)	TR'	Mandatory	
TRLR_RECORD_CNT	PIC 9(9)		Mandatory	

MCO to ASPEN NF LOC Response file (ASPEN 113)

The MCO is expected is create a file daily back to ASPEN, even if there are no assessments to be reported on for that day. The interface files are transmitted directly between ASPEN and the MCOs using secure FTP. ASPEN Batch cycle starts at 7:00

PM MT each day and the Jobs that process LOC files from MCOs and TPA are kicked off as soon as the batch cycle is started. MCO's should post files by 6:45PM MT each day to be processed on the same day.

The MCO is required to approve or deny the NF LOC within 5 business days from the completed packet. ASPEN is programmed to close all new applications if it is not disposed within 90 days (for disability based MA categories) and 45 days (for all other MA categories). So if LOC response for disability based nursing facility or community benefit is not received by the 89th day from application date, the case will be closed. For all other non-disability based IC/Waiver categories that day would be 44th day from the application. Once the MCO has made their determination of NFLOC, the MCO will send ASPEN a file that contains Level of Care (LOC) information for individuals requested on the ASPEN to MCO LOC daily send file.

The following rules apply to how the MCO submits LOC determinations:

- **The MCO must never submit a 113 for a Medicaid pending client that was not on that MCO's 112. If the MCO receives a packet from a nursing facility for a client that is not already enrolled with the MCO and the client has not appeared on a 112 file, the MCO should contact LTSSB who can inquire in ASPEN to determine which MCO the NFLOC determination has been assigned. The MCO can then return the packet to the nursing facility with the instruction to submit to that MCO.**
- **The MCO must never submit a 113 for an ongoing Medicaid client that was not on that MCO's 112. It is possible, for short term approvals, due to the timing when the MCO sends the initial approval, that the MCO will be ready to submit the ongoing approval before ASPEN has generated the request on the 112. When this happens, the MCO must wait for the 112 request. For example:**
    - ASPEN sent an LOC request in 112 file to the MCO on 18-FEB-2019 with request date as 01-FEB-2019.
    - ASPEN received a LOC response in 113 file from the MCO on 19-FEB-2019 with LOC approved from 01-FEB-2019 to 01-MAY-2019. This span was accepted.
    - On 12-MAR-2019, ASPEN received a LOC approval in 113 file from the MCO with LOC approved from 02-MAY-2019 to 01-MAY-2020. This was rejected because the only request date currently on file in ASPEN was for February 1. ASPEN sends out the renewal requests 90 ,45 and 30 days from expiration. The first notification is sent well in advance before the MCOs have to start the renewal process(60 days from the expiration). But in this scenario, the initial LOC approval from 01-FEB-2019 to 01-MAY-2019 was received on 19th FEB 2019 and the 90th day from the LOC expiration date falls on 1 FEB 2019. Because the 90 day trigger was missed, the next trigger for ASPEN to send the 112 would be on March 17 and again on April 12.
- **If the MCO receives a request from a nursing facility to change the client from low to high NF or vice versa that change should be handled internally by the MCO, but should never be sent to ASPEN.**

- The SNF/NF is required to conduct specific types of assessments and clinical documentation based on the type of admission (skilled/acute vs custodial/LTC). If the resident meets skill care upon admission, only an authorization is to be issued, no NF LOC assignment, as this is a physical health benefit.
- The ASPEN system does not issue a 112 file for the dates the resident was receiving skilled/acute care in the SNF/NF. Once and ONLY **if** the resident reverts to custodial care (long term care) should the NF LOC begin and the ASPEN should then send the 112 with the request date care switched to custodial/LTC.
- MCOs must return a LOC determination as a continuous span starting during the month of (or) before the 'Request Date.' Please note below the instruction re: Request Date.
- If the MCO sends a LOC denial, either administrative or medical, followed by a LOC Approval, the LOC Spans must be a continuous span. See below for examples.
- If the MCO sends more than one LOC approval span on the same day, the LOC spans must be continuous span.
- Stand-Alone LOC Denials, either administrative or medical, must be sent as Same-Day Spans (LOC begin date same as LOC end date) starting during the month of the 'Request Date.' A Stand-Alone LOC Denial is considered to be an LOC Denial that is not sent along with an Approval in the same 113 File
- ASPEN shall not accept multiple LOC Spans for the same individual with overlapping LOC Dates in the same 113 File.
- Open-Ended NF LOC Approvals can only be received when the individual is approved or pending on the below COE's:
  - 90: Medicaid Waiver - AIDS
  - 91: Medicaid Waiver - Aged
  - 92: Medicaid Waiver - Brain Injury
  - 93: Medicaid Waiver – Blind
  - 94: Medicaid Waiver – Disabled

  There must be a prior LOC Span with an end date in the future or within the last 90 days of the Open-Ended LOC Approval Begin Date.
- Open-Ended LOC Approvals shall be sent with a 'blank' LOC End Date.
- End-Dated LOC Approval Spans cannot be more than 366 days.
- The MCO must have received the most recent LOC request (if there was an LOC Request sent within 90 Days) or be the individual's enrolled/chosen MCO with the individual pending or approved on an IC/Waiver COE.
- If the MCO sends a retroactive LOC determination, the MCO must send all other LOC Spans that start after the retroactive LOC begin date. Refer to Example J below for examples.
- If the MCO sends a retroactive LOC determination, the MCO must send all the future LOC spans

Request Dates and LOC Sequence Numbers

For a Medicaid Pending client, the MCO may receive multiple records for the same client on the 112s. Each record will have a different LOC sequence number. When the MCO makes their LOC determination and is sending that on the 113 file, the MCO can use any of the LOC sequence numbers, it doesn't matter which one as long as the request dates are the same.

For a Medicaid pending client, the MCO may receive multiple records for the same client on the 112s with different Request Dates. The MCO must always respond with the earliest Request Date and should use the sequence number that was sent for that request date.

See the examples below for the 113 File validations and how MCO's must send LOC determinations:

a. The MCOs/TPA must return an LOC determination as a continuous span starting during the month of (or) before the 'Request Date.'

Example:

- Individual's eligibility is pending for LOC in ASPEN for months Jan, Feb and March. Date of Application and LOC Request triggered on 23-JAN-18.
- LOC 'Request Date' sent as 01-JAN-18 as this is the first day of the application month.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
1	MCO/TPA Determines that individual is Approved from 1-JAN-18 to 31-DEC-18				
1a	1-JAN-18	31-DEC-18	AP	Accepted	Approved all pending months
2	MCO/TPA Determines that individual is Approved from 28-JAN-18 to 27-JAN-19				
2a	28-JAN-18	27-JAN-19	AP	Accepted	Approved all pending months
3	MCO/TPA Determines that individual is Approved from 15-FEB-18 to 14-FEB-19				
	1-JAN-18	14-FEB-18	DN	Accepted – both records must both be received in the same 113 file.	
3a	15-FEB-18	14-FEB-19	AP		Deny Jan, Approve Feb Ongoing
3b	15-FEB-18	14-FEB-19	AP	Rejected – E13	
4	MCO/TPA Determines that individual is Approved from 15-MAR-18 to 14-MAR-19				
	1-JAN-18	14-MAR-18	DN	Accepted – both records must both be received in the same 113 file.	Deny Jan and Feb, Approve March Ongoing
4a	15-MAR-18	14-MAR-19	AP		
4b	15-FEB-18	14-FEB-19	AP	Rejected – E13	

5	MCO/TPA Determines that individual is Approved from 15-FEB-18 to 14-FEB-19				
	20-JAN-18	14-FEB-18	DN	Accepted – both records must both be received in the same 113 file.	Deny Jan, Approve Feb Ongoing
5a	15-FEB-18	14-FEB-19	AP		
5b	15-FEB-18	14-FEB-19	AP	Rejected – E13	
6	MCO/TPA Determines that individual is Approved from 1-NOV-17 to 31-OCT-18. The LOC Approval Begin Date received from the MCO/TPA is 2 months prior to the 'Request Date'.				
6a	1-NOV-17	31-OCT-18	AP	Accepted	Approved all pending months
7	MCO/TPA sends spans that have a gap (not continuous) in the same 113 file.				
7a	01-JAN-18	28-JAN-18	AP or DN		
7b	02-MAR-18	01-MAR-19	AP	Rejected – E13	

b. <u>Stand-Alone</u> LOC Denials must be sent as Same-Day Spans starting during the month of the 'Request Date.'

- A Stand-Alone LOC Denial is considered to be an LOC Denial that is not sent along with an Approval in the same 113 File.

Example:

- Individual's eligibility is pending for LOC in ASPEN for months Jan, Feb and March. Date of Application and LOC Request triggered on 23-JAN-18.
- LOC 'Request Date' Sent as 01-JAN-18 as this is the 1st of the pending edg.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
8	MCO/TPA Determines that individual is Denied for Level of Care.				
8a	1-JAN-18	1-JAN-18	DN	Accepted	Deny All Months
8b	20-JAN-18	20-JAN-18	DN	Accepted	Deny All Months
8c	15-FEB-18	15-FEB-18	DN	Rejected – E14	
8d	1-DEC-17	1-DEC-17	DN	Rejected – E14	
8e	1-JAN-18	2-JAN-18	DN	Rejected – E14	
8f	1-JAN-18	12-DEC-19	DN	Rejected – E14	
8g	15-JAN-18	16-JAN-18	DN	Rejected – E14	
8h	15-FEB-18	14-FEB-19	DN	Rejected – E14	
8i	01-JAN-18	Open- Ended	DN	Rejected – E14	

Note: ASPEN is not expecting Same-Day Denials if a denial is received in the same file as an LOC Approval. Refer to examples 3, 4 and 5 for LOC Denials sent along with Approvals.

c. MCOs/TPA cannot send LOC Spans with overlapping LOC Dates in the same 113 File:

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
9	MCO sends an overlapping Open- Ended Approval Span and an End-Dated Approval Span in the same 113 File.				
	01-JAN-18	Open- Ended	AP		
9a	02-FEB-18	01-FEB-19	AP	Rejected – E11	
10	MCO/TPA sends overlapping End- Dated Approval Spans in the same 113 File.				
	01-JAN-18	31-DEC-18	AP		
10a	01-FEB-18	31-JAN-19	AP	Rejected – E11	
11	MCO/TPA sends an overlapping LOC Approval and Denial in the same 113 File.				
	01-JAN-18	15-MAR-18	DN		
11a	01-FEB-18	31-JAN-19	AP	Rejected – E11	

Note: The scenarios above are not exhaustive of all types of Overlapping LOC Spans that the MCOs/TPA could send in the 113 File.

d. LOC Span does not cover all pending months in ASPEN. LOC is determined starting during the month of (or) before the 'Request Date.'

Example:

- Individual requires an LOC determination made for the months Jan through June. LOC was requested on 23-APR-18 with the 'Request Date' sent as 01-JAN-18 as this is the 1st of the pending EDG.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
12	MCO sends LOC Approval from 1-JAN-18 to 31-MAR-18 and the approval is sent on April 30th 2018.				
12a	01-JAN-18	31-MAR-18	AP	Accepted	Approve the months for which LOC was received and send another LOC renewal request to the MCO for the remaining pending months.

Note: Even though the LOC Response is accepted, the Individual cannot receive benefits until an LOC Determination is received for all of the pending months.

e. The MCO/TPA must have received the most recent LOC request (if there was an LOC Request sent within 90 Days) or be the individuals enrolled/chosen MCO with the individual pending or approved on an IC/Waiver COE.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility

13	LOC Approval received from an MCO that did not receive the most recent LOC Request within the last 90 days and is not the enrolled MCO or client choice. Individual is not currently approved on IC or Waiver.				
13a	02-JAN-18	01-JAN-19	AP	E16: Rejected	
14	LOC Approval received from an MCO that did not receive the most recent LOC Request within the last 90 days and the individual is not pending on IC or Waiver. Individual is not currently approved on IC or Waiver.				
14a	01-JAN-18	01-JAN-18	AP	E16: Rejected	

f. Only the MCO's can send Open-Ended NF LOC Approvals:

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
15	An Open-Ended LOC Determination is received from the TPA.				
15a	1-JAN-18	Open - Ended	AP	Rejected – E12	

g. Open-Ended NF LOC Approvals shall only be accepted when individual is approved or pending on the below COE's:

- **90: Medicaid Waiver - AIDS**
- **91: Medicaid Waiver - Aged**
- **92: Medicaid Waiver - Brain Injury**
- **93: Medicaid Waiver - Blind**
- **94: Medicaid Waiver - Disabled**

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
16	An Open-Ended LOC Determination is received from an MCO for an Individual that is pending or approved on COE 94: Medicaid Waiver – Disabled.				
16a	1-JAN-18	Open - Ended	AP	Accepted	Approve months received
17	An Open-Ended LOC Determination is received from an MCO for an Individual that is pending or approved for COE 96: Medicaid Waiver - Developmentally Disabled.				
17a	1-JAN-18	Open - Ended	AP	Rejected – E12	

h. There must be a prior LOC Span with an end date in the future or within the last 90 days of the Open-Ended LOC Approval Begin Date.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility

18	An Open-Ended LOC Determination is received from an MCO for an Individual that is pending or approved for COE 94: Medicaid Waiver – Disabled. Individual has existing LOC approval ending in future or in the past 90 days.				
18a	1-JAN-18	Open - Ended	AP	Accepted	Approve months received
19	An Open-Ended LOC Determination is received from an MCO for an Individual that is pending or approved for COE 94: Medicaid Waiver – Disabled. Individual does not have existing LOC approval ending in future or in the past 90 days.				
19a	1-JAN-18	Open - Ended	AP	Rejected – E12	

i. End-Dated LOC Approval Spans cannot be more than 366 days.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
19	MCO/TPA sends an End-Dated LOC Approval as a span of more than 366 days				
19a	1-JAN-198	31-MAR-19	AP	Rejected – E15	

j. **If MCO/TPA sends a retroactive LOC determination, the MCO/TPA must send all other LOC Spans that start after the retroactive LOC begin date.**
There are situations where a retroactive LOC determination is requested after a current LOC determination has been established.

Example:
- An Individual submits an application for IC/Waiver on 3/17/18. The Individual's eligibility is approved in ASPEN for months March and ongoing with an LOC approval span received from the MCO/TPA on 4/12/18 as 03/01/2018 – 2/28/2019. This individual has no other LOC spans established in ASPEN.
- Individual applies for two prior months Medicaid on 4/15/18 for the retro months January and February of 2018. The individual has no LOC determined for these months so another LOC Request is sent on 4/15/18 to the MCO/TPA with a Request Date as 1/1/18 as this is the least of the prior Medicaid requested months.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
20	MCO/TPA sends an LOC Approval for the retro months January and February 2018. The MCO/TPA does not intend to make any change to the LOC Approval for the current and ongoing span.				
20a	01-JAN-18	28-FEB-18	AP	Accepted – This is the best way for the MCO/TPA to send this LOC approval.	Approve retro months and current months remain approved
	01-MAR-2018	28-FEB-19	AP		
20b	01-JAN-18	01-MAR-18	AP	Accepted- but MCOs/TPA should send the current span as well.	Because ASPEN gives precedence to the most recent LOC, this LOC

					Approval should be sent along with the current LOC Approval.
21	MCO/TPA sends an LOC Denial for the retro months January and February 2018. The MCO/TPA does not intend to make any change to the LOC Approval for the current and ongoing span.				
21a	01-JAN-18	28-FEB-18	DN	Accepted – This is the best way for the MCO/TPA to send this LOC approval.	Approve retro months and current months remain approved
	01-MAR-2018	28-FEB-19	AP		
21b	01-JAN-18	01-JAN-18	DN	Accepted- but MCOs/TPA should send the current span as well.	Because ASPEN gives precedence to the most recent LOC, this LOC Denial should be sent along with the current LOC Approval. If the current approval span is not sent, ASPEN shall terminate the client's eligibility by considering the denial.

Files will be submitted as follows:

MCO	File Transfer Location	File Name
BCBS	BCBS Server	ABCS01R
Presbyterian	PRESB Server	APRS01R
Western Sky	WSCC Server	AWSK01R

The file layout for the 113 file is as follows:

Data Element	Position	Type & Size	Mandatory/Optional	Description
HDR_RECORD_IND		PIC X(2)	Mandatory	HD'
HDR_FILE_NAME		PIC X(5)	Mandatory	BCBS/PRESB/WEST
HDR_DATE		PIC X(8)	Mandatory	CCYYMMDD
DISPOSITION DATE	1-8	DATE	Mandatory	MMDDYYYY Date the LOC was determined. Format: MMDDYYYY
DISPOSITION REASON CODE	9-10	AN, 2	Mandatory	Reason for the disposition. Values: Approved - AP Medical Denial - DM (denial because the individual does not meet their LOC - medical necessity) Administrative Denial - DA (Denied by MCO/TPA for other reasons)
LOC BEGIN DATE	11-18	DATE	Optional	MMDDYYYY LOC begin date. If the disposition is approved, start date will be populated in the file. Format: MMDDYYYY

Data Element	Position	Type & Size	Mandatory/Optional	Description
LOC END DATE	19-26	DATE	Optional	MMDDYYYY Level of Care end date. LOC Denials sent as Same-Day Spans must show LOC begin date same as LOC end date starting using the 'Request Date.
FIRST NAME	27-56	AN, 30	Mandatory	Individual first name.
LAST NAME	57-86	AN, 30	Mandatory	Individual First name.
DOB	87-94	DATE	Mandatory	MMDDYYYY individual date of birth.
SSN	95-103	AN, 9	Mandatory	Individual SSN.
ASPEN CLIENT ID	104-112	AN, 9	Mandatory	Individual ASPEN client ID (MCI ID). ID will be sent if present in MCO/TPA system. Format: Alpha numeric.
FILLER	113-120	DATE	Optional	
FILLER	121-128	DATE	Optional	
Case Manager/consultant entity (Waiver) Address GROUP HEADER				GROUP HEADER
CASE MANAGER/CONSULTANT ENTITY	129-168	AN, 40	Optional	Field will be populated with the case manager/consultant entity. If no case manager/consultant entity exists, the value in this field should be blank. The case manager/consultant entity will be sent by MCO/TPA and received by ASPEN as text.
CASEMANAGER_ADDR_ST_NAME	169-198	AN, 30	Optional	Street name for the address of the consultant entity/case manager.
CASEMANAGER_ADDR_CITY	199-223	AN, 25	Optional	City for the address of the consultant entity/case manager.
CASEMANAGER_ADDR_STATE	224-225	AN, 2	Optional	State for the address of the consultant entity/case manager.
CASEMANAGER_ADDR_ZIP5	226-230	AN, 5	Optional	ZIP5 for the address of the consultant entity/case manager.
CASEMANAGER_ADDR_ZIP4	231-234	AN, 4	Optional	ZIP4 for the address of the consultant entity/case manager.
LOC_SEQ_NUM	235-243	AN, 9	Optional	The MCO/TPA is expected to return the 'LOC Sequence Number' that was received in the 112 File as 'pass back data'
TRLR_RECORD_IND	PIC X(2)	TR'	Mandatory	
TRLR_RECORD_CNT	PIC 9(9)		Mandatory	

ASPEN to MCO NF LOC Exceptions Response file (ASPEN 114)

ASPEN will produce a response file to inform the MCOs of the interface level processing status of the LOC Response File (113 file). This file –the 114 File, shall be generated upon processing the 113 File and shall include processing and exception details. The 114 File shall be generated as a response to each 113 file received from the MCO. Note: If ASPEN does not receive a 113 File from the MCOs/TPA, a 114 File shall not be sent.

ASPEN shall FTP the 114 file in the same way the 112 file is sent, by placing the file in each MCO's STS folder. The File Transfer locations and File Name where ASPEN shall send the 114 File are listed below:

MCO File Transfer Location File Name

BCBS	/BCBS/Inbound/	ABCS03S
Presbyterian	/PRESB/Inbound/	APRS03S
Western Sky	/WEST/Inbound/	AWSK03S

The 114 File shall contain the data that was received in the LOC Response file (113 file) from the MCO, with two new fields added

Data Element	Position	Type & Size	Mandatory/Optional	Description
HEADER RECORD				
HDR_RECORD	1-234	VARCHAR2(234)	Mandatory	This field will contain the header as it was received on the 113 file
Filler	235-237	VARCHAR2(3)	Optional	This field will contain spaces filled in
RECORD				
RECORD_RECEIVED_FROM_MCOTPA	1-243	VARCHAR2(234)	Mandatory	This Field will contain the record as it was received on the 113 file from MCO/TPA
NA	244-294	NA	NA	
PROCESS FLAG	295	VARCHAR2(1)	Mandatory	This field indicates if the record was processed and Level of Care successfully updated: 'S' – Level of Care Updated 'E' – Error while updating Level of Care 'N' – Not Processed
EXCEPTION REASON CODE	296-297	VARCHAR2(2)	Optional	This field contains the Exception Reason Code if the record had an Exception. See 'EXCEPTION RSN CD' tab
TRAILER RECORD				
TRLR_RECORD	1-294	VARCHAR2(234)	Mandatory	This field will contain the Trailer as it was received on the 113 file
Filler	295-297	VARCHAR2(3)	Optional	This field will contain spaces filled in

Code	**Process Flag**
S	Level of Care Updated
E	Error while updating Level of Care
N	Not Processed

When there is an Exception, the Process flag is set to 'E'. An example of what you might see in the 114 file is 'E03'. When there is an exception, the record is considered as processed.

Exception Reason Codes

Code	Exception Reason
01	Input Data Error – Header or Trailer record is not available in the file

02	Input Data Error – Total data records in the file does not match with the Trailer record count
03	Input Data Error – Record is in incorrect format
04	Input Data Error – Individual ID and SSN are not available in the file
05	Input Data Error – Individual is not found with the Individual ID received
06	Input Data Error – Individual is not found with the SSN received
07	Input Data Error – SSN received is in invalid format
08	Input Data Error – Individual ID and SSN on the file do not belong to the same Individual ID in ASPEN
09	Unexpected Technical Error
10	Input Data Error – Invalid LOC Authorization Begin or End Date
11	Input Data Error – Overlapping LOC Spans for the same individual
12	Input Data Error – Open- Ended LOC Span not valid for this program or individual
13	Input Data Error – LOC is not determined as a continuous span starting on or before the month of the 'Request Date'.
14	Input Data Error – Stand Alone LOC Denial Record is not a Same-Day Span starting during the month of the 'Request Date.
15	Input Data Error – End- Dated LOC Approval Span is more than 366 days
16	Input Data Error – LOC Determination received from an MCO/TPA that did not receive the most recent LOC Request (within the last 90 days) or is not the enrolled/chosen MCO

The exceptions described above are all critical exceptions, meaning ASPEN shall reject the record and the LOC Determinations shall not be updated in the System. The MCO's are expected to correct and resend the LOC determination(s).

With exception of E09 – Unexpected Technical Error, this Exception shall be monitored and investigated by the ASPEN Development Team

Timeliness Requirements for Reporting NFLOC SOC Spans to Omnicaid

MCOs are required to complete level of care determinations for enrollees and to communicate when a NFLOC is determined and a setting of care plan is developed. MCOs are required to submit the SOC spans in advance of the start of community benefit services via the Omnicaid interface. If there is an error in the SOC span that was submitted by the MCO, an error report is generated to the MCO and the SOC span must be corrected prior to the month in which Community Benefit services begin. Retroactive spans for clients in nursing facilities can be submitted. MAD realizes that there are limited circumstances that may require a SOC span to be submitted for a retroactive time period. For example: an existing member whose Medicaid recertification was approved retroactively to avoid a gap in a category of eligibility. The following provides clarification regarding the process for the Managed Care Organization's submission of retroactive exception requests.

Submission of Exception Requests

1. Prior to submission of retroactive exception requests, MCOs must submit the

NF LOC SOC prospectively to begin the following month and only request the exception for the current or prior months. For the prospective period, MCOs should enter the SOC for the upcoming month (e.g., If the current month is August, the prospective month, and the earliest the begin date can be entered is September). In rare instances when the monthly cap cycle has run, the MCO may submit the exception request to HSD.

2. MCOs must submit retroactive exception requests to Kristen Borderswood, LTSSB Community Benefit Manager at KristenA.Borderwoo@state.nm.us and copy Theresa Griego Theresam.griego@state.nm.us as needed, but should not send more than one file per day. MCOs should not send more than 20 members per file. Larger files may result in a delay in approval/denial(s) beyond the seven (7) business days indicated in LOD #47. Any anticipated delay will be communicated to the MCO within the seven (7) business days.

3. MCOs should not send the same member/exception request more than once unless requested by LTSSB.

Documentation to Accompany the Request Must Include:

1. Member Information as follows:
   a) Member Name
   b) Medicaid ID
   c) DOB
   d) Date Span Requiring Retro Review
   e) SOC for Retro Span
   f) Reason for Request for Retroactive SOC
2. All of the data fields in the order outlined in the example table below.
3. As much detail as possible related to the request, including extenuating circumstances or reason for urgency.
4. Whether services have been provided during the requested retroactive period and include the begin date of the services.
5. Reason Code. See the table below for reason codes.

If the LTSSB reviewer has any questions regarding the request, the request will be sent back to the MCO and will delay the determination beyond the seven (7) business days.

Example of a Complete Request:

Rejection Date (if applicable)	Request sent to LTSSB Date	Medicaid ID	Member First Name	Member Last Name	DOB	NF LOC Begin Date	NF LOC End Date	SOC	LTC Assessment Date	Reason	Reason Code (see table below)

	3/30/16	11111111	Roger	Rabbit	11/11/1970	4/11/16	7/31/16	ADS	6/16/15	Member was planning to switch to SDCB and his SOC was changed to SBD effective 4/1116. On 3/28/16, member notified his care coordinator that he changed his mind and did not want to switch to SDCB. ABCB services have continued to be provided.	4

HSD Approval/Denial of Exception Requests

HSD will approve exception requests under certain circumstances. (See table below) All approvals and denials will be made on a case-by-case basis. Once approved or denied, the MCO will be informed of the approval or denial via email.

Code	Retro NF LOC SOC Exception Reason	Retro Entry Approved
1.	MCO switches-when prior MCO did not meet NF LOC timeline	Yes
2.	Community reintegration	Yes, depending on the member's eligibility status
3.	Continuation of benefits (COB) related to a pending appeal/fair hearing	Yes
4.	SOC switches due to change in CB model (Agency-Based to Self-Directed or vice versa)	Yes
5.	Member urgently needs services in current month (i.e., member transitioning from hospital to assisted living facility)	Yes
6.	MCO data entry error (i.e., wrong dates or wrong SOC)	No
7.	NFLOC approved or entered late	No
8.	CNA scheduling difficulty with the member	No

Closing NF LOC/SOC spans

The following provides direction regarding the process to close the NF LOC/SOC date spans for Not Otherwise Medicaid Eligible (NOME) members and Full-Medicaid members.

NOME members not accessing CB services for 90 consecutive calendar days or more:

The MCO shall send a Reminder Notice to the member after 30 calendar days of non-utilization of CB services. The Reminder Notice shall be sent to the member's most recently reported address. The Reminder Notice shall advise the member that in 60 calendar days (include end date) if CB services are not utilized, his/her NF LOC/SOC will be closed and this will result in loss of Medicaid Eligibility. The member must also be notified that he/she must be approved for a waiver allocation and go through the eligibility process should they request that Community Benefits be re-established. ***Please note that cases that closed prior to May 1, 2017 do not require a Reminder Notice.***

The MCO must send a Notice of Action (NOA) after 60 consecutive calendar days on non-utilization of CB services. The NOA shall advise the member that in 30 calendar days (include end date), his/her NF LOC/SOC will be closed and will include Appeal and Fair Hearing rights.

ASPEN INTERFACE: The MCO shall wait 10 business days from the date of the NOA to submit an ASPEN interface file requesting closure of the Category of Eligibility (COE), as an Administrative Denial. The Administrative Denial is reported as one day (09/12/15 - 09/12/15) and is the first date of non-utilization of CB services.

The Income Support Division (ISD) will close the Waiver COE and issue a Notice of Case Action (NOCA) to the member offering Fair Hearing rights.

OMNICAID INTERFACE: The MCO shall retroactively close the NF LOC/SOC date span via the MCO to HSD Omnicaid interface file.

Example: *Current NF LOC and SOC is 07/01/15 – 06/30/16.*

Member went without CB services or refused CB services from 9/12/15 through 12/17/15.

The modified NF LOC and SOC span is 07/01/15 – **09/11/15**. Please note that the 9/11/15 date reflects the last day the member received CB services.

The MCO must ensure that processes are in place to terminate the Prior Authorization(s) PA(s) issued to provider(s) using appropriate dates.

The retroactive SOC date span submitted on the MCO to HSD interface must always have the same **begin** date as the existing LTC span; that is, there can be no retroactive change to the SOC **begin** date.

If the member expresses interest in re-establishing CB services, the MCO must assist the member by placing his/her name on the Central Registry and advise the member that he/she must wait to become eligible for an allocation and complete the eligibility process.

Full Medicaid members not accessing community benefit services for 90 consecutive days or more:

The MCO shall send a Reminder Notice to the member after 30 calendar days of non-utilization of CB services. The Reminder Notice shall be sent to the member's most recently reported address. The Reminder Notice shall advise the member that in 60 calendar days (include end date) if CB services are not utilized, his/her NF LOC/SOC will be closed and this will result in the

member no longer being able to access CB services without the completion of a new Comprehensive Needs Assessment (CNA).

The MCO must send a NOA after 60 consecutive calendar days on non-utilization of CB services. The NOA shall advise the member that in 30 calendar days (include end date), his/her NF LOC/SOC will be closed and will include Appeal and Fair Hearing Rights.

ASPEN INTERFACE: The MCO does not send any information via the MCO to ASPEN interface.

OMNICAID INTERFACE: The MCO shall retroactively close the NF LOC/SOC date span via the MCO to HSD interface file.

Example: *Current NF LOC and SOC is 07/01/15 – 06/30/16.*

Member went without CB services or refused CB services from 9/12/15 through 12/17/15.

The modified NF LOC and SOC span is 07/01/15 – 09/11/15. Please note that the 9/11/15 date reflects the last day the member received services.

MCO must ensure that processes are in place to terminate the PA(s) issued to provider(s) using appropriate dates.

The retro closure span submitted on the MCO to HSD interface must always have the same **begin** date as the existing LTC span; that is, there can be no retro change to the span **begin** date.

If a member requests reinstatement of services, the MCO shall schedule and complete a CNA and conduct a medical eligibility determination.

MCOs must issue PA(s) to the appropriate provider(s) using appropriate reinstatement dates.

Community Benefit Model Change

The MCO must never submit a Long Term Care (LTC) span that overlaps an existing span submitted by another MCO. The existing span should be closed and a new span sent. When a client transfers to the MCO, that client continues to retain the LTC span that was in place with the previous MCO. The receiving MCO should not send any update to that LTC span just because the MCO transferred. That LTC span remains in effect until its end date, unless the receiving MCO has identified a change that needs to occur to that span due to a change in SOC or NF LOC determination.

Reminder: a client is not allowed to be approved for self-direction without having spent at least 120 days in agency directed Community Benefit services. When a member moves from ABCB to SDBC or vice versa, the MCO shall submit the updated NF LOC and SOC date spans via the Omnicaid MCO to HSD interface file 90 calendar days prior to the effective date the member is expected to begin participating in the new service delivery model. This is done so that the Self Direction contractor can plan for the new client's needs. However, the start date of the new SOC span must be the actual planned start date of the new service delivery model. Overlap of SOC spans is not allowed. The SOC shall be changed from

1) ADB to SDB or ANW to SNW; or
2) SDB to ADB or SNW to ANW

When a change in setting of care occurs, that change must take place within the existing NFLOC period or at the beginning of a new NFLOC period. The MCO must report the SOC

start date as the first day the member is expected to begin participating in the new service delivery model. The new SOC start date will usually be different than the start date of the existing 12 month NF LOC period (the new SOC could start at the beginning of a new NFLOC period); however the SOC end date must not exceed the existing 12 month NF LOC period end date.

For example, a client receives an assessment for Community Benefit on 2/23/19 with an ADB span that began 3/1/2019. Their NF LOC period runs from 3/1/19-2/28/20. Their SOC span can have starts and stops within that period, but generally, the MCO will enter a 12 month span for 3/1/2019 – 2/28/2020. If the client wishes to switch to community benefit after 120 days, the MCO should send a long term care span on the MCO to HSD interface in April for the switch to SDB with an effective begin date in July, That span should have the begin date of 7/1/2019 and the end date of 2/28/2020 (their existing 12 month NF LOC period) and should reflect the most recent assessment date. By no later than January 1, the MCO should have completed a reassessment and will enter a new 12 month NF LOC period and SOC span from 3/1/19-2/28/20,

Allowed Changes to the Community Benefit Long Term Care Span

The MCO is allowed to submit Community Benefit Long Term Care spans where the difference between the incoming begin date and end date is not more than 12 months. If the client's COE is 095 or 096, the MCO should NEVER submit a Community Benefit Long Term Care span without confirming the client does not have a Mi Via or Supports Waiver Long Term Care span or Waiver authorization in effect. Even if the client's COE 095/096 has been closed and a different COE is reported on the roster, the MCO should still validate with the client and case manager to determine whether the COE change is temporary or the client has left the DD/Med Frag or Supports waiver. Effective with the December, 2019 roster, DD/Med Frag waiver authorizations will be reported on the roster as long term care spans with level of care 'MR0'. And effective July 1, 2020, Supports Waiver authorizations will be reported as long term care spans with level of care MR0 and Setting of care SWA or SWD. When an already enrolled client is newly authorized for the 'MR0' level of care, that will be communicated to the MCO on the daily Long Term Care Reconciliation file the morning after the span is entered into Omnicaid. Many clients with COE 095 or 096 also have eligibility as SSI clients. There may be times when the 095 or 096 is not reestablished timely so that there may be short periods where the client reverts to the SSI COE. Usually the 095/096 will be reinstated and no break in the DD or Med Frag waiver will occur.

The following decision tree can be used to determine under what conditions a Community Benefit span can be submitted and what the system will record in the Long Term Care span.

Conditions	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8
Incoming span overlaps existing span	N	N	Y	Y	Y	Y	Y	Y
Incoming begin date < existing begin date	*	*	Y	N	N	N	N	N
Incoming begin date = existing begin date	*	*	*	Y	Y	Y	N	N
incoming SOC = existing SOC	*	*	*	Y	Y	N	Y	N
Incoming end date = existing end date	*	*	*	Y	N	*	*	*
Incoming begin date < first of next month	Y	N	*	*	*	*	*	*
Actions								

No update	X		X	X				
Ignore as duplicate				X				
Post error 45 (retro)	X		X					
Void existing span						X		
Terminate existing span 1 day before incoming begin date							X	X
Add new incoming span		X				X	X	X
Update existing span with incoming end date					X			

DD or Med Frag Waiver Change from Community Benefit

Some clients may be approved and receiving Community Benefit services and are later approved for a DD or Med Frag Waiver category (095, 096). There will often be a period of overlap between their former Medicaid COE and the new Waiver COE (095 or 096). Or the former Medicaid COE may terminate and the client only have COE 095 or 096, but waiver services have not yet been implemented. Once the MCO receives the COE 095 or 096 on the roster file, that should be the trigger that this is a client who needs to transition from Community Benefit provided by the MCO to Waiver services that are not covered by the MCO. The Care Coordinator is expected to work closely with the Case Manager who is helping the client develop a plan of care and coordinate the closing of Community Benefit services prior to the start of the Waiver services authorization. The TPA entering the Waiver authorization will close the NFLOC SOC span when they open the Waiver authorization (DD Waiver) or Waiver LTC span (for MiVia and Supports Waiver). The MCO will not be paid the LTC cohort once the Waiver Prior Authorization or Mi Via/Supports Waiver LTC span is entered into Omnicaid. The roster file will, starting December, 2019, contain the LOC/SOC for clients in the DD/Med Frag waiver programs whose services are carved out of managed care. These spans will contain LOC = MR0- and SOC either MIV (Mi Via). All MR0 spans are included so the MCO is aware when LTC is authorized for these clients, in case the MCO has implemented community benefit while waiting for the client's waiver approval.
It is important that if the MCO is aware that Waiver services have started but continues to see an open NFLOC SOC span and no MR0 LTC span, that the MCO contact the client's case manager and report the situation to HSD.

Supports Waiver

Beginning July 1, 2020 the new HCBS Supports Waiver (SW) will offer an array of specified HCBS waiver services to clients with COE 096; less than is offered to clients approved through the existing DD waiver or Mi Via waiver. The intention is to provide critical services to clients who are on the DD waiver wait list until a slot in the regular waiver is available. Clients approved for SW will be able to choose to receive those services as either Self-Directed or Agency-Based (traditional) model.

DOH maintains the DD wait list and will be responsible for identifying and releasing allocation to the Supports Waiver. An Allocation packet is given to the client who is instructed to submit a Medicaid application to ISD and LOC to the TPA. The LOC request is evaluated and if approved is entered into Omnicaid by the TPA.

In Omnicaid we will identify approvals for SW by entering long term care spans with a Level of Care 'MR0' and new Setting of Care values. We will report these approvals to the MCOs in the roster and the LTC file using existing fields that capture LTC spans by establishing Two New

Setting of Care values to be associated with MR0 Level of Care – 'SWD' Supports Waiver Self Directed and 'SWA' Supports Waiver Agency Directed. Just like regular DD Waiver services, the Support Waiver services are not provided by the MCO and when a client is approved for Supports Waiver any MCO Community Benefit service would be discontinued.

Long Term Care Interface File

HSD produces a monthly Long Term Care file that contains recipients enrolled in Centennial Care that have overlapping LTC spans with a nursing facility (NFL) or Non-nursing facility (MR0) level of care going back two years. Recipients with DD/MF waivers should not be in a NFL level of care. This file is provided as a reconciliation file and should be used by the MCO to match against the LTC spans on their files to ensure both systems have the same information. If data is out of synch, the MCO should contact HSD to report the difference and either correct on their system or send corrections to Omnicaid via the MCO to HSD file.

In addition to the monthly file, HSD produces a daily LTC Interface file that reports any LTC span that was updated since the previous night's cycle. This is done so that the MCO will have up to date information re: any LTC spans entered. The daily file is sent to show updates received but is also intended as a way for the MCO to validate what they have against what is in Omnicaid.

If a DD or Med Frag Waiver Prior Auth is added for a member, this authorization will be shown on the daily and monthly file as a Long Term Care Span so that the MCO can better coordinate.

The file layout for both the monthly and daily LTC Interface file is:

```
01 HEADER-RECORD.
   05 HEADER-TYPE      PIC X(02).
   05 FILLER           PIC X(01).
   05 HEADER-MCO       PIC X(30).
   05 FILLER           PIC X(03).
   05 HEADER-DATE      PIC X(8).
   05 FILLER           PIC X(01).
   05 HEADER-DESC      PIC X(14.
   05 FILLER           PIC X(59).

01 DETAIL.
   05 RECIP-MCD-CARD-ID-NO  PIC X(10).
   05 SYS-ID           PIC 9(9).
   05 MCO-P-ID         PIC X(8).
   05 LTC-SPN-BEG-DT   PIC X(10).
   05 LTC-SPN-END-DT   PIC X(10).
   05 LTC-P-ID         PIC X(8).
   05 LOC              PIC X(3).
   05 LAST-ASSESS-DT   PIC X(10).
   05 SOC              PIC X(03).
   05 LTC-ADD-USER     PIC X(07).
   05 LTC-ADD-DT       PIC X(10).
   05 LTC-UPD-USER     PIC X(07).
   05 LTC-UPD-DT       PIC X(10).
```

```
   05 COE-SPN-BEG-DT    PIC X(10).
   05 FILLER            PIC X(01).
   05 COE-SPN-END-DT    PIC X(10).
   05 FILLER            PIC X(01).
   05 COE-CD            PIC X(03).


01 TRAILER-RECORD.
   05 TRAILER-TYPE      PIC X(2).
   05 FILLER            PIC X(1).
   05 TRAILER-COUNT     PIC 9(9).
   05 FILLER            PIC X(106).
```

Target Field	Std Edit	Req	Def	Specifications	Note Ref
MEDICAID-CARD-ID		A	X(10)	This will either be the SYS-ID preceded by a '3' for clients Medicaid eligible prior to 12/4/2017 or the ASPEN-MCI-ID preceded by a '2' for new clients who are first time eligible as of 12/4/2017	
SYS-ID		A	9(09)		
MCO-P-ID		A	X(08)		
LTC-SPN-BEG-DT		A	X(10)	For DD/MF Waiver, this is the PA effective date	
LTC-SPN-END-DT		A	X(10)	For DD/MF Waiver, this is the PA effective date	
LTC-P-ID		A	X(08)	For DD and MF Waiver, this will be the provider ID from the authorization	
LOC		A	X(03)	The DD/MF waiver authorizations will be reported here with LOC = 'DDW' OR 'MFW'. For MiVia and Supports Waiver authorizations LOC = MR0	
LAST-ASSESS-DT		A	X(10)		
SOC		A	X(03)	For Mi Via waiver authorizations SOC = 'MIV'. Supports Waiver authorizations will be reported here with SOC = 'SWD' or 'SWA'	
LTC-ADD-USER		A	X(10)		
LTC-ADD-DT		A	X(10)		
LTC-UPD-USER		A	X (07)		
LTC-UPD-DT		A	X(10)		
COE-SPN-BEG-DT		C	X(10)		1
FILLER			X (01)		
COE-SPN-END-DT		C	X(10)		
FILLER			X (01)		
COE-CD		C	X(03)		

Notes:

1) The COE data will only appear if the recipient had a COE of 095/096 and is being reported with a Mi Via, Supports Waiver, DD Waiver or Med Frag Waiver.

Long term care Claims rules
The following rules for Community Benefit and Nursing Facility claims and encounters will serve as clarification to issues identified by HSD and/or the MCOs regarding edits that need to be in place to ensure the MCOs' correct payment of claims and submission of encounters.

COMMUNITY BENEFIT CLAIMS/ENCOUNTER RULES
Correct payment of Community Benefit services requires attention to the Provider billing the claim, the services on the claim and the client and their eligibility and approval for long term care services.

PROVIDER:

1. The ONLY provider type allowed on a Community Benefit encounter is the provider type 363 which is matched to the taxonomy 3747P1801X submitted on encounters. Provider Type 344 is the waiver provider type for clients in the DD and Med Frag waiver or Supports waiver for which we pay via FFS and is not allowed to bill for services rendered under Centennial Care. There are a small number of instances where a nursing facility is allowed to render respite services for a short period. The time frame is usually 5 or 6 days and is not commonly used.
2. Many providers who are enrolled as a Community Benefit provider (type 363) are also enrolled as other types of providers. These include provider types 324 Private Duty Nursing, 361 Home Health, 301 Physician, 211-212 Nursing Facility, 311 Clinic, OT, PT and ST Therapists (451-455), 344 Med Frag and DD waiver, 362 Hospice, etc. Because the provider may have multiple lines of business, it is possible that the provider may get confused and bill a Community Benefit service using a taxonomy that is not Community Benefit or vice versa. This means that the MCO must have in place sufficient edits that compare the taxonomy on the claim to the procedure codes on the claim to prevent payment if the procedure code is only allowed for Community Benefit and the taxonomy isn't 3747P1801X. Please refer to the list of taxonomy to provider type crosswalk to see what taxonomies relate to which Omnicaid provider types.
3. **EPSDT** – A child in need of support services should always receive those services through EPSDT instead of Community Benefit if possible. An agency approved to render EPSDT services (additional services children under the age of 21 may receive) is NEVER a Community Benefit provider (provider type 363). Provider Type 324, Private Duty Nursing providers may bill EPSDT aide and nursing services as an EPSDT service. See NMAC 8.320 for more details about EPSDT providers and covered services.

SERVICES:

1. There should never be a community benefit service paid to a provider other than PT 363, unless that service is:

a. Respite allowed to be billed by the nursing facility for a short term, or
b. Allowed as an EPSDT service for a client under age 21, in which case it is not Community Benefit and should not be billed by PT 363 (see #5 below).

Nor should there ever be an encounter for provider type 363 which contains any procedure not allowed on the Community Benefit procedure code list. *Any encounter claim line from a provider type 363 with a procedure that is not a Community Benefit will be denied with Omnicaid exception 0281.* There are 2 lists of procedure codes allowed for Community Benefit: Agency-Based Codes and Self-Directed Codes:

Agency-Based Services, Service Codes and Applicable Units of Service

SERVICE TYPE	CODE	UNIT INCREMENTS 1 UNIT =
Adult Day Health	S5100	15 minutes
Assisted Living	T2031	Day
Community Transition Services	T2038	Per service
Emergency Response	S5161	Month
Emergency Response High Need	S5161 U1	Month
Environmental Modifications	S5165	1 unit per project
Behavior Support Consultation	H2019	15 minutes
Behavior Support Consultation, Clinic Based	H2019TT	15 minutes
Employment Supports	H2024	Day
Home Health Aide	S9122	Hour
Nutritional Counseling	S9470	Hour
Personal Care-Consumer Directed	99509	Hour
Personal Care-Consumer Delegated	T1019	15 minutes
Personal Care-Directed training	S5110	15 minutes
Personal Care-Directed-Administrative Fee	G9006	1 unit + 1 month
Personal Care-Directed Advertisement Reimbursement Fee	G9012	1 Advertisement
Private Duty Nursing for Adults – RN	T1002	15 minutes
Private Duty Nursing for Adults – LPN	T1003	15 minutes
Respite RN	T1002 U1	15 minutes

SERVICE TYPE	CODE	UNIT INCREMENTS 1 UNIT =
Private Duty Nursing for Adults – LPN	T1003 U1	15 min
Respite	99509 U1	Hour
Physical Therapy for Adults	G0151	15 minutes
Occupational Therapy for Adults	G0152	15 minutes
Speech Language Therapy for Adults	G0153	15 minutes

Personal Care Services (PCS) Consumer Directed Model Code Definitions

Personal Care Consumer-Directed	99509	Hour	The rate for ongoing attendant services. The rate includes both the employee's and the employer's share of Social Security withholding and the cost for worker's compensation insurance. The maximum number of hours billable is determined by the authorization issued by the MCO which must be approved by the MCO Medicaid Utilization Review Department.
Personal Care Consumer-Directed Training	S5110	15 minutes	The rate for training provided to the consumer or their attendant at the request of the consumer. There is an annual maximum of eight (8) hours of training allowed per consumer.
Personal Care Consumer-Directed Advertisement Reimbursement Fee	G9012	1 unit = 1 advertisement	The maximum allowable rate for advertising. Consumers are reimbursed for up to two (2) advertisements per year if seeking a new Personal Care Attendant. If the billed amount exceeds the maximum allowable rate, the billed amount will be reduced to the maximum allowable rate. The advertising reimbursement is allowed only for actual and necessary advertising. Documentation is required in the case file.
Personal Care Consumer-Directed Administrative Fee	G9006	1 unit = 1 month	The rate for fiscal intermediary tasks such as processing payroll for the consumer's Personal Care Attendants,

			producing reports required by the Medical Assistance Division, processing claims for Consumer-Directed Personal Care services (including Income Tax and Social Security withholding) and submitting billings to the MCO.

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Self-Directed Personal Care	99509	99509	Hour	minimum wage - $14.60
HH Aide	S9122	S9122	Hour	$16.32
Employment Supports (includes Job Coach)	T2019	T2019	15 min.	$2.15 - $6.93
Job Developer (Per job that is developed for member)	T2019	T2019JD	Each	$100-$700
Customized Community Supports (adult day hab.)	S5100	S5100	15 min.	$1.36-$8.82
PT	G0151	G0151	15 min.	$13.51 - $24.22
OT	G0152	G0152	15 min.	$12.74 - $23.71
Speech/Language Pathology	G0153	G0153	15 min.	$16.06 - $24.22
Behavior Support Consultation	H2019	H2019	15 min.	$12.24 - $20.65
Private Duty Nursing – Adults- RN	T1002	T1002	15 min.	$10.90
Private Duty Nursing – Adults- LPN	T1003	T1003	15 min	$6.79
Nutritional Counseling	S9470	S9470	Hour	$42.83
Acupuncture	97810	97810	15 min.	$12.50-$25.00
Biofeedback	90901	90901	Visit	$50.00-$100.00
Chiropractic	98940	98940	Visit	$50.00-$100.00
Cognitive Rehabilitation Therapy	97532	97532	15 min.	$12.50-$25.00
Hippotherapy	S8940	S8940	Visit	$50.00-$100.00
Massage Therapy	97124	97124	15 min.	$12.50-$25.00
Naprapathy	S8990	S8990	Visit	$50.00-$100.00
Native American Healers	S9445	S9445	Session	As approved by MCO
Respite Standard (not provided by RN, LPN or HHA)	T1005	T1005SD	15 min.	$3.38
Respite RN	T1005	T1005RN	15 min.	$10.90
Respite LPN	T1005	T1005LPN	15 min.	$6.79
Respite HH Aide	T1005	T1005HHA	15 min.	$4.08

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Emergency Response (monthly fee)	S5161	S5161	Each	$36.71-$40.79
Emergency Response (testing and maintenance)	S5160	S5160	Each	As approved by MCO
Environmental Modifications	S5165	S5165	Each	As approved by MCO (maximum of $5,000 every 5 years)
Transportation Mile	T2049	T2049	Per Mile	$0.34-$.40
Transportation Commercial Carrier Pass	T2004	T2004	Each	As approved by MCO
Start Up-Goods	T2028	T2028	Each	As approved by MCO
Fees and Memberships	T1999	T1999CP-I	Each	As approved by MCO
Coaching/education for parents, spouse or others (not available for paid caregivers)	T1999	T1999CE-I	Each	As approved by MCO
Coaching/education for parents, spouse or others classes only (not available for paid caregivers)	T1999	T1999CL-I	Each	As approved by MCO
Coaching/education for parents, spouse or others conferences and seminars (not available for paid caregivers)	T1999	T1999CS-I	Each	As approved by MCO
Technology for Safety and Independence	T1999	T1999TS	Each	As approved by MCO
Cell phone service (including data/GPS)	T1999	T1999CELL	Each	$0.00-$100.00
Cell phone and related equipment	T1999	T1999CPEP	Each	As approved by MCO
Cell phone/landline	T1999	T1999CPL	Each	As approved by MCO
Internet service	T1999	T1999IS	Each	As approved by MCO
Landline service	T1999	T1999LS	Each	As approved by MCO
Internet/cell phone	T1999	T1999IC	Each	As approved by MCO
Internet/cell phone/landline	T1999	T1999ICL	Each	As approved by MCO
Internet/landline	T1999	T1999IL	Each	As approved by MCO
Fax machine	T1999	T1999FX	Each	As approved by MCO

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Computer	T1999	T1999CR	Each	As approved by MCO
Office supplies	T1999	T1999OS	Each	As approved by MCO
Printer	T1999	T1999PR	Each	As approved by MCO
Health-related equipment and supplies	T1999	T1999HR-I	Each	As approved by MCO
Adaptive equipment and supplies	T1999	T1999AE-I	Each	As approved by MCO
Exercise equipment and related items	T1999	T199EE-I	Each	As approved by MCO
Nutritional supplements	T1999	T1999NS-I	Each	As approved by MCO
OTC medications	T1999	T1999OM-I	Each	As approved by MCO
Household related goods	T1999	T1999HG-I	Each	As approved by MCO
Appliances for independence	T1999	T1999AI-I	Each	As approved by MCO
Adaptive furniture	T1999	T1999AF-I	Each	As approved by MCO

2. Community Benefit Services must be edited to ensure that the units billed do not exceed what is reasonable based on the unit definition. For example, it is unreasonable for there to be more than 24 units of 99509 billed in a day since this is an hourly code. It is unreasonable for there to be more than 31 units of T2031 billed in a month with 31 days since this is a per diem code. And so on.
3. You may not allow providers to routinely bill units for an entire month regardless of which days service was provided. Doing this creates a problem with duplicate edits and will be disallowed by auditors. For example, a claim showing dates of service 9/1/16-9/30/16 for 20 units can create a problem if the 20 units were in fact only used between 9/1 and 9/17, for example, or if the client leaves at some point to enter a nursing facility or hospital or hospice or dies, etc. The service should be billed only for the days service was rendered. Days can be grouped together on a claim, but only if services were rendered every day within that span. For the most part, with Community Benefit services (except for those that are billed on a per diem or monthly basis), you can't tell if this is the case or not, so providers should be instructed to report separately each service by the exact day or span of days it was rendered. This is regardless of whether the claim is for Agency-Based or Self-Directed.

4. The MCO must have edits in place to deny Community Benefit claims submitted for dates of service that overlap dates the client was not in the home; either dates of hospitalization or rehab, or for dates the client was not eligible and enrolled with the MCO.
5. **EPSDT** - There are some procedure codes that are defined as both Community Benefit and EPSDT codes. These are: Home Health Aide, PT, OT and Speech services: S9122, G0151, G0152, G0153. When these services are rendered to a client under the age of 21, they must be billed by a provider other than a Community Benefit provider and the client shouldn't have a long term care span solely to receive the service (the client who receives EPSDT services, could, however, also be receiving some other Community Benefit service not available through EPSDT for which they would require a long term care span). No other Community Benefit procedure code than these 3 above should ever be billed as an EPSDT service.

   A Private Duty Nursing Agency (PT 324) with a NM DOH Home Health agency is intended to be the default provider for skilled nursing under the EPSDT benefit; although an FQHC is also allowed to bill EPSDT services. Private Duty Nursing services should be billed using a combination of revenue code and procedure code (if billed on the UB-04/837I) or procedure code only (if billed on the CMS1500/837P)allowed for Private Duty Nursing and FQHC providers. These revenue codes are 0550-0552 and procedure code is T1000 TD and TE. See NMAC 8.320 for more details about EPSDT covered services.

   For clients in need of personal care type services, the appropriate procedure code under EPSDT S5125 is allowed as Attendant Care rendered by a provider type 324 and if billed on the UB-04/837I,the appropriate revenue code 0570 - 0572 HOME HEALTH AIDE must be included.

   Providers who are required to provide electronic visit verification may bill a stipend for caregivers to utilize their personal smartphone and existing data plan. The entire stipend must be paid to the caregiver and the agency may not retain any of it. All stipend payments made by the MCOs are inclusive of gross receipts tax (GRT). The code G9005 is the code to be billed under EPSDT as the EVV Stipend. When billed by the Home Health Agency, bill the G9005 with the revenue code 0569 MEDICAL SOCIAL (HOME HEALTH)- OTHER MEDICAL SOCIAL SERVICES.

6. **Environmental Mods Only** – It is not a valid use of the Community Benefit to authorize a client whose only need is for Environmental Modifications. HSD is reviewing claims for clients authorized for Community Benefit where this is the

only service used and will be communicating to the MCOs about actions to be taken.

CLIENT

1. There should never be an encounter submitted with a taxonomy 3747P1801X (provider type 363) for whom we do not already have a long term care span showing a community benefit setting of care. *Any Community Benefit encounter submitted without a matching LTC span will be denied with exception 0331.*
2. There should never be a community benefit setting of care entered into our system by the MCO for a client for whom we don't have a community benefit encounter submitted within at least 120 days of the SOC begin date. *HSD will be running routine queries of encounters against Community Benefit SOC spans and adjusting capitations paid at the long term care cohort when encounters are not present.*
3. **EPSDT** - Members under the age of 21 are eligible for a wider range of services through the EPSDT benefit. Special Rehabilitative services such as physical therapy, speech therapy, occupational therapy, hearing and language services, behavioral health services, case management and EPSDT PCS and Private Duty Nursing services are all covered EPSDT services. A client receiving these services is not considered a client receiving Community Benefit and a long term care span should not be entered for them, unless they are also eligible for and receiving some other Community Benefit service not covered under EPSDT.
4. **ABP Exempt** – Client with a COE 100 must always have been identified with a Disability Type Code with a begin date that is less than or equal to the date you are approving them for Community Benefit. The dates do not need to be in synch with the Community Benefit NFL SOC span, only that it is entered starting on or before the NFLOC span.

NURSING FACILITY CLAIMS/ENCOUNTER RULES

1. The ONLY provider type allowed on a Nursing Facility encounter is the provider type 211 or 212 and in order for the encounter to be recorded as a long term care encounter it must have type of bill codes 65X, 66X, 69X, 86X, 89X, 21X, 22X
2. There should never be a non-crossover encounter submitted with a provider type 211, 212 for greater than a 120 day stay for a client for whom we do not already have a long term care span showing a nursing facility setting of care. *Any Nursing Facility encounter submitted without a matching LTC span will post an exception 0331, but will not be denied. Staff will periodically review all nursing facility encounters that post 0331 to determine if the stay was in fact a short term stay.*
3. There should never be a nursing facility setting of care entered into our system by the MCO for a client for whom we don't subsequently receive a nursing facility

encounter submitted within at least 120 days of the SOC begin date (***or Client Enrollment Add Date, if >= SOC Begin Date***). If for some reason, the client doesn't end up utilizing the nursing facility, the NFL/INF span should be voided or terminated. *HSD will be running routine queries of encounters against Nursing Facility SOC spans and adjusting capitations paid at the long term care cohort when encounters are not present.*

4. MCOs should not be denying nursing facility claims for timely filing based solely on the Admit date, but must also compare against the date the enrollment was added. If the client's enrollment add date is after the claims's last date of service, The client's enrollment add date should be used to determine whether the claim has been timely filed. For example, a client approved in September with retro enrollment to May, should not have their nursing facility claim denied for May and June based on a 90 day timely filing rule since the enrollment begin date didn't get added until September .
5. When a client changes nursing facility or the nursing facility has a change of ownership that changes the Provider Id from what is on the Long Term Care Span, the MCO is responsible for sending an update to that span. *Failure to do so, will result in Exception 0336 denying the nursing facility claim.*
6. Nursing Facilities should not be allowed to bill routinely with first of the month and last of the month, but in fact the actual span of days the client was in the facility. Routinely billing the entire month of days regardless of the days covered results in errors and audit findings.
7. Clients in Hospice, provider type 362, who are in Nursing Facilities have their claims submitted by the hospice provider using revenue codes 0658/0659. The MCO must not pay the nursing facility directly since that payment is made by the Hospice provider. And, there must be a long term care span showing SOC = INF. *Any Nursing Facility encounter submitted with the Hospice Revenue Codes 0658 or 0659 without a matching LTC span will be denied with exception 0331.*
8. Claims from Nursing Facilities and Hospice should not have ancillary charges in addition to the per diem codes. The per diem codes are intended to cover **all** services the NF offers.
9. **ABP Exempt** – Client with a COE 100 must always have been identified with a Disability Type Code with a begin date that is less than or equal to the date you are approving them for Nursing Facility. The dates do not need to be in synch with the Nursing Facility NFLOC SOC span, only that it is entered starting on or before the NFLOC span.

LONG TERM CARE EDITS

The following Edits will post and deny for Encounters:

0281 Service Not Allowed For Community Benefit Provider - this is a new edit that will be set to Deny effective March 1, 2017

This new Edit will post to the line when the billing provider is type 363

And

Document type = E (Encounter)

And

Billing Provider Specialty is not 078 and procedure code is **NOT** on system list 4860 (Agency Based Codes)

OR

Billing Provider Specialty is 078 and procedure code is **NOT** on system list 4861 (Self Directed Codes)

0331No LTC Span Available For First Date Of Service – this is an edit that is set to deny already.

If the Provider Type is 211 or 212 and the admit date is more than 120 days prior to the claim LDOS,

If true, then check for a non-voided LTC span where the span begin date is <= the Claim LDOS and the span end date >= claim FDOS where the Level of Care of 'NFL' and Setting of Care of 'INF'.

If not found, then post the exception 0331.

If found, then confirm that the span begin date <= FDOS. If not, then post exception 0331. If the span begin date is <= FDOS, then continue to exception 0709.

If the Provider Type is 362 and Revenue Code is 0658 or 0659 and the admit date is more than 120 days prior to the claim LDOS

If true, then check for a non-voided LTC span where the span begin date is <= the Claim LDOS and the span end date >= claim FDOS where the Level of Care of 'NFL' and Setting of Care of 'INF'.

If not found, then post the exception 0331.

If found, then confirm that the span begin date <= FDOS. If not, then post exception 0331. If the span begin date is <= FDOS, then continue to exception 0709.

If the Provider Type is 363

If true, then check for a non-voided LTC span where the span begin date is <= the Claim LDOS and the span end date >= claim FDOS where the Level of Care of 'NFL' and Setting of Care of 'ANW', 'SNW', 'ADB', or 'SBD'.

If not found, then post the exception 0331.

If found, then confirm that the span begin date <= FDOS. If not, then post exception 0331. If the span begin date is <= FDOS, then continue to exception 0709.

0336 Billing Provider Not Authorized by LTC Span or Lockin– this is an edit that is set to deny already.

The nursing facility provider ID in the Long Term Care span does not match the nursing facility claims billing provider ID. .

Care Coordination, Administration and Support Broker

Care Coordination

The MCO registers itself as the provider of Care Coordination as provider type 222. PT 222 Care Coordination is allowed to bill the following range of codes:
98967 98968 96160 G9012 S5190 T2024
when that care coordination has been rendered by the MCO itself.

If the client is in CareLink NM, care coordination is part of the service that the CLNM provider renders and is billed to the MCO and comes to Omnicaid as a CareLink encounter. The MCO may not bill Care Coordination under their provider type 222 using procedure code T2024 for months the client is enrolled in CareLink NM.

MCO Administrative Services/Support Broker Services

The MCO registers itself as the provider of Administrative services as provider type 223. We initially set this up to accommodate any administrative services rendered by MCO staff other than Care Coordination. HSD needs to know the support broker services utilized by the client but does not need to know the specific support broker who rendered the support. Therefore, any support broker services, whether rendered directly by MCO staff or contractors or by agencies contracted with the MCO, should be submitted as encounters to Conduent using the MCO's provider type 223 on the Professional claim type with procedure code T2025. Individual Support Brokers should not be enrolled with Omnicaid. The intention of this is to allow an MCO to submit Support Broker services for its Self Directed Community Benefit population (not the Mi Via population for whom all Mi Via and related services are handled completely outside of Centennial Care).

Since the provider types 222 and 223 are utilized by the MCOs and the MCOs do not bill with NPI and taxonomy, the MCO provider records have been established with different zip codes since the zip code would be the only differentiation with the MCO's FEIN to map to the provider record. Please note the zip codes established for each provider type and submit encounters accordingly.

MANAGED CARE TO HSD INTERFACE FILE

The Managed Care Organization is responsible for submitting a daily interface file to report on clients whose status has changed in any way. This includes notification of:

- Client's most recent assessment type (HRA (H), CNA (C), NTM (N), DMR (D)), level code and date
- Client's most recent categorization status and date of categorization
- PCP assignment,
- NF level of care and setting of care – new assignments or changes,
- Community long term care assignment or change,
- Health Home assignment,

If the MCO does not have any changes to report, a file is not sent.

Conduent transfers the MCO to HSD files to the mainframe at 8 PM EDT from DMZ, so it is recommended that the MCOs post their files no later than 7:45 PM EDT. .

The file layout for this file (MCOASMNT.mmddyyyy.zip) is as follows. All Date fields are in the format ccccmmdd:

```
01  WFB46050-INPUT-RECORD.
*
     05  WFB46050-DATA                          PIC X(188).
*
     05  WFB46050-DATA-X        REDEFINES WFB46050-DATA.
         10  WFB46050-RECORD-TYPE               PIC X(001).
         10  WFB46050-INPUT-DATA                PIC X(204).
*
     05  WFB46050-HEADER-RECD   REDEFINES WFB46050-DATA.
         10  WFB46050-HEADER-REC                PIC X(01).
         10  WFB46050-MCO-PROVIDER-ID           PIC X(08).
         10 FILLER                             PIC X(02).
         10  WFB46050-FILE-CREATE-DATE          PIC X(08).
*
     05  WFB46050-DETAIL-RECD   REDEFINES WFB46050-DATA.
         10  WFB46050-DETAIL-REC                PIC X(01).
         10  WFB46050-MEDICAID-SWIPE-ID         PIC X(14).
         10  WFB46050-B-FST-NAM                 PIC X(15).
         10  WFB46050-B-LAST-NAM                PIC X(21).
         10  WFB46050-B-DOB-DT                  PIC X(08).
         10  WFB46050-CARE-COORD-DT             PIC X(08).
         10  WFB46050-CARE-COORD-TY             PIC X(01).
         10  WFB46050-CARE-COORD-LVL            PIC X(01).
         10  WFB46050-CARE-COORD-EFF-DT         PIC X(08).
         10  WFB46050-CARE-COORD-END-DT         PIC X(08).
         10  WFB46050-PROVIDER-NPI              PIC X(10).
         10  WFB46050-PCP-ASSIGN-EFF-DT         PIC X(08).
         10  WFB46050-LTC-ASSESS-DT             PIC X(08).
         10  WFB46050-NF-LVL-CARE               PIC X(03).
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           10  WFB46050-NF-LVL-CARE-EFF-DT       PIC X(08).
           10  WFB46050-NF-LVL-CARE-END-DT       PIC X(08).
           10  WFB46050-CARE-SETTING             PIC X(03).
           10  WFB46050-CARE-SETTING-ID          PIC X(10).
           10  WFB46050-HLTH-HOME-TY-CD          PIC X(01).
           10  WFB46050-HLTH-HOME-NPI            PIC X(10).
           10  WFB46050-HLTH-HOME-EFF-DT         PIC X(08).
           10  WFB46050-HLTH-HOME-END-DT         PIC X(08).
           10  FILLER                            PIC X(15).
           10  WFB46050-DISABIL-TY-CD            PIC X(03).
           10  WFB46050-DISABIL-EFF-DT           PIC X(10).
           10  WFB46050-DISABIL-END-DT           PIC X(10).

*
       05  WFB46050-TRAILER-RECD  REDEFINES WFB46050-DATA.
           10  WFB46050-TRAILER-REC              PIC X(01).
           10  WFB46050-TRLR-RECD-CNT            PIC 9(05).
           10  FILLER                            PIC X(198).
*
```

Source Field	SIZE	Std Edit	REQ	Specifications
HEADER-RECORD		N/A	N/A	
RECORD-TYPE	Character (1)	N/A	A	H = HEADER
MCO PROVIDER ID	Character (8)	N/A	A	The Centennial Care MCO Provider ID
FILE-CREATE-DATE	Date	N/A	A	Date formats should be ccccmmdd

Source Field	SIZE	Std Edit	REQ	Specifications
DETAIL-RECORD				
RECORD-TYPE	Character (1)	N/A	A	D = DETAIL
MEDICAID ID CARD NUMBER	Character (14)	N/A	A	This is the swipe card id of the Medicaid client. Must be numeric.
MEMBER FIRST NAME	Character (15)	N/A	A	Cannot be spaces
MEMBER LAST NAME	Character (21)	N/A	A	Cannot be spaces
MEMBER DATE OF BIRTH	Date	N/A	A	Must be a valid date if entered (format ccccmmdd)
The following fields for Care Coordination and Health Home are only completed by the MCO for clients not approved for health home by CareLink NM (CLNM). Once a client is in CareLink HH (CC values 6,7,8,9,) the MCO does not do the comprehensive needs assessment; the HH does and it is recorded within BHSD Star. The HRA is always done by the MCO, and if the client goes into CLNM before a HRA is conducted, the need for it is waived; the HH does not do it – rather the CNA takes its place.				
C ASSESSMENT DATE	Date	Date	C	Must be a valid date if entered. This is filled in any time the MCO **attempts or completes a Health Risk Assessment (HRA) or a Comprehensive Needs Assessment (CNA);;** required initially wi/30 days of enrollment and then ongoing whenever there is a health risk assessment. Client may be assigned care coordination or health home as a result of this assessment. IF CARE COORDINATION ASSESSMENT TYPE IS PRESENT, CC ASSESS DT IS REQUIRED. ALSO, IF CARE COORDINATION ASSESSMENT IS POPULATED, THE CARE COORDINATION LEVEL AND DATES

Source Field	SIZE	Std Edit	REQ	Specifications
				MUST ALSO BE ENTERED. SEE NOTE AT END OF THE FILE LAYOUT
CARE COORDINATION ASSESSMENT TYPE	Character (1)	N/A	C	Defines the type of assessment being reported. Valid Values: D - Data Mining Review N – New To Medicaid Review H – Health Risk Assessment C – Comprehensive Needs Assessment The Health Risk Assessment (HRA) is always done by the MCO unless the client goes into CareLink NM before one is completed, in which case the HRA is waived. IF CARE COORDINATION ASSESSMENT DATE IS PRESENT, CC ASSESS TYPE IS REQUIRED
CARE COORDINATION LEVEL	Character (1)	Y	C	Must be a valid value: 0 Client Unable to be reached 1 Member considered in General Population 2 Care Co. Level 2 3 Care Co. Level 3 4 Client Refused Care Coordination 5 Client Difficult to Engage A Shared Functions- Level 2 B Shared Functions- Level 3 C Full Delegation- Level 2 D Full Delegation- Level 3 **THE FOLLOWING ARE VALID VALUES BUT ARE ASSIGNED BY CARELINK NM AND NOT ALLOWED TO BE ENTERED BY THE MCO** 6 – Health Home Care Coord – lowest level 7 – Health Home Care Coord – mid-level 8 – Health Home Care Coord – awaiting level evaluation 9 – Health Home Care Coord – high intensity – DISCONTINUED EFF 8/1/2023 IF CARE COORDINATION LEVEL 1 thru 3 or A thru D IS PRESENT, CC ASSESS DT AND TYPE EITHER MUST ALREADY BE ON FILE WITH DATE WITHIN THE PAST 12 MONTHS OR IS REQUIRED TO BE SUBMITTED WITH THIS FILE AND CARE COORDINATION EFF AND END DATE IS REQUIRED
CARE COORDINATION EFFECTIVE DATE	Date	Date	C	Required if client is assigned care coordination levels 1 thru 3 or Values A thru D. Must be a valid date if entered. IF CARE COORDINATION EFF DATE IS PRESENT, CC LEVEL AND CC END DT IS REQUIRED
CARE COORDINATION END DATE	Date	Date	C	Required if care coordination effective date is populated. Open ended date is 99991231. IF CARE COORDINATION END DATE IS PRESENT, CC LEVEL AND CC EFF DT IS REQUIRED
PCP ASSIGNED PROVIDER NPI	Character (10)	N/A	C	Must be a valid NPI number. Not Required for dual eligible clients, If the PCP assigned date is present, the PCP provider ID must be present
PCP ASSIGNED EFFECTIVE DATE	Date	Date	C	Must be a valid date If the PCP provider ID is identified, there must be a PCP assigned date present
LTC ASSESSMENT DATE	Date	Date	C	Date of most recent LTC Assessment.** Must be a valid date Reported as the most recent LTC assessment when first reported and thereafter only reported when the LTC assessment is completed IF a LTC assessment is completed, it is assumed that there will be an update to the NF LOC dates. Even if there is no change to the NF LOC and SOC, all the LTC fields must be completed.
NF LEVEL OF CARE	Character (3)	Y	N	Must be a valid value: NFL is the only valid value that can be reported by the CC MCO Only reported if an assessment has been completed, a change In the LTC span is being made, or if there is a termination of NFL LOC
NF LEVEL OF CARE	Date	Date	N	Must be a valid date Must be submitted with the NF Level of Care,

Source Field	SIZE	Std Edit	REQ	Specifications
EFFECTIVE DATE				NFL, to indicate a renewed LTC span associated with an annual assessment or to indicate a change in the setting of care. If you are sending a termination to the NF LOC, this date should be the same as the last effective date submitted (which will be reflected in the Enrollment Roster file). **If the SOC= 'INF', this date can be entered retroactively. If the SOC is one of the Community Benefit values (ADB, ANW, SDB, SNW), this date may never be prior to the first day of the upcoming month. If extenuating circumstances exist the MCO can contact HSD to request an exception.**
NF LEVEL OF CARE END DATE	Date	Date	N	Required if NFL Level of Care effective date is populated. **Cannot be greater than one year after the effective date, UNLESS the client is being approved for continuous NFLOC. If approved for continuous NFLOC, the end date should be entered as 99991231..**
SETTING OF CARE	Character (3)	Y	C	Required if level of care is "NFL". Must be submitted for a reassessment, change in SOC or termination of LOC". Must be a valid value: INF,ADB, SDB, ANW, SNW.
SETTING OF CARE PROVIDER ID	Character (10)	N/A	C	This is the provider NPI number or Provider ID for the nursing facility or primary Community Services provider. Dummy provider id 99999998 allowed for SOC values of ADB and ANW. The provider id for the SOC values SDB or SNW should be the FMA Provider ID IF the client is in a Nursing Facility, this must be a valid NPI on file with Omnicaid. If the client is in Self Directed, the Provider id must be entered as 78507251. If the client is in Agency Based the provider id should be entered as 99999998
HEALTH HOME TYPE	Character (1)	Y	C	Required if client is assigned to a health home or project that is similar to a health home as indicated by the presence of a health home provider and assignment date. Not required if member assigned to Health Home by Carelink Must be a valid value: A – ECHO CARE B - CSA (Core Service Agency) THE FOLLOWING IS A VALID VALUE BUT CAN NEVER BE ASSIGNED BY THE MCO. C - CARELINK NM (cannot be entered by the MCO)
HEALTH HOME ASSIGNED PROVIDER NPI	Character (10)	N/A	C	Required if client is assigned to a Health Home other than CareLink NM . Not required if member assigned to Health Home by Carelink
HEALTH HOME EFFECTIVE DATE	Date	Date	C	Required if client is assigned to a health home. Must be a valid date.
HEALTH HOME END DATE	Date	Date	C	Required if Health Home effective date is populated. Open ended date is 99991231.
DISABILITY TYPE CODE	Character (3)	V	N	This code only pertains to clients with ABP category 100. Do not send for any other clients. Valid Values are: PH – Physical – denotes client requires assistance with 1 Activity of Daily Living (ADL) ME –denotes Client receiving tx for Substance Abuse If the client meets the criteria for both; the MCO shall designate 'ME' as the higher priority code.
DISABILITY EFFECTIVE DATE	Date	Date	C	Date on which the client has been determined by the MCO to have the Disability Type Code noted above. This cannot be < 1/1/2014 and must be < Disability End Date
DISABILITY END DATE	Date	Date	C	Date on which the Disability Type Code ends. Default date is open-ended 99991231

Source Field	SIZE	Std Edit	REQ	Specifications
PROV-TRAILER-RECORD	Character (1)	N/A	A	T = TRAILER
RECORD-COUNT	Number 99999	N/A	A	Count of all detail records sent in file 5 digits, right justified, zero filled

Care Coordination Assessment and Level Data Requirements

Effective July, 2021, HSD has two new Care Coordination assessment types; valid value 'N' which stands for New to Medicaid Review and valid value 'D' which stands for Data Mining Review. The MCO shall adhere to all contract requirements to complete the HRA. These new values will only be allowed when submitted with a CC Level 0, 1, 4 or 5 as outlined below. Conversely, the existing values of H (HRA) or C (CNA) can be submitted with any CC Level.

1. The MCO's use of the assessment type 'N' is intended for those instances where the client is new to Medicaid and the MCO is unable to complete the required HRA within 30 days, due to the Member being Unable to Reach (CCL0-UTR), Refused Care Coordination (CCL4-RCC) or Difficult to Engage (CCL5-DTE). The assessment date associated with the type 'N' would be the date the MCO completed all contract required attempts to complete the HRA. The MCO shall conduct data mining on Members with an assessment type 'N' after the Member has been enrolled with the MCO for one quarter. At that time, the MCO must change the Member's assessment type from 'N' to 'D', 'H' or 'C'. The assessment date associated with the new type replacing 'N' would be the date the assessment type was performed (i.e., either the date the data mining was performed or the assessment completed).

2. The MCO's use of the assessment type D is intended for those instances where the client is:

    a. Transitioning from another MCO where the client's CC Level assigned by the transferring MCO is Unable to Reach (CCL0-UTR), Refused Care Coordination (CCL4-RCC) or Difficult to Engage (CCL5-DTE) or for whom there is no prior CC span, or a prior CC span has expired. The MCO shall adhere to all contract requirements to complete the HRA. Data mining against the claims data sent by the transferring MCO must then be completed for Members with CCL0, CCL4 or CCL5 within thirty (30) Calendar Days of MCO notification of Members transition. The data mining review date associated with the type 'D' would be the date the data mining was performed.

    b. Ongoing clients where the client's CC Level is '1' (General Population), '0' (Client Unable to be Reached), '4' (Client Refused Care Coordination), or '5' (Client Difficult to Engage) and there is no indication, through a Data Mining Review, of a change in the Member's condition that would require a higher CC level. The

CCL0, CCL1, CCL4, or CCL5 Member would then be recategorized as CCL1 with an Assessment Type 'D'."

All Care Coordination Levels must have an assessment type and date on file. If the MCO submits a CC span without an assessment type and date, Omnicaid will look to see if there is already a span on file with a Care Coordination begin date that is greater to or equal to the incoming span that has a previously submitted assessment type and date. If so, Omnicaid will accept the incoming CC level and dates and copy that most recent prior existing assessment type and date into the new CC span.

An incoming CC span without an assessment type and date where there is no prior assessment type and date in an existing CC span will be rejected with error 32: CC ASSESS TYPE/DATE REQUIRED

There is no expiration for a CC assessment date; the system will not edit to ensure the assessment has been completed within the past 12 months or that Data Mining is being completed every quarter. Although there are program policy requirements related to when the MCO should conduct re-assessments, the system will not try to enforce these requirements. There will be periodic reporting HSD will do to determine if the assessment requirements are being done timely.

If an incoming span with CC Level 2, 3 or A-D is submitted with an assessment type 'D' or 'N', a new error will post to the incoming record: error 51 ASSESS TYPE D/N NOT VALID FOR CC LEVEL

When submitting a CC span for any level (including levels 0, 1, 4 or 5) for a client, an MCO must submit a CC assessment type of 'N' (NMA), 'D' (DMA), 'H; (HRA) or 'C' (CNA) along with an assessment date if an assessment type and assessment date is not already on file in Omnicaid.

Changes to the end date of a CC span without any change in CC level will just update the end date of the existing span instead of voiding and replacing it (this doesn't affect the MCOs, is just an efficiency fix). if the incoming assessment type and/or date is different from the existing as well, the system will also accept the update of these fields in addition to the end date.

If the incoming CC span overlaps an existing span, but its begin date is greater than the existing span's begin date, the system will cut back the existing span's end date to 1 day prior to the incoming span's begin date and accept the incoming span.

The system will not allow an incoming CC effective date or assessment date to be greater than 1 month in the future from the interface date. If submitted, a new error will post: error 52 CC EFF DT/ASSESS DT > 1 MONTH IN FUTURE

NOTE: Care Coordination assessments performed by the MCO must always be entered with all 5 fields populated: Assessment Date, Assessment Type, Care Coordination Level and Care Coordination Effective and End dates. If the Health Risk assessment and Comprehensive Assessment are both entered with a Care Coordination Level and Effective/End dates, the Care

Coordination Effective Date must be different for the two records as shown in the example here:

First Record

WFB46050-CARE-COORD-DT 20191103
WFB46050-CARE-COORD-TY H
WFB46050-CARE-COORD-LVL 2
WFB46050-CARE-COORD-EFF-DT 20191103
WFB46050-CARE-COORD-END-DT 99991231

Second record

WFB46050-CARE-COORD-DT 20191104
WFB46050-CARE-COORD-TY C
WFB46050-CARE-COORD-LVL 2
WFB46050-CARE-COORD-EFF-DT 20191104
WFB46050-CARE-COORD-END-DT 99991231

If the client changes care coordination level, the MCO can submit just the Care Coordination Level with the new effective and end dates without resending the Care Coordination Assessment date and type; unless a new assessment has in fact been done.

Long Term Care Data Requirements

** NOTE: Long Term Care fields are intended to be sent as a block of data. The MCO is supposed to conduct an assessment of clients in long term care at least annually based on their last assessment date. When a LTC assessment is completed, the MCO is expected to communicate the date of the assessment, the new effective date of the long term care LOC and SOC and all those associated fields (LOC, SOC, effective date, end date, and SOC provider NPI). So for example, if the client's current LTC information is as follows:

LTC ASSESSMENT DATE	6/11/2016
NF LEVEL OF CARE	NFL
NF LEVEL OF CARE EFFECTIVE DATE	7/1/2016
NF LEVEL OF CARE END DATE	6/30/2017
SETTING OF CARE	SDB
SETTING OF CARE PROVIDER NPI	9999999998

The MCO would be expected to complete a NF LOC assessment **with sufficient time to enable entry of the next years effective date** by no later than **6/30/2016**. **The Community Benefit SOC cannot be entered retroactively.** Once completed, the MCO would send the information in on the MCO to HSD file as follows (assuming no change)

LTC ASSESSMENT DATE	5/31/2017
NF LEVEL OF CARE	NFL
NF LEVEL OF CARE EFFECTIVE DATE	7/1/2017
NF LEVEL OF CARE END DATE	6/30/2018
SETTING OF CARE	SDB
SETTING OF CARE PROVIDER NPI	9999999998

If, for example, during this most recent assessment period, the client changes status and moves from the Community Benefit to a Nursing Home, the information would be sent as follows **(The SOC INF can be entered retroactively)**:

LTC ASSESSMENT DATE	11/17/2017
NF LEVEL OF CARE	NFL
NF LEVEL OF CARE EFFECTIVE DATE	11/1/2017
NF LEVEL OF CARE END DATE	10/31/2018
SETTING OF CARE	INF

SETTING OF CARE PROVIDER NPI	1902804156

If, for example, during this most recent assessment period, the client leaves the nursing facility and is no longer in a NF LOC, the information may look as follows:

LTC ASSESSMENT DATE	12/17/2017
NF LEVEL OF CARE	NFL
NF LEVEL OF CARE EFFECTIVE DATE	11/1/2017
NF LEVEL OF CARE END DATE	12/31/2017
SETTING OF CARE	INF
SETTING OF CARE PROVIDER NPI	1902804156

MANAGED CARE INTERFACE ERROR FILE

The daily files from the MCOs are used to update the Client Detail, Health Home, Care Coordination, and Long Term Care (LTC) tables. There are several distinct sections or types of data in the input file: demographic data to identify the client, data to update the client detail table, data to update the Care Coordination table, data to update the Health Home table, and data to update the Long Term Care span table. Each of these sections of data used to update Omnicaid are subject to their own sets of validation edits, and data that if invalid in one section will not cause valid data to be ignored in another section. For example, a client's LTC span data may be updated even if the Care Coordination dates are rejected as being invalid..

The following errors and error file will be produced from the running of the daily MCO to HSD interface file. Edit errors encountered during the processing of the MCO to HSD Interface will be written out to a file to be sent back to the MCOs. Errors may be critical or non critical. Critical errors will prevent updates from being made in Omnicaid.

Edit Errors produced during update**:**

Error Num	Critical/Non-Critical	Error Message	Meaning
01	Critical	CLIENT NOT FOUND	The client was not found in OMNICAID. The swipe card id is used to read the B_ALT_ID_TB. If the B_SYS_ID is not found for the swipe card id, the error will be posted. The entire record will be rejected and no further edits will be done.
02	Critical	CARE COORDINATION DATE INVALID	The care coordination date in the file is invalid in content or format. This edit is done only if the care coordination date is greater than spaces.
03	Critical	NFL LOC CODE INVALID	The facility location code, if specified, must be equal to WV-B5075-C-NURSING-FACILITY (NFL).
04	Critical	INVALID CARE COORDINATION TYPE	The care coordination type, if specified, is not "C" or "H". This is checked against the valid values table, WVB0468C.
05	Critical	SETTING OF CARE CODE MUST BE SPECIFIED	The WFB46050-CARE-SETTING from the input file must be specified. It cannot be spaces.

Error Num	Critical/Non-Critical	Error Message	Meaning
06	Critical	HEALTH HOME NPI NOT ON FILE	An NPI was specified in the WFB46050-HLTH-HOME-NPI field of the input record, but the NPI could not be found on the Provider NPI Cross Reference table (P_NPI_XMTCH_TB table).
07	Critical	INVALID HEALTH HOME TYPE	The home health level code from the input record (WFB46050-HLTH-HOME-TY-CD) could not be found on the valid value table, WVB1741C. Value'C' is not allowed - this value may be submitted only via the CareLink NM interface.
08	Critical	INVALID CARE CORDINATION LEVEL	The care coordination level from the input file (WFB46050-CARE-COORD-LVL) could not be found on the valid values table, WVB7487C. Values'6', '7', '8' and '9' are not allowed - these values may be submitted only via the CareLink NM interface.
10	Critical	CLIENT ID NAME OR DATE OF BIRTH MISMATCH	The last name through the first blank and the date of birth from the input record do not match that of the data returned from the client table. The entire record will be rejected and no further edits will be done.
12	Critical	INVALID DISABILITY TYPE EFFECTIVE DATE	Disability Type effective date must be a valid date
14	Critical	DISABILITY TYPE CODE IS INVALID	The disability type code from the input record (WFB46050-DISABIL-TY-CD) cannot be found on the valid values table, WVB2698C
15	Critical	INVALID LTC ASSESSMENT DATE	The long term care assessment date from the input file, WFB46050-LTC-ASSESS-DT, is not a valid date.
16	Critical	INVALID LVL CARE EFFECTIVE DATE	The level of care effective date from the input file, WFB46050-NF-LVL-CARE-EFF-DT, is not a valid date.
17	Critical	INVALID LVL CARE END DATE	The level of care end date (WFB46050-NF-LVL-CARE-END-DT) is not a valid date.
18	Critical	INVALID SETTING OF CARE - LTC	The long term setting of care from the input file (WFB46050-CARE-SETTING) is not 'ADB', 'ANW', 'INF', 'SDB', or 'SNW'.
19	Critical	CARE COORDINATION EFFECTIVE DATE INVALID	The care coordination effective date from the input file (WFB46050-CARE-COORD-EFF-DT) is not a valid date.
20	Critical	INVALID CARE COORDINATION END DATE	The care coordination end date from the input file (WFB46050-CARE-COORD-END-DT) is not a valid date.
21	Critical	HEALTH HOME EFFECTIVE	The home health effective date from

Error Num	Critical/Non-Critical	Error Message	Meaning
		DATE IS NOT VALID	the input file (WFB46050-HLTH-HOME-EFF-DT) is not a valid date.
22	Critical	HEALTH HOME END DATE IS NOT VALID	The home health end date from the input file (WFB46050-HLTH-HOME-END-DT) is not a valid date.
23	Critical	COORD END DATE MUST BE => BEGIN DATE	The care coordination end date from the input file (WFB46050-CARE-COORD-END-DT) cannot be less than the care coordination begin date from the input file (WFB46050-CARE-COORD-EFF-DT). The end date must be equal to or greater than the effective date.
24	Critical	HEALTH HOME END DATE NOT > BEGIN DATE	The home health end date from the input file (WFB46050-HLTH-HOME-END-DT) must be greater than the home health effective date from the input file (WFB46050-HLTH-HOME-EFF-DT).
25	Critical	LTC END DATE MUST BE > LTC BEGIN DATE	The long term care end date from the input file (WFB46050-NF-LVL-CARE-END-DT must be greater than the long term care end date from the input file (WFB46050-NF-LVL-CARE-EFF-DT).
27	Critical	PCP ASSIGN EFFECTIVE DATE INVALID	The PCP assign date from the input file (WFB46050-PCP-ASSIGN-EFF-DT) is not a valid date.
28	Critical	CC ASSESS DATE REQUIRED FOR ASSESS TYPE	The care coordination type ((WFB46050-CARE-COORD-TY) is specified on the input record, but the care coordination assessment date (WFB46050-CARE-COORD-DT) is not specified. Both fields are required if one of the fields is specified.
29	Critical	CC ASSESS TYPE REQUIRED FOR ASSESS DATE	The care coordination type ((WFB46050-CARE-COORD-TY) is not specified on the input record, but the care coordination assessment date (WFB46050-CARE-COORD-DT) is specified. Both fields are required if one of the fields is specified.
30	Critical	CC LEVEL, CC EFF/END DATES REQUIRED	The care coordination level (WFB46050-CARE-COORD-LVL – values 0-5 and A-D) is specified, but either the care coordination effective date (WFB46050-CARE-COORD-EFF-DT) **or** the care coordination end date (WFB46050-CARE-COORD-END-DT) is not specified.
32	Critical	CC BEG/END, CC ASSESS DATE REQUIRED	The care coordination level (WFB46050-CARE-COORD-LVL – values 1, 2, 3, A-D) is specified, and

Error Num	Critical/Non-Critical	Error Message	Meaning
			the care coordination date from the input file (WFB46050-CARE-COORD-DT) is not specified, and no assessment date can be found on the B_CARE_COORD_TB for the client.
33	Critical	CC LEVEL & CC END DATE REQUIRED	The care coordination effective date (WFB46050-CARE-COORD-EFF-DT) is specified, but either the care coordination level (WFB46050-CARE-COORD-LVL) or the care coordination end date (WFB46050-CARE-COORD-END-DT) is not specified.
34	Critical	SETNG OF CARE PROV NOT ON FILE OR BLANK	The LTC provider id from the input file (WFB46050-CARE-SETTING-ID) is specified, and is not "99999998". If the WFB46050-CARE-SETTING-ID is an NPI , it cannot be found on the P_NPI_XMTCH_TB table.. If the WFB46050-CARE-SETTING-ID is a Medicaid provider id , it cannot be found on the P_PROV_TB table. For INF providers, the provider type must be 211 (Nursing facility, private) or 212 (Nursing facility, state), and the provider's most recent enrollment status must be Active (60) or None-MCO provider (70). If the provider number is an NPI, the NPI's end effective date must be on or after the submitted LTC begin date (WFB46050-NF-LVL-CARE-EFF-DT).
35	Critical	PROVIDER NPI NOT ON FILE	The provider NPI (WFB46050-PROVIDER-NPI) is specified but cannot be found on the P_NPI_XMTCH_TB table.
36	Critical	LTC ASSESS DATE REQD FOR LTC BEG/END	The LTC assessment date (WFB46050-LTC-ASSESS-DT) is not specified on the input file, but either the level of care effective date (WFB46050-NF-LVL-CARE-EFF-DT) or the level of care end date (WFB46050-NF-LVL-CARE-END-DT) is specified.
37	Critical	NO ASSESS DATE FOUND FOR COORD INSERT	No care coordination assessment date was present on the input file AND no B_CC_ASSESS_DT could be found on the B_CARE_COORD_TB.
38	Critical	INVALID DISABILITY TYPE END DATE	Disability Type end date must be a valid date.
39	Critical	DISABIL END DATE MUST BE => EFF DATE	Disability Type end date must be greater than the effective date.
40	Critical	NO UPDATES MADE TO	The record was processed, but no

Error Num	Critical/Non-Critical	Error Message	Meaning
		OMNICAID	updates were made to Omnicaid. Critical errors can post to the error file, but the error 40 may not appear on the error report. This happens when there is data for more than 1 table (ex: home health and care coordination) in the record, but edits prevented one of updates from occurring, but the data for the other passed all edits and OMNICAID updated.
41	Critical	INVALID RECORD TYPE	The record type on the record is not 'H', 'D', or 'T' (Header, Detail, or Trailer). The entire record will be rejected and no further edits will be done.
42	Critical	DISABIL DATE REQUIRED FOR DISABIL TYPE	If a disability type is received, disability dates must be provided as well.
43	Critical	DISABIL TYPE REQUIRED FOR DISABIL DATE	If disability dates are provided, there must be a disability type provided.
44	Critical	DISABIL EFF DATE MUST => CC ENROLL DATE	If the client has a disability type, then the disability begin date must be provided and it must be >= the client' s Centennial Care first enrollment date.
45	Critical	RETRO COMMNTY BENEFIT ENROLL NOT ALLOWED	LTC Level Of Care = NFL and LTC Setting Of Care = 'ANW' or 'ADB or 'SNW' or 'SDB' and LTC Begin Date is less than first of the upcoming month.
46	Critical	CLIENT HAS OVERLAPPING CARELINK HHM SPAN	Client has existing open health home span with type 'C'. MCO source transactions cannot overlay this span.
47	Critical	CLIENT HAS OVERLAPPING CARELINK CC SPAN	Client has existing overlapping health home span with type C and care coordination level '6' or '7'. MCO source transactions cannot overlay this span.
49	Critical	CLIENT HAS OVERLAPPING WAIVER PRIOR AUTH	Client has a DD Waiver (PA type W) or Supports Waiver (PA type = S) prior authorization with a status of Approved (A), Closed (C) or Suspended (S) with a PA effective and end date span that overlaps the LTC begin and end date span on the incoming transaction.
50	Critical	NFL OVERLAPS EXISTING NON-NFL LOC SPAN	Client has a non-NFL level of care LTC span with begin and end dates that overlap the begin and end date span on the incoming transaction.
51	Critical	CC ASSESS TYPE NOT VALID FOR CC LEVEL	Incoming transaction has assessment type D (Data Mining Assessment) and incoming CC level is other than 0, 1, 4 or 5, or incoming transaction has assessment type N (New to Medicaid) and incoming CC level is other than 0, 4 or 5
52	Critical	CC EFF DT/ASSESS DT > 1	Incoming transaction has a CC

Error Num	Critical/Non-Critical	Error Message	Meaning
		MONTH IN FUTURE	effective date or assessment date that is more than 1 month in the future from the current date.

*For errors 49 and 50, MCO is instructed to contact LaRisa.Rodges@state.nm.us to coordinate closure of any Waiver Prior Auths or non-NFL LTC spans prior to resubmitting the NFL LTC span

Errors produced in the interface of the MCO to HSD file will be produced in an error file containing all errors generated during the update process (CC_ERRORS_mmddyyyy.zip). The format of this file:

```
    Field Name                          Pos     Format     Len
01 WFB46051-ERROR-RECORD                  1        248    248
  05 WFB46051-DATA                        1  C     248    248  Redefined
  05 WFB46051-HEADER-RECD                 1        248    248  Redefinition
    10 WFB46051-HEADER-REC                1  C       1      1
    10 WFB46051-NPI-ID                    2  C      10     10
    10 WFB46051-FILE-CREATE-DT           12  C       8      8
    10 FILLER                            20  C     229    229
  05 WFB46051-DETAIL-RECD                 1        248    248  Redefinition
    10 WFB46051-DETAIL-REC                1  C       1      1
    10 WFB46051-DTL-FILE-CREATE-DT        2  C       8      8
    10 WFB46051-MCO-NPI-ID               10  C      10     10
    10 WFB46051-ERR-NUM                  20  C       2      2
    10 WFB46051-ERR-MSG                  22  C      40     40
    10 WFB46051-MEDICAID-SWIPE-ID        62  C      14     14
    10 WFB46051-B-FST-NAM                76  C      15     15
    10 WFB46051-B-LAST-NAM               91  C      21     21
    10 WFB46051-B-DOB-DT                112  C       8      8
    10 WFB46051-CARE-COORD-DT           120  C       8      8
    10 WFB46051-CARE-COORD-TY           128  C       1      1
   10 WFB46051-CARE-COORD-LVL           129  C       1      1
   10 WFB46051-CARE-COORD-EFF-DT        130  C       8      8
   10 WFB46051-CARE-COORD-END-DT        138  C       8      8
   10 WFB46051-PROVIDER-NPI             146  C      10     10
   10 WFB46051-PCP-ASSIGN-EFF-DT        156  C       8      8
   10 WFB46051-LTC-ASSESS-DT            164  C       8      8
   10 WFB46051-NF-LVL-CARE              172  C       3      3
   10 WFB46051-NF-LVL-CARE-EFF-DT       175  C       8      8
   10 WFB46051-NF-LVL-CARE-END-DT       183  C       8      8
   10 WFB46051-CARE-SETTING             191  C       3      3
   10 WFB46051-CARE-SETTING-NPI         194  C      10     10
   10 WFB46051-HLTH-HOME-TY-CD          204  C       1      1
   10 WFB46051-HLTH-HOME-NPI            205  C      10     10
   10 WFB46051-HLTH-HOME-EFF-DT         215  C       8      8
   10 WFB46051-HLTH-HOME-END-DT         223  C       8      8
   10 WFB46051-FILLER                   231  N      15      7
   10 WFB46051-DISABIL-TY-CD            246  C       3      3
05 WFB46051-TRAILER-RECD                 1        248    248  Redefinition
  10 WFB46051-TRAILER-REC                1  C       1      1
  10 WFB46051-TRLR-RECD-CNT              2  N       5      5
  10 FILLER                              7  C     242    242
```

Source Field	SIZE	Specifications
RECORD-TYPE	Character (1)	H = HEADER
MCO NPI	Character (10)	The Centennial Care Provider NPI
FILE-CREATE-DATE	Date	Format of date is ccccmmdd

Source Field	SIZE	Comment
FILE-CREATE-DATE	Date	
MCO NPI	Character (10)	The Centennial Care Provider NPI
ERROR NUMBER	Number (2)	(See errors produced out of the update)
ERROR TEXT	Char (40)	(See errors produced out of the update)
MEDICAID ID CARD NUMBER	Character (14)	Values from incoming file
MEMBER FIRST NAME	Character (15)	Values from incoming file
MEMBER LAST NAME	Character (21)	Values from incoming file
MEMBER DATE OF BIRTH	Date	Values from incoming file
CARE COORDINATION ASSESSMENT DATE	Date	Values from incoming file
CARE COORDINATION ASSESSMENT TYPE	Character (1)	Values from incoming file
CARE COORDINATION LEVEL	Character (1)	Values from incoming file
CARE COORDINATION EFFECTIVE DATE	Date	Values from incoming file
CARE COORDINATION END DATE	Date	Values from incoming file
PCP ASSIGNED PROVIDER NPI	Character (10)	Values from incoming file
PCP ASSIGNED EFFECTIVE DATE	Date	Values from incoming file
LTC ASSESSMENT DATE	Date	Values from incoming file
NF LEVEL OF CARE	Character (3)	Values from incoming file
NF LEVEL OF CARE EFFECTIVE DATE	Date	Values from incoming file
NF LEVEL OF CARE END DATE	Date	Values from incoming file
SETTING OF CARE	Character (3)	Values from incoming file
SETTING OF CARE PROVIDER NPI	Character (10)	Values from incoming file
HEALTH HOME TYPE	Character (1)	Values from incoming file
HEALTH HOME ASSIGNED PROVIDER NPI	Character (10)	Values from incoming file
HEALTH HOME EFFECTIVE DATE	Date	Values from incoming file
HEALTH HOME END DATE	Date	Values from incoming file
FILLER	Character (15)	
DISABILITY TYPE CODE	Character (3)	Values from incoming file

Source Field	SIZE	Comment
PROV-TRAILER-RECORD	Character (1)	T = TRAILER
RECORD-COUNT	Number 99999	Count of all detail records sent in file

IV: THIRD PARTY LIABILITY

Clients with other insurance are reported by HSD to the MCOs and the MCOs are expected to share information they receive about third party coverage with HSD so that all parties can accurately collect third party payments for Medicaid clients. Medicare coverage is reported separately as Medicare spans and is not included in the TPL files.

TPL File to MCOs

TPL coverage available in HSD's client records is reported to the MCOs, including any retroactive coverage added for any client who is eligible for that month's enrollment in this monthly interface file. The file layout is as follows:

```
01 WFH48050-TPL-INFO-RECORD.
   05  WFH48050-MCO-PROV-ID              PIC X(08).
   05  WFH48050-MCO-PLAN-NUM             PIC X(04).
   05  WFH48050-RECIP-MCD-CARD-ID-NO     PIC X(14).
   05 WFH48050-ASPEN-MCI-ID           PIC X(09).
   05  WFH48050-RECIP-NAME               PIC X(37).
   05  WFH48050-DOB                      PIC X(08).
   05  WFH48050-POLICY-INFO OCCURS 10 TIMES.
       10  WFH48050-CARRIER-ID           PIC X(06).
       10  WFH48050-POLICY-NUM           PIC X(16).
       10  WFH48050-POL-BEGIN-DATE       PIC X(08).
       10  WFH48050-POL-END-DATE         PIC X(08).
       10  WFH48050-GROUP-NUM            PIC X(16).
       10  WFH48050-POLICYHOLDER-NAME    PIC X(37).
       10  WFH48050-POLICYHOLDER-ID      PIC X(11).
       10  WFH48050-RELATIONSHIP         PIC X(10).
       10  WFH48050-INPATIENT-CVRG-IND   PIC X(01).
       10  WFH48050-OUTPATIENT-CVRG-IND  PIC X(01).
       10  WFH48050-SURGERY-CVRG-IND     PIC X(01).
       10  WFH48050-LAB-CVRG-IND         PIC X(01).
       10  WFH48050-XRAY-CVRG-IND        PIC X(01).
       10  WFH48050-ANESTHESIA-CVRG-IND  PIC X(01).
       10  WFH48050-DRUG-STND-CVRG-IND   PIC X(01).
       10  WFH48050-MAJOR-MED-CVRG-IND   PIC X(01).
       10  WFH48050-DENTAL-CVRG-IND      PIC X(01).
       10  WFH48050-VISION-CVRG-IND      PIC X(01).
       10  WFH48050-ACCIDENT-CVRG-IND    PIC X(01).
       10  WFH48050-CASUALTY-CVRG-IND    PIC X(01).
       10  WFH48050-WORK-COMP-CVRG-IND   PIC X(01).
       10  WFH48050-INDEMNITY-CVRG-IND   PIC X(01).
       10  WFH48050-NURSING-CVRG-IND     PIC X(01).
       10  WFH48050-HMO-DRUG-CVRG-IND    PIC X(01).
       10  WFH48050-PARTA-SUPP-CVRG-IND  PIC X(01).
       10  WFH48050-PARTB-SUPP-CVRG-IND  PIC X(01).
       10  WFH48050-TRANSPORT-CVRG-IND   PIC X(01).
       10  WFH48050-CANCER-CVRG-IND      PIC X(01).
       10  WFH48050-BLACK-LUNG-CVRG-IND  PIC X(01).
       10  WFH48050-HMO-STND-CVRG-IND    PIC X(01).
       10  WFH48050-AMB-MH-CVRG-IND      PIC X(01).
       10  WFH48050-INP-MH-CVRG-IND      PIC X(01).
```

```
    10  WFH48050-HEARING-CVRG-IND     PIC X(01).
    10  WFH48050-HMO-AMB-MH-CVRG-IND  PIC X(01).
    10  WFH48050-HMO-INP-MH-CVRG-IND  PIC X(01).
    10  WFH48050-DENTAL-HMO-CVRG-IND  PIC X(01).
    10  WFH48050-VISION-HMO-CVRG-IND  PIC X(01).
    10  WFH48050-HEARING-HMO-CVRG-IND PIC X(01).
    10  FILLER                        PIC X(08).
05 WFH48050-B-LCKN-TY-CD              PIC X(03).
05 FILLER                             PIC X(17).
```

Field	Req	Def	Specifications
WFH48050-MCO-PROV-ID	A	N/A	From current enrollment span.
WFH48050-MCO-PLAN-NUM	A	N/A	From current enrollment span.
WFH48050-RECIP-MCD-CARD-ID-NO	A	N/A	
WFH48050-ASPEN-MCI-ID	A	N/A	
WFH48050-RECIP-NAME	A	N/A	
WFH48050-DOB	A	N/A	
WFH48050-CARRIER-ID	A	N/A	
WFH48050-POLICY-NUM	A	N/A	
WFH48050-POL-BEGIN-DATE	A	N/A	
WFH48050-POL-END-DATE	A	N/A	
WFH48050-GROUP-NUM	A	N/A	
WFH48050-POLICYHOLDER-NAME	A	N/A	
WFH48050-POLICYHOLDER-ID	A	N/A	Policy holder SSN with dashes
WFH48050-RELATIONSHIP	A	N/A	Short description of T_CVRG_CLNT_REL_CD from valid value table.
WFH48050- INPATIENT-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '01'. Otherwise, set to "N'.
WFH48050-OUTPATIENT-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '02'. Otherwise, set to "N'.
WFH48050-SURGERY-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '03'. Otherwise, set to "N'.
WFH48050-LAB-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '04'. Otherwise, set to "N'.
WFH48050-XRAY-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '05'. Otherwise, set to "N'.
WFH48050-ANESTHESIA-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '06'. Otherwise, set to "N'.
WFH48050- DRUG-STND -CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '07'. Otherwise, set to "N'.
WFH48050- MAJOR MEDICAL -CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '08'. Otherwise, set to "N'.
WFH48050- DENTAL-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '09'. Otherwise, set to "N'.
WFH48050-VISION-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '10'. Otherwise, set to "N'.
WFH48050-ACCIDENT-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '11'. Otherwise, set to "N'.

Field	Req	Def	Specifications
WFH48050-CASUALTY-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '12'. Otherwise, set to "N'.
WFH48050-WORKMANS'COMP-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '13'. Otherwise, set to "N'.
WFH48050-INDEMNITY-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '14'. Otherwise, set to "N'.
WFH48050- NURSING -CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '15'. Otherwise, set to "N'.
WFH48050-HMO-DRUG-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '16'. Otherwise, set to "N'.
WFH48050- PARTA-SUPP-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '17'. Otherwise, set to "N'.
WFH48050-PARTB-SUPP-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '18'. Otherwise, set to "N'.
WFH48050-TRANSPORT-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '19'. Otherwise, set to "N'.
WFH48050- CANCER-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '20'. Otherwise, set to "N'.
WFH48050-BLACK LUNG-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '21'. Otherwise, set to "N'.
WFH48050-HMO/STANDARD-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '22'. Otherwise, set to "N'.
WFH48050-AMB-MH-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '23'. Otherwise, set to "N'.
WFH48050-INP-MH-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '24'. Otherwise, set to "N'.
WFH48050-HEARING-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '25'. Otherwise, set to "N'.
WFH48050-HMO-AMB-MH-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '26'. Otherwise, set to "N'.
WFH48050-HMO-INP-MH-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '27'. Otherwise, set to "N'.
WFH48050-DENTAL HMO-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '28'. Otherwise, set to "N'.
WFH48050-VISION HMO-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '29'. Otherwise, set to "N'.
WFH48050-HEARING HMO-CVRG-IND	A	N/A	Set to 'Y' when T_CVRG_PLCY_CD = '29'. Otherwise, set to "N'.

Carrier File to MCO's

Each month, along with the generation of the TPL file, the MMIS generates a carrier file that identifies all the known, active TPL carriers on file with Omnicaid. The file layout is:

```
001800*              CARRIER LISTING RECORD              *
001900*----------------------------------------------------------*
002000*
002100 01 WFT15050-CARRIER-LIST-RECORD.
002200    05  WFT15050-CARR-ID          PIC X(06).
002300    05  WFT15050-CARR-NAME        PIC X(40).
```

```
002400    05  WFT15050-CARR-LINE1-AD       PIC X(40).
002500    05  WFT15050-CARR-LINE2-AD       PIC X(40).
002600    05  WFT15050-CARR-CITY           PIC X(40).
002700    05  WFT15050-CARR-STATE          PIC X(02).
002800    05  WFT15050-CARR-ZIP5           PIC X(05).
002900    05  WFT15050-CARR-ZIP4           PIC X(04).
003000    05  WFT15050-CARR-PHONE          PIC X(10).
003100    05  WFT15050-CARR-BILL-MD-CD     PIC X(02).
003200    05  WFT15050-CARR-BILL-MD-DESC   PIC X(10).
003300    05  WFT15050-CARR-TY-CD          PIC X(01).
003400    05  WFT15050-CARR-TY-DESC        PIC X(10).
003500    05  WFT15050-CARR-TERM-DT        PIC X(10).
003600    05  FILLER                       PIC X(80).
```

TPL Carrier Billing Med Cd - The medium used for submitting TPL carrier billing.

Value	Long
B	Both Electronic and Paper
E	Electronic Billing Submission
P	Paper Billing

TPL Carrier Type Code - This field describes the persons or organizations for TPL billing.

Value	Long
A	Attorney
B	Both (Health & Non-Health)
H	Health
N	Non-Health

MCO Reporting of TPL Adds and Updates

When the MCO becomes aware that a client's third party coverage is not reported accurately on the Omnicaid TPL file, the MCO is required to report an add or update record on the MCO to HSD TPL file for research and adding or updating to Omnicaid. MCO's are asked to report this on a no less than weekly basis using the following interface file submitted on the DMZ in the MCOs' TPL folder: Omnicaid will validate this file and produce two output files: the one that passed the edit will be written to: VALID file and the invalid one will be written to INVALID file with an appropriate error message (one record per each type of error). The VALID file will be used to produce report RB320 that Conduent uses to update TPL and the INVALID file will be sent back to the MCOs. The record count in the trailer record must be equal to the number of the records in the input file, not counting the header and trailer record.:

The TPL files are transferred to the mainframe a 8 PM EDT from DMZ, so it is recommended that the MCO submit their file no later than 7:45 PM EDT.

There are four types of transactions that the MCO may submit on this file: Adds, Updates, Terminations and Voids.

ADDS: If the MCO identifies TPL that has not been reported on the HSD TPL file, the MCO will submit a record that does not match an existing client coverage record client id, carrier, policy number, or does match these but does not overlap the existing dates. This will be considered by Omnicaid as an add transaction.

UPDATES: If the MCO identifies some change in the existing data other than begin and end dates, a record would be submitted that matches the existing span except for a change to policy information such as coverage code, policyholder, etc.

TERMINATIONS: If the MCO identifies that coverage that has been reported from Omnicaid as open is no longer active coverage, the MCO should submit a termination transaction defined as transactions where the MCO submits an end date that is not open ended and is earlier than the end date reported by Omnicaid. The span submitted by the MCO must match what Omnicaid has sent to the MCO as existing client coverage on client id, carrier, policy number, and begin date. The existing client coverage record will be updated with the incoming end date. If the MCO submits an end date that is not open ended and the incoming date span overlaps multiple existing client coverage records where the input data matches the existing client coverage record on client id, carrier, and policy number, a new error message would be generated. Also, if the incoming end date is not open ended and the incoming date span overlaps a single existing client coverage record where the input data matches the existing client coverage record on client id, carrier, and policy number but the begin date does not match, the same new error message will be generated: 030-INPUT TERM REQUEST HAS NO MATCH IN OMNICAID

VOIDS: If the MCO identifies that the TPL reported by HSD is incorrect and the client never had the coverage that is identified, the MCO should submit a void transaction defined as transactions where the MCO submits a begin date = end date. The existing span in Omnicaid that matches the client coverage record client id, carrier, policy number, and begin date will be voided. If an incoming void transaction does not match an existing client coverage record on client id, carrier, policy number, and begin date, a new error message would be generated: 029-INPUT VOID REQUEST HAS NO MATCH IN OMNICAID

FILE SUBMISSION: Files should be named in the format MCOTPL.MMDDCCYY.ZIP and placed on the DMZ in the MCO's TPL folder.

```
01  WFB32150-TO-OMNICAID-TPL-HEADER.
    05  WFB32150-HDR                    PIC X(02.
        88  WFB32150-HEADER                 VALUE 'HD'.
    05  WFB32150-SOURCE                 PIC X(20).
        88 WFB32150-88-ASPEN                VALUE 'TPLASPEN            '.
        88 WFB32150-88-PRESBYTERIAN         VALUE 'TPLPRESBYTERIAN     '.
        88 WFB32150-88-BCBS                 VALUE 'TPLBCBS             '.
        88 WFB32150-88- WESTERN SKY          VALUE 'TPLWESTERN SKY'.
        88 WFB32150-88-HMS                  VALUE 'TPLHMS              '.
    05  WFB32150-CREATION-DATE          PIC X(08).
    05  FILLER                          PIC X(50).

01  WFB32150-TO-OMNICAID-TPL-TRAILER.
    05  FILLER                          PIC X(02).
        88 WFB32150-88-TRLR               VALUE 'TR'.
    05  WFB32150-RECORD-CNT             PIC 9(09).
    05  FILLER                          PIC X(61).

01  WFB32150-TO-OMNICAID-TPL-DETAIL.
     05  WFB32150-MCI-ID                PIC X(09).
     05  WFB32150-SSN-NUM               PIC X(09).
     05  WFB32150-FST-NAM               PIC X(15).
     05  WFB32150-LST-NAM               PIC X(21).
     05  WFB32150-DOB-DT                PIC X(08).
     05  WFB32150-TPL-DATA
           OCCURS 10 TIMES
           INDEXED BY TPL-IDX.
       10 WFB32150-INSUR-ID             PIC X(06).
       10 WFB32150-INSUR-NAM            PIC X(40).
       10 WFB32150-INSUR-LINE1-AD       PIC X(40).
       10 WFB32150-INSUR-LINE2-AD       PIC X(40).
       10 WFB32150-INSUR-CITY-NAM       PIC X(40).
       10 WFB32150-INSUR-ST-CD          PIC X(02).
       10 WFB32150-INSUR-ZIP5-CD        PIC X(05).
       10 WFB32150-INSUR-ZIP4-CD        PIC X(04).
       10 WFB32150-INSUR-PHONE          PIC X(10).
       10 WFB32150-INSUR-PHONE-EXT      PIC X(04).
       10 WFB32150-PLCY-NUM             PIC X(20).
       10 WFB32150-PLCY-RESRC-CD        PIC X(02).
       10 WFB32150-PLCY-BEG-DT          PIC X(08).
       10 WFB32150-PLCY-END-DT          PIC X(08).
```

```
10 WFB32150-PLCY-GRP-ID           PIC X(20).
10 WFB32150-PLCY-EMPLR-RELTD      PIC X(01).
10 WFB32150-PLCYHLDR-MCI-ID       PIC X(09).
10 WFB32150-PLCYHLDR-FST-NAM      PIC X(20).
10 WFB32150-PLCYHLDR-MI-NAM       PIC X(01).
10 WFB32150-PLCYHLDR-LST-NAM      PIC X(20).
10 WFB32150-PLCYHLDR-SSN          PIC X(09).
10 WFB32150-PLCYHLDR-DOB          PIC X(08).
10 WFB32150-CVRG-SOURCE           PIC X(20).
10 WFB32150-CLNT-CVRG-BEG-DT      PIC X(08).
10 WFB32150-CLNT-CVRG-END-DT      PIC X(08).
10 WFB32150-CLNT-REL-POLICYHLDR   PIC X(01).
10 WFB32150-CVRG-TYPE-CD
   OCCURS 10 TIMES INDEXED BY TCTYP-IDX    PIC X(02).
```

Source Field	Std Edit	Req	Def	Specifications	Note Ref
WFB32150-TO-OMNICAID-TPL-HEADER					
WFB32150-HDR	N/A	A	'HD'		
WFB32150-SOURCE	N/A	A		'TPLASPEN' - For Aspen 'TPLPRESBYTERIAN' - For Presbyterian 'TPLBCBS' - For Blue Cross Blue Shield ' 'TPLWESTERN SKY' – For Western Sky 'TPLHMS' - For HMS	
WFB32150-CREATION-DATE	D	A	N/A	The date that the interface file is created All dates in the file must be format CCYYMMDD	
WFB32150-MCI-ID	N/A	A	N/A	ASPEN will populate this with the ASPEN MCI, HMS/MCOs would fill in with The Medicaid card ID minus the leading zeros and the leading '3' or '2'; resulting in a 9 digit number.	
WFB32150-SSN-NUM	N/A	N	N/A	Member's SSN / Insured's SSN	
WFB32150-FST-NAM	N/A	N	N/A	Member's first name / Insured's first name (MCO)	
WFB32150-LST-NAM	N/A	N	N/A	Member's last name / Insured's last name (MCO)	
WFB32150-DOB-DT	D	N	N/A	Member's DOB / Insured's DOB (MCO) CCYYMMDD	
WFB32150-TPL-DATA OCCURS 10 TIMES					
WFB32150-INSUR-ID	N/A	C	N/A	Carrier Id. If entered, it must exist on carrier table (TCARRITB)	1
WFB32150-INSUR-NAM	N/A	C	N/A	Carrier's Name	2
WFB32150-INSUR-LINE1-AD	N/A	C	N/A	Carrier's address (address line 1)	2
WFB32150-INSUR-LINE2-AD	N/A	N	N/A	Carrier's address (address line 2)	
WFB32150-INSUR-CITY-NAM	N/A	C	N/A	Carrier's address (City 's name)	2
WFB32150-INSUR-ST-CD	V	C	N/A	Carrier's address (State's code) - valid value copybook WVP2638C.	2,3
WFB32150-INSUR-ZIP5-CD	N/A	N	N/A	Carrier's address (zip code 5)	2
WFB32150-INSUR-ZIP4-CD	N/A	N	N/A	Carrier's address (zip code 4)	
WFB32150-INSUR-PHONE	N/A	N	N/A	Carrier's phone number	
WFB32150-INSUR-PHONE-EXT	N/A	N	N/A	Carrier's phone number - extention	
WFB32150-PLCY-NUM	N/A	A	N/A	Policy number	
WFB32150-PLCY-RESRC-CD	N/A	N	N/A	Policy resource code	6

Source Field	Std Edit	Req	Def	Specifications	Note Ref
WFB32150-PLCY-BEG-DT	D	A	N/A	Policy's effective date, must contain a valid date CCYYMMDD	
WFB32150-PLCY-END-DT	D	N	N/A	Policy end date CCYYMMDD If entered, it should be => WFB32150-PLCY-BEG-DT and valid date	
WFB32150-PLCY-GRP-ID	N/A	N	N/A	Policy group Id	
WFB32150-PLCY-EMPLR-RELTD	N/A	N	N/A	The data in this field is not stored anywhere in OMNICAID	
WFB32150-PLCYHLDR-MCI-ID	N/A	N	N/A	ASPEN will populate this with the ASPEN MCI, HMS/MCOs would fill in with client system Id of the policy holder if known – Medicaid card Id minus the leading 3 or 2 Can be space, but if filled in then must be numeric and exist on BDTAILTB.	
WFB32150-PLCYHLDR-FST-NAM	N/A	N	N/A	Policy holder first name	
WFB32150-PLCYHLDR-MI-NAM	N/A	N	N/A	Policy holder middle name	
WFB32150-PLCYHLDR-LST-NAM	N/A	N	N/A	Policy holder last name	
WFB32150-PLCYHLDR-SSN	N/A	N	N/A	Policy holder SSN	
WFB32150-PLCYHLDR-DOB	N/A	N	N/A	Policy holder DOB	
WFB32150-CVRG-SOURCE	N/A	N	N/A	Policy holder coverage source (Carrier's Name)	
WFB32150-CLNT-CVRG-BEG-DT	N/A	A	N/A	Client's coverage effective date CCYYMMDD	
WFB32150-CLNT-CVRG-END-DT	D	N	N/A	Client's coverage end date CCYYMMDD If entered, it must be => WFB32150-CLNT-CVRG-BEG-DT and valid date	
WFB32150-CLNT-REL-POLICYHLDR	V	N	N/A	Client's relationship to the policyholder code. If entered, it must be a valid value (valid value copybook WVT2534C)	4
WFB32150-CVRG-TYPE-CD OCCURS 10 TIMES	V	N	N/A	If entered, it must be a valid value (valid value copybook WVT2558C)	5

LEGEND: **For Req: A = Always For Std Edits: D = Date Edit V = Valid Value Edit C = Conditionally N = Numeric Edits S = System Generated N = Never**

1. If new carrier, this field should be blank
2. If new carrier, this field is required
3. State code (valid value WVP2638C):

State Name	State Code
ALASKA	AK
ALABAMA	AL-
ARKANSAS	AR
AMERICAN SAMOA	AS
ARIZONA	AZ
CALIFORNIA	CA
COLORADO	CO
CONNECTICUT	CT
WASHINGTON DC	DC
DELAWARE	DE
FLORIDA	FL
GEORGIA	GA
GUAM	GU
HAWAII	HI
IOWA	IA
IDAHO	ID
ILLINOIS	IL
INDIANA	IN
KANSAS	KS
KENTUCKY	KY
LOUISIANA	LA
MASSACHUSE	MA
MARYLAND	MD
MAINE	ME
MICHIGAN	MI
MINNESOTA	MN
MISSOURI	MO
NORTH-MARIANA-ISLMP	
MISSISSIPPI	MS
MONTANA	MT
NORTH CAROLINA	NC
NORTH DAKOTA	ND
NEBRASKA	NE
NEW HAMPSHIRE	NH
NEW JERSEY	NJ
NEW-MEXICO	NM
NATIONAL	NT
NEVADA	NV
NEW-YORK	NY
OHIO	OH
OKLAHOMA	OK
OREGON	OR
PENNSYLVAN	PA
PUERTO RICO	PR
RHODE	RI

SOUTH CAROLINA SC	TEXAS TX	WASHINGTON WA
SOUTH DAKOTA SD	UTAH UT	WISCONSIN WI
TENNESSEE TN	VIRGINIA VA	WYOMING WY
	VIRGIN ISLAND VI	
	VERMONT VT	

4. Client's relationship to the policyholder (valid value WVT2534C):

Client's relationship	Code
UNKNOWN	0
SELF	1
SPOUSE	2
CHILD	3
STEPCHILD	4
FOSTER-CHILD	5
GRANDPARENT	6
OTHER	9

5. TPL coverage type code (valid value WVT 2558C):

TPL coverage type	Code		
INPATIENT	01	HMO/DRUG	16
OUTPATIENT	02	MEDICARE SUPPLY A	17
SURGERY	03	MEDICARE SUPPLY B	18
LAB	04	TRANSPORTATION	19
XRAY	05	CANCER	20
ANESTHESIA	06	BLACK-LUNG	21
DRUG/STANDARD	07	HMO/STANDARD	22
MAJOR MEDICAL	08	MENTAL/AMBULATORY	23
DENTAL	09	MENTAL/INPATIENT	24
VISION	10	HEARING	25
ACCIDENT	11	MENTAL/HMO AMBULATORY	26
CASUALTY	12	MENTAL/HMO IMENTAL	27
WORKMEN'S COMP	13	DENTAL/HMO	28
INDEMNITY	14	VISION/HMO	29
NURSING	15	HEARING/HMO	30

6. TPL policy resource code.

Absent Parent 1	Health Insurance 4	
Casualty 2	Other Insurance 5	Unassigned 7
EPSDT 3	Pregnant 6	

OMNICAID TO MCO TPL INVALID TRANSACTIONS

On a daily basis (Monday through Saturday), after Omnicaid receives the TPL interface file from the MCOs, it runs the interface file thru the TPL edit program, the invalid transactions will be written to an output file. This file contains the same information as the input but an error message is added to the end of the output record.

```
01  WFB32151-OMNICAID-OUTPUT-RECORD.
```

```
    05  WFB32151-MCI-ID                PIC X(09).
    05  WFB32151-SSN-NUM               PIC X(09).
    05  WFB32151-FST-NAM               PIC X(15).
    05  WFB32151-LST-NAM               PIC X(21).
    05  WFB32151-DOB-DT                PIC X(08).
    05  WFB32151-TPL-DATA
          OCCURS 10 TIMES
          INDEXED BY WFB32151-TPL-IDX
      10 WFB32151-INSUR-ID             PIC X(06).
      10 WFB32151-INSUR-NAM            PIC X(40).
      10 WFB32151-INSUR-LINE1-AD       PIC X(40).
      10 WFB32151-INSUR-LINE2-AD       PIC X(40).
      10 WFB32151-INSUR-CITY-NAM       PIC X(40).
      10 WFB32151-INSUR-ST-CD          PIC X(02).
      10 WFB32151-INSUR-ZIP5-CD        PIC X(05).
       10 WFB32151-INSUR-ZIP4-CD           PIC X(04).
       10 WFB32151-INSUR-PHONE             PIC X(10).
       10 WFB32151-INSUR-PHONE-EXT         PIC X(04).
       10 WFB32151-PLCY-NUM                PIC X(20).
       10 WFB32151-PLCY-RESRC-CD           PIC X(02).
       10 WFB32151-PLCY-BEG-DT             PIC X(08).
       10 WFB32151-PLCY-END-DT             PIC X(08).
       10 WFB32151-PLCY-GRP-ID             PIC X(20).
       10 WFB32151-PLCY-EMPLR-RELTD        PIC X(01).
       10 WFB32151-PLCYHLDR-MCI-ID         PIC X(09).
       10 WFB32151-PLCYHLDR-FST-NAM        PIC X(20).
       10 WFB32151-PLCYHLDR-MI-NAM         PIC X(01).
       10 WFB32151-PLCYHLDR-LST-NAM        PIC X(20).
       10 WFB32151-PLCYHLDR-SSN            PIC X(09).
       10 WFB32151-PLCYHLDR-DOB            PIC X(08).
       10 WFB32151-CVRG-SOURCE             PIC X(20).
       10 WFB32151-CLNT-CVRG-BEG-DT        PIC X(08).
       10 WFB32151-CLNT-CVRG-END-DT        PIC X(08).
       10 WFB32151-CLNT-REL-POLICYHLDR     PIC X(01).
       10 WFB32151-CVRG-TYPE-CD
           OCCURS  10  TIMES
           INDEXED BY WFB32151-TCTYP-IDX    PIC X(02).
10 WFB32151-MESSAGE                PIC X(50).
```

Source Column	Std Edit	Req	Def	Specifications	Note Ref
WFB32150-MCI-ID	N/A	N/A	N/A		
WFB32150-SSN-NUM	N/A	N/A	N/A		
WFB32150-FST-NAM	N	A	N/A		
WFB32150-LST-NAM	V	A	N/A		
WFB32150-DOB-DT	N	A	N/A		
WFB32150-TPL-DATA OCCURS 10 TIMES					
WFB32150-INSUR-ID	N/A	N	N/A		
WFB32150-INSUR-NAM	N/A	A	N/A		
WFB32150-INSUR-LINE1-AD	N/A	N/A	N/A		
WFB32150-INSUR-LINE2-AD	N/A	N/A	N/A		
WFB32150-INSUR-CITY-NAM	N/A	N/A	N/A		

Source Column	Std Edit	Req	Def	Specifications	Note Ref
WFB32150-INSUR-ST-CD	N/A	N/A	N/A		
WFB32150-INSUR-ZIP5-CD	N/A	N/A	N/A		
WFB32150-INSUR-ZIP4-CD	N/A	N/A	N/A		
WFB32150-INSUR-PHONE	N/A	N/A	N/A		
WFB32150-INSUR-PHONE-EXT	N/A	N/A	N/A		
WFB32150-PLCY-NUM	N/A	N/A	N/A		
WFB32150-PLCY-RESRC-CD	N/A	N/A	N/A		
WFB32150-PLCY-BEG-DT	N/A	N/A	N/A		
WFB32150-PLCY-END-DT	N/A	N/A	N/A		
WFB32150-PLCY-GRP-ID	N/A	N/A	N/A		
WFB32150-PLCY-EMPLR-RELTD	N/A	N/A	N/A		
WFB32150-PLCYHLDR-MCI-ID	N/A	N/A	N/A		
WFB32150-PLCYHLDR-FST-NAM	N/A	N/A	N/A		
WFB32150-PLCYHLDR-MI-NAM	N/A	N/A	N/A		
WFB32150-PLCYHLDR-LST-NAM	N/A	N/A	N/A		
WFB32150-PLCYHLDR-SSN	N/A	N/A	N/A		
WFB32150-PLCYHLDR-DOB	N/A	N/A	N/A		
WFB32150-CVRG-SOURCE	N/A	N/A	N/A		
WFB32150-CLNT-CVRG-BEG-DT	N/A	N/A	N/A		
WFB32150-CLNT-CVRG-END-DT	N/A	N/A	N/A		
WFB32150-CLNT-REL-POLICYHLDR	N/A	N/A	N/A		
	N/A	N/A	N/A		
Program generated	N/A	N/A	N/A	Error message	

LEGEND: For Req: A = Always For Std Edits: D = Date Edit V = Valid Value Edit
C = Conditionally N = Numeric Edits S = System Generated N = Never

1. TPL edit error list (critical errors):

```
001-MCI ID IS REQUIRED
002-MISSING TPL DATA
003-CLIENT ID IS REQUIRED
004-CLIENT MCI ID IS NOT ON FILE                    For
all MCOs and DOH
004-CLIENT MCI ID IS NOT ON FILE (ORIGINAL)         For
ASPEN only
005-CLIENT MCI ID IS NOT ON FILE (RECYCLE)          For
ASPEN only
006-PLCYHLDR MCI ID IS NOT ON FILE (BDTAILTB)
007-CLIENT ID IS NOT ON OMNICAID TABLE (BDTAILTB)
008-SSN IS REQUIRED
009-INPUT SSN NOT MATCH WITH SSN ON FILE
010-CLIENT'S IDENT. NOT MATCH(SSN/LAST NAME)
011-PLCYHLDR SYSID IS NOT ON FILE (BDTAILTB)
```

012-CARRIER ID IS NOT ON CARRIER TABLE (TCARRITB)
013-POLICY NUMBER IS REQUIRED
014-POLICY BEGIN DATE IS REQUIRED
015-POLICY BEGIN DATE IS INVALID
016-POLICY END DATE IS INVALID
017-POLICY BEGIN DT SHOULD BE <= POLICY END DT
018-CLIENT COVERAGE BEGIN DATE IS REQUIRED
019-CLIENT COVERAGE BEGIN DATE IS INVALID
020-CLIENT COVERAGE END DATE IS INVALID
021-CL CVRG BEGIN DT SHOULD BE <= CL CVRG END DT
022-CLIENT COVERAGE TYPE CODE IS INVALID
023-CARRIER'S ADDRESS STATE CODE IS INVALID
024-CLIENT CVRG SPAN IS NOT COVERED BY POLICY SPAN
025-SAME CLIENT/PLCYHOLDER MCI BUT DIFFERENT NAME
026-MISSING CVRG TYPE CD, AT LEAST ONE IS REQUIRED
027-PLCY BEG DATE MORE THAN 2 MOS IN FUTURE
028-CLNT CVRG BEG DATE MORE THAN 2 MOS IN FUTURE
029-INPUT VOID REQUEST HAS NO MATCH IN OMNICAID
030-INPUT TERM REQUEST HAS NO MATCH IN OMNICAID

2. TPL update error list (critical errors):

100-UNABLE TO IDENTIFY CARRIER/PLCY, NO TPL UPDATE
101-MULTIPLE CARRIERS MATCHED, NO TPL UPDATE
102-MISSING DATA IN REQUIRED FIELDS FOR CARRIER
103-MUTIPLE CARRIER/PLCY MATCHED, NO TPL UPDATE
104-POLICY EXISTS ON FILE W/ DIFFERENT CARRIER ID
105-OVERLAP CLIENT COVERAGE FOUND, NO TPL UPDATE

V. CAPITATION PAYMENT

The Monthly enrollment cycle that generates the 834 and Supplemental Roster files also generates the Capitation or Per Member Per Month (PMPM) claims for all the Medicaid Managed Care enrollees for the upcoming month.

Capitation claims are processed through the MMIS claims processing system on the first Saturday of the enrollment month with a payment date of the following Monday. For example, if the Full enrollment cycle occurs on June 25, 2014 for the enrollment month of July, 2014, the PMPM claims created will be processed on July 5, 2014, with the 820 and 834 available the morning of July 7, 2014.

The system's process for determining a client's health plan capitation rate is described in detail below. If the system is unable to determine the appropriate capitation rate for a client, it terminates the client's health plan enrollment span.

Rate Cohort Determination

The following chart describes the rate cohorts for centennial care. Each member has 2 cohorts assigned, one for physical health and the other for behavioral health. The selection of a COE for cohort assignment is hierarchical if a client has more than one COE that overlaps. If a client has a waiver COE and a regular Medicaid COE, the regular Medicaid COE will always be chosen. We can therefore assume that anywhere that the COE criteria shows a Waiver COE (09x), that the client does not have a regular Medicaid COE and thus the waiver COE has been chosen. The BH Cohorts can be assigned using the corresponding physical health cohort that the client is in.

Starting with the July, 2022 capitations, any original capitation claim generated for Dates of Service from July 1, 2021 thru June, 2024 will be created with 3 cohorts instead of two. The ARP cohorts will be set up exactly as their PH cohort counterpart, just with the small ARP amount. Thus if the physical health cohort is 001, the ARP cohort is 401, if the physical health cohort is 110, the ARP cohort is 510, PH cohort 300, ARP cohort 600, etc.

PH cohort	ARP cohort
001-012	401-412
110-122	510-522
300-322	600-622

Any adjustment capitation claim for dates of service from April 2022 on will generate the 3 lines (PH, BH, ARP) on the debit claim. If the original was paid with the 3 lines (date of payment July 2022 on), then the credit claim will also have the 3 lines. But if the original was paid prior to July 2022 it will only have 2 cohort lines and therefore so will the credit claim.

The amount noted on the roster file is still reported as PH and BH, with the PH amount including both the PH and ARP payments combined. The ARP payment is reported in its separate line solely for federal reporting.

PHYSICAL HEALTH COHORTS FOR REGULAR MEDICAID BENEFIT PACKAGE

Cohort #	Rate Type	Cohort_Desc	COE_Cd	Low_ Age	High _Age	Gender	LOC	SOC	Medicare (Part A or Part B or both)	Geo County Code
001	2 - Newborn	TANF/AFDC, MA KIDS, CYFD 0-2 MONTHS	006, 017, 027, 028, 031, 032, 036, 071, 086, 402, 403, 420, 421, 037, 060, 061, 066, 072, 400, 401, 003, 004,081, 083, 084, 090, 091, 092, 093, 094, 095, 096	0	0	F & M	NONE	N/A	NO	N/A
002	1- Regular	TANF/AFDC, MA KIDS 2 MOS THRU 20 YRS	027, 028, 031, 032, 052, 072, 400, 401, 036, 071, 200, 402, 403, 420, 421	0	20	F & M	NONE	N/A	NO	N/A
003	1- Regular	TANF/AFDC 21 THRU 49 FEMALE	027, 028, 052, 072, 200	19	49	F	NONE	N/A	NO	N/A
004	1- Regular	TANF/AFDC 21 THRU 49 MALE	027, 028, 072, 200	19	49	M	NONE	N/A	NO	N/A
005	1- Regular	TANF/AFDC 50+	027, 028, 052, 072, 200	50	255	F & M	NONE	N/A	NO	N/A
006	1- Regular	SSI & WAIVER 2 MOS TO 1 YEAR MALE AND FEMALE	003, 004,081, 083, 084, 090, 091, 092, 093, 094, 095, 096	0	0	F &M	NONE	N/A	NO	N/A
007	1- Regular	SSI & WAIVER 1 YEAR THRU 20 YEARS MALE & FEMALE	003, 004, 074, 081, 083, 084, 090, 091, 092, 093, 094, 095, 096	1	20	F &M	NONE	N/A	NO	N/A
008	1- Regular	SSI & WAIVER 21 THRU 39 FEMALE	003, 004, 074,081, 083, 084, 090, 091, 092, 093, 094, 095, 096	21	39	F	NONE	N/A	NO	N/A
009	1- Regular	SSI & WAIVER 21 THRU 39 MALE	003, 004, 074, 081, 083, 084, 090, 091, 092, 093, 094, 095, 096	21	39	F	NONE	N/A	NO	N/A
010	1- Regular	SSI & WAIVER 40+	001, 003, 004, 074,081, 083, 084, 090, 091, 092, 093, 094, 095, 096	40	255	F &M	NONE	N/A	NO	N/A
011	1- Regular	PW/MA 15 THRU 49	030, 035, 300, 301	15	59	F	NONE	N/A	NO	N/A
012	1- Regular	CYFD 2 MONTHS THRU 20 YEARS	006, 017, 037, 060, 061, 066, 086	0	26	F &M	NONE	N/A	NO	N/A

Cohort #	Rate Type	Cohort_Desc	COE_Cd	Low_ Age	High _Age	Gender	LOC	SOC	Medicare (Part A or Part B or both)	Geo County Code
300	V- Dual NFLOC	LTC - NF LOC DUALS	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 086, 090, 091, 092, 093, 094, 095, 096, 200, 300, 301, 400, 401, 036, 071, 402, 403, 420, 421	0	255	F & M	NFL	INF, ANW, ADB	Y	01, 03, 05, 06, 08, 13, 14, 15, 17, 20, 22, 23, 24, 26, 28, 30, 32, 33,
301	W - Dual MiVia	LTC - MI VIA Self Directed DUALS	090, 091, 092, 093, 094 (only the waiver COEs (090-094) are eligible for Self -Directed, however, a client could have overlapping eligibility with another regular Medicaid COE in which case the regular Medicaid COE is what will appear on the Roster file).	0	255	F & M	NFL	SNW, SDB	Y	N/A
302	X - Non-Dual NFLOC	LTC - NF LOC NON DUALS	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 090, 091, 086, 092, 093, 094, 095, 096, 200, 300, 301, 400, 401, 036, 071, 402, 403, 420, 421	0	255	F & M	NFL	INF, ANW, ADB	NO	01, 03, 05, 06, 08, 13, 14, 15, 17, 20, 22, 23, 24, 26, 28, 30, 32, 33,
303	Y - Non-Dual MiVia	LTC - MI VIA Self Directed NON DUALS	090, 091, 092, 093, 094 (only the waiver COEs (090-094) are eligible for Self -Directed, however, a client could have overlapping eligibility with another regular Medicaid COE in which case the regular Medicaid COE is what will appear on the Roster file).	0	255	F & M	NFL	SNW, SDB	NO	N/A

Cohort #	Rate Type	Cohort_Desc	COE_Cd	Low_ Age	High _Age	Gender	LOC	SOC	Medicare (Part A or Part B or both)	Geo County Code
304	Z - Healthy Duals	LTC - HEALTHY DUALS	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 086, 090, 091, 092, 093, 094, 095, 096, 200, 300, 301, 400, 401, 036, 071, 402, 403, 420, 421	0	255	F & M	Not = NFL	N/A	Y	N/A
310	Q - Dual NFLOC - Ph2	LTC - NF LOC DUALS PH REG2	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 086, 090, 091, 092, 093, 094, 0095, 096, 200, 300, 301, 400, 401, 036, 071, 402, 403, 420, 421	0	255	F & M	NFL	INF, ANW, ADB	Y	02, 07, 09, 12, 16, 19, 27
312	R - Non-dual NFLOC - Ph2	LTC - NF LOC NON DUALS PHREG2	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 086, 090, 091, 092, 093, 094, 095, 096, 200, 300, 301, 400, 401, 036, 071, 402, 403, 420, 421	0	255	F & M	NFL	INF, ANW, ADB	NO	02, 07, 09, 12, 16, 19, 27
320	U - Dual NFLOC - Ph5	LTC - NF LOC DUALS PH REG5	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 086, 090, 091, 092, 093, 094, 095, 096, 200, 300, 301, 400, 401, 036, 071, 402, 403, 420, 421	0	255	F & M	NFL	INF, ANW, ADB	Y	04 10 11 18 21 25 29 31
322	9 - Non-dual NFLOC - Ph5	LTC - NF LOC NON DUALS PH REG5	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084,086, 090, 091, 092, 093, 094, 095, 096, 200, 300, 301,	0	255	F & M	NFL	INF, ANW, ADB	NO	04 10 11 18 21 25 29 31

Cohort #	Rate Type	Cohort_Desc	COE_Cd	Low_ Age	High _Age	Gender	LOC	SOC	Medicare (Part A or Part B or both)	Geo County Code
			400, 401, 036, 071, 402, 403, 420, 421							

Geo County Code - (Either the INF provider's location is within the county or non-INF client's geo county)

Cohorts 006 through 010 include the clients who are not in long term care or those clients who are DD Waiver or Med Frag clients. The clients in this cohort have all their physical health needs covered in the cohort, and their DD/Med Frag waiver are paid FFS. Since it is possible for a D&E waiver client to have the financial eligibility for this category without accompanying LTC span in place, any client with waiver financial elig but no LTC span will fall here.

BH COHORTS - CONSIDER CRITERIA SIMPLY BEING THE PHYSICAL HEALTH COHORT ASSIGNED

Cohort #	Rate Type	Cohort_Desc	COE_Cd	Low_Age	High_Age	Gender	Corresponding Cohort
201	B - BH - Non-LTC Non-Dual Non-ABP	BH TANF/AFDC M & F	027, 028, 030, 031,032,033,034, 035, 060, 061, 072, 073, 036, 071, 402, 403, 420, 421, 200, 300, 301,400, 401	0	255	F & M	001-005, 011
202	B - BH - Non-LTC Non-Dual Non-ABP	BH CYFD M & F	006, 017, 037, 066, 086	0	26	F & M	012
203	B - BH - Non-LTC Non-Dual Non-ABP	BH SSI, B&D, WAIVER - 0 TO 14 YRS M & F	003, 004, 081, 083, 084,090, 091, 092, 093, 094, 095, 096	0	14	F & M	006-010

204	B - BH - Non-LTC Non-Dual Non-ABP	BH SSI, B&D, WAIVER - 15 TO 20 YRS M & F	003, 004, 074,081, 083, 084, 090, 091, 092, 093, 094, 095, 096	15	20		
205	B - BH - Non-LTC Non-Dual Non-ABP	BH SSI, B&D, WAIVER - 21 + YRS M & F	001, 003, 004, 074, 081, 083, 084, 090, 091, 092, 093, 094, 095, 096	21	255		
206	C - BH LTC Non-dual	BH LTC NON DUAL	001, 003, 004, 006,017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 086, 036, 071, 090, 091, 092, 093, 094, 095, 096, 402, 403, 420, 421, 200, 300, 301, 400, 401	0	255	F & M	302, 303, 312, 322
207	S - BH LTC Dual	BH LTC DUAL	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 086, 036, 071, 090, 091, 092, 093, 094, 095, 096, 402, 403, 420, 421, 200, 300, 301, 400, 401	0	255	F & M	300, 301, 304, 310, 320
208	6 - BH ABP	BH ABP	COE 100	18	65	F & M	110-122

ALTERNATIVE BENEFIT PACKAGE POPULATION - USING SCI COHORTS REDEFINED

Cohort #	Cohort Description	COE Criteria	Min Age	Max Age	Gender
110	ABP, ages 19-20 M	COE 100	18	20	M
111	ABP, ages 19-20 F	COE 100	18	20	F
112	ABP, ages 21-29 M	COE 100	21	29	M
114	ABP, ages 21-29 F	COE 100	21	29	F
115	ABP, ages 30-39 M	COE 100	30	39	M
116	ABP, ages 30-39 F	COE 100	30	39	F
117	ABP, ages 40-49 M	COE 100	40	49	M

Cohort #	Cohort Description	COE Criteria	Min Age	Max Age	Gender
118	ABP, ages 40-49 F	COE 100	40	49	F
119	ABP, ages 50-59 M	COE 100	50	59	M
120	ABP, ages 50-59 F	COE 100	50	59	F
121	ABP, ages 60-64 M	COE 100	60	65	M
122	ABP, ages 60-64 F	COE 100	60	65	F

Enrollment Terminations – No Rate Cohort Found

If a rate cohort that matches the client's characteristics does not exist, the enrollment roster will reflect a cohort number 999 and no capitation payment is made for that month for that client. These clients are listed on the Client Capitation Error Report which is available to State staff who work to identify why the client is enrolled but not meeting any cohort definition. The MCO is expected to enroll the client, despite the cohort 999 and render services. State staff will correct whatever error is causing the cohort 999 to post and either the cohort will be assigned and paid or the client will be determined not eligible to be enrolled. If the client is not eligible to be enrolled, the enrollment will be recouped. Whenever the system terminates a client's plan enrollment, it also closes the client's rate cohort history span as of the end of the month for which the last capitation payment was made.

Capitation Claim Generation

The system may generate capitation claims for only the current capitation month for each client or for one or more retroactive capitation months for each client based on the last capitation date on the lockin span. It continues generating claims until the first of the upcoming month or the enrollment ending date, whichever is earlier. If for any reason a capitation claim cannot be created for a given month, the system stops the attempt with that month for that client and health plan provider, and does not attempt to create any other claim for other months. For example, if the system determines that a capitation claim is required for October, November, and December, the process starts with October. If a successful claim is generated for October, the system attempts to generate a claim for November. If the claim cannot be generated for October, the system stops and does not attempt to generate claims for November or December.

Capitation processing will generate one capitation for each member per month, with an amount for the BH cohort and an amount for the PH cohort. The capitation claim gets generated with the two payments reflected in two lines on the same claim.

On all capitation claims, the sum of the line item submitted charges is the submitted charge on the claim record. The dates of service are the month begin and end dates. Capitation claims are passed directly into the Claims Processing Subsystem adjudication cycle. The Claims Processing Subsystem checks for duplicates to ensure no capitation claim is paid more than once and submits the claims for processing during the first payment cycle of the most recently capitated month. The Claims Processing Subsystem sets the reimbursement amount on the capitation claims to equal the submitted charge before paying the claims.

Capitation Adjustments

It is the nature of eligibility and enrollment that clients lose eligibility for enrollment which results in a recoupment span that is sent on the roster file; only to be added back retroactively at a later date. For this reason, HSD doesn't recover the capitation payment to the MCO until after a significant lag period has transpired. There are two exceptions to this: clients for whom we've received a date of death and clients for whom we receive notice of incarceration. HSD does recover the capitations for months after

the date of death or incarceration begin month without any lag factor. MCOs recovering paid claims from providers based on the roster recoupment span is a premature action that places an unnecessary burden on the providers and the MCO. HSD instructs the MCOs that they must not recover claim payments from providers upon receipt of the recoupment span on the Enrollment Roster file. MCOs must wait and only recoup from the providers if the capitation payment for the month of service that covers that claim's dates of service is voided by HSD. The capitation voids are reported on the 820, the electronic remittance.

HSD routinely adjusts or voids capitations for the following reasons:

1. **Retroactive Medicare** – HSD receives Medicare determinations via numerous files it receives from SSA and CMS. When a Medicare span is added it is reported on the Enrollment Roster for the MCO to take action. If the Medicare determination is for retroactive dates for which capitation has been paid at a non-Medicare cohort, the capitation will be adjusted, going back 21 months from the month the Medicare is added. This allows the provider to bill Medicare when the MCO returns any claims to them as a result of our capitation adjustment. Clients eligible in COE 100 are not eligible if they have Medicare. Since at the time the provider paid the claim, it was not known that the client had Medicare, we do not adjust capitations for clients with COE 100 who receive retroactive Medicare if there has been a paid encounter for that month.
2. **Date of Death** – Client Date of Death is typically entered retroactively and the MCO will receive the DOD on its Enrollment Roster file if it occurs simultaneously with the managed care termination. However, sometimes the DOD comes in after we have terminated enrollment in which case the MCO doesn't receive notice of that DOD. If there is any question, the DOD is shown on the Web Portal when a client inquiry is done. A monthly reconciliation identifies any dates of death entered for which HSD has paid capitations beyond the month of death. These capitations are voided up to 5 years retro.
3. **Loss of Eligibility & Incarceration** – The Omnicaid system identifies any client's who've lost eligibility or been incarcerated for which HSD has paid capitation beyond the month the eligibility was terminated. The MCO is given the loss of eligibility termination date and incarceration dates on the Enrollment Roster file. Omnicaid creates a Recoupment spans for up to 2 years back with a 2 month lag time. We allow the 2 month lag in order for any temporary changes in eligibility to be resolved. For example, a client loss of eligibility effective 8/31/2017 received in September will result in a termination of the managed care enrollment effective 8/31/2017 but will not result in a recoupment span unless it is still terminated as of November 2, 2017. The recoupment span for September will be generated in November. Once the recoupment span is created in Omnicaid, a monthly report is generated allowing an additional one month lag to identify capitations which should be voided. In the above example, the recoupment for September will not be identified for recovery of the capitation until December. These identified capitations are compared against encounters and any months for which an encounter was paid are excluded from recovery. The remaining capitations are voided.

4. **Retroactive INF Spans** – HSD allows the MCO to enter retroactive INF long term care spans in recognition that sometimes eligibility and/or level of care determinations for someone in a nursing home may come in after their admission. A monthly reconciliation is done to identify those retroactive INF spans for which a long term care cohort capitation was not paid. Any short term stays or stays not substantiated with a nursing facility encounter are excluded. The remaining capitations are adjusted to pay at the higher long term care cohort.
5. **Retroactive Newborns** – Newborn clients whose mother is in Managed Care at the time of birth are eligible for a higher newborn cohort for the 1st two months of life. Some client eligibility is added incorrectly, not including the client's birth month. When this happens and the client is enrolled to Managed Care effective with their second month of life, the newborn cohort is not paid. Later, when the newborn's birth month eligibility is sent and the retroactive enrollment for the birth month occurs, the birth month is capitated at the newborn cohort, but the second month of life remains capitated at the non-newborn cohort. A monthly reconciliation is run to identify these mispaid capitations and adjust them.

HSD has identified specific claim adjustment reason codes for each of the recoupments (Medicare, DOD, Loss of Eligibility, Incarceration) that will appear on the MCO's remittance (820). The MCO is expected to do whatever reconciliation of its records using the remittance along with information submitted on the Enrollment Roster.

Valid Value	Long Desc
010	Capitation Rate Updates
013	Capitation Enrollment Updates
015	Cap Void DOD
016	Cap Adjust Retro Medicare
021	Loss of Eligibility
020	Long Term Care Reconciliation
101	Retroactive INF Adjustment
102	Retroactive Newborn Adjustment
103	Void Incarcerated Client

820 Premium Payment File

Conduent will produce the 820 Premium Payment file out of each weekly payment cycle. This file contains a record of all capitation claims and capitation recoupments as well as any gross level payments or recoveries. The Companion Guide is on the HSD website to explain any NM specific completion of data http://www.hsd.state.nm.us/mad/5010HIPAAforNMMedicaidProviders.html .

Current MCO Plan Files

Each month, along with the 834 and Supplemental Roster file, the MMIS generates a report for each MCO that shows each of the rate cohorts for that plan. The purpose of this report is to enable the MCOs to validate the rates on the Supplemental Roster file or on the 820:

The rate cohort type code indicates the type of capitation rate that is paid for clients who match the criteria for the cohort with that rate type.

Each MCO carries a *Plan Number* designation, which you will see carried on all MCO reports and files. The Plan Number is merely an extension of the Managed Care Provider Number and identifies only the MCO Plan for that MCO; there is no inherent meaning to the plan number. The Plan Report is placed on the MMIS MCO's website for the MCO's to access.

The file layout for the Current MCO Plans Report is shown on the following page:

```
                                        NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM          PROCESSING DATE:  99/99/9999
REPT:   NMMHNNNN-RH440  HUMAN SERVICES DEPARTMENT          PROCESSING TIME:  99:99:99
                                                                                                      PAGE:  99,999
                                                  P L A N   F I L E   R E P O R T
                                                        AS OF 99/99/9999

      PROVIDER NUMBER: 99999999          PLAN EFFECTIVE DATE: 99/99/9999              PLAN END DATE:    99/99/9999
      PLAN NUMBER:     9999                 PLAN NAME: XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3          LAST UPDATE DATE: 99/99/9999
      PLAN TYPE:  X                   TOLL FREE PHONE:     (999)999-9999     USER ID:          XXXXXXX
      MENTAL HEALTH:  X       MEDICARE:     X XXXXXXXXX1     NATIVE AMERICAN:  X XXXXXXXXX1
      TPL:  X       LTC:      X XXXXXXXXX1
      ASSIGNMENT PCT:  999                  ENROLLMENT COUNT:    999,999                  MAX ENROLLMENT:   999,999

    ------------------------------------------------PLAN  COVERAGE INFORMATION ---------------------------------------------

    ELIG CAT / FED MATCH: XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X
                          XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X
                          XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X
                          XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X / XXX X

    COUNTY:               99  99  99  99  99  99  99  99  99  99  99  99  99  99  99  99
                          99  99  99  99  99  99  99  99  99  99  99  99  99  99  99

    ------------------------------------------------ EXCLUSIONS BY INCLUDED PROV TYPE-----------------------------------------
    PROVIDER TYPE       SPECIALTY EXCLUSIONS        SERVICE EXCLUSIONS
    --- ----------      --- ----------------        ---- ------------------------------
    XXX XXXXXXXXX1      XXX XXXXXXXXX1              XXXX XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3
                        XXX XXXXXXXXX1              XXXX XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3
    XXX XXXXXXXXX1      XXX XXXXXXXXX1              XXXX XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3
    ------------------------------------------------ LISTS OF SERVICES EXCLUDED FROM PLAN ------------------------------------------
    LIST NAME
    ------------------------------------
    XXXX  XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3
    XXXX  XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3
    XXXX  XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3

-------------------------------------------------------- PLAN RATES ------------------------------------------------------------
COHORT        COHORT
NUMBER        DESCRIPTION   TYPE         SERVICE AREA    BEGIN DATE     END DATE      CAPITATION RATE
------  ----------------------------   ------------   -------------   -----------   ----------    ----------------
 XXX    XXXXXXXXX1XXXXXXXXX2XXXXXXXXX3     X  XXXXXXXXX1    X XXXXXXXXX1   99/99/9999    99/99/9999      $  99,999.99
                                              99/99/9999    99/99/9999      $  99,999.99
                                             99/99/9999    99/99/9999      $  99,999.99
```

VI. MCO CLAIMS PAYMENT & REPORTING SPECIAL INSTRUCTIONS

Although the MCO has its own policies for claims processing, including prior authorization and payment rates, there are a number of federal requirements the MCO needs to be aware of. The purpose of this section is to share HSD's payment policies that prevent over payment and explain the process for receipt and payment of Crossover Claims. For example, the MCO may have their own rates for hospital based reimbursement, and not use HSD's method, which happens to differ from Medicare. But we at least want the MCO to know that there is a precedent for reducing hospital based professional services in both Medicare and Medicaid.

Services Excluded from Medicare Billing

The MCO must not require billing to Medicare for services that are not covered Medicare services. Pursuant to NMAC 8.302.3.12 and NMAC 8.302.3.12 C(2), "If a medically necessary service is excluded from Medicare and it is a MAD covered benefit, MAD will pay for the service."

HSD/MAD has determined that the following Community Benefit services are not covered by Medicare:.

- Adult Day Health (S5100)
- Assisted Living (T2031)
- Community Transition Services (T2038)
- Emergency Response (S5161)
- Emergency Response High Need (S5161 U1)
- Environmental Modifications (S5165)
- Behavior Support Consultation (H2019)
- Behavior Support Consultation, clinic bases (H2019TT)
- Employment Supports (H2024)
- Home Health Aide (S9122)
- Nutritional Counseling (S9470)
- Personal Care-Consumer Directed (99509)
- Personal Care-Consumer Delegated (T1019)
- Personal Care-Directed training (S5110)
- Personal Care-Directed-Administrative Fee (G9006)
- Personal Care-Directed Advertisement Reimbursement Fee (G9012)

HSD/MAD has determined that the following EPSDT services are not covered by Medicare:.

- Targeted Case Management (T2023)
- Attendant Care Services (S5125)
- Nursing Assessment/Evaluation (T1001)
- Qualified Physical Therapist Services (G0151)

- Qualified Occupational Therapist Services (G0152)
- Qualified Speech-Language Pathologist Services (G0153)

Crossover Claims

When Medicare parts A, B, or C has paid a claim, The MCO adjudicating the Medicaid payment cannot deny consideration of the patient responsibility (co-insurance, deductible, or copayments) based on Medicaid limitations such as program coverage of the service, medical necessity issues, or prior authorization. For this reason, payments for co-insurance, deductible, and copayments are even made on chiropractor services.

Medicare retroactive entitlement results in the original capitation payment being adjusted to pay a capitation that is appropriate for dual-eligible coverage. The MCO may recoup payments for services that can still be paid. Providers must be notified by Centennial Care that the recoupment is due to retroactive Medicare Entitlement so they may bill Medicare timely. Supplemental instructions from Centennial Care may be necessary regarding applicable filing limits for coinsurance, deductible, copayments, and repayment following Medicare denial.

Special Part B Only Instructions

When a Medicaid eligible individual only has Part B Medicare coverage and has an inpatient stay, Medicare pays on the Part B charges. Medicaid pays the OMB inpatient encounter rate less the amount paid by Medicare, (by having the provider submit the inpatient claim showing the Medicare Part B payment), and also less any Medicaid payment for the co-insurance/deductible on the part B charges that may already have been paid. Payments made to the physician by Medicare or Medicaid should not be deducted from payment to the hospital.

MCO's are instructed to do the following:

- Pay the Medicaid Inpatient Encounter rate to the provider for services provided to Medicare Part B only recipients that had an inpatient stay,
- One of the following options can be used:
  1) The cross-over claim can be denied, allowing the provider to submit their claim as an inpatient claim with the Part B payment entered on the claim just as would be customary for a commercial insurance payment. The Provider is then reimbursed at the Medicaid Inpatient rate less the Medicare Part B payment; or
  2) Pay the Medicare Part B coinsurance and deductible amount and have the Provider send the inpatient claim showing the amount that Medicare paid as well as the amount Medicaid already paid towards the coinsurance and deductible. The claim is then paid at the Medicaid Inpatient OMB rate less the Medicare Part B payment and less the co-insurance/deductible payment that was already paid by Medicaid.
- Provide written billing instructions for the claims to I.H.S. and Tribal 638 providers.

Payment of the Crossover Claim

Although the MCO should only pay coinsurance, deductible, psych amount and the patient responsibility on a Crossover claim, normal pricing logic is followed so that cost savings analysis can be performed later.

Institutional Crossover Pricing

a. Determine the Allowed Charge – this involves applying lower of logic (unless an exclusion is allowed)
b. **Allowed Charge =** Medicare Coinsurance Amount + Medicare Deductible Amount + Psych Amount + Patient Responsibility
c. COMPARE TO
d. MCO'S Calculated Allowed Charge – (Medicare Paid Amount + Medicare Sequestration Amount) **= New Calculation**
e. When the **New Calculation** is less than the Allowed Charge, then it is used as the MCO's allowed amount.

The lower of logic payment limitation is **bypassed** under the following circumstances:

- When the claim type is inpatient and the billing provider type is 211 through 218 (nursing facilities, ICF-MR, RTC, and TFC), or 221 (IHS)
- When the claim type is inpatient, the DRG code is 999 (ungroupable for DRG versions 25 or greater).
- When the claim type is outpatient and the billing provider type is 201 through 218, and the provider location is instate or border.
- When the claim type is outpatient and the billing provider type is 221, 313, 314, 315 (IHS, FQHC, RHC), or 455 (rehab center).

Professional Crossover Pricing

1. Determine the Allowed Charge – this involves applying lower of logic (unless an exclusion is allowed)
    a. **Allowed Charge =** Medicare Coinsurance Amount + Medicare Deductible Amount
    b. COMPARE TO
    c. MCO'S Calculated Allowed Charge – (Medicare Paid Amount + Medicare Sequestration Amount) **= New Calculation**
    d. When the **New Calculation** is less than the Allowed Charge, then it is used as the MCO's allowed amount.
2. The lower of logic payment limitation is **bypassed** under the following circumstances:
    a. When the billing provider type is 363 (community benefit).
    b. When the line item service area code is Anesthesia and the procedure code is 10000 – 99999 inclusive.
3. For Part B, if there is a psych amount on the claim, or if the coinsurance is within one penny of half of the Medicare allowed amount, then the claim will perform the lesser of logic

Coordination of Benefits Agreement (COBA)

The Centers for Medicare & Medicaid Services (CMS) developed a model national

contract, called the Coordination of Benefits Agreement (COBA), which standardizes the way that eligibility and Medicare claims payment information within a claims crossover context is exchanged. COBAs permit other insurers and benefit programs (also known as trading partners) to send eligibility information to CMS and receive Medicare paid claims data for processing supplemental insurance benefits for Medicare beneficiaries from CMS' national crossover contractor, the Coordination of Benefits Contractor (COBC). Medicare contractors, courtesy of their Data Centers, submit all claims for crossover to the COBC nightly via 837 flat file formats and/or NCPDP. The COBC will edit claims for required elements. Any files that fail business edits for claim structure will not be processed. Instead, the COBC will ask the contractors to re-transmit the entire file. Upon acceptance of the file, the COBC will run the file through its customized claims translator to convert the file to an outbound HIPAA ANSI format and perform HIPAA validation. Then, after referencing the frequency and media type specifications established in the COBA database for the trading partner, the COBC will sort the claims by COBA IDs for transmission to the trading partners.

HSD, as the New Mexico Medicaid COBA trading partner, sends the eligibility information for all NM clients who are dual eligibles and receives the COBA claims files for those clients identified as FFS. The COBA contractor will send claims files for managed care clients directly to the MCOs. HSD will prepare separate files to send to COBA for clients enrolled with each MCO. COBA will then send directly to the MCO any claims for dates of service for which clients are enrolled with the MCO. MCOs must have their own trading partner agreement with the COBA contractor and are responsible for establishing their connections for the COBA claims transmissions.

The COBA 5010 Companion Guide can be found at
https://www.cms.gov/files/document/coordination-benefits-agreement-coba-companion-guide-health-insurance-portability-and-accountability.pdf

In addition to the Companion Guide, the following is provided:
MCOs will follow their normal encounter data rules. The following fields are additional fields that are required to identify the claim as a crossover and show the amounts allowed and paid by Medicare as well as the client's deductible and coinsurance. Our goal with this is to receive the required data that allows us to identify the claim as a crossover claim and to have correctly reflected in our system what Medicare paid and the amount of the Medicare coinsurance and deductible; in addition to the amount the MCO paid.

837 PROFESSIONAL

THE CRITICAL COMPONENT IN OUR ABILITY TO CLASSIFY THE PROFESSIONAL FORMAT AS A CROSSOVER CLAIM IS THAT A PROFESSIONAL CROSSOVER CLAIM MUST CONTAIN:

1. MEDICARE PAID AMOUNTS THAT ARE GREATER THAN $0 (REPORTED IN HEADER OR LINE 2430 SVD AS SHOWN BELOW) AND

2. LOOP 2320 SBR09 = 'MB' OR '16', AND

3. CAS SEGMENTS MUST BE PRESENT AT THE LINE OR HEADER WITH AT LEAST CAS REASON CODE = '1' OR '2' AND ASSOCIATED AMOUNTS

Although the Medicare Allowed Amount is not captured directly on the claim, as per HIPAA 837 instructions: The Allowed amount is calculated using the prior payer's payment information coupled with adjustment information in the CAS segments. The prior payer payment + the sum total of all patient responsible adjustment amounts = the Allowed amount. The Patient Responsible adjustments are identified by use of the Category Code PR in CAS01.

LOOP 2010BA – NM108 – 'MI'
NM109 – Client's HIC Number (Medicare ID Number)

LOOP 2320 SBR OTHER SUBSCRIBER INFORMATION
SBR01 = P
SBR09 = MB

LOOP 2320 CAS CLAIM LEVEL ADJUSTMENTS
If any claim level adjustments were made, these would be reported here. Otherwise the critical Medicare Line Item Coinsurance and Deductible amounts are shown in the Loop 2430 CAS segments.

LOOP 2320 AMT COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT
AMT01 = D
AMT02 = Sum of Line Item MEDICARE PAID AMTs

LOOP 2330A NM1 OTHER SUBSCRIBER NAME
NM101-NM103 – AS INDICATED BY THE TR3
NM108 = MI
NM109 = CLIENT'S MEDICARE HIC NUMBER

LOOP 2330B NM1 OTHER PAYER NAME
NM101 = PR
NM102 = 2
NM103 = 'COBA'
NM108 = PI
NM109 = COBA [MUST BE EQUAL TO LOOP 2430, SVD01]

LOOP 2330B DTP CLAIM ADJUDICATION DATE (2430 DTP segment can be used instead)
DTP01 = 573
DTP02 = D8
DTP03 – Date Medicare adjudicated the claim

LOOP 2330B REF OTHER PAYER SECONDARY IDENTIFIER
REF01 = F8
REF02 = Medicare Claim Number

LOOP 2430 SVD SERVICE LINE ADJUDICATION
SVD01 = COBA (MUST BE THE SAME AS REPORTED IN 2330B NM109)
SVD02 = Amount Medicare Paid on the Line
SVD03-1 = HC

SVD03-2 = LI Procedure code
SVD03-3-6 = Procedure Modifiers if applicable
SVD05 = Number of Units Paid

LOOP 2430 CAS LINE ADJUSTMENT

CAS02 – **For every Medicare claim there MUST be at least 1 of the following CAS segments and in many cases 2 CAS segments**,

- CAS02=1 (Medicare Deductible) and
- CAS05=2 (Medicare Coinsurance).

- Another frequent CAS segment used is CAS05= 122, Medicare psych amount

ANY CAS SEGMENT REPORTED MUST HAVE AN ASSOCIATED CAS AMOUNT

The MCO would continue to report their paid amount on the 2400 HCP Segment if the claim was adjudicated at the line; otherwise it would be reported at the header level. The MCO's Paid Amount should equal the lesser of the Medicare deductible/coinsurance amounts or the MCO's payment amount.

837 INSTITUTIONAL

THE CRITICAL COMPONENT IN OUR ABILITY TO CLASSIFY THE INSTITUTIONAL FORMAT AS A CROSSOVER CLAIM IS THAT AN INSTITUTIONAL CROSSOVER CLAIM MUST CONTAIN:

1. **HEADER OR LINE MEDICARE PAID AMOUNTS THAT ARE GREATER THAN $0 (REPORTED IN 2320 OR 2430 AMT AS SHOWN BELOW) AND**

2. **LOOP 2320 SBR09 = 'MA' OR 'MB' OR '16', AND**

3. **LOOP 2320 (FOR INPATIENT) OR LOOP 2430 (FOR OUTPATIENT) CAS AMOUNTS SEGMENTS MUST BE PRESENT WITH AT LEAST CAS REASON CODE = '1' OR '2' AND ASSOCIATED AMOUNTS**

LOOP 2010BA – NM108 – 'MI'
NM109 – Client's HIC Number (Medicare ID Number)

LOOP 2320 SBR OTHER SUBSCRIBER INFORMATION

SBR01 = P
SBR09 = MA or MB

LOOP 2320 CAS CLAIM LEVEL OR LOOP 2430 CAS LINE LEVEL ADJUSTMENTS

CAS02 – **For every Medicare claim there MUST be at least 1 of the following CAS segments and in many cases 2 CAS segments**,

- CAS02=1 (Medicare Deductible) and
- CAS05=2 (Medicare Coinsurance).

- Another frequent CAS segment used is CAS05= 122, Medicare psych amount

ANY CAS SEGMENT REPORTED MUST HAVE AN ASSOCIATED CAS AMOUNT

LOOP 2320 OR LOOP 2430 AMT COORDINATION OF BENEFITS (COB) TOTAL MEDICARE PAID AMOUNT
AMT01 = N1
AMT02 = Sum of Line Item MEDICARE PAID AMTs

LOOP 2330A NM1 OTHER SUBSCRIBER NAME
NM101-NM103 – AS INDICATED BY THE IG
NM108 = MI
NM109 = CLIENT'S MEDICARE HIC NUMBER

LOOP 2330B NM1 OTHER PAYER NAME
NM101 = PR
NM102 = 2
NM103 = 'COBA'
NM108 = PI
NM109 = [MUST BE EQUAL TO LOOP 2430, SVD01]

LOOP 2330B DTP CLAIM ADJUDICATION DATE
DTP01 = 573
DTP02 = D8
DTP03 – Date Medicare adjudicated the claim

LOOP 2330B REF OTHER PAYER SECONDARY IDENTIFIER
REF01 = F8
REF02 = Medicare Claim Number

The MCO would continue to report their paid amount on the 2300 OR 2400 HCP Segment. The MCO's Paid Amount should equal the lesser of the Medicare deductible/coinsurance amounts or the MCO's payment amount.

Third Party Liability (TPL)

The MCO is expected to report all TPL applied to claims on the encounter in the appropriate COB and CAS segments. The MCO Paid amount must reflect the final payment by the MCO less any third party payments received.

Long Term Care Services and Medical Care Credit/Patient Liability

Clients are approved for long term care services once a level of care assessment is completed and the client is found to meet the nursing facility level of care (NFLOC). The MCO is responsible for communicating level of care and setting of care information to HSD for clients enrolled for whom the MCO has determined meet NF LOC and updating that information when a client's situation changes. The MCO is responsible for ensuring that any long term care claims paid are for dates of service for which clients are approved for that SOC and for that provider and that services have been rendered in accordance with the client's plan of care. The revenue codes 0022, 0024 are Medicare codes that are supposed to be used in Medicare billings for short term stays and should only appear on a crossover claim. And for Medicare, the instructions for Inpatient Rehabilitation Facility (IRF) PPS, are when the revenue center code = '0024', the total charges will be zero. Nursing Facility Charges for long term care covered

days that are not Medicare covered skilled care should be billed with the revenue codes 0190 and the submitted charges should be greater than $0. The 0190 accommodation revenue code must have total charges equal the rate times the units.

Clients who meet nursing facility level but are not eligible for Medicaid under normal financial standards of income may have eligibility determined using an institutional care standard of income. These clients will always have a Category of Eligibility of either 081, 083, or 084. Any amount of income deemed in excess of this institutional standard is determined to be the member's responsibility for their own care. This medical care credit (MCC), or patient liability, must be paid for any services rendered in the nursing home for which there is any Medicaid payment to be made; otherwise the member would not be eligible under that category.

The MCC is computed by the county Income Support Division (ISD) office for the first full calendar month of NF care. The MCC amount may be $0 if that is the result of the calculation. Notice of the MCC amount is electronically sent from the ISD office to the NF and the amount is sent from ASPEN to Omnicaid and then on to the MCOs in the Enrollment Roster and on the MCO Informational file. Sometimes, ISD may correct an amount previously reported and communicate that in a separate MAD 200 notice of adjustment form. The medical care credit amount must be collected by the nursing facility and reported on the nursing facility claim form but, regardless, the MCO is responsible for deducting the appropriate medical care credit from the nursing facility payment.

The medical care credit is the amount of the member's income used to reduce the Medicaid payment to the institution where the member resides. A member must make this payment directly to the institution. A Medical Care Credit is not paid for stays in an acute care setting. The amount of the medical care credit is always determined prospectively. The ISD worker computes a medical care credit starting with the first full month of institutional care. No medical care credit is required for the month the recipient enters the institution if [he or she is] they are admitted after the first moment of the first day of the month.

The member is not required to pay a medical care credit for the month of discharge from the institution. The medical care credit must be paid if the member is transferred to another institution or makes a short visit outside the institution. No medical care credit is charged for the month in which a member who received Medicaid institutional care services dies. This will prevent a deficit for the institution when a benefit, such as social security, must be returned due to the death of a beneficiary. No medical care credits are applied for any period of retroactive eligibility under this provision

The MCC is deducted from a Medicare crossover claim for NF services. On crossover claims sent to the MCO for deductible and co-insurance amounts, the MCC is applied against the amount payable on the cross over. The MCC is applied to a claim if the member has been eligible for Medicare only and then becomes eligible for Medicaid as

long as the member has been in the NF the full month. The MCC is taken from the co-insurance payment and/or the Medicaid payment.

When the member transfers from one facility to another, the MCC is taken by the facility in which the resident resided on the first day of the month. A remaining amount of the MCC for the month is applied to additional facility if not satisfied by the first facility.

Since providers often bill weekly, this requires the MCO system to keep track of the MCC still due across more than one claim, and potentially across more than one provider when the member is transferred to a different NF during the month.

The MCC is applied to a claim even though a member has used all the reserve bed days while out of the facility, but not permanently discharged or expired while out of facility. When there is a re-admission the MCC is completed, unless readmit is 30 days post leave, than re-entry is considered a new admission.

The MCC is applied to the nursing facility claim regardless of which revenue codes or type of bill code is billed

The MCC or patient liability amount applied to the nursing facility claim must be reported in the 2300 loop AMT Patient Amount Paid segment of the institutional claim and the MCO Amt Paid must be the allowed amount minus this patient liability amount.

Pricing and the Medicaid Fee Schedule

The New Mexico Fee Schedule posted on the DMZ shows pricing options identified by Factor Code (FC) and modifiers to distinguish between new equipment (use modifier NU) and rentals (use modifier RR). The state may request an invoice during the review for pricing on HCPCS with the rate $0.00. The pricing notes “General Fee Schedule” and “General by Report” and “Manual Review Fee Schedule” are for the global or purchase rates. The pricing notes “Rental Fee Schedule” and “Rental by Report” and “Rental Manual Price-Fee Schedule” are for the rental rates. The pricing notes “26 Fee Schedule (FS)” and “26 by Report” are for the professional component rates when modifier 26 is used. The pricing notes “TC Fee Schedule” and “TC by Report” are for the technical component rates when modifier TC is used.

A procedure reflecting a FC 5 – General by Report with a Value of 0 or Outpatient Hospital pricing, FC Y - OPPS All with a Source Code of J6-OPPS NM Medicaid Price Review, does not mean the service is not covered. The MCO needs to review the service to determine a reimbursement rate to the provider.

When reviewing the HSD fee schedules, for procedures reflecting a FC 5 or FC Y, the MCO should determine the appropriate payment amount by doing the following:

1. Check the Medicare fee schedules to see if a rate has been established,
2. If not and it is a service that you can obtain an invoice for, request the invoice (either the manufacturer or the distributers document reflecting their charges to the provider) and use the information to price the claim line

3. If an invoice is not available or it is a service that is not invoice driven, such as medical or surgical procedures, identify similar procedures that are already priced and use those as a guide to come up with a reimbursement.

Gross Receipts Tax

New Mexico Medicaid services are generally subject to New Mexico Gross Receipts tax (GRT). Only taxable providers (For profit) include tax on their claims and only services which have the tax indicator on the reference file are taxable services. MCOs are expected to negotiate the GRT as part of their rate negotiations with providers. Providers are instructed to include their calculated tax in their billed charges and the MCOs reimbursement must include the Gross Receipts Tax. The MCO Paid Amount must include the GRT amount.

VII. PROVIDER MANAGED CARE ENROLLMENT AND PROVIDER FILE INTERFACES

HSD requires any provider who requests participation with the MCO who is not enrolled with Medicaid as either a FFS or Managed Care Only provider to register with Conduent. Regardless of whether the provider is a contract or non-contracted provider to the MCO, the provider has to appear on the Medicaid Master provider file in order for an encounter to process correctly, with one exception.

The requirement to enroll ordering or referring providers, per §438.602(b)(1), applies to all **network** providers and includes network providers who order or refer to other providers who provide services under the state plan or under a waiver of the plan. With respect to ORPs who only order or refer services for beneficiaries in managed care, this requirement does not extend to providers designated as out of-network or who do not meet the definition of network provider in 42 CFR 438.2.

The enrollment process for a Managed Care provider is not the full enrollment process required of FFS providers and does not require or qualify the provider to participate as a FFS provider. It does, however, allow HSD to set the provider types and specialties that a provider is assigned, which in turn dictates the allowed taxonomy codes that the provider must submit on its claims to the MCO. The MCO is still responsible for certifying any provider who participates with the MCO and maintaining complete provider information for these providers. The enrollment process for a Managed Care provider who is a non-contracted or out-of-state provider is simplified even more than the streamlined process for the MC contracted provider.

HSD will communicate provider enrollment in a monthly and daily file; both of which share the same layout:

1. A monthly Provider Master File submitted by HSD to the MCO as a full file monthly of all FFS and MC Only Enrolled providers
2. A daily Provider Confirmation file submitted by HSD to the MCOs on a daily basis containing new provider enrollments or changes in status.

Provider Master File

HSD/MAD will generate a Provider Master file that identifies all Medicaid FFS enrolled providers and all Managed Care Only providers. Under Centennial Care, Omnicaid will not create another MC provider record if that provider is enrolled as a FFS provider. MCOs may contract with FFS providers and MC-Only providers. If the provider is not on the Provider Master file and the Centennial Care MCO intends to pay a claim with that provider associated on the claim, the provider must be enrolled with Omnicaid as a MC-Only or FFS provider.

The Managed Care Provider Enrollment Process will work as follows:

1. HSD will transmit a monthly Provider Master file to the MCOs that shows all FFS and MC-Only provider as well as any terminated or pended providers
2. HSD will transmit a daily update Provider Confirmation file to the MCO showing any newly added enrolled Medicaid FFS providers or MC-Only providers, and newly terminated providers.

3. The MCO should perform outreach and Refer any provider they intend to pay claims for who doesn't appear on the Provider Master or Confirmation file as a Medicaid FFS or MC-Only provider to NM Medicaid's Provider Web Portal for enrollment with the NM Medicaid program.

Providers will be enrolled with a separate Medicaid Provider Id for each occurrence of a different NPI (or tax id for atypical providers), Medicaid Provider type(s) and Servicing Location Zip code. Once a provider has enrolled as a Medicaid FFS or Managed Care-Only provider, that status will be communicated on the Provider Confirmation file to all the participating MCOs and the process does not need to be repeated. No encounter claim from a provider will be accepted by NM Omnicaid unless that provider has been enrolled in the NM Medicaid program.

Monthly, HSD will send a full Provider Master file that lists:

- all the providers identified as active FFS (status 60) or MC-only providers (status 70,
- any Provider that has a termination /denied/pending status with an effective date within the past 4 years (not including any providers not active as of 1/1/2014)

The MCO is responsible for recording each Provider listed on the NM Medicaid Provider Master/Confirmation file with whom the MCO intends to do business in the MCO's system with the NPI, the assigned Provider Type, Specialty (if applicable), and dates. This data must be used to edit claims and ensure that the appropriate provider taxonomy and provider servicing location zip code is assigned to encounter claims.

The MCO is responsible for providing automated access to members and providers of a directory of all that MCO's enrolled providers and identification of a member's PCP and/or Health Home assignment

The MCO will be responsible for referring any provider who notifies the MCO of a change in their location, licensure or certification, or status to the Conduent Provider Enrollment Unit for updating their enrollment status with the NM Medicaid program.

The MCO is responsible for terminating their relationship with a provider when the provider has been terminated 'for cause' by HSD. From the Provider Enrollment perspective, a "for cause" provider termination is directly related to federal regulations. Here is the definition from the Medicaid Provider Enrollment Compendium (MPEC) that State Medicaid Agencies use:

> **For Cause Termination** means a termination, as defined in subparagraph (11) of this section by an SMA of the provider's billing privileges, of which appeal rights have been exhausted or the time for appeal has expired. For Cause terminations are terminations related to fraud, integrity, or quality issues which run counter to the overall success of the Medicaid Program. For the purpose of CMS review, for cause reasons for termination closely

mirror the regulatory authorities for Medicare revocations found in 42 CFR § 424.535. See also MPEC 01.10.02; 01.01.02.

The Omnicaid Provider Enrollment Statuses that MAD uses to identify a "for cause" termination are as highlighted:

Value	Long
01	Term-Medicaid Authority
02	Medicare Termination
05	Medicare Exclusion

Provider Master File/Provider Confirmation File Layout

The file layout for the Provider Master file and Provider Confirmation file will be the same. HSD sends the Provider Master or Confirmation File with all fields populated. *[The only difference between the Provider Master and Confirmation file is that the Master is a once monthly full file; whereas the Confirmation is a daily update only file.]* .

The provider's NPI is always the key identifier, unless the provider is an atypical provider without NPI, in which case, the identifier will be the provider's tax id (EIN) or Social Security Number (SSN), if used for tax purposes instead of a EIN. The NPI number or EIN/SSN, for atypical providers, submitted on encounters must then match a provider on file that has been added as a FFS or MC-only enrolled provider.

HSD assigns a separate Medicaid Provider ID record for each provider type on file for every combination of Provider NPI, Provider Type, and Zip Code. Thus, if a provider NPI xxxxxxxxxx has one provider type in one location and another provider type in that same location as well as in a different location, there will be 3 records present on the file; each with its own Medicaid Provider ID number. The only exception to this is that a servicing only provider who can be expected to be on a claim as a rendering, referring, ordering provider should only be assigned one provider id based on that practitioner's primary location; in order to avoid problems with identifying the correct Medicaid ID in Omnicaid since the 837 doesn't contain a zip code for the rendering provider.

There should be no duplicate combinations of NPI (or EIN/SSN if the provider is an atypical), provider type and location zip code. The Omnicaid system uses the NPI, taxonomy code and zip code on the incoming encounter to match to the correct provider id on the Omnicaid system. A file of taxonomy codes matched to provider type will be provided to the MCOs.

The file layout for the Provider Master/ Confirmation file is as follows. The file name should be in the format:
PROV_CONFIRM.mmddyyyy.ZIP
PROV_MASTER.mmddyyy.ZIP
:

Provider Master Header record

```
001400 01  WFP20050-HEADER-RECORD.
001500      05  WFP20050-RECORD-TYPE         PIC X(1).
001600          88  WFP20050-REC-TYPE-HDR          VALUE 'H'.
001700      05  WFP20050-FILE-TYPE           PIC X(1).
001800          88  WFP20050-FILE-TYPE-CONFIRM     VALUE 'C'.
002000          88  WFP20050-FILE-TYPE-MASTER      VALUE 'M'.
002200      05  WFP20050-MCO-ID              PIC X(8).
002300      05  WFP20050-FILE-CREATE-DATE.
002400          10  WFP20050-FILE-CREATE-CC  PIC X(2).
002500          10  WFP20050-FILE-CREATE-YY  PIC X(2).
002600          10  WFP20050-FILE-CREATE-MM  PIC X(2).
002700          10  WFP20050-FILE-CREATE-DD  PIC X(2).
003000      05  FILLER                       PIC X(568).
```

Provider Master Detail record/Provider Confirmation

```
01  WFP20100-PROVIDER-RECORD.
     05  WFP20100-RECORD-TYPE         PIC X(01).
     05  WFP20100-PROV-STATUS         PIC X(02).
     05  WFP20100-PROV-NPI-ID         PIC X(10).
     05  WFP20100-PROV-EIN-SSN        PIC X(09).
     05  WFP20100-SORT-NAME           PIC X(45).
     05  WFP20100-PROV-MEDICAID-ID    PIC X(08).
     05  WFP20100-SVC-ADDRESS-AREA.
         10  WFP20100-SVC-ADDR-LINE1  PIC X(45).
         10  WFP20100-SVC-ADDR-LINE2  PIC X(45).
         10  WFP20100-SVC-CITY        PIC X(20).
         10  WFP20100-SVC-ST          PIC X(02).
         10  WFP20100-SVC-ZIP5        PIC X(05).
         10  WFP20100-SVC-ZIP4        PIC X(04).
         10  WFP20100-SVC-GEO-CNTY    PIC X(02).
     05  WFP20100-SVC-PROV-PHONE      PIC X(10).
     05  WFP20100-MAIL-ADDRESS-AREA.
         10  WFP20100-MAIL-ADDR-LINE1 PIC X(45).
         10  WFP20100-MAIL-ADDR-LINE2 PIC X(45).
         10  WFP20100-MAIL-CITY       PIC X(20).
         10  WFP20100-MAIL-ST         PIC X(02).
         10  WFP20100-MAIL-ZIP5       PIC X(05).
         10  WFP20100-MAIL-ZIP4       PIC X(04).
     05  WFP20100-P-HLTH-HM-IND       PIC X(01).
     05  FILLER                       PIC X(110).
     05  WFP20100-PROV-TY-CD          PIC X(03).
     05  WFP20100-SPECIALTY-DATA
                 OCCURS 9 TIMES.
         10  WFP20100-PROV-SPECIALTY  PIC X(03).
     05  WFP20100-OMNICAID-PROV-BEG-DT.
         10  WFP20100-OMNI-PROV-BEG-CC
                       PIC X(02).
         10  WFP20100-OMNI-PROV-BEG-YY
                       PIC X(02).
         10  WFP20100-OMNI-PROV-BEG-MM
                       PIC X(02).
         10  WFP20100-OMNI-PROV-BEG-DD
                       PIC X(02).
     05  WFP20100-OMNICAID-PROV-END-DT.
```

```
        10  WFP20100-OMNI-PROV-END-CC
                        PIC X(02).
        10  WFP20100-OMNI-PROV-END-YY
                        PIC X(02).
        10  WFP20100-OMNI-PROV-END-MM
                        PIC X(02).
        10  WFP20100-OMNI-PROV-END-DD
                        PIC X(02).
    05  WFP20100-PROFIT-IND          PIC X(01).
    05  WFP20100-P-NAM               PIC X(45).
    05  WFP20100-P-DBA-NAM           PIC X(45).
    05  WFP20100-P-IHS-IND           PIC X(01).
    05  WFP20100-TREAT-FIRSTND       PIC X(01).
    05  WFP20100-HI-FI-WRAP-IND      PIC X(01).
    05  FILLER                       PIC X(06).
```

Provider Master Trailer record

```
001500 01  WFP20200-TRAILER-RECORD.
001600      05  WFP20200-RECORD-TYPE   PIC X(01).
001700          88  WFP20200-REC-TYPE-TLR
001800                      VALUE 'T'.
001900      05  WFP20200-RECORD-COUNT  PIC 9(09).
002200      05  FILLER                 PIC X(576).
```

PROVIDER STATUS CODES

Value	Description		
01	Term-Medicaid Authority	21	Denied Two Prov Numbers
02	Medicare Termination	22	Denied-Prov Already Has Num
03	Term-License Revoked	23	Denied Not Eligible
04	Term-License Expired	24	Denied for Other Reasons
05	Medicare Exclusion	40	Pending No Lic/Temp Lic
06	Term-Change Of Ownership	41	Pending Signed Agreement
07	No Claims Activity	42	Pending Missing Documentation
08	Term-Provider Deceased	43	Pending Rate Determination
09	Term-Pending	44	Pending Status Approval
10	Term-Voluntary Termination	45	Pending Web Application
11	Terminated- MCO Authority	46	Pend-License/Cert Verif
13	Term-No Reverification	60	Active
20	Denied-Invalid License	70	None-MCO Prov-See MCO Status
		99	NPI ID Missing For Provider

Source Field	Std Edit	Req	Specifications
PROV-HEADER-RECORD	N/A	N/A	
RECORD-TYPE	N/A	N	H = HEADER P = PROVIDER T = TRAILER

Source Field	Std Edit	Req	Specifications
FILE TYPE			M – PROVIDER MASTER FILE – FULL FILE SUBMITTED MONTHLY TO THE MCO C – PROVIDER CONFIRMATION FILE – UPDATE FILE SUBMITTED DAILY OR FULL FILE SUBMITTED PERIODICALLY
MCO-ID	N/A	A	The Provider ID assigned to the MCO – MUST BE POPULATED IF THE FILE TYPE IS N
FILE-CREATE-DATE	N/A	A	

Target Field	Target Field Type	Target Field Size	Source Table / File	Source Column / Field	Std Edit	Req	Specifications	
WFP20100-PROVIDER-RECORD	N/A	N/A	N/A	N/A	N/A	N/A		
WFP20100-RECORD-TYPE	Alphanumeric	1	N/A	RECORD-TYPE	N/A	A	P = Provider	
WFP20100-PROV- STATUS	Alphanumeric	2	P_ENROL_STAT_TB	P_ENROL_STAT_TY_CD	N/A	A	Current provider enrollment status code (see list at end)	
WFP20100-PROV-NPI-ID	Alphanumeric	10	P_NPI_XMTCH_TB	P_NPI_ID	N/A	C	Required for all health care providers.	
WFP20100-PROV-EIN-SSN	Alphanumeric	9	P_PROV_TB	P_FED_TAX_ID P_SSN_NUM	N/A	C	The provider's EIN or SSN required if provider is an atypical	
WFP20100-PROV-SORT-NAME	Alphanumeric	45	P_PROV_TB	P_SORT_NAM	N/A	A	Format is: LAST NAME, space FIRST NAME space MIDDLE INITIAL space TITLE Facilities whose name starts with "The" should be entered with the facility name not including "The".	
WFP20100-PROV-MEDICAID-ID	Alphanumeric	8	P_PROV_TB	P_ID	N/A	A	Omnicaid provider id	
WFP20100-SVC-ADDRESS-AREA	N/A		N/A	N/A	N/A	N/A	This is the location at which the provider renders services.	
WFP20100-SVC-ADDR-LINE1	Alphanumeric	45	P_ADDR_TB	P_LINE1_AD	N/A	A	Location address line 1	
WFP20100-SVC-ADDR-LINE2	Alphanumeric	45	P_ADDR_TB	P_LINE2_AD	N/A	N	Location address line 2	
WFP20100-SVC-CITY	Alphanumeric	20	P_ADDR_TB	P_CITY_NAM	N/A	A	Location city	
WFP20100-SVC-ST	Alphanumeric	2	P_ADDR_TB	P_ST_CD	N/A	A	Location state	
WFP20100-SVC-ZIP5	Alphanumeric	5	P_ADDR_TB	P_ZIP5_CD	N/A	A	Generate from zip codes for the Location address	
WFP20100-SVC-ZIP4	Alphanumeric	4	P_ADDR_TB	P_ZIP4_CD	N/A	A	Generate from zip codes for the Location address	
WFP20100-SVC-GEO-CNTY	Alphanumeric	2	P_ADDR_TB	P_CNTY_CD	N/A	A	Location county	
WFP20100-SVC-PROV- PHONE	Alphanumeric	10	P_ADDR_TB	P_PHON_NUM	N/A	A	Phone number	
WFP20100-MAIL-ADDRESS-AREA			N/A	N/A	N/A	N/A		

Target Field	Target Field Type	Target Field Size	Source Table / File	Source Column / Field	Std Edit	Req	Specifications	
WFP20100-MAIL-ADDR-LINE1	Alphanumeric	45	P_ADDR_TB	P_LINE1_AD	N/A	A	Mailing address line 1	
WFP20100-MAIL-ADDR-LINE2	Alphanumeric	45	P_ADDR_TB	P_LINE2_AD	N/A	N	Mailing address line 2	
WFP20100-MAIL-CITY	Alphanumeric	20	P_ADDR_TB	P_CITY_NAM	N/A	A	Mailing city	
WFP20100-MAIL-ST	Alphanumeric	2	P_ADDR_TB	P_ST_CD	N/A	A	Mailing state	
WFP20100-MAIL-ZIP5	Alphanumeric	5	P_ADDR_TB	P_ZIP5_CD	N/A	A	Mailing zip	
WFP20100-MAIL-ZIP4	Alphanumeric	4	P_ADDR_TB	P_ZIP4_CD	N/A	A	Mailing zip+4	
WFP20100-HEALTH-HOME-IND	Alphanumeric	3			N/A	N	Value of 'Y' indicates provider is approved for Health Home services	
WFP20100-PROV-TY-CD	Alphanumeric	3	P_PROV_TB	P_TY_CD	N/A	C	The provider type is assigned by HSD. There will be a separate record for each provider type on file for every provider. There will be no duplicate combinations of NPI, provider type and location zip code, or EIN/SSN	
WFP20100-SPECIALTY-DATA	N/A	N/A	N/A	N/A	N/A	N/A	A provider may have more than one specialty assigned. There will be ~~3~~ 9 occurrences.	
WFP20100-PROV-SPECIALTY	Alphanumeric	3	P_SPECL_TB	P_SPECL_CD	N/A		The provider specialty assigned by HSD.	
WFP20100-OMNICAID PROV- BEG-DT	Alphanumeric	10	P_ENROL_STAT_TB	P_STAT_EFF_DT	N/A	A	This will always be filled in by Omnicaid and is the date on which the provider is enrolled with Omnicaid as a provider. This will always be the most current status. For example, a provider is a status 60 with effective date 1/1/10 on the first provider master to the MCO. Then for some reason the provider gets terminated on 6/1/14 and becomes active again on 7/1/14. We will have sent the MCO a provider record showing the 1/1/10 effective date for status 60, a termination for 6/1/14, and then an enrollment record for 7/1/14 Format: CCYYMMDD	
WFP20100-OMNICAID PROV-END-DT	Alphanumeric	10	P_ENROL_STAT_TB	P_STAT_EFF_DT	N/A	A	This will always be filled in by Omnicaid and will always be an open-ended date unless the provider's status is terminated.. Format: CCYYMMDD	
WFP20100 PROFIT-IND	Alphanumeric	1					This indicates if this provider is a profit of non-profit provider. This indicator will have a value of 'Y' of 'N'.	
WFP20100-P-NAM	Alphanumeric	45			N/A	N		

Target Field	Target Field Type	Target Field Size	Source Table / File	Source Column / Field	Std Edit	Req	Specifications	
WFP20100-P-DBA-NAM	Alphanumeric	45			N/A	N		
WFP20100-P-IHS-IND	Alphanumeric	1					A value of 'Y' identifies an IHS provider	
WFP20100-TREAT-FIRST-IND	Alphanumeric	1					A value of 'Y' identifies a provider approved for Treat First	
WFP20100-HI-FI-WRAP-IND	Alphanumeric	1					A value of 'Y' identifies a provider approved for Hi Fidelity Wrap Around Services	
FILLER	Alphanumeric	6						

Provider Web Portal

Providers who are not enrolled as Medicaid FFS providers or as MC-Only providers can submit their application for enrollment through the Medicaid Provider Web Portal. The application will be entered with a pending ID number and Provider Operations staff will review the application in light of Omnicaid requirements for the given provider type. For example, Community Based providers must be licensed to provide many services and so may have to submit additional documentation showing their licensure in order to be approved. Provider Operations has instructions and will contact the provider to obtain any necessary documentation.

There are two types of Managed Care Only provider enrollment on the web portal.

1. HSD MC-Only Contracted – abbreviated application but for the most part, just like a FFS provider
2. MC-Only Restricted providers – this is a streamlined application that does not include licensure information; does include tax information but optional only and requires no uploads of documents to the web. The intention is that the MCO is completing abbreviated applications on behalf of participating providers and would not have access to documentation required on the MCO provider enrollment applications currently available on the web portal.

MCOs or Providers access the NM Medicaid Web Portal for Provider Enrollment via this URL: https://nmmedicaid.portal.conduent.com/webportal/enrollOnline

MC-Only Restricted Provider Enrollment

The Managed Care Organization (MCO) is able to enroll certain providers using the MCO Restricted enrollment. The allowable providers for this MCO Restricted enrollment are:

1. Medicare Only providers (these are providers who appear on a crossover claim that are not otherwise Medicaid providers)
2. Pharmacies (provider type 416) that are not part of the MCO's network
3. Dentists (provider type 421) that are not part of the MCO's network

4. Out-of-State Non-Network providers (except those located in TX, CO, AZ, UT)

The MCO should enter their Medicaid Provider ID and complete the information on the Web Portal as if you were the Medicaid provider the MCO is trying to enroll.

CHANGES TO THE PROVIDER RECORD

Providers and MCOs can submit concerns and requests (e.g., including duplicate providers, expedited provider registrations, and back dating) to the State's MAD Provider Enrollment email (mad.providerenrollment@hsd.nm.gov) or to the Consolidated Call Center (1-800-299-7304) so all requests can be tracked and responded to.

If the MCO becomes aware that the effective date of the provider enrollment is not sufficient to cover dates of service for its members, a request to back date the enrollment begin date can be made. For MCO-Only providers with enrollment status 70, the MCO can make this request themselves via the MAD Provider Enrollment email or CCSC. For FFS & MC providers with enrollment status 60, since the enrollment belongs to the provider they need to submit the request to backdate and not the MCO.

PROVIDER TYPES THAT CAN'T COEXIST

The following is part of duplicate checking logic for provider enrollment to prevent enrollment of a provider more than once for a provider type that should not be allowed to coexist.

The following pairs of provider types should never coexist for the same NPI, regardless of location

211	NursFacPvt	Nursing Facility, Private	NRSNG-FAC-PR
212	NursFac St	Nursing Facility, State	NRSNG-FAC-ST
214	ICFMRPrvt	ICF MR Private	ICFMR-PRVT
215	ICF MR St	ICF MR State Owned	ICFMR-ST-OWN
216	ResTrJCAHO	Residential Trtmnt Ctr. JCAHO	RES-TR-JCAHO
217	ResTrtCtr	Residentl Trtmnt Ctr Not JCAHO	RES-TRT-CTR

The following pairs of provider types should never coexist for the same NPI, in the same location (defined as same 9 digit zip code). These physician provider types should also not coexist for the same NPI with any other provider type between the ranges of 211-445, regardless of location

301	Physicn M	Physician, MD	PHYSICIAN-MD
302	Physicn DO & ND	Physician, DO & ND	PHYSICIAN-DO & ND

The provider type

303	Prof Comp	Physician Component for Hosptl	PHYS-CMP-HOS

should only be allowed to coexist for the same NPI, in the same location (defined as same 9 digit zip code) **with the following provider types.**

201 Hospital, General Acute
202 Hospital, Rehabilitation Unit in a General Acute Hospital
203 Hospital, Rehabilitation
204 Hospital, Psychiatric Unit in a General Acute Hospital
205 Hospital, Psychiatric
211 Nursing Facility, Private

212 Nursing Facility, State
213 Hospital, Swing-Bed
214 ICF MR Private
215 ICF MR State Owned
221 Indian Health Services Hospital or Tribal Compacts

Note: 303 cannot coexist with any other provider type between the range of 222-445 and can only coexist with the list above if at the same location.

The following groups of provider types should never coexist for the same NPI, in the same location (defined as same 9 digit zip code).

306	ClNursSpec	Clinical Nurse Specialist	CLINIC-NURSE-SPEC
316	Nurse CNP	Nurse, CN Practitioner	NURSE-CN-PRCT
317	Nurse RN	Nurse, RN	NURSE-RN
318	Nurse CRNA	Nurse, CRNA	NURSE-CRNA
311	ClinicDxTr	Clin Non-prft Trtmnt&Diag Ctr	CLN-NPR-TR-DG
312	ClinicFmPl	Clinic, Family Planning	CLN-FAM-PLNG
313	FQHC	Clinic Federally Qlfd Hlth Ctr	CL-FD-QLF-HCT
314	RH Clinic	Clin, Rural Hlth Med, Freestnd	CLN-RHLTH-MD
315	RHC hspbsd	Clin,Rural Hlth Med, Hosp Bsd	CL-RR-HLTH-MD
322	Midwfe Nur	Midwife, Certified Nurse	MIDWIFE-CERT-NURSE
323	Midwfe Lay	Midwife, Lay	MIDWIFE-LAY
336	Orthotist	Orthotist	ORTHOTIST
337	Prosthetst	Prosthetist	PROSTHETIST
338	ProsthOrth	Prosthetist & Orthotist	PROSTH-ORTH
351	LabClnical	Lab, Clinical Free Standing	LB-CLN-FR-STN
352	Radlgy Fac	Radiology Facility	RDLGY-FCLTV
353	Lab&RadFac	Lab, Clinical With Radiology	LB-CLN-RDLGY
354	LabDgnstic	Laboratory, Diagnostic	LAB-DIAG

If provider is PT and OT, make them a PT and not have both

451	OcupThrpst	Occup Therapist, Lic & Cert	OCUP-THRPST
452	OccThrpLic	Occupational Therpst Licensed	OCC-THRP-LIC
453	PhysThrpst	Physical Therapist, Lic & Cert	PHYS-THRPST
454	PhsThrpLic	Physical Therapist, Licensed	PHS-THRP-LIC
457	SpThrLicCt	SpeechTherapistChldAdltLicCert	SP-THRP-CHLD
458	SpThr Schl	Speech Therapist Child,Sch Cer	SP-THER-SC-CT
421	Dentist	Dentist	DENTIST
422	ClnRHlthDn	Clinical, Rural Health, Dental	CLN-RHLTH-DN
423	DntlHygnst	Dental Hygienist	DENTAL-HYGNST

Community Benefit can only be provided by a provider type 363. If a provider is enrolled as PT 344, you must have that provider enroll as type 363 before rendering Community Benefit services.

363 Community Benefit Provider

The following are all individual service renderers (except PT 433, but which also should have only 1 licensed location) which should never exist as more than one provider type between the ranges of 211-445 per NPI regardless of location

430	BehHealWor	Behavioral Health Worker	BEHAVR-HEALTH-WORK
431	Psychlgst	Psychologist, PHd, EdD,PsyD	PSYCHOLOGIST
433	MH DOH	Clinic, MH Center(DOH)	MNT-HLTH-CNT
435	LPCC	LPCC (Lic Prof Clinic Counslr)	LPCC
436	LMFT	LMFT (Lic Marr&Family Therap)	LMFT
437	LMSW	LMSW (Lic Mstr Lev Social Wkr)	LMSW
438	PsySchCert	Psychologist School Certified	PSYCH-SCH-CERT

439	PsyAssLisc	Psychologist Associate License	PSYCH-ASSO-LISC
440	LADAC	Lic Alchol & Drug Abuse Cnslr	LADAC
443	PsyNursCNS	Nurse Psych Nurse Specialist	NRS-PS-NRS-SP
444	LISW	LISW (Lic Indpndnt Soc Worker)	LISW
445	Cnslr Mstr	Licensed Masters Level Counsel	LC-MST-LV-CNS

PROVIDER TYPE AND SPECIALTY

Provider type and specialty are assigned based on the licensure and certification of the provider. Depending on the types of services a provider's licensure/certification allows, a provider may have multiple provider records in Omnicaid, one for each type and servicing location. The MCO must be aware of the services a given provider type may render in order to ensure that the appropriate taxonomy is used. For example, a provider may enroll with Omnicaid as a Home Health provider type which has specific taxonomies associated. If the MCO and provider determine that the provider should also provide Community Benefit services, a separate provider type must be assigned by HSD which associates to a different set of taxonomies. Home Health services are billed on an institutional claim with CMS defined revenue codes and the home health taxonomies whereas Community Benefit services are billed on a professional claim with HCPC codes defined by HSD. The same provider may also be licensed/certified as a DME provider which also bills on a professional claim with its own taxonomies. The MCO is responsible for ensuring that providers are shown on the provider file with the appropriate provider types and specialties for the services contracted with that MCO and that the MCO pays claims with the correct taxonomies for that provider type and group of services.

The following is the approved HSD provider type and specialty list. Providers may have only one type, but may have more than one specialty

Prov_Type_Cd	Prov_Type_Desc	Specialty_Cd	Prov_Specialty_Desc
201	Hospital, General Acute		
201	Hospital, General Acute	139	Mobile Resp and Stab Svcs
201	Hospital, General Acute	149	Mobile Crisis Team
202	Hospital, PPS Exempt, Rehab		
202	Hospital, PPS Exempt, Rehab	127	Childrens Specialty Hospital
202	Hospital, PPS Exempt, Rehab	128	Long Term Acute Care Hospital
202	Hospital, PPS Exempt, Rehab	129	Rehabilitation Hospital
202	Hospital, PPS Exempt, Rehab	134	Other Specialty Hospital
203	Hospital, Rehabilitation	127	Childrens Specialty Hospital
203	Hospital, Rehabilitation	128	Long Term Acute Care Hospital
203	Hospital, Rehabilitation	129	Rehabilitation Hospital
203	Hospital, Rehabilitation	134	Other Specialty Hospital
204	Hospital, PPS Exempt, Psychiat		
205	Hospital, Psychiatric		
211	Nursing Facility, Private		
212	Nursing Facility, State		
213	Hospital, Swing Bed		
214	ICF for Ind w Intell Dis Prv		
215	ICF for Ind w Intell Dis StOwn		
216	Residential Trtmnt Ctr. JCAHO	260	Juvenile ARTC for BH
216	Residential Trtmnt Ctr. JCAHO	261	Adult ARTC SUD

216	Residential Trtmnt Ctr. JCAHO	262	Qualified Res Treatment Progrm
217	Residentl Trtmnt Ctr Not JCAHO		
218	Treatment Foster Care Svcs		
219	Group Home		
221	Indian Health Svcs Hospital	100	Hospital
221	Indian Health Svcs Hospital	101	Case Management
221	Indian Health Svcs Hospital	102	Dental
221	Indian Health Svcs Hospital	103	Enhanced EPSDT Res Beh Hlth Sv
221	Indian Health Svcs Hospital	104	FQHC Paid at IHS OMB Rates
221	Indian Health Svcs Hospital	105	Transportation
221	Indian Health Svcs Hospital	106	Ambulatory Surgery
221	Indian Health Svcs Hospital	149	Mobile Crisis Team
221	Indian Health Svcs Hospital	139	Mobile Resp and Stab Svcs
222	Care Coordinator		
223	MCO Administration		
301	Physician, MD	001	General Practic
301	Physician, MD	002	GeneralOtherSpecializedSurgery
301	Physician, MD	003	Allergy
301	Physician, MD	004	Ear, Nose, Throat
301	Physician, MD	005	Anesthesiology
301	Physician, MD	006	Cardiology
301	Physician, MD	007	Dermatology
301	Physician, MD	008	Family Practice
301	Physician, MD	010	Gastroenterology
301	Physician, MD	011	Hematology or Oncology
301	Physician, MD	012	Manipulative Therapy
301	Physician, MD	013	Neurology
301	Physician, MD	014	Neurological Surgery
301	Physician, MD	015	Obstetrics
301	Physician, MD	016	OB - GYN
301	Physician, MD	017	Eye, Ear Nose, Throat
301	Physician, MD	018	Ophthamology
301	Physician, MD	019	Neonatology
301	Physician, MD	020	Orthopedic Surgery
301	Physician, MD	021	Emergency Medicine
301	Physician, MD	022	Pathology
301	Physician, MD	023	Periph Vascular Disease
301	Physician, MD	024	Plastic Surgery
301	Physician, MD	025	Physical Medicine Rehab
301	Physician, MD	026	Psychiatry, Other
301	Physician, MD	027	Pain Management
301	Physician, MD	028	Proctology
301	Physician, MD	029	Pulmonary Disease

301	Physician, MD	030	Radiology
301	Physician, MD	032	Radiation Therapy
301	Physician, MD	033	Thoracic Surgery
301	Physician, MD	034	Urology
301	Physician, MD	036	Nuclear Medicine
301	Physician, MD	037	Pediatrics
301	Physician, MD	038	Geriatrics
301	Physician, MD	039	Nephrology
301	Physician, MD	040	Hand Surgery
301	Physician, MD	041	Internal Medicine
301	Physician, MD	042	Cardiology, Pediatric
301	Physician, MD	043	Allergy, Pediatric
301	Physician, MD	044	Public Health
301	Physician, MD	046	Preventative Medicine
301	Physician, MD	047	Psych, Board Certif,Child/Adol
301	Physician, MD	048	Endocrinology Diabetes Metabol
301	Physician, MD	049	Multiple Specialties
301	Physician, MD	050	Addictionologist
301	Physician, MD	140	CardiacPeripheralVascularSurgy
301	Physician, MD	141	Critical Care
301	Physician, MD	142	Genetics or Genetic Counseling
301	Physician, MD	143	Hospitalist
301	Physician, MD	144	Oral & Maxilliofacial Surgery
301	Physician, MD	145	Rheumatology
301	Physician, MD	146	Sleep Medicine
301	Physician, MD	147	Sports Medicine
301	Physician, MD	148	Transplant Surgery
301	Physician, MD	150	Austism Eval Provider
302	Doctors of Osteopathy and Natu	001	General Practic
302	Doctors of Osteopathy and Natu	002	GeneralOtherSpecializedSurgery
302	Doctors of Osteopathy and Natu	003	Allergy
302	Doctors of Osteopathy and Natu	004	Ear, Nose, Throat
302	Doctors of Osteopathy and Natu	005	Anesthesiology
302	Doctors of Osteopathy and Natu	006	Cardiology
302	Doctors of Osteopathy and Natu	007	Dermatology
302	Doctors of Osteopathy and Natu	008	Family Practice
302	Doctors of Osteopathy and Natu	010	Gastroenterology
302	Doctors of Osteopathy and Natu	011	Hematology or Oncology
302	Doctors of Osteopathy and Natu	012	Manipulative Therapy
302	Doctors of Osteopathy and Natu	013	Neurology
302	Doctors of Osteopathy and Natu	014	Neurological Surgery
302	Doctors of Osteopathy and Natu	015	Obstetrics
302	Doctors of Osteopathy and Natu	016	OB - GYN

302	Doctors of Osteopathy and Natu	017	Eye, Ear Nose, Throat
302	Doctors of Osteopathy and Natu	018	Ophthamology
302	Doctors of Osteopathy and Natu	019	Neonatology
302	Doctors of Osteopathy and Natu	020	Orthopedic Surgery
302	Doctors of Osteopathy and Natu	021	Emergency Medicine
302	Doctors of Osteopathy and Natu	022	Pathology
302	Doctors of Osteopathy and Natu	023	Periph Vascular Disease
302	Doctors of Osteopathy and Natu	024	Plastic Surgery
302	Doctors of Osteopathy and Natu	025	Physical Medicine Rehab
302	Doctors of Osteopathy and Natu	026	Psychiatry, Other
302	Doctors of Osteopathy and Natu	027	Pain Management
302	Doctors of Osteopathy and Natu	028	Proctology
302	Doctors of Osteopathy and Natu	029	Pulmonary Disease
302	Doctors of Osteopathy and Natu	030	Radiology
302	Doctors of Osteopathy and Natu	032	Radiation Therapy
302	Doctors of Osteopathy and Natu	033	Thoracic Surgery
302	Doctors of Osteopathy and Natu	034	Urology
302	Doctors of Osteopathy and Natu	036	Nuclear Medicine
302	Doctors of Osteopathy and Natu	037	Pediatrics
302	Doctors of Osteopathy and Natu	038	Geriatrics
302	Doctors of Osteopathy and Natu	039	Nephrology
302	Doctors of Osteopathy and Natu	040	Hand Surgery
302	Doctors of Osteopathy and Natu	041	Internal Medicine
302	Doctors of Osteopathy and Natu	042	Cardiology, Pediatric
302	Doctors of Osteopathy and Natu	043	Allergy, Pediatric
302	Doctors of Osteopathy and Natu	044	Public Health
302	Doctors of Osteopathy and Natu	046	Preventative Medicine
302	Doctors of Osteopathy and Natu	047	Psych, Board Certif,Child/Adol
302	Doctors of Osteopathy and Natu	048	Endocrinology Diabetes Metabol
302	Doctors of Osteopathy and Natu	049	Multiple Specialties
302	Doctors of Osteopathy and Natu	050	Addictionologist
302	Doctors of Osteopathy and Natu	140	CardiacPeripheralVascularSurgy
302	Doctors of Osteopathy and Natu	141	Critical Care
302	Doctors of Osteopathy and Natu	142	Genetics or Genetic Counseling
302	Doctors of Osteopathy and Natu	143	Hospitalist
302	Doctors of Osteopathy and Natu	144	Oral & Maxilliofacial Surgery
302	Doctors of Osteopathy and Natu	145	Rheumatology
302	Doctors of Osteopathy and Natu	146	Sleep Medicine
302	Doctors of Osteopathy and Natu	147	Sports Medicine
302	Doctors of Osteopathy and Natu	148	Transplant Surgery
302	Doctors of Osteopathy and Natu	150	Austism Eval Provider
302	Doctors of Osteopathy and Natu	300	Naturopathic Doctor
303	Physician Component for Hosptl	001	General Practic

303	Physician Component for Hosptl	002	GeneralOtherSpecializedSurgery
303	Physician Component for Hosptl	003	Allergy
303	Physician Component for Hosptl	004	Ear, Nose, Throat
303	Physician Component for Hosptl	005	Anesthesiology
303	Physician Component for Hosptl	006	Cardiology
303	Physician Component for Hosptl	007	Dermatology
303	Physician Component for Hosptl	008	Family Practice
303	Physician Component for Hosptl	010	Gastroenterology
303	Physician Component for Hosptl	011	Hematology or Oncology
303	Physician Component for Hosptl	012	Manipulative Therapy
303	Physician Component for Hosptl	013	Neurology
303	Physician Component for Hosptl	014	Neurological Surgery
303	Physician Component for Hosptl	015	Obstetrics
303	Physician Component for Hosptl	016	OB - GYN
303	Physician Component for Hosptl	017	Eye, Ear Nose, Throat
303	Physician Component for Hosptl	018	Ophthamology
303	Physician Component for Hosptl	019	Neonatology
303	Physician Component for Hosptl	020	Orthopedic Surgery
303	Physician Component for Hosptl	021	Emergency Medicine
303	Physician Component for Hosptl	022	Pathology
303	Physician Component for Hosptl	023	Periph Vascular Disease
303	Physician Component for Hosptl	024	Plastic Surgery
303	Physician Component for Hosptl	025	Physical Medicine Rehab
303	Physician Component for Hosptl	026	Psychiatry, Other
303	Physician Component for Hosptl	027	Pain Management
303	Physician Component for Hosptl	028	Proctology
303	Physician Component for Hosptl	029	Pulmonary Disease
303	Physician Component for Hosptl	030	Radiology
303	Physician Component for Hosptl	032	Radiation Therapy
303	Physician Component for Hosptl	033	Thoracic Surgery
303	Physician Component for Hosptl	034	Urology
303	Physician Component for Hosptl	036	Nuclear Medicine
303	Physician Component for Hosptl	037	Pediatrics
303	Physician Component for Hosptl	038	Geriatrics
303	Physician Component for Hosptl	039	Nephrology
303	Physician Component for Hosptl	040	Hand Surgery
303	Physician Component for Hosptl	041	Internal Medicine
303	Physician Component for Hosptl	042	Cardiology, Pediatric
303	Physician Component for Hosptl	043	Allergy, Pediatric
303	Physician Component for Hosptl	044	Public Health
303	Physician Component for Hosptl	046	Preventative Medicine
303	Physician Component for Hosptl	047	Psych, Board Certif,Child/Adol
303	Physician Component for Hosptl	048	Endocrinology Diabetes Metabol

303	Physician Component for Hosptl	049	Multiple Specialties
303	Physician Component for Hosptl	050	Addictionologist
303	Physician Component for Hosptl	140	CardiacPeripheralVascularSurgy
303	Physician Component for Hosptl	141	Critical Care
303	Physician Component for Hosptl	142	Genetics or Genetic Counseling
303	Physician Component for Hosptl	143	Hospitalist
303	Physician Component for Hosptl	144	Oral & Maxilliofacial Surgery
303	Physician Component for Hosptl	145	Rheumatology
303	Physician Component for Hosptl	146	Sleep Medicine
303	Physician Component for Hosptl	147	Sports Medicine
303	Physician Component for Hosptl	148	Transplant Surgery
304	Community Crisis Center Provid		
305	Physician Assistant		
306	Clinical Nurse Specialist		
311	Clin Non-prft Trtmnt&Diag Ctr		
312	Clinic, Family Planning		
313	Clinic Federally Qlfd Hlth Ctr	139	Mobile Resp and Stab Svcs
313	Clinic Federally Qlfd Hlth Ctr	149	Mobile Crisis Team
313	Clinic Federally Qlfd Hlth Ctr	190	School Based
313	Clinic Federally Qlfd Hlth Ctr	191	Medical Only
313	Clinic Federally Qlfd Hlth Ctr	192	Medical and Dental
313	Clinic Federally Qlfd Hlth Ctr	193	Medical and Dental and BH
313	Clinic Federally Qlfd Hlth Ctr	194	Medical and BH
313	Clinic Federally Qlfd Hlth Ctr	195	IHS or Tribal
314	Clin, Rural Hlth Med, Freestnd		
315	Clin,Rural Hlth Med, Hosp Bsd		
316	Nurse, CN Practitioner	090	General
316	Nurse, CN Practitioner	091	Family
316	Nurse, CN Practitioner	092	Pediatrics Nurse Practitioner
316	Nurse, CN Practitioner	093	Obstetrics Nurse Practitioner
316	Nurse, CN Practitioner	097	Psychiatric
317	Nurse, Home Visit EPSDT PCA	059	Psychiatric RN
317	Nurse, Home Visit EPSDT PCA	094	School Nurse
317	Nurse, Home Visit EPSDT PCA	095	EPSDT Screening Nurse
317	Nurse, Home Visit EPSDT PCA	096	Other RN
317	Nurse, Home Visit EPSDT PCA	153	LPN
317	Nurse, Home Visit EPSDT PCA	202	Home Visiting Agency
317	Nurse, Home Visit EPSDT PCA	203	Home Visitor Nurse
317	Nurse, Home Visit EPSDT PCA	204	Home Visitor Non Clinician
318	Nurse, CRNA		
319	Anesthetist Assistant		
320	Pharmacist Clinical		
321	School Based Health Centers		

322	Midwife, Certified Nurse		
323	Midwife, Lay		
324	Nursing, Private Duty		
325	Podiatrist		
331	Audiologist		
333	Dietician		
334	Optician		
335	Optometrist		
336	Orthotist		
337	Prosthetist		
338	Prosthetist & Orthotist		
341	Chiropractor		
342	Crisis Triage Center licensed	108	Intensive Outpt Substance Abus
342	Crisis Triage Center licensed	139	Mobile Resp and Stab Svcs
342	Crisis Triage Center licensed	149	Mobile Crisis Team
342	Crisis Triage Center licensed	246	Residential or Non Residential
342	Crisis Triage Center licensed	247	Non Residential Only
343	Opioid Treatment Center		
344	Licensed Comm Benefit Prov	069	Mi Via Consultant
344	Licensed Comm Benefit Prov	070	Develop Disabil Waiver
344	Licensed Comm Benefit Prov	071	Disabled&Elderly Waiver
344	Licensed Comm Benefit Prov	072	Supports Waiver
344	Licensed Comm Benefit Prov	073	Medically Fragile Waiver
344	Licensed Comm Benefit Prov	074	DD Waiver Case Manager
344	Licensed Comm Benefit Prov	075	Disabled & Elderly Waiver Case
344	Licensed Comm Benefit Prov	076	Supports Waiver Case Manager
344	Licensed Comm Benefit Prov	077	Med Fragile Waiver Case Mgr
344	Licensed Comm Benefit Prov	078	Mi Via Financial Manage Agent
345	Schools		
345	Schools	085	School Based Health Center
346	Lodging, Meals		
351	Lab, Clinical Free Standing		
352	Radiology Facility		
353	Lab, Clinical With Radiology		
354	Laboratory, Diagnostic		
361	Home Health Agency		
362	Hospice		
363	Non-Licensed Comm Benefit Prov	173	Nursing Respite
363	Non-Licensed Comm Benefit Prov	174	Behavior Support Consultation
363	Non-Licensed Comm Benefit Prov	175	Emergency Response

363	Non-Licensed Comm Benefit Prov	176	Employment Supports
363	Non-Licensed Comm Benefit Prov	177	Environmental Modifications
363	Non-Licensed Comm Benefit Prov	178	Home Health Aide
363	Non-Licensed Comm Benefit Prov	179	Private Duty Nursing for Adult
363	Non-Licensed Comm Benefit Prov	180	Respite
363	Non-Licensed Comm Benefit Prov	181	Skilled Maintenance Therapy
363	Non-Licensed Comm Benefit Prov	182	Personal Care
363	Non-Licensed Comm Benefit Prov	183	Assisted Living
363	Non-Licensed Comm Benefit Prov	184	Adult Day Health
363	Non-Licensed Comm Benefit Prov	185	Community Transition Services
363	Non-Licensed Comm Benefit Prov	186	Occupational Therapy Adults
363	Non-Licensed Comm Benefit Prov	187	Physical Therapy Adults
363	Non-Licensed Comm Benefit Prov	188	Speech Therapy Adults
363	Non-Licensed Comm Benefit Prov	189	Nutritional Counseling
364	Ambulatory Surgical Center		
401	Ambulance, Air		
402	Ambulance, Ground		
403	Handivan		
404	Taxi or MCO Gen Trans Cntrctr		
405	Birth Center, Licensed		
411	Order Referr Presc or Comm Hlt	109	Pharmacist Prescriber
411	Order Referr Presc or Comm Hlt	110	Other Order or Referring Pract
411	Order Referr Presc or Comm Hlt	230	Certified CHW
411	Order Referr Presc or Comm Hlt	231	Non Certified CHW
411	Order Referr Presc or Comm Hlt	232	IHS or Tribal CHW
412	Hearing Aid Supplier		
414	Medical Supply Company		
415	IV Infusion Services		
416	Pharmacy		
417	Clinic, Rural Health Pharmacy		
421	Dentist	055	Dentistry
421	Dentist	056	OralEndoPeriodntics&otherSurgy
421	Dentist	057	Certified for Behavior Mngmnt
422	Clinical, Rural Health, Dental		
423	Dental Hygienist	160	In Collaborative Practice

423	Dental Hygienist	161	Not in Collaborative Practice
430	Behavioral Health Worker	084	Other Behavioral Health Worker
430	Behavioral Health Worker	098	BH Tech BCAT/RBT
430	Behavioral Health Worker	113	Behavioral Mngmnt Svc Worker
430	Behavioral Health Worker	114	Peer Support Worker Certified
430	Behavioral Health Worker	115	Family Peer Supp Worker Certif
430	Behavioral Health Worker	116	Community Support Worker
430	Behavioral Health Worker	117	Correctional Peer Specialist
430	Behavioral Health Worker	118	RGSTR Independent MII CNSL
430	Behavioral Health Worker	119	Baccalaureate Social Worker
430	Behavioral Health Worker	151	BCaBA
430	Behavioral Health Worker	248	Psych RN not board cert
431	Psychologist, PHd, EdD,PsyD	111	Not Certified for Prescribing
431	Psychologist, PHd, EdD,PsyD	112	Certified for Prescribing
431	Psychologist, PHd, EdD,PsyD	132	Autism Disorder ABA Services
431	Psychologist, PHd, EdD,PsyD	135	Functional Family Therapy
431	Psychologist, PHd, EdD,PsyD	136	Trauma-Focused CBT
431	Psychologist, PHd, EdD,PsyD	137	Eye Move Desensit & Reprocess
431	Psychologist, PHd, EdD,PsyD	138	Dialectical BT
431	Psychologist, PHd, EdD,PsyD	150	Austism Eval Provider
432	Behavioral Health Agency	080	Adult Psychosocial Rehab Svcs
432	Behavioral Health Agency	081	Behavioral Mgmt Svcs
432	Behavioral Health Agency	082	Day Treatment Services
432	Behavioral Health Agency	107	Comprehensive Comm Supp Serv
432	Behavioral Health Agency	108	Intensive Outpt Substance Abus
432	Behavioral Health Agency	130	ACT
432	Behavioral Health Agency	131	MST
432	Behavioral Health Agency	132	Autism Disorder ABA Services
432	Behavioral Health Agency	133	Evaluation and Therapies
432	Behavioral Health Agency	135	Functional Family Therapy
432	Behavioral Health Agency	136	Trauma-Focused CBT
432	Behavioral Health Agency	137	Eye Move Desensit & Reprocess
432	Behavioral Health Agency	138	Dialectical BT
432	Behavioral Health Agency	251	Crisis Service Commun Provider
432	Behavioral Health Agency	139	Mobile Resp and Stab Svcs
432	Behavioral Health Agency	149	Mobile Crisis Team
433	Clinic, MH Center(DOH)	080	Adult Psychosocial Rehab Svcs
433	Clinic, MH Center(DOH)	081	Behavioral Mgmt Svcs
433	Clinic, MH Center(DOH)	082	Day Treatment Services
433	Clinic, MH Center(DOH)	107	Comprehensive Comm Supp Serv
433	Clinic, MH Center(DOH)	108	Intensive Outpt Substance Abus
433	Clinic, MH Center(DOH)	130	ACT
433	Clinic, MH Center(DOH)	131	MST

433	Clinic, MH Center(DOH)	132	Autism Disorder ABA Services
433	Clinic, MH Center(DOH)	133	Evaluation and Therapies
433	Clinic, MH Center(DOH)	135	Functional Family Therapy
433	Clinic, MH Center(DOH)	136	Trauma-Focused CBT
433	Clinic, MH Center(DOH)	137	Eye Move Desensit & Reprocess
433	Clinic, MH Center(DOH)	138	Dialectical BT
433	Clinic, MH Center(DOH)	139	Mobile Resp and Stab Svcs
433	Clinic, MH Center(DOH)	149	Mobile Crisis Team
435	LPCC (Lic Prof Clinic Counslr)	135	Functional Family Therapy
435	LPCC (Lic Prof Clinic Counslr)	136	Trauma-Focused CBT
435	LPCC (Lic Prof Clinic Counslr)	137	Eye Move Desensit & Reprocess
435	LPCC (Lic Prof Clinic Counslr)	138	Dialectical BT
435	LPCC (Lic Prof Clinic Counslr)	240	LPCC
435	LPCC (Lic Prof Clinic Counslr)	241	LPCC and ABA tech
436	LMFT (Lic Marr&Family Therap)	135	Functional Family Therapy
436	LMFT (Lic Marr&Family Therap)	136	Trauma-Focused CBT
436	LMFT (Lic Marr&Family Therap)	137	Eye Move Desensit & Reprocess
436	LMFT (Lic Marr&Family Therap)	138	Dialectical BT
436	LMFT (Lic Marr&Family Therap)	242	LMFT
436	LMFT (Lic Marr&Family Therap)	243	LMFT and ABA tech
437	LMSW (Lic Mstr Lev Social Wkr)		
438	Psychologist School Certified		
439	Psychologist Associate License		
440	Substance Abuse Counselors	124	LicensedAlcohol/Drug AbuseCnsl
440	Substance Abuse Counselors	125	Licensed Substance Abuse Assoc
440	Substance Abuse Counselors	250	CADC
441	Psychosocial Rehab & Develop	062	Develop Disabled Children
441	Psychosocial Rehab & Develop	063	Develop Disabled Adult
441	Psychosocial Rehab & Develop	080	Adult Psychosocial Rehab Svcs
441	Psychosocial Rehab & Develop	081	Behavioral Mgmt Svcs
441	Psychosocial Rehab & Develop	082	Day Treatment Services
441	Psychosocial Rehab & Develop	083	Early Intervention Svcs
441	Psychosocial Rehab & Develop	084	Other Behavioral Health Worker
441	Psychosocial Rehab & Develop	130	ACT
441	Psychosocial Rehab & Develop	131	MST
441	Psychosocial Rehab & Develop	132	Autism Disorder ABA Services
443	Nurse Psych Nurse Specialist		
444	SW (Lic Clinical Soc Worker)	135	Functional Family Therapy
444	SW (Lic Clinical Soc Worker)	136	Trauma-Focused CBT
444	SW (Lic Clinical Soc Worker)	137	Eye Move Desensit & Reprocess
444	SW (Lic Clinical Soc Worker)	138	Dialectical BT
444	SW (Lic Clinical Soc Worker)	244	LCSW
444	SW (Lic Clinical Soc Worker)	245	LCSW and ABA tech

445	Lic Counselors Thrpsts & SW	058	Lic Assoc Marr&Fam Thera Sprvd
445	Lic Counselors Thrpsts & SW	084	Other Behavioral Health Worker
445	Lic Counselors Thrpsts & SW	086	Mstrs Lvl Psychologist Sprvd
445	Lic Counselors Thrpsts & SW	087	Lic Mstrs Lvl Social Wkr Sprvd
445	Lic Counselors Thrpsts & SW	088	Psychologist Assoc Licd Sprvd
445	Lic Counselors Thrpsts & SW	089	Mstr of Arts(Psychl Rel) Sprvd
445	Lic Counselors Thrpsts & SW	099	Behavior Analyst, BCBA BCBA-D
445	Lic Counselors Thrpsts & SW	119	Baccalaureate Social Worker
445	Lic Counselors Thrpsts & SW	121	Licensed Prof MH Counselor
445	Lic Counselors Thrpsts & SW	122	LMHC-Lic MH Couslr-undr sprvsn
445	Lic Counselors Thrpsts & SW	123	Licensed Prof Art Therapist
445	Lic Counselors Thrpsts & SW	126	Advncd Nurse Pract Not Cert
445	Lic Counselors Thrpsts & SW	135	Functional Family Therapy
445	Lic Counselors Thrpsts & SW	136	Trauma-Focused CBT
445	Lic Counselors Thrpsts & SW	137	Eye Move Desensit & Reprocess
445	Lic Counselors Thrpsts & SW	138	Dialectical BT
445	Lic Counselors Thrpsts & SW	151	BCaBA
445	Lic Counselors Thrpsts & SW	252	ABA Speciality Care
445	Lic Counselors Thrpsts & SW	253	BCBA or BCBA-D apprv Spec Care
445	Lic Counselors Thrpsts & SW	254	Master Level BH Intern
445	Lic Counselors Thrpsts & SW	255	Psychology Intern
445	Lic Counselors Thrpsts & SW	256	PreLicensure Psy Post Doctorat
446	Core Service Agency	080	Adult Psychosocial Rehab Svcs
446	Core Service Agency	081	Behavioral Mgmt Svcs
446	Core Service Agency	082	Day Treatment Services
446	Core Service Agency	107	Comprehensive Comm Supp Serv
446	Core Service Agency	108	Intensive Outpt Substance Abus
446	Core Service Agency	130	ACT
446	Core Service Agency	131	MST
446	Core Service Agency	132	Autism Disorder ABA Services
446	Core Service Agency	133	Evaluation and Therapies
446	Core Service Agency	135	Functional Family Therapy
446	Core Service Agency	136	Trauma-Focused CBT
446	Core Service Agency	137	Eye Move Desensit & Reprocess
446	Core Service Agency	138	Dialectical BT
446	Core Service Agency	139	Mobile Resp and Stab Svcs
446	Core Service Agency	149	Mobile Crisis Team
447	Renal Dialysis Facility		
451	Occup Therapist, Lic & Cert		
452	Occupational Therpst Licensed		
453	Physical Therapist, Lic & Cert		
454	Physical Therapist, Licensed		
455	Rehabilitation Ctr, Compr Outp		

457	SpeechTherapistChldAdltLicCert		
458	Speech Therapist Child,Sch Cer		
462	Case Management	060	Chronically Mentally Ill
462	Case Management	061	(EPSDT) Children
462	Case Management	062	Develop Disabled Children
462	Case Management	063	Develop Disabled Adult
462	Case Management	064	Maternal&Childcare (FF)
462	Case Management	065	Traumatic Brain Injury
462	Case Management	066	Abused, Neglected Adult
462	Case Management	067	SED Children
462	Case Management	068	Case Management - Other
462	Case Management	069	Mi Via Consultant
901	Acupuncturist, Licensed		
902	Dental Clinic, Fed Qualified		
903	Pharmacy Clinic, Fed Qualified		
904	Physical Health Enhanced Svc		
905	Rehab Center, Not Certified		
906	Speech Therapist, Not Certifie		
921	Counselor, Bachelor's Level		
922	Behavioral Health Enhanced Svc		
922	Behavioral Health Enhanced Svc	135	Functional Family Therapy
922	Behavioral Health Enhanced Svc	136	Trauma-Focused CBT
922	Behavioral Health Enhanced Svc	137	Eye Move Desensit & Reprocess
922	Behavioral Health Enhanced Svc	138	Dialectical BT
923	Promatora/Traditional Healer		
924	Counselor, Other		
931	Psychologist, Intern for Ph.D.		
932	Psychologist, Bachelor's Level		
933	Psychologist, Master's Intern		
951	Social Worker, Bachelor Level		
952	Social Worker,Other Master's		
953	Social Worker, Intern		

PROVIDER NETWORK INTERFACE

Federal requirements for provider participation in Medicaid require that all Providers, including providers only participating as managed care providers, must meet the same provider enrollment requirements. The only exception is those providers that are not part of the MCO's network. The new Provider Network file will be sent by the MCOs as a full file each month for providers considered to be in-network as of the first of that month. The provider's network status has no direct relationship to their enrollment, but will over time be used, along with other information on the provider file, to determine necessary documentation in order to continue participation. In-Network status should be sent with an open-ended end date. Please note that the begin date cannot precede CC2.0, so if any provider has been in-network prior to that time, please default the begin date to 1/1/2014. If the MCO determines a provider to no longer be considered in-network, an end date must be sent.

The file header:

```
01  MCO-NETWORK-HEADER-RECORD.
    05  MCO-NETWORK-RECORD-TYPE          PIC X(1).
         88  MCO-NETWORK-REC-TYPE-HDR  VALUE 'H'.
    05  MCO-NETWORK-MCO-ID               PIC X(8).
    05  MCO-NETWORK-FILE-CREATE-DATE.
        10  MCO-NETWORK-FILE-CREATE-CC  PIC X(2).
        10  MCO-NETWORK-FILE-CREATE-YY  PIC X(2).
        10  MCO-NETWORK-FILE-CREATE-MM  PIC X(2).
        10  MCO-NETWORK-FILE-CREATE-DD  PIC X(2).
    05  FILLER                           PIC X(133).
```

The file detail:

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01  MCO-NETWORK-PROVIDER-RECORD.
    05  MCO-NETWORK-RECORD-TYPE      PIC X(01).
        88  MCO-NETWORK-REC-TYPE-PROV  VALUE 'P'.
    05  FILLER                       PIC X(01).
    05  MCO-NETWORK-PROV-ID          PIC X(08).
    05  FILLER                       PIC X(01).
    05  MCO-NETWORK-NPI-ID           PIC X(10).
    05  FILLER                       PIC X(01).
    05  MCO-NETWORK-BEG-DT.
        10  MCO-NETWORK-BEG-CC       PIC X(02).
        10  MCO-NETWORK-BEG-YY       PIC X(02).
        10  MCO-NETWORK-BEG-MM       PIC X(02).
        10  MCO-NETWORK-BEG-DD       PIC X(02).
    05  FILLER                       PIC X(01).
    05  MCO-NETWORK-END-DT.
        10  MCO-NETWORK-END-CC       PIC X(02).
        10  MCO-NETWORK-END-YY       PIC X(02).
        10  MCO-NETWORK-END-MM       PIC X(02).
        10  MCO-NETWORK-END-DD       PIC X(02).
    05  FILLER                       PIC X(01).
    05  MCO-NETWORK-PROV-NAM         PIC X(45).
    05  FILLER                       PIC X(65).
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The file trailer:

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01  MCO-NETWORK-TRAILER-RECORD.
    05  MCO-NETWORK-RECORD-TYPE     PIC X(01).
        88  MCO-NETWORK-TRAILER   VALUE 'T'.
    05  MCO-NETWORK-RECORD-COUNT    PIC 9(09).
    05  FILLER                      PIC X(140).
```

The incoming file will be checked to ensure data is accurate and an error file will be posted back to the MCOs if the following errors are found.

Error Code	Error Description	Comment
01	PROVIDER NPI INVALID	Validate the MCO-NETWORK-NPI-ID on input file is found on P-NPI-XMTCH-TB; If not validate the MCO-NETWORK-PROV-ID is found on P-NPI-XMTCH-TB. If not found post edit.
02	MEDICAID ID INVALID	Validate the MCO-NETWORK-PROV-ID on the input file is found on the Provider table. If not found post edit.
03	NPI/MEDICAID ID MISMATCH	Validate the input file MCO-NETWORK-NPI-ID and MCO-NETWORK-PROV-ID are found on the P_NPI_XMTCH_TB. If not found post edit.
04	MCO ID INVALID	The header line MCO-NETWORK-MCO-ID is validated against System LIST 0501. If not found post edit.
05	NETWORK BEGIN DT INVALID	Edit will post for any of the following: • MCO-NETWORK-BEG-DT is spaces • MCO-NETWORK-BEG-DT is a bad date • MCO-NETWORK-BEG-DT is less than 2014-01-01 • MCO-NETWORK-BEG-DT is greater than MCO-NETWORK-END-DT
06	NETWORK END DATE INVALID	Edit will post for any of the following: • MCO-NETWORK-END-DT is spaces • MCO-NETWORK-END-DT is a bad date • MCO-NETWORK-END-DT is less than 2014-01-01
07	NETWORK DATE NOT IN NETWORK	The begin network date is greater than monthly processing date.
08	HEADER REC MISSING	
09	TRAILER REC INVALID	
10	Existing Provider not on input	There is a provider on the DB2 table that did not have an entry in the input file so it was end dated.
11	Input span overlaps existing span.	Input Network date span overlaps existing Network date span in OmniCaid DB2.

An error file will be returned to the MCO in the following format:

```
01  MCO-NETWORK-ERR-HEADER-RECORD.
    05  MCO-NETWORK-ERR-RECORD-TYPE         PIC X(1).
        88  MCO-NETWORK-REC-TYPE-HDR  VALUE 'H'.
    05  MCO-NETWORK-ERR-MCO-ID              PIC X(8).
    05  MCO-NETWORK-ERR-FILE-CREATE-DATE.
        10  MCO-NETWORK-ERR-FILE-CREATE-CC  PIC X(2).
```

```
         10  MCO-NETWORK-ERR-FILE-CREATE-YY  PIC X(2).
         10  MCO-NETWORK-ERR-FILE-CREATE-MM  PIC X(2).
         10  MCO-NETWORK-ERR-FILE-CREATE-DD  PIC X(2).
     05  FILLER                              PIC X(133).

01  MCO-NETWORK-ERR-PROVIDER-RECORD.
    05  MCO-NETWORK-ERR-RECORD-TYPE         PIC X(01).
        88  MCO-NETWORK-REC-TYPE-ERR  VALUE 'E'.
    05  MCO-NETWORK-ERROR-NO                PIC X(02).   Example -  03
    05  MCO-NETWORK-ERROR-TXT               PIC X(40). Example - PROVIDER NPI
INVALID
    05  MCO-NETWORK-ERR-INPUT-DTL.                          Data from input file
positions 3:107
        10  MCO-NETWORK-PROV-ID              PIC X(08).
        10  FILLER                           PIC X(01).
        10  MCO-NETWORK-NPI-ID               PIC X(10).
        10  FILLER                           PIC X(01).
        10  MCO-NETWORK-BEG-DT.
            15  MCO-NETWORK-BEG-CC           PIC X(02).
            15  MCO-NETWORK-BEG-YY           PIC X(02).
            15  MCO-NETWORK-BEG-MM           PIC X(02).
            15  MCO-NETWORK-BEG-DD           PIC X(02).
        10  FILLER                           PIC X(01).
        10  MCO-NETWORK-END-DT.
            15  MCO-NETWORK-END-CC           PIC X(02).
            15  MCO-NETWORK-END-YY           PIC X(02).
            15  MCO-NETWORK-END-MM           PIC X(02).
            15  MCO-NETWORK-END-DD           PIC X(02).
        10  FILLER                           PIC X(01).
        10  MCO-NETWORK-PROV-NAM             PIC X(45).
        10  FILLER                           PIC X(24).


01  MCO-NETWORK-ERR-TRAILER-RECORD.
     05  MCO-NETWORK-ERR-RECORD-TYPE         PIC X(01).
         88  MCO-NETWORK-TRAILER   VALUE 'T'.
     05  MCO-NETWORK-ERR-RECORD-COUNT        PIC 9(09).
     05  FILLER                              PIC X(140).
```

VIII. ENCOUNTERS

HSD collects encounter data to meet state and federal accountability, quality of care, performance, and rate setting objectives. HSD and other auditors and governmental agencies use encounters to assess cost-effectiveness, utilization trends, service delivery patterns, MCO activities and outcomes, appropriate management of client's health care needs and third party insurance plans reimbursement, compliance with claims payment and encounter completeness, accuracy and timeliness.

Paid Encounters are always submitted by the MCO using either 837 or NCPDP standard transaction formats. The following sections outline the procedures for these submissions. The companion guides for the Managed Care HIPAA transactions are at http://www.hsd.state.nm.us/mad/5010HIPAAforNMMedicaidProviders.html .

Submission of NCPDP Transactions

NCPDP files are uploaded directly to the State's DMZ site as per the instructions in the DMZ instructions section of this manual. NCPDP files are transferred to the mainframe a 8 PM EDT from DMZ, so it is recommended that the MCO submit their file no later than 7:45 PM EDT.

NCPDP Encounter Submission Process Timeline

DAY	TIME	ACTION
Day 1	Before 6pm MT	Upload NCPDP zip file to DMZ
Day 1	6pm MT	Uploaded files are transferred to the pharmacy claims processing system
Day 2	12am MT	Pharmacy batch jobs start
Day 2	6pm MT	Adjudicated pharmacy claims are transferred to the NM MMIS system
Day 3	8am MT	NM MMIS encounter reports are processed and placed on the DMZ

Because of the way we process NCPDP claims only one (1) file may be submitted per processing day. Our processing days are Monday thru Friday. The files placed on DMZ are transmitted to PBM for processing at 8 PM EDT on each processing day. Any file uploaded to DMZ after 8 PM EDT would be considered the next day's file as far as determine the number submitted. If multiple files are placed on DMZ in a processing day one of the file will be overlaid when they are transferred to PBM.

The maximum number of encounters that may be submitted in a Daily Submission is 100,000 B1 or B2 claims, or 50,000 B3 claims.

MCO Trading Partner and 837 Encounter Testing Procedures

The 837 transactions are submitted to the Fiscal Agent's EDI Gateway, where they are validated for format and conformance to implementation and companion guide content. The implementation guides and New Mexico Companion Guides for Managed Care Encounters (both the 837 Companion Guides and NCPDP Payer Sheet) are found on the HSD Website at http://www.hsd.state.nm.us/providers/hippa-standard-companion-guides.aspx and can be downloaded from the NM HIPAADesk at https://www.commercedesk.com/sites/sonm/start.jsp?uid=Wqd3sza&SiteKey=sonm&Re

sultCode=3 .

The steps to becoming an MCO Trading Partner and submitting production encounter files are as follows:

1. Complete a new Trading Partner Agreement (TPA) for 5010 transactions.
   a. The form is available on the New Mexico Medicaid Website at: https://nmmedicaid.Conduent-inc.com/nm/general/loadstatic.do?page=ProviderInformation.htm
   b. Complete the form and send it to the address shown on the form.

2. Once the New Mexico HIPAA Helpdesk receives your signed TPA, they will enter your information into our Trading Partner Management System (TPMS) and provide you details on submission of your 837 transactions for testing.
   a. You will be granted access to the Commerce Desk for HIPAA transaction format validation.
   b. You will also be granted access to the CONDUENT EDI file submission portal along with a password and logon ID.

3. Validate your 837 files using Commerce Desk
   a. Submit your test file to https://sites.edifecs.com/index.jsp?Conduent
   b. Your files only need to pass SNIP levels 1 and 2 without errors. (That is, if you have a SNIP level 5 error, or a SNIP level 1 warning (not error), then your file is considered 'passed' for 5010 validation.)
   c. You should submit your files to this location first to ensure they pass 5010 validation.

4. Submit your valid 837 files to the CONDUENT EDI gateway.
   a. There are 2 methods for submitting files:
      1) EDI Online, which requires a human submitting files, an
      2) EDI DMZ, an SFTP connection, which allows automated delivery and receipt of files.
   b. You can use either or both methods.
   c. In either case, you will receive response files and reports (999, TA1, 277CA).

6. Once you have submitted 3 files of at least 10 valid claims each, contact the PIB Encounter testing contact to let them know you are ready to have your files reviewed by the State.

7. The claims will be reviewed by the State and once approved, you will be granted permission to submit 5010 version 837 claims or encounters to the Production system.

If you have any questions, contact the New Mexico HIPAA Helpdesk (HIPAAHelpdesk@Conduent-inc.com).

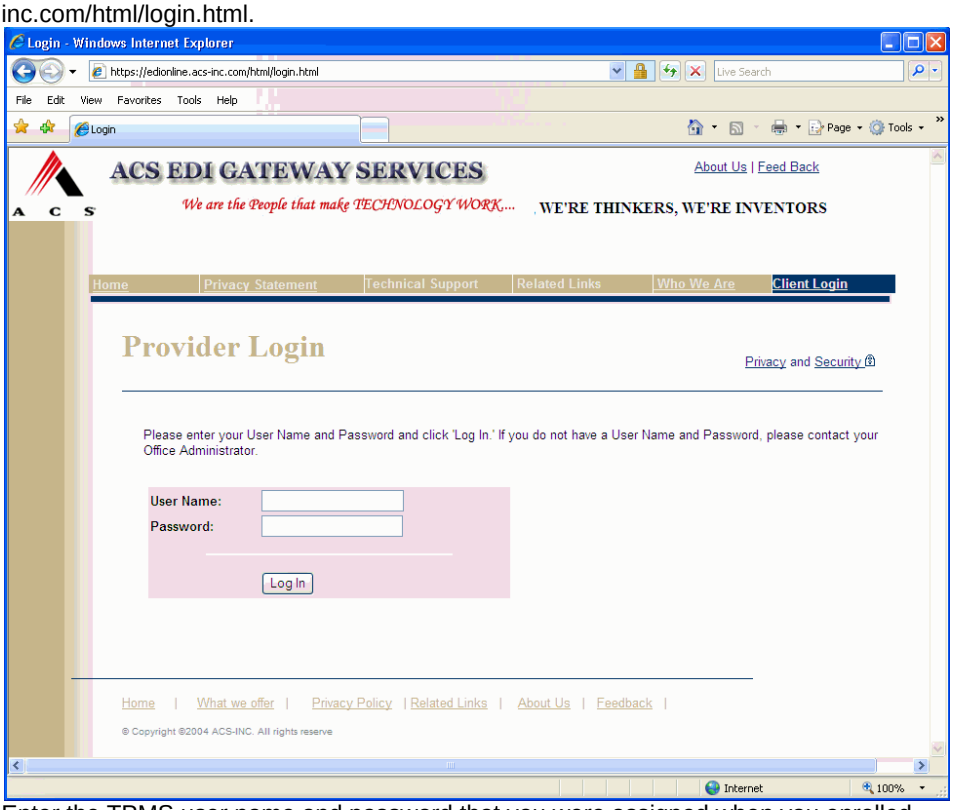
EDI Online Instructions

The CONDUENT EDI Online tool provides the healthcare providers the ability to conduct business electronically with CONDUENT EDI.
EDI Online capability allows users to:

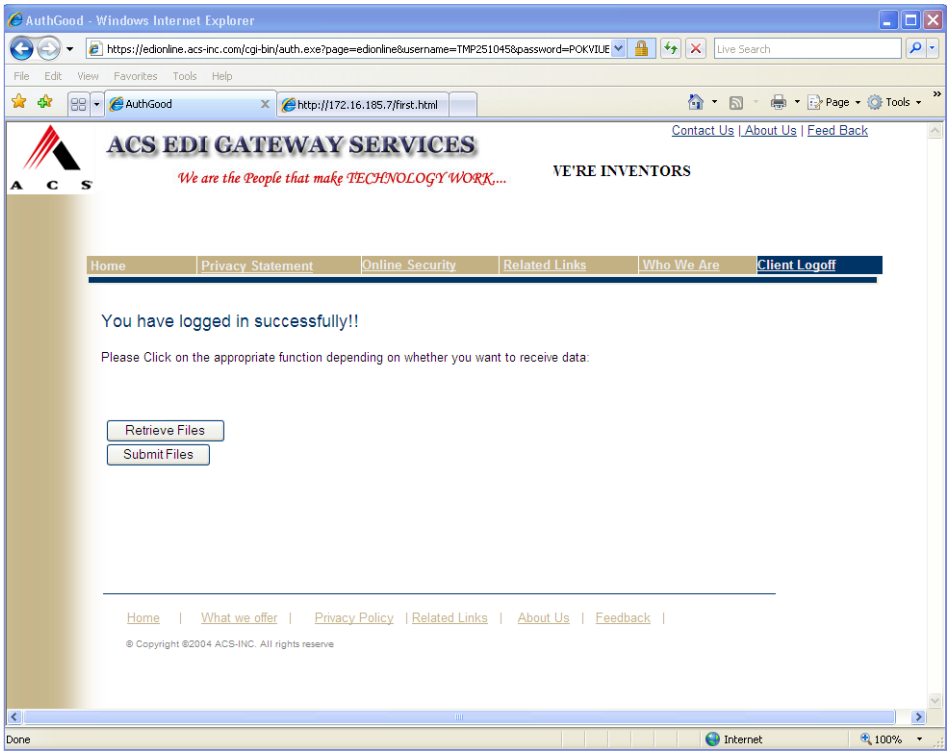
- Submit 5010 837 X123 transactions
- Retrieve response transactions and files, including 999s, Online confirmation reports, 277CAs and 835s.

Access to the site for New Mexico Medicaid Trading Partners is administered through the New Mexico HIPAA Helpdesk (HIPAAHelpdesk@Conduent-inc.com).

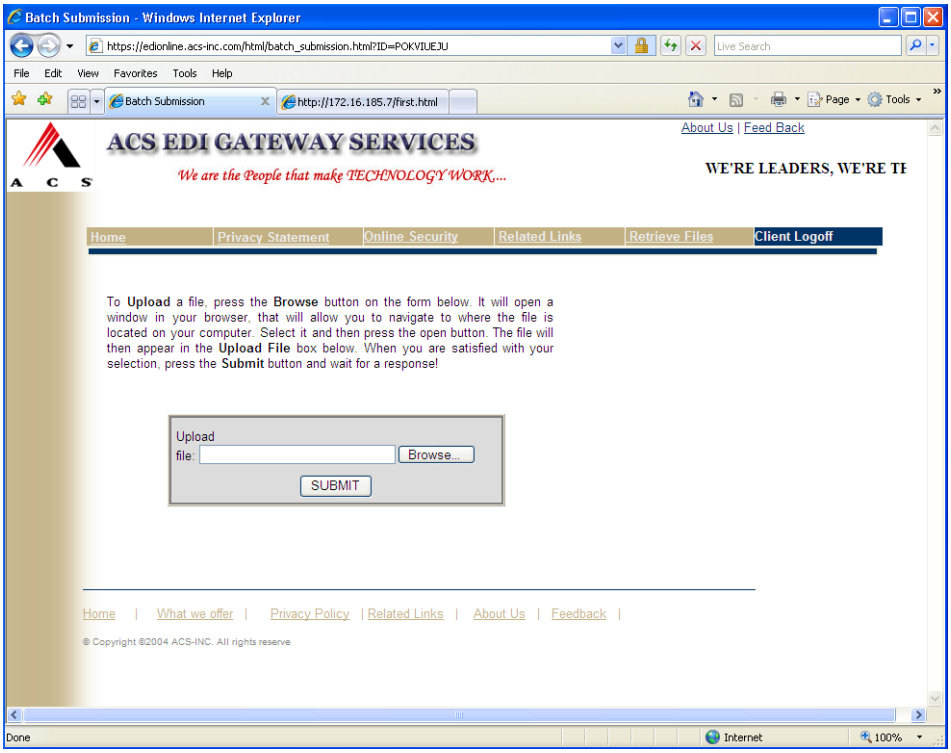
To get started, access the CONDUENT EDI Login page: https://edionline.Conduent-inc.com/html/login.html.



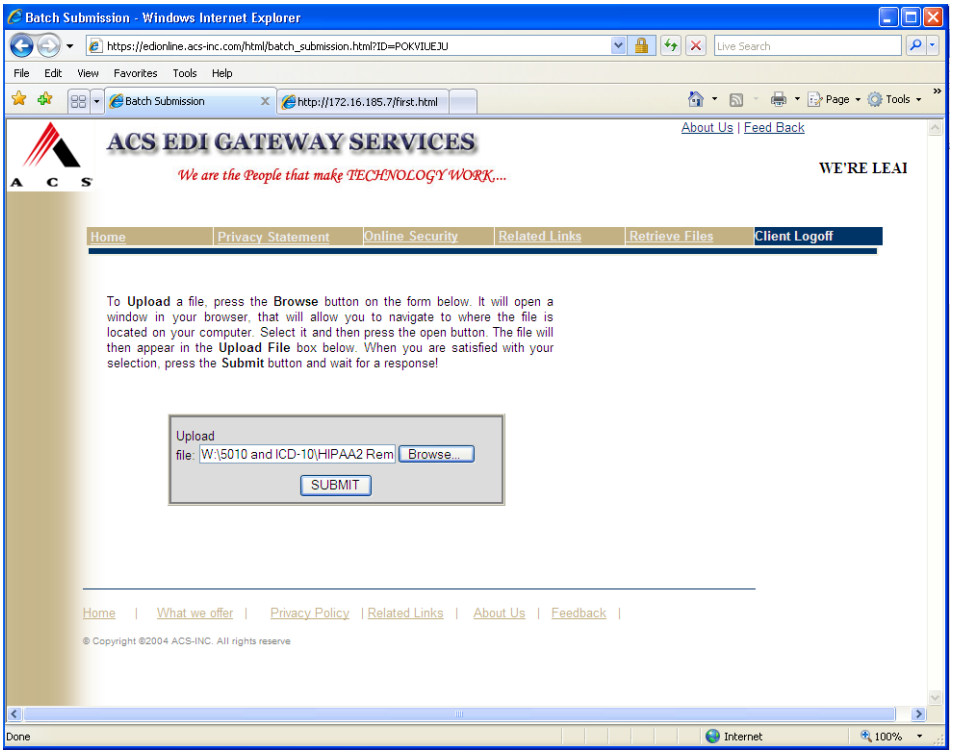
Enter the TPMS user name and password that you were assigned when you enrolled for EDI services, and click the **Log In** button.
Once you login successfully, the next window confirms your login information was correct.
To submit files, click on 'Submit Files' button.



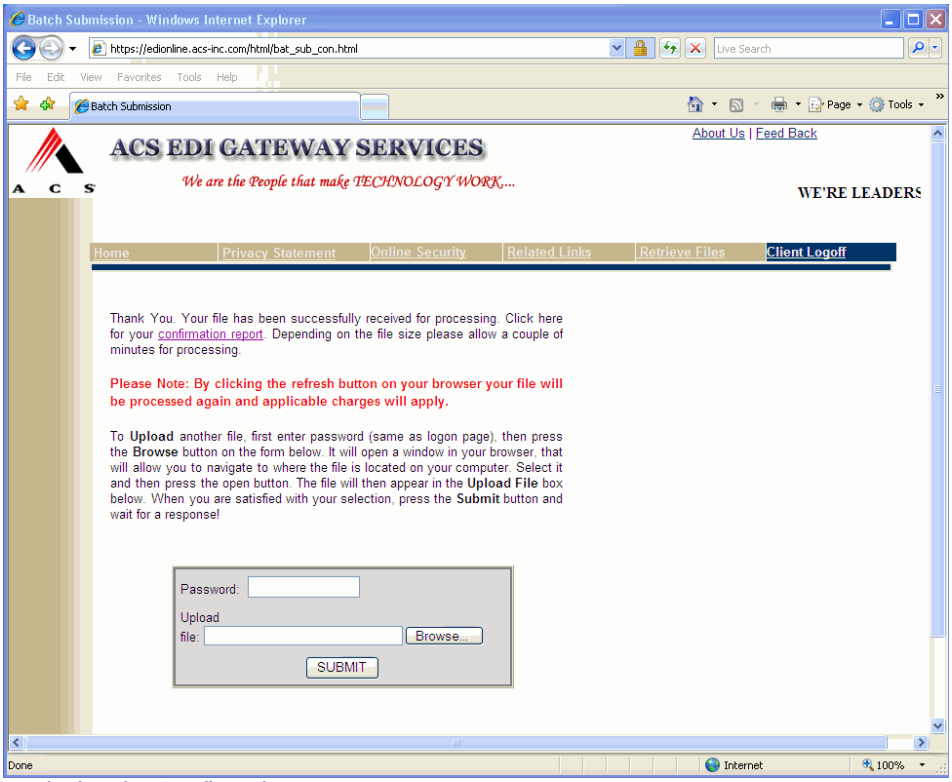
The next window prompts you to navigate to the location of the file you wish to upload using the 'Browse' button.



Once you've used the Browse button to locate your file, you are ready to click the 'Submit' button.

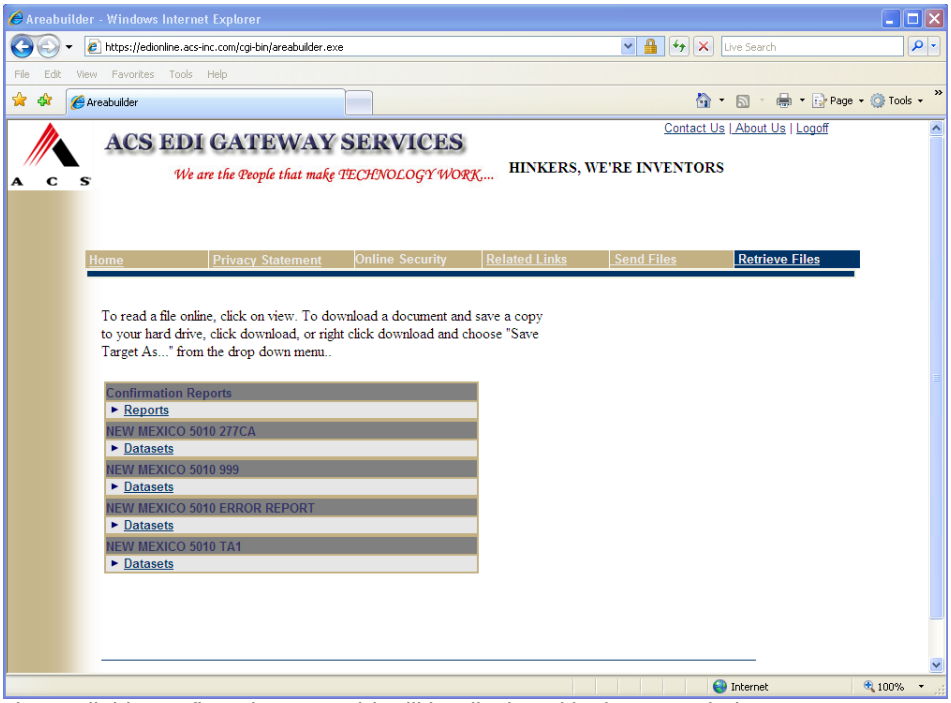


EDI Online will return a window stating that your file was successfully submitted. There is a link to view the confirmation report. You can either click the link or click on the menu item 'Retrieve Files'.

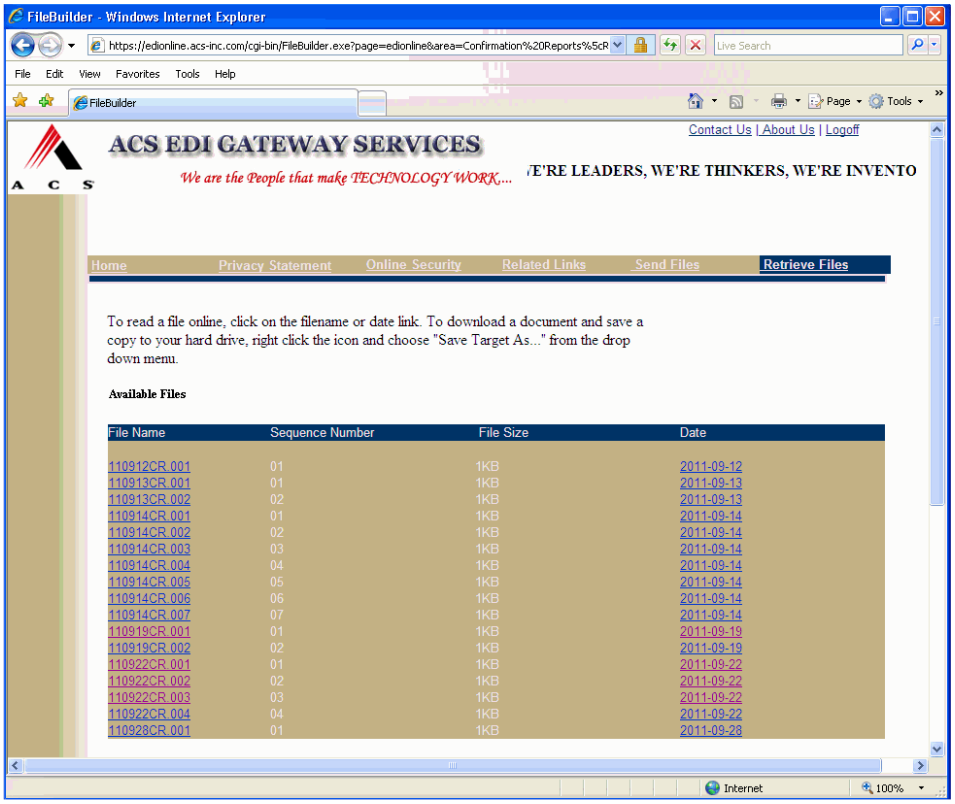


Retrieving the Confirmation Report

Once you click on the Confirmation Report link (or Retrieve Files), the next window will display a 'Reports' link under the heading 'Confirmation Reports'. Click on the link to navigate to the confirmation report.



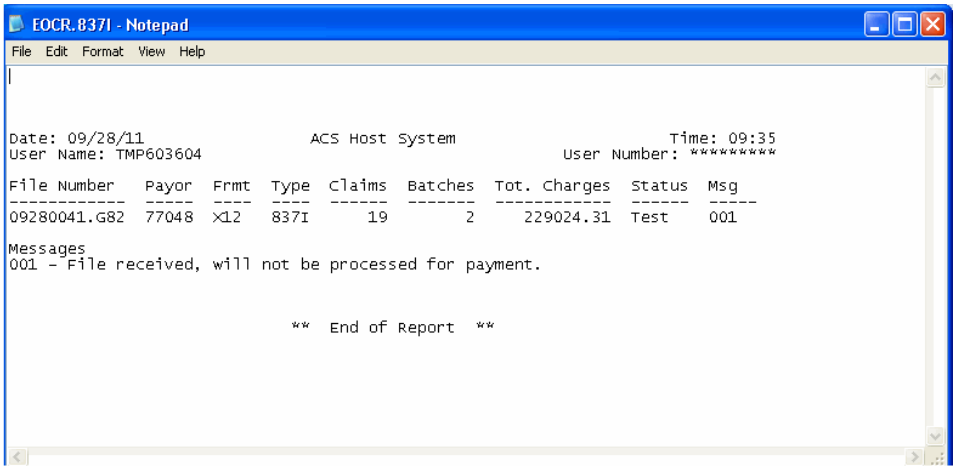
The available confirmation report(s) will be displayed in the next window.



The last report is the one from your most recent file submission. Make sure that the date coincides with the date you submitted the file.
Sometimes, there is a lag of up to 15 minutes before your report appears in the list.
- If you don't see a report for your submission, then refresh the screen.
- If you submit multiple files in one day, the sequence number in the file name will be increased by 1.

Click on your report.
- You will be prompted to save the file. (You will not be allowed to view the report without first saving it).
- Once the file is saved to a desired location, you will be prompted to Open the file.
- You can use Notepad to open the report.

If you do not receive a confirmation report after 15 minutes, contact the New Mexico HIPAA Helpdesk to report the delay.
The following is an example of a confirmation report:



The message, **'001 – File received, will not be processed for payment.'** indicates that your file upload was successful. The message states that it will not be processed for payment because the file that we uploaded was a **test** file.

To retrieve the HTML Confirmation Report , 277CA, and TA1 Files, Follow similar procedures as above.

837 Encounter Submission Rules and EDI & Conduent Timing and Flow

The MCO may submit one or more 837 transaction files, however, the Maximum file size is 45 MB. The maximum size of a batch (defined as the number of claims in a ST/SE loop) is 5000 claims and the maximum number of claims submitted per night is 50,000 on the weekdays and 100,000 on the weekend (Saturday/Sunday). MCOs may not submit one claim per ST/SE loop because this creates a multitude of batches and there is a batch limit within Omnicaid. **Crossovers and non-crossovers can be submitted in the same file.**

Within 15 minutes, reports and responses are available to the trading partner on ***EDI Online,*** including:

1. Online Confirmation Report - Verify that your file was accepted on this report. If the file is rejected, you may not receive the remainder of the reports.
2. HTML Compliance Report - Your files only need to pass SNIP level 1 and 2 in order to be passed to the MMIS for processing.
3. 999 X12 transaction
4. TA1 X12 transaction (if requested in 837 X12 transaction)

If the expected responses do not appear after 15 minutes, the MCO should contact HIPAAHelpdesk@Conduent-inc.com with the following information:

- *TP ID*
- *Trading Partner Business Name*

- *Trading Partner's contact name, phone and/or email*
- *Date and Time 837 file was submitted*
- *Any other particulars that will help with the resolution process*

The HIPAA Helpdesk will troubleshoot the issue and respond to within 24 hours.

Internal CONDUENT processing:
CONDUENT EDI accepts and translates the 837 data for use by the NM MMIS.

Every 2 hours from 10am ET through 6pm ET, Monday – Friday, the NM MMIS System pulls claim/encounter data from EDI and performs front-end claims processing and **claims adjudication**. This process also produces **277CA** files transmitted back to EDI for delivery to the trading partner via EDI Online. The claims adjudication cycle starts at 7 pm ET.

CONDUENT will run daily claims cycles at 1pm ET, Monday through Friday. In addition to daily claims reporting, the daily claims cycle also finalizes encounter voids and produces the **MCO RC070-071 flat files and RC072 reports**.

Within 24 hours of file submission, the resultant 277CA X12 transactions are posted to ***EDI Online***. The 277CA X12 transaction reflects files which have made it from the EDI to Omnicaid and have gone through Omnicaid's pre-processor. The 277CA X12 will tell the MCO whether the file has passed the pre-processor and gone on through full adjudication.

If the 277CA transaction does not appear after 24 hours, the MCO should contact HIPAAHelpdesk@Conduent-inc.com with the following information:

- *TP ID*
- *Trading Partner Business Name*
- *Trading Partner's contact name, phone and/or email*
- *Date and Time 837 file was submitted*
- *Any other particulars that will help with the resolution process*

The Helpdesk will troubleshoot the issue and respond within 24 hours.

Each morning, the following should be available to the MCO:

- MCO encounter flat files and reports should be available on DMZ.

EDI assigns an internal file "Tracking ID" to each 837 file submitted. This is a unique number that will never be repeated for another file. The Tracking ID allows EDI to associate a claim to the file is was submitted on. EDI keeps up to 7 years history of raw 837 data for submitted claims.

The 31 character EDI trace number structure is as follows:
Positions 1 – 15 – file-specific Tracking ID

Positions 16 – 23 – ST/SE sequence number within the file – starts at 00000001 for each file and increments by 1 for each ST/SE in the file
Positions 24 – 31 – CLM segment sequence within the file – starts at 00000001 for each file and increments by 1 for each CLM segment in the file across all ST/SEs – does not start over at 00000001 for each ST/SE

File Tracking ID allows multiple ST/SE loops within the same file to be aggregated for reporting. MCOs are encouraged to submit all their claims in one file per type within multiple ST/SE loops of 5000 claims each. Multiple files of one type submitted on 1 day will each be recorded and reported on the RC72 as a separate file.

In Case of Questions or Problems:

Submitters with questions or problems submitting files, or with questions about their claims should contact the HIPAA HelpDesk at 800-299-7304. The HIPAA HelpDesk is open from 8 a.m. to 5 p.m. MST (Monday – Friday).

Submission Deadline: Files should be submitted on a weekly basis. MCO's can submit files as frequently as they wish.

Resubmission: Rejected data files must be corrected and resubmitted within 5 working days of the notice of rejection from the translator. Denied Encounters must be resubmitted within 30 days of the date of the notice of denial from HSD.

Encounter Data Submission Requirements

MCO's must collect data on every encounter between a MCO's enrollee and an MCO staff or any provider paid by the MCO, regardless of whether the provider is contracted or non-contracted. The MCO's are to transmit all paid encounters completely and timely to HSD using HIPAA standard formats and standard code sets according to the contract requirements; which vary according to program and specified in that program's contract:

An encounter is:

- any claim adjudicated and paid by the MCO or any of its subcontractors for a client covered by NM's Centennial Care program.
- Any record of a service provided by the MCO or any of its subcontractors or encounter between the MCO or its subcontractors and a client covered by NM's Centennial Care program which was not adjudicated as a claim but represents a client-specific service or administrative activity for which there is an expense associated.

HSD/MAD maintains oversight responsibility for evaluating and monitoring the volume, completeness, timeliness, and quality of encounter data submitted by the MCO. If the MCO elects to contract with a subcontractor, the MCO must ensure that the subcontractor complies with all claims and encounter requirements. The MCO must submit all encounter data for all services paid to HSD/MAD. The MCO is responsible for the quality, accuracy, and timeliness of all encounter data submitted to HSD/MAD. HSD/MAD shall communicate directly with the MCO any requirements and/or deficiencies regarding completeness, quality, accuracy and timeliness of encounter data, and not with any third party MCO. Failure to submit accurate and complete encounter data will result in financial penalties determined by

HSD/MAD based upon the error, and/or the repetitive nature of the error and/or the frequency of the errors. The MCO shall submit encounter data to HSD/MAD in accordance with the following:

The MCO is required to submit to HSD the following:

- all original claims/claim lines paid by the MCO. This includes Medicaid payments for Medicaid clients and it includes Medicare payments made on behalf of Medicaid clients even if there is no Medicaid payment on the Medicare claim;
- DO NOT submit Denied Claims or Denied Lines on a Paid Claim;
- all adjustment/void claims of previously reported paid claims, submitted according to the same timeliness standards as required of paid/denied original claims. If the original encounter was denied by Omnicaid, the MCO should take the following steps:
    1. Evaluate if the claim was submitted incorrectly by the provider/subcontractor
        - If so, return the claim to the source to be corrected and resubmitted.
        - If not, determine whether the MCO made an error in transcribing the claim to the 837/NCPDP encounter file.
    2. If the claim is returned to the source to be corrected and resubmitted, the MCO should submit this correction as an adjustment reflecting the original Denied TCN and showing the received date and paid date of the resubmitted claim.
    3. If the claim is corrected by the MCO as a transcription error, the MCO should:
        - If the original claim was submitted in error (i.e., claim had been previously submitted and wasn't paid twice or claim was not the last paid in chain claim for that client and that service), resubmit the encounter as a void reflecting the original Denied TCN
        - If the original claim was submitted as a result of an error made by the MCO in its transmission, resubmit as an original with the original received and paid dates.

    Adjustment and voids of previously submitted claims must be identified as such according to instructions in the HIPAA Technical Requirements guide and NM Companion guides, including the Omnicaid TCN of the previously paid encounter that the adjustment/void modifies.

Encounter Timeliness Requirement

HSD/MAD encounter timeliness requirements attempt to ensure that the MCO submits to HSD all its encounters within a reasonable period of its final adjudication. The MCO must submit to HSD/MAD at least ninety percent (90%) of its Claims, originals and adjustments within thirty (30) Calendar Days of the date of adjudication, and ninety-nine percent (99%) within sixty (60) Calendar Days of the date of adjudication, regardless of whether the encounter is from a subcontractor, subcapitated arrangement, or performed by the MCO. It is not acceptable to withhold submission of encounters because the MCO believes the encounters may not pass NM encounter edits

The MCO is expected to have written contractual requirements of subcontractors or providers that pay their own claims to submit encounters to the MCO on a timely basis which ensures that the MCO can meet its timeliness requirements for encounter submission.

Encounter Accuracy Requirement
The MCO meets encounter accuracy requirements by submitting MCO paid encounters with no more than a three percent (3%) error rate per invoice type (837I, 837P, 837D, NCPDP), calculated for a quarter's worth of submission. This calculation is performed by collecting all the original encounters processed by Omnicaid during the quarter (i.e., pulling all claims with an Omnicaid paid date within the quarter) and evaluating the paid vs denied by invoice type and claim type. This evaluation excludes any denials which have subsequently been paid during the quarter, any denials which are duplicates (multiple denials during a quarter will only be counted once), and any denials which were voided during the quarter. HSD will provide the MCO with both summary level and detail level data on their Encounter Accuracy rates.

HSD/MAD will monitor the MCO corrections to NM denied encounters by random sampling. Seventy-five percent (75%) of the NM denied encounters included in the random sample with 75% that must have been corrected and resubmitted by the MCO within thirty (30) days of denial by HSD

The MCO is expected to edit encounters prior to submission to prevent or decrease submission of duplicate encounters and other types of encounter errors. The edits applied by HSD for encounters is in a later section of this manual for use by the MCO's to perform their own edits to ensure optimum accuracy and completeness.

Encounter Completeness Requirement
The MCO must meet encounter completeness requirements by submitting to HSD/MAD a report of the amount of MCO payment for all MCO paid claims by date of payment and date of service, including a tally of any IBNR clams, according to a format specified by HSD/MAD; referred to as the Lag Report. This report will be compared to encounter data to evaluate the completeness of data submitted. A variance between the MCO's report and the record of encounters received cannot exceed 10% for months of payment greater than 90 days. In other words, for example, for the payment month of July, 90% of encounters paid in the months of April and before should be complete in the Omnicaid system.

The Lag Report
Each month, the MCO is to complete an excel workbook with 5 spreadsheets that show all paid claims amounts broken down by the following categories:

- Institutional Inpatient
- Institutional Outpatient
- Professional
- Pharmacy

- Combined

The definition for the different categories is as follows:

- Institutional Inpatient – Any claims paid on an 837I (or UB92 paper claim)where TOB = 11x, 12x, 65x, 66x, 69x, 89x, 21x, 22x
- Institutional Outpatient - Any claims paid on an 837I (or UB92 paper claim)where TOB Is Not = 11x, 12x, 65x, 66x, 69x, 89x, 21x, 22x
- Professional – Any claims paid on an 837P (or HCFA1500 paper claim)
- Pharmacy – Any claim paid on the NCPDP claim format
- Combined – All Claims paid

A copy of the Lag Report is on the following page. The report is to be run and submitted no later than the first Friday of each month for the payments made through the end of the preceding month. The sample on the next page only shows one year of data, but the report is not an annual, it keeps running with prior months of data included.

HSD-25HSD/MAD Medicaid Lag Report
Funding: Medicaid Centennial Care Services

ServiceDate:01/01/2012 to 12/31/2012

PaidDate:01/01/2012 to 12/31/2012

ReportRunDate:01/06/2013

		MONTHS OF SERVICE											
Months OF Payment	**1/1/2012**	**2/1/2012**	**3/1/2012**	**4/1/2012**	**5/1/2012**	**6/1/2012**	**7/1/2012**	**8/1/2012**	**9/1/2012**	**10/1/2012**	**11/1/2012**	**12/1/2012**	**Total**
1/1/2012	$8,428,185		$-	$-	$-	$-	$-	$-	$-	$-	$-		**$18,474,003**
2/1/2012	$7,595,548	$8,673,015		$-	$-	$-	$-	$-	$-	$-	$-		**$17,147,591**
3/1/2012	$1,294,401	$7,556,501	$9,126,158		$-	$-	$-	$-	$-	$-	$-		**$18,424,929**
4/1/2012	$195,661	$1,032,529	$7,719,737	$7,477,142		$-	$-	$-	$-	$-	$-		**$16,194,500**
5/1/2012	$45,096	$152,625	$1,178,479	$7,995,501	$8,249,387		$-	$-	$-	$-	$-		**$17,651,552**
6/1/2012	$12,695	$17,172	$147,259	$1,545,312	$8,005,005	$7,298,632	$-	$-	$-	$-	$-		**$17,272,118**
7/1/2012	$31,741	$28,160	$37,947	$132,708	$1,682,731	$7,733,263	$6,559,713		$-	$-	$-		**$16,327,602**
8/1/2012	$3,136	$1,799	$28,238	$57,519	$165,400	$1,390,752	$8,692,051	$7,682,252		$-	$-		**$18,117,903**
9/1/2012	$8,709	$9,145	$9,435	$26,819	$79,446	$205,429	$906,527	$8,146,087	$6,957,044	$-	$-		**$16,378,982**
10/1/2012	$7,029	$5,080	$15,752	$15,820	$78,006	$73,408	$115,381	$1,107,833	$7,368,573	$7,625,397	$-		**$16,411,130**
11/1/2012	$7,289	$6,203	$12,854	$13,407	$10,758	$12,887	$23,942	$335,557	$1,086,079	$7,990,749	$6,968,280		**$16,551,897**
12/1/2012	$391	$779	$886	$1,833	$2,067	$(1,187)	$40,280	$75,658	$370,181	$1,799,546	$8,129,876	$6,398,412	**$16,781,303**
Summary by MOS	**$17,626,503**	**$17,480,234**	**$18,275,366**	**$17,263,897**	**$18,271,769**	**$16,713,220**	**$16,334,306**	**$17,378,302**	**$15,875,272**	**$17,648,909**	**$16,410,788**	**$13,499,856**	**$743,759,549**

The MCO is responsible to report all data noted as "required" in the HIPAA Technical Reports, and HSD/MAD's Encounter Companion Guides with specific attention to the following financial information that will be used to ensure accuracy of claims payment and to set future capitation rates:

a. Actual MCO Paid Amount on all claims/lines paid by the MCO or subcontractor. This amount must be the amount paid minus any third party or client copay collected.
b. An MCO Paid Amount equivalent for any claims/lines not paid as fee for service claim/line, with a pricing process code that indicates the amount shown is an equivalent amount (e.g., subcapitated providers/clients);
c. Claim Adjustment reason codes (CAS codes) with Remark Codes as needed to designate the reasons any claim/line is not paid at the provider's billed charge (e.g., bundling);
d. Any payments by any third party payer, copayments from the client, or adjustments to the claim/line's pricing reported with the appropriate claim adjustment reason and remark codes.
e. Payment to IHS, FQHC, and RHC providers using institutional claim formats and including the encounter rate paid on one line of the claim, but including all services rendered as part of that encounter.
f. Any services provided to clients directly by MCO staff (e.g., care coordination, assessments, etc.) must be submitted to HSD/MAD as encounter data using agreed upon coding and meeting all HIPAA transaction standards

837 Encounter Adjustments/Voids

The MCO can adjust or void an encounter that has been previously adjudicated in Omnicaid by using the HIPAA 837 adjustment transaction. Pharmacy encounters submitted via NCPDP format are adjusted/voided using the same NCPDP format as outlined earlier in this manual. Please refer to the New Mexico Companion Guides for Managed Care Encounters (both the 837 Companion Guides and NCPDP Payer Sheet) for specific instructions re: how to submit a void or adjustment encounter. The companion guides are found on the HSD web portal at http://www.hsd.state.nm.us/mad/5010HIPAAforNMMedicaidProviders.html

Adjustment and Void encounters must match the original encounter on the following data elements:

- Billing Provider NPI (or Tax ID if the original was submitted for an atypical provider),
- Client ID, and
- The Omnicaid TCN of the original paid encounter that must be entered on the adjustment encounter.

The 837 transaction file can only contain encounters of one format type. Thus, all 837Ps must be submitted on one file, all 837Is must be submitted on a separate file, and all 837Ds must be submitted on another separate file. Furthermore, crossover encounters should always be batched separately from other, non-crossover encounters. However, the MCO may submit original encounters, adjustments and voids in the same batch. The encounters will continue through the regular encounter system edits and will appear on the RC070/071 and on the RC072.

If an encounter is accepted, it will appear on the RC070/071 and on the RC072 with any exceptions that apply. Any adjustment/void encounters submitted that don't match the required fields or which are found to have been previously adjusted, will also be shown on the RC070/071 report as denied with any of the following exception codes:

- 0840 Replcmt or Cred is in Process - Another adjustment or void request is already in process for this encounter.
- 0842 Client ID Match Not Found - The client ID on the adjustment or void request does not match the client ID on the encounter that is being adjusted or voided.
- 0843 Bill Prov Match Not Found - The billing provider number on the adjustment or void request does not match the billing provider number on the encounter that is being adjusted or voided. The tax id of the atypical billing provider or the Medicaid ID if the encounter being adjusted was prior to NPI mandate on the adjustment or void must result in a match to the Omnicaid Medicaid ID number submitted on the original encounter.

- 0844 Blng NPI Match Not Found - The NPI on the adjustment or void must result in a match to the Omnicaid Medicaid ID number submitted on the original encounter. The taxonomy is not needed for matching purposes on the adjustment or void request.
- 0845 Clm Already Cred or Replcd - The encounter that is being adjusted or voided has already been adjusted or voided. An encounter can only be voided once. Adjustments to previously adjusted encounters may be made but any such requests must be submitted with the TCN assigned to the most recent adjudicated adjustment, not the TCN of the original encounter. This is considered a duplicate encounter and is set to Deny and Report.
- 0850 ADJ/VOID Req Not Processed - The original Omnicaid TCN to adjust or void is missing or invalid. OR The original Omnicaid TCN to adjust or void does not match a previously paid encounter.
- 0856 A Credit May Not Be Adjusted

If an adjustment or void request cannot be processed for any of these reasons, it will be denied and the original encounter will remain in its original status. If an adjustment is submitted and the credit is accepted but the debit is denied for any reason other than the above, the credit side of the claim is accepted but the replacement or debit side is denied.

Adjustment Processing

An adjustment allows the MCO to correct a previously submitted encounter. In Omnicaid, when the adjustment claim is adjudicated, Omnicaid marks the original encounter as having been credited. It then creates a credit, or negative of the original encounter, and a replacement debit that reflects the 'new' or adjusted encounter. Here are some special considerations regarding encounter adjustments:

1. If the reason for the encounter adjustment is to correct the NPI of the provider or the original claim was paid with a different client ID than was originally submitted, the MCO must instead void the original encounter and then resubmit the claim as an original encounter. **It is critical that the voids be submitted in a separate cycle from the 'new' claim submission.**
2. If the reason for the encounter adjustment is that some, but not all, lines on the claim have since been denied by the MCO, the encounter adjustment should include only the lines that should now correctly reflect paid. As stated above, Omnicaid will create a negative of the original claim and the adjustment claim will in essence, replace that original. For example, if an encounter was submitted originally and paid in Omnicaid with 5 lines and one of those lines has since been recouped by the MCO, the adjustment encounter will contain only the 4 lines that are now considered by the MCO as valid; Omnicaid will void the 5 line encounter and process the 4 line encounter.

Void Processing

A void is submitted to nullify **all** individual lines originally submitted on an encounter without supplying additional corrected data. It works at the claim header level and all services originally accepted on that TCN will be voided. When the MCO submits a void, the original encounter is credited and a credit encounter is created (but without the replacement debit encounter that is created for an adjustment).

Omnicaid System-Generated Adjustments

HSD has the capability to mass adjust encounters, whether in a paid or denied status in Omnicaid. A mass adjustment request could be made in order to override edits that are posting to encounters that the State wishes to bypass or in order to void encounters that are in a paid status that audit has determined to be invalid or for other reasons that would be explained to the MCO prior to action taken.

When a system-generated adjustment is performed, a separate set of RC reports will be generated so that the MCO will receive an accounting of the mass adjustment separate from any encounter claims it has submitted.
The system-generated adjustment RC reports can be identified by the MA that precedes the report name. For example, instead of the usual report name RC070-RC071_07092016.ZIP, the system-generated adjustment will be named MA_RC070-RC071_07092016.ZIP. Likewise for the RC072, instead of RC072_07092016.ZIP, you'll see MA_ RC072_07092016.ZIP

NPI and Taxonomy Specific Instructions

All encounters must be submitted with an NPI number for any provider other than an atypical provider. Only "Atypical" providers (non-healthcare providers) may continue to file claims without an NPI Number. These include:

- Community Benefit providers (PT 363),
- handivans, taxis, and
- meals and lodging providers.

Schools and behavioral health providers are not exempt and must obtain NPI numbers. Atypical provider claims must be submitted with the provider's Tax ID number. Of course, if the provider has an NPI, that should be used.

Every encounter submitted for a healthcare provider with an NPI number must also include that provider's taxonomy number, ***if that provider has more than one Centennial Care provider type associated with that NPI.*** Provider type 344 (DD/Med Frag Waiver provider) is **not** a Centennial Care provider type. **The MCO must not require a taxonomy to be submitted on a claim if the provider has only 1 Centennial Care provider type under that NPI.** The provider who only has 1 Centennial Care provider type enrolled in Omnicaid under 1 NPI number will always have a single match to a provider ID in Omnicaid and taxonomy is not used.

Taxonomy is a 10 digit number that enables providers to indicate their type of practice and specialty on a encounter form. Use of taxonomy and the NPI is mandatory on healthcare encounters ***if needed to adjudicate the claim***. The MCO must never deny payment to a provider for not submitting a taxonomy or the 'right' taxonomy if that provider has only 1 line of business for Centennial Care. A provider of Community Benefit (provider type 363) who also provides waiver services under FFS (provider type 344) is not considered to have 2 lines of business for Centennial Care.

HSD recommends a taxonomy to be used for each provider record it enrolls and communicates this on the Provider Master and Confirmation files. ***The MCO is cautioned not to use the taxonomy found on the NPI registry for a New Mexico provider, but rather to use the Taxonomy to Provider Type crosswalk that we provide.*** The NPI registry records the taxonomy self-chosen by the provider, often at a corporate level and does not always reflect the licensure/certification under which the provider is operating in New Mexico. New Mexico assigns the provider types based on the specific program the provider is requesting on its application and the provider's licensure/certification for that program. The possible taxonomy codes for a given provider type are then identified by New Mexico on the crosswalk based on all the applicable taxonomies that relate to that provider's New Mexico licensure/certification.

- CONDUENT will use the NPI number and the taxonomy as reported on the encounter to determine the Medicaid ID number of the provider to whom payment is to be made.
- Taxonomy is required on the encounter when the NPI is used for the billing, rendering, and attending providers if any of those providers has more than one

type associated with that NPI. Providers must state the taxonomy when registering for the NPI number. However, the provider is not restricted to using this same taxonomy when filing a encounter if the provider has other types of encounters and business.

- Taxonomy will be used by CONDUENT to locate the appropriate Medicaid ID number when the provider has one NPI ID number for two or more lines of business. For example, if a home health agency also has a hospice Medicaid ID number and a private duty nursing number, and the provider chooses to apply for only one NPI, different taxonomies are used by the provider to indicate when the encounter is for home health, hospice, or private duty nursing.

Selecting a Taxonomy for an Encounter – It is strongly encouraged that the MCO require its providers with two or more lines of business to submit their claims with taxonomy codes and institute some editing between the provider type assigned by HSD and the taxonomy coming in on the claim. In the event the MCO pays a claim without a taxonomy code from a healthcare provider, the MCO can use the file of taxonomy to provider type crossmatch to assign a taxonomy code that will match the provider type of the provider on Omnicaid.

The following tips for validating taxonomy on claims is provided:

- For some providers, there may not be an apparent single taxonomy but, rather, there may be several different possibilities.
- Community Benefit providers, when using an NPI number, must use the taxonomy appropriate for that provider type but cannot use that same taxonomy on a non-community benefit service encounter. This distinction is very important in order for encounters to be processed appropriately.
- Hospital PPS exempt units must use the psych unit or rehab unit taxonomy to distinguish the unit from their acute care facility.
- Hospitals must use the hospital taxonomy for both their inpatient and outpatient departments. They cannot use the clinic taxonomies for outpatient hospital services.
- IHS hospitals do not have a special IHS taxonomy and therefore will use the acute care hospital taxonomy. There is a special taxonomy for an IHS pharmacy.
- Non-licensed Community Based providers (Personal Care Option) are Atypical and so do not need to use NPI or taxonomy unless they are part of a health care provider that uses the same NPI with different provider type, in which case they must use the taxonomy 3747P1801X.
- Pharmacy providers who do not have a separate DME/Medical Supply provider number who are submitting Professional (HCFA1500) encounters for medical supplies can still use the pharmacy taxonomy even if the encounter is not a pharmacy encounter.
- Physicians may use any physician taxonomy which appropriately describes his or her specialty.

- Radiology facility taxonomy is very confusing. A radiology facility may choose the taxonomy which best describes the facility. Any of those listed will be accepted.
- The BH taxonomy choices available do not generally reflect NM licensing categories or provider education levels. The list provided by the BH program may be helpful when a provider needs to locate a BH provider taxonomy which more closely corresponds to NM Medicaid provider types.

Use Of Location Zip Code

When an individual provider has more than one location, special procedures apply.

If it is not possible for the provider to obtain different NPI numbers for each location, the best alternative for a provider may be to work with the NM Taxation and Revenue Department to see if the business qualifies for one tax rate. Refer to the publication FYI 200 at http://www.tax.state.nm.us/pubs/fyi200.pdf, page 3, on the NM Tax and Rev web site or call a NM Tax and Rev district office.

If the above alternatives are not possible, the billing provider ZIP code on the encounter must be the ZIP code for the physical location which matches the Medicaid ID number for that location. For example, if an individual provider were an optometrist who has individual Medicaid ID numbers for practices in Santa Fe and Taos but only one NPI for both locations, the optometrist's encounter must contain the NPI, taxonomy, and the ZIP code for either the Santa Fe or Taos location, depending at which location the service took place. CONDUENT will then associate the NPI and zip code with the correct Medicaid ID number and make payment at the correct tax rate.

When the multiple Medicaid ID numbers are for locations that are individually certified or licensed, such as hospitals and nursing facilities, the Medical Assistance Division expects the provider to have separate NPI for each location.

Reporting of MCO Paid Amount

The MCO Paid Amount is reported on the 837 in the HCP01 segment and on the NCPDP in the Gross Amount Due field. The pricing process code in the 837 HCP02 is used to describe the payment being reported. The NCPDP amount must always be the amount paid to the Pharmacy. The following guidelines are to be followed in reporting the paid amount on the 837. The MCO should make every effort to report an amount of payment for the service, including providing a FFS equivalent if the service was capitated. Only the conditions that meet pricing process code 00 and 04 will be allowed to reflect a $0 Paid Amount ***and must always reflect a $0 payment***.

00 Zero Pricing (Not Covered Under Contract)	Use on line pricing to indicate line(s) not priced because service has been reimbursed through other means. Vaccines are the best example of this. They are a service rendered but may have been paid through DOH vaccines program. MCO Paid Amt will be expected to be zero on the line but the line is not considered to be denied.
01 Priced as Billed at 100%	
02 Priced at the Standard Fee Schedule	
03 Priced at a Contractual Percentage	
04 Bundled Pricing	Use on line pricing to indicate line(s) not priced individually but included in bundled payment amount shown on another line. MCO Allowed Amt will be expected to be zero on the line but the line is not considered to be denied.
05 Peer Review Pricing	
07 Flat Rate Pricing	
08 Combination Pricing	
09 Maternity Pricing	
10 Other Pricing	Use if MCO Allowed Amount reflects a FFS equivalent. MCO and subcontractor have not paid this amount as the service is capitated and only a PMPM has been paid for the services reflected on the claim or the service has been rendered by an employee of the MCO and thus hasn't incurred a direct payment amount. The MCO Allowed Amount must not be 0
11 Lower of Cost	
12 Ratio of Cost	
13 Cost Reimbursed	
14 Adjustment Pricing	

Reporting of COB and CAS on Encounters

Exception 0162 is the edit that will post if an out of balance situation exists for claims with COB and CAS reported. The exception balances header to header and line to line as shown here:

Edit 0162 will post when

- If line Level COB is present, the sum of the 2400 SVC203 loop (C-TOT-CHRG-AMT) must equal the sum amounts in loop 2430 CAS Service Line Adjustments (C-CAS-AMT) + Sum of amounts in loop 2430 SVD02 Service Line Paid Amount (C-LI-PYR-PYMT-AMT)

- If only header level COB is present, the header amounts must balance (PLEASE NOTE: if line COB is present, even if the header amounts balance, the edit will still post if the line levels don't balance).

  Loop 2300 CLM02 Total claim Charge Amount (C-TOT-CHRG-AMT) must equal Sum amounts in Loop 2320 CAS Header Service Adjustments (C-CAS-AMT) + Loop 2320 AMT Claim Paid Amount (C-COB-PYR-PYMT-AMT)

Reporting of Interest payments

The requirement for Interest payments is stated in the MCO's contract which refers to New Mexico Administrative Code.

4.19.1.7 **Paying interest as required in Paragraph (1) of subsection 8.308.20.9 (E) of NMAC;**

NMAC says:

(1) The MCO shall pay a contracted and non-contracted provider interest on the MCO's liability at the rate of one and one-half percent per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating provider and not paid within 30 calendar days of the date of receipt of an electronic claim and 45 calendar days of receipt of a paper claim. Interest shall accrue from the 31st calendar day for electronic claims and from the 46th calendar day for manual claims. The MCO shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HSD/MAD.

As clarification of this, Interest is calculated on the amount due or paid (not the amount billed). Prompt Pay interest begins to accrue on an untimely paid clean claim on the first day after the deadline for payment and ends on the date of payment. Thus, interest on electronic clean claims starts to accrue on the 31st calendar day following receipt without payment. Interest on manual clean claims starts to accrue on the 46th day following receipt without payment.

The MCO shall not be required to pay any interest calculated to be less than two dollars ($2.00). The interest shall be paid within 30 days of the payment of the claim

1. MCOs are instructed to report on the encounter any interest paid on a claim or claim line by using a CAS segment. The CAS reason code for Interest payment is 225 Interest Payment by Payer. On the encounters, interest is to be reported at the header level. If reporting interest payment without any other third party payment (amount the MCO paid is not a third party payment), enter SBR segments as follows based on the number of payers on the claim, using the 2320 Payer code 'ZZ' for the interest payment.

SBR values when paid interest		
SINGLE PAYER		
2000B	S	MC
2320	P	ZZ
TWO PAYER MEDICARE		
2000B	T	MC
2320 1st	S	ZZ
2320 2nd	P	MB

TWO PAYER COMMERCIAL		
2000B	T	MC
2320 1st	S	ZZ
2320 2nd	P	CI
THREE PAYER		
2000B	A	MC
2320 1st	T	ZZ
2320 2nd	P	MB
2320 3rd	S	CI

2. The MCO reports the interest payment in the 2320 Loop like this:
   CAS*OA*225*3.00 (example interest amount)
   AMT* D*0
3. The MCO must include the 2330A NM1 and N4 spans in order for the claim to pass EDI edits
4. If reporting interest payment where there is also some other third party payment, the balancing rules must be followed which means that all the third party payments must be included on the claim, along with CAS segments that fully balance up to the Billed Charges (either Total Billed Charges at the header or lines balance with billed charges at the line).

The interest payment is to be included in the overall MCO Payment Amount reported in the HCP segment. For claims where the payment amount HCP02 segment is only reported at the line level, add the interest amount on the first service line.

ENCOUNTER EDITING

The MMIS checks for duplicates and validates the encounter input against the Client Eligibility, Provider, and Procedure Formulary File, appending critical information to the individual encounters. The duplicate checking process
s compares the MCO ICN of the next record to the previous record within the same file and to any in-history MCO ICN. If the MCO ICN is the same, the duplicate record is denied. Duplicate checking also checks the in process encounter to history encounters checking the Dates of Service, Provider, Client, and service information to identify duplicates of encounters previously paid.

The first step in Encounter adjudication involves assigning a claim type to the encounter. This claim type assignment is integral to the editing of the claim. The procedure and revenue reference files all contain a table of allowed claim types and as you can see from the chart below, only certain provider types are allowed for certain claim types:

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
I	UB-04	Inpatient	Batch Type U – UB-04 (OR)========== Batch Type A – UB-04 Crossover	Type of Bill = 11X 12X 621 AND Provider Type = 201-205, 221 (OR)========== Type of Bill = 11X 12X AND Provider Type = 201-205 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND Not an IHS Facility AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810) (OR)========== Type of Bill = 12X AND Batch Document Type Code not equal "E" (Encounter) (OR)========== Type of Bill = 11X or 12X AND Provider Type = 922 or 904 AND Batch Document Type Code equal "E" (Encounter)	General Hospital Mental Hospital (OR)========== (for X12N-ADJ , X12N and type of bill code digits 1-2 = 12) AND Batch Document Type Code not equal "E" (Encounter) OR Value Code = XO AND Type of Bill – 11X 12X AND Batch Document Type Code not equal "E" (Encounter)
O	UB-04	Outpatient Note: This is	Batch Type U – UB-04	Type of Bill = 13X 71X 72X	Outpatient Hospital Rural Health Clinic Freestanding Dialysis Center

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
		the default code for UB-04's.	(OR)========== Batch Type A – UB-04 Crossover	73X 74X 75X 76X 77X 84X AND Provider Type = 201-205, 221, 313, 314,315, 455, 447 OR Claim Type not previously assigned as CT 1, N, V or H. Provider type 364 and 218 would fall into this category. (OR)========== Type of Bill = 13X 71X 72X 73X 74X 75X 76X 77X 84X AND Provider Type = 201-205, 315 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND Not an IHS Facility AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810)	Freestanding FQHC Outpatient Rehabilitation Facility Ambulatory Surgery Center Freestanding Birthing Center

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
N	UB-04	Long Term Care	Batch Type U – UB-04	Type of Bill = 65X 66X 69X 86X 89X AND Provider Type = 211-215, 216-217, 219, 221 (OR) Batch Document Type Cd = "E" (Encounter) AND Type of Bill = 65X 66X 69X 86X 89X 21X 22X AND Provider Type = 211-215, 216-218, 219, 221	
			(OR)========== Batch Type A – UB-04 Crossover	(OR)========== Type of Bill = 65X 66X 69X 86X 89X AND Provider Type = 216 AND	
				Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND Not an IHS Facility AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810)	
P	CMS-1500	Practitioner/Physician Note: This is the default code for CMS-1500's.	Batch Type H – CMS-1500 (OR)========== Batch Type B – HCFA Crossover	Claim Type not previously assigned as CT L, S, T, W, or X. (OR)========== Claim Type not previously assigned as CT L, S, T, W, or X. AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810) AND Provider Billing Type is not 341, 344, 363, 447, 705, 463-999	Edit 0032 (Provider Type/Claim Type Conflict) posts if default is assigned.
D	ADA Dental	Dental	Batch Type D – ADA Dental		

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
L	CMS-1500	Independent Laboratory, X-Ray	Batch Type H –CMS-1500 (OR)========== Batch Type B – HCFA Crossover	Provider Type = 351-354 (OR)========== Provider Type = 351-354 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810) AND Provider Billing Type is not 341, 344, 363, 447, 705, 463-999	
S	CMS-1500	Medical Supply	Batch Type H –CMS-1500 (OR)========== Batch Type B – HCFA Crossover	Provider Type = 336-338, 411, 414-417 (OR)========== Provider Type = 336-338, 411, 414-417 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810) AND Provider Billing Type is not 341, 344, 363, 447, 705, 463-999	
V	UB-04	Home Health	Batch Type U – UB-04 (OR)========== Batch Type A – UB-04 Crossover	Type of Bill = 32X (Discontinued as of 02/27/14) 33X 34X AND Provider Type = 361 (OR) Batch Document Type Cd = "E" (Encounter) AND Type of Bill = 32X (Discontinued as of 02/27/14) 33X 34X AND Revenue Code '0550' THRU '0559', '0570' THRU '0579' , '0580' THRU '0589' , '0590' THRU '0599'. OR Provider Type = 361 (OR)========== Type of Bill = 32X (Discontinued as of 02/27/14) 33X 34X AND	

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
				Provider Type = 361 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND Not an IHS Facility AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810)	
T	CMS-1500	Transportation	Batch Type H – CMS-1500 (OR)========== Batch Type B – HCFA Crossover	Provider Type = 401-405 (OR)========== Provider Type = 401-405 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810) AND Provider Billing Type is not 341, 344, 363, 447, 705, 463-999	
A	UB-04	Mcare Part A Crossover	Batch Type A – UB-04 Crossover	Type of Bill = 110-118 180-188 210-218 280-288 410-418 510-518 61X AND Header Medicare Allowed Amount is greater than 0 OR Provider Billing Code is not Unrestricted or Billing Only OR Provider Billing Type is 211-215, 217-218, 221 OR An IHS Facility OR There is an Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810)	
B	CMS-1500	Mcare Part B Crossover	Batch Type B – CMS-1500 Crossover	Header Medicare Allowed Amount is greater than 0 OR Provider Billing Code is not Unrestricted or Billing Only OR There is an Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810) AND Provider Billing Type is not 341, 344, 363, 447, 705, 463-999	
C	UB-04	Mcare UB-04 Part B Crossover	Batch Type A– UB-04 Crossover	Type of Bill =120-128 131-135 137-138	

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
		Note: This is the default code for UB-04 Crossover's.		13P 13I 141 145 147-148 22X 231 235 237-238 241 245 247-248 331-335 337-338 341-344 62X 711-715 717-718 721-725 727-728 741-745 747-748 75X 76X 811-815 817-818 821-825 827-828 831-835 837-838 AND Header Medicare Allowed Amount is greater than 0 OR Provider Billing Code not Unrestricted or Billing Only OR Provider Billing Type is 221, 313-314, 455 OR An IHS Facility OR There is an Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810)	

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
H	UB-04	Hospice	Batch Type U – UB-04 (OR)========== Batch Type A – UB-04 Crossover	Type of Bill = 81X 82X AND Provider Type = 362 (OR) Batch Document Type Cd = "E" (Encounter) AND Type of Bill = 81X 82X AND Revenue Code '0650' THRU '0658' (OR)========== Type of Bill = 81X 82X AND Provider Type = 362 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND Not an HIS Facility AND There is no Administrative Claim Adjustment Segments (CAS) for the Medicare Payer. (system list 4810)	Hospice

Once the claim type is assigned, the system attempts to match the NPI, taxonomy and zip code on the claim to the correct provider record in Omnicaid. See section **NPI Specific Instruction** for more information on this. Further editing ensures the client is eligible and enrolled with the MCO on the dates of service and that the service is allowed for that claim type and provider type and type of bill (if its an institutional claim). The reference files listed in the Reference File section can be used by the MCOs to ensure their own edits are in synch with how Omnicaid is editing. **However, please note,** these tables simply show all provider types allowed for all codes and all claim types allowed for all codes. But the system is only going to allow if the claim type, provider type and service code all agree. So, for example, the revenue code file that shows allowed type of bill codes will show ALL allowed type of bill codes, but based on the provider who is billing and the claim type that's been assigned, only certain type of bill codes are allowed for that given combination.

The validation process includes edits that are set to "Pay and Report", "Deny and Report", and "Deny". "Pay and Report" edit exceptions post when there is an error in the information in a field, but the error is not determined to be critical to the acceptance of the line item/encounter, so the encounter/line is accepted. Only those encounter line items that receive a "Pay" status or a "Pay and Report" edit exception are accepted as Paid by HSD's system. The "Deny and Report" status is set for adjustment rejection edits and services such as Abortion that can't be paid with federal funds.

The errors are accumulated and if the batch has deny errors, the MCO is required to correct the encounters reported as "Deny" errors and resubmit them within 30 days of the error report. If the error represents what the MCO believes is an accurate payment, the claim should be sent to HSD for evaluation.

Duplicate Processing and the Use of Modifiers

Duplicate processing is the same for all encounter claim types. An encounter is rejected as a duplicate when the conditions on the Duplicate Editing Chart that follows are met. Duplicate processing will not record as a duplicate when these fields match within the same encounter (i.e., ICN.). When an encounter denies because of a duplicate, the error message on the *Denied Encounter Adjudication Cycle Detail Report* will show the MCO's ICN # that the encounter duped against.

To avoid having encounters that the MCO considers valid denying as duplicates, (i.e., the MCO is submitting a second claim for the same client, same date of service, same provider and same procedure code but the MCO has allowed the service but our system will deny as a duplicate) the MCO can use a valid modifier to differentiate the service as a non-duplicate service for any HCPC procedure. Whenever possible, the differentiating modifier should be specific to the procedure and those modifiers allowed for that procedure code. And the differentiating modifier would not be needed for the first occurrence of a service, but would be used for the second occurrence of the service code for the same dates of service, same provider, and same enrollee (e.g., U1). The non-specific series U1-U9 can be used to differentiate, except for Dental procedures which don't allow these modifiers. A third occurrence of the same procedure code would thus require use of a different modifier (e.g., U2), and so on. If the service is already defined using one of these modifiers, the MCO could use a second modifier to further differentiate the services. For example, the service is defined with the procedure and modifier U1, the MCO would submit the second occurrence of this service for the same client, same day, same provider with a U1 and a U2 modifier.

Duplicate Encounter Edit Table

The following charts define how Encounter Exceptions work for different claim types: **Note:** The following service versus same service edits must be turned on for either FFS or Encounter to post. If they are not turned on, they will not post. However, the system supports all service versus same service edits for both FFS and Encounter.

Claim Type = I (Inpatient) and none of the lines of the claim contains revenue code = 0169 Edits Post to Header

Same Provider – Exception 1361	**Same Provider – Exception 1362**
1. Same client ID. (B_SYS_ID) 2. Same dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID) The New Mexico OmniCaid MMIS does **not** post this exception if only one of the claim's revenue codes is between 0810 and 0819 or between 0890 and 0899	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID)
Different Provider – Exception 1371	**Different Provider – Exception 1372**
1. Same client ID (B_SYS_ID) 2. Same or overlapping dates of service; see Note 3 (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Different enterprise provider number. (C_BLNG_NTRPRS_ID)	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Different from dates. (C_HDR_SVC_FST_DT) 4. Different enterprise provider number. (C_BLNG_NTRPRS_ID) 5. The claim with the earliest from date does not have the same admission date and through date. (C_HDR_ADMIT_DT C_HDR_SVC_LST_DT) 6. The claim with the earliest from date has a hospital pay mode of "C" (DRG). (C_BSE_AMT_SRC_CD) 7. The claim with the earliest from date does not have a patient status of "02" (discharge/ transferred to another short-term general hospital for inpatient care). (C_PAT_STAT_CD)

Claim Type = I (Inpatient) and one of the lines of the claim contains revenue code = 0169 = Awaiting Placement **Edits Post to Header**

Same Provider – Exception 1361	**Same Provider – Exception 1362**
1. Same client ID. (B_SYS_ID) 2. Same dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID)	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID)
Different Provider – Exception 1371	**Different Provider – Exception 1372**
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Different enterprise provider number. (C_BLNG_NTRPRS_ID)	

Claim Type = O (Outpatient) and Type of Bill NOT 71x, 72x, 73x or 79x **Edits Post to Line**

Same Provider – Exception 1361	
1. Same client ID.(B_SYS_ID) 2. Same date of service. (C_LI_FST_DOS_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code or modifier; see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R-PROC-MOD) The system will bypass the edit if one of the claims has a modifier 76 or 77 and the other doesn't. The system will bypass the edit if one of the claims has a modifier 59 and the Service area is Pathology. The system will bypass the edit if the Billing Provider Type is 221, 313, 314, 315 and the rendering provider on the in process is different from the rendering provider on the history claim, The system will bypass the edit If the Billing Provider Type is 221, 313, 314, 315 and the rendering provider on the in process is different from the rendering provider on the history claim, bypass.exception.	
Different Provider – Exception 1371	**Different Provider – Exception 1372**
1. Same client ID. (B_SYS_ID) 2. Same date of service. (C_LI_FST_DOS_DT) 3. Different enterprise provider number.	1. Same client ID. (B_SYS_ID) 2. Same date of service. (C_LI_FST_DOS_DT) 3. Different enterprise provider number.

(C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code or modifier; see Notes 5a, 5b. (R_REV_CD or R_PROC_CD or R-PROC-MOD) 5. Same billed charge. (C_LI_SUBM_CHRG_AMT) 6. The servicing provider type (P_TY_CD from C_LI_TB) on both claims is **not** "221" (Indian health services hospital).	(C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code or modifier; see Notes 5a, 5b and 16. (R_REV_CD or R_PROC_CD or R-PROC-MOD) 5. Same billed charge. (C_LI_SUBM_CHRG_AMT) 6. The servicing provider type (P_TY_CD from C_LI_TB) on both claims is "221" (Indian health services hospital).

Claim Type = O (Outpatient) and Type of Bill = 73x and 79X = Federally Qualified Health Center (FQHC) Edits Post to Line

Same Provider – Exception 1361	
1. Same client ID. (B_SYS_ID) 2. Same date of service. (C_LI_FST_DOS_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R_PROC_MOD) The system will bypass the edit if one of the claims has a modifier 76 or 77 and the other doesn't. The system will bypass the edit if one of the claims has a modifier 59 and the Service area is Pathology. The system will bypass the edit if the Billing Provider Type is 221, 313, 314, 315 and the rendering provider on the in process is different from the rendering provider on the history claim,. The system will bypass the edit If the Billing Provider Type is 221, 313, 314, 315 and the rendering provider on the in process is different from the rendering provider on the history claim, bypass.exception	
Different Provider – Exception 1371	
1. Same client ID. (B_SYS_ID) 2. Same date of service. (C_LI_FST_DOS_DT) 3. Different enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R_PROC_MOD)	

Claim Type = O (Outpatient) and Type of Bill = 72x = Renal Dialysis Edits Post to Line

Same Provider – Exception 1361	
1. Same client ID. (B_SYS_ID) 2. Same date of service. (C_LI_FST_DOS_DT) 3. Same enterprise provider number.	

(C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R_PROC_MOD) The system will bypass the edit if one of the claims has a modifier 76 or 77 and the other doesn't. The system will bypass the edit if one of the claims has a modifier 59 and the Service area is Pathology.
Different Provider – Exception 1371
1. Same client ID. (B_SYS_ID) 2. Same date of service. (C_LI_FST_DOS_DT) 3. Different enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD, or R_PROC_MOD)

Claim Type = O (Outpatient) and Type of Bill = 71x and NM Prov. Type = 315 = Rural Health Clinic – Free Standing Edits Post to Line

Same Provider – Exception 1361
1. Same client ID. (B_SYS_ID) 2. Same date of service. (C_LI_FST_DOS_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD, or R_PROC_MOD) The system will bypass the edit if one of the claims has a modifier 76 or 77 and the other doesn't. The system will bypass the edit if one of the claims has a modifier 59 and the Service area is Pathology.
Different Provider – Exception 1371
1. Same client ID. (B_SYS_ID) 2. Same date of service. (C_LI_FST_DOS_DT) 3. Different enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R_PROC_MOD) The system will bypass the edit if the Billing Provider Type is 221, 313, 314, 315 and the rendering provider on the in process is different from the rendering provider on the history claim,

Claim Type = O (Outpatient) and Type of Bill = 71x and NM Prov. Type = 314 = Rural Health Clinic – Hospital Based Edits Post to Line

Same Provider – Exception 1361	
1. Same client ID. (B_SYS_ID) 2. Same date of service. (C_LI_FST_DOS_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R_PROC_MOD) The system will bypass the edit if one of the claims has a modifier 76 or 77 and the other doesn't. The system will bypass the edit if one of the claims has a modifier 59 and the Service area is Pathology. The system will bypass the edit if the Billing Provider Type is 221, 313, 314, 315 and the rendering provider on the in process is different from the rendering provider on the history claim,.	

Different Provider – Exception 1371	
1. Same client ID. (B_SYS_ID) 2. Same date of service. (C_LI_FST_DOS_DT) 3. Different enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R_PROC_MOD)	

Claim Type = N (Long Term Care) Edits Post to Header

Same Provider – Exception 1361	**Same Provider – Exception 1362**
1. Same client ID. (B_SYS_ID) 2. Same dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID)	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID)
Different Provider – Exception 1371	
1. Same client ID (B_SYS_ID) 2. Same or overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Different enterprise provider number. (C_BLNG_NTRPRS_ID)	

Claim Type = P (Practitioner/Physician) and NM Prov. Type NOT = (364, 324, 342-343, 346, 441, 462, 363, 901, 431-433, 435-437, 443-446, 451-455, 457-458, 904-906, 331, 334-335, or 412) Edits Post to Line

Same Provider – Exception 1361	**Same Provider – Exception 1362**	**Same Provider – Exception 1363**	**Same Provider – Exception 1364**	**Same Provider – Exception 1365**	**Same Provider – Exception 1366**	
1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number 3. Same procedure code; see Note 16. (R_PROC_CD) 4. Same service component code. (C_SVC_COMPONENT_CD) 5. The history and in-process claims' lines have the same modifiers The New Mexico OmniCaid MMIS does **not** post this exception if one of the following conditions occurs; see Notes 10, 11, 12, 13 and 14.	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number 3. Same procedure code; see Note 16. (R_PROC_CD) 4. Same service component code. (C_SVC_COMPONENT_CD) 5. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if one of the following conditions occurs; see Notes 10, 11, 12, 13 and 14.	1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number 3. Same procedure code; see Note 16. (R_PROC_CD) 4. Same service component code. (C_SVC_COMPONENT_CD) 5. The claims meet the conditions in Note 11b. 6. The history and in-process claims' lines have the same modifiers The New Mexico OmniCaid MMIS does **not** post this exception if one of the following conditions occurs; see Notes 10,12 and 13.	1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number 3. Same procedure code; see Note 16. (R_PROC_CD) 4. Same service component code. (C_SVC_COMPONENT_CD) 5. The claims meet the conditions in Note 13. 6. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if one of the following conditions occurs; see Notes 10, 12 and 14.	1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number 3. The paid claim's service component code is "2" (surgery) and the in-process claim's service component code is "8" (assistant surgery). (C_SVC_COMPONENT_CD) 4. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if the servicing provider is a group. (PROV_INDIV_GRP_IND)	1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number 3. The in-process claim's service component code is "2" (surgery) and the paid claim's service component code is "8" (assistant surgery). (C_SVC_COMPONENT_CD) 4. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if the servicing provider is a group. (PROV_INDIV_GRP_IND)	
Different Provider – Exception 1371	**Different Provider – Exception 1372**	**Different Provider – Exception 1373**	**Different Provider – Exception 1374**	**Different Provider – Exception 1375**		
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different servicing provider number.	1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different servicing provider number.	1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different servicing provider number.	1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different enterprise provider number.	1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different servicing provider number. (C_RNDR_PROV_ID)		

(C_RNDR_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. Same service component code. (C_SVC_COMPONENT_CD) 6. Same Billed Charge. 7. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if one of the following conditions occurs; see Notes 9, 10, 11, 13, 14 and 17.	(C_RNDR_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. Same service component code. (C_SVC_COMPONENT_CD) 6. The claims meet the conditions in Note 11b. 7. Same Billed Charge. 8. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if one of the following conditions occurs; see Notes 9, 10, 12, 13 and 14.	(C_RNDR_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. Same service component code. (C_SVC_COMPONENT_CD) 6. The claims meet the conditions in Note 13. 7. Same Billed Charge. 8. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if one of the following conditions occurs; see Notes 9, 10 and 12.	(C_BLNG_PROV_ID) 4. Same servicing provider number. (C_RNDR_PROV_ID) 5. Same procedure code, see Note 16. (R_PROC_CD) 6. Same Billed Charge. 7. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if one of the following conditions occurs; see Notes 10, 11 and 14.	4. Same procedure code; see Note 16. (R_PROC_CD) 5. Same service component code. (C_SVC_COMPONENT_CD) 6. Same bill charged. (C_LI_SUBM_CHRG_AMT) 7. Same servicing provider specialty. (P_SPECL_CD) 8. The claims meet the conditions in Note 9. 9. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if the claims meet the conditions in Note 10.		

Claim Type = P (Practitioner/Physician) and NM Prov. Type = 364 = Ambulatory Surgical Center **Edits Post to Line**

Same Provider – Exception 1361	**Same Provider – Exception 1362**
1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers.	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers on.
Different Provider – Exception 1371	**Different Provider – Exception 1372**
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers.	

Claim Type = P (Practitioner/Physician) and NM Prov. Type = 324, 342-343, 346, 441, 462, 363, or 901= Misc/Enhanced EPSDT Edits Post to Line

Same Provider – Exception 1361	**Same Provider – Exception 1362**	**Same Provider – Exception 1369**
1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers. New Mexico Omnicaid does not post this exception if the following condition occurs; see note 14.	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers.	1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers.
Different Provider – Exception 1371		**Different Provider – Exception 1379**
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. Same Billed Charge 6. The history and in-process claims' lines have the same modifiers. New Mexico Omnicaid does not post this exception if the following condition occurs; see note 14.		1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_ DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_RNDR_NTRPRS_ID FROM C_LI_HCFA1500_TB) 4. Same procedure code, see Note 16. (R_PROC_CD) 5. Same Billed Charge. 6. The HIS claim and the IP claim's lines have the same modifiers.

Claim Type = P (Practitioner/Physician) and NM Prov. Type = 431-433, 435-437, or 443-446 = Psychiatric Edits Post to Line

Same Provider – Exception 1361	**Same Provider – Exception 1362**	**Same Provider – Exception 1369**
1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number 3. Same procedure code; see Note 16.(R_PROC_CD) 4. The history and in-process claims' lines have the same modifiers.	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number 3. Same procedure code; see Note 16. (R_PROC_CD) 4. The history and in-process claims' lines have the same modifiers.	1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number 3. Same procedure code, see Note 16. (R_PROC_CD) 4. The history and in-process claims' lines have the same modifiers.
Different Provider – Exception 1371		**Different Provider – Exception 1379**
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different enterprise provider number. (C_RNDR_NTRPRS_ID from C_LI_TB) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers.		1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different enterprise provider number. (C_RNDR_NTRPRS_ID FROM C_LI_HCFA1500_TB) 4. Same procedure code, see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers

Claim Type = P (Practitioner/Physician) and NM Prov. Type = 451-455, 457-458, or 904-906 = Rehabilitation Edits Post to Line

Same Provider – Exception 1361	Same Provider – Exception 1362	Same Provider – Exception 1369
1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers.	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers	1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers
Different Provider – Exception 1371	**Different Provider – Exception 1372**	**Different Provider – Exception 1379**
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers.		1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers

Claim Type = P (Practitioner/Physician) and NM Prov. Type = 331, 334-335, or 412 = Vision and Hearing Edits Post to Line

Same Provider – Exception 1361	Same Provider – Exception 1362	Same Provider – Exception 1369
1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers.	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers	1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers .
Different Provider – Exception 1371		**Different Provider – Exception 1379**

1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers. .		1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers

Claim Type = D (Dental) Edits Post to Line

Same Provider – Exception 1361
1. Same client ID. (B_SYS_ID) 2. Same date of service. (C_LI_FST_DOS_DT) 3. Same billing provider number or same servicing provider or IP billing provider equal I servicing provider or IP servicing provider equal I billing provider. (C_BLNG_PROV_ID) 5. Criteria to fail exception: Procedure code is the same on both claims and Oral cavity is the same on both claims and Tooth number is the same on both claims. 6. Criteria to fail exception: Procedure code is the same on both claims and Oral cavity is the same on both claims and Tooth number is blank on both claims. 7. Criteria to bypass the exception: Procedure code is the same on both claims and Oral cavity is the same on both claims and Tooth number is different on both claims. 8. Criteria to fail the exception: Procedure code is the same on both claims and Oral cavity is the same on both claims and Tooth number is blank on one claim and valued on the other. 9. Criteria to fail the exception: Procedure code is the same on both claims and Oral cavity is blank on both claims and Tooth number is the same on both claims. 10. Criteria to fail the exception: Procedure code is the same on both claims and Oral cavity is blank on both claims and Tooth number is blank on both claims. 11. Criteria to bypass the exception: Procedure code is the same on both claims and oral cavity is blank on both claims and tooth number is different on both claims. 12. Criteria to fail the exception: Procedure code is the same on both claims and oral cavity is blank on both claims and tooth number is blank on one claim and valued on the other. 13. Criteria to fail the exception: Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is the same on both claims. 14. Criteria to by pass the exception: Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is blank on both claims. 15. Criteria to by pass the exception: Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is blank on both claims. 16. Criteria to by pass the exception: Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is blank on one claim and valued on the other. 17. Criteria to fail the exception: Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is the same on both claims. 18. Criteria to fail the exception: Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is blank on both claims.

19. Criteria to by pass the exception:
Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is different on both claims.
20. Criteria to fail the exception:
Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is blank on one claim and valued on the other.

Different Provider – Exception 1371

1. Same client ID.
(B_SYS_ID)
2. Same date of service.
(C_LI_FST_DOS_DT)
3. Different enterprise provider number.
(C_RNDR_NTRPRS_ID from C_LI_TB)
5. Criteria to fail exception:
Procedure code is the same on both claims and oral cavity is the same on both claims and tooth number is the same on both claims.
6. Criteria to fail exception:
Procedure code is the same on both claims and oral cavity is the same on both claims and tooth number is blank on both claims.
7. Criteria to bypass the exception:
Procedure code is the same on both claims and oral cavity is the same on both claims and tooth number is different on both claims.
8. Criteria to fail the exception:
Procedure code is the same on both claims and oral cavity is the same on both claims and tooth number is blank on one claim and valued on the other.
9. Criteria to fail the exception:
Procedure code is the same on both claims and oral cavity is blank on both claims and tooth number is the same on both claims.
10. Criteria to fail the exception:
Procedure code is the same on both claims and oral cavity is blank on both claims and tooth number is blank on both claims.
11. Criteria to bypass the exception:
Procedure code is the same on both claims and oral cavity is blank on both claims and tooth number is different on both claims.
12. Criteria to fail the exception:
Procedure code is the same on both claims and oral cavity is blank on both claims and tooth number is blank on one claim and valued on the other.
13. Criteria to fail the exception:
Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is the same on both claims.
14. Criteria to by pass the exception:
Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is blank on both claims.
15. Criteria to by pass the exception:
Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is blank on both claims.
16. Criteria to by pass the exception: Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is blank on one claim and valued on the other.
17. Criteria to fail the exception:
Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is the same on both claims.
18. Criteria to fail the exception:
Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is blank on both claims.
19. Criteria to by pass the exception:
Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is different on both claims.
20. Criteria to fail the exception:
Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is blank on one claim and valued on the other.

Claim Type = L (Independent Laboratory, X-Ray) Edits Post to Line

Same Provider – Exception 1361	**Same Provider – Exception 1362**	**Same Provider – Exception 1363**	**Same Provider – Exception 1364**	**Same Provider – Exception 1369**
Old – New 1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. Same service component code. (C_SVC_COMPONENT_CD) 6. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if one of the following conditions occurs; see Notes 11, 13.	Old – 0752 1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. Same service component code. (C_SVC_COMPONENT_CD) 6. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if one of the following conditions occurs; see Notes 11, 13.	Old – New 1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. Same service component code. (C_SVC_COMPONENT_CD) 6. The claims meet the conditions in Note 11b. 7. The history and in-process claims' lines have the same modifiers The New Mexico OmniCaid MMIS does **not** post this exception if the claims meet the conditions in Note 13.	Old – New 1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. Same service component code. (C_SVC_COMPONENT_CD) 6. The claims meet the conditions in Note 13. 7. The history and in-process claims' lines have the same modifiers.	1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD) 5. Same service component code. (C_SVC_COMPONENT_CD) 6. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if one of the following conditions occurs; see Notes 11 and 13.
Different Provider – Exception 1371	**Different Provider – Exception 1372**			**Different Provider – Exception 1379**
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. Same service component code. (C_SVC_COMPONENT_CD) 6. Different billed charge. (C_LI_SUBM_CHRG_AMT) 7. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if the claims meet the conditions in Notes 11.	1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. Same service component code. (C_SVC_COMPONENT_CD) 6. Same billed charge. (C_LI_SUBM_CHRG_AMT) 7. The claims meet the conditions in Note 11b. 8. The history and in-process claims' lines have the same modifiers. .			1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD) 5. Same service component code. (C_SVC_COMPONENT_CD) 6. Different billed charge. (C_LI_SUBM_CHRG_AMT) 7. The history and in-process claims' lines have the same modifiers.

				The New Mexico OmniCaid MMIS does **not** post this exception if the claims meet the conditions in Note 11.

Claim Type = S (Medical Supply) Edits Post to Line

Same Provider – Exception 1361	Same Provider – Exception 1362	Same Provider – Exception 1369
1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers The New Mexico OmniCaid MMIS does **not** post this exception if the procedure code modifier on one claim is "LT" (left side of the body) and the procedure code modifier on the other claim is "RT" (right side of the body). (C_PROC_MOD_XXX_CD where XXX = 1ST or 2ND or 3RD or 4TH). Or meets the criteria in Note 14.	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if the procedure code modifier on one claim is "LT" (left side of the body) and the procedure code modifier on the other claim is "RT" (right side of the body). (C_PROC_MOD_XXX_CD where XXX = 1ST or 2ND or 3RD or 4TH). Or meets the criteria in Note 14.	1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers The New Mexico OmniCaid MMIS does **not** post this exception if the procedure code modifier on one claim is "LT" (left side of the body) and the procedure code modifier on the other claim is "RT" (right side of the body). (C_PROC_MOD_XXX_CD (WHERE XXX = 1ST OR 2ND OR 3RD OR 4TH)).
Different Provider – Exception 1371		**Different Provider – Exception 1379**
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. Same billed charge. (C_LI_SUBM_CHRG_AMT) 6. The history and in-process claims' lines have the same modifiers		1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD 5. Same billed charge. (C_LI_SUBM_CHRG_AMT) 6. The history and in-process claims' lines have the same modifiers.

Claim Type = V (Home Health) Edits Post to Line

Same Provider – Exception 1361	Same Provider – Exception 1362
1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number.	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number.

(C_BLNG_NTRPRS_ID) 4. Same revenue code, see Notes 5b and 16. (R_REV_CD)	(C_BLNG_NTRPRS_ID) 4. Same revenue code, see Note 5b and 16. (R_REV_CD)
Different Provider – Exception 1371	
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Different enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code, see Notes 5b and 16. (R_REV_CD)	

Claim Type = T (Transportation) Edits Post to Line

Same Provider – Exception 1361	Same Provider – Exception 1362	Same Provider – Exception 1369
1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) . (C_BLNG_PROV_ID) . Same procedure code; see Note 16. (R_PROC_CD) 6. The history and in-process claims' lines have the same modifiers	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD) 5. The history and in-process claims' lines have the same modifiers	1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD) 6. The history and in-process claims' lines have the same modifiers. The New Mexico OmniCaid MMIS does **not** post this exception if the procedure code is in the additional miles system list (4725)

Different Provider – Exception 1371	Different Provider – Exception 1379
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note	1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD) 6. Same billed charge. (C_LI_SUBM_CHRG_AMT) 7. The history and in-process claims' lines have the

16. (R_PROC_CD) 6. Same billed charge. (C_LI_SUBM_CHRG_AMT) 7. The history and in-process claims' lines have the same modifiers.	same modifiers The New Mexico OmniCaid MMIS does **not** post this exception if the procedure code is in the additional miles system list (4725)

Claim Type = A (Medicare Part A Crossover) and Type of Bill = 11x, 12x, 81x, or 82x = Institutional Part A Crossover Edits Post to Header

Same Provider – Exception 1361	**Same Provider – Exception 1362**
1. Same client ID. (B_SYS_ID) 2. Same dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID)	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID)
Different Provider – Exception 1371	**Different Provider – Exception 1372**
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Different enterprise provider number. (C_BLNG_NTRPRS_ID)	

Claim Type = A (Medicare Part A Crossover) and Type of Bill = 18x, 21x, 22x, 25x, 26x, 27x, 28x, 62x, 65x, 66x, 67x, or 68x = Medicare Long Term Care Part A Crossover Edits Post to Header

Same Provider – Exception 1361	**Same Provider – Exception 1362**
1. Same client ID. (B_SYS_ID) 2. Same dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID)	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID)
Different Provider – Exception 1371	**Different Provider – Exception 1372**
1. Same client ID.	

(B_SYS_ID) 2. Same or overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Different enterprise provider number. (C_BLNG_NTRPRS_ID)	

Claim Type = B (Medicare Part B Crossover) Edits Post to Line

Same Provider – Exception 1361	Same Provider – Exception 1362	Same Provider – Exception 1363- Post to Header
1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16b. (R_PROC_CD). Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code. 5. Same billed amount. 6. The history and in-process claims' lines have the same modifiers.	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16b. (R_PROC_CD). Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code. 5. The history and in-process claims' lines have the same modifiers.	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16b (R_PROC_CD). Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code. 5. The history and in-process claims' lines have the same modifiers. 6. Both claims have the same header deductible.

Different Provider – Exception 1371	Different Provider – Exception 1372	Different Provider – Exception 1373- Post to Header
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16b. (R_PROC_CD). Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code. 5. Same billed amount. 6. The history and in-process claims' lines have the same modifiers.		1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code, see Note 16b (R_PROC_CD). Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code. 5. The history and in-process claims' lines have the same modifiers. 6. Both claims have the same header deductible amount.

Claim Type = C (Medicare UB92 Part B Crossover) Edits Post to Header

Same Provider – Exception 1361	Same Provider – Exception 1362
1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code, see Notes 5a, 5b, and 16b. (R_REV_CD or R_PROC_CD) Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code or the Revenue Code.	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code, see Notes 5a, 5b, and 16b. (R_REV_CD or R_PROC_CD) Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code or the Revenue Code.
Different Provider – Exception 1371	**Different Provider – Exception 1372**
. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Different enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code, see Notes 5a, 5b, and 16b. (R_REV_CD or R_PROC_CD) Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code or the Revenue Code.	

Claim Type = H (Hospice) Edits Post to Line

Same Provider – Exception 1361	Same Provider – Exception 1362
1. Same client ID. (B_SYS_ID) 2. Same dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code; see Notes 5b and 16. (R_REV_CD)	1. Same client ID. (B_SYS_ID) 2. Overlapping dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Same enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code; see Notes 5b and 16. (R_REV_CD)
Different Provider – Exception 1371	**Different Provider – Exception 1372**
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service.	

(C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Different enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Same revenue code; see Notes 5b and 16. (R_REV_CD)	

The encounter edits below compare claims of different types where either there are crossover and non-crossover claims for the same/overlapping dates of service or where there are inpatient/residential and outpatient for the same/overlapping datesof service. Omnicaid always pays the crossover and denies the non-crossover, pays the inpatient and denies the outpatient. Omnicaid will system-adjust the encounter that is determined to be denied due to the duplicate condition and we will report these on a separate batch of RC reports to the MCO.

Exception	Title and Description
0600	**Suspect Duplicate Professional Or Technical Component, Covered By Complete Service** **Description (posts to line for all claim types below):** The New Mexico OmniCaid MMIS posts this exception when it compares a paid claim line for one of the claim types listed below to an in-process claim line for one of the claim types listed below. For example, the New Mexico OmniCaid MMIS compares physician claim lines to psychiatric claim lines or physician claim lines to physician claim lines or outpatient claim lines to vision and hearing claim lines, etc. **Claim types that the New Mexico OmniCaid MMIS compares to each other:** **Form Claim Type** CMS-1500 Lab/Radiology (L) CMS-1500 Misc/Enhances EPSDT (P and Prov. Ty. = 324, 342-343, 346, 441, 462, 363, or 901) UB-04 Outpatient (O and Type of Bill NOT 71x, 72x, or 73x) CMS-1500 Physician (P and Prov. Ty. NOT (364, 324, 342-343, 346, 441, 462, 363, 901, 431-433, 435-437, 443-446, 331, 334-335, 412, 451-455, 457-458, or 904-906)) CMS-1500 Psychiatric (P and Prov. Ty. = 431-433, 435-437, or 443-446) CMS-1500 Vision and Hearing (P and Prov. Ty. = 331, 334-335, or 412) **If the New Mexico OmniCaid MMIS is comparing two HFCA-1500 claim types, it uses these criteria:** 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claim lines have the same dates of service or the dates of service overlap. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Both claim lines have the service area and is one of these: "LAB" (laboratory) "RAD" (radiology). (R_SVC_AREA_CD) 1. Both claims have the same procedure code. See note 16c (R_PROC_CD) 2. The service component code on one claim is "C" (complete) and the service component code on the other claim is "T" (technical component) or "P" (professional). (C_SVC_COMPONENT_CD) **If the New Mexico OmniCaid MMIS is comparing a HFCA-1500 claim to a UB-04 claim type, it uses these criteria:** 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Both claims have the same service area and the service area is one of these: "LAB" (laboratory) "RAD" (radiology). (R_SVC_AREA_CD) 3. Both claims have the same procedure code. See note 16c (R_PROC_CD) 4. The HFCA-1500 claim's service component code is "C" (complete) or "T" (technical component) or "P" (professional component) . (C_SVC_COMPONENT_CD) 5. The HFCA-1500 claim's place of service is "22" (on-campus outpatient hospital) or "19" (off-campus outpatient hospital) or 05 IHS Free Standing Facility or 06 IHS Provider-based Facility or 07 Tribal 638 FreeStnding Fclty or 08 Tribal 638 Prov-based Facility or 23 Emergency Room Hospital or 24 Ambulatory Surgical Center or 20 Urgent Care Facility. (R_PL_OF_SVC_CD) If the edit posts, the system will generate a replacement request for the related history if the in-process claim is an outpatient and the paid claim is not.

0652	**Suspect Duplicate Service, Covered By Inpatient DRG Claim** **Description (posts to the header of the in-patient, Awaiting Placement, and Long Term Care claim; posts to line for all other claim types listed below):** The New Mexico OmniCaid MMIS posts this exception when it compares either: 1. An in-process inpatient claim to a paid claim line for one of the claim types listed below, or 2. An in-process claim line for one of the claim types listed below to a paid inpatient claim. **Claim types that the New Mexico OmniCaid MMIS compares to the inpatient claim:** Ambulatory Surgical Center (P and NM Prov. Ty. = 364) Awaiting Placement (I and at least one line with revenue code = 0169) Medical Supply (S) + Waiver (W) Home Health (V) Hospice (H) Lab/Radiology (L) Long Term Care (N) Outpatient (O) Misc/Enhanced EPSDT (P and Prov. Ty. = 324, 342-343, 346, 441, 462, 363, or 901) + Rehabilitation (P and Prov. Ty. = 451-455, 457-458, or 904-906) + Transportation (T) + + The New Mexico OmniCaid MMIS does not post this exception if the claim's procedure code is listed in Notes 2 or 4. * The New Mexico OmniCaid MMIS does not post this exception if either claim's provider type is 313, 314, 315 or 346. See Note 1. **The two claims that the New Mexico OmniCaid MMIS compares meet all of the following criteria:** 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT or C_LI_FST_DOS_DT C_LI_LAST_DOS_DT depending on the claim type) 3. The inpatient claim has a Base Amount Source Code is 'DO', 'DS', or 'DT' (DRG) (C_BSE_AMT_SRC_CD) 4. For the claim types listed below, the New Mexico OmniCaid MMIS performs these additional edits: **Medical Supply or Waiver:** The New Mexico OmniCaid MMIS does **not** post this exception if: 1. The line DOS is within 3 days of the Inpatient Claim Admit or Discharge Date. **Lab/Radiology:** 1. The lab/Radiology claim's service component code is **not** "P" (professional component). (C_SVC_COMPONENT_CD) **Long Term Care:** See Note 6. **Transportation:** The New Mexico OmniCaid MMIS does **not** post this exception if: 1. The transportation claim's servicing provider type (P_TY_CD) is "401" (air ambulance), or

	2. The transportation claim's servicing provider type (P_TY_CD) is "403" (handivan) and the recipient's age (C_HDR_CLNT_AGE) at the time of service is less than 18, or 3. The transportation claim's servicing provider type (P_TY_CD) is "404" (taxi) and the recipient's age (C_HDR_CLNT_AGE) at the time of service is less than 18. **Outpatient:** The New Mexico OmniCaid MMIS does **not** post this exception if: 1. The outpatient claim has only one line and the revenue code (R_REV_CD) on that line is "0545" (air ambulance). 2. The outpatient claim's revenue code (R_REV_CD) is in the bone marrow transplant revenue codes system list (4724) or the donor charge revenue codes system list (4723). 3. The outpatient claim contains one of the "donation" diagnosis codes (V59-V59.9 plus the equivalent ICD-10 diagnosis codes of Z52-Z52.999. **The outpatient claim procedure code is on general system list 4824.**

0653	**Suspect Duplicate Service, Covered By Inpatient Non-DRG Claim** **Description (posts to the header of the in-patient claim; posts to line for all other claim types listed below):** The New Mexico OmniCaid MMIS posts this exception when it compares either: 1. An in-process inpatient claim to a paid claim line for one of the claim types listed below, or 2. An in-process claim line for one of the claim types listed below to a paid inpatient claim. **Claim types that the New Mexico OmniCaid MMIS compares to the inpatient claim:** Ambulatory Surgical Center (P and NM Prov. Ty. = 364) Awaiting Placement (I and at least one line has revenue code = 0169) Medical Supply (S) + Waiver (W) Home Health (V) Lab/Radiology (L) Long Term Care (N) Misc/Enhanced EPSDT (P and Prov. Ty. = 324, 342-343, 346, 441, 462, 363, or 901) + Rehabilitation (P and Prov. Ty. = 451-455, 457-458, or 904-906) + + The New Mexico OmniCaid MMIS does not post this exception if the claim's procedure code is listed in Notes 2 or 4. * The New Mexico OmniCaid MMIS does not post this exception if either claim's provider type is 313, 314, 315 or 346. See Note 1. **The two claims that the New Mexico OmniCaid MMIS compares meet all of the following criteria:** 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT or C_LI_FST_DOS_DT C_LI_LAST_DOS_DT depending on the claim type) 3. The inpatient claim does **not** have a Base Amount Source Code is 'DO', 'DS', or 'DT' (DRG) (C_BSE_AMT_SRC_CD) 4. For the claim types listed below, the New Mexico OmniCaid MMIS does these additional edits: **Medical Supply:** The New Mexico OmniCaid MMIS does **not** post this exception if: 1. The line DOS is within 3 days of the Inpatient Claim Admit or Discharge Date. **Lab/Radiology:** 1. The lab/Radiology claim's service component code (C_SVC_COMPONENT_CD) is **not** "P" (professional component). **Long Term Care:** See Note 6.

0686	**Suspect Duplicate, Medicare Part A Claim Overlaps with Another Service** Description (this edit posts to the header of all claim types listed below): The New Mexico OmniCaid MMIS posts this exception when it compares either: 1. An in-process Medicare institutional Part A crossover to a paid claim for one of the claim types listed below, or 2. An in-process claim for one of the claim types listed below to a paid Medicare institutional Part A crossover. Claim types that the New Mexico OmniCaid MMIS compares to the Medicare institutional Part A crossover: Home Health (V) Hospice (H) Inpatient (I) Long Term Care (N) Medicare Long Term Care Part A Crossover (A and Type of Bill = 18x, 21x, 22x, 25x, 26x, 27x, 28x, 62x, 65x, 66x, 67x, or 68x) Renal Dialysis Center (O and Type of Bill = 72x) Outpatient (O) Ambulatory Surgical Center (P and NM Prov Type = 364) Medical Supply (S) Waiver (W) Lab/Radiology (L) Misc/Enhanced EPSDT (P and Prov Type = 324, 342, 343, 346, 363, 441, 462, or 901) Rehabilitation (P and Prov Type = 451-455, 457, 458, or 904-906) Transportation (T) The New Mexico OmniCaid MMIS does not post this exception if the claim's procedure code is listed in Note 2. See Notes 1 and 2. The two claims that the New Mexico OmniCaid MMIS compares meet all of the following criteria: 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT or C_LI_FST_DOS_DT_C_LI_LAST_DOS_DT depending on the claim type) 3. For the claim types listed below, the New Mexico OmniCaid MMIS does these additional edits. Long Term Care: See Note 6. Lab/Radiology: 1. The lab/radiology claim's service component code is not "P" (professional component). (C_SVC_COMPONENT_CD) Outpatient: The New Mexico OmniCaid MMIS does not post this exception if: 1. The outpatient claim has only one line and the revenue code (R_REV_CD_ on that line is "0545" (air ambulance). 2. The outpatient claim's revenue code is in the bone marrow transplant revenue codes system list (4724) or the donor charge revenue codes system list (4723). Transportation: The New Mexico OmniCaid MMIS does not post this exception if: 1. The transportation claim's servicing provider type (P_TY_CD) is "401" (air ambulance), or 2. The transportation claim's servicing provider type is "403" (handivan) and the client's age (C_HDR_CLNT_AGE) at the time of service is less than 18, or 3. The transportation claim's servicing provider type is "404" (taxi) and the client's age at the time of service is less than 18.

0689	**Suspect Duplicate Service, Covered By Medicare Institutional Part B Crossover** Description (this edit posts to the header of all claim types): The New Mexico OmniCaid MMIS posts this exception when it compares either: 1. An in-process Medicare institutional Part B crossover claim line to a paid claim line for one of the claim types listed below, or 2. An in-process claim line for one of the claim types listed below to a paid Medicare institutional Part B crossover claim line. Claim types that the New Mexico OmniCaid MMIS compares to the Medicare institutional Part B crossover: FQHC (O and Type of Bill = 73x) Home Health (V) Hospice (H) Outpatient (O and Type of Bill NOT 71x, 72x, or 73x) Renal Dialysis Center (O and Type of Bill = 72x) Inpatient Part B of Part A (I and Type of Bill = 12x) See Note 1. The two claims that the New Mexico OmniCaid MMIS compares meet all of the following criteria: 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT). 3. Both claims have the same enterprise provider number. (C_BLNG_NTRPRS_ID) 4. For the claim types listed below, the New Mexico OmniCaid MMIS does these additional edits: FQHC: 1. The FQHC claim's revenue code is not "0949" (other free standing clinic). (R_REV_CD)
0779	**Suspect Duplicate Service, Covered By Hospice Claim** Description (posts to the header of Awaiting Placement, Inpatient, and Long Term claims and posts to the line of all other claim types listed below): The New Mexico OmniCaid MMIS posts this exception when it compares either: 1. An in-process hospice claim to a paid claim for one of the claim types listed below, or 2. An in-process claim for one of the claim types listed below to a paid hospice claim. Claim types that the New Mexico OmniCaid MMIS compares to the hospice claim: Medical Supply (S) Home Health (V) Physician (P and Billing Prov. Ty. = 363) See Note 1. The two claims that the New Mexico OmniCaid MMIS compares meet all of the following criteria: 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT or C_LI_FST_DOS_DT_C_LI_LAST_DOS_DT depending on the claim type)

0782	**Suspect Duplicate Service, Covered By Medicare Professional Part B Crossover** Description (this edit posts to the line of all claim types listed below): The New Mexico OmniCaid MMIS posts this exception when it compares either: 1. An in-process Medicare professional crossover to a paid claim for one of the of the claim types listed below, or 2. An in-process claim for one of the claim types listed below to a paid Medicare professional crossover claim. Claim types that the New Mexico OmniCaid MMIS compares to the Medicare Professional Part B crossover: Ambulatory Surgical Center (P and NM Prov. Ty. = 364) Dental (D) Medical Supply (S) Lab/Radiology (L) Physician (P and Prov. Ty. NOT (364, 324, 342-343, 346, 441, 462, 363, 901, 431-433, 435-437, 443- 446, 331, 334-335, 412, 451-455, 457-458, or 904-906)) Psychiatric (P and Prov. Ty. = 431-433, 435-437, or 443-446) Transportation (T) Vision and Hearing (P and Prov. Ty. = 331, 334-335, or 412) See Note 1. The two claims that the New Mexico OmniCaid MMIS compares meet all of the following criteria: 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap. (C_LI_FST_DOS_DT_C_LI_LAST_DOS_DT) 3. Both claims have the same enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Both claims have the same procedure code; see Note 16. (R_PROC_CD)
0783	**Suspect Duplicate Long Term Care, Waiver, or Personal Care Options Claim** The New Mexico OmniCaid MMIS posts this exception when it compares either an in-process long term care claim to a paid Waiver claim or Personal Care Option claim, or an in-process Waiver claim or Personal Care Option claim to a paid long term care claim, and the two claims meet all of the following criteria: This edit posts to the header. Claim types that the New Mexico OmniCaid MMIS compares to each other: Long Term Care (N) Waiver (W) Personal Care (P and Prov Type = 363) 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT or C_LI_FST_DOS_DT_C_LI_LAST_DOS_DT depending on the claim type)

1384	**Suspect Duplicate Medicare Institutional Part A Crossover and Medicare Institutional Part B Crossover** The New Mexico OmniCaid MMIS posts this exception when it compares either an in-process Medicare institutional Part A crossover to a paid Medical institutional Part B crossover, or an in-process Medical institutional Part B crossover claim to a paid Medicare institutional Part A crossover claim, and the two claims meet all of the following criteria: This edit posts to the header. Claim types that the New Mexico OmniCaid MMIS compares to each other: Medicare Institutional Part A Crossover (A and Type of Bill = 11x, 12x, 81x, or 82x) Medicare UB-04 Part B Crossover (C) 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Both claims have the same Medicare allowed amount. (C_MCARE_ALLOW_AMT)

Note	Description
1	The New Mexico OmniCaid MMIS contains a system list for this exception that allows MAD to list the claim types that the New Mexico OmniCaid MMIS will automatically replace. When the New Mexico OmniCaid MMIS compares the two claims, the New Mexico OmniCaid MMIS automatically replaces the paid claim if it is for a claim type on the system list (4731).
2	The New Mexico OmniCaid MMIS does not post this exception if the claim's procedure code is listed in the System List (4729).
3	Before the New Mexico OmniCaid MMIS compares the dates, it does the following: Inpatient and Long Term Care Claims: 1. If the claim's last digit of the type of bill is "1" (admit through discharge claim) or "4" (last bill of a series of bills), the New Mexico OmniCaid MMIS subtracts one day from the claim's last date of service (C_HDR_SVC_LST_DT). (The last date of service becomes one day earlier than what the provider billed because the provider does not get paid for the last day.) If the New Mexico OmniCaid MMIS is comparing an **inpatient** claim to a **Medical Supply** claim, the New Mexico OmniCaid MMIS subtracts three days from the inpatient claim's last date of service (C_HDR_SVC_LST_DT). (MAD does not care whether these claims overlap during this time because they assume that the Medical Supply services are related to the client's discharge.) If the New Mexico OmniCaid MMIS is comparing an **inpatient** claim to an **Administrative Fee** claim (claim type = M and NM Prov. Ty. Not 701-704), the New Mexico OmniCaid MMIS subtracts 31 days from the inpatient claim's last date of service (C_HDR_SVC_LST_DT). (MAD does not care whether these claims overlap during this time because they assume that the administrative fee services are related to the client's discharge.) 2. If the claim's last digit of the type of bill is "1" (admit through discharge) or "2" (first bill of a series of bills), the New Mexico OmniCaid MMIS adds one day to the claim's first date of service (C_HDR_SVC_FST_DT). (The first date of service becomes one day later than what the provider billed because any other service that the client receives the same day that they enter the hospital or nursing home, MAD assumes, was rendered before the client entered the facility.)

Note	Description
	For UB-92 claims the New Mexico OmniCaid MMIS uses the C_TY_OF_BLL_1_2_CD/C_TY_OF_BILL_3_CD. Medicare Institutional Part A and Long Term Care Part A Crossovers: 1. The New Mexico OmniCaid MMIS subtracts one day from the claim's last date of service (C_HDR_SVC_LST_DT). (MAD does not care whether the last date of service overlaps another claim by one day.) The New Mexico OmniCaid MMIS adds one day to the claim's first date of service (C_HDR_SVC_FST_DT). (MAD does not care whether the last date of service overlaps another claim by one day.)
4	
5a	If both claim lines being compared have a procedure code that is non-spaces, then use procedure code for the comparison; otherwise use revenue code for the comparison.
5b	The program does **not** compare the lines when the in-process claim's line item non-covered amount (C_NN_CVRD_CHRG_AMT) equals the in-process claim's line item submitted revenue amount (C_LI_SUBM_CHRG_AMT). The program stops the comparison when the line item revenue code (R_REV_CD) on either claim is "0001."
6	The New Mexico OmniCaid MMIS determines the covered period between the inpatient claim and the long-term care claim. The covered period begin date is the earliest first date of service (C_HDR_SVC_FST_DT) on the two claims. The covered period end date is the most recent last date of service (C_HDR_SVC_LST_DT) on the two claims. The New Mexico OmniCaid MMIS calculates the **covered number of days** (covered period end date minus covered period begin date plus 1). Next, the New Mexico OmniCaid MMIS calculates the number of days covered by each claim (last date of service minus first date of service plus 1). The New Mexico OmniCaid MMIS calculates the **total claim days** by adding the LTC claim and the inpatient claim covered days together. The New Mexico OmniCaid MMIS subtracts the total reserve days on the LTC claim from the total claim days. The New Mexico OmniCaid MMIS posts the exception if the total claim days are more than the covered period days. Please note that the New Mexico OmniCaid MMIS uses the dates of service that it calculates according to Note 3.
9	Both claims have the same service area (R_SVC_AREA_CD) and the service area is one of these: "RAD" (Radiology) "LAB" (Laboratory) "EM" (evaluation/management consultation) OR Both claims have the same procedure code (R_PROC_CD), which is in one of these ranges: "36400" through "36425" OR "36600" through "36660."
10	The service area (R_SVC_AREA_CD) on both claims is "ANE" (anesthesia) and the first, second, third or fourth modifier (C_PROC_MOD_XXX_CD (WHERE XXX = 1ST OR 2ND OR 3rd OR 4th)) on one claim is: "QX" (CRNA with medical direction physician) AND The first, second, third or fourth modifier (C_PROC_MOD_XXX_CD (WHERE XXX = 1ST OR 2ND OR 3rd OR 4th)) on the other claim is one of these:

Note	Description
	"AA" (anesthesiologist personally performs service or directs only one anesthetist CRNA) "QK" (direction of 2, 3, 4 CRNAs) "QY" "QZ" "P1" "P2" "P3" "P4" "P5" "P6"
11	The Service Area Code on the two lines are equal and the service area (R_SVC_AREA_CD) is one of these: "ANE" (anesthesia) "DEN" (dental) "LAB" (laboratory) "MED" (medicine) "RAD" (radiology) "SUR"(surgery) AND The first,second, third or fourth modifier (C_PROC_MOD_XXX_CD (WHERE XXX = 1ST OR 2ND OR 3rd OR 4th)) on one claim is one of these: "76"(repeat procedure by same physician) OR "77" (repeat procedure by a different physician).
11b	Both claims have the same service area (R_SVC_AREA_CD) and the service area is one of these: "ANE" (anesthesia) "DEN" (dental) "LAB" (laboratory) "MED" (medicine) "RAD" (radiology) "SUR" (surgery) AND Both claims have the same modifier (C_PROC_MOD_XXX_CD (WHERE XXX = 1ST OR 2ND OR 3rd OR 4th)) and the modifier is one of these: "76" (repeat procedure by same physician) OR "77" (repeat procedure by different physician).
12	The place of service(R_PL_OF_SVC_CD) on both claims is one of these: "21" (inpatient hospital) "51" (inpatient psychiatric facility) OR "61" (comprehensive inpatient rehabilitation facility) AND The billing provider type (P_TY_CD) on both claims is "303" (physician component for hospital) and the procedure code (R_PROC_CD) is in one of these ranges: "70000" through "79999" (radiology) OR "R0000" through "R0000" (radiology).
13	The place of service (R_PL_OF_SVC_CD) on both claims is one of these: "21" (inpatient hospital) "51" (inpatient psychiatric facility) "61" (comprehensive inpatient rehabilitation facility) AND The service component code (C_SVC_COMPONENT_CD) on both claims is "P" (professional component).
14	When comparing a History claim to an In-process claim and both claims' billing provider type is 363 (personal care), either claim's line has a modifier on system list 4801.

Note	Description
16	The New Mexico OmniCaid MMIS does **not** post this exception if it occurs on the same claim and the service's duplicate check indicator (C_LI_DUPL_CHK_IND) is "Y" (allow duplicate lines on the same claim).
16b	The New Mexico OmniCaid MMIS does **not** post this exception if it occurs on the same claim.
17	The modifier (C_PROC_MOD_XXX_CD (WHERE XXX = 1^{ST} OR 2^{ND} OR 3^{RD} OR 4^{TH})) on both claims is one of these: "62" (two surgeons) "66" (surgical team) "AK" (nurse practitioner, team member, rural) "AL" (nurse practitioner, team member, non-rural) "AM" (physician, team member) "AU"(PA services, other than assistant surgery, team member).

Outputs of the Encounter Processing

In addition to the outputs from EDI for files submitted to it, there are output files/reports from Omnicaid once the encounters are adjudicated. For every encounter file that is processed, there are three possible outputs:

- *ENCOUNTER ADJUDICATION CYCLE SUMMARY REPORT* RC-072 – This report summarizes by type of claim within batch the total number of claims errors along with a summary of the total unduplicated paid and denied. If the claims have been system-adjusted by Omnicaid, these will report separately on a report labeled MA_RC072. The exception codes are listed according to Deny, Deny & Report, Pay & Report status. Since some exceptions post to the header and some to the line, a column for # claims with error and a column for # lines with error is shown. If the error posts to the header, it is considered to post to all the lines on the claim. This report also lists the percentage of submitted encounters paid and denied in a file. Abortion encounters that are not eligible for federal funds, and encounters submitted as void or adjustment that the State can't void or adjust all post the Deny & Report status and are not considered as part of either denied or paid claims, and are subtracted from the number submitted as well, so are not counted as part of the overall error rate.

  Institutional Inpatient encounters are adjudicated at the claim level and thus will be accepted or denied in their entirety. Thus, if there is an error in any line item on an Institutional Inpatient encounter, the entire encounter claim will deny. Professional and Institutional Non-Inpatient encounters will be accepted or denied on a line item basis. Header level edits will cause the entire encounter to deny. Professional and Institutional Non-Inpatient encounters could have some lines accepted and some denied. Each line item on a Drug encounter is assigned its own claim number. Thus each line it treated as a claim and will be accepted or denied on its own. The error calculation for Professional and Institutional Non-Inpatient encounters is performed as the number of encounter lines denied divided by the number of encounter lines submitted; less any Deny & Report lines. The Institutional Inpatient and Drug encounter error calculation is performed as the number of claims denied divided by the number of encounter claims submitted.
- RC70/71 *FLAT FILE* – The RC070 and RC071 flat files are produced daily for Drug and Non Drug Encounter Claims and contain detail information for all claims submitted in a batch. The claims data is extracted from DB2 tables and processed to produce a flat file with the batches sent from EDI and PDCS sorted by batch type 837I or 837P or Drug or Void. The file contains a Header record with the Batch information, Detail records of line items both paid and denied with both header level and line level exceptions that would cause the claim to deny and a Trailer record that has total record counts. If the claims have been system-adjusted by Omnicaid due to a duplicate condition, these will report separately on a report labeled MA_RC070_RC071.
- PDCS FAILED REVERSAL – RC073 – Reversal claims that are sent to PDCS which PDCS cannot match to a paid claim in their system are referred to as a failed reversal and are reported on this report.

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Encounter Outcome Reports

Encounter Adjudication Cycle Summary Report – RC072

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1                                    NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM              PROCESSING DATE:  04/05/2013
 REPT:  NMMC0040-RC072                            HUMAN SERVICES DEPARTMENT                         PROCESSING TIME:  16:02:11
                                                                                                               PAGE:        1
                       ENCOUNTER ADJUDICATION CYCLE SUMMARY REPORT - MANAGED CARE HEALTH PLAN
                                                  AS OF: 04/05/2013
 BATCH NUMBER:          000000000216033
 MCO NUMBER:  000XXXXX
 BATCH TYPE:            INST-INPT

                                                                                                  PERCENTAGE OF
           EXCEPTION                                          # EXCEPTION        # EXC POSTED @ CLM  CLAIMS/LINES WITH   EXCEPTION
             CODE            EXCEPTION DESCRIPTION          POSTED AT LINE     ALL LINES AFFECTED  EXCEPTIONS           DISPOSITION
           ---------     ------------------------------     ---------------    ----------------    -------------        -----------

             1152        HEALTH PLAN PROVIDER NOT AUTHO                              2               0.50 %            DENY
             0850        ADJ/VOID REQ NOT PROCESSED                                  5               1.24 %            DENY RPT
             1371        E -POSS DUP-DIFFERENT PROVIDER                              1               0.25 %            DENY RPT
             0051        E-SUM OF ACCM DYS NOT=TOT DYS                               4               0.99 %            PAY RPT
             0058        E - PAT STAT/ TYPE BILL CONFLI                              3               0.74 %            PAY RPT
             0182        E-MISS/INVALID CVD/NON DAYS                                 4               0.99 %            PAY RPT
             0303        E - ATTENDING # IS MISS/INVAL                              21               5.20 %            PAY RPT
             0310        ATTEND NPI NOT FOUND                                       21               5.20 %            PAY RPT
             0315        ATTEN NPI MATCH MULTI MCAID ID                             97              24.01 %            PAY RPT
             0325        TRAUMA/ACCIDENT CLAIM                                      30               7.43 %            PAY RPT
             0750        E-CLNT HAS TPL RESUB W/TPL EOB                              4               0.99 %            PAY RPT

                                                                                                                  # CLAIMS
      # PAY & REPORT (POSSIBLY DUPLICATED COUNT)                                                                    184
      # DENY (POSSIBLY DUPLICATED COUNT)                                                                             2
      # DENY & REPORT (POSSIBLY DUPLICATED COUNT)                                                                    6

      # UNDUPLICATED PAID                                                                                          396  99.50 %
      # UNDUPLICATED DENY                                                                                            2   0.50 %
      TOTAL PAID AND DENIED                                                                                        398
      # UNDUPLICATED DUPLICATES AND FAILED REVERSALS (DENY & REPORT STATUS)                                          6
         GRAND TOTAL SUBMITTED                                                                                     404

 BATCH NUMBER:          000000000216033
 MCO NUMBER:  000XXXXX
 BATCH TYPE:            INST-NON-INPT
```

EXCEPTION CODE	EXCEPTION DESCRIPTION	# EXCEPTION POSTED AT LINE	# EXC POSTED @ CLM ALL LINES AFFECTED	PERCENTAGE OF CLAIMS/LINES WITH EXCEPTIONS	EXCEPTION DISPOSITION
0141	E-CLIENT ID NOT ON FILE		1	0.01 %	DENY
0189	E- SUB UNITS OF SERV MISSING	1		0.01 %	DENY
0296	BILLING NPI NOT FOUND		2	0.01 %	DENY
0424	E-BILL PROV NOT ENROLL ON DOS		2	0.01 %	DENY
1152	HEALTH PLAN PROVIDER NOT AUTHO	13		0.07 %	DENY
0850	ADJ/VOID REQ NOT PROCESSED		76	0.43 %	DENY RPT
1361	E - EXACT DUPLICATE	11		0.06 %	DENY RPT
1362	E - POSSIBLE DUP-SAME PROVIDER	39		0.22 %	DENY RPT
0182	E-MISS/INVALID CVD/NON DAYS		3	0.02 %	PAY RPT
0325	TRAUMA/ACCIDENT CLAIM		590	3.33 %	PAY RPT
0435	E - PROC/SEX CNFL	1		0.01 %	PAY RPT
0454	E-PRINCIPAL DIAG/AGE CONFLICT		1	0.01 %	PAY RPT
0750	E-CLNT HAS TPL RESUB W/TPL EOB		51	0.29 %	PAY RPT

	# LINES	
# PAY & REPORT (POSSIBLY DUPLICATED COUNT)	646	
# DENY (POSSIBLY DUPLICATED COUNT)	19	
# DENY & REPORT (POSSIBLY DUPLICATED COUNT)	126	
# UNDUPLICATED PAID	17,619	99.95 %
# UNDUPLICATED DENY	8	0.05 %
TOTAL PAID AND DENIED	17,627	
# UNDUPLICATED DUPLICATES AND FAILED REVERSALS (DENY & REPORT STATUS)	87	
GRAND TOTAL SUBMITTED	17,714	

BATCH NUMBER: 000000001162360
MCO NUMBER: 000XXXXX
BATCH TYPE: PROF

EXCEPTION CODE	EXCEPTION DESCRIPTION	# EXCEPTION POSTED AT LINE	# EXC POSTED @ CLM ALL LINES AFFECTED	PERCENTAGE OF CLAIMS/LINES WITH EXCEPTIONS	EXCEPTION DISPOSITION
0141	E-CLIENT ID NOT ON FILE		117	0.24 %	DENY
0189	E- SUB UNITS OF SERV MISSING	1		0.00 %	DENY
0296	BILLING NPI NOT FOUND		1,081	2.26 %	DENY
0299	BLNG NPI MATCH MULTI MCAID ID		234	0.49 %	DENY
0306	BILLING NPI REQUIRED		250	0.52 %	DENY
0424	E-BILL PROV NOT ENROLL ON DOS	2,476		5.18 %	DENY

0430	E-PROCEDURE NOT ON FILE	8		0.02 %	DENY
0519	NDC NOT VALID	16		0.03 %	DENY
0520	HCPCS CODE REQ NDC	22		0.05 %	DENY
0671	ABORTION REQUIRES REVIEW	2		0.00 %	DENY
1151	LOCKIN ENDS BEFORE ENCTR LDOS	7		0.01 %	DENY
1152	HEALTH PLAN PROVIDER NOT AUTHO	142		0.30 %	DENY
1253	E-CLAIM DOS/CLIENT DOD CONFL	5		0.01 %	DENY
0850	ADJ/VOID REQ NOT PROCESSED		3,251	6.80 %	DENY RPT
1361	E - EXACT DUPLICATE	92		0.19 %	DENY RPT
1362	E - POSSIBLE DUP-SAME PROVIDER	8		0.02 %	DENY RPT
0294	SVC FACI REQUIRES NPI	6,006		12.57 %	PAY RPT
0312	BLNG NPI FOUND-TXNMY NO MATCH		358	0.75 %	PAY RPT
0325	TRAUMA/ACCIDENT CLAIM	2,434		5.09 %	PAY RPT

RC70/71 RECORD LAYOUTS

```
01 ENCT-HDR-RECORD. 326 bytes
   05 ENCT-HDR-REC-CD  PIC X(01)VALUE 'H'.
   05 ENCT-HDR-FILLER-1  PIC X(01)VALUE ','.
   05 ENCT-HDR-MC-PROV-ID  PIC X(08).
   05 ENCT-HDR-FILLER-2  PIC X(01)VALUE ','.
   05 ENCT-HDR-BATCH-NUM      PIC X(16).
   05 ENCT-HDR-FILLER-3  PIC X(01)VALUE ','.
   05 ENCT-HDR-BATCH-TY PIC X(04).
      88 ENCT-HDR-BATCH-837I VALUE '837I'.
      88 ENCT-HDR-BATCH-INPT  VALUE 'INPT'.
      88 ENCT-HDR-BATCH-837P           VALUE '837P'.
      88 ENCT-HDR-BATCH-DRUG  VALUE 'DRUG'.
   05 ENCT-HDR-FILLER-4                PIC X(294).


01 ENCT-DTL-RECORD. 326 bytes
   05 ENCT-DTL-REC-CD       PIC X(01)   VALUE 'D'.
   05 ENCT-DTL-FILLER-1  PIC X(01)VALUE ','.
   05 ENCT-DTL-MC-PROV-ID      PIC X(08).
   05 ENCT-DTL-FILLER-2  PIC X(01)VALUE ','.
   05 ENCT-XCN-NUM  PIC X(31).
   05 ENCT-DTL-FILLER-3  PIC X(01)VALUE ','.
   05 ENCT-TCN-NUM             PIC 9(17).
   05 ENCT-DTL-FILLER-4  PIC X(01)VALUE ','.
   05 ENCT-HDR-SUBMITTER-ID   PIC X(16).
   05 ENCT-DTL-FILLER-5  PIC X(01)VALUE ','.
   05 ENCT-HDR-STAT-CD       PIC X(01).
      88 ENCT-HDR-STAT-CD-PD          VALUE 'P'.
      88 ENCT-HDR-STAT-CD-DND         VALUE 'D'.
   05 ENCT-DTL-FILLER-6  PIC X(01)VALUE ','.
   05 ENCT-HDR-TY-CD          PIC X(01).
   05 ENCT-DTL-FILLER-7  PIC X(01)VALUE ','.
   05 ENCT-HDR-TXN-CD                 PIC X(01).
 88 ENCT-HDR-TXN-CD-ORIGVALUE '0'.
 88 ENCT-HDR-TXN-CD-VOIDVALUE '1'.
 88 ENCT-HDR-TXN-CD-CRADJVALUE '2'.
 88 ENCT-HDR-TXN-CD-DBADJVALUE '3'.
 88 ENCT-HDR-TXN-CD-DNDRPLVALUE '4'.
   05 ENCT-DTL-FILLER-8  PIC X(01)VALUE ','.
   05 ENCT-ALT-ID            PIC X(14).
   05 ENCT-DTL-FILLER-9  PIC X(01)VALUE ','.
   05 ENCT-PROV-ID-IND        PIC X(01).
```

```
88 ENCT-PROV-ID-IND-OTHERVALUE 'O'.
88 ENCT-PROV-ID-IND-SSNVALUE 'S'.
88 ENCT-PROV-ID-IND-TAXIDVALUE 'T'.
88 ENCT-PROV-ID-IND-NPIVALUE 'N'.
  05 ENCT-DTL-FILLER-10 PIC X(01)VALUE ','.
  05 ENCT-PROV-ID  PIC X(15).
  05 ENCT-DTL-FILLER-11 PIC X(01)VALUE ','.
  05 ENCT-BLNG-PROV-IDPIC X(08).
  05 ENCT-DTL-FILLER-12 PIC X(01)VALUE ','.
  05 ENCT-BLNG-PROV-TXNMY-CDPIC X(10).
  05 ENCT-DTL-FILLER-13 PIC X(01)VALUE ','.
  05 ENCT-BLNG-PROV-ZIP-CDPIC X(05).
  05 ENCT-DTL-FILLER-14 PIC X(01)VALUE ','.
  05 ENCT-MCO-TCN-DAT      PIC X(20).
  05 ENCT-DTL-FILLER-15 PIC X(01)VALUE ','.
  05 ENCT-TOT-REIMB-AMT-SGNPIC X(01).
  05 ENCT-TOT-REIMB-AMT    PIC 9(09)V99.
  05 ENCT-DTL-FILLER-16 PIC X(01)VALUE ','.
  05 ENCT-MC-ENCT-PD-AMT-SGN PIC X(01).
  05 ENCT-MC-ENCT-PD-AMT    PIC 9(09)V99.
  05 ENCT-DTL-FILLER-17 PIC X(01)VALUE ','.
  05 ENCT-ADJUD-DT        PIC X(10).
  05 ENCT-DTL-FILLER-18 PIC X(01)VALUE ','.
  05 ENCT-PLN-TY   PIC X(01).
  05 ENCT-DTL-FILLER-19 PIC X(01)VALUE ','.
  05 ENCT-PLN-NUM     PIC X(04).
  05 ENCT-DTL-FILLER-20 PIC X(01)VALUE ','.
  05 ENCT-LI-NUMPIC 9(03).
  05 ENCT-DTL-FILLER-21 PIC X(01)VALUE ','.
  05 ENCT-LI-STAT-CD   PIC X(01).
88 ENCT-LI-STAT-CD-PDVALUE 'P'.
88 ENCT-LI-STAT-CD-DENIEDVALUE 'D'.
  05 ENCT-DTL-FILLER-22 PIC X(01)VALUE ','.
  05 ENCT-LI-EXC-CD       PIC 9(04).
  05 ENCT-DTL-FILLER-23 PIC X(01)VALUE ','.
  05 ENCT-LI-MC-ENCT-PD-AMT-SGN PIC X(01).
  05 ENCT-LI-MC-ENCT-PD-AMT PIC PIC 9(09)V99.
  05 ENCT-DTL-FILLER-24 PIC X(01)VALUE ','.
  05 ENCT-LI-REIMB-AMT-PD-SGN PIC X(01).
  05 ENCT-LI-REIMB-AMT-PDPIC 9(09)V99.
  05 ENCT-DTL-FILLER-25 PIC X(01)VALUE ','.
  05 ENCT-LI-DUP-TCN  PIC X(17).
  05 ENCT-DTL-FILLER-26 PIC X(01)VALUE ','.
```

```
   05 ENCT-LI-DUP-LI  PIC 9(03).
   05 ENCT-DTL-FILLER-27  PIC X(01)VALUE ',’.
   05 ENCT-LI-DUP-MCO-TCN-DAT    PIC X(20).
   05 ENCT-DTL-FILLER-28  PIC X(01)VALUE ',’.
   05 ENCT-LI-REPLCD-TCN   PIC X(17).
   05 ENCT-DTL-FILLER-29  PIC X(01)VALUE ',’.
   05 ENCT-LI-REPLCD-MCO-TCN-DAT    PIC X(20).


01 ENCT-TRL-RECORD. 326 bytes
   05 ENCT-TRL-REC-CD  PIC X(01)    VALUE 'T’.
   05 ENCT-TRL-FILLER-1  PIC X(01)VALUE ',’.
   05 ENCT-TRL-MC-PROV-ID  PIC X(08).
   05 ENCT-TRL-FILLER-2  PIC X(01)VALUE ',’.
   05 ENCT-TRL-BATCH-NUM      PIC X(16).
   05 ENCT-TRL-FILLER-3  PIC X(01)VALUE ',’.
   05 ENCT-TRL-REC-TOTAL  PIC 9(09).
   05 ENCT-TRL-FILLER-4  PIC X(01)VALUE ',’.
   05 ENCT-TRL-BATCH-TYPIC X(04).
   05 ENCT-TRL-FILLER                  PIC X(284).
```

Target Column	Std Edit	Req	Def	Specifications	Note Ref
ENCT-HDR-REC-CD		A	'H'	Denotes Header Record	
ENCT-DTL-REC-CD		A	'D'	Denotes Detail Record	
ENCT-TRL-REC-CD		A	'T'	Denotes Trailer Record	
ENCT-HDR-MC-PROV-ID		A	n/a	The OmniCaid Managed Care Provider ID.	
ENCT-BATCH-NUM		A	n/a	First 16 bytes of XCN	
ENCT-BATCH-TY		A	n/a	The HIPAA Transaction Type based on the C-HDR-ID-CD: 61-INPT (Institutional Inpatient whereas inpatient is defined as C-HDR-TY-CD equal 'I' INPATIENT or 'A' MCARE-A-XOVER.) 61- 837I (Institutional Claims that are not inpatient.) 60 -837P – Professional and Dental Claims 62 -DRUG – Pharmacy claims submitted to PDCS Denied Voids/Adjustments - VOID	

Target Column	Std Edit	Req	Def	Specifications	Note Ref
ENCT-XCN-NUM		A	n/a	The translator trace number.	
ENCT-TCN-NUM		A	n/a	The OmniCaid claim number.	
ENCT-HDR-SUBMITTER-ID		A	n/a	The submitter id of MCO, usually the Tax Id of the organization.	
ENCT-HDR-STAT-CD		A	n/a	Payment status of the claim: P – Paid claims D – Denied claims	
ENCT-HDR-TY-CD		A	n/a	The OmniCaid claim type assigned to the claim.	
ENCT-HDR-TXN-TY-CD		A	n/a	Indicates the claim type from an accounting standpoint. 1 –Void 2 – Credit of the Adjustment 3 – Debit of the Adjustment 4- Denied Void/Adjustment	
ENCT-ALT-ID		A	n/a	Medicaid Client Id	
ENCT-PROV-ID-IND		A	O	O=NETWORK BLNG-ID S=SSN N=NPI ID T=TAX ID	
ENCT-PROV-ID		A	n/a	The MCO Provider ID. Pre-NPI this will contain the Network Billing Provider ID, Post-NPI it will contain the NPI ID, SSN or Tax ID.	
ENCT-BLNG-PROV-ID		A	n/a	The OmniCaid billing provider id of the MCO network provider id.	
ENCT-BLNG-PROV-TXNMY-CD		C	spaces	Billing provider taxonomy code. HIPAA enhancement. This code contains Provider type, 2 byte alphanumeric Classification code, 2 byte alphanumeric Area of specialization, 5 byte alphanumeric	
ENCT-BLNG-PROV-ZIP-CD		A	n/a	Billing provider zip code. HIPAA enhancement. This will help in getting the gross reciepts tax figured out when the taxonomy comes in on the 837 claim.	
ENCT-MCO-TCN-DAT		A	n/a	The MCO claim number.	
ENCT-TOT-REIMB-AMT-SGN		C	+	Positive or Negative for sign for Reimbursement Amount: + for positive - for negative. For future adjustments and voids.	
ENCT-TOT-REIMB-AMT		A	zero	The OmniCaid calculated payment amount if we were to “pay” the	

Target Column	Std Edit	Req	Def	Specifications	Note Ref
				claim as a FFS claim.	
ENCT-MC-ENCT-PD-AMT-SGN		C	+	Positive or Negative for sign for MC Paid Amount: + for positive - for negative For future adjustments and voids	
ENCT-MC-ENCT-PAID-AMT		A	zero	The amount the MCO paid for the claim.	
ENCT-ADJUD-DT		A	n/a	The date the claim was adjudicated in OmniCaid.	
ENCT-PLN-NUM		C	space	The OmniCaid MCO Plan Number	
ENCT-PLN-TY		C	Space	The OmniCaid MCO Plan Type	
ENCT-LI-NUM		C	n/a	The claim line number.	
ENCT-LI-STAT-CD		C	n/a	Payment status of the claim line: P – Paid claims D – Denied claims	
ENCT-LI-EXC-CD		C	n/a	The claim exception code.	
ENCT-LI-REIMB-AMT-SGN		C	+	Positive or Negative for sign for Reimbursement Amount: + for positive - for negative. For future adjustments and voids.	
ENCT-LI-REIMB-AMT-PD		C	zero	The OmniCaid calculated payment amount if we were to "pay" the claim as a FFS claim.	
ENCT-MC-ENCT-PD-AMT-SGN		C	+	Positive or Negative for sign for MC Paid Amount: + for positive - for negative For future adjustments and voids	
ENCT-LI-ENCT-AMT-PD		C	zero	Amount the MCO paid on the encounter line item.	
ENCT-LINE-DUP-TCN		C	space	The TCN of the claim that is in conflict with this claim.	
ENCT-LINE-DUP-LINE		C	zero	The line item of the claim that is in conflict with this claim.	
ENCT-LINE-DUP-TCN		C	space	The MCO's TCN of the claims that is in conflict with this claim.	
ENCT-LI-REPLCD-TCN		C	Space	The TCN of the claim that was replaced by the adjustment	
ENCT-LI-REPLCD-MCO-TCN-DAT		C	Space	The MCO's TCN of the claim that was replaced by the adjustment	
ENCT-TRL-REC-TOTAL		A	n/a	Number of total detail records for batch ~~including header and trailer~~.	

PDCS FAILED ENCOUNTERS – RC073

The RC073 comes directly out of PDCS when PDCS did not have enough information to build a claim to send through adjudication. Drug claims that are B1, B2 or B3 are included on this report.

RC073 Layout					RC073 Explanations
ENCT-HDR-RECORD.	32 Bytes				
ENCT-HDR-REC-CD	PIC	X(01)	VALUE	'H'.	'H'.
ENCT-HDR-FILLER-1	PIC	X(01)	VALUE	','.	','.
ENCT-HDR-MC-PROV-ID	PIC	X(08).			MCO Network. See below for complete network list.
ENCT-HDR-FILLER-2	PIC	X(01)	VALUE	','.	','.
ENCT-HDR-BATCH-NUM	PIC	X(16).			B1, B2 or B3 followed by processing date (CCYY-MM-DD)
ENCT-HDR-FILLER-3	PIC	X(01)	VALUE	','.	','.
ENCT-HDR-BATCH-TY	PIC	X(04).		'DRUG'	'DRUG'
ENCT-DTL-RECORD.	279 Bytes				
ENCT-DTL-REC-CD	PIC	X(01)	VALUE	'D'.	'D'.
ENCT-DTL-FILLER-1	PIC	X(01)	VALUE	','.	','.
ENCT-DTL-MC-PROV-ID	PIC	X(08).			MCO Network. See below for complete network list.
ENCT-DTL-FILLER-2	PIC	X(01)	VALUE	','.	','.
ENCT-XCN-NUM	PIC	X(23).			spaces
ENCT-DTL-FILLER-3	PIC	X(01)	VALUE	','.	','.
ENCT-TCN-NUM	PIC	9(17).			spaces
ENCT-DTL-FILLER-4	PIC	X(01)	VALUE	','.	','.
ENCT-HDR-SUBMITTER-ID	PIC	X(16).			spaces
ENCT-DTL-FILLER-5	PIC	X(01)	VALUE	','.	','.
ENCT-HDR-STAT-CD	PIC	X(01).			spaces
ENCT-HDR-STAT-CD-PD			VALUE	'P'.	
ENCT-HDR-STAT-CD-DND			VALUE	'D'.	
ENCT-DTL-FILLER-6	PIC	X(01)	VALUE	','.	','.
ENCT-HDR-TY-CD	PIC	X(01)			spaces
ENCT-DTL-FILLER-7	PIC	X(01)	VALUE	','.	','.
ENCT-HDR-TXN-CD	PIC	X(01).			spaces
ENCT-HDR-TXN-CD-ORIG			VALUE	'0'.	
ENCT-HDR-TXN-CD-VOID			VALUE	'1'.	
ENCT-HDR-TXN-CD-CRADJ			VALUE	'2'.	
ENCT-HDR-TXN-CD-DBADJ			VALUE	'3'.	
ENCT-HDR-TXN-CD-DNDRPL			VALUE	'4'.	
ENCT-DTL-FILLER-8	PIC	X(01)	VALUE	','.	','.
ENCT-ALT-ID	PIC	X(14).			Client ID
ENCT-DTL-FILLER-9	PIC	X(01)	VALUE	','.	','.
ENCT-PROV-ID-IND	PIC	X(01).			spaces

RC073 Layout					RC073 Explanations
ENCT-PROV-ID-IND-OTHER			VALUE	'O'.	
ENCT-PROV-ID-IND-SSN			VALUE	'S'.	
ENCT-PROV-ID-IND-TAXID			VALUE	'T'.	
ENCT-PROV-ID-IND-NPI			VALUE	'N'.	
ENCT-DTL-FILLER-10	PIC	X(01)	VALUE	','.	','.
ENCT-PROV-ID	PIC	X(15).			Provider ID
ENCT-DTL-FILLER-11	PIC	X(01)	VALUE	','.	','.
ENCT-BLNG-PROV-ID	PIC	X(08).			spaces
ENCT-DTL-FILLER-12	PIC	X(01)	VALUE	','.	','.
ENCT-BLNG-PROV-TXNMY-CD	PIC	X(10).			spaces
ENCT-DTL-FILLER-13	PIC	X(01)	VALUE	','.	','.
ENCT-BLNG-PROV-ZIP-CD	PIC	X(05).			spaces
ENCT-DTL-FILLER-14	PIC	X(01)	VALUE	','.	','.
ENCT-MCO-TCN-DAT	PIC	X(20).			MCO TCN
ENCT-DTL-FILLER-15	PIC	X(01)	VALUE	','.	','.
ENCT-TOT-REIMB-AMT-SGN	PIC	X(01).			spaces
ENCT-TOT-REIMB-AMT	PIC	9(09)V99.			spaces
ENCT-DTL-FILLER-16	PIC	X(01)	VALUE	','.	','.
ENCT-MC-ENCT-PD-AMT-SGN	PIC	X(01).			spaces
ENCT-MC-ENCT-PD-AMT	PIC	9(09)V99.			spaces
ENCT-DTL-FILLER-17	PIC	X(01)	VALUE	','.	','.
ENCT-ADJUD-DT	PIC	X(10).			Date of Adjudication (CCYY-MM-DD)
ENCT-DTL-FILLER-18	PIC	X(01)	VALUE	','.	','.
ENCT-PLN-TY	PIC	X(01).			spaces
ENCT-DTL-FILLER-19	PIC	X(01)	VALUE	','.	','.
ENCT-PLN-NUM	PIC	X(04).			spaces
ENCT-DTL-FILLER-20	PIC	X(01)	VALUE	','.	','.
ENCT-LI-NUM	PIC	9(03).			spaces
ENCT-DTL-FILLER-21	PIC	X(01)	VALUE	','.	','.
ENCT-LI-STAT-CD	PIC	X(01).			spaces
ENCT-LI-STAT-CD-PD			VALUE	'P'.	
ENCT-LI-STAT-CD-DENIED			VALUE	'D'.	
ENCT-DTL-FILLER-22	PIC	X(01)	VALUE	','.	','.
ENCT-LI-EXC-CD	PIC	9(04).			spaces
ENCT-DTL-FILLER-23	PIC	X(01)	VALUE	','.	','.
ENCT-LI-MC-ENCT-PD-AMT-SGN	PIC	X(01).			spaces
ENCT-LI-MC-ENCT-PD-AMT	PIC	9(09)V99.			spaces
ENCT-DTL-FILLER-24	PIC	X(01)	VALUE	','.	','.
ENCT-LI-REIMB-AMT-PD-SGN	PIC	X(01).			spaces
ENCT-LI-REIMB-AMT-PD	PIC	9(09)V99.			spaces

RC073 Layout					RC073 Explanations
ENCT-DTL-FILLER-25	PIC	X(01)	VALUE	‘,’.	‘,’.
ENCT-LI-DUP-TCN	PIC	X(17).			spaces
ENCT-DTL-FILLER-26	PIC	X(01)	VALUE	‘,’.	‘,’.
ENCT-LI-DUP-LI	PIC	9(03).			spaces
ENCT-DTL-FILLER-27	PIC	X(01)	VALUE	‘,’.	‘,’.
ENCT-LI-DUP-MCO-TCN-DAT	PIC	X(20).			spaces
ENCT-TRL-RECORD.	42 Bytes				
ENCT-TRL-REC-CD	PIC	X(01)	VALUE	‘T’.	‘T’.
ENCT-TRL-FILLER-1	PIC	X(01)	VALUE	‘,’.	‘,’.
ENCT-TRL-MC-PROV-ID	PIC	X(08).			MCO Network. See below for complete network list.
ENCT-TRL-FILLER-2	PIC	X(01)	VALUE	‘,’.	‘,’.
ENCT-TRL-BATCH-NUM	PIC	X(16).			B1, B2 or B3 followed by processing date
ENCT-TRL-FILLER-3	PIC	X(01)	VALUE	‘,’.	‘,’.
ENCT-TRL-REC-TOTAL	PIC	9(09).			record count
ENCT-TRL-FILLER-4	PIC	X(01)	VALUE	‘,’.	‘,’.
ENCT-TRL-BATCH-TY	PIC	X(04).			'DRUG'

Network to Provider ID Crosswalk

000M1814	Presbyterian	814
30039720	Western Sky	720
42101522	Blue Cross Blue Shield	873

Exception Edit Error Codes

The exception edit codes shown here are only those used by the Omnicaid system once the claims have cleared EDI. There are additional edits within EDI that are documented in the CMS Implementation Guide and the State's Companion Guide; both of which are on the State's website and the HIPAADesk Website.

The encounters with errors will be reported on the *DENIED ENCOUNTER ADJUDICATION CYCLE DETAIL FLAT FILE* RC70/71 using exception edit error codes. The description of each error is provided on the next page.

Exception Edit Error codes are set to either "Pay and Report", "Deny and Report" or "Deny". A line or header can have multiple exceptions that post. Regardless, any deny exception will cause that line/header to deny.

Claims Exception Errors for Non-Drug Claims

Exception codes may carry a different disposition per claim type. Each claim type set to Deny or Deny and Report for an Encounter is shown below.

Exception_Cd	Exception_Short_Desc	Claim_Type	Exception_Disp
32	E-PROVIDER/CLAIM TYPE CONFLICT	Long Term Care	Deny
32	E-PROVIDER/CLAIM TYPE CONFLICT	Outpatient	Deny
32	E-PROVIDER/CLAIM TYPE CONFLICT	Practitioner/Physician	Deny
46	E - TOT REV CHARGE MISS/INV	Home Health	Deny
46	E - TOT REV CHARGE MISS/INV	Hospice	Deny
46	E - TOT REV CHARGE MISS/INV	Inpatient	Deny
46	E - TOT REV CHARGE MISS/INV	Long Term Care	Deny
46	E - TOT REV CHARGE MISS/INV	Mcare UB Part B Crossover	Deny
46	E - TOT REV CHARGE MISS/INV	Outpatient	Deny
51	E-SUM OF ACCM DYS NOT=TOT DYS	Hospice	Deny
51	E-SUM OF ACCM DYS NOT=TOT DYS	Inpatient	Deny
51	E-SUM OF ACCM DYS NOT=TOT DYS	Long Term Care	Deny
72	E - ACCOM REV CODE MISSING	Inpatient	Deny
72	E - ACCOM REV CODE MISSING	Mcare Part A Crossover	Deny
76	CLAIM DOS SPANS ICD10 EFF DT	Home Health	Deny
76	CLAIM DOS SPANS ICD10 EFF DT	Hospice	Deny
76	CLAIM DOS SPANS ICD10 EFF DT	Inpatient	Deny
76	CLAIM DOS SPANS ICD10 EFF DT	Laboratory and Xray	Deny
76	CLAIM DOS SPANS ICD10 EFF DT	Long Term Care	Deny
76	CLAIM DOS SPANS ICD10 EFF DT	Medical Supply	Deny
76	CLAIM DOS SPANS ICD10 EFF DT	Outpatient	Deny
76	CLAIM DOS SPANS ICD10 EFF DT	Practitioner/Physician	Deny
76	CLAIM DOS SPANS ICD10 EFF DT	Transportation	Deny
97	PLAN PAYMENT MISSING/INVALID	Dental	Deny

97	PLAN PAYMENT MISSING/INVALID	Home Health	Deny
97	PLAN PAYMENT MISSING/INVALID	Hospice	Deny
97	PLAN PAYMENT MISSING/INVALID	Inpatient	Deny
97	PLAN PAYMENT MISSING/INVALID	Laboratory and Xray	Deny
97	PLAN PAYMENT MISSING/INVALID	Long Term Care	Deny
97	PLAN PAYMENT MISSING/INVALID	Mcare Part A Crossover	Deny
97	PLAN PAYMENT MISSING/INVALID	Mcare Part B Crossover	Deny
97	PLAN PAYMENT MISSING/INVALID	Mcare UB Part B Crossover	Deny
97	PLAN PAYMENT MISSING/INVALID	Medical Supply	Deny
97	PLAN PAYMENT MISSING/INVALID	Outpatient	Deny
97	PLAN PAYMENT MISSING/INVALID	Practitioner/Physician	Deny
97	PLAN PAYMENT MISSING/INVALID	Transportation	Deny
99	OUTPAT ENCOUNTER W/O DATA REC	Mcare UB Part B Crossover	Deny
99	OUTPAT ENCOUNTER W/O DATA REC	Outpatient	Deny
100	MCO PAID DATE MISSING/INVALID	Dental	Deny
100	MCO PAID DATE MISSING/INVALID	Home Health	Deny
100	MCO PAID DATE MISSING/INVALID	Hospice	Deny
100	MCO PAID DATE MISSING/INVALID	Inpatient	Deny
100	MCO PAID DATE MISSING/INVALID	Laboratory and Xray	Deny
100	MCO PAID DATE MISSING/INVALID	Long Term Care	Deny
100	MCO PAID DATE MISSING/INVALID	Mcare Part A Crossover	Deny
100	MCO PAID DATE MISSING/INVALID	Mcare Part B Crossover	Deny
100	MCO PAID DATE MISSING/INVALID	Mcare UB Part B Crossover	Deny
100	MCO PAID DATE MISSING/INVALID	Medical Supply	Deny
100	MCO PAID DATE MISSING/INVALID	Outpatient	Deny
100	MCO PAID DATE MISSING/INVALID	Practitioner/Physician	Deny
100	MCO PAID DATE MISSING/INVALID	Transportation	Deny
117	E - MODIFIER 1 INVALID	Laboratory and Xray	Deny
117	E - MODIFIER 1 INVALID	Medical Supply	Deny
117	E - MODIFIER 1 INVALID	Practitioner/Physician	Deny
117	E - MODIFIER 1 INVALID	Transportation	Deny
120	E- BILLING PROVIDER IS MISSIN	Dental	Deny
120	E- BILLING PROVIDER IS MISSIN	Home Health	Deny
120	E- BILLING PROVIDER IS MISSIN	Hospice	Deny
120	E- BILLING PROVIDER IS MISSIN	Inpatient	Deny
120	E- BILLING PROVIDER IS MISSIN	Laboratory and Xray	Deny
120	E- BILLING PROVIDER IS MISSIN	Long Term Care	Deny
120	E- BILLING PROVIDER IS MISSIN	Mcare Part A Crossover	Deny
120	E- BILLING PROVIDER IS MISSIN	Mcare Part B Crossover	Deny
120	E- BILLING PROVIDER IS MISSIN	Mcare UB Part B Crossover	Deny

120	E- BILLING PROVIDER IS MISSIN	Medical Supply	Deny
120	E- BILLING PROVIDER IS MISSIN	Outpatient	Deny
120	E- BILLING PROVIDER IS MISSIN	Practitioner/Physician	Deny
120	E- BILLING PROVIDER IS MISSIN	Transportation	Deny
121	E - MOD 2 INVALID	Laboratory and Xray	Deny
121	E - MOD 2 INVALID	Medical Supply	Deny
121	E - MOD 2 INVALID	Practitioner/Physician	Deny
121	E - MOD 2 INVALID	Transportation	Deny
124	E - FROM DOS IS MISSING	Capitation (MC)	Deny
124	E - FROM DOS IS MISSING	Dental	Deny
124	E - FROM DOS IS MISSING	Hospice	Deny
124	E - FROM DOS IS MISSING	Inpatient	Deny
124	E - FROM DOS IS MISSING	Laboratory and Xray	Deny
124	E - FROM DOS IS MISSING	Long Term Care	Deny
124	E - FROM DOS IS MISSING	Mcare Part A Crossover	Deny
124	E - FROM DOS IS MISSING	Mcare Part B Crossover	Deny
124	E - FROM DOS IS MISSING	Mcare UB Part B Crossover	Deny
124	E - FROM DOS IS MISSING	Medical Supply	Deny
124	E - FROM DOS IS MISSING	Outpatient	Deny
124	E - FROM DOS IS MISSING	Practitioner/Physician	Deny
124	E - FROM DOS IS MISSING	Transportation	Deny
126	E - FIRST DOS AFTER LAST DOS	Home Health	Deny
126	E - FIRST DOS AFTER LAST DOS	Hospice	Deny
126	E - FIRST DOS AFTER LAST DOS	Inpatient	Deny
126	E - FIRST DOS AFTER LAST DOS	Laboratory and Xray	Deny
126	E - FIRST DOS AFTER LAST DOS	Long Term Care	Deny
126	E - FIRST DOS AFTER LAST DOS	Mcare Part A Crossover	Deny
126	E - FIRST DOS AFTER LAST DOS	Mcare Part B Crossover	Deny
126	E - FIRST DOS AFTER LAST DOS	Mcare UB Part B Crossover	Deny
126	E - FIRST DOS AFTER LAST DOS	Medical Supply	Deny
126	E - FIRST DOS AFTER LAST DOS	Outpatient	Deny
126	E - FIRST DOS AFTER LAST DOS	Practitioner/Physician	Deny
126	E - FIRST DOS AFTER LAST DOS	Transportation	Deny
127	E- LAST DOS AFTER TCN DATE	Home Health	Deny
127	E- LAST DOS AFTER TCN DATE	Hospice	Deny
127	E- LAST DOS AFTER TCN DATE	Inpatient	Deny
127	E- LAST DOS AFTER TCN DATE	Laboratory and Xray	Deny
127	E- LAST DOS AFTER TCN DATE	Long Term Care	Deny
127	E- LAST DOS AFTER TCN DATE	Mcare Part A Crossover	Deny
127	E- LAST DOS AFTER TCN DATE	Mcare UB Part B Crossover	Deny

127	E- LAST DOS AFTER TCN DATE	Medical Supply	Deny
127	E- LAST DOS AFTER TCN DATE	Outpatient	Deny
127	E- LAST DOS AFTER TCN DATE	Practitioner/Physician	Deny
127	E- LAST DOS AFTER TCN DATE	Transportation	Deny
129	E - CLIENT ID IS MISSING	Dental	Deny
129	E - CLIENT ID IS MISSING	Home Health	Deny
129	E - CLIENT ID IS MISSING	Hospice	Deny
129	E - CLIENT ID IS MISSING	Inpatient	Deny
129	E - CLIENT ID IS MISSING	Laboratory and Xray	Deny
129	E - CLIENT ID IS MISSING	Long Term Care	Deny
129	E - CLIENT ID IS MISSING	Mcare Part A Crossover	Deny
129	E - CLIENT ID IS MISSING	Mcare Part B Crossover	Deny
129	E - CLIENT ID IS MISSING	Mcare UB Part B Crossover	Deny
129	E - CLIENT ID IS MISSING	Medical Supply	Deny
129	E - CLIENT ID IS MISSING	Outpatient	Deny
129	E - CLIENT ID IS MISSING	Practitioner/Physician	Deny
129	E - CLIENT ID IS MISSING	Transportation	Deny
130	E - CLIENT DOB IS MISS/INVAL	Dental	Deny
130	E - CLIENT DOB IS MISS/INVAL	Home Health	Deny
130	E - CLIENT DOB IS MISS/INVAL	Hospice	Deny
130	E - CLIENT DOB IS MISS/INVAL	Inpatient	Deny
130	E - CLIENT DOB IS MISS/INVAL	Laboratory and Xray	Deny
130	E - CLIENT DOB IS MISS/INVAL	Long Term Care	Deny
130	E - CLIENT DOB IS MISS/INVAL	Mcare Part A Crossover	Deny
130	E - CLIENT DOB IS MISS/INVAL	Mcare Part B Crossover	Deny
130	E - CLIENT DOB IS MISS/INVAL	Mcare UB Part B Crossover	Deny
130	E - CLIENT DOB IS MISS/INVAL	Medical Supply	Deny
130	E - CLIENT DOB IS MISS/INVAL	Outpatient	Deny
130	E - CLIENT DOB IS MISS/INVAL	Practitioner/Physician	Deny
130	E - CLIENT DOB IS MISS/INVAL	Transportation	Deny
141	E-CLIENT ID NOT ON FILE	Dental	Deny
141	E-CLIENT ID NOT ON FILE	Home Health	Deny
141	E-CLIENT ID NOT ON FILE	Hospice	Deny
141	E-CLIENT ID NOT ON FILE	Inpatient	Deny
141	E-CLIENT ID NOT ON FILE	Laboratory and Xray	Deny
141	E-CLIENT ID NOT ON FILE	Long Term Care	Deny
141	E-CLIENT ID NOT ON FILE	Mcare Part A Crossover	Deny
141	E-CLIENT ID NOT ON FILE	Mcare Part B Crossover	Deny
141	E-CLIENT ID NOT ON FILE	Mcare UB Part B Crossover	Deny
141	E-CLIENT ID NOT ON FILE	Medical Supply	Deny

141	E-CLIENT ID NOT ON FILE	Outpatient	Deny
141	E-CLIENT ID NOT ON FILE	Practitioner/Physician	Deny
141	E-CLIENT ID NOT ON FILE	Transportation	Deny
148	E - REV CODE IS MISSING	Home Health	Deny
148	E - REV CODE IS MISSING	Hospice	Deny
148	E - REV CODE IS MISSING	Inpatient	Deny
148	E - REV CODE IS MISSING	Long Term Care	Deny
148	E - REV CODE IS MISSING	Mcare Part A Crossover	Deny
148	E - REV CODE IS MISSING	Mcare UB Part B Crossover	Deny
148	E - REV CODE IS MISSING	Outpatient	Deny
150	E - PLACE SERV MISS/INVALID	Dental	Deny
150	E - PLACE SERV MISS/INVALID	Laboratory and Xray	Deny
150	E - PLACE SERV MISS/INVALID	Mcare Part B Crossover	Deny
150	E - PLACE SERV MISS/INVALID	Medical Supply	Deny
150	E - PLACE SERV MISS/INVALID	Practitioner/Physician	Deny
150	E - PLACE SERV MISS/INVALID	Transportation	Deny
155	E - LAST DOS IS MISSING	Home Health	Deny
155	E - LAST DOS IS MISSING	Hospice	Deny
155	E - LAST DOS IS MISSING	Inpatient	Deny
155	E - LAST DOS IS MISSING	Laboratory and Xray	Deny
155	E - LAST DOS IS MISSING	Long Term Care	Deny
155	E - LAST DOS IS MISSING	Mcare Part A Crossover	Deny
155	E - LAST DOS IS MISSING	Mcare Part B Crossover	Deny
155	E - LAST DOS IS MISSING	Mcare UB Part B Crossover	Deny
155	E - LAST DOS IS MISSING	Medical Supply	Deny
155	E - LAST DOS IS MISSING	Outpatient	Deny
155	E - LAST DOS IS MISSING	Practitioner/Physician	Deny
155	E - LAST DOS IS MISSING	Transportation	Deny
162	OTHER PYR PYMT DOES NOT BALANC	Dental	Deny
162	OTHER PYR PYMT DOES NOT BALANC	Home Health	Deny
162	OTHER PYR PYMT DOES NOT BALANC	Hospice	Deny
162	OTHER PYR PYMT DOES NOT BALANC	Inpatient	Deny
162	OTHER PYR PYMT DOES NOT BALANC	Laboratory and Xray	Deny
162	OTHER PYR PYMT DOES NOT BALANC	Long Term Care	Deny
162	OTHER PYR PYMT DOES NOT BALANC	Mcare Part A Crossover	Deny
162	OTHER PYR PYMT DOES NOT BALANC	Mcare Part B Crossover	Deny
162	OTHER PYR PYMT DOES NOT BALANC	Mcare UB Part B Crossover	Deny
162	OTHER PYR PYMT DOES NOT BALANC	Medical Supply	Deny
162	OTHER PYR PYMT DOES NOT BALANC	Outpatient	Deny
162	OTHER PYR PYMT DOES NOT BALANC	Practitioner/Physician	Deny

162	OTHER PYR PYMT DOES NOT BALANC	Transportation	Deny
163	E-LINE DOS OUT FROM/THRU DATE	Home Health	Deny
163	E-LINE DOS OUT FROM/THRU DATE	Hospice	Deny
163	E-LINE DOS OUT FROM/THRU DATE	Inpatient	Deny
163	E-LINE DOS OUT FROM/THRU DATE	Long Term Care	Deny
163	E-LINE DOS OUT FROM/THRU DATE	Mcare Part A Crossover	Deny
163	E-LINE DOS OUT FROM/THRU DATE	Mcare UB Part B Crossover	Deny
163	E-LINE DOS OUT FROM/THRU DATE	Outpatient	Deny
166	CLM ADM DT GT THE DISCHARG DT	Inpatient	Deny
166	CLM ADM DT GT THE DISCHARG DT	Mcare Part A Crossover	Deny
167	E - ADMIT DATE IS MISSING	Inpatient	Deny
167	E - ADMIT DATE IS MISSING	Mcare Part A Crossover	Deny
172	E - PROCEDURE CODE MISSING	Dental	Deny
172	E - PROCEDURE CODE MISSING	Laboratory and Xray	Deny
172	E - PROCEDURE CODE MISSING	Mcare Part B Crossover	Deny
172	E - PROCEDURE CODE MISSING	Mcare UB Part B Crossover	Deny
172	E - PROCEDURE CODE MISSING	Medical Supply	Deny
172	E - PROCEDURE CODE MISSING	Practitioner/Physician	Deny
172	E - PROCEDURE CODE MISSING	Transportation	Deny
182	E-MISS/INVALID CVD/NON DAYS	Inpatient	Deny
182	E-MISS/INVALID CVD/NON DAYS	Long Term Care	Deny
182	E-MISS/INVALID CVD/NON DAYS	Mcare Part A Crossover	Deny
188	E - PATIENT STATUS INVALID	Hospice	Deny
188	E - PATIENT STATUS INVALID	Inpatient	Deny
188	E - PATIENT STATUS INVALID	Long Term Care	Deny
189	E- SUB UNITS OF SERV MISSING	Home Health	Deny
189	E- SUB UNITS OF SERV MISSING	Hospice	Deny
189	E- SUB UNITS OF SERV MISSING	Inpatient	Deny
189	E- SUB UNITS OF SERV MISSING	Laboratory and Xray	Deny
189	E- SUB UNITS OF SERV MISSING	Long Term Care	Deny
189	E- SUB UNITS OF SERV MISSING	Mcare Part A Crossover	Deny
189	E- SUB UNITS OF SERV MISSING	Mcare Part B Crossover	Deny
189	E- SUB UNITS OF SERV MISSING	Mcare UB Part B Crossover	Deny
189	E- SUB UNITS OF SERV MISSING	Medical Supply	Deny
189	E- SUB UNITS OF SERV MISSING	Outpatient	Deny
189	E- SUB UNITS OF SERV MISSING	Practitioner/Physician	Deny
189	E- SUB UNITS OF SERV MISSING	Transportation	Deny
201	CRED/REPLCMT TCN MIS OR INV	Capitation (MC)	Deny
201	CRED/REPLCMT TCN MIS OR INV	Credit Request	Deny
201	CRED/REPLCMT TCN MIS OR INV	Dental	Deny

201	CRED/REPLCMT TCN MIS OR INV	Financial Transaction	Deny
201	CRED/REPLCMT TCN MIS OR INV	Home Health	Deny
201	CRED/REPLCMT TCN MIS OR INV	Hospice	Deny
201	CRED/REPLCMT TCN MIS OR INV	Inpatient	Deny
201	CRED/REPLCMT TCN MIS OR INV	Laboratory and Xray	Deny
201	CRED/REPLCMT TCN MIS OR INV	Long Term Care	Deny
201	CRED/REPLCMT TCN MIS OR INV	Mcare Part A Crossover	Deny
201	CRED/REPLCMT TCN MIS OR INV	Mcare Part B Crossover	Deny
201	CRED/REPLCMT TCN MIS OR INV	Mcare Pharm Part B Crossover	Deny
201	CRED/REPLCMT TCN MIS OR INV	Mcare UB Part B Crossover	Deny
201	CRED/REPLCMT TCN MIS OR INV	Medical Supply	Deny
201	CRED/REPLCMT TCN MIS OR INV	Outpatient	Deny
201	CRED/REPLCMT TCN MIS OR INV	Pharmacy (RX)	Deny
201	CRED/REPLCMT TCN MIS OR INV	Practitioner/Physician	Deny
201	CRED/REPLCMT TCN MIS OR INV	Replacement Request	Deny
201	CRED/REPLCMT TCN MIS OR INV	Transportation	Deny
222	E-CLIENT NAME/DOB MISMATCH	Dental	Deny
222	E-CLIENT NAME/DOB MISMATCH	Home Health	Deny
222	E-CLIENT NAME/DOB MISMATCH	Hospice	Deny
222	E-CLIENT NAME/DOB MISMATCH	Inpatient	Deny
222	E-CLIENT NAME/DOB MISMATCH	Laboratory and Xray	Deny
222	E-CLIENT NAME/DOB MISMATCH	Long Term Care	Deny
222	E-CLIENT NAME/DOB MISMATCH	Mcare Part A Crossover	Deny
222	E-CLIENT NAME/DOB MISMATCH	Mcare Part B Crossover	Deny
222	E-CLIENT NAME/DOB MISMATCH	Mcare UB Part B Crossover	Deny
222	E-CLIENT NAME/DOB MISMATCH	Medical Supply	Deny
222	E-CLIENT NAME/DOB MISMATCH	Outpatient	Deny
222	E-CLIENT NAME/DOB MISMATCH	Practitioner/Physician	Deny
222	E-CLIENT NAME/DOB MISMATCH	Transportation	Deny
253	E- DIAGNOSIS NOT VALID FOR DOS	Home Health	Deny
253	E- DIAGNOSIS NOT VALID FOR DOS	Hospice	Deny
253	E- DIAGNOSIS NOT VALID FOR DOS	Inpatient	Deny
253	E- DIAGNOSIS NOT VALID FOR DOS	Laboratory and Xray	Deny
253	E- DIAGNOSIS NOT VALID FOR DOS	Long Term Care	Deny
253	E- DIAGNOSIS NOT VALID FOR DOS	Mcare Part A Crossover	Deny
253	E- DIAGNOSIS NOT VALID FOR DOS	Mcare Part B Crossover	Deny
253	E- DIAGNOSIS NOT VALID FOR DOS	Mcare UB Part B Crossover	Deny
253	E- DIAGNOSIS NOT VALID FOR DOS	Medical Supply	Deny
253	E- DIAGNOSIS NOT VALID FOR DOS	Outpatient	Deny
253	E- DIAGNOSIS NOT VALID FOR DOS	Practitioner/Physician	Deny

253	E- DIAGNOSIS NOT VALID FOR DOS	Transportation	Deny
260	DIAGNOSIS CODE NOT SPECIFIC	Home Health	Deny
260	DIAGNOSIS CODE NOT SPECIFIC	Hospice	Deny
260	DIAGNOSIS CODE NOT SPECIFIC	Inpatient	Deny
260	DIAGNOSIS CODE NOT SPECIFIC	Laboratory and Xray	Deny
260	DIAGNOSIS CODE NOT SPECIFIC	Long Term Care	Deny
260	DIAGNOSIS CODE NOT SPECIFIC	Mcare Part A Crossover	Deny
260	DIAGNOSIS CODE NOT SPECIFIC	Mcare Part B Crossover	Deny
260	DIAGNOSIS CODE NOT SPECIFIC	Mcare UB Part B Crossover	Deny
260	DIAGNOSIS CODE NOT SPECIFIC	Medical Supply	Deny
260	DIAGNOSIS CODE NOT SPECIFIC	Outpatient	Deny
260	DIAGNOSIS CODE NOT SPECIFIC	Practitioner/Physician	Deny
260	DIAGNOSIS CODE NOT SPECIFIC	Transportation	Deny
281	SVRC NT ALLW COMM BENEFIT PRV	Practitioner/Physician	Deny
284	TRANSITION SVCS> 90 DAYS	Practitioner/Physician	Deny
295	INVALID BILLING NPI	Dental	Deny
295	INVALID BILLING NPI	Home Health	Deny
295	INVALID BILLING NPI	Hospice	Deny
295	INVALID BILLING NPI	Inpatient	Deny
295	INVALID BILLING NPI	Laboratory and Xray	Deny
295	INVALID BILLING NPI	Long Term Care	Deny
295	INVALID BILLING NPI	Mcare Part A Crossover	Deny
295	INVALID BILLING NPI	Mcare Part B Crossover	Deny
295	INVALID BILLING NPI	Mcare UB Part B Crossover	Deny
295	INVALID BILLING NPI	Medical Supply	Deny
295	INVALID BILLING NPI	Outpatient	Deny
295	INVALID BILLING NPI	Practitioner/Physician	Deny
295	INVALID BILLING NPI	Transportation	Deny
296	BILLING NPI NOT FOUND	Dental	Deny
296	BILLING NPI NOT FOUND	Home Health	Deny
296	BILLING NPI NOT FOUND	Hospice	Deny
296	BILLING NPI NOT FOUND	Inpatient	Deny
296	BILLING NPI NOT FOUND	Laboratory and Xray	Deny
296	BILLING NPI NOT FOUND	Long Term Care	Deny
296	BILLING NPI NOT FOUND	Mcare Part A Crossover	Deny
296	BILLING NPI NOT FOUND	Mcare Part B Crossover	Deny
296	BILLING NPI NOT FOUND	Mcare UB Part B Crossover	Deny
296	BILLING NPI NOT FOUND	Medical Supply	Deny
296	BILLING NPI NOT FOUND	Outpatient	Deny
296	BILLING NPI NOT FOUND	Practitioner/Physician	Deny

296	BILLING NPI NOT FOUND	Transportation	Deny
299	BLNG NPI MATCH MULTI MCAID ID	Dental	Deny
299	BLNG NPI MATCH MULTI MCAID ID	Home Health	Deny
299	BLNG NPI MATCH MULTI MCAID ID	Hospice	Deny
299	BLNG NPI MATCH MULTI MCAID ID	Inpatient	Deny
299	BLNG NPI MATCH MULTI MCAID ID	Laboratory and Xray	Deny
299	BLNG NPI MATCH MULTI MCAID ID	Long Term Care	Deny
299	BLNG NPI MATCH MULTI MCAID ID	Mcare Part A Crossover	Deny
299	BLNG NPI MATCH MULTI MCAID ID	Mcare Part B Crossover	Deny
299	BLNG NPI MATCH MULTI MCAID ID	Mcare UB Part B Crossover	Deny
299	BLNG NPI MATCH MULTI MCAID ID	Medical Supply	Deny
299	BLNG NPI MATCH MULTI MCAID ID	Outpatient	Deny
299	BLNG NPI MATCH MULTI MCAID ID	Practitioner/Physician	Deny
299	BLNG NPI MATCH MULTI MCAID ID	Transportation	Deny
300	E-BILLING PROV NOT ON FILE	Dental	Deny
300	E-BILLING PROV NOT ON FILE	Home Health	Deny
300	E-BILLING PROV NOT ON FILE	Hospice	Deny
300	E-BILLING PROV NOT ON FILE	Inpatient	Deny
300	E-BILLING PROV NOT ON FILE	Laboratory and Xray	Deny
300	E-BILLING PROV NOT ON FILE	Long Term Care	Deny
300	E-BILLING PROV NOT ON FILE	Mcare Part A Crossover	Deny
300	E-BILLING PROV NOT ON FILE	Mcare Part B Crossover	Deny
300	E-BILLING PROV NOT ON FILE	Mcare UB Part B Crossover	Deny
300	E-BILLING PROV NOT ON FILE	Medical Supply	Deny
300	E-BILLING PROV NOT ON FILE	Outpatient	Deny
300	E-BILLING PROV NOT ON FILE	Practitioner/Physician	Deny
300	E-BILLING PROV NOT ON FILE	Transportation	Deny
302	ATTENDING PROV # NOT ON FILE	Mcare Part A Crossover	Deny
303	E - ATTENDING # IS MISS/INVAL	Home Health	Deny
303	E - ATTENDING # IS MISS/INVAL	Hospice	Deny
303	E - ATTENDING # IS MISS/INVAL	Inpatient	Deny
303	E - ATTENDING # IS MISS/INVAL	Long Term Care	Deny
303	E - ATTENDING # IS MISS/INVAL	Mcare Part A Crossover	Deny
306	BILLING NPI REQUIRED	Dental	Deny
306	BILLING NPI REQUIRED	Home Health	Deny
306	BILLING NPI REQUIRED	Hospice	Deny
306	BILLING NPI REQUIRED	Inpatient	Deny
306	BILLING NPI REQUIRED	Laboratory and Xray	Deny
306	BILLING NPI REQUIRED	Long Term Care	Deny
306	BILLING NPI REQUIRED	Mcare Part A Crossover	Deny

306	BILLING NPI REQUIRED	Mcare Part B Crossover	Deny
306	BILLING NPI REQUIRED	Mcare UB Part B Crossover	Deny
306	BILLING NPI REQUIRED	Medical Supply	Deny
306	BILLING NPI REQUIRED	Outpatient	Deny
306	BILLING NPI REQUIRED	Practitioner/Physician	Deny
306	BILLING NPI REQUIRED	Transportation	Deny
309	INVALID ATTEND NPI	Home Health	Deny
309	INVALID ATTEND NPI	Hospice	Deny
309	INVALID ATTEND NPI	Inpatient	Deny
309	INVALID ATTEND NPI	Long Term Care	Deny
309	INVALID ATTEND NPI	Mcare Part A Crossover	Deny
310	ATTEND NPI NOT FOUND	Home Health	Deny
310	ATTEND NPI NOT FOUND	Hospice	Deny
310	ATTEND NPI NOT FOUND	Inpatient	Deny
310	ATTEND NPI NOT FOUND	Long Term Care	Deny
310	ATTEND NPI NOT FOUND	Mcare Part A Crossover	Deny
315	ATTEN NPI MATCH MULTI MCAID ID	Home Health	Deny
315	ATTEN NPI MATCH MULTI MCAID ID	Hospice	Deny
315	ATTEN NPI MATCH MULTI MCAID ID	Inpatient	Deny
315	ATTEN NPI MATCH MULTI MCAID ID	Long Term Care	Deny
315	ATTEN NPI MATCH MULTI MCAID ID	Mcare Part A Crossover	Deny
317	ATTENDING NPI REQUIRED	Home Health	Deny
317	ATTENDING NPI REQUIRED	Hospice	Deny
317	ATTENDING NPI REQUIRED	Inpatient	Deny
317	ATTENDING NPI REQUIRED	Long Term Care	Deny
317	ATTENDING NPI REQUIRED	Mcare Part A Crossover	Deny
318	BLNG SSN/TAX ID NOT FOUND	Practitioner/Physician	Deny
319	BLNG SSN/TAX MATCH MULTI MCAID	Mcare Part B Crossover	Deny
319	BLNG SSN/TAX MATCH MULTI MCAID	Practitioner/Physician	Deny
319	BLNG SSN/TAX MATCH MULTI MCAID	Transportation	Deny
331	NO LTC SPAN AVAIL FOR FRST DOS	Hospice	Deny
331	NO LTC SPAN AVAIL FOR FRST DOS	Long Term Care	Deny
331	NO LTC SPAN AVAIL FOR FRST DOS	Practitioner/Physician	Deny
332	E- DIAG CODE MISSING	Inpatient	Deny
332	E- DIAG CODE MISSING	Laboratory and Xray	Deny
332	E- DIAG CODE MISSING	Mcare Part A Crossover	Deny
332	E- DIAG CODE MISSING	Mcare Part B Crossover	Deny
332	E- DIAG CODE MISSING	Mcare UB Part B Crossover	Deny
332	E- DIAG CODE MISSING	Outpatient	Deny
332	E- DIAG CODE MISSING	Practitioner/Physician	Deny

336	PROVIDER NOT AUTH FOR PATIENT	Long Term Care	Deny
347	E - REV CODE NOT ON FILE	Home Health	Deny
347	E - REV CODE NOT ON FILE	Hospice	Deny
347	E - REV CODE NOT ON FILE	Long Term Care	Deny
347	E - REV CODE NOT ON FILE	Outpatient	Deny
350	CLAIM AUDITED NO ADJUST ALLOW	Credit Request	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Dental	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Home Health	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Hospice	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Inpatient	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Laboratory and Xray	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Long Term Care	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Mcare Part A Crossover	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Mcare Part B Crossover	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Mcare UB Part B Crossover	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Medical Supply	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Outpatient	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Practitioner/Physician	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Replacement Request	Deny & Report
350	CLAIM AUDITED NO ADJUST ALLOW	Transportation	Deny & Report
361	E-TOOTH/QUADRANT # REQUIRED	Dental	Deny
367	PROV REVIEW FOR TYPE/PROC	Dental	Deny
367	PROV REVIEW FOR TYPE/PROC	Home Health	Deny
367	PROV REVIEW FOR TYPE/PROC	Hospice	Deny
367	PROV REVIEW FOR TYPE/PROC	Laboratory and Xray	Deny
367	PROV REVIEW FOR TYPE/PROC	Long Term Care	Deny
367	PROV REVIEW FOR TYPE/PROC	Mcare Part B Crossover	Deny
367	PROV REVIEW FOR TYPE/PROC	Medical Supply	Deny
367	PROV REVIEW FOR TYPE/PROC	Outpatient	Deny
367	PROV REVIEW FOR TYPE/PROC	Practitioner/Physician	Deny
367	PROV REVIEW FOR TYPE/PROC	Transportation	Deny
368	BILL PROV REVIEW FOR TYPE/REV	Home Health	Deny
368	BILL PROV REVIEW FOR TYPE/REV	Hospice	Deny
368	BILL PROV REVIEW FOR TYPE/REV	Inpatient	Deny
368	BILL PROV REVIEW FOR TYPE/REV	Long Term Care	Deny
368	BILL PROV REVIEW FOR TYPE/REV	Outpatient	Deny
372	E- PROC/CLM TYPE CNFL	Dental	Deny
372	E- PROC/CLM TYPE CNFL	Laboratory and Xray	Deny
372	E- PROC/CLM TYPE CNFL	Medical Supply	Deny
372	E- PROC/CLM TYPE CNFL	Practitioner/Physician	Deny

372	E- PROC/CLM TYPE CNFL	Transportation	Deny
373	E-REV/TYPE OF BILL CNFL	Home Health	Deny
373	E-REV/TYPE OF BILL CNFL	Hospice	Deny
373	E-REV/TYPE OF BILL CNFL	Inpatient	Deny
373	E-REV/TYPE OF BILL CNFL	Long Term Care	Deny
373	E-REV/TYPE OF BILL CNFL	Outpatient	Deny
377	MISSING OR INVALID COST CENTER	Capitation (MC)	Deny
377	MISSING OR INVALID COST CENTER	Credit Request	Deny
377	MISSING OR INVALID COST CENTER	Dental	Deny
377	MISSING OR INVALID COST CENTER	Financial Transaction	Deny
377	MISSING OR INVALID COST CENTER	Home Health	Deny
377	MISSING OR INVALID COST CENTER	Hospice	Deny
377	MISSING OR INVALID COST CENTER	Inpatient	Deny
377	MISSING OR INVALID COST CENTER	Laboratory and Xray	Deny
377	MISSING OR INVALID COST CENTER	Long Term Care	Deny
377	MISSING OR INVALID COST CENTER	Mcare Part A Crossover	Deny
377	MISSING OR INVALID COST CENTER	Mcare Part B Crossover	Deny
377	MISSING OR INVALID COST CENTER	Mcare Pharm Part B Crossover	Deny
377	MISSING OR INVALID COST CENTER	Mcare UB Part B Crossover	Deny
377	MISSING OR INVALID COST CENTER	Medical Supply	Deny
377	MISSING OR INVALID COST CENTER	Outpatient	Deny
377	MISSING OR INVALID COST CENTER	Pharmacy (RX)	Deny
377	MISSING OR INVALID COST CENTER	Practitioner/Physician	Deny
377	MISSING OR INVALID COST CENTER	Replacement Request	Deny
377	MISSING OR INVALID COST CENTER	Transportation	Deny
392	SURGICAL PROC CD NOT SPECIFIC	Inpatient	Deny
392	SURGICAL PROC CD NOT SPECIFIC	Mcare Part A Crossover	Deny
392	SURGICAL PROC CD NOT SPECIFIC	Mcare UB Part B Crossover	Deny
405	PROC CD IS VALUE ADDED BH	Long Term Care	Deny
405	PROC CD IS VALUE ADDED BH	Outpatient	Deny
405	PROC CD IS VALUE ADDED BH	Practitioner/Physician	Deny
406	REV CODE IS VAULE ADDED BH	Inpatient	Deny
406	REV CODE IS VAULE ADDED BH	Long Term Care	Deny
406	REV CODE IS VAULE ADDED BH	Outpatient	Deny
412	RENDERING/DESTINATION PROVIDER NOT ON DATA BASE	Laboratory and Xray	Deny
412	RENDERING/DESTINATION PROVIDER NOT ON DATA BASE	Mcare UB Part B Crossover	Deny
412	RENDERING/DESTINATION PROVIDER NOT ON DATA BASE	Practitioner/Physician	Deny
424	E-BILL PROV NOT ENROLL ON DOS	Dental	Deny

424	E-BILL PROV NOT ENROLL ON DOS	Home Health	Deny
424	E-BILL PROV NOT ENROLL ON DOS	Hospice	Deny
424	E-BILL PROV NOT ENROLL ON DOS	Inpatient	Deny
424	E-BILL PROV NOT ENROLL ON DOS	Laboratory and Xray	Deny
424	E-BILL PROV NOT ENROLL ON DOS	Long Term Care	Deny
424	E-BILL PROV NOT ENROLL ON DOS	Mcare Part A Crossover	Deny
424	E-BILL PROV NOT ENROLL ON DOS	Mcare Part B Crossover	Deny
424	E-BILL PROV NOT ENROLL ON DOS	Mcare UB Part B Crossover	Deny
424	E-BILL PROV NOT ENROLL ON DOS	Medical Supply	Deny
424	E-BILL PROV NOT ENROLL ON DOS	Outpatient	Deny
424	E-BILL PROV NOT ENROLL ON DOS	Practitioner/Physician	Deny
424	E-BILL PROV NOT ENROLL ON DOS	Transportation	Deny
430	E-PROCEDURE NOT ON FILE	Dental	Deny
430	E-PROCEDURE NOT ON FILE	Laboratory and Xray	Deny
430	E-PROCEDURE NOT ON FILE	Mcare Part B Crossover	Deny
430	E-PROCEDURE NOT ON FILE	Medical Supply	Deny
430	E-PROCEDURE NOT ON FILE	Practitioner/Physician	Deny
430	E-PROCEDURE NOT ON FILE	Transportation	Deny
440	E - 6TH (F) DIAG NOT ON FILE	Home Health	Deny
440	E - 6TH (F) DIAG NOT ON FILE	Hospice	Deny
440	E - 6TH (F) DIAG NOT ON FILE	Inpatient	Deny
440	E - 6TH (F) DIAG NOT ON FILE	Laboratory and Xray	Deny
440	E - 6TH (F) DIAG NOT ON FILE	Long Term Care	Deny
440	E - 6TH (F) DIAG NOT ON FILE	Mcare Part A Crossover	Deny
440	E - 6TH (F) DIAG NOT ON FILE	Mcare Part B Crossover	Deny
440	E - 6TH (F) DIAG NOT ON FILE	Mcare UB Part B Crossover	Deny
440	E - 6TH (F) DIAG NOT ON FILE	Medical Supply	Deny
440	E - 6TH (F) DIAG NOT ON FILE	Outpatient	Deny
440	E - 6TH (F) DIAG NOT ON FILE	Practitioner/Physician	Deny
440	E - 6TH (F) DIAG NOT ON FILE	Transportation	Deny
446	E-7TH (G) DIAG NOT ON FILE	Home Health	Deny
446	E-7TH (G) DIAG NOT ON FILE	Hospice	Deny
446	E-7TH (G) DIAG NOT ON FILE	Inpatient	Deny
446	E-7TH (G) DIAG NOT ON FILE	Laboratory and Xray	Deny
446	E-7TH (G) DIAG NOT ON FILE	Long Term Care	Deny
446	E-7TH (G) DIAG NOT ON FILE	Mcare Part A Crossover	Deny
446	E-7TH (G) DIAG NOT ON FILE	Mcare Part B Crossover	Deny
446	E-7TH (G) DIAG NOT ON FILE	Mcare UB Part B Crossover	Deny
446	E-7TH (G) DIAG NOT ON FILE	Medical Supply	Deny
446	E-7TH (G) DIAG NOT ON FILE	Outpatient	Deny

446	E-7TH (G) DIAG NOT ON FILE	Practitioner/Physician	Deny
446	E-7TH (G) DIAG NOT ON FILE	Transportation	Deny
450	E-1ST (A) DIAG NOT ON FILE	Home Health	Deny
450	E-1ST (A) DIAG NOT ON FILE	Hospice	Deny
450	E-1ST (A) DIAG NOT ON FILE	Inpatient	Deny
450	E-1ST (A) DIAG NOT ON FILE	Laboratory and Xray	Deny
450	E-1ST (A) DIAG NOT ON FILE	Long Term Care	Deny
450	E-1ST (A) DIAG NOT ON FILE	Mcare Part A Crossover	Deny
450	E-1ST (A) DIAG NOT ON FILE	Mcare Part B Crossover	Deny
450	E-1ST (A) DIAG NOT ON FILE	Mcare UB Part B Crossover	Deny
450	E-1ST (A) DIAG NOT ON FILE	Medical Supply	Deny
450	E-1ST (A) DIAG NOT ON FILE	Outpatient	Deny
450	E-1ST (A) DIAG NOT ON FILE	Practitioner/Physician	Deny
450	E-1ST (A) DIAG NOT ON FILE	Transportation	Deny
453	NON-RELATED DIAG CODE INVALID	Laboratory and Xray	Deny
453	NON-RELATED DIAG CODE INVALID	Mcare Part B Crossover	Deny
453	NON-RELATED DIAG CODE INVALID	Practitioner/Physician	Deny
458	E-8TH (H) DIAG NOT ON FILE	Home Health	Deny
458	E-8TH (H) DIAG NOT ON FILE	Hospice	Deny
458	E-8TH (H) DIAG NOT ON FILE	Inpatient	Deny
458	E-8TH (H) DIAG NOT ON FILE	Laboratory and Xray	Deny
458	E-8TH (H) DIAG NOT ON FILE	Long Term Care	Deny
458	E-8TH (H) DIAG NOT ON FILE	Mcare Part A Crossover	Deny
458	E-8TH (H) DIAG NOT ON FILE	Mcare Part B Crossover	Deny
458	E-8TH (H) DIAG NOT ON FILE	Mcare UB Part B Crossover	Deny
458	E-8TH (H) DIAG NOT ON FILE	Medical Supply	Deny
458	E-8TH (H) DIAG NOT ON FILE	Outpatient	Deny
458	E-8TH (H) DIAG NOT ON FILE	Practitioner/Physician	Deny
458	E-8TH (H) DIAG NOT ON FILE	Transportation	Deny
460	E - 2ND (B) DIAG NOT ON FILE	Home Health	Deny
460	E - 2ND (B) DIAG NOT ON FILE	Hospice	Deny
460	E - 2ND (B) DIAG NOT ON FILE	Inpatient	Deny
460	E - 2ND (B) DIAG NOT ON FILE	Laboratory and Xray	Deny
460	E - 2ND (B) DIAG NOT ON FILE	Long Term Care	Deny
460	E - 2ND (B) DIAG NOT ON FILE	Mcare Part A Crossover	Deny
460	E - 2ND (B) DIAG NOT ON FILE	Mcare Part B Crossover	Deny
460	E - 2ND (B) DIAG NOT ON FILE	Mcare UB Part B Crossover	Deny
460	E - 2ND (B) DIAG NOT ON FILE	Medical Supply	Deny
460	E - 2ND (B) DIAG NOT ON FILE	Outpatient	Deny
460	E - 2ND (B) DIAG NOT ON FILE	Practitioner/Physician	Deny

460	E - 2ND (B) DIAG NOT ON FILE	Transportation	Deny
470	E -3RD (C) DIAG NOT ON FILE	Home Health	Deny
470	E -3RD (C) DIAG NOT ON FILE	Hospice	Deny
470	E -3RD (C) DIAG NOT ON FILE	Inpatient	Deny
470	E -3RD (C) DIAG NOT ON FILE	Laboratory and Xray	Deny
470	E -3RD (C) DIAG NOT ON FILE	Long Term Care	Deny
470	E -3RD (C) DIAG NOT ON FILE	Mcare Part A Crossover	Deny
470	E -3RD (C) DIAG NOT ON FILE	Mcare Part B Crossover	Deny
470	E -3RD (C) DIAG NOT ON FILE	Mcare UB Part B Crossover	Deny
470	E -3RD (C) DIAG NOT ON FILE	Medical Supply	Deny
470	E -3RD (C) DIAG NOT ON FILE	Outpatient	Deny
470	E -3RD (C) DIAG NOT ON FILE	Practitioner/Physician	Deny
470	E -3RD (C) DIAG NOT ON FILE	Transportation	Deny
472	E-9TH (I) DIAG NOT ON FILE	Home Health	Deny
472	E-9TH (I) DIAG NOT ON FILE	Hospice	Deny
472	E-9TH (I) DIAG NOT ON FILE	Inpatient	Deny
472	E-9TH (I) DIAG NOT ON FILE	Laboratory and Xray	Deny
472	E-9TH (I) DIAG NOT ON FILE	Long Term Care	Deny
472	E-9TH (I) DIAG NOT ON FILE	Mcare Part A Crossover	Deny
472	E-9TH (I) DIAG NOT ON FILE	Mcare Part B Crossover	Deny
472	E-9TH (I) DIAG NOT ON FILE	Mcare UB Part B Crossover	Deny
472	E-9TH (I) DIAG NOT ON FILE	Medical Supply	Deny
472	E-9TH (I) DIAG NOT ON FILE	Outpatient	Deny
472	E-9TH (I) DIAG NOT ON FILE	Practitioner/Physician	Deny
472	E-9TH (I) DIAG NOT ON FILE	Transportation	Deny
480	E - 4TH (D) DIAG NOT ON FILE	Home Health	Deny
480	E - 4TH (D) DIAG NOT ON FILE	Hospice	Deny
480	E - 4TH (D) DIAG NOT ON FILE	Inpatient	Deny
480	E - 4TH (D) DIAG NOT ON FILE	Laboratory and Xray	Deny
480	E - 4TH (D) DIAG NOT ON FILE	Long Term Care	Deny
480	E - 4TH (D) DIAG NOT ON FILE	Mcare Part A Crossover	Deny
480	E - 4TH (D) DIAG NOT ON FILE	Mcare Part B Crossover	Deny
480	E - 4TH (D) DIAG NOT ON FILE	Mcare UB Part B Crossover	Deny
480	E - 4TH (D) DIAG NOT ON FILE	Medical Supply	Deny
480	E - 4TH (D) DIAG NOT ON FILE	Outpatient	Deny
480	E - 4TH (D) DIAG NOT ON FILE	Practitioner/Physician	Deny
480	E - 4TH (D) DIAG NOT ON FILE	Transportation	Deny
488	E - ADM DIAG NOT ON FILE	Hospice	Deny
488	E - ADM DIAG NOT ON FILE	Inpatient	Deny
488	E - ADM DIAG NOT ON FILE	Long Term Care	Deny

488	E - ADM DIAG NOT ON FILE	Mcare Part A Crossover	Deny
490	E - 5TH (E) DIAG NOT ON FILE	Home Health	Deny
490	E - 5TH (E) DIAG NOT ON FILE	Hospice	Deny
490	E - 5TH (E) DIAG NOT ON FILE	Inpatient	Deny
490	E - 5TH (E) DIAG NOT ON FILE	Laboratory and Xray	Deny
490	E - 5TH (E) DIAG NOT ON FILE	Long Term Care	Deny
490	E - 5TH (E) DIAG NOT ON FILE	Mcare Part A Crossover	Deny
490	E - 5TH (E) DIAG NOT ON FILE	Mcare Part B Crossover	Deny
490	E - 5TH (E) DIAG NOT ON FILE	Mcare UB Part B Crossover	Deny
490	E - 5TH (E) DIAG NOT ON FILE	Medical Supply	Deny
490	E - 5TH (E) DIAG NOT ON FILE	Outpatient	Deny
490	E - 5TH (E) DIAG NOT ON FILE	Practitioner/Physician	Deny
490	E - 5TH (E) DIAG NOT ON FILE	Transportation	Deny
496	E-CLM NOT SUB W/IN 2 YR LIMIT	Dental	Deny
496	E-CLM NOT SUB W/IN 2 YR LIMIT	Home Health	Deny
496	E-CLM NOT SUB W/IN 2 YR LIMIT	Hospice	Deny
496	E-CLM NOT SUB W/IN 2 YR LIMIT	Inpatient	Deny
496	E-CLM NOT SUB W/IN 2 YR LIMIT	Laboratory and Xray	Deny
496	E-CLM NOT SUB W/IN 2 YR LIMIT	Long Term Care	Deny
496	E-CLM NOT SUB W/IN 2 YR LIMIT	Mcare Part A Crossover	Deny
496	E-CLM NOT SUB W/IN 2 YR LIMIT	Mcare Part B Crossover	Deny
496	E-CLM NOT SUB W/IN 2 YR LIMIT	Mcare UB Part B Crossover	Deny
496	E-CLM NOT SUB W/IN 2 YR LIMIT	Medical Supply	Deny
496	E-CLM NOT SUB W/IN 2 YR LIMIT	Outpatient	Deny
496	E-CLM NOT SUB W/IN 2 YR LIMIT	Practitioner/Physician	Deny
496	E-CLM NOT SUB W/IN 2 YR LIMIT	Transportation	Deny
519	NDC NOT VALID	Outpatient	Deny
519	NDC NOT VALID	Practitioner/Physician	Deny
520	HCPCS CODE REQ NDC	Medical Supply	Deny
520	HCPCS CODE REQ NDC	Outpatient	Deny
520	HCPCS CODE REQ NDC	Practitioner/Physician	Deny
550	E - PRIN.SURG PROC NOT ON FILE	Inpatient	Deny
550	E - PRIN.SURG PROC NOT ON FILE	Mcare Part A Crossover	Deny
550	E - PRIN.SURG PROC NOT ON FILE	Mcare UB Part B Crossover	Deny
550	E - PRIN.SURG PROC NOT ON FILE	Outpatient	Deny
598	POA IND REQUIRED	Inpatient	Deny
652	SUSPECT DUP, COVERED BY INPT	Home Health	Deny
652	SUSPECT DUP, COVERED BY INPT	Hospice	Deny
652	SUSPECT DUP, COVERED BY INPT	Laboratory and Xray	Deny
652	SUSPECT DUP, COVERED BY INPT	Long Term Care	Deny

652	SUSPECT DUP, COVERED BY INPT	Medical Supply	Deny
652	SUSPECT DUP, COVERED BY INPT	Practitioner/Physician	Deny
652	SUSPECT DUP, COVERED BY INPT	Transportation	Deny
653	SUSPECT DUP, COVERED BY INPT	Home Health	Deny
653	SUSPECT DUP, COVERED BY INPT	Hospice	Deny
653	SUSPECT DUP, COVERED BY INPT	Laboratory and Xray	Deny
653	SUSPECT DUP, COVERED BY INPT	Long Term Care	Deny
653	SUSPECT DUP, COVERED BY INPT	Medical Supply	Deny
653	SUSPECT DUP, COVERED BY INPT	Outpatient	Deny
653	SUSPECT DUP, COVERED BY INPT	Practitioner/Physician	Deny
653	SUSPECT DUP, COVERED BY INPT	Transportation	Deny
671	ABORTION REQUIRES REVIEW	Inpatient	Deny & Report
671	ABORTION REQUIRES REVIEW	Mcare Part A Crossover	Deny & Report
671	ABORTION REQUIRES REVIEW	Mcare Part B Crossover	Deny & Report
671	ABORTION REQUIRES REVIEW	Mcare UB Part B Crossover	Deny & Report
671	ABORTION REQUIRES REVIEW	Outpatient	Deny & Report
671	ABORTION REQUIRES REVIEW	Practitioner/Physician	Deny & Report
686	SUSPECT DUPE PART A CLM OVER	Home Health	Deny
686	SUSPECT DUPE PART A CLM OVER	Hospice	Deny
686	SUSPECT DUPE PART A CLM OVER	Inpatient	Deny
686	SUSPECT DUPE PART A CLM OVER	Laboratory and Xray	Deny
686	SUSPECT DUPE PART A CLM OVER	Long Term Care	Deny
686	SUSPECT DUPE PART A CLM OVER	Medical Supply	Deny
686	SUSPECT DUPE PART A CLM OVER	Outpatient	Deny
686	SUSPECT DUPE PART A CLM OVER	Practitioner/Physician	Deny
686	SUSPECT DUPE PART A CLM OVER	Transportation	Deny
702	E - DOS IS BEFORE DOB	Dental	Deny
702	E - DOS IS BEFORE DOB	Home Health	Deny
702	E - DOS IS BEFORE DOB	Hospice	Deny
702	E - DOS IS BEFORE DOB	Inpatient	Deny
702	E - DOS IS BEFORE DOB	Laboratory and Xray	Deny
702	E - DOS IS BEFORE DOB	Long Term Care	Deny
702	E - DOS IS BEFORE DOB	Mcare Part A Crossover	Deny
702	E - DOS IS BEFORE DOB	Mcare Part B Crossover	Deny
702	E - DOS IS BEFORE DOB	Mcare UB Part B Crossover	Deny
702	E - DOS IS BEFORE DOB	Medical Supply	Deny
702	E - DOS IS BEFORE DOB	Outpatient	Deny
702	E - DOS IS BEFORE DOB	Practitioner/Physician	Deny
702	E - DOS IS BEFORE DOB	Transportation	Deny
707	E-PROC NOT PREGNANCY RELATED	Dental	Deny

707	E-PROC NOT PREGNANCY RELATED	Home Health	Deny
707	E-PROC NOT PREGNANCY RELATED	Hospice	Deny
707	E-PROC NOT PREGNANCY RELATED	Inpatient	Deny
707	E-PROC NOT PREGNANCY RELATED	Long Term Care	Deny
707	E-PROC NOT PREGNANCY RELATED	Mcare Part A Crossover	Deny
707	E-PROC NOT PREGNANCY RELATED	Mcare Part B Crossover	Deny
707	E-PROC NOT PREGNANCY RELATED	Mcare UB Part B Crossover	Deny
707	E-PROC NOT PREGNANCY RELATED	Outpatient	Deny
707	E-PROC NOT PREGNANCY RELATED	Practitioner/Physician	Deny
718	NO DED/CO-INS ON X-OVER CLM	Mcare Part A Crossover	Deny
718	NO DED/CO-INS ON X-OVER CLM	Mcare Part B Crossover	Deny
718	NO DED/CO-INS ON X-OVER CLM	Mcare UB Part B Crossover	Deny
779	SUSPECT DUP COV BY HOSPICE CL	Home Health	Deny
779	SUSPECT DUP COV BY HOSPICE CL	Long Term Care	Deny
779	SUSPECT DUP COV BY HOSPICE CL	Medical Supply	Deny
779	SUSPECT DUP COV BY HOSPICE CL	Practitioner/Physician	Deny
782	SUSP DUP COVERED BY MCARE PT B	Dental	Deny
782	SUSP DUP COVERED BY MCARE PT B	Laboratory and Xray	Deny
782	SUSP DUP COVERED BY MCARE PT B	Medical Supply	Deny
782	SUSP DUP COVERED BY MCARE PT B	Practitioner/Physician	Deny
782	SUSP DUP COVERED BY MCARE PT B	Transportation	Deny
812	8TH CONDITION CODE INVALID	Home Health	Deny & Report
812	8TH CONDITION CODE INVALID	Hospice	Deny & Report
812	8TH CONDITION CODE INVALID	Inpatient	Deny & Report
812	8TH CONDITION CODE INVALID	Long Term Care	Deny & Report
812	8TH CONDITION CODE INVALID	Outpatient	Deny & Report
813	9TH CONDITION CODE INVALID	Home Health	Deny & Report
813	9TH CONDITION CODE INVALID	Hospice	Deny & Report
813	9TH CONDITION CODE INVALID	Inpatient	Deny & Report
813	9TH CONDITION CODE INVALID	Long Term Care	Deny & Report
813	9TH CONDITION CODE INVALID	Outpatient	Deny & Report
814	10TH CONDITION CODE INVALID	Home Health	Deny & Report
814	10TH CONDITION CODE INVALID	Hospice	Deny & Report
814	10TH CONDITION CODE INVALID	Inpatient	Deny & Report
814	10TH CONDITION CODE INVALID	Long Term Care	Deny & Report
814	10TH CONDITION CODE INVALID	Outpatient	Deny & Report
840	REPLCMT OR CRED IS IN PROCESS	Capitation (MC)	Deny
840	REPLCMT OR CRED IS IN PROCESS	Credit Request	Deny
840	REPLCMT OR CRED IS IN PROCESS	Dental	Deny
840	REPLCMT OR CRED IS IN PROCESS	Financial Transaction	Deny

840	REPLCMT OR CRED IS IN PROCESS	Home Health	Deny
840	REPLCMT OR CRED IS IN PROCESS	Hospice	Deny
840	REPLCMT OR CRED IS IN PROCESS	Inpatient	Deny
840	REPLCMT OR CRED IS IN PROCESS	Laboratory and Xray	Deny
840	REPLCMT OR CRED IS IN PROCESS	Long Term Care	Deny
840	REPLCMT OR CRED IS IN PROCESS	Mcare Part A Crossover	Deny
840	REPLCMT OR CRED IS IN PROCESS	Mcare Part B Crossover	Deny
840	REPLCMT OR CRED IS IN PROCESS	Mcare Pharm Part B Crossover	Deny
840	REPLCMT OR CRED IS IN PROCESS	Mcare UB Part B Crossover	Deny
840	REPLCMT OR CRED IS IN PROCESS	Medical Supply	Deny
840	REPLCMT OR CRED IS IN PROCESS	Outpatient	Deny
840	REPLCMT OR CRED IS IN PROCESS	Pharmacy (RX)	Deny
840	REPLCMT OR CRED IS IN PROCESS	Practitioner/Physician	Deny
840	REPLCMT OR CRED IS IN PROCESS	Replacement Request	Deny
840	REPLCMT OR CRED IS IN PROCESS	Transportation	Deny
841	MCO PROV ID MUST MATCH ORIG	Capitation (MC)	Deny
841	MCO PROV ID MUST MATCH ORIG	Credit Request	Deny
841	MCO PROV ID MUST MATCH ORIG	Dental	Deny
841	MCO PROV ID MUST MATCH ORIG	Financial Transaction	Deny
841	MCO PROV ID MUST MATCH ORIG	Home Health	Deny
841	MCO PROV ID MUST MATCH ORIG	Hospice	Deny
841	MCO PROV ID MUST MATCH ORIG	Inpatient	Deny
841	MCO PROV ID MUST MATCH ORIG	Laboratory and Xray	Deny
841	MCO PROV ID MUST MATCH ORIG	Long Term Care	Deny
841	MCO PROV ID MUST MATCH ORIG	Mcare Part A Crossover	Deny
841	MCO PROV ID MUST MATCH ORIG	Mcare Part B Crossover	Deny
841	MCO PROV ID MUST MATCH ORIG	Mcare Pharm Part B Crossover	Deny
841	MCO PROV ID MUST MATCH ORIG	Mcare UB Part B Crossover	Deny
841	MCO PROV ID MUST MATCH ORIG	Medical Supply	Deny
841	MCO PROV ID MUST MATCH ORIG	Outpatient	Deny
841	MCO PROV ID MUST MATCH ORIG	Pharmacy (RX)	Deny
841	MCO PROV ID MUST MATCH ORIG	Practitioner/Physician	Deny
841	MCO PROV ID MUST MATCH ORIG	Replacement Request	Deny
841	MCO PROV ID MUST MATCH ORIG	Transportation	Deny
845	CLM ALREADY CRED OR REPLCD	Capitation (MC)	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Credit Request	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Dental	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Financial Transaction	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Home Health	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Hospice	Deny & Report

845	CLM ALREADY CRED OR REPLCD	Inpatient	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Laboratory and Xray	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Long Term Care	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Mcare Part A Crossover	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Mcare Part B Crossover	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Mcare Pharm Part B Crossover	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Mcare UB Part B Crossover	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Medical Supply	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Outpatient	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Pharmacy (RX)	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Practitioner/Physician	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Replacement Request	Deny & Report
845	CLM ALREADY CRED OR REPLCD	Transportation	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Capitation (MC)	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Credit Request	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Dental	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Financial Transaction	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Home Health	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Hospice	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Inpatient	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Laboratory and Xray	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Long Term Care	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Mcare Part A Crossover	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Mcare Part B Crossover	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Mcare Pharm Part B Crossover	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Mcare UB Part B Crossover	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Medical Supply	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Outpatient	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Pharmacy (RX)	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Practitioner/Physician	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Replacement Request	Deny & Report
850	ADJ/VOID REQ NOT PROCESSED	Transportation	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Capitation (MC)	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Credit Request	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Dental	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Financial Transaction	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Home Health	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Hospice	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Inpatient	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Laboratory and Xray	Deny & Report

856	A CREDIT MAY NOT BE ADJUSTED	Long Term Care	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Mcare Part A Crossover	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Mcare Part B Crossover	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Mcare Pharm Part B Crossover	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Mcare UB Part B Crossover	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Medical Supply	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Outpatient	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Pharmacy (RX)	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Practitioner/Physician	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Replacement Request	Deny & Report
856	A CREDIT MAY NOT BE ADJUSTED	Transportation	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Credit Request	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Dental	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Home Health	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Hospice	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Inpatient	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Laboratory and Xray	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Long Term Care	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Mcare Part A Crossover	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Mcare Part B Crossover	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Mcare UB Part B Crossover	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Medical Supply	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Outpatient	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Practitioner/Physician	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Replacement Request	Deny & Report
857	CANNOT ADJ DENIED REPLACEMENT	Transportation	Deny & Report
868	E-TOOTH NUMBER INVALID	Dental	Deny
870	E-TYPE OF BILL IS MISS OR INV	Home Health	Deny
870	E-TYPE OF BILL IS MISS OR INV	Hospice	Deny
870	E-TYPE OF BILL IS MISS OR INV	Inpatient	Deny
870	E-TYPE OF BILL IS MISS OR INV	Long Term Care	Deny
870	E-TYPE OF BILL IS MISS OR INV	Mcare Part A Crossover	Deny
870	E-TYPE OF BILL IS MISS OR INV	Mcare UB Part B Crossover	Deny
870	E-TYPE OF BILL IS MISS OR INV	Outpatient	Deny
899	MORE THAN 25 EXCEPTIONS	Dental	Deny
899	MORE THAN 25 EXCEPTIONS	Home Health	Deny
899	MORE THAN 25 EXCEPTIONS	Hospice	Deny
899	MORE THAN 25 EXCEPTIONS	Inpatient	Deny
899	MORE THAN 25 EXCEPTIONS	Laboratory and Xray	Deny
899	MORE THAN 25 EXCEPTIONS	Long Term Care	Deny

899	MORE THAN 25 EXCEPTIONS	Mcare Part A Crossover	Deny
899	MORE THAN 25 EXCEPTIONS	Mcare Part B Crossover	Deny
899	MORE THAN 25 EXCEPTIONS	Mcare UB Part B Crossover	Deny
899	MORE THAN 25 EXCEPTIONS	Medical Supply	Deny
899	MORE THAN 25 EXCEPTIONS	Outpatient	Deny
899	MORE THAN 25 EXCEPTIONS	Practitioner/Physician	Deny
899	MORE THAN 25 EXCEPTIONS	Transportation	Deny
930	SURG PROCEDURE NOT VALID	Inpatient	Deny
930	SURG PROCEDURE NOT VALID	Mcare Part A Crossover	Deny
930	SURG PROCEDURE NOT VALID	Mcare UB Part B Crossover	Deny
1150	NO HLTH PLAN FOR ENCOUNTER DOS	Dental	Deny
1150	NO HLTH PLAN FOR ENCOUNTER DOS	Home Health	Deny
1150	NO HLTH PLAN FOR ENCOUNTER DOS	Hospice	Deny
1150	NO HLTH PLAN FOR ENCOUNTER DOS	Inpatient	Deny
1150	NO HLTH PLAN FOR ENCOUNTER DOS	Laboratory and Xray	Deny
1150	NO HLTH PLAN FOR ENCOUNTER DOS	Long Term Care	Deny
1150	NO HLTH PLAN FOR ENCOUNTER DOS	Mcare Part A Crossover	Deny
1150	NO HLTH PLAN FOR ENCOUNTER DOS	Mcare Part B Crossover	Deny
1150	NO HLTH PLAN FOR ENCOUNTER DOS	Mcare UB Part B Crossover	Deny
1150	NO HLTH PLAN FOR ENCOUNTER DOS	Medical Supply	Deny
1150	NO HLTH PLAN FOR ENCOUNTER DOS	Outpatient	Deny
1150	NO HLTH PLAN FOR ENCOUNTER DOS	Practitioner/Physician	Deny
1150	NO HLTH PLAN FOR ENCOUNTER DOS	Transportation	Deny
1151	LOCKIN ENDS BEFORE ENCTR LDOS	Dental	Deny
1151	LOCKIN ENDS BEFORE ENCTR LDOS	Laboratory and Xray	Deny
1151	LOCKIN ENDS BEFORE ENCTR LDOS	Mcare Part B Crossover	Deny
1151	LOCKIN ENDS BEFORE ENCTR LDOS	Medical Supply	Deny
1151	LOCKIN ENDS BEFORE ENCTR LDOS	Practitioner/Physician	Deny
1151	LOCKIN ENDS BEFORE ENCTR LDOS	Transportation	Deny
1152	HEALTH PLAN PROVIDER NOT AUTHO	Dental	Deny
1152	HEALTH PLAN PROVIDER NOT AUTHO	Home Health	Deny
1152	HEALTH PLAN PROVIDER NOT AUTHO	Hospice	Deny
1152	HEALTH PLAN PROVIDER NOT AUTHO	Inpatient	Deny
1152	HEALTH PLAN PROVIDER NOT AUTHO	Laboratory and Xray	Deny
1152	HEALTH PLAN PROVIDER NOT AUTHO	Long Term Care	Deny
1152	HEALTH PLAN PROVIDER NOT AUTHO	Mcare Part A Crossover	Deny
1152	HEALTH PLAN PROVIDER NOT AUTHO	Mcare Part B Crossover	Deny
1152	HEALTH PLAN PROVIDER NOT AUTHO	Mcare UB Part B Crossover	Deny
1152	HEALTH PLAN PROVIDER NOT AUTHO	Medical Supply	Deny
1152	HEALTH PLAN PROVIDER NOT AUTHO	Outpatient	Deny

1152	HEALTH PLAN PROVIDER NOT AUTHO	Practitioner/Physician	Deny
1152	HEALTH PLAN PROVIDER NOT AUTHO	Transportation	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Dental	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Home Health	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Hospice	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Inpatient	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Laboratory and Xray	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Long Term Care	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Mcare Part A Crossover	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Mcare Part B Crossover	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Mcare UB Part B Crossover	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Medical Supply	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Outpatient	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Pharmacy (RX)	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Practitioner/Physician	Deny
1160	NO HP ENTRY FOR DOS FOR CC PLA	Transportation	Deny
1186	E - ADMIT HOUR INV	Home Health	Deny
1186	E - ADMIT HOUR INV	Hospice	Deny
1186	E - ADMIT HOUR INV	Inpatient	Deny
1186	E - ADMIT HOUR INV	Long Term Care	Deny
1186	E - ADMIT HOUR INV	Mcare Part A Crossover	Deny
1186	E - ADMIT HOUR INV	Mcare UB Part B Crossover	Deny
1186	E - ADMIT HOUR INV	Outpatient	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Capitation (MC)	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Credit Request	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Dental	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Financial Transaction	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Home Health	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Hospice	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Inpatient	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Laboratory and Xray	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Long Term Care	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Mcare Part A Crossover	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Mcare Part B Crossover	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Mcare Pharm Part B Crossover	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Mcare UB Part B Crossover	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Medical Supply	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Outpatient	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Pharmacy (RX)	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Practitioner/Physician	Deny

1253	E-CLAIM DOS/CLIENT DOD CONFL	Replacement Request	Deny
1253	E-CLAIM DOS/CLIENT DOD CONFL	Transportation	Deny
1361	E - EXACT DUPLICATE	Dental	Deny
1361	E - EXACT DUPLICATE	Home Health	Deny
1361	E - EXACT DUPLICATE	Hospice	Deny
1361	E - EXACT DUPLICATE	Inpatient	Deny
1361	E - EXACT DUPLICATE	Laboratory and Xray	Deny
1361	E - EXACT DUPLICATE	Long Term Care	Deny
1361	E - EXACT DUPLICATE	Mcare Part A Crossover	Deny
1361	E - EXACT DUPLICATE	Mcare Part B Crossover	Deny
1361	E - EXACT DUPLICATE	Mcare UB Part B Crossover	Deny
1361	E - EXACT DUPLICATE	Medical Supply	Deny
1361	E - EXACT DUPLICATE	Outpatient	Deny
1361	E - EXACT DUPLICATE	Practitioner/Physician	Deny
1361	E - EXACT DUPLICATE	Transportation	Deny
1362	E - POSSIBLE DUP-SAME PROVIDER	Home Health	Deny
1362	E - POSSIBLE DUP-SAME PROVIDER	Hospice	Deny
1362	E - POSSIBLE DUP-SAME PROVIDER	Inpatient	Deny
1362	E - POSSIBLE DUP-SAME PROVIDER	Laboratory and Xray	Deny
1362	E - POSSIBLE DUP-SAME PROVIDER	Long Term Care	Deny
1362	E - POSSIBLE DUP-SAME PROVIDER	Mcare Part A Crossover	Deny
1362	E - POSSIBLE DUP-SAME PROVIDER	Mcare Part B Crossover	Deny
1362	E - POSSIBLE DUP-SAME PROVIDER	Medical Supply	Deny
1362	E - POSSIBLE DUP-SAME PROVIDER	Practitioner/Physician	Deny
1362	E - POSSIBLE DUP-SAME PROVIDER	Transportation	Deny
1363	POSSIBLE DUP - SAME PROVIDER	Laboratory and Xray	Deny
1363	POSSIBLE DUP - SAME PROVIDER	Mcare Part B Crossover	Deny
1363	POSSIBLE DUP - SAME PROVIDER	Practitioner/Physician	Deny
1371	E -POSS DUP-DIFFERENT PROVIDER	Inpatient	Deny
1371	E -POSS DUP-DIFFERENT PROVIDER	Long Term Care	Deny
1371	E -POSS DUP-DIFFERENT PROVIDER	Mcare Part A Crossover	Deny
1384	SUSP DUP MCARE PT A & B X-OVER	Mcare UB Part B Crossover	Deny
1900	10TH (J) DIAG NOT ON FILE	Home Health	Deny
1900	10TH (J) DIAG NOT ON FILE	Hospice	Deny
1900	10TH (J) DIAG NOT ON FILE	Inpatient	Deny
1900	10TH (J) DIAG NOT ON FILE	Long Term Care	Deny
1900	10TH (J) DIAG NOT ON FILE	Mcare Part A Crossover	Deny
1900	10TH (J) DIAG NOT ON FILE	Mcare Part B Crossover	Deny
1900	10TH (J) DIAG NOT ON FILE	Mcare UB Part B Crossover	Deny
1900	10TH (J) DIAG NOT ON FILE	Medical Supply	Deny

1900	10TH (J) DIAG NOT ON FILE	Outpatient	Deny
1900	10TH (J) DIAG NOT ON FILE	Practitioner/Physician	Deny
1900	10TH (J) DIAG NOT ON FILE	Transportation	Deny
6158	REFRACTION LMT 1 YR FOR CHILD	Mcare Part B Crossover	Deny
6158	REFRACTION LMT 1 YR FOR CHILD	Practitioner/Physician	Deny
6159	RP/REFIT EYEWEAR 1/60 DAYS	Mcare Part B Crossover	Deny
6159	RP/REFIT EYEWEAR 1/60 DAYS	Practitioner/Physician	Deny
6172	ULTRAFILTRATION VS DIALYSIS	Outpatient	Deny
6195	CLRCTL GNE TEST ONC 3 YRS	Laboratory and Xray	Deny
6201	CARELINK CO/CARE FEE MONT	Practitioner/Physician	Deny

Most Frequent Medicaid Exceptions

NM Medicaid manages appropriate payment of services by assigning provider types and specialties to specific service codes. There are two primary edits that apply specifically to the provider type allowed for a procedure and the rendering provider type when the Rendering provider is required. The edit 0367 **Prov Requires Review for Proc/Type Combo** will post if the provider billing or rendering the service is not one of the allowed provider types as per the procedure reference file; except that the State uses a system list to allow exceptions to the provider types shown on the procedure code file. The edit 0412 **Rendering Provider Required** will deny claims that are submitted for codes that require a rendering provider if the rendering provider is not submitted; again, with an exception allowed based on provider types on a system list. There are additional edits that will post if the rendering provider on the claim is not enrolled and/or not allowed for that procedure.

The referring provider required indicator on the procedure code file that specifies when a rendering is required is intended to ensure for certain procedures that when a billing provider is a group, the individual practitioner gets reported on the claim as the rendering. The procedure code file also contains which provider types are allowed for that procedure. Generally, for encounters we apply the edit 0367 a bit more broadly than for FFS by looking also at the rendering provider when the billing provider type isn't one of the allowed for that procedure, and if the rendering provider is one of the allowed types on the procedure code file, the edit will not post. The edit 0412 simply says that the rendering provider indicator is S or B, the rendering provider has to be on the claim and on our provider master database. However, the system bypasses this exception if the billing provider type is equal to the billing provider type on system list "4542" (Billing Provider Types). So, for example: H0001 has the referring provider required indicator on the reference database associated with the line item procedure code on the claim equal to 'S' (Rendering) and H0001 allows PT 313 and 343. Since both PTs are on system list 4542, this means that the rendering provider is not required to be on the claim.

The state will supply the system list to the MCOs for their use in editing. Changes to these lists occur very infrequently.

The description for the following exceptions are provided for the MCO's reference as these errors are the most frequently experienced. Refer to above chart to see if the exception is set to deny or just pay and report.

Claim Exception Cd	Exception Short Desc	Exception Description
0032	E-PROVIDER/CLAIM TYPE CONFLICT	The claim has been assigned a claim type of Practitioner, but the Billing Provider Type Code is not on system list 4960 (Provider Types allowed on Clm Ty P) (**Note:** this condition occurs when a claim with a Batch Type of HCFA is assigned a claim type of Practitioner by default). OR The claim has been assigned a claim type of Outpatient ('O')_ or MCARE Part B Xover ('C'), first Date Of Service (DOS) is greater than or equal to the Centennial Care Implementation date (PARM 0100 Subsystem H) and Billing Provider Type is not one of the Outpatient provider types (201, 202, 203, 204, 205, 221, 313, 314, 315, 364, 447). OR The claim has been assigned a claim type of Long Term Care ('N'), first Date Of Service (DOS) is greater than or equal to the Centennial Care Implementation date (PARM 0100 Subsystem H) and Billing Provider Type is not one of the LTC provider types (211, 212, 213, 214, 215, 216, 217, 218, 219).
0051	E-SUM OF ACCM DYS NOT=TOT DYS	The sum of the submitted units for all the claim revenue codes that match the revenue codes on system list "4490" (Accommodation Revenue Codes) does not equal the covered days. The system uses the first date of service to access the correct list of accommodation revenue codes. If the provider rate type is DRG, the system uses the last date of service instead of the first date of service. A rate type of DRG is identified by the base rate source code of "DO" (Outlier), "DS" (Standard,) or "DT" (Transfer). The system bypasses this exception if a revenue code of "720" – (Labor Room/Delivery General Classification) is present on any of the claim lines and the sum of the claim line submitted units for the accommodation revenue codes is less than the covered days.
0058	E – PAT STAT/ TYPE BILL CONFLI	The claim header paitent status code conflicts with the claim header type of bill as follows: The last character of type of bill is "1" (Admit Thru Discharge Claim) or "4" (Interim Billing – Last Claim) and the patient status is "30" (Still a Patient), "31" (Still a Patient, State- Assigned) or "32" (Still a Patient, Waiting Placement). OR The last character of type of bill is "2" (Interim Billing – First Claim) or "3" (Continuing Claim) and the patient status is not "30" (Still a Patient), "31" (Still a Patient, State- Assigned) or "32" (Still a Patient, Waiting Placement).
0072	E – ACCOM REV CODE MISSING	The claim does not contain a line item with a revenue code equal to any of the revenue codes found on system list "4490" (Accommodation Revenue Codes). The system bypasses this exception when the revenue code is equal to "0720" (Labor Room/delivery General Classification) and the last date of service minus the first date of service equals one.
0077	E –SERV DATE SPAN MORE ONE DOS	The procedure span days indicator is set to "N" (No) indicating the dates of service cannot span days. AND The claim line first date of service does not equal the claim line last date of service.
0097	Plan Payment Missing/Invalid	The encounter claim or line has a MC paid amount = zero and the procedure pricing code is not "00" (Zero Pricing (Not Covered)) or 04 Bundled Pricing. Bypass edit 0097 for Centennial Care encounter if: 2. Header Pricing Methodology code (C-PRCNG-PROCESS-CD) is '00' or '04', or 3. Billing Provider Type (C-BLNG-PROV-TY-CD) equal to 211 or 212

Claim Exception Cd	Exception Short Desc	Exception Description
		and (Value Code (W1C40521-C-VALU-CD (n)) = '23' and Value Code Amt (W1C41521-C-UB92-VALU-CD-AMT (n)) > $0;) or 4. Line Item Prior Payment Amount (C-COB-PYR-PYMT-AMT (n)) is > $0 OR c.d. if the Copay, NF Patient Liability or TPL reported in the claim exceeds 25% of the billed charges.
0105	E-DUPE INPATIENT/OUTPATIENT	This edit is posted at the header level of inpatient claims and at the line level of outpatient claims when the client IDs are equal, the billing provider numbers are equal, and the line first date of service or line last date of service of the outpatient claim equals the first date of service of the inpatient claim or the line first date of service or the line last date of service of the outpatient claim equals the last date of service of the inpatient claim.and the last digit of the type of bill on the inpatient claim is 1 (admit) or 4 (last claim). This edit is posted to all outpatient claims in process (if the above criteria are met). The edit is posted to Inpatient claims only when the associated outpatient claim already has been paid. During the adjudication cycle, the system performs special processing for each inpatient claim that has exception 0105 posted. An adjustment request is generated for the conflict outpatient claim with an adjustment reason = "550" resulting in a claim credit to the outpatient claim. We are requesting that the '550' process (process that recoups an earlier paid oupt claim based on the setting of certain dupe exceptions) work for encounters also. Secondly, we want to add a bypass exception to the edit as follows: Bypass If the Outpatient encounter claim revenue code is between 0300 and 0349 and diagnosis code on the outpatient claim is different from the admitting diagnosis on the inpatient claim.
0109	E- SURGERY FOLLOW-UP CVRS SVC	The follow-up service billed should have been part of the surgery billing. The following conditions must be true when comparing a current and previously paid claim: This edit posts when a medical procedure code for a follow-up office visit per system list "4599" is billed within the span of days between the first date of service and the follow-up date of another claim with a surgical procedure, the rendering provider numbers are equal, and the first three digits of the primary diagnosis codes are equal (practitioner claims only). The follow-up date is calculated by adding the post-op days from the Reference database to the line item procedure's first date of service.
0112	E- DOS CANNOT SPAN MONTHS	The claim header first date of service month is not equal to the claim header last date of service month. OR The claim header first date of service year is not equal to the claim header last date of service year. Only the following billing provider types apply to this edit: • "211" (Nursing Facility, Private) • "212" (Nursing Facility, State) • "213" (Hospital, Swing Bed) • "214" (ICF MR Private) • "215" (ICF MR State Owned) • "216" (Residential Treatment Center – JCAHO) • "217" (Residential Treatment Center – Not JCAHO) • "218" (Treatment Foster Care Services) • "362" (Hospice) • "705" (PACE) For hospice claims (claim type = "H"), the system bypasses this exception unless one of the claim's revenue codes is "0658" or "0659."

Claim Exception Cd	Exception Short Desc	Exception Description
0113	E – ADMIT/FROM DATE CONFLICT	The admission date is greater than the first date of service.
0114	E- ADMIT SOURCE MISSING/ INVAL	The source of admission is missing from the claim. OR The source of admission is present on the claim, but it is not a valid value.
0132	E – SUBD CHARGE IS MISSING	The line item submitted charge is missing. The edit is bypassed if the procedure code is on system list 4751 (Bypass Procs for Edit 0132). The edit posts to the line for all claim types.
0147	E – ADMIT TYPE INVALID	Inpatient Claims: The admit type is not a valid value or is equal to spaces. Outpatient Claims: The admit type is greater than spaces and is not a valid value.
0157	E-LINE COUNT IS INVALID	The claim line item count is zero or the claim line item count is greater than maximum number of line items on the claim.
0160	E – TOTAL CLAIM CHARGE CONFLIC	The sum of the line item submitted charges is not equal to the total submitted charges or the sum of the line item non-covered charges is not equal to the total non-covered charges. The total submitted charges and total non-covered charges are keyed on the line item of the claim associated with revenue code “0001.” The sum of the line item submitted charges does not add up to the total claim charge
0182	E-MISS/INVALID CVD/NON DAYS	The through date of service minus the from date of service must be within three days of the covered days plus the non-covered days – if patient status equals 30 one day is added, otherwise the edit will post. If it’s an Encounter claim with Claim Type N, Billing Provider Type ‘211’ or ‘213’, and if any claim line contains a therapy revenue code of 0420-0449, then the exception will be bypassed. This applies to both inpatient claims and long term care claims (in our system claim types I or N. If you see the claim type assignment chart, you'll see the TOB 86x is classified as long term care
0185	E- HOSPICE SUB UNT GRT TOT DYS	The patient status on the claim is equal to “30” (Still patient) and the line item submitted units of service associated with revenue code “0658” or “0659” is greater than the statement through coverage date minus statement from coverage date plus one. OR The patient status on the claim is NOT equal to “30” (Still patient) and the line item submitted units of service associated with revenue code “0658” or “0659” is greater than the statement through coverage date minus statement from coverage date
0205	E – REFERRING PROV REQUIRED	The referring provider required indicator on the reference database associated with the line item procedure code on the claim is equal to “Y” (Yes) and the line item referring provider on the claim is blank
0239	OPPS OBSERV STAY 23 HOUR LIMIT	The claim is an OPPS claim, the procedure code = G0378 (HOSPITAL OBSERVATION SERVICE, PER HOUR) and the submitted units are greater than the service maximum allowed units on the OPPS procedure pricing span. The OPPS procedure pricing spans are identified as those on the Procedure Pricing Span table which have a Factor Code = ‘Y’. An OPPS claims is defined as: 1. Header Date of service greater than or equal to the OPPS effective start date on parameter 4840 for FFS claims or parameter 4841 for Encounter claims. 2. Claim Type = ‘O’ or ‘C’

Claim Exception Cd	Exception Short Desc	Exception Description
		3. Type of Bill = '13X' or '83X' 4. Provider Type = '201' or '203
0263	Crossover Claim – No Medicare on File	
0261	CLIENT IS MEDICARE PART C ELIGIBLE	The client database indicates that the client has Medicare Part C coverage for the claim dates of service and there is no attachment code "59." This edit is bypassed for the following reasons: 1. If attachment code "74" is present on the claim, or the claim contains a CAS Reason that is present on system list 4811 for the Medicare payor (MA, MB or 16). 2. The claim type is "S" (Medical Supply) AND the POS is "21" (Inpatient), "31" (Skilled Nursing Facility), "32" (Nursing Facility), "55" (Residential Substance Abuse Treatment Center), or "56" (Psychiatric Residential Treatment Center). 3. The provider type on the claim is "313" (FQHC) and the procedure code is "YE010," "YE011," "YE012," "YE013," "YE014," or "YE015." 4. Provider type "435" (LPCC), "436" (LMFT), "443" (CNS), or "444" (LISW). 5. Note for Outpatient claims: This edit is bypassed for a line, if the revenue code on that line is present on the system list ("4733"). Edit revision to bypass if the Medicare coverage code on the procedure formulary file doesn't indicate the code is covered. Edit needs revision for encounters – For Encounters, The client database indicates the client has Medicare Part C coverage for the claim dates of service but the C-COB-FLN-IND-CD IS NOT EQUAL TO MA, MB OR MI
0264	E-CLIENT IS MCARE PT A ELIGIBL	The client database indicates that the client has Medicare Part A coverage for the claim dates of service and there is no attachment code "59." The edit is bypassed if attachment code "74" is present on the claim, or the claim a CAS Reason that is present on system list 4811 for the Medicare payor The client database indicates that the client has Medicare Part A coverage for the claim dates of service but the C-COB-FLN-IND-CD IS NOT EQUAL TO MA OR MI
0265	E-CLIENT IS MCARE PT B ELIGIBL	The client database indicates the client has Medicare Part B coverage for the claim dates of service and the procedure code has Medicare Part B coverage, but there is NO attachment code "59." OR The claim is an outpatient claim and the client database indicates the client has Medicare Part B coverage for the claim dates of service, but there is NO attachment code "59." Note for Outpatient claims: This edit is bypassed for a line, if the revenue code on that line is present on the system list ("4733") of revenue codes that are to bypass edit 0265. OR The claim is an inpatient Part B only non-crossover claim and the client does – have Medicare Part B coverage and the type of bill is NOT equal to "121," "122," "123," "124," "821," "823," or "824." This edit is bypassed for the following reasons: 1) The claim type is "S" (Medical Supply) AND the POS is "21" (Inpatient), "31" (Skilled Nursing Facility), "32" (Nursing Facility), "55" (Residential Substance Abuse Treatment Center), or "56" (Psychiatric Residential Treatment Center). 2 3) Provider type "435" (LPCC), "436" (LMFT), "443" (CNS), or "444" (LISW). 4) Attachment code "70" or "74" is present on the claim. 5) Claim contains a CAS Reason that is present on system list 4811 for the Medicare payor.

Claim Exception Cd	Exception Short Desc	Exception Description
		Edit needs revision for encounters – For Encounters, The client database indicates the client has Medicare Part B coverage for the claim dates of service and the procedure code has Medicare Part B coverage, but the C-COB-FLN-IND-CD IS NOT EQUAL TO MB OR MI This edit is bypassed for a line, if the revenue code on that line is present on the system list ("4733") of revenue codes that are to bypass edit 0265. OR The claim is an outpatient claim and the client database indicates the client has Medicare Part B coverage for the claim dates of service, but the C-COB-FLN-IND-CD IS NOT EQUAL TO MB OR MI This edit is bypassed for a line, if the revenue code on that line is present on the system list ("4733") of revenue codes that are to bypass edit 0265. OR The claim is an inpatient Part B only non-crossover claim and the client does have Medicare Part B coverage and the type of bill is NOT equal to "121," "122," "123," "124," "821," "823," or "824." RETAIN ADDITIONAL BYPASS CRITERIA
0313	CAT OF SERV CANNOT BE DETERMIN	Inpatient, Medicare Part A Crossover, Long Term Care Claims: The claim category of service cannot be determined from the rules in the category of service determination table. All Other Claim Types: The line item category of service cannot be determined from the rules in the category of service determination table.
0314	Inpatient Services Not Payable for Presumptive Eligibility	Inpatient Claim Types: The client's category of eligibility is equal to "035" (Preg WM FM 3 Presumptive Elig), and the Federal Match code is equal to "3" (100% FFP, Preg Presmpt, SCHIP). Physician Claim Types: The client's category of eligibility is equal to "035" (Preg WM FM 3 Presumptive Elig), and the Federal Match code is equal to "3" (100% FFP, Preg Presmpt, SCHIP), and the place of treatment is equal to "21" (Inpatient). Modiy to add COEs 300 and 301 where fed match = 3
0322	Servicing Facility NPI for School Based Health Centers Missing/Invalid	The new edit would deny a claim where the billing provider type is 321 and a Servicing Facility NPI id has not been submitted on the claim, or the Servicing Facility NPI id has been submitted but does not match an enrolled provider with a status of '60' or '70' and dates that cover the dates of service on the claim/encounter.
0331	NO LTC SPAN AVAIL FOR FRST DOS	If the Provider Type is 211 or 212 and the admit date is greater than 120 days less than the last date of service. If not true, then bypass edits 0331, 0709 and 0336 since LTC spans are not required for these claims If true, then check for a non-voided LTC span where the span begin date is <= the Claim LDOS and the span end date >= claim FDOS where the Level of Care of 'NFL' and Setting of Care of 'INF' (WV-B0457-C-NURSING-FACILITY). If not found, then post the exception 0331. If found, then confirm that the span begin date <= FDOS. If not, then post exception 0331. If the span begin date is <= FDOS, then continue to exception 0709. If the Provider Type is 362 and Revenue Code is 0658 or 0659 and the admit date is greater than 120 days less than the last date of service If true, then check for a non-voided LTC span where the span begin date is <= the Claim LDOS and the span end date >= claim FDOS where the Level of Care of 'NFL' and Setting of Care of 'INF'.

Claim Exception Cd	Exception Short Desc	Exception Description
		If not found, then post the exception 0331. If found, then confirm that the span begin date <= FDOS. If not, then post exception 0331. If the span begin date is <= FDOS, then continue to exception 0709. If the Provider Type is 363 If true, then check for a non-voided LTC span where the span begin date is <= the Claim LDOS and the span end date >= claim FDOS where the Level of Care of 'NFL' and Setting of Care of 'ANW', 'SNW', 'ADB', or 'SBD'. If not found, then post the exception 0331. If the client's Setting of Care is 'INF' that covers the dates of service and procedure code is T2038 or S5165 then bypass posting exception edit 0331. If found, then confirm that the span begin date <= FDOS. If not, then post exception 0331. If the span begin date is <= FDOS, then continue to exception 0709. For hospice claims, the system bypasses this exception unless the revenue code is "0658" or "0659."
0333	LVL CRE NOT AUTH BY LTC SPAN	Long Term Care (LTC) Claims: The claim level of care submitted in the HCPCS/Rate code field is invalid when compared to the client LTC span level of care code. 1. The line item revenue code is equal to "0190." 2. If the provider type is equal "217" (RTC) or "216" (A-RTC) and the claim submitted level of care is greater than the client LTC span level of care (within that provider's level of care values). Valid level of care codes for each are: • "217" (RTC): TR1, TR2, TR3, TR4 • "216" (A-RTC): AR3, AR4, AR5 3. For all other provider types, including Nursing Home, MR, and TFC, the claim submitted level of care is NOT equal to the client LTC span level of care. Hospice Claims: 1. If the line item revenue code is equal to "0658," then the client LTC span level of care must equal "LNF." 2. If the line item revenue code is equal to "0659," then the client LTC span level of care must equal "HNF." Edit revision to be 285nclude285 to managed care – For encounters, if PT = 211 or 212, the LTC span Level of Care NFL with SOC INF must cover DOS OR if PT = 363, Level of Care NFL with SOC ADB, SDB, ANW, SNW must cover DOS.
0338	Service Not Payable For LTC Client	The procedure code LTC indicator is "Y" (indicating that the service is covered by LTC). AND The client LTC span covers the claim line item dates of service (indicating that the client was in an LTC facility during the service period). AND The provider's level of care on the client LTC span is equal to "HNF," "LNF," "MR1," "MR2," or "MR3" (the other additional LOC values indicate that the client is in a Treatment Care Facility and for which the edit should NOT post). AND The procedure code modifiers do not equal "U1".

Claim Exception Cd	Exception Short Desc	Exception Description
		Modify to read "AND The provider's level of care on the client LTC span is equal to "NFL" with Setting of Care = 'INF" or LOC is "MR1," "MR2," or "MR3"
0340	PT NOT ELIG FOR LTC DUE TO TRA	The claim's primary category of eligibility is "001", "003", "004", "081", "083", "084" and the associated federal match code is equal to "X" or "4" (Restricted SSI).
0363	E - PROC/MOD 1 CONFLICTING	The procedure code modifier include/exclude code on the reference database is equal to "I" (Include) and the claim's first procedure code modifier on the line item does not match any of the procedure code modifiers listed on the reference database. OR The procedure code modifier include/exclude code on the reference database is equal to "E" (Exclude) and the claim's first procedure code modifier on the line item matches a procedure code modifier listed on the reference database. If the reference database does not contain a procedure code modifier, then this exception is bypassed. If the modifier value on the claim matches a modifier on system list "4651" (Bypass Procedure Modifiers), this edit is bypassed. If the claim is an OPPS claim, then this exception is bypassed. An OPPS claim has the following attributes: Claim Type O or C, Type of Bill 013X or 083X, Billing Provider Type '201' or '203', and Header First Date of Service on or after Date Value on System Parameter 4840 for FFS and System Parameter 4841 for Encounter claims. The procedure code modifier include/exclude code on the reference database is equal to "I" (Include) and the claim's first procedure code modifier on the line item does not match any of the procedure code modifiers listed on the reference database. OR the procedure code modifier include/exclude code on the reference database is equal to "E" (Exclude) and the claim's first procedure code modifier on the line item matches a procedure code modifier listed on the reference database. If the reference database does not contain a procedure code modifier, then this exception is bypassed. If the modifier value on the claim matches a modifier on system list "4651" (Bypass Procedure Modifiers), this edit is bypassed. If the claim is an OPPS claim, then this exception is bypassed. An OPPS claim has the following attributes: Claim Type O or C, Type of Bill 013X or 083X, Billing Provider Type '201' or '203', and Header First Date of Service on or after Date Value on System Parameter 4840 for FFS and System Parameter 4841 for Encounter claims.
0341	REFERRING NPI REQUIRED	The Referring NPI is not present on the claim, and the Medicaid provider's "Healthcare Provider" flag is equal to 'Y'. If the Referring Provider Medicaid ID is spaces, the edit is bypassed
0362	E-TOOTH SURFACE REQUIRED	The tooth surface required indicator on the procedure record is equal to tooth surface required, and none of the six tooth surfaces on the line item have a value other than spaces. OR The tooth surface required indicator on the procedure record is equal to tooth surface required, the procedure code is equal to D1351 and the tooth surface is not O-Occlusal, OB (Occlusal-Buccal) or OL (Occlusal-Lingual).
0364	E- PROC/TOOTH/QUAD NBR CNFL	The tooth number include/exclude code on the reference database associated with the line item procedure code on the claim is equal to "I" (Include) and the line item tooth number on the the claim is not equal to any of the tooth numbers included on the reference database. OR The tooth number include/exclude code on the reference database

Claim Exception Cd	Exception Short Desc	Exception Description
		associated with the line item procedure code on the claim is equal to "E" (Exclude) and the line item tooth number on the the claim is equal to one of the tooth numbers excluded on the reference database.
0367	BILL PROV REVIEW FOR TYPE/PROC	All Claim Types: This edit will be bypassed for all encounter claims whose procedure code is found on general system list 4774. This edit will also be bypassed if the procedure code modifier is 'AS', the rendering provider type is '305', '306', '316', '320', '322' or '323', and the procedure code is within range 11000-69999. All Non-Inpatient UB-04 Claim Types: The provider type include/exclude code on the reference procedure code database is equal to "I" (Include) and the billing provider type on the claim does NOT match any of the provider types listed on the reference procedure code database. OR The provider type indicator on the reference procedure code database is set to "E" (Exclude) and the billing provider type on the claim matches a provider type listed on the reference procedure code database. This edit is not executed for Inpatient Claims **Note:** If the reference database does not contain a provider type, this exception is bypassed. The edit will also be bypassed for OPPS claims. An OPPS claim has the following attributes: Claim Type O or C, Type of Bill 013X or 083X or 851, Billing Provider Type '201' or '203', and Header First Date of Service on or after Date Value on System Parameter 4840 for FFS and System Parameter 4841 for Encounter claims. In addition, the edit will be bypassed when Outpatient (Claim Type O) and the Billing Provider Type is 313 (FQHC). All Other Claim Types: The provider type include/exclude coded on the reference procedure code database is equal to "I" (Include) and the rendering provider type on the claim does NOT match any of the provider types listed on the reference procedure code database. OR The provider type include/exclude code on the reference procedure code database is equal to "E" (Exclude) and the rendering provider type on the claim matches a provider type listed on the reference procedure code database. **Note:** If the reference procedure code database does not contain a provider type, this exception is bypassed. **Note:** ForAll HCFA (Professional) Claim Types: The rendering provider's type is used first for this edit. If edit would post based on the rendering provider's type, then the billing provider's type code is used, if the procedure code is found on system list "4547" (Procedures that can use either Rendering or Billing Provider Type/Specialty). **Note:** ForAll CMS-1500 Claim Types: The edit is bypassed if the billing provider is found on system list 4775 and the procedure code is found on system list 4776 (H0043 AND H0044).

Claim Exception Cd	Exception Short Desc	Exception Description
		Note: ForAll Encounter HCFA (Professional) and Encounter Dental Claim Types: The rendering provider's type is used first for this edit. If edit would post based on the rendering provider's type, then the billing provider's type code is used. For All Encounters: The edit is bypassed when the provider type is 221, 314, 315 and the MCO Paid Amount on the line is 0.
0368	BILL PROV REVIEW FOR TYPE/REV	The provider type include/exclude code on the reference revenue code database is equal to "I" (Include) and the billing provider type on the claim does NOT match any of the provider types listed on the reference revenue code database. OR The provider type indicator on the reference revenue code database is set to "E" (Exclude) and the billing provider type on the claim matches a provider type listed on the reference revenue code database. Note: If the reference revenue code database does not contain a provider type, this exception is bypassed.
0372	E- PROC/CLM TYPE CNFL	The procedure claim type include/exclude code on the reference database is equal to "I" (Include) and the claim type on the claim does not match any of the claim types listed on the reference database. OR The procedure claim type include/exclude code on the reference database is equal to "E" (Exclude) and the claim type on the claim matches a claim type listed on the reference database. If the reference database does not contain a claim type, then this exception is bypassed. The edit will also be bypassed for OPPS claims. An OPPS claim has the following attributes: Claim Type O or C, Type of Bill 013X or 083X, Billing Provider Type '201' or '203', and Header First Date of Service on or after Date Value on System Parameter 4840 for FFS and System Parameter 4841 for Encounter claims.
0373	E-REV/TYPE OF BILL CNFL	The revenue type of bill include/exclude code on the reference database is equal to "I" (Include) and the type of bill on the claim does not match any of the type of bill values listed on the reference database. OR The revenue type of bill include/exclude code on the reference database is equal to "E" (Exclude) and the type of bill on the claim matches a type of bill value listed on the reference database. If the reference database does not contain a type of bill, then this exception is bypassed.
0376	E-PROC REQUIRES MODIFIER	The procedure code modifier required indicator on the reference database is equal to "Y" (Yes) and both line item procedure code modifiers on the claim are equal to spaces or zeroes
0386	Proc Code Exists on ABP System List 4755	post to the claim line, if the procedure code is included in system list 4755 – PROC CODES INCLUDED IN ABP - LIST TWO. The edit will bypass: If the claim's primary COE is equal to "100" and the recipient's disability indicator is set to <spaces> OR If the claim's primary COE is equal to "030", "035", "300" or "301" OR If the recipient is under 21

Claim Exception Cd	Exception Short Desc	Exception Description
0388	E-FQHC PROV CANT BILL X-OVER	The billing provider type is "313" (Clinic Federally Qualified Health Center). Note: Only applies to crossover claims (Controlled via Exception Disposition Table).
0412	E-REND/DEST NOT ON DATA BASE	If the referring provider required indicator on the reference database associated with the line item procedure code on the claim is equal to 'S' (Rendering) or 'B' (Both); the rendering provider is required on the claim. This edit posts if the rendering provider number if present on the claim does not have a corresponding row on the provider master database. The system bypasses this exception if the billing provider type is equal to the billing provider type on system list "4542" (Billing Provider Types).
0422	RENDERING PROV NOT ENROLLED	The edit posts if both of the following conditions are NOT true: • The line item last date of service is encompassed by the rendering provider enrollment span dates. • The rendering provider enrollment status is equal to "60" (Active). This edit logic is bypassed if the billing provider type is equal to the billing provider type on system list "4542" (Billing Provider Types). Add that the rendering provider enrollment status can be = '70' or '60' for encounters
0425	E-PROV NOT A VALID BILL PROV	This edit determines if the billing provider is not allowed to submit claims. The edit posts if the Billing Provider Code is equal to "S" (Service Only – No Claims).
0496	CLAIM NOT SUBMITTED WITHIN THE TWO YEAR FILING PERIOD	Remove Encounter bypass logic
0497	TIMELY FILING-RVW GRACE PERIOD	The adjustment or resubmission claim was not received within the filing grace period. For adjustments, the edit will post when the replacement claim was not received within 90 days of the replaced TCN's paid date and the replaced TCN was timely as defined in edit 0815/0820.
0596	E – DIAGNOSIS RELATED CODE INV	The line item first, second, third, fourth, fifth, sixth, seventh, or eighth diagnosis related code is not a valid value, references a diagnosis code that is equal to spaces, or is repeated in another related diagnosis field on the same line.
0709	LTC SPAN ENDS BEFORE LAST DOS	The LTC end date is before the claim last date of service or the LTC discharge date (date associated with occurrence code "42") is before the claim last date of service. The system bypasses this exception if the discharge date or LTC end date one day prior to the last date of service and the claim frequency code is "1" (Admission Through Discharge) or "4" (Interim Billing – Discharge Clm). For hospice claims, the system bypasses this exception unless the revenue code is "0658" or "0659." (Rev Codes 0658/0659 should only be used with clients who have a NFL/INF span in place)
0778	Suspect Duplicate Home Health and Waiver Claim	For Centennial Care, modify this exception to post for encounters when claim type V compares to claim with Provider Type 363 where 1. Both claims have the same client ID. (B_SYS_ID) 5. Both claims have the same dates of service or the dates of service overlap. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT). 3. The Community Benefit claim's procedure code is the Waiver system list (4728)
0900	MCARE DENIED FOR ADMIN RSNS	Medicare denied because the amount paid was zero and one of the following administration reasons is on system list 4810
0901	NON MCARE DENIED FOR ADMIN RSN	Other (non-Medicare payer) denied because the amount paid was zero and one of the following administrative reasons is on system list 4810
0905	PART B ONLY AND TOB IS NOT 12X	The client is covered by part B only (C_CLNT_MCARE_CD is equal to "B") and Bill type is equal to "11X".

Claim Exception Cd	Exception Short Desc	Exception Description
0956	ORAL CAVITY REQUIRED	If the procedure code indicates that an oral cavity is required and the field is spaces or not a valid value (please refer to OmniAdd for a list of the valid values), the exception 'Oral cavity required' is posted
0957	PROC/ORAL CAVITY CONFLICT	The oral cavity include/exclude code on the reference database associated with the line item procedure code on the claim is equal to "I" (Include) and the line item oral cavity on the the claim is not equal to any of the oral cavity values included on the reference database. OR The oral cavity include/exclude code on the reference database associated with the line item procedure code on the claim is equal to "E" (Exclude) and the line item oral cavity on the the claim is equal to one of the oral cavity values excluded on the reference database.
1160	No Health Plan Entry for DOS for CC Plan	DOS are not covered by a lockin span for the MCO submitting the encounter Encounter edit that replaces edits 1150, 1151, and 1152
1274	PATIENT STATUS CLIENT DATE OF DEATH CONFLICT	The patient status on the claim is equal to "20" (Expired), and the date of death on the client master database is not present

Pharmacy Claims Exception Errors

The following codes are all set to deny for encounters.

EXC_CD	DISP	SHORT_DESC	LONG_DESC
4001	Deny	M/I BIN	THE BIN NUMBER IS MISSING OR DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED BELOW. 610084 OR 007060 OR 009555 OR 007912
4002	Deny	M/I VERSION NUMBER	THE VERSION NUMBER IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD
4003	Deny	M/I VERSION NUMBER	THE VERSION NUMBER IS NOT ONE OF THE VERSIONS THAT THE CUSTOMER ACCEPTS FOR PROCESSING.
4004	Deny	M/I TRANSACTION CODE	THE TRANSACTION CODE IS MISSING (ZEROS) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD IN VERSION 3.2.
4005	Deny	M/I TRANSACTION CODE	THE TRANSACTION CODE IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD IN VERSION 5.1.
4006	Deny	M/I TRANSACTION CODE	THE TRANSACTION CODE IS NOT ONE OF THE TRANSACTION CODES IN VERSION 3.2 OR 5.1 THAT THE CUSTOMER ACCEPTS FOR PROCESSING.
4007	Deny	M/I PROCESSOR CONTROL NUMBER	M/I PROCESSOR CONTROL #DRRXTEST = TESTDRRXPROD = PRODUCTIONDRRXACCP = ACCEPTANCE
4009	Deny	M/I PHARMACY NUMBER	THE PHARMACY PROVIDER ID DOES NOT EXIST ON THE PROVIDER MASTER TABLE.
4010	Deny	M/I CARDHOLDER ID	THE MEMBER ID IS MISSING OR EQUAL SPACES.
4011	Deny	M/I CARDHOLDER ID	THE MEMBER ID IS MISSING (ZERO).

4012	Deny	M/I BIRTHDATE	MSG NOT FOUND
4013	Deny	M/I BIRTHDATE	MSG NOT FOUND
4014	Deny	M/I BIRTHDATE	NOT USEDDOB ON CLAIM MUST BE WITHIN ONE YEAR OF PARTICIPANT'S ACTUAL DOBBE/MA
4019	Deny	M/I OTHER COVERAGE CODE	THE OTHER COVERAGE CODE IS MISSING OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4023	Deny	M/I DATE OF SERVICE	ANYTHING ELECTRONIC IS DENIED. ANY PAPER CLAIM IS REVIEWED.
4025	Deny	M/I PRESCRIPTION/SERVICE REFER	IF PRESCRIPTION NUMBER IS MISSING (ZEROS) OR NOT NUMERIC - THEN POST THE ERROR.
4027	Deny	M/I FILL NUMBER	IP REFILL INDICATOR (FILL NUMBER) IS EQUAL TO ZEROSOR(IP REFILL INDICATOR (FILL NUMBER) IS GREATER THAN ZEROSANDIP PROVIDER NUMBER EQUALS HISTORY PROVIDER NUMBERANDIP PRESCRIPTION NUMBER EQUALS HISTORY PRESCRIPTION NUMBERANDIP GSN EQUALS HISTORY GSN ANDIP DATE PRESCRIBED EQUALS HISTORY DATE PRESCRIBED)
4028	Deny	M/I FILL NUMBER	THE PRESCRIPTION REFILL NUMBER (FILL NUMBER) IS NOT NUMERIC.
4030	Deny	M/I DAYS SUPPLY	M/I DAYS SUPPLY
4033	Deny	M/I COMPOUND CODE	EDIT POSTED IF NOT 0 - 1 - 2NOTE: COMPOUNDS (VALUE 2) ACCEPTED IN 5.1
4034	Deny	M/I PRODUCT/SERVICE ID	THE NATIONAL DRUG CODE (NDC) IS MISSING - NON-NUMERIC - OR ALL ZEROS.
4037	Deny	M/I DISPENSED AS WRITTEN CODE	THE DISPENSE AS WRITTEN DAW/PRODUCT SELECTION CODE DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4039	Deny	M/I PRESCRIBER IDENTIFICATION	THE PRESCRIBER ID IS MISSING (SPACES).
4040	Deny	M/I PRESCRIBER IDENTIFICATION	PRESCRIBER WRITING PRESCRIPTION FOR SCHEDULE II,III,IV AND V DRUG MUST HAVE A VALID DEA# ON FILE
4042	Deny	M/I PRESCRIBER IDENTIFICATION	THE PRESCRIBER ID QUALIFIER IS EQUAL TO DEA AND THE FIRST TWO POSITIONS OF THE PRESCRIBER PROVIDER ID ARE NOT ALPHANUMERIC ORTHE PRESCRIBER ID QUALIFIER IS EQUAL TO DEA AND THE LAST SEVEN POSITIONS OF THE PRESCRIBER PROVIDER ID DO NOT PASS THE CHECK SUM VALIDATION ROUTINE.
4043	Deny	M/I DATE RX WRITTEN	THE DATE PRESCRIPTION WRITTEN IS MISSING OR INVALID
4044	Deny	M/I DATE RX WRITTEN	THE CLAIM DATE PRESCRIBED IS LESS THAN THE DATE THE PARTICIPANT ELIGIBILITY ON THE PARTICIPANT MEMBER TABLE BEGAN MINUS 30 DAYS OR THE CLAIM DATE PRESCRIBED IS GREATER THAN THE DATE THE PARTICIPANT ELIGIBILITY ON THE PARTICIPANT MEMBER TABLE ENDED.

4045	Deny	M/I DATE RX WRITTEN	THE DRUG IS A SCHEDULE II DRUG AND THE NUMBER OF DAYS SINCE THE DATE PRESCRIBED IS MORE THAN 30 DAYS PRIOR TO THE FIRST DATE OF SERVICE
4067	Deny	M/I PA/MC CODE AND NUMBER	EDIT IGNORED
4067	Deny	M/I PRESCRIPTION ORIGIN CODE	MEDICAID DOES NOT ACCEPT THE DEFAULT ORIGIN CODE
4074	Deny	M/I COORDINATION OF BENEFITS/O	MISSING/INVALID COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT - 5.1 ONLYA COB SEGMENT IS PRESENT AND THE COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT IS MISSING (ZEROS).
4075	Deny	PHARMACY NOT CONTRACTED WITH P	THE DATE OF SERVICE DOES NOT FALL WITHIN THE DATE RANGE ON THE PROVIDER NETWORK TABLE THAT THE PROVIDER WAS ELIGIBLE TO PROVIDE SERVICES.ORTHE DATE OF SERVICE DOES FALL WITHIN THE DATE RANGE ON THE PROVIDER NETWORK TABLE THAT THE PROVIDER WAS ELIGIBLE TO PROVIDE SERVICES FOR THE PLAN BUT THE NETWORK WAS NOT VALID FO
4075	Deny	PHARMACY NOT CONTRACTED WITH P	PHARMACY NOT ON FILE - PHARMACY NOT CONTRACTED WITH PLAN ON DATE OF SERVICE. FOR ENROLLMENT OR STATUS ISSUES REFER PHARMACY TO ACS ALBUQUERQUE AT 800-299-7304 EXT 193.
4078	Deny	M/I OTHER PAYER COVERAGE TYPE	THE OTHER PAYER COVERAGE TYPE (COB HEIRARCHY) IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4079	Deny	M/I OTHER PAYER REJECT COUNT	A COB SEGMENT IS PRESENT AND THE OTHER PAYER REJECT COUNT IS MISSING.
4081	Deny	NON-MATCHED PHARMACY NUMBER	THE SERVICE PHARMACY PROVIDER ID DOES NOT EXIST ON THE PROVIDER MASTER TABLE.
4082	Deny	NON-MATCHED GROUP ID	B - GROUP RECORD NOT ON FILE
4083	Deny	NON-MATCHED GROUP ID	ACS REQUIRED A - 1ST DATE OF SVC NOT IN RANGE OF THE PLAN ON THE GROUP FILE
4085	Deny	NON-MATCHED GROUP ID	C - MAIL ORDER CLAIM: MAIL ORDER PRICING ID NOT ON THE GROUP FILE.
4086	Deny	NON-MATCHED CARDHOLDER ID	NON-MATCHED MEMBER ID. MEMBER NOT FOUND ON ELIGIBILITY FILE.
4089	Deny	NON-MATCHED NDC #	NON-MATCHED NDC (NOT ON DRUG FILE)
4090	Deny	NON-MATCHED PRESCRIBER IDENTIF	PHYSICIAN LIC# NOT ON FILE (LOCKIN)
4092	Deny	DRUG NOT COVERED FOR PATIENT A	POST IF MINIMUM AGE ON CUSTOM RECORD AND PATIENT IS BELOW THAT AGE AND NO PA EXISTS.11/26 EOB EDIT MOVED FROM EDIT 88
4094	Deny	DRUG NOT COVERED FOR PATIENT G	DRUG NOT COVERED FOR PATIENT GENDER. IF THE DRUG IS SPECIFIED FOR A PARTICULAR GENDER ON THE CUSTOM RECORD AND THE PATIENT IS NOT THAT GENDER AND NO

			PRIOR AUTHORIZATION ON THE MEDICAL PROFILE; THEN POST THE ERROR.
4097	Deny	PATIENT IS NOT COVERED	PATIENT NOT COVERED - CHECKS THE COVERAGE DATA ON THE ELIGIBILITY FILE TO SEE IF THE CLAIM FDOS IS IN RANGE. ALSO CHECKS THE RELATIONSHIP TO DETERMINE IF THE MEMBER IS COVERED AND CHECKS TO SEE IF IT IS A COVERED MEMBER ID. IF NOT COVERED FOR ANY OF THESE REASONS; THEN POST THE ERROR.
4102	Pay&Rpt	NO REBATE FOR NDC PER CMS	DENY THE CLAIM IF THE NDC HAS NO REBATE FOR DATE OF SERVICE, PER CMS. ALSO POSTS IF LABELER HAS NO SIGNED AGREEMENT WITH CMS FOR DATE OF SERVICE, BECAUSE NDC REBATE STATUS IS IRRELEVANT IF LABELER DOES NOT HAVE CMS REBATE CONTRACT.
4103	Deny	PATIENT AGE EXCEEDS MAXIMUM AG	POST IF DRUG HAS A MAXIMUM AGE SPECIFIED ON A CUSTOMER RECORD AND THE AGE OF THE MEMBER EXCEEDS THIS MAXIMUM
4110	Deny	M/I DUR/PPS CODE COUNTER	THE DUR/PPS CODE COUNTER IS MISSING (ZEROS).
4113	Deny	PRODUCT/SERVICE NOT COVERED	A =DESI DRUG(LESS THAN EFFECTIVE DRUG) - NON-REIMBURSABLE
4114	Deny	PRODUCT/SERVICE NOT COVERED	IF THE PRODUCT/SERVICE ID QUALIFIER INDICATES THAT THE PRODUCT/SERVICE ID FIELD CONTAINS A NDC ANDTHE NDC IS A PLAN NON-COVERED DRUG FROM THE BENEFIT LIMIT RANGE TABLEANDNO PREVIOUS PRICING EDITS HAVE BEEN SET FOR THIS CLAIM ANDTHE PLAN BENEFIT LIMIT OVERRIDE PA IS NOT EQUAL TO I (OVERRIDE INITIAL RX).
4115	Deny	PRODUCT/SERVICE NOT COVERED	I= DEFAULT CODE - NOT COVERED ON PLAN
4116	Deny	PRODUCT/SERVICE NOT COVERED	NDC NOT COVERED - REASON CODES:A =DESI DRUGB =NO REBATEC = NOT COVERED ON PLAN FILED =NO VALID PRICING CATEGORY ON GROUP FILE FOR DOS E =NO PRICING ON DRUG FILE FOR DATE OF CLAIMF =NO MAIL-ORDER SERVICE FOR CLIENTG =MAIL-ORDER FOR MAINTENANCE DRUGS ONLYI= DEFAULT CODE - NOT COVERED ON PLAN
4117	Deny	PRODUCT/SERVICE NOT COVERED	NO SIGNED REBATE AGREEMENT (REASON CODE B).
4118	Deny	PRODUCT/SERVICE NOT COVERED	F =NO MAIL-ORDER SERVICE FOR CLIENT
4119	Deny	PRODUCT/SERVICE NOT COVERED	G =MAIL-ORDER FOR MAINTENANCE DRUGS ONLY
4120	Deny	PRODUCT/SERVICE NOT COVERED	D =NO VALID PRICING CATEGORY ON GROUP FILE FOR DOS

4123	Deny	PRODUCT/SERVICE NOT COVERED	REASON CODE E: NO PRICE ON DRUG FILETHE PRODUCT/SERVICE ID QUALIFIER INDICATES THAT THE PRODUCT/SERVICE ID FIELD CONTAINS A NDC AND NO DRUG PRICING DATA FOR THE DRUG WAS IN EFFECT FOR THE CLAIM DATE OF SERVICE.
4125	Deny	PRIOR AUTHORIZATION REQUIRED	STEPCAREIF THE CUSTOMER PARTICIPATES IN STEPCARE ANDTHE DRUG IS NOT COVERED BY THE PLAN OR BY A PA ANDTHE REJECT CODE ON THE STEPCARE RECORD IS 75 ANDTHE NUMBER OF AGENTS TAKEN IS LESS THAN THE NUMBER OF AGENTS REQUIRED ORTHE AMOUNT OF TIME THE DRUGS WERE TAKEN WAS LESS THAN THE THERAPY SPAN REQUIRED.ORIF
4126	Deny	PLAN LIMITATIONS EXCEEDED	STEPCAREIF THE STEPCARE INDICATOR ON THE CUSTOMER AND GROUP TABLES IS EQUAL TO 'Y' ANDTHE DRUG IS NOT COVERED BY THE PLAN OR BY A PA ANDTHE REJECT CODE ON THE STEPCARE RECORD IS 76 ANDTHE NUMBER OF AGENTS TAKEN IS LESS THAN THE NUMBER OF AGENTS REQUIRED ORTHE AMOUNT OF TIME THE DRUGS WERE TAKEN WAS LESS THA
4132	Deny	PA REQUIRED - STATE	PA REQUIRED. CONTACT NEBRASKA MEDICAID AT 877-255-3092
4133	Deny	PRIOR AUTHORIZATION REQUIRED	IF THE DUR AMOUNT LIMIT ACCUMULATOR EQUALS 'ALL'ANDTHE DUR AMOUNT LIMIT TOTAL (A CALCULATED FIELD) IS GREATER THAN THE DUR AMOUNT LIMIT FROM THE PLAN BENEFITS LIMIT TABLE ANDTHE DUR AMOUNT LIMIT STATUS ON THE PLAN'S BENEFITS LIMIT TABLE EQUALS 'P'ANDTHERE IS NO PRIOR AUTHORIZATION INDICATED ON THE CLAIM.
4134	Deny	PRIOR AUTHORIZATION REQUIRED	THE PRIOR AUTHORIZATION USED UNITS PLUS THE CLAIM DRUG QUANTITY IS GREATER THAN THE PRIOR AUTHORIZATION APPROVED UNITS AMOUNT
4140	Deny	PRIOR AUTHORIZATION REQUIRED	IF THE (CUSTOM PLAN MAX UNITS ACCUM IS NOT EQUAL TO N (NONE) ORTHE CUSTOM PLAN MAX UNITS IS NOT EQUAL TO WORK DEFAULT MAX UNITS (99999.999)) AND THE CUSTOM PLAN MAX UNITS ACCUM EQUALS C (ACUTE DOSE ONLY) AND THE CUSTOM PLAN MAINTENANCE CLAIM DOSE LESS THAN WORK DEFAULT DOSE (9999.999) AND THE DAILY DOSE (D
4141	Deny	PRIOR AUTHORIZATION REQUIRED	IF THE CUSTOM PLAN MAX UNITS ACCUM EQUALS A (ALL DOSES) AND THE CLAIM SUBMITTED QUANTITY IS GREATER THAN CUSTOM PLAN MAX UNITS ANDTHE CUSTOM PLAN MAX UNITS STATUS EQUALS P (PA REQUIRED) AND THE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED).

4142	Deny	PRIOR AUTHORIZATION REQUIRED	IF THE CUSTOM PLAN MAX NUMBER OF REFILLS IS NOT EQUAL TO UNLIMITED (999) AND THE PLAN BENEFIT LIMIT OVERRIDE PA EQUALS I (OVERRIDE INITIAL RX) AND THE CLAIM REFILL INDICATOR GREATER 0 ANDTHE CUSTOM PLAN MAX NUMBER OF REFILLS LESS THAN (<) THE CLAIM REFILL INDICATOR ANDTHE PRIOR AUTHORIZATION INDICATOR IS
4143	Deny	PRIOR AUTHORIZATION REQUIRED	THE PLAN BENEFIT LIMITS INDICATE NOT COVERED ANDTHE CLAIM PA TYPE CODE NOT = '8' (PA OVERRIDE) ANDTHE PLAN BENEFIT LIMIT OVERRIDE PA EQUALS I (OVERRIDE INITIAL RX) AND THE CLAIM REFILL INDICATOR IS EQUAL TO 0 AND THE PLAN BENEFIT LIMT MED CERT INDICATOR = 'Y' (OVERRIDE) ANDTHE CLAIM PA INDICATOR NOT = P
4144	Deny	PRIOR AUTHORIZATION REQUIRED	IF THE CUSTOM PLAN MAX NUMBER OF REFILLS IS NOT EQUAL TO UNLIMITED (999) AND THE PLAN BENEFIT LIMIT OVERRIDE PA EQUALS Y (OVERRIDE) AND THE CUSTOM PLAN MAX NUMBER OF REFILLS LESS THAN CLAIM REFILL INDICATOR AND THE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED).
4145	Deny	PRIOR AUTHORIZATION REQUIRED	PA REQUIRED. CALL ACS TECHNICAL DESK AT 8665064379. DRUG REQUIRES PA PER PLAN.
4146	Deny	PRIOR AUTHORIZATION REQUIRED	IF THE PLAN BENEFIT LIMIT OVERRIDE PA EQUALS I (OVERRIDE INITIAL RX) ANDTHE CLAIM REFILL INDICATOR EQUALS 0 AND THE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED).
4148	Deny	PRIOR AUTHORIZATION REQUIRED	CLIENT SPECIFIC (MA) PA REQUIRED FOR TELEPHONE PRESCRIPTION SCHEDULE II DRUG (ALSO HANDLES OXYCONTIN LIMITS EXCEEDED EDIT)IF THE PRESCRIPTION ORIGINATED BY TELEPHONE FOR A SCHEDULE II DRUG AND IT IS NOT AN EMERGENCY SERVICE LEVEL ANDIT IS NOT A PAPER CLAIM
4149	Deny	PRIOR AUTHORIZATION REQUIRED	IF THE DAILY DOSE (DERIVED BY TAKING CLAIM SUBMITTED QUANTITY / CLAIM DAYS SUPPLY) GREATER THAN CUSTOM PLAN MAINTENANCE CLAIM DOSE AND THE CUSTOM PLAN MAINTENANCE INDICATOR EQUALS PAY ANDTHE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED).
4150	Deny	PRIOR AUTHORIZATION REQUIRED	IF THE CUSTOM PLAN MAXIMUM DAILY DOSE UNITS IS NOT EQUAL TO 0 ANDTHE DAILY DOSE (DERIVED BY TAKING CLAIM SUBMITTED QUANTITY / CLAIM DAYS SUPPLY) GREATER THAN CUSTOM PLAN MAXIMUM DAILY DOSE AND CLAIM DOSE INDICATOR EQUALS 'PAY' ANDTHE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED

4151	Deny	PRIOR AUTHORIZATION REQUIRED	IF THE CUSTOM PLAN MINIMUM DAILY DOSE UNITS IS NOT EQUAL TO 0 AND THE DAILY DOSE (DERIVED BY TAKING CLAIM SUBMITTED QUANTITY / CLAIM DAYS SUPPLY) IS LESS THAN THE CUSTOM PLAN MINIMUM DAILY DOSE ANDTHE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED).
4152	Deny	PRIOR AUTHORIZATION REQUIRED	THE CLAIM PARTICIPANT AGE IS NOT LESS THAN THE CUSTOM PLAN DRUG MAXIMUM AGEAND THE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED)AND THE CUSTOM PLAN AGE EDIT STATUS EQUALS PA REQUIRED ANDTHE CLAIM'S PRIOR AUTHORIZATION TYPE CODE NOT = PA OVERRIDE ('8').
4153	Deny	PRIOR AUTHORIZATION REQUIRED	IF THE CLAIM PARTICIPANT AGE IS NOT GREATER THAN THE CUSTOM PLAN DRUG MINIMUM AGE AND THE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED) AND THE CUSTOM PLAN AGE EDIT STATUS EQUALS PA REQUIRED ANDTHE CLAIM'S PRIOR AUTHORIZATION TYPE CODE NOT = PA OVERRIDE ('8').
4154	Deny	PRIOR AUTHORIZATION REQUIRED	THE (CUSTOM PLAN DAYS SUPPLIED ACCUM IS NOT EQUAL TO N (NONE) AND THE CUSTOM PLAN DAYS SUPPLIED IS NOT EQUAL TO WORK DEFAULT DAYS (999)) AND THE CUSTOM PLAN DAYS SUPPLIED ACCUM EQUALS C (ACUTE DOSE ONLY) AND THE CUSTOM PLAN MAINTENANCE CLAIM DOSE LESS THAN THE WORK DEFAULT DOSE (9999.999) AND THE DAILY DOS
4155	Deny	PRIOR AUTHORIZATION REQUIRED	IF THE CUSTOM PLAN DAYS SUPPLIED ACCUM EQUALS A (ALL DOSES) AND THE CLAIM SUBMITTED DAYS IS GREATER THAN THE CUSTOM PLAN DAYS SUPPLIED AND THE CUSTOM PLAN DAYS SUPPLIED STATUS EQUALS P (PA REQUIRED) AND THE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED).
4156	Deny	PRIOR AUTHORIZATION REQUIRED	AN ENTRY ON THE CUSTOM RECORD EXISTS ANDTHE DUR UNITS ACCUMULATOR CODE ON THE CUSTOM RECORD IS NOT EQUAL TO N ANDTHE DUR UNITS AMOUNT ON THE CUSTOM RECORD IS GREATER THAN +0.000 AND LESS THAN +99999.999AND((THE DUR UNITS ACCUMULATOR CODE ON THE CUSTOM RECORD EQUALS C (ACUTE)) AND(IP DAILY DOSE IS GREATER T
4157	Deny	PRIOR AUTHORIZATION REQUIRED	AN ENTRY EXISTS ON THE CUSTOM RECORDANDDUR DAYS SUPPLY ACCUMULATOR CODE ON THE CUSTOM RECORD IS NOT EQUAL TO N ANDDUR DAYS SUPPLY AMOUNT ON THE CUSTOM RECORD IS GREATER THAN +0 AND LESS THAN +999AND((DUR DAYS SUPPLY ACCUMULATOR CODE

			ON THE CUSTOM RECORD EQUALS C (ACUTE))AND(IP DAILY DOSE IS GREATER THAN THE
4158	Deny	PRIOR AUTHORIZATION REQUIRED	AN ENTRY EXISTS ON THE CUSTOM RECORDANDDUR MAX RX ACCUMULATOR CODE ON THE CUSTOM RECORD IS NOT EQUAL TO N ANDDUR MAX RX AMOUNT ON THE CUSTOM RECORD IS GREATER THAN +0 AND LESS THAN +999AND((DUR MAX RX ACCUMULATOR CODE ON THE CUSTOM RECORD EQUALS C (ACUTE))AND(IP DAILY DOSE IS GREATER THAN THE MAINTENANCE CL
4160	Deny	PLAN LIMITATIONS EXCEEDED	H =CUSTOM REC; DAILY DOSE > MAINTENANCE CLAIM DOSE
4161	Deny	PLAN LIMITATIONS EXCEEDED	THE NUMBER OF SCRIPTS ON THE PLAN RECORD IS GREATER THAN ZERO AND LESS THAN 999.ANDTHE SCRIPT LIMIT TOTAL IS GREATER THAN THE NUMBER OF SCRIPTS ON THE PLAN RECORD.ANDPRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO 1 OR 3 ANDTHE PRESCRIPTION LIMIT EXEMPT INDICATOR ON THE CUSTOM RECORD IS NOT EQUAL TO Y
4162	Deny	PLAN LIMITATIONS EXCEEDED	(THE CUSTOM PLAN DAYS SUPPLIED ACCUM IS NOT EQUAL TO N (NONE) OR THE CUSTOM PLAN DAYS SUPPLIED IS NOT EQUAL TO WORK DEFAULT DAYS (999))ANDTHE CUSTOM PLAN DAYS SUPPLIED ACCUM EQUALS C (ACUTE DOSE ONLY)ANDTHE CUSTOM PLAN MAINTENANCE CLAIM DOSE LESS THAN WORK DEFAULT DOSE (9999.999)ANDTHE DAILY DOSE IS GREATE
4163	Deny	PLAN LIMITATIONS EXCEEDED	G =CUSTOM REC; ACUTE DOSE - SUBMITTED DAYS > MAX DAYS SUP FOR SPEC CLAIM
4164	Deny	PLAN LIMITATIONS EXCEEDED	(THE CUSTOM PLAN MAX UNITS ACCUM IS NOT EQUAL TO N (NONE) ANDTHE CUSTOM PLAN MAX UNITS IS NOT EQUAL TO WORK DEFAULT MAX UNITS (99999.999)) ANDTHE CUSTOM PLAN MAX UNITS ACCUM EQUALS C (ACUTE DOSE ONLY)ANDTHE CUSTOM PLAN MAINTENANCE CLAIM DOSE LESS THAN WORK DEFAULT DOSE (9999.999)ANDTHE DAILY DOSE IS GREATE
4165	Deny	PLAN LIMITATIONS EXCEEDED	D =CUSTOM REC; ALL DOSES - SUBMITTED UNITS > MAX UNITS FOR SPEC CLAIM
4166	Deny	PLAN LIMITATIONS EXCEEDED	O =PLAN FILE MAX SCRIPTS EXCEEDED FOR A SPECIFIC DURATION
4167	Deny	PLAN LIMITATIONS EXCEEDED	AN ENTRY EXISTS ON THE CUSTOM RECORD AND DUR UNITS ACCUMULATOR CODE ON THE CUSTOM RECORD IS NOT EQUAL TO N AND DUR UNITS AMOUNT ON THE CUSTOM RECORD IS GREATER THAN +0.000 AND LESS THAN +99999.999 AND ((DUR UNITS ACCUMULATOR

			CODE ON THE CUSTOM RECORD EQUALS C (ACUTE))AND (IP DAILY DOSE IS GREATER THAN T
4168	Deny	PLAN LIMITATIONS EXCEEDED	F =CUSTOM REC; ALL DOSES - SUBMITTED DAYS > MAX DAYS SUPP FOR SPEC CLAIM
4169	Deny	PLAN LIMITATIONS EXCEEDED	I =CUSTOM REC; ALL DOSES - MAX NUM OF SCRIPTS EXCEEDED FOR SPEC DUR
4171	Deny	PLAN LIMITATIONS EXCEEDED	M =CUSTOM REC; ALL DOSES - SUBMITTED UNITS > MAX UNITS FOR SPEC DUR
4172	Deny	PLAN LIMITATIONS EXCEEDED	N =CUSTOM REC; ACUTE DOSE - SUBMITTED UNITS > MAX UNITS FOR SPEC DUR
4173	Deny	DISCONTINUED PRODUCT/SERVICE I	DISCONTINUED NDC NUMBER - HCFA
4177	Deny	REFILL TOO SOON	REFILL TOO SOON
4184	Deny	CLAIM TOO OLD	IF CLAIM IS OLDER THAN THE FILING LIMIT ESTABLISHED ON THE GROUP FILE; THEN THE ERROR IS POSTED.
4185	Deny	DUPLICATE PAID/CAPTURED CLAIM	THE HISTORY CLAIM'S PHARMACY PROVIDER EQUALS IN PROCESS CLAIM'S PHARMACY PROVIDER ANDTHE HISTORY CLAIM'S PARTICIPANT ID EQUALS IN PROCESS CLAIM'S PARTICIPANT ID ANDTHE HISTORY CLAIM'S FIRST DATE OF SERVICE (FDOS) EQUALS IN PROCESS CLAIM'S FDOSANDTHE HISTORY CLAIM'S MEMBER NUMBER EQUALS IN PROCESS CLAIM'S MEMBER
4186	Deny	DUPLICATE PAID/CAPTURED CLAIM	THE HISTORY CLAIM'S PARTICIPANT ID EQUALS IN PROCESS CLAIM'S PARTICIPANT ID ANDTHE HISTORY CLAIM'S FIRST DATE OF SERVICE (FDOS) EQUALS IN PROCESS CLAIM'S FDOSANDTHE HISTORY CLAIM'S MEMBER NUMBER EQUALS IN PROCESS CLAIM'S MEMBER NUMBERANDTHE HISTORY CLAIM'S GENERIC CODE EQUALS IN PROCESS CLAIM'S GENERIC CODEAND
4187	Deny	CLAIM NOT PROCESSED	THE MAXIMUM NUMBER OF ENTRIES FOR THE RELATED HISTORY TABLE HAVE BEEN MET OR EXCEEDED.PROGRAM: S780C / S780 ADD-TO-RLTD-HIST
4188	Deny	CLAIM NOT PROCESSED	CLAIM NOT PROCESSED - REJECT CODE NOT FOUND ON REJECT CONTROL TABLE OR TOO MANY REJECT CODES ARE POSTED TO CLAIM OR RELATED HISTORY ENTRIES EXCEEDED FOR CLAIM OR PARTICIPANT
4189	Deny	REVERSAL NOT PROCESSED	THE ORIGINAL CLAIM THAT IS ATTEMPTING TO BE ADJUSTED/CREDITED HAS ALREADY BEEN CREDITED.
4190	Deny	REVERSAL NOT PROCESSED	THE ORIGINAL CLAIM THAT IS ATTEMPTING TO BE ADJUSTED/CREDITED IS IN THE PROCESS OF BEING CREDITED.
4191	Deny	REVERSAL NOT PROCESSED	THE ORIGINAL CLAIM THAT IS ATTEMPTING TO BE ADJUSTED/CREDITED WAS DENIED.

4192	Deny	CLAIM HAS NOT BEEN PAID/CAPTUR	THE ORIGINAL CLAIM THAT IS ATTEMPTING TO BE ADJUSTED/CREDITED WAS NOT FOUND OR IS A CREDIT.
4193	Deny	CLAIM HAS NOT BEEN PAID/CAPTUR	THE ORIGINAL CLAIM THAT IS ATTEMPTING TO BE CREDITED IS A MAIL ORDER CLAIM
4206	Deny	DATE WRITTEN IS AFTER DATE FIL	THE DATE PRESCRIPTION WRITTEN IS GREATER THAN THE DATE OF SERVICE.
4207	Deny	PRODUCT NOT COVERED NON-PARTIC	THE PRODUCT/SERVICE ID QUALIFIER INDICATES THAT THE PRODUCT/SERVICE ID FIELD CONTAINS A NDC AND((DRUG REBATE DATA IS FOUND FOR THE CLAIM'S NDC AND DATE OF SERVICE ON THE DRUG REBATE TABLE AND THE DRUG REBATE CODE FOR THE NDC = NO REBATE ('0') AND THE NDC IS NOT A REBATE EXEMPT NDC (HARD-CODED TABLE - MAS
4208	Deny	PATIENT ENROLLED UNDER MANAGED	MSG NOT FOUND
4209	Deny	DAYS SUPPLY LIMITATION FOR PRO	EXCEEDS CUSTOM DAYS SUPPLIED LIMITS - 5.1 ONLYTHE CUSTOM PLAN DAYS SUPPLIED ACCUM EQUALS A (ALL DOSES) ANDTHE CLAIM SUBMITTED DAYS GREATER THAN CUSTOM PLAN DAYS SUPPLIEDANDTHE CUSTOM PLAN DAYS SUPPLIED STATUS EQUALS D (DENY)ANDTHE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED
4212	Deny	M/I SEGMENT IDENTIFICATION	THE SEGMENT IS A MANDATORY SEGMENT AND THE SEGMENT IDENTIFIER IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD
4213	Deny	M/I TRANSACTION COUNT	THE TRANSACTION COUNT IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4214	Deny	M/I PROFESSIONAL SERVICE FEE S	THE PRODUCT/SERVICE ID QUALIFIER IS NOT NDC AND THE PROFESSIONAL SERVICE FEE SUBMITTED IS MISSING (ZEROS).
4215	Deny	M/I SERVICE PROVIDER ID QUALIF	THE SERVICE PROVIDER ID QUALIFIER IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4227	Deny	M/I GROSS AMOUNT DUE	MCO PAID AMT IS INVALID. MCO PD AMT MUST BE > ZERO
4229	Deny	M/I OTHER PAYER AMOUNT PAID	MISSING DENY DATE (IF THE OTHER COVERAGE CODE IS 3 (OTHER COVERAGE EXISTS - THIS CLAIM NOT COVERED) OR 4 (OTHER COVERAGE EXISTS - PAYMENT NOT COLLECTED)) ANDTHE PAYERID DATE IS NOT NUMERIC OR THE PAYERID DATE IS NOT GREATER THAN ZEROS OR THE PAYERID PAID AMOUNT IS GREATER THAN ZEROS.
4231	Deny	M/I OTHER PAYER AMOUNT PAID	CLAIM REQUIRES TPL REVIEW (MASSACHUSETTS SPECIFIC)IF THE OTHER COVERAGE CODE IS 2 (OTHER COVERAGE EXISTS - PAYMENT COLLECTED) ANDTHE PAYERID PAID AMOUNT IS MISSING (ZERO). ORIF THE

			OTHER COVERAGE CODE IS '0' (NOT SPECIFIED) OR '1' (NO OTHER COVERAGE IDENTIFIED) '3' (OTHER COVERAGE EXISTS - THIS CLAM NOT COVERED)
4236	Deny	COMPOUND ING COMPONENT COUNT	A COMPOUND SEGMENT IS PRESENT AND THE COMPOUND INGREDIENT COMPONENT COUNT IS ZEROS.
4237	Deny	COMPOUND ING QUANTITY	THE COMPOUND INGREDIENT QUANTITY IS MISSING (ZEROS).
4239	Deny	M/I PRESCRIPTION/SERVICE REFER	THE PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4240	Deny	M/I ASSOCIATED PRESCRIPTION/SE	THE ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER IS MISSING (ZEROS) ON A REVERSAL FOR A COMPLETION TRANSACTION.
4241	Deny	M/I ASSOCIATED PRESCRIPTION/SE	THE ASSOCIATED PRESCRIPTION/SERVICE DATE IS MISSING (ZEROS) ON THE REVERSAL OF A COMPLETION TRANSACTION
4243	Deny	M/I QUANTITY PRESCRIBED	THE QUANTITY PRESCRIBED IS MISSING (ZEROS).
4244	Deny	M/I PRIOR AUTHORIZATION TYPE C	THE PRIOR AUTHORIZATION TYPE CODE DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD ORTHE PRIOR AUTHORIZATION TYPE CODE IS MISSING AND THE PRIOR AUTHORIZATION NUMBER IS PRESENT.
4247	Deny	M/I PRESCRIBER ID QUALIFIER	THE PRESCRIBER ID QUALIFIER IS MISSING AND A PRESCRIBER ID EXISTS ORIOR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD
4250	Deny	M/I REASON FOR SERVICE CODE	EDIT IGNORED
4256	Deny	M/I QUANTITY DISPENSED	EDIT IGNORED
4263	Deny	PROVIDER ID	THE PHARMACY PROVIDER ID IS MISSING AND THE PHARMACY PROVIDER ID QUALIFIER IS PRESENT.
4267	Deny	M/I OTHER PAYER AMOUNT PAID CO	A COB SEGMENT IS PRESENT AND THE OTHER PAYER AMOUNT PAID COUNT IS MISSING (ZEROS).
4268	Deny	M/I OTHER PAYER AMOUNT PAID CO	THE OTHER PAYER AMOUNT PAID COUNT DOES NOT MATCH THE NUMBER OF OTHER PAYER AMOUNT PAID FIELDS RECEIVED ON A COB/OTHER PAYMENTS SEGMENT.
4269	Deny	M/I OTHER PAYER AMOUNT PAID QU	THE OTHER PAYER AMOUNT PAID QUALIFIER IS MISSING (SPACES) AND THE OTHER PAYER AMOUNT PAID IS GREATER THAN ZEROS.
4270	Deny	M/I OTHER PAYER AMOUNT PAID QU	THE OTHER PAYER AMOUNT PAID QUALIFIER DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD
4271	Deny	M/I DISPENSING STATUS	IF THE DISPENSING STATUS IS MISSING (SPACES) ANDTHE QUANTITY INTENDED TO BE DISPENSED IS GREATER THAN

			ZEROS OR THE DAYS SUPPLY INTENDED TO BE DISPENSED IS GREATER THAN ZEROS.
4272	Deny	M/I DISPENSING STATUS	THE DISPENSING STATUS DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4274	Deny	M/I QUANTITY INTENDED TO BE DI	THE QUANTITY INTENDED TO BE DISPENSED IS MISSING (ZEROS) AND THE DISPENSING STATUS INDICATES A PARTIAL FILL ('P') OR 'C'.
4275	Deny	M/I QUANTITY INTENDED TO BE DI	THE QUANTITY INTENDED TO BE DISPENSED IS GREATER THAN ZEROS BUT THE DISPENSING STATUS DOES NOT INDICATE A PARTIAL FILL ('P').
4276	Deny	M/I DAYS SUPPLY INTENDED TO BE	THE DAYS SUPPLY INTENDED TO BE DISPENSED IS MISSING (ZEROS) AND THE DISPENSING STATUS INDICATES A PARTIAL FILL ('P').
4285	Pay&Rpt	M/I OTHER AMOUNT CLAIMED SUBMI	THE OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD AND THE OTHER AMOUNT CLAIMED SUBMITTED AMOUNT IS GREATER THAN ZERO.
4293	Deny	MEMBER LOCKED INTO SPECIFIC PR	PARTICIPANT/PROVIDER LOCKIN MISMATCHTHE CLAIM FIRST DATE OF SERVICE FELL WITHIN THE DATE RANGE OF ONE OF THE PROVIDERS IN THE LOCKIN TABLE BUT THE CLAIM PROVIDER NUMBER IS NOT EQUAL TO THE PROVIDER NUMBER IN THE LOCKIN TABLE.
4297	Deny	INVALID TRANSACTION COUNT FOR	THE TRANSACTION COUNT IS GREATER THAN 4 FOR A BILLING - REVERSAL - OR REBILL REQUEST.
4298	Deny	M/I CLAIM SEGMENT	A CLAIM SEGMENT WAS NOT RECEIVED WITH A BILLING REQUEST.
4299	Deny	M/I CLAIM SEGMENT	A CLAIM SEGMENT WAS RECEIVED WITH AN ELIGIBILITY REQUEST.
4300	Deny	M/I CLINICAL SEGMENT	A CLINICAL SEGMENT WAS RECEIVED WITH AN ELIGIBILITY, A REVERSAL, A PRIOR AUTHORIZATION REVERSAL, OR A PRIOR AUTHORIZATION INQUIRY REQUEST.
4302	Deny	M/I COB/OTHER PAYMENTS SEGMENT	MSG NOT FOUND
4303	Deny	M/I COB/OTHER PAYMENTS SEGMENT	A COB/OTHER PAYMENTS SEGMENT WAS RECEIVED WITH AN ELIGIBILITY - A REVERSAL - OR A PRIOR AUTHORIZATION REVERSAL REQUEST.
4304	Deny	M/I COMPOUND SEGMENT	MSG NOT FOUND
4305	Deny	M/I COMPOUND SEGMENT	A COMPOUND SEGMENT WAS RECEIVED WITH AN ELIGIBILITY OR A REVERSAL REQUEST.
4307	Deny	M/I DUR/PPS SEGMENT	MSG NOT FOUND
4308	Deny	M/I DUR/PPS SEGMENT	DUR/PPS SEGMENT INVALID WITH ELIGIBILITY REQUEST - 5.1 ONLYA DUR/PPS SEGMENT WAS RECEIVED WITH AN ELIGIBILITY REQUEST.

4309	Deny	M/I INSURANCE SEGMENT	MSG NOT FOUND
4310	Deny	M/I INSURANCE SEGMENT	MSG NOT FOUND
4315	Deny	M/I PRESCRIBER SEGMENT	MSG NOT FOUND
4316	Deny	M/I PRESCRIBER SEGMENT	PRESCRIBER SEGMENT INVALID WITH REQUEST TYPE - 5.1 ONLYA PRESCRIBER SEGMENT WAS RECEIVED WITH AN ELIGIBILITY OR A REVERSAL REQUEST.
4317	Deny	M/I PRICING SEGMENT	MSG NOT FOUND
4318	Deny	M/I PRICING SEGMENT	PRICING SEGMENT INVALID WITH ELIGIBILITY REQUEST - 5.1 ONLYA PRICING SEGMENT WAS RECEIVED WITH AN ELIGIBILITY REQUEST
4319	Deny	M/I PRIOR AUTHORIZATION SEGMEN	MSG NOT FOUND
4320	Deny	M/I PRIOR AUTHORIZATION SEGMEN	PRIOR AUTHORIZATION SEGMENT INVALID WITH REQUEST TYPE - 5.1 ONLYA PRIOR AUTHORIZATION SEGMENT WAS RECEIVED WITH AN ELIGIBILITY OR A REVERSAL REQUEST.
4321	Deny	M/I TRANSACTION HEADER SEGMENT	MISSING MANDATORY TRANSACTION HEADER SEGMENT - 5.1 ONLYAN ELIGIBILITY - BILLING - REVERSAL - OR RE-BILL REQUEST WAS RECEIVED WITHOUT A MANDATORY TRANSACTION HEADER SEGMENT.
4322	Deny	INV PROCESSOR CONTROL NUMBER	CAREMARK DOES NOT PROCESS MARYLAND PHYSICINS CARE CLAIMS FOR THIS DOS - SUBMIT CLAIM TO EXPRESS SCRIPTS PBM FOR MPC MCO WITH PCN = PRODUR01 AND GROUP ID = RX8809. THIS NEW EXCEPTION BE SET TO DENY. ANY CLAIM WITH A DOS> 07/01/2017 AND WITH A PCN OF CAREMARK (ADV)SHOULD RECEIVE THE NEW EDIT.
4325	Deny	NON-MATCHED ASSOCIATED PRESCRI	ASSOCIATED PRESCRIPTION/SERVICE DATE DOES NOT MATCH DOS - 5.1 ONLYTHE ASSOCIATED PRESCRIPTION/SERVICE DATE ON A CLAIM SEGMENT WITH A DISPENSING STATUS OF C (COMPLETION FILL) DID NOT MATCH THE DATE OF SERVICE ON THE MATCHING PARTIAL FILL TRANSACTION.
4326	Deny	ASSOCIATED PRESCRIPTION/SERVIC	THE ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER ON A CLAIM SEGMENT WITH A DISPENSING STATUS OF C (COMPLETION FILL) DID NOT MATCH THE REFERENCE NUMBER ON THE MATCHING PARTIAL FILL TRANSACTION
4328	Deny	COMPOUND INGREDIENT COMPONENT	THE COMPOUND INGREDIENT COMPONENT COUNT DOES NOT MATCH THE NUMBER OF COMPOUND PRODUCT ID'S RECEIVED ON A COMPOUND SEGMENT.
4329	Deny	COORDINATION OF BENEFITS/OTHER	THE COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT DOES NOT MATCH THE NUMBER OF COB/OTHER PAYMENT SEGMENTS RECEIVED.

4330	Deny	DATE OF SERVICE PRIOR TO DATE	DOS LESS THAN DOB - 5.1 ONLYTHE CLAIM DATE OF SERVICE IS LESS THAN THE CLAIM DATE OF BIRTH.
4331	Deny	DIAGNOSIS CODE COUNT DOES NOT	THE DIAGNOSIS CODE COUNT DOES NOT MATCH THE NUMBER OF DIAGNOSIS CODES ON A CLINICAL SEGMENT.
4332	Deny	DUR/PPS CODE COUNTER OUT OF SE	THE SETS OF DUR/PPS INFORMATION WERE RECEIVED OUT OF NUMERICAL SEQUENCE.
4333	Deny	FIELD IS NON-REPEATABLE	IS THIS USED IN COMBINATION WITH OTHER INVALID REJECT CODES SO THAT THE FIELD IS IDENTIFIED?
4334	Deny	MULTIPLE PARTIALS NOT ALLOWED	MORE THAN ONE PARTIAL FILL TRANSACTIONS WERE RECEIVED FOR THE SAME PRESCRIPTION/SERVICE ID.
4335	Deny	DIFFERENT DRUG ENTITY BETWEEN	THE PRODUCT/SERVICE ID AND/OR QUALIFIER ON THE COMPLETION TRANSACTION (DISPENSING STATUS OF C) DOES NOT MATCH THE PRODUCT/SERVICE ID AND/OR QUALIFIER ON THE ASSOCIATED PARTIAL FILL TRANSACTION (DISPENSING STATUS OF P).
4336	Deny	MISMATCHED CARDHOLDER/GROUP ID	THE MEMBER ID AND THE GROUP ID ON THE INSURANCE SEGMENT OF A COMPLETION TRANSACTION (DISPENSING STATUS OF C) DOES NOT MATCH THE MEMBER ID AND GROUP ID ON THE INSURANCE SEGMENT OF THE ASSOCIATED PARTIAL FILL TRANSACTION (DISPENSING STATUS OF P).
4337	Deny	M/I COMPOUND PRODUCT ID QUALIF	THE COMPOUND PRODUCT ID QUALIFIER IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4338	Deny	IMPROPER ORDER OF 'DISPENSING	COMPLETION WITH NO PARTIAL - 5.1 ONLYA CLAIM SEGMENT WITH A DISPENSING STATUS OF C WAS RECEIVED BUT NO MATCHING PARTIAL FILL TRANSACTION (DISPENSING STATUS OF P) COULD BE FOUND
4339	Deny	M/I ASSOCIATED PRESCRIPTION/SE	THE ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER ON A CLAIM SEGMENT WITH A DISPENSING STATUS OF C IS MISSING (ZEROS).
4340	Deny	M/I ASSOCIATED PRESCRIPTION/SE	THE ASSOCIATED PRESCRIPTION/SERVICE DATE ON A CLAIM SEGMENT WITH A DISPENSING STATUS OF C IS MISSING (ZEROS) OR IT IS NOT A VALID DATE.
4342	Deny	PLAN LIMITS EXCEEDED ON INTEND	INTENDED QUANTITY EXCEEDS PLAN LIMITS THE QUANTITY INTENDED TO BE DISPENSE RECEIVED ON A CLAIM SEGMENT WITH A P DISPENSING STATUS EXCEEDS THE MAXIMUM DISPENSED QUANTITY LIMITS ON THE PLAN FOR WHICH THE PARTICIPANT IS ELIGIBLE.
4343	Deny	PLAN LIMITS EXCEEDED ON INTEND	INTENDED DAYS SUPPLY EXCEEDS PLAN LIMITS - 5.1 ONLYTHE DAYS SUPPLY INTENDED TO BE DISPENSE RECEIVED ON A CLAIM SEGMENT WITH A P DISPENSING STATUS EXCEEDS THE MAXIMUM SUBMITTED DAYS LIMITS ON THE PLAN FOR WHICH THE PARTICIPANT IS ELIGIBLE.

4344	Deny	OUT OF SEQUENCE 'P' REVERSAL O	PARTIAL REVERSED BEFORE COMPLETION REVERSED - 5.1 ONLYA REVERSAL FOR A PARTIAL FILL TRANSACTION WAS SUBMITTED BEFORE THE COMPLETION TRANSACTION WAS REVERSED. THE REPLACEMENT TCN NUMBER ON THE MATCHING COMPLETION TCN IS ZEROS. SEE PAGE 7 OF NM BLUEPRINT.NOTE: 5.1 SAME DAY INSPECT DISPENSING STATUS IN ORDER TO REVE
4345	Deny	M/I ASSOCIATED PRESCRIPTION/SE	THE ASSOCIATED PRESCRIPTION/SERVICE DATE IS MISSING (ZEROS) OR IS AN INVALID DATE WHEN A CLAIM SEGMENT WITH A DISPENSING STATUS OF P WAS RECEIVED.ASSOCIATED FIELDS ARE NOT REQUIRED ON A PARTIAL TRANSACTION.
4346	Deny	M/I ASSOCIATED PRESCRIPTION/SE	THE ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER IS MISSING (ZEROS) AND THE DISPENSING STATUS IS P .ASSOCIATED FIELDS ARE NOT REQUIRED ON A PARTIAL TRANSACTION. THIS EDIT DOES NOT MAKE SENSE.
4347	Deny	MANDATORY DATA ELEMENTS MUST O	OPTIONAL FIELDS PRECEDE MANDATORY FIELDS A SEGMENT OF ANY TYPE WAS RECEIVED WITH AN OPTIONAL FIELD OR FIELDS PRECEDING THE MANDATORY FIELDS.
4348	Deny	OTHER AMOUNT CLAIMED SUBMITTED	THE OTHER AMOUNT CLAIMED SUBMITTED COUNT DOES NOT MATCH THE NUMBER OF OTHER AMOUNT CLAIMED SUBMITTED FIELDS RECEIVED ON A PRICING SEGMENT.
4349	Deny	OTHER PAYER REJECT COUNT DOES	THE OTHER PAYER REJECT COUNT DOES MATCH THE NUMBER OF OTHER PAYER REJECT CODES RECEIVED ON A COB/OTHER PAYMENTS SEGMENT
4350	Deny	PROCEDURE MODIFIER CODE COUNT	THE PROCEDURE MODIFIER CODE COUNT DOES NOT MATCH THE NUMBER OF PROCEDURE MODIFIER CODES RECEIVED ON A CLAIM SEGMENT
4351	Deny	PROCEDURE MODIFIER CODE INVALI	MSG NOT FOUND
4352	Deny	PRODUCT/SERVICE ID MUST BE ZER	THE PRODUCT/SERVICE ID ON THE CLAIM SEGMENT WAS NOT ZEROS WHEN THE PRODUCT/SERVICE ID QUALIFIER INDICATED THAT THE CLAIM WAS FOR DUR/PROFESSIONAL PHARMACY SERVICE.
4353	Deny	PROD/SVC NOT APPROPR FOR LOC	PROD/SVC NOT APPROPR FOR LOC
4354	Deny	REPEATING SEGMENT NOT ALLOWED	AN IDENTICAL SEGMENT WAS SUBMITTED ON A SINGLE TRANSACTION.
4355	Deny	VALUE IN GROSS AMOUNT DUE DOES	GROSS AMOUNT DUE FOR RX = INGREDIENT COST SUBMITTED + DISPENSING FEE SUBMITTED + FLAT SALES TAX AMOUNT SUBMITTED + PERCENTAGE SALES TAX SUBMITTED
4356	Deny	M/I PROCEDURE MODIFIER CODE CO	THE PROCEDURE MODIFIER CODE COUNT IS MISSING (ZEROS) AND A PROCEDURE MODIFIER IS PRESENT.

4357	Deny	M/I COMPOUND PRODUCT ID	THE COMPOUND PRODUCT ID IS MISSING (SPACES).
4359	Deny	M/I DIAGNOSIS CODE COUNT	THE DIAGNOSIS CODE COUNT IS MISSING (ZEROS) AND A DIAGNOSIS CODE IS PRESENT.
4360	Deny	M/I DIAGNOSIS CODE QUALIFIER	THE DIAGNOSIS CODE QUALIFIER IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4361	Deny	M/I CLINICAL INFORMATION COUNT	THE CLINICAL INFORMATION COUNTER IS MISSING (ZEROS) OR IT DOES NOT MATCH THE NUMBER OF SETS OF MEASUREMENT FIELDS ON A CLINICAL SEGMENT.
4362	Deny	M/I MEASUREMENT DATE	THE MEASUREMENT DATE IS MISSING (ZEROS).
4363	Deny	CLAIM NOT PROCESSED	THIS EDIT WILL POST IF THE HEADER-LEVEL OVERRIDE EXCEPTION LOCATION CODE DOES NOT HAVE A MATCHING CODE ON THE REFERENCE TEXT LOCATION DATABASE
4364	Deny	CLAIM NOT PROCESSED	THIS EXCEPTION CAN BE POSTED TO THE CLAIM IF A LOGIC ERROR - SUCH AS A MISSING REPLACED TCN NUMBER FOR A CREDIT TRANSACTION - OR A CREDIT WITH A CLAIM STATUS OF TO-BE-DENIED - OCCURS. IN SOME INSTANCES - IT CAN BE USED TO DENOTE UNEXPECTED SQL CODES FROM DB2 CALLS - WHERE IT MIGHT ALSO BE USED IN CONJUNCTION WITH TH
4369	Deny	NON-MATCHED CARDHOLDER ID	THE PARTICIPANT ID ON THE REPLACEMENT OR CREDIT REQUEST DOES NOT MATCH THE PARTICIPANT ID ON THE CLAIM THAT IS BEING REPLACED OR CREDITED.
4371	Deny	PLAN LIMITS EXCEEDED	MORE THAN 1 CLAIM FOR FIRST DOSE OF MULTI-DOSE NDC.
4374	Deny	CLAIM HAS NOT BEEN PAID/CAPTUR	A CREDIT CLAIM CANNOT BE ADJUSTED. THE REPLACEMENT CLAIM OF AN ADJUSTMENT CAN BE VOIDED OR REPLACED - BUT THE CREDIT CLAIM OF AN ADJUSTMENT CAN NEVER BE VOIDED OR REPLACED.THIS EDIT CAN POST TO PROVIDER SUBMITTED CREDIT REQUESTS - PROVIDER SUBMITTED REPLACEMENT CLAIMS - ONLINE ENTERED CREDIT REQUESTS - AND ONLINE EN
4375	Deny	CLAIM NOT PROCESSED	THIS EXCEPTION CAN BE USED TO SUSPEND THE CLAIM IF A LOGIC ERROR - SUCH AS A SUBSCRIPT OUT OF BOUNDS - OCCURS
4376	Deny	REVERSAL NOT PROCESSED	THE ADUSTMENT REASON CODE ENTERED ON THE REQUEST IS MISSING OR INVALID (NOT NUMERIC OR NOT ON VALID VALUES TABLE). SEE THE DATA DICTIONARY FOR A LIST OF VALID VALUES.
4379	Deny	CLAIM NOT PROCESSED	THE MEMBER ID NUMBER ON THE CLAIM OR ADJUSTMENT BEING PROCESSED IS CURRENTLY BEING UPDATED BY ANOTHER USER OR SYSTEM PROCESS. (THIS SITUATION SHOULD RARELY OCCUR. SIMPLY TRYING TO

			PROCESS AGAIN NORMALLY RESULTS IN THIS EXCEPTION NOT OCCURRING AGAIN).
4385	Deny	M/I DAYS SUPPLY	THE CLAIM'S SUBMITTED DAYS SUPPLY AMOUNT (DAYS SUPPLY) > PLAN HEADER DAYS SUPPLY LIMIT (OR MAINTENANCE DAYS SUPPLY LIMIT FOR MAINTENANCE DRUGS)ANDA CUSTOM PLAN BENEFIT LIMIT RECORD EXISTS FOR THIS CUSTOMER - PLAN - AND BENEFIT LIMIT TYPE AND(THE CUSTOM PLAN ACCUMULATION CODE = 'NO EDIT' ORTHE CUSTOM PLAN'S D
4386	Deny	M/I DAYS SUPPLY	THE CLAIM'S SUBMITTED DAYS SUPPLY AMOUNT (DAYS SUPPLY) > PLAN HEADER DAYS SUPPLY LIMIT (OR MAINTENANCE DAYS SUPPLY LIMIT FOR MAINTENANCE DRUGS)ANDA CUSTOM PLAN BENEFIT LIMIT RECORD EXISTS FOR THIS CUSTOMER - PLAN - AND BENEFIT LIMIT TYPE ANDTHE CUSTOM PLAN ACCUMULATION CODE = 'EDIT ACUTE ONLY' ANDTHE CUSTOM
4387	Deny	M/I DAYS SUPPLY	THE CLAIM'S SUBMITTED DAYS SUPPLY AMOUNT (DAYS SUPPLY) > PLAN HEADER DAYS SUPPLY LIMIT (OR MAINTENANCE DAYS SUPPLY LIMIT FOR MAINTENANCE DRUGS)ANDA CUSTOM PLAN BENEFIT LIMIT RECORD EXISTS FOR THIS CUSTOMER - PLAN - AND BENEFIT LIMIT TYPE ANDTHE CUSTOM PLAN ACCUMULATION CODE = 'EDIT ALL DRUGS' ANDTHE CLAIM'S
4388	Deny	M/I DAYS SUPPLY	THE PLAN'S MAX UNITS LIMIT < UNLIMITED UNITS (9999.999) ANDTHE CLAIM'S DRUG SUBMITTED QUANTITY > PLAN'S MAX UNITS LIMIT ANDNO CUSTOM PLAN BENEFIT LIMIT RECORD EXISTS FOR THIS CUSTOMER - PLAN - AND BENEFIT LIMIT TYPE
4389	Deny	M/I DAYS SUPPLY	THE PLAN'S MAX UNITS LIMIT < UNLIMITED UNITS (9999.999) ANDTHE CLAIM'S DRUG SUBMITTED QUANTITY > PLAN'S MAX UNITS LIMIT ANDA CUSTOM PLAN BENEFIT LIMIT RECORD EXISTS FOR THIS CUSTOMER - PLAN - AND BENEFIT LIMIT TYPE ANDTHE CUSTOM PLAN MAX UNITS ACCUMULATION CODE = 'NO EDIT' ANDTHE CUSTOM PLAN'S UNITS LIM
4390	Deny	M/I DAYS SUPPLY	THE CUSTOM PLAN MAX UNITS ACCUMULATION CODE = 'EDIT ACUTE ONLY' ANDTHE CUSTOM PLAN'S MAINTENANCE DOSE < DEFAULT DAILY DOSE (9999.999) ANDTHE CLAIM'S CALCULATED DAILY DOSE > CUSTOM PLAN'S MAINTENANCE DOSE ANDTHE CLAIM'S DRUG SUBMITTED QUANTITY > PLAN'S MAX UNITS LIMIT
4391	Deny	M/I DAYS SUPPLY	THE CUSTOM PLAN MAX UNITS ACCUMULATION CODE = 'EDIT ALL DRUGS' ANDTHE CLAIM'S DRUG SUBMITTED QUANTITY > CUSTOM PLAN'S MAX UNITS LIMIT
4400	Deny	M/I DAYS SUPPLY	EDIT IGNORED

4401	Deny	M/I DAYS SUPPLY	EDIT IGNORED
4403	Deny	M/I DAYS SUPPLY	A CUSTOM PLAN BENEFIT LIMIT RECORD DOES NOT EXIST FOR THIS CUSTOMER - PLAN - AND BENEFIT LIMIT TYPE ANDTHE CLAIM'S SUBMITTED DAYS SUPPLY AMOUNT (DAYS SUPPLY) > PLAN HEADER DAYS SUPPLY LIMIT (OR MAINTENANCE DAYS SUPPLY LIMIT FOR MAINTENANCE DRUGS)
4404	Deny	CLAIM NOT PROCESSED	FORMULARY TYPE CODE FOR THE PLAN NOT = 'N' (NO FORMULARY) ANDNO FORMULARY IS FOUND ON THE DRUG FORMULARY TABLE
4411	Deny	COMPOUND NOT COVERED	SUBMISSION CLARIFICATION CODE = 08 IS NOT ALLOWED FOR MEDICARE PART D DUAL ELIGIBLE PARTICIPANTS
4414	Deny	CLAIM NOT PROCESSED	THE PHARMACY'S PHYSICAL ADDRESS INFORMATION COULD NOT BE FOUND.
4415	Deny	CLAIM NOT PROCESSED	IF THE LOADED EXCEPTION COUNT IS 0.
4416	Deny	M/I DISPENSING STATUS	COMPOUND CODE IS EQUAL TO '2' AND THE DISPENSING STATUS IS GREATER THAN SPACES.
4417	Deny	M/I ASSOCIATED PRESCRIPTION/SE	PARTIAL AND COMPLETION NOT ALLOWED ON SAME DAY 5.1 ONLYFIRST DATE OF SERVICE EQUAL ASSOCIATED PRESCRIPTION/SERVICE DATE.
4420	Deny	CLAIM IS POST DATED	BATCH DATE LESS THAN FIRST DATE OF SERVICE
4421	Deny	NON-MATCHED PRESCRIBER IDENTIF	PRESCRIBER ID NOT FOUND ON PROVIDER ENROLLMENT ELIGIBILITY TABLE. PRESCRIBER ID NOT VALID FOR THIS CLIENT
4429	Deny	PATIENT IS NOT COVERED	IF THE PARTICIPANT IS PRODUCTION AND THE CLAIM WAS MARKED AS A TEST CLAIM BECAUSE IT CONTAINED A TEST PROVIDER
4430	Deny	M/I REASON FOR SERVICE CODE	DUR OVERRIDE CONFLICT THE REASON FOR SERVICE IS MISSING AND THE DUR INTERVENE CODE OR DUR OUTCOME CODE IS PRESENT.
4439	Deny	REVERSAL NOT PROCESSED	AN ADJUSTMENT REQUEST RECORD HAS TARGETED A HISTORY RECORD FOR ADJUSTMENT - BUT THE HISTORY RECORD HAS BEEN SUSPENDED
4441	Deny	REVERSAL NOT PROCESSED	AN ADJUSTMENT REQUEST RECORD HAS TARGETED A HISTORY RECORD FOR ADJUSTMENT - BUT THE HISTORY RECORD HAS BEEN VOIDED
4443	Deny	REVERSAL NOT PROCESSED	AN ADJUSTMENT REQUEST RECORD HAS TARGETED A HISTORY RECORD FOR ADJUSTMENT - BUT THE KEYED REPLACED NUMBER (TCN) ON THE ADJUSTMENT REQUEST RECORD THAT IDENTIFIES THE HISTORY RECORD IS EQUAL TO ZEROS.
4445	Deny	CLAIM NOT PROCESSED	CLAIMS IS SYSTEM GENERATED AND(TRANSACTION TYPE IS VOID ORTRANSACTION TYPE IS DEBIT OF ADJUSTMENT)ANDCYCLE NUMBER EQUAL ZEROAND BATCH NUMBER IS LESS THAT SYSTEM GENERATED BATCH NUMBER

4446	Deny	PRIOR AUTHORIZATION REQUIRED	DUR EDIT POSTED WITH A CONFLICT CODE OF HD (HIGH DOSE) - PA REQUIRED
4447	Deny	PRIOR AUTHORIZATION REQUIRED	THE IN PROCESS BILLING PROVIDER ID NOT EQUAL HISTORY BILLING PROVIDER ID AND FIRST DATE OF SERVICE ON THE CURRENT CLAIM MUST BE AFTER THE FIRST DATE OF SERVICE ON THE HISTORY CLAIM. AND FIRST DATE OF SERVICE ON THE CURRENT CLAIM MUST BE BEFORE THE DATE CALCULATED TO BE THE HISTORY CLAIM'S FIRST DATE OF SERVICE PL
4448	Deny	PRIOR AUTHORIZATION REQUIRED	DRUG TO DRUG INTERACTION
4449	Deny	PRIOR AUTHORIZATION REQUIRED	IF MEDICAL PROFILE OVERRIDE INDICATOR SET TO NO AND (HISTORY FDOS IS GREATER THAN IP FDOS OR AFTER PROCESSING THROUGH ALL OF HISTORY CLAIMS) AND THE DOSE FORM ON THE DRUG RECORD FROM THE IP NDC MUST EQUAL 'EACH' OR 'MILLILITER' AND CALCULATED DAILY DOSE MUST BE MORE THAN THE MAXIMUM DAILY DOSE ON THE DRUG RE
4450	Deny	M/I PRODUCT/SERVICE ID	THE PRODUCT/SERVICE ID QUALIFIER INDICATES THE PRODUCT/SERVICE ID IS AN NDC ANDTHE NDC IS MISSING OR NON-NUMERIC.
4460	Deny&Rpt	SUBMIT BILL TO OTHER PROCESSOR	PRIMARY PAID AMOUNT IS < 20% OF ALLOWABLE CHARGE
4464	Deny	PRODUCT/SERVICE NOT COVERED	CLIENT IS IN NURSING HOME - PLEASE TRY MEDICARE D
4465	Deny	PRODUCT / SERVICE NOT COVERED	CVG FOR MEDICARE XO OR WAIVER SVC ONLY
4474	Deny	CLAIM TOO OLD	REVERSALS RESULTING IN A PAYMENT FROM THE STATE MUST BE FILED WITHIN 6 MONTHS
4475	Deny	CLAIM TOO OLD	CLAIM IS NOT AN ADJUSTMENT, LOCKED INTO A PLAN AND MEDICARE A OR B, NO CLAIM WILL BE ACCEPTED AFTER 731 DAYS (2 YRS) FROM THE ORIGINAL FILL DATE
4476	Deny	CLAIM TOO OLD	CLAIM IS NOT AN ADJUSTMENT, LOCKED INTO A PLAN AND MEDICARE A OR B, NO CLAIM WILL BE ACCEPTED AFTER 190 DAYS (6 MONTHS) FROM THE PRIMARY PAYER DATE
4477	Deny	CLAIM TOO OLD	CLAIM IS NOT AN ADJUSTMENT, LOCKED INTO A PLAN AND NOT MEDICARE A OR B, NO CLAIM WILL BE ACCEPTED 366 DAYS (1 YR) FROM FDOS
4478	Deny	CLAIM TOO OLD	PHARMACY HAS 120 DAYS FROM THE ELIGIBILITY ADD DATE TO ADJUDICATE A CLAIM
4479	Deny	SUBMIT BILL TO OTHER PROCESSOR	PART D PLAN MAY COVER ITEM - FILE WITH PART D PLAN OR COMPLETE OTHER COVERAGE CODE AS APPROPRIATE.
4480	5	NDC NOT COVERED	PART D IS RESPONSIBLE FOR THIS ITEM OR CLASS OF ITEMS - CONTACT MEDICAREPART D PLAN. MEDICAID CANNOT PAY.

4501	5	NON-MATCHED PHARMACY NUMBER	DISPENSING PHARMACY ID NOT SUBMITTED AS AN NPI OR THE SUBMITTED NPI DOES NOT EXIST ON THE PROVIDER MASTER TABLE.
4502	5	NON-MATCHED PRESCRIBER ID	PRESCRIBER ID NOT SUBMITTED AS AN NPI OR THE SUBMITTED NPI DOES NOT EXIST ON THE PROVIDER MASTER TABLE.
4503	Deny	NON-MATCHED PRESCRIBER ID	PRESCRIBER QUALIFIER NOT ALLOWED
4504	Deny	NON-MATCHED PHARMACY NUMBER	PROVIDER QUALIFIER NOT ALLOWED
4568	Deny	M/I QUANTITY PRESCRIBED	QUANTITY PRESCRIBED IS NOT SUBMITTED/NOT SUBMITTED IN REQUIRED FORMAT FOR SCHEDULE II DRUG
4569	Deny	M/I QUANTITY DISPENSED	QUANTITY DISPENSED IS GREATER THAN THE QUANTITY PRESCRIBED FOR SCHEDULE II DRUG
4617	5	NO CMS/LABELER REBATE CONTRACT	DENY THE CLAIM IF THE LABELER HAS NO SIGNED REBATE AGREEMENT IN AFFECT WITH CMS FOR DATE OF SERVICE.
4619	5	NDC NOT COVERED	DENY THE CLAIM IF THE DATE FILLED IS A PRE-DETERMINED PERIOD PAST THE DRUG OBSOLETE DATE (NOT CMS TERM DATE)
4629	Deny	RESERVED FOR FUTURE USE	RESERVED FOR FUTURE USE
4645	Deny	INV PRODUCT/SERVICE ID	POST EDIT WHEN A LINE ITEM ON A 5.1 CLAIM IS A DUMMY DRUG. A DUMMY DRUG WILL HAVE CONSULTEC AS THE MANUFACTORS NAME.
4665	Deny	M/I DATE RX WRITTEN	- POST IF DATE WRITTEN IS LESS THAN 1/1/1750 OR GREATER THAN 12/31/2150 - POST IF DATE WRITTEN IS MORE THAN 5 YEARS PRIOR TO THE FDOS- POST IF DATE WRITTEN IS GREATER THAN DOS
4681	Deny	INV FLAT SALES TAX AMT SUBM	SUBMITTED SALES TAX IS EQUAL TO OR GREATER THAN U&C, SILK TICKET 988
4682	Deny	INV PCNT SALES TAX AMT SUBM	PERCENTAGE SALES TAX AMOUNT SUBMITTED IS EQUAL TO OR GREATER THAN U&C, SILK TICKET 988
4683	Deny	NON-COV NDC - NOT REBATEABLE	THE PRODUCT/SERVICE ID QUALIFIER INDICATES THAT THE PRODUCT/SERVICE ID FIELD CONTAINS AN NDC & DRUG REBATE DATA IS FOUND FOR THE CLAIM'S NDC & DATE OF SERVICE ON THE DRUG REBATE TABLE & THE DRUG REBATE CODE FOR THE NDC = NO REBATE ('0') AND THE NDC IS NOT A REBATE EXEMPT NDC**5.1 EDIT ONLY-SEE 4684 FOR 3.2 EDIT**
4684	Deny	PROD NOT COV-NOT REBATEABLE	THE PRODUCT/SERVICE ID QUALIFIER INDICATES THAT THE PRODUCT/SERVICE ID FIELD CONTAINS AN NDC & DRUG REBATE DATA IS FOUND FOR THE CLAIM'S NDC & DATE OF SERVICE ON THE DRUG REBATE TABLE & THE DRUG REBATE CODE FOR THE NDC = NO REBATE ('0') AND THE NDC IS NOT A REBATE EXEMPT NDC**3.2 EDIT ONLY-SEE 4683 FOR 5.1 EDIT**

4728	Deny	FILLED BEFORE COV EFFECTIVE	THIS EXCEPTION POSTS WHEN THERE IS NO ELIGIBILITY AND OVERRIDE CODE 2 IS SUBMITTED
4751	Deny	M/I GROUP ID	GROUP NUMBER MUST BE INCAID100 FOR ALL INDIANA PLANS
4751	Deny	M/I GROUP ID	M/I GROUP ID
4756	Deny	M/I LEVEL OF SERVICE	POST EDIT IF NOT VALID VALUE: 00=NOT SPECIFIED01=PATIENT CONSULTATION02=HOME DELIVERY03=EMERGENCY04=24 HOUR SERVICE05=PATIENT CONSULTATION ABOUT GENERIC PRODUCT SELECTION2-10-03 CHANGED PDCS DESCRIPTION AND MOVED EOB 0207 TO NEW EXCEPTION CODE 4961 - SPECIFIC TO ILLEGAL ALIEN
4764	Deny	INVALID OTHER PAYER COV TYPE	INVALID OTHER PAYER COVERAGE TYPE
4765	Deny	PATIENT/CARD HOLDER ID NAME MI	MEMBER NAME & NUMBER DISAGREE
4775	Deny	OTHER CVRG- PAYER AMT DISCREP	SUM OF SUBMITTED OTHER PAYER PATIENT RESPONSIBILITY AMOUNTS MUST BE GREATER THAN ZERO WHEN OCC = 4
4777	Deny	M/I OTHER PAYER REJECT COUNT	OTHER PAYER REJECT COUNT MUST BE GREATER THAN OR EQUAL TO 1 WHEN OCC = 3
4778	Deny	M/I OTHER PAYER REJECT CODE	AT LEAST ONE OTHER PAYER REJECT CODE IS REQUIRED TO BE SUBMITTED WHEN OCC = 3
4779	Deny	OTHER CVRG- PAYER AMT DISCREP	SUM OF SUBMITTED OTHER PAYER AMOUNT PAID AMOUNTS MUST BE GREATER THAN ZERO WHEN OCC = 2
4780	Deny	INV PAYER-PAT RESP AMT COUNT	M/I OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT
4781	Deny	M/I PAYER-PAT RESP AMT QUAL	M/I OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER
4782	Deny	INV PATIENT ID QUALIFIER	M/I PATIENT ID QUALIFIER
4786	Deny	HOST PROCESSING ERROR	EDIT IGNORED
4787	Deny	M/I PATIENT'S FIRST NAME	FIRST NAME NOT EDITED SEPARATELY. IF THE FIRST NAME IS MISSING ON THE CLAIM; SYSTEM RETURNS COB 0238. THIS EDIT HAS BEEN MAPPED TO CB; M/I PATIENT'S LAST NAME.
4789	Deny	M/I PATIENT'S LAST NAME	MEMBER NAME MISSING
4791	Deny	PRIOR AUTH REQUIRED	RESERVED FOR FUTURE USE
4798	Deny	M/I PATIENT LOCATION CODE	NURSE FACILITY PT. IND. INVLD
4799	Deny	M/I OTHER COVERAGE CODE	MEMBER COVERED BY PRIVATE INS
4800	Deny	M/I DATE OF SERVICE	DATE DISP. EARLIER THAN PRSCRBD
4801	Deny	M/I DATE OF SERVICE	DATE DISP. AFTER BILLING DATE

4802	Deny	CLAIM IS POST DATED	DATE BILLED AFTER ADJUDICATION DATE
4803	Deny	M/I PRODUCT/SERVICE ID	NDC INVALID FORMAT
4808	Deny	PATIENT IS NOT COVERED	POST EDIT IF SPENDDOWN DATE IS SAME AS DATE OF SERVICE. IF EDIT FAILS - ALSO POST EDIT M5 (REQUIRES MANUAL CLAIM).
4810	Deny	PATIENT IS NOT COVERED	MEMBER ENROLLED W/MCO ON DOS
4811	Deny	PATIENT IS NOT COVERED	MEMBER ELIG IN SLMB & QDWI
4813	Deny	PATIENT IS NOT COVERED	MEMBER HAS OTHER INSURANCE BUT NO OTHER PAYOR AMT OR OTHER PAYOR DATE SUBMITTED ON THE CLAIM
4823	Deny	PLAN LIMITATIONS EXCEEDED	PLAN LIMITATIONS EXCEEDED - PRIOR AUTHORIZATION REQUIRED FROM HEALTH CARE EXCEL 800-457-4518
4824	Deny	OTHER PYR PT RESP CNT ERR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT DOES NOT MATCH NUMBER OF REPETITIONS
4825	Deny	M/I BENEFIT STAGE COUNT ERROR	BENEFIT STAGE COUNT DOES NOT MATCH NUMBER OF REPETITIONS
4826	Deny	SUB CLARIF CD COUNT ERROR	SUBMISSION CLARIFICATION CODE COUNT DOES NOT MATCH NUMBER OF REPETITIONS
4827	Deny	M/I SUB CLARIFICATION CD CNT	M/I SUBMISSION CLARIFICATION CODE COUNT
4828	Deny	INV COMPOUND INGRED MOD CNT	M/I COMPOUND INGREDIENT MODIFIER CODE COUNT
4831	Deny	PLAN LIMITATIONS EXCEEDED	PLAN LIMITS EXCEEDED - SEE BELOW REASON CODES:B =CUSTOM REC; ALL DOSES - MAX $ LIMIT EXCEEDED FOR SPEC DUR
4832	Deny	PLAN LIMITATIONS EXCEEDED	C =CUSTOM REC; ACUTE DOSE - MAX $ LIMIT EXCEEDED FOR SPEC DURATION
4833	Deny	PLAN LIMITATIONS EXCEEDED	P= PATIENT EXCEEDS MONTHLY REFILL LIMIT
4834	Deny	CLAIM HAS NOT BEEN PAID/CAPTUR	CLAIM HAS NOT BEEN PAID/CAPTURED - IF MATCHING HISTORY CLAIM WAS A CREDIT OR INCUMBENT OR MAIL-ORDER; THE ERROR IS POSTED TO THE CLAIM (FINANCIAL EOB)
4834	Deny	CLAIM HAS NOT BEEN PAID	CLAIM HAS NOT BEEN PAID OR CAPTURED. ADJUSTMENT CLAIM IS REJECTED CREDIT WILL COMPLETE
4835	Deny	REVERSAL NOT PROCESSED	REVERSAL NOT PROCESSED - IF THE MATCHING HISTORY CLAIM WAS FOUND AND WAS ALREADY CREDITED; OR WAS TO-BE-CREDITED; OR THE ORIGINAL CLAIM WAS DENIED; THEN THE ERROR IS POSTED.
4842	Deny	M/I USUAL & CUSTOMARY CHARGE	SUSPEND A CLAIM IF BILLED AMOUNT IS > THAN OR EQUAL TO 500% OF ALLOWED AMOUNT OR IF BILLED AMOUNT IS < LESS THAN OR EQUAL TO 20% OF ALLOWED AMOUNT. SUSPEND TO LOCATION CODE 40.

4843	Deny	M/I USUAL & CUSTOMARY CHARGE	590 CLAIMS UNDER $150 SHOULD DENY WITH NCPDP REJECT DQ AND EOB 0429
4847	Deny	M/I QUANTITY DISPENSED	MSG NOT FOUND
4850	Deny	HOST PROVIDER FILE ERROR	MSG NOT FOUND
4852	Deny	M/I DAYS SUPPLY	EDIT WILL CHECK FOR BOTH MISSING AND INVALID CONDITIONS
4854	Deny	DUPLICATE PAID/CAPTURED CLAIM	DUP CHECK: SEARCHES HISTORY. IF A CLAIM WITH THE SAME FDOS AND 1ST 5 CHARACTERS OF THE GCN'S ARE EQUAL; THEN DUP CHECK CONTINUES. IF PRIOR AUTHORIZATION IS REQUIRED; OR THE PRESCRIBING PHYSICIAN DEA NUMBERS ARE EQUAL; OR THE PRIOR AUTH MED CERT CODE INDICATES MEDICAL CERTIFICATION; OR THE DENIAL OVERRIDE IS SET TO M
4855	5	M/I OTHER PAYER AMOUNT PAID	IF THE OTHER INSURANCE INDICATOR = 3 OR 4; AND THE PRIMARY PAYER DATE NOT NUMERIC OR NOT > ZEROES OR THE OTHER AMOUNT IS NOT EQUAL TO ZEROES; THEN THE ERROR IS POSTED.
4855	Deny	M/I OTHER PAYER AMOUNT PAID	IF THE OTHER INSURANCE INDICATOR = 3 OR 4; AND THE PRIMARY PAYER DATE NOT NUMERIC OR NOT > ZEROES OR THE OTHER AMOUNT IS NOT EQUAL TO ZEROES; THEN THE ERROR IS POSTED.
4857	Deny	MEMBER LOCKED INTO SPECIFIC PR	MEMBER LOCKED TO SPECIFIC DR
4858	Deny	CLAIM TOO OLD	THE ENCOUNTER CLAIM IS GREATHER THAN TWO (2) YEARS FROM THE FIRST DATE OF SERVICE.
4859	Deny	M/I DATE OF SERVICE	DATE DISPENSED IS INVALID
4861	Deny	PHARMACY NOT CONTRACTED WITH P	PROV. INELIG. TO BILL FOR DOS
4862	Deny	INV DATE PRESCRIPTION WRITTEN	THE NUMBER OF DAYS SINCE DATE RX WRITTEN HAS BEEN EXCEEDED BASED ON THE DEA CONTROL SCHEDULE
4864	Deny	PATIENT IS NOT COVERED	EDIT POSTED IF DOS IS BEFORE SPENDDOWN DATE.EDIT ALSO POSTED FOR OTHER NON-SPENDDOWN RELATED ELIGIBILITY.
4865	Deny	PATIENT IS NOT COVERED	FILLED AFTER COVERAGE EXPIRED
4866	Deny	PATIENT IS NOT COVERED	FILLED AFTER COVERAGE TERMINATED
4867	Deny	PLAN LIMITATIONS EXCEEDED	E =CUSTOM REC; ACUTE DOSE - SUBMITTED UNITS > MAX UNITS FOR SPEC CLAIM
4868	Deny	PLAN LIMITATIONS EXCEEDED	J =CUSTOM REC; ACUTE DOSE - MAX NUM SCRIPTS EXCEEDED FOR SPEC DUR
4869	Deny	PLAN LIMITATIONS EXCEEDED	K =CUSTOM REC; ALL DOSES - SUBMITTED DAYS > MAX DAYS SUPP FOR SPEC DURATION
4870	Deny	PLAN LIMITATIONS EXCEEDED	L =CUSTOM REC: ACUTE DOSE - SUBMITTED DAYS > MAX DAYS SUPP FOR SPEC DURATION

4871	Deny	CLAIM IS POST DATED	CLAIM POST DATED
4873	Deny	M/I QUANTITY DISPENSED	EDIT WILL CHECK FOR BOTH MISSING AND INVALID CONDITIONS
4874	Deny	RESERVED FOR FUTURE USE	RESERVED FOR FUTURE USE
4876	Deny	INV UNIT OF MEASURE	THE UNIT OF MEASURE CODE IS NOT EQUAL TO THE VALID VALUES
4879	5	DUR REJECT ERROR	THE CLIENT HAS FILLED A NALOXONE PRESCRIPTION WITHIN THE PAST 30 DAYS.
4910	Deny	M/I CARDHOLDER ID	MEMBER ID NOT IN VALID FORMAT
4911	Deny	PATIENT IS NOT COVERED	FILLED BEFORE COVERAGE EFFECTIVE - IF THE CLAIM'S FDOS FALLS BEFORE THE OLDEST COVERAGE BEGINNING DATE IN THE COVERAGE TABLE (ELIGIBILITY FILE); THEN THE ERROR IS POSTED.
4913	Deny	PLAN LIMITATIONS EXCEEDED	CSR 43 - GREATER THAN 34 DAYS SUPPLY FOR NON-MAINT. DRUG PRIOR AUTHORIZATION REQUIRED FROM HEALTH CARE EXCEL 800-457-4518
4914	Deny	PRIOR AUTHORIZATION REQUIRED	NON-PDL DRUG - PRIOR AUTHORIZATION REQUIRED (TCP PROGRAM)
4916	Deny	PRIOR AUTHORIZATION REQUIRED	12-11 ADDED NEW EXCEPTION CODE FOR START/END DATE FOR IRDP PROGRAM (CSR 60)
4918	Deny	M/I SMOKER/NON-SMOKER CODE	MSG NOT FOUND
4919	Deny	M/I PRESCRIBER LOCATION CODE	MSG NOT FOUND
4929	Deny	PATIENT SPENDDOWN NOT MET	NEW EDIT FOR 5.1 - ACTIVE IN BASE
4931	Deny	QMB (QUALIFIED MEDICARE BENEFI	MSG NOT FOUND
4933	Deny	M/I ORIGINALLY PRESCRIBED PROD	MSG NOT FOUND
4934	Deny	M/I ORIGINALLY PRESCRIBED QUAN	MSG NOT FOUND
4935	Deny	M/I COMPOUND DOSAGE FORM DESCR	THE COMPOUND DOSAGE FORM DESCRIPTION CODE DOES NOT MATCH ONE OF THE NCPDP VALID VALUES
4936	Deny	M/I COMPOUND DISPENSING UNIT F	MSG NOT FOUND
4937	Deny	COMPOUND ROUTE OF ADMINISTRATI	THE COMPOUND DISPENSING UNIT FORM INDICATOR DOES NOT MATCH ONE OF THE NCPDP VALID VALUES
4938	Deny	M/I ORIGINALLY PRESCRIBED PROD	MSG NOT FOUND
4951	Deny	PA REVERSAL OUT OF ORDER	MSG NOT FOUND
4952	Deny	PARTIAL FILL TRANSACTION NOT S	MSG NOT FOUND

4953	Deny	COMPLETION TRANSACTION NOT PER	MSG NOT FOUND
4954	Deny	SYNTAX ERROR	MSG NOT FOUND
4956	Deny	REQUIRES MANUAL CLAIM	EDIT POSTED WHEN SPENDDOWN DATE IS SAME AS DATE OF SERVICE.SHOULD ACCOMPANY EDIT 65 (PATIENT NOT COVERED) - EXCEPTION CODE 4808 - EOB 0385 (SPENDDOWN DATE SAME AS DOS).
4958	Deny	PATIENT IS NOT COVERED	PATIENT NO LONGER COVERED BECAUSE DECEASED
4959	Deny	M/I OTHER PAYER AMOUNT PAID	EDIT NEEDED TO CREATE ADDITINOAL REPORTS FOR PA SUBSYSTEM (CSR 14).
4960	Deny	CLAIM NOT PROCESSED	SET IF ATTEMPTING TO ROLL OFF OLD HISTORY AND WS-010-NO-ROLL-OFFPROGRAM: PDDC8622 / S560 ROLL-OFF-HIST-SECTION
4961	Deny	M/I LEVEL OF SERVICE	EDIT POSTED FOR: 1) ILLEGAL ALLIENS; 2) NON-ALIENS - OVERRIDE RESTRICTED CARD (LOCKIN) AND 3) NON-ALIENS - EMERGENCY FILLS [03 & < 5 DAYS SUPPLY]
4962	5	SUBMIT BILL TO OTHER PROCESSOR	CLAIM INDICATES OTHER COVERAGE BUT MAINFRAME FILES DON'T HAVE COB/TPL INFO ON FILE. PAY THE CLAIM BUT POST THE EXCEPTION. NO EOB REQUIRED.
4964	Deny	MEMBER LOCKED INTO SPECIFIC PR	IF PARTICIPANT IS LOCKED IN TO A PHYSICIAN AND THE CLAIM HAS AN OUT OF STATE PROVIDER; DENY THE CLAIM WITH NCPDP REJECT M2
4965	Deny	PRIOR AUTHORIZATION REQUIRED	590 CLAIMS IN EXCESS OF $500 REQUIRE PA. IF THERE IS NO PA; THE CLAIM SHOULD DENY FOR NCPDP EDIT 75 AND EOB 3002.
4967	Deny	PRODUCT/SERVICE NOT COVERED	MCO PARTICIPANTS MUST SUBMIT TO THE MCO (MANAGED CARE ORG.)
4968	Deny	PLAN LIMITATIONS EXCEEDED	NON-PDL DRUG - SUPPLY LIMITED (TCP PROGRAM)
4970	Deny	PLAN LIMITATIONS EXCEEDED	STEP CARE - GREATER THAN 90 DAYS IN 180 DAYS OF RANITIDINE OR NIZATIDINE > 150 MG/DAY; FAMOTIDINE > 20MG/DAY; CIMETIDINE > 400MG/DAY PA REQUIRED FROM HEALTH CARE EXCEL 800-457-4518
4971	Deny	PRIOR AUTHORIZATION REQUIRED	STEP CARE - PRAVACHOL IS NON-PDL IF PATIENT NOT RECEIVING ANTIVIRAL THERAPY; TXCL W5B OR W5C. ARBS REQUIRE PREVIOUS TX WITH ACEIS WITHIN LAST 365 DAYS; OTHERWISE PRIOR AUTH REQUIRED (TCP PROGRAM)
4972	Deny	REQUIRES MANUAL CLAIM	COMPOUND CLAIMS EXCEEDING $200 REQUIRE PAPER CLAIM
4977	Deny	NON-MATCHED PRESCRIBER IDENTIF	PHYSICIAN LIC# NOT ON FILE
4978	Deny	PRODUCT/SERVICE NOT COVERED	MEDICAL SUPPLIES NOT COVERED AT POS EFFECTIVE 3/17/03 AND NUTRITIONALS NOT COVERED EFFECTIVE 4/3/03

4979	Deny	M/I PRESCRIBER IDENTIFICATION	PRESCRIBER WRITING PRESCRIPTION FOR SCHEDULE II DRUG MUST HAVE A VALID DEA# ON FILE
4983	Deny	PA REQUIRED	CONTACT ACS CLINICAL DESK AT 866-506-4379EDIT HISTORY: 4-1 CREATED EDIT 4984 AND 4983 TO BREAK OUT UNIQUE LOGIC PREVIOUSLY UNDER THE 4132 EXCEPTION CODE (DRUG PROGRAM); AS REQUESTED BY MARGARET AND PATTY
4984	Deny	PA REQUIRED	PA REQUIRED. CONTACT ACS CLINICAL DESK AT 866-506-4379EDIT HISTORY: 4-1 CREATED EDIT 4984 AND 4983 TO BREAK OUT UNIQUE LOGIC PREVIOUSLY UNDER THE 4132 EXCEPTION CODE (DRUG PROGRAM); AS REQUESTED BY MARGARET AND PATTY
4985	Deny	PATIENT NOT COVERED	EDIT WILL POST IF MEMBER IS NOT COVERED BY MEDICAID EVEN IF ELIGIBLE UNDER A SPECIFIC PLAN

PHARMACY DENIALS DUE TO NDC NOT ON FILE

Since HSD uses First Databank and the MCOs use Medispan, there is the possibility that the MCO's will recognize an NDC code that is not on the State's formulary. In the event that the MCO has an NDC code that is denied as not being on the State's formulary, the MCO is instructed to submit the following spreadsheet containing the list of NDCs denied to Conduent who will then work with our FDB representative at PDCS to add those NDC codes that can be added. Once the adds are done, the MCO can resubmit the denied encounters.

The following template should be used and sent to:
Marvin.boyd@Conduent.com

FIRST DATABANK
ADD PRODUCT/IMAGE REQUEST FORM

NDC #	Manufacturer Name	Label Name Product Description	UPC #	Package Size	OTC/RX	NDC/UPC	IMAGE

Submission of Corrections to Encounter Files

If the MCO receives a 997 or an HTML Error report from TIE, or fails to receive a balancing report from TIE, the MCO will know that the Encounter file was rejected in its entirety and must be corrected and resubmitted. The naming convention for the resubmission of this file should follow that shown in Encounter Submission Procedures section of this manual.

The MCO is expected to resubmit any encounters that are denied. A pattern of errors on the *ENCOUNTER ADJUDICATION CYCLE SUMMARY REPORT* (RC-072) that exceeds 3% denied may result in a corrective action request. Corrections to denied encounters may be resubmitted in a separate resubmission file or combined in with the next batch of encounters being submitted.

837I (Institutional) inpatient and NCPDP (Drug) encounters will be accepted or denied in their entirety. Thus, if there is an error in any line item on an inpatient 837I or Drug claim, the entire encounter claim will deny. 837I non-inpatient, 837P and 837D (Professional/Dental) encounters will be accepted or denied on a line item basis. Header level edits will cause the entire encounter to deny. Otherwise, the 837I non-inpatient, 837P and 837D encounter could have some lines accepted and some denied. The error calculation for 837I non-inpatient, 837P and 837D encounters is performed as the number of encounter lines denied divided by the number of encounter lines submitted (minus duplicates and failed reversals). The 837I Inpatient and Drug encounter error calculation is performed as the number of claims denied divided by the number of encounter claims submitted (minus duplicates and failed reversals).

The *DENIED ENCOUNTER ADJUDICATION CYCLE DETAIL FLAT FILE* RC70/71 will include all encounters that deny at the header level and any line items that were denied. The MCO should submit the entire claim as an adjustment so that lines previously submitted don't error off as duplicates if resubmitted on the claim.

IX. SUPPORTING FILES

Reference Files

To support various functions of the Managed Care Organization, HSD makes available on a monthly basis a variety of Provider, Rates, and Formulary files. These files are uploaded on the DMZ on the morning of the 2nd of each month in the section titled "Provider, Rates & Formulary Files". The files included are:

- DRG RELATIVE WEIGHTS - MRDRGRW.CSV
- PROCEDURE CODE FORMULARY FILE WITH INDICATORS; INCLUDING TAXABLE STATUS (r_tax_ind="y") MRPCFRM.CSV
- PLACE OF SERVICE CODES BY PROCEDURE CODE - MRPLSVC.CSV
- REVENUE CODE FORMULARY FILE WITH INDICATORS; INCLUDING TAXABLE STATUS (r_tax_ind="y") - MRRVFRM.CSV
- REVENUE CODE BY PROVIDER RATES - MRRCPRV.CSV
- PROCEDURE CODE PRICING SPANS - MRPCPRC.CSV
- SPECIAL PROCEDURE CODE PRICING - MRSPPRC.CSV
- PROCEDURE MATRIX FILE –- MRPMTRX.CSV
- PA REQUIRED FOR PROC - MRPAREQ.CSV
- INSTITUTIONAL PRICING TABLE - MRPRCNG.CSV
- PROCEDURE CLAIM TYPES AND PROVIDER TYPES ALLOWED – MRPRPRT.ZIP
- REVENUE CODE WITH TYPE OF BILL - MRRVTOB.ZIP
- PROVIDER TYPE TAXONOMY CROSSWALK - MRPTXNY.ZIP

The following details these file layouts.

Diagnosis Related Group Relative Weights - MRDRGRW.CSV

Interface record layout for diagnosis related group relative weights

Column #	Field Name	Field Type	Format	Max size	Description
1	DRG code	Alphanumeric		5	DRG code
2	DRG description	Alphanumeric		40	DRG description
3	DRG begin date	Date	CCYY-MM-DD	10	DRG begin date
4	DRG end date	Date	CCYY-MM-DD	10	DRG end date
5	Code related weight amount	Numeric	+9999999.99	11	Code related weight amount
6	Service covered code	Alphanumeric		1	Service covered code
7	DRG FMDG code	Alphanumeric		2	DRG FMDG code
8	Interface Creation Date	Date	CCYY-MM-DD	10	Interface Creation Date

Procedure Code Formulary File - MRPCFRM.CSV

Interface record layout for procedure code formulary file with indicators

Col #	Field Name	Field Type	Format	Max size	Description
1	Procedure code	Alphanumeric		7	Procedure code

Col #	Field Name	Field Type	Format	Max size	Description
2	Procedure begin date	Date	CCYY-MM-DD	10	Procedure begin date
3	Procedure end date	Date	CCYY-MM-DD	10	Procedure end date
4	Diagnosis indicator	Alphanumeric		1	Diagnosis indicator
5	Service emergency indicator	Alphanumeric		1	Service emergency indicator
6	Service covered code	Alphanumeric		1	Service covered code
7	Procedure minimum age	Numeric	999	3	Procedure minimum age
8	Procedure maximum age	Numeric	999	3	Procedure maximum age
9	Sex code	Alphanumeric		1	Sex code
10	Family planning code	Alphanumeric		1	Family planning code
11	Sterilization code	Alphanumeric		1	Sterilization code
12	Abortion indicator	Alphanumeric		1	Abortion indicator
13	Referral code	Alphanumeric		1	Referral code (Value 'S' = Rendering Required)
14	Tooth number indicator	Alphanumeric		1	Tooth number indicator
15	Tooth surface indicator	Alphanumeric		1	Tooth surface indicator
16	Multiple surgery indicator	Alphanumeric		1	Multiple surgery indicator
17	PStop days	Numeric	999	3	PStop days
18	Service area code	Alphanumeric		1	Service area code
19	Type unit code	Alphanumeric		1	Type unit code
20	Modification include indicator	Alphanumeric		1	Modification include indicator
21	Place of service include indicator	Alphanumeric		1	Place of service include indicator
22	Provider specialty include indicator	Alphanumeric		1	Provider specialty include indicator
23	Provider type include indicator	Alphanumeric		1	Provider type include indicator
24	Procedure modifier required indicator	Alphanumeric		1	Procedure modifier required indicator
25	CM type include indicator	Alphanumeric		1	CM type include indicator
26	Partial unit indicator	Alphanumeric		1	Partial unit indicator
27	Oral cavity indicator	Alphanumeric		1	Oral cavity indicator
28	Procedure short description	Alphanumeric		40	Procedure short description
29	Conversion unit factor number	Numeric	+9999.999	9	Conversion unit factor number
30	Procedure LTC indicator	Alphanumeric		1	Procedure LTC indicator
31	Retain history code	Alphanumeric		1	Retain history code
32	Duplicate check indicator	Alphanumeric		1	Duplicate check indicator
33	Interface Creation Date	Date	CCYY-MM-DD	10	Interface Creation Date

Place of Service by Procedure Code File - MRPLSVC.CSV

Interface record layout for place of service codes by procedure code

Col #	Field Name	Field Type	Format	Max size	Description
1	Procedure code	Alphanumeric		7	Procedure code
2	Place of service code	Alphanumeric		2	Place of service code
3	Interface Creation Date	Date	CCYY-MM-DD	10	Interface Creation Date

Revenue Code Formulary File - MRRVFRM.CSV

Interface record layout for revenue code formulary file with indicators

Col #	Field Name	Field Type	Format	Max size	Description
1	Revenue code	Alphanumeric		7	Revenue code
2	Procedure short description	Alphanumeric		40	Procedure short description
3	Revenue type code	Alphanumeric		1	Revenue type code
4	Revenue begin date	Date	CCYY-MM-DD	10	Revenue begin date
5	Revenue end date	Date	CCYY-MM-DD	10	Revenue end date
6	Service covered code	Alphanumeric		1	Service covered code
7	Procedure minimum age	Numeric	999	3	Procedure minimum age
8	Procedure maximum age	Numeric	999	3	Procedure maximum age
9	Sex code	Alphanumeric		1	Sex code
10	Provider specialty included indicator	Alphanumeric		1	Provider specialty included indicator
11	Provider type included indicator	Alphanumeric		1	Provider type included indicator
12	Billing type included indicator	Alphanumeric		1	Billing type included indicator
13	Pricing type code	Alphanumeric		1	Pricing type code
14	Pricing begin date	Date	CCYY-MM-DD	10	Pricing begin date
15	Pricing factor code	Alphanumeric		1	Pricing factor code
16	Pricing end date	Date	CCYY-MM-DD	10	Pricing end date
17	Pricing tax indicator	Alphanumeric		1	Pricing tax indicator
18	Pricing maximum units	Numeric	+999999999.	11	Pricing maximum units
19	Pricing procedure amount	Numeric	+9999999.99	11	Pricing procedure amount
20	Rate Source Code	Alphanumeric		2	See Values List Below
21	Interface Creation Date	Date	CCYY-MM-DD	10	Date interface file was created

Revenue Code By Provider Rates File - MRRCPRV.CSV

Interface record layout for revenue code by provider rates

Col #	Field Name	Field Type	Format	Max size	Description
1	Revenue code	Alphanumeric		7	Revenue code
2	Revenue type code	Alphanumeric		1	Revenue type code
3	Provider ID	Alphanumeric		8	Provider ID
4	Provider type code	Alphanumeric		3	Provider type code
5	Provider sort name	Alphanumeric		35	Provider sort name
6	Provider location county code	Alphanumeric		2	Provider location county code
7	Rate begin date	Date	CCYY-MM-DD	10	Rate begin date
8	Rate end date	Date	CCYY-MM-DD	10	Rate end date
9	Rate source code	Alphanumeric		2	Rate source code
10	Rate amount	Numeric	+9999999.99	11	Rate amount
11	Interface Creation Date	Date	CCYY-MM-DD	10	Interface Creation Date

Procedure Code Pricing Span File - MRPCPRC.CSV

Interface record layout for procedure code pricing spans

Col #	Field Name	Field Type	Format	Max size	Description
1	Procedure code	Alphanumeric		7	Procedure code
2	Pricing begin date	Date	CCYY-MM-DD	10	Pricing begin date
3	Factor code	Alphanumeric		1	Factor code
4	Pricing end date	Date	CCYY-MM-DD	10	Pricing end date
5	Tax indicator	Alphanumeric		1	Tax indicator
6	Maximum unit amount	Numeric	+999999999	10	Maximum unit amount
7	Procedure pricing amount	Numeric	+9999999.99	11	Procedure pricing amount
8	Rate Source Code	Alphanumeric		2	See Values List Below
8	Interface Creation Date	Date	CCYY-MM-DD	10	Interface Creation Date

Special Procedure Code Pricing File - MRSPPRC.CSV

Interface record layout for special procedure code pricing

Col #	Field Name	Field Type	Format	Max size	Description
1	Procedure code	Alphanumeric		7	Procedure code
2	Rate type code	Alphanumeric		2	Rate type code
3	Rate hierarchy number	Numeric	9	1	Rate hierarchy number
4	Billing provider ID	Alphanumeric		8	Billing provider ID
5	Provider sort name	Alphanumeric		35	Provider sort name
6	Billing provider type code	Alphanumeric		3	Billing provider type code
7	Rendering provider type code	Alphanumeric		3	Rendering provider type code
8	Category of eligibility code	Alphanumeric		3	Category of eligibility code
9	Billing specialty code	Alphanumeric		3	Billing specialty code
10	Rendering specialty code	Alphanumeric		3	Rendering specialty code
11	Procedure modifier 1st code	Alphanumeric		2	Procedure modifier 1st code
12	Procedure modifier 2nd code	Alphanumeric		2	Procedure modifier 2nd code
13	Procedure modifier 3rd cod	Alphanumeric		2	Procedure modifier 3rd cod
14	Procedure modifier 4th code	Alphanumeric		2	Procedure modifier 4th code
15	Major program code	Alphanumeric		1	Major program code
16	Rate begin date	Date	CCYY-MM-DD	10	Rate begin date
17	Rate end date	Date	CCYY-MM-DD	10	Rate end date
18	Rate source code	Alphanumeric		2	Rate source code
19	Rate amount	Numeric	+9999999.99	11	Rate amount
20	Interface Creation Date	Date	CCYY-MM-DD	10	Interface Creation Date

The special procedure pricing is used when a procedure is not paid across the board at the same pricing, or perhaps not paid to any but a select group of providers. The Rate type has the following values which are used to specify which combination of factors is used to evaluate the pricing. For the most part, the type isn't all that necessary since the fields themselves will indicate what is being used. For instance, if the type is A, the only field populated will be provider; if rate type is F, the provider type and COE will be populated, etc.:

Field: R-RT-TY-CD R-Reference

Rate Modifier type field. Table r_rt_proc_specl_tb will contain 8+ ways of modifying a rate on a procedure. This identifies the type of rate modifier (Blng/Rend type, Rend-Ty/COE, Rend-Ty, etc.)

Value	Long
A	Provider
B	Billing, Rendering Type
C	Rendering Type, COE
D	Rendering Type

E	Rendering Specialty
F	Billing Type, COE
G	Billing Type
H	Billing Specialty
I	Procedure Code

Procedure Matrix File - MRPMTRX.CSV

Interface record layout for procedure matrix file

Col #	Field Name	Field Type	Format	Max size	Description
1	From Procedure Code	Alphanumeric		7	From procedure code
2	To Procedure Code	Alphanumeric		7	To procedure code
3	Service Area Code	Alphanumeric		1	Service Area Code
4	Rate Begin Date	Date	CCYY-MM-DD	10	Rate Begin Date
5	Rate End Date	Date	CCYY-MM-DD	10	Rate End Date
6	Rate Percent	Numeric	+99999.99	9	Provider billing code
7	Rate Amount	Numeric	+9999999.99	11	Provider enrollment status type code
8	Interface Creation Date	Date	CCYY-MM-DD	10	Date interface file was created

Prior Authorization Required File - MRPAREQ.CSV

Interface record layout for PA required for procedure code

Col #	Field Name	Field Type	Format	Max size	Description
1	Procedure code	Alphanumeric		7	Procedure code
2	Prior authorization required code	Alphanumeric		1	Prior authorization required code
3	Interface Creation Date	Date	CCYY-MM-DD	10	Date interface file was created

Institutional Pricing File - MRPRCNG.CSV

Interface record layout for institutional pricing file

Col #	Field Name	Field Type	Format	Max size	Description
1	Provider ID	Alphanumeric		8	Provider ID
2	Major program code	Alphanumeric		1	Major program code
3	Provider type code	Alphanumeric		3	Provider type code
4	Provider type description	Alphanumeric		30	Provider type description
5	Provider location code	Alphanumeric		1	Provider location code
6	Provider sort name	Alphanumeric		35	Provider sort name
7	Doing Business As	Alphanumeric		35	Provider "Doing Business As" Name
8	Provider enrolled status	Alphanumeric		1	Provider enrolled status
9	Location county code	Alphanumeric		2	Location county code
10	Pricing begin date	Date	CCYY-MM-DD	10	Pricing begin date
11	Charge modification code	Alphanumeric		1	Charge modification code
12	Level of care code	Alphanumeric		3	Level of care code
13	Pricing end date	Date	CCYY-MM-DD	10	Pricing end date
14	Passthru amount	Numeric	+9999999.99	11	Passthru amount
15	Rate amount	Numeric	+9999999.99	11	Rate amount
16	Rate percent	Numeric	+9999.999	9	Rate percent
17	Enrolled status end date	Date	CCYY-MM-	10	Enrolled status end date

Col #	Field Name	Field Type	Format	Max size	Description
18	Enrolled status type code	Alphanumeric	DD	2	Enrolled status type code
19	Interface Creation Date	Date	CCYY-MM-DD	10	Date interface file was created

Rate Source Code

Value	Long
AI	Appropriated Increase
AR	Audited Rate
BP	Baseline Price
CA	CPI Adjustment
CC	Cost to Charge Ratio
CP	Capitation
CS	Comparable Service
CT	Contract
EC	Equipmnt and/or Supply Catalog
FP	Federal Pricing
HA	OPPS Always Packaged
HP	OPPS HCPCS Pricing
J1	OPPS Price Mcare APC St Ind Q1
J2	OPPS Price Mcare APC St Ind Q2
J3	OPPS Price Mcare APC St Ind Q3
J5	OPPS NM Mcaid Pay Price Revw
J6	OPPS NM Medicaid Price Review
J7	OPPS NM Medicaid Not Covered
J8	OPPS NM Medicaid Special Revw
J9	OPPS NM Medicaid Covered
JA	OPPS NM Fee Sched APC St Ind A
JB	OPPS Not Payable APC St Ind B
JC	OPPS NotCvrd Inpt APC St Ind C
JE	OPPS Not Covered APC St Ind E
JF	OPPS Price Mcare APC St Ind F
JG	OPPS Price Mcare APC St Ind G
JH	OPPS Price Mcare APC St Ind H
JK	OPPS Price Mcare APC St Ind K
JL	OPPS Price Mcare APC St Ind L
JM	OPPS Not Payable APC St Ind M
JN	OPPS PackagdServ APC St Ind N
JP	OPPS Price Mcare APC St Ind P
JR	OPPS Price Mcare APC St Ind R
JS	OPPS Price Mcare APC St Ind S
JT	OPPS Multi Reduct APC St Ind T
JU	OPPS Price Mcare APC St Ind U
JV	OPPS Price Mcare APC St Ind V
JX	OPPS Price Mcare APC St Ind X
JY	OPPS Not Payable APC St Ind Y
LM	Legislative Mandate
MB	Medicare BC\BS
MR	Manufacturers Retail Price
PM	Percent of Medicare
RV	Relative Value
SD	State Determined (default)
TP	Third Party
WA	AWP + Administration
WC	Wholesale Cost
WD	Average Wholesale Price (AWP)
WP	Average Wholesale Price
ZZ	Not Applicable

FACTOR CODES

Value	Long
0	ASC Not Covered
1	General Fee Schedule
2	General Relative Value Scale
3	Manual Review Fee Schedule
4	Manual Review RVS
5	General by Report
6	General Not Covered
7	ASC Fee Schedule
8	ASC Manual Review Fee Schedule
9	ASC By Report
A	26 Fee Schedule (FS)
B	26 Relative Value Scale (RVS)
C	26 Manual Review Fee Schedule
D	26 Manual Review RVS
E	26 by Report
F	26 Not Covered
G	TC Fee Schedule

H	TC Relative Value Scale	R	Rental Not Covered
I	TC Manual Review Fee Sched	S	Anesthesia Fee Schedule
J	TC Manual Review RVS	T	Anesthesia Relative Value Scal
K	TC by Report	U	Anesthesia Manual Review Fee
L	TC Not Covered	V	Anesthesia Manual Review RVS
M	Rental Fee Schedule	W	Anesthesia by Report
N	Rental Relative Value Scale	X	Anesthesia Not Covered
O	Rental Manual Price-Fee Sched	Y	Outp Prospective Pmt System
P	Rental Manual Price-RVS	Z	Not Applicable
Q	Rental by Report		

Field: R-INST-CHRG-MOD-CD
Pricing control code used to "Rate" (by provider number) price Inpatient claims, along with certain Outpatient claims, including Long Term Care (LTC) claims.

Value	*Long*
A	*Inpatient Percent of Charge*
B	Outpatient Percent of Charge
C	Inpatient Per Diem
D	LTC Per Diem
E	IHS Per Diem
F	Diagnostic Related Group (DRG)
G	Outp Prosp Pmt Sys Pct of Base

Procedure claim types and provider types allowed – MRPRPRT.ZIP
Displays for all active procedure codes whether provider type, provider specialty or claim type is specified and if it is (indicator = 'I'), displays all valid provider type/claims types.

Column #	Field Name	Field Type	Format	Max size
1	Procedure Code	Alphanumeric		X(7)
2	Procedure Code Description	Alphanumeric		X(40)
3	Provider type include indicator	Alphanumeric		X(1)
4	Provider type code	Alphanumeric		X(3)
5	Provider type description	Alphanumeric		X(30)
6	Clam type include indicator	Alphanumeric		X(1)
7	Claim type	Alphanumeric		X(1)
8	Claim type description	Alphanumeric		X(30)
9	Provider Specialty include ind	Alphanumeric		X(1)
10	Provider Specialty Code	Alphanumeric		X(1)
11	Provider Specialty Description	Alphanumeric		X(1)
12	Current Date	Date CCYY-MM-DD		10

Revenue code with type of bill - MRRVTOB.ZIP
Displays for all active revenue codes by revenue type (inpat, outpt or long term care) whether provider type or type of bill code is specified and if it is (indicator = 'I'), displays

all valid provider type/type of bill codes.

Column #	Field Name	Field Type	Format	Max size
1	Revenue code	Alphanumeric		X(7)
2	Revenue code description	Alphanumeric		X(40)
3	Revenue type code	Alphanumeric		X(1)
4	Revenue type of bill include indicator	Alphanumeric		X(1)
5	Revenue provider type include indicator	Alphanumeric		X(1)
6	Revenue type of bill code	Alphanumeric		X(3)
7	Provider type code	Alphanumeric		X(3)

Provider type taxonomy crosswalk - MRPTXNY.ZIP

Column #	Field Name	Field Type	Format	Max size
1	Provider type code	Alphanumeric		X(3)
2	Provider type description	Alphanumeric		X(30)
3	Taxonomy code	Alphanumeric		X(10)

X DMZ SCHEDULE AND USER GUIDE

New Mexico Move It Schedule for Files to DMZ

Category	Path	Sub Folder	Sub Folder	File Name	Retention	Frequency	Time	
Client	/Distribution/NM Operations/(MCO Name)/Client/	LTC Recon/		LTCRECONDAILY_mmddyyyy.ZIP	7	Daily	7 AM EST	MC
				LTCRECON_[mm][dd][yyyy].zip				
		Enrollment_Rosters/	Monthly	CC_FULL_mmddyyyy.zip				
			Daily/	CC_DAILY_mmddyyyy.zip	10	Daily	7 AM EST	MC
					10	Daily	7 AM EST	MC
		MC Informational File		MC_INFO_mmddyyyy.ZIP				
		MCO TO HSD/	To State/	(MCO)ASMNT.mmddyyyy.zip				
			Error_Reports/	CC_ERRORS_mmddyyyy.zip	7	Daily	10 AM EST	MC
Encounter Reports	/Distribution/NM Operations/(MCO Name)/Encounter_Reports/	Drug/		RC070-RC071_mmddyyyy.ZIP	24	Daily	10 AM EST	MC
				RC072_mmddyyyy.ZIP	24	Daily	10 AM EST	MC
				RC073_mmddyyyy.zip	24	Daily	10 AM EST	MC
		Non_Drug/		MA_RC070-RC071_mmddyyyy.ZIP	24	Daily	10 AM EST	MC
				MA_RC072_mmddyyyy.ZIP	24	Daily	10 AM EST	MC
				RC070-RC071_mmddyyyy.ZIP	24	Daily	10 AM EST	MC

			RC072_mmddyyyy.ZIP	24	Daily	10 AM EST	MC
NCPDP							
	/Distribution/NM Operations/(MCO Name)/NCPDP/						
		Prod/					
			(MCO)PDCSC.mmddyyyy.zip	7	M - F	By 8 PM EST	MC
		Test/					
			(MCO)PDCSC.mmddyyyy.zip	7	M - F	No Request	MC
Other							
	/Distribution/NM Operations/(MCO Name)/Other/						
		From Conduent/					
			As needed	7	Any	As needed	Co
		From State/					
			As needed	7	Any	As needed	MC
		To Conduent/					
			As needed	7	Any	As needed	Sta
		To State/					
			As needed	7	Any	As needed	MC
Remittance							
	/Distribution/NM Operations/(MCO Name)/Remittance/						
			CC_03252018.zip	10	Sunday	3 AM EST	MC
TPL							
	/Distribution/NM Operations/(MCO Name)/TPL/						
			(MCO)TPL.mmddyyyy.zip	45	Daily	By 8 PM EST	MC
			TPL_ERRORS_mmddyyyy.zip	45	Daily	7 AM EST	MC
	Posted morning after Full Managed Care Cycle		CC_TPL_mmddyyyy.zip	45	Monthly	7 AM EST	MC
Carrier Listing							

/Distribution/NM Operations/Carrier_Listing/						
Posted morning after Full Managed Care Cycle		CARRIER-LIST_mmddyyyy.zip	45	Monthly	7 AM EST	MC
Provider, Rate & Formulary Files						
/Distribution/NM Operations/Provider, Rate & Formulary Files/						
		CC_PROV_MASTER_mmddyyyy.ZIP	45	2nd of Mth	7 AM EST	MC
		DRG_Relative_Weights_mmddyyyy.zip	45	2nd of Mth	7 AM EST	MC
		Institutional_Pricing_Table_mmddyyyy.zip	45	2nd of Mth	7 AM EST	MC
		PA_Required_for_Procedure_mmddyyyy.zip	45	2nd of Mth	7 AM EST	MC
		Place_of_Service_Codes_mmddyyyy.zip	45	2nd of Mth	7 AM EST	MC
		Procedure_Code_Formulary_mmddyyyy.zip	45	2nd of Mth	7 AM EST	MC
		Procedure_Code_Pricing_Spans_mmddyyyy.zip	45	2nd of Mth	7 AM EST	MC
		Procedure_Code_Provider_and_Claim_Types_mmddyyyy.ZIP	45	2nd of Mth	7 AM EST	MC
		Procedure_Matrix_mmddyyyy.zip	45	2nd of Mth	7 AM EST	MC
		Provider_Taxonomy_Codes_mmddyyyy.ZIP	45	2nd of Mth	7 AM EST	MC
		Revenue_Code_by_Provider_Rates_mmddyyyy.zip	45	2nd of Mth	7 AM EST	MC
		Revenue_Code_Formulary_mmddyyyy.zip	45	2nd of Mth	7 AM EST	MC
		Revenue_Codes_and_Types_of_Bill_mmddyyyy.ZIP	45	2nd of Mth	7 AM EST	MC
		Special_Procedure_Code_Pricing_mmddyyyy.zip	45	2nd of Mth	7 AM EST	MC
	Confirmations/					
		PROV_CONFIRM_mmddyyyy.ZIP	10	Daily	10 AM EST	MC
EDI Gateway						
/Distribution/EDI Gateway/B2B5010/77048/(Trading Partner ID)/						
	FromEDI/					
		Confirmation Reports/				
		yymmddCR.nnn	30	Daily	Various	ED
		NEW MEXICO 5010 271/				
		???	30	???	Various	ED
		NEW MEXICO 5010 277CA/				
		NM_yymmdd_77048_O_590215_9550011_277ca_(TPID)_277CA.nnn	30	Daily	Various	ED
		NEW MEXICO 5010 820/				
		NM_yymmdd_77048_O_591019_(MCO ID)_820_(TPID)_820.nnn	30	Weekly	Various	ED
		NEW MEXICO 5010 834/				

		NM_yymmdd_77048_O_589730_(MCO IDnnnn)_834_(TPID)_834.nnn	30	Daily	Various	ED
	NEW MEXICO 5010 835/					
		???	30	???	Various	ED
	NEW MEXICO 5010 999/					
		NM_yymmdd_03060046_N87_9550010_999.nnn	30	Daily	Various	ED
	NEW MEXICO 5010 ERROR REPORT/					
		NM_yymmdd_ERR.nnn	30	Daily	Various	ED
	NEW MEXICO 5010 TA1/					
		NM_yymmdd_03050184_N88_9545456_TA1.nnn	30	Daily	Various	ED
ToEDI/						
	837 Encounter Files	Varies from MCO to MCO	30	Daily	Various	MC

New Mexico

Users Guide

Table of Contents

Overview

The New Mexico MOVEit DMZ is a secure file transfer facility being used to transfer files and reports between Conduent, New Mexico State Departments, New Mexico MCOs, and Third Parties designated by the state of New Mexico. The files and reports to be transferred between entities are uploaded by the transmitting entity into a designated folder that the receiving entity has the authority to read and/or download the file or report from. The access security in MOVEit DMZ is controlled at the folder level. Users are granted Read, Write, Delete, List, and/or Notify access to each folder, that they need, to perform their duties. Administrators in MOVEit DMZ may also be granted Sub and/or Admin authority so that they may create folders and/or administer the user's folder access rights.

Each folder in MOVEit DMZ has a number of retention days associated with it. The number of retention days controls how long a file or report will remain in that folder before they are automatically deleted from that folder and MOVEit DMZ. The number of retention days is expressed in calendar days and not work days. As a general rule, folders that contain daily or weekly files have a 10 day retention period and folders for monthly files have a 45 day retention period. There are exceptions to the number of days on certain folders. If you have a question about the retention for a specific folder please contact one of the New Mexico MOVEit DMZ administrators.

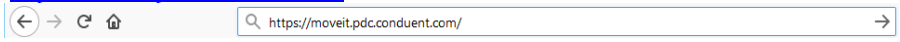
The New Mexico MOVEit DMZ is NOT a file storage area.

The Website

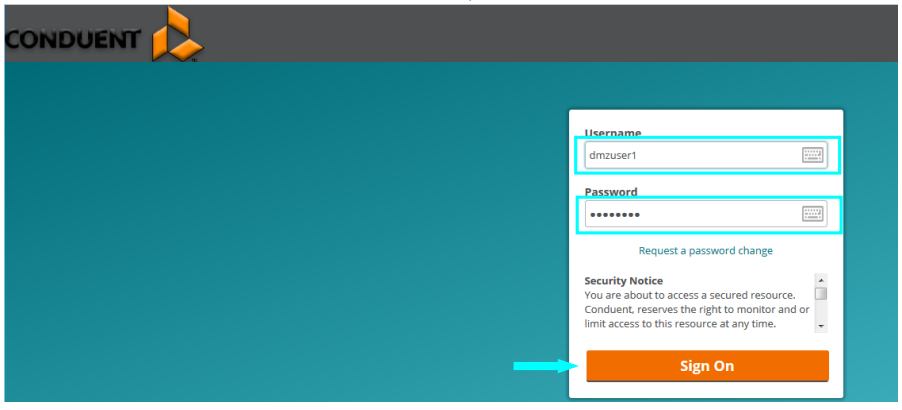
The New Mexico MOVEit DMZ is access via the World Wide Web and may be accessed from any computer with one of the major web browsers installed. The URL of the New Mexico MOVEit DMZ is https://moveit.pdc.conduent.com/ . This is a secure website and may only be accessed by an authorized user.

Logging On

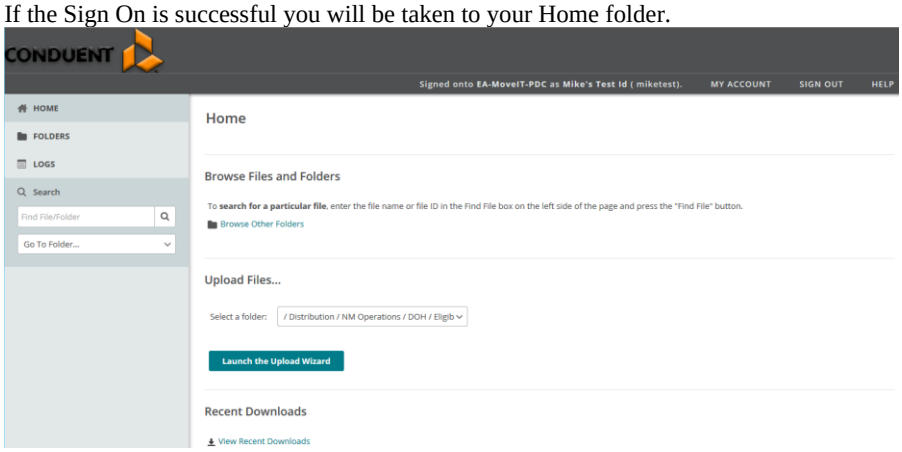
Enter the New Mexico MOVEit DMZ URL in your browsers address bar.
https://moveit.pdc.conduent.com/



You will receive the Sign On screen. Enter your User ID and Password and then click **Sign On**.

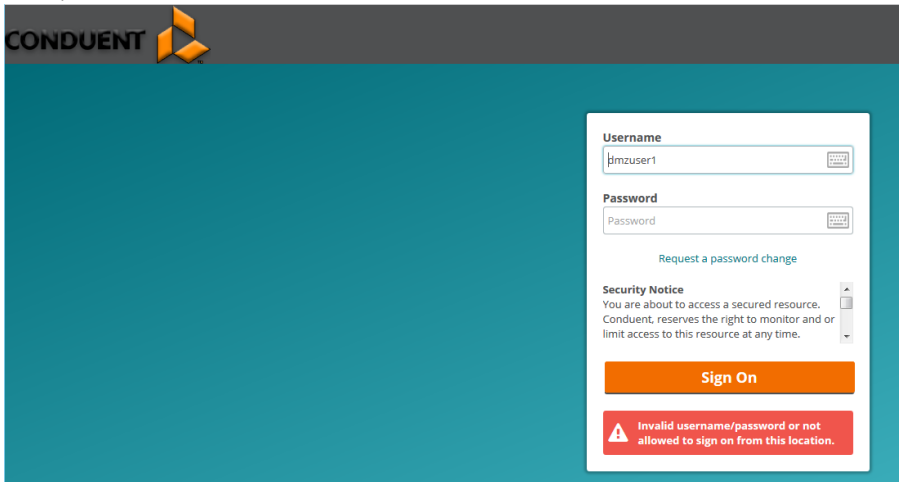


If the Sign On is successful you will be taken to your Home folder.



If the Sign On failed you will receive the Sign On screen with the following message:

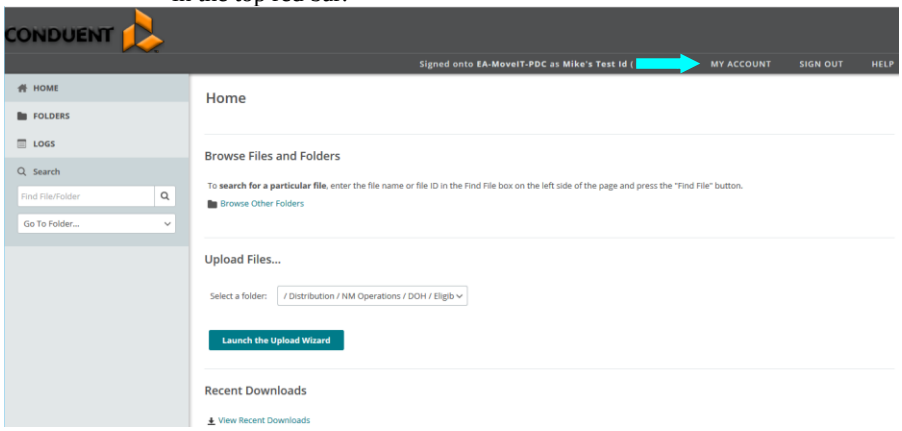
This message is generic to help prevent unauthorized access to the New Mexico MOVEit DMZ.



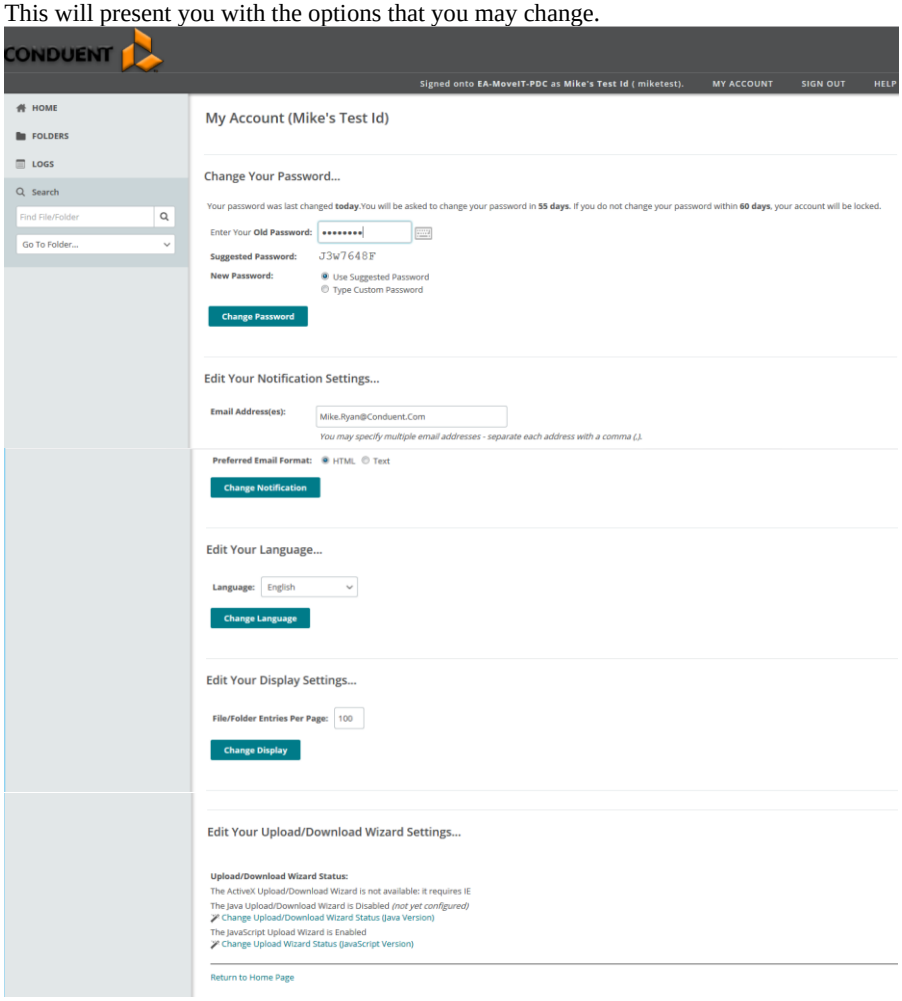
Remember that the Username is not case sensitive but the Password is. If you have received this screen try to reenter your information. If you continue to receive this screen please contact one of the New Mexico MOVEit DMZ administrators to have a new password assigned and to verify your Username.

Your Account Options

From your home page you can change some of your account options by clicking on MY ACCOUNT in the top red bar.

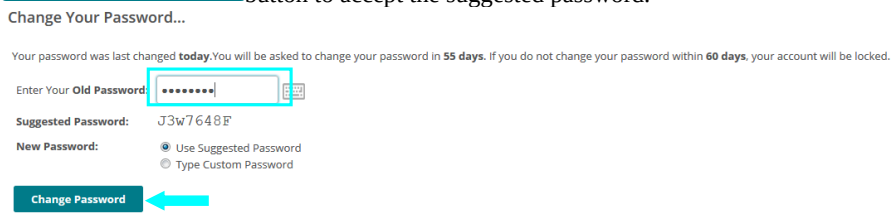


This will present you with the options that you may change.

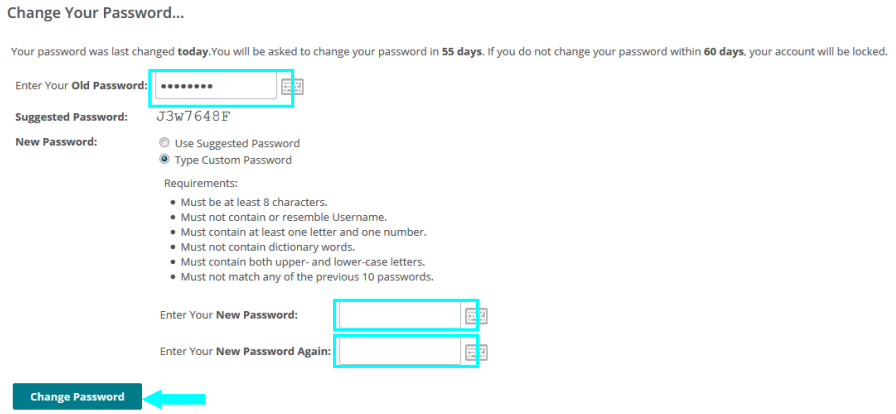


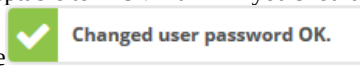
Changing Your Password

You will need to enter your existing password in the space provided and then click on the **Change Password** button to accept the suggested password.

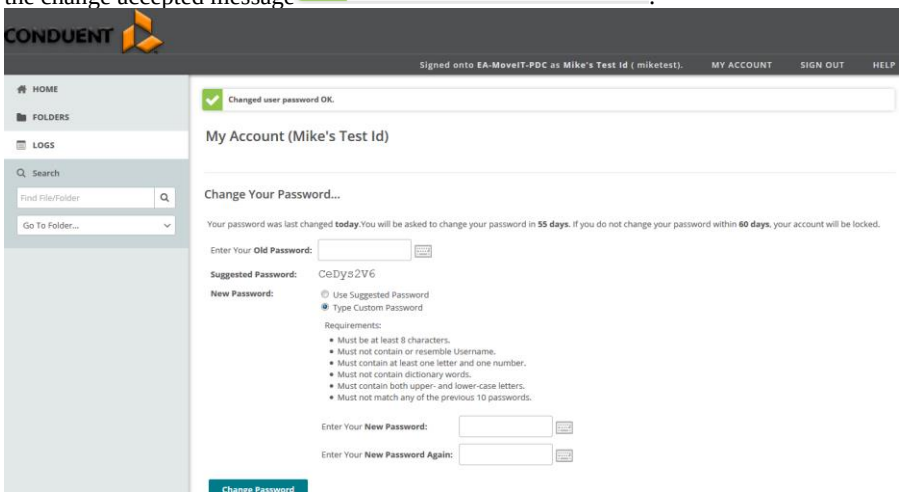


If you want to enter a custom password, First click on the Type Custom Password radio button and the screen will change to allow you to enter your custom password.

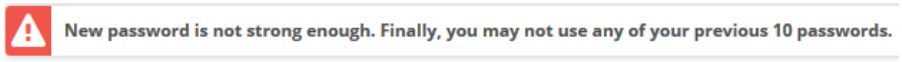


If your new password is acceptable to MOVEit DMZ you should get the next screen with the change accepted message 

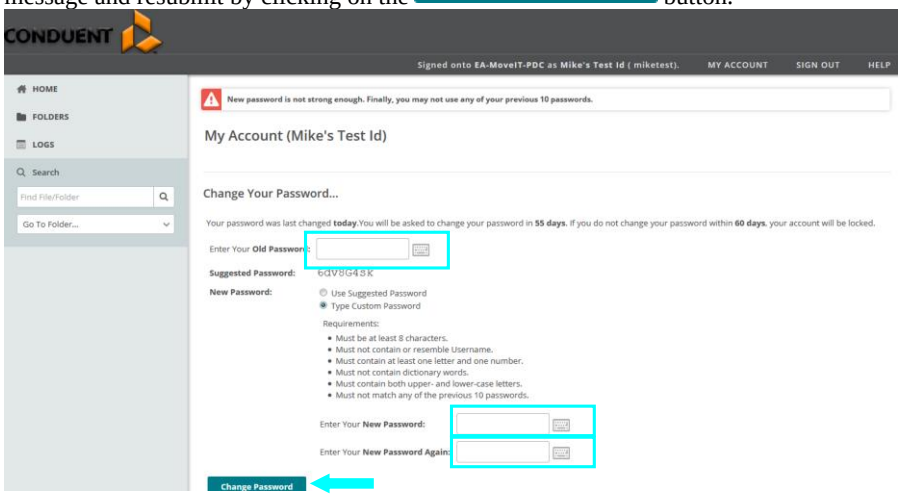
.



If your new password is not acceptable to MOVEit DMZ you will get this screen and the rejected message:

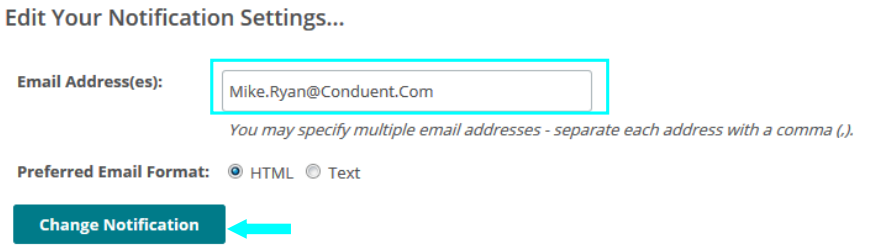


Reenter your information and correct your new password to conform to the rules in the message and resubmit by clicking on the **Change Password** button.

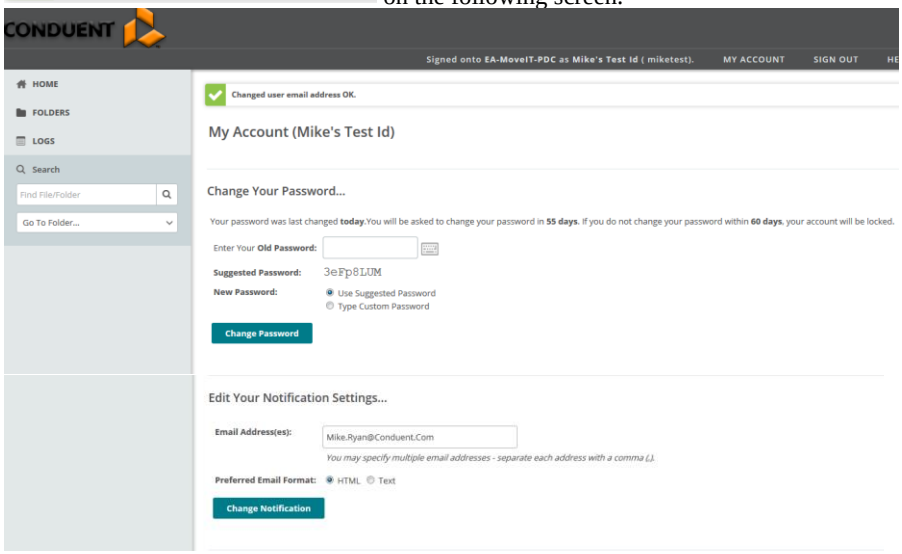


Your Notification Settings

To change your 'Notification Setting' just over type the current values with your updated information and click on the **Change Notification** button.



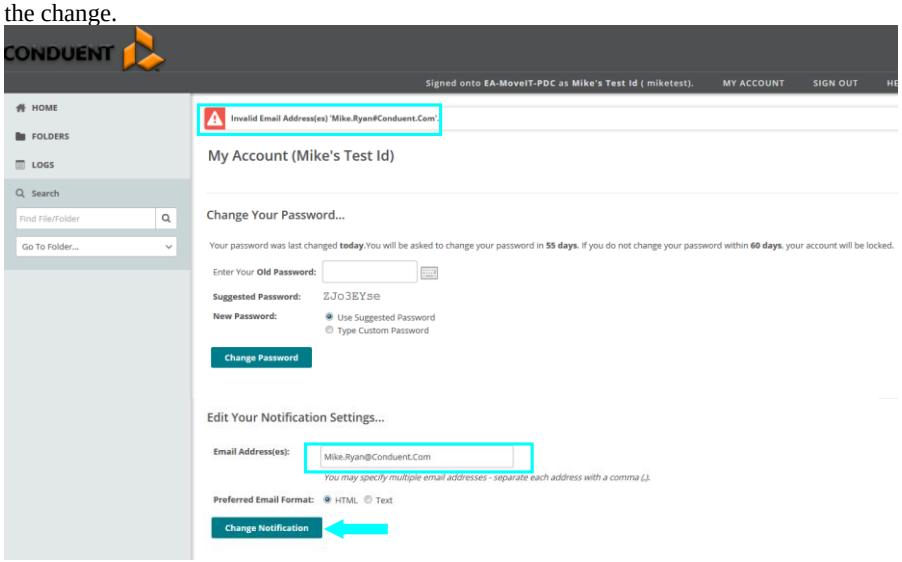
If your changes are accepted you will get this OK message **Changed user email address OK.** on the following screen.



If you enter an invalid email address you will get this message

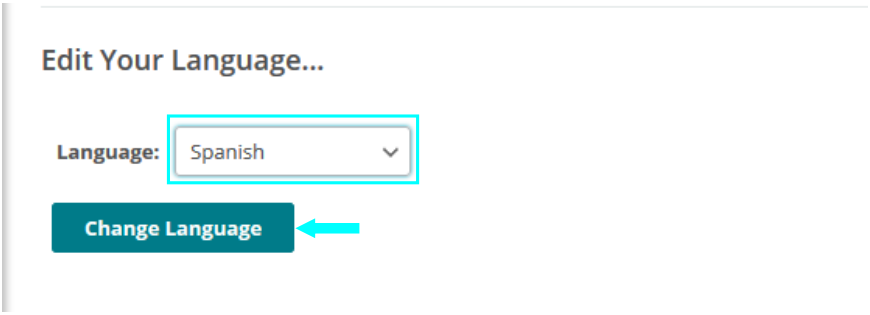
Invalid Email Address(es) 'Mike.Ryan#Conduent.Com'.

showing the invalid address. The screen will be redisplayed with the original email address redisplayed. Enter a valid email address and resubmit if you still need to make the change.

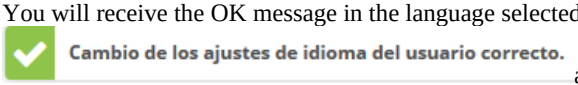


Your Language Setting

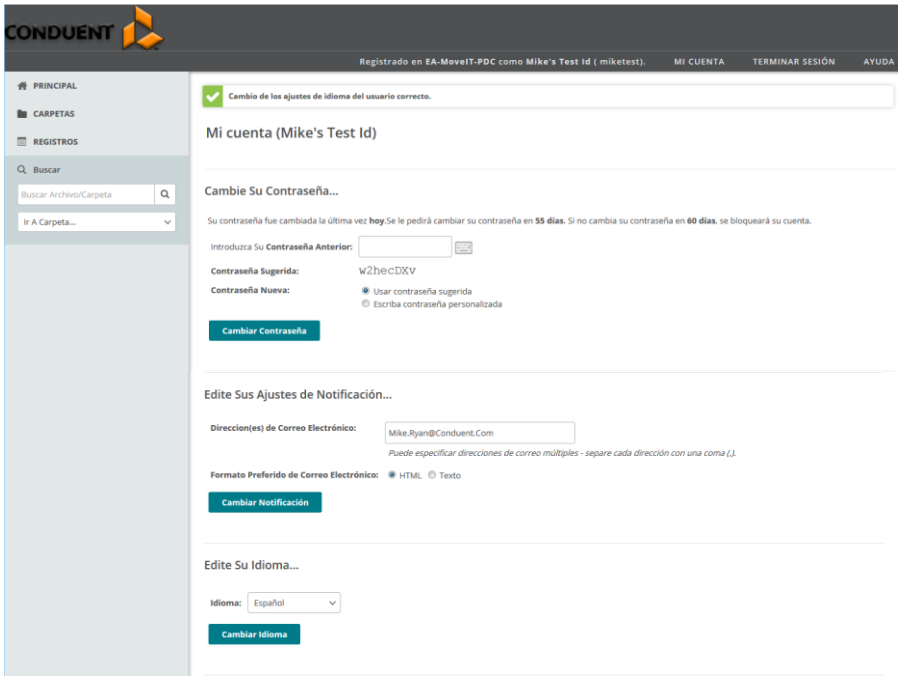
Here you can adjust the language that the screens are displayed in from the dropdown menu by selecting the language you want and then click the **Change Language** button.



You will receive the OK message in the language selected



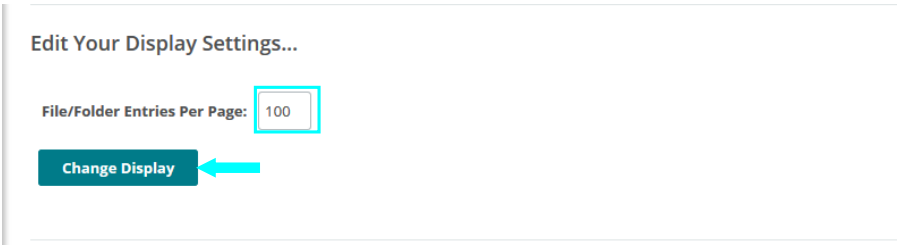
and the screen will then be displayed in that language.


CONDUENT
Registrado en EA-MoveIT-PDC como Mike's Test Id (miketest).
MI CUENTA
TERMINAR SESIÓN
AYUDA
PRINCIPAL
CARPETAS
REGISTROS
Buscar
Buscar Archivo/Carpeta
Ir A Carpeta...
Cambio de los ajustes de idioma del usuario correcto.
Mi cuenta (Mike's Test Id)
Cambie Su Contraseña...
Su contraseña fue cambiada la última vez hoy.Se le pedirá cambiar su contraseña en 55 días. Si no cambia su contraseña en 60 días, se bloqueará su cuenta.
Introduzca Su Contraseña Anterior:
Contraseña Sugerida:
w2hecDXv
Contraseña Nueva:
Usar contraseña sugerida
Escriba contraseña personalizada
Cambiar Contraseña
Edite Sus Ajustes de Notificación...
Direccion(es) de Correo Electrónico:
Mike.Ryan@Conduent.Com
Puede especificar direcciones de correo múltiples - separe cada dirección con una coma (,).
Formato Preferido de Correo Electrónico:
HTML
Texto
Cambiar Notificación
Edite Su Idioma...
Idioma:
Español
Cambiar Idioma

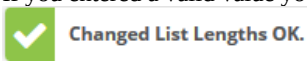
Your Display Setting

Here you can adjust the number of folders or files that will be displayed on any given page. The valid values for number of entries on a page are between 5 and 200. If you enter a value outside of this range you will get an error message.

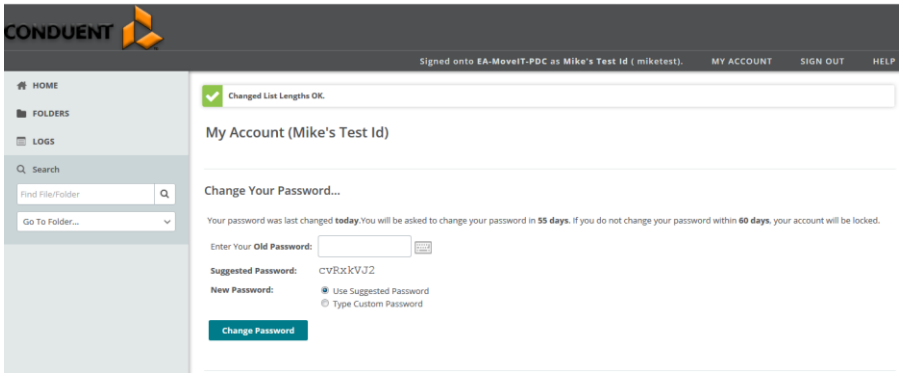
Enter the number of entries you want on a page and then click the **Change Display** button.



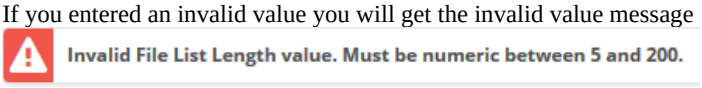
If you entered a valid value you will get the accepted message



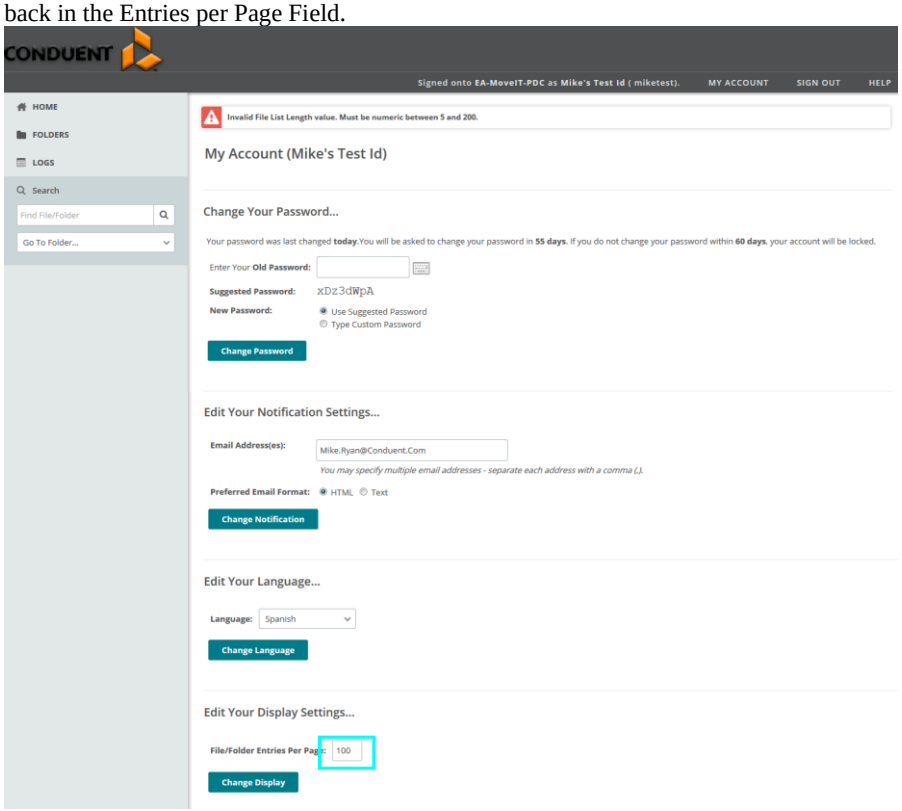
and be returned to top of the Account Options page



If you entered an invalid value you will get the invalid value message



and be returned to top of the Account Options page and the original value will be placed back in the Entries per Page Field.



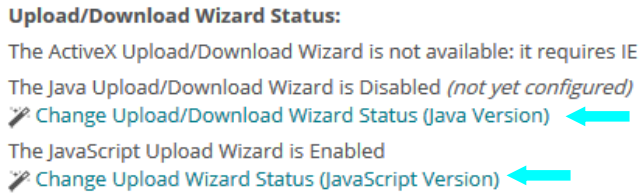
Edit Your Upload/Download Wizard Settings…

We recommend that you leave the Wizard active and use it whenever uploading or downloading files.

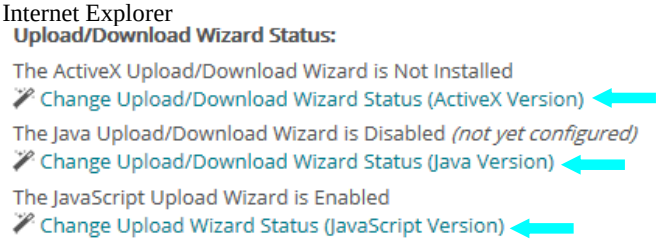
In this area you can activate or deactivate the Upload/Download Wizard. If you are using Internet Explore as your browser then the ActiveX Wizard will be an option. If you are using FireFox or any other browser then you will be using the Java Version or the JavsScript Version

You can change the current status of the Wizard by clicking on
Change Upload/Download Wizard Status (Java Version) or
Change Upload Wizard Status (JavaScript Version) or
Change Upload/Download Wizard Status (ActiveX Version)
as shown below. Your options here will depend upon the browser you are using.

Mozilla FireFox

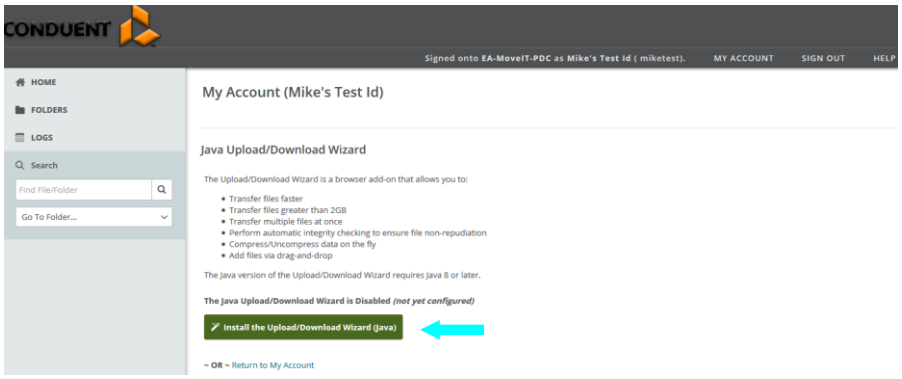


Internet Explorer

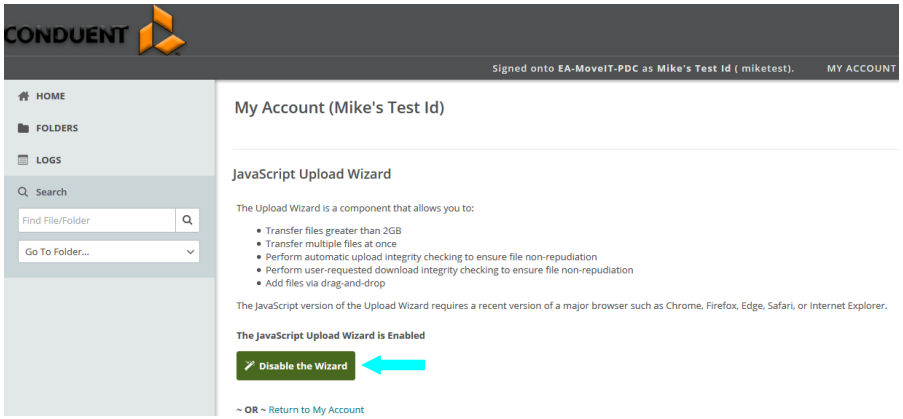


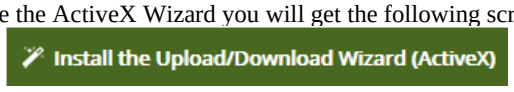
If you are using the Java or JavaScript Wizard you will get the following screen that will give you the options to “Enable” the Wizard if not enabled or “Disable” if it is currently enabled by clicking on your choice.

You will get this screen when trying to “Enable” the Wizard



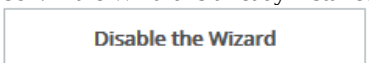
Or this screen if you are trying to “Disable” the Wizard



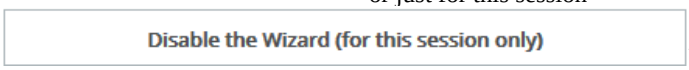
If you want to use the ActiveX Wizard you will get the following screen that will give you the option to 

by clicking on this

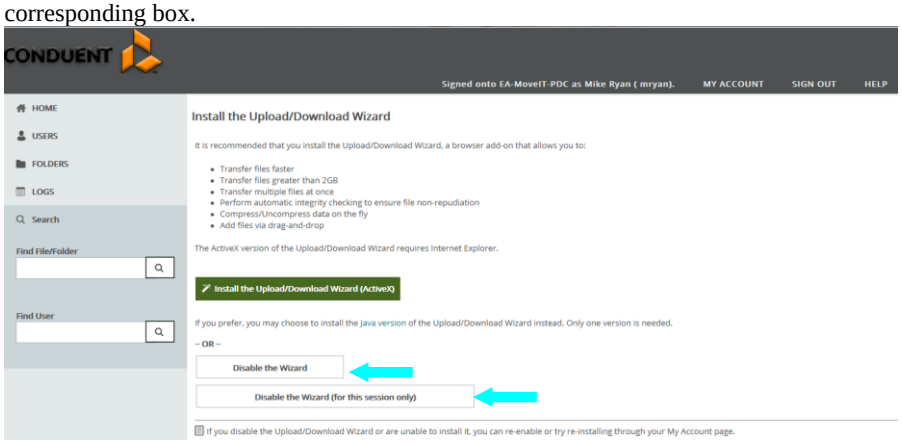
box. If the Wizard is already installed then you can either Disable the Wizard completely



or just for this session



by clicking on the corresponding box.

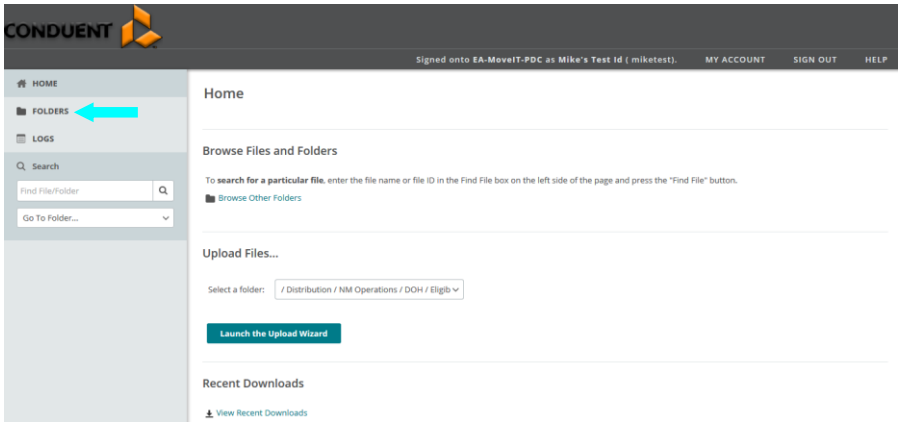


Navigation

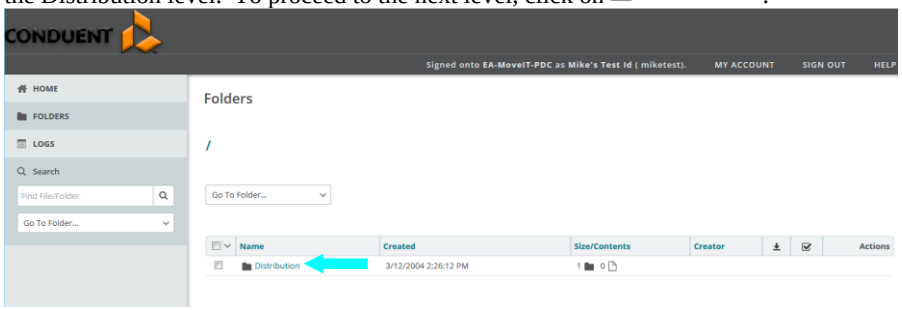
In general navigation in MOVEit DMZ is as simple as point and click. On any of the DMZ screens when you see an underlined word you may click on that word and you will be taken to that screen. The next two sections will show you two ways to navigate to the file or folder that you want to work with.

The Step Down Method

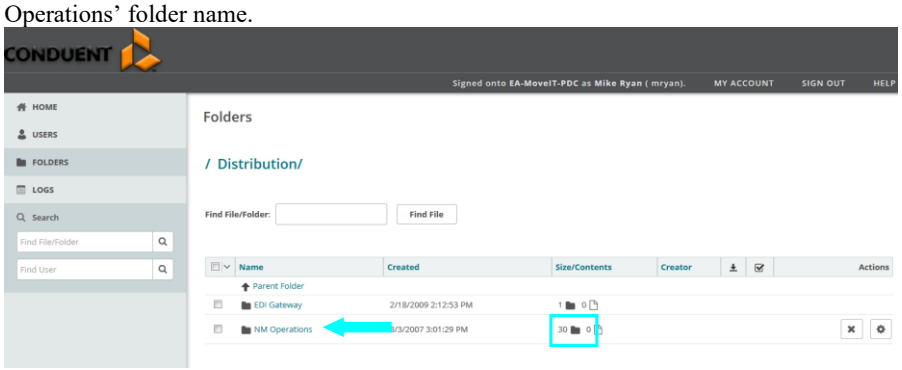
The Step Down Method will take you one level deeper into the folder structure each time you select the next folder in the chain. Once you are signed on and are on your home page start the process by clicking on the FOLDERS icon on the upper left of the screen.



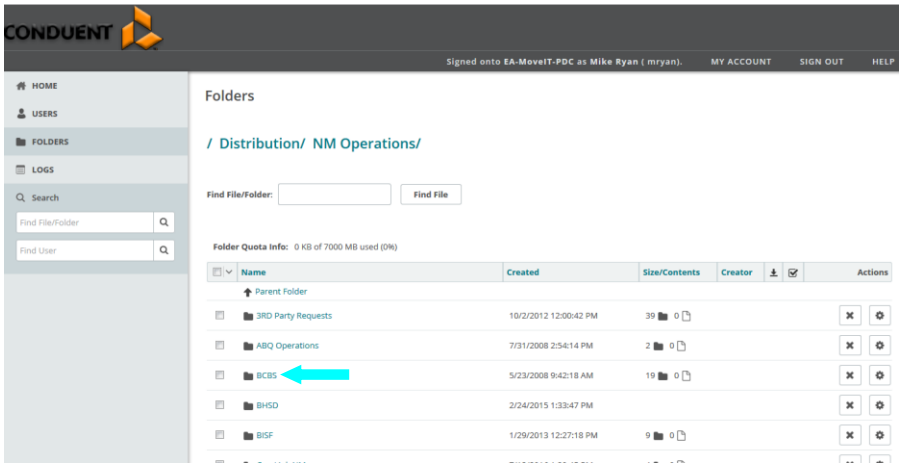
You will be taken to the first level to which you have access, which in most cases will be the Distribution level. To proceed to the next level, click on Distribution .



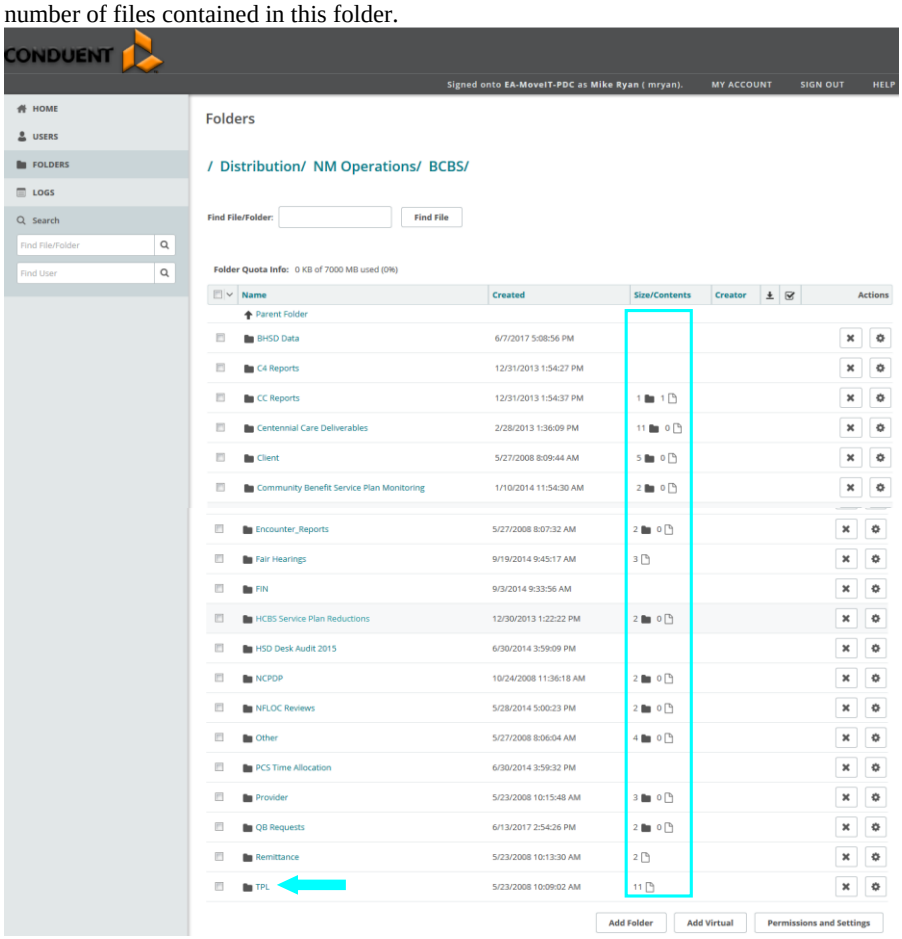
The next level will be displayed as seen below. Note that the 'NM Operations' folder shows that there are 30 sub folders to this one. To see the next level, click on the 'NM Operations' folder name.



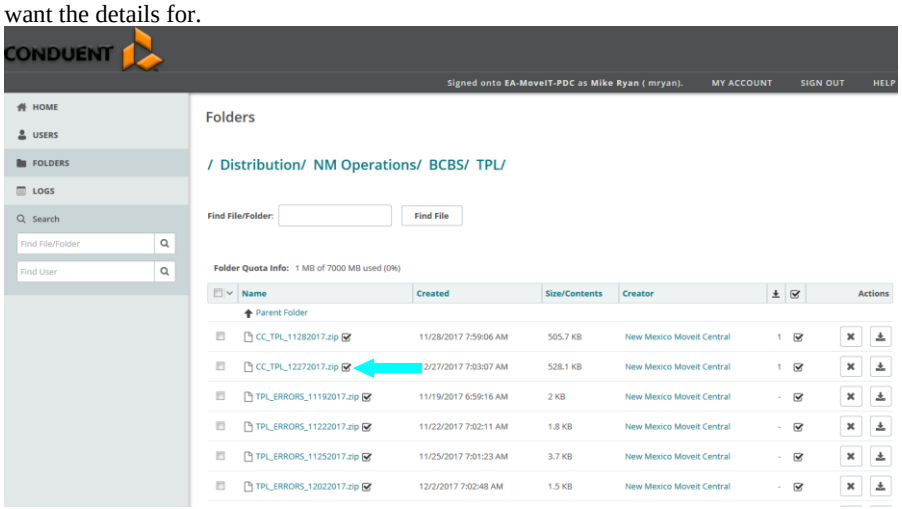
This next screen will vary, depending on the number of files to which you have access, at each level as you continue to drill down to the various levels. You continue to drill down, by clicking on the name of the folder you want, to reach the next level.


CONDUENT
Signed onto EA-MoveIT-PDC as Mike Ryan (mryan).
MY ACCOUNT
SIGN OUT
HELP
HOME
USERS
FOLDERS
LOGS
Search
Find File/Folder
Find User
Folders
/ Distribution/ NM Operations/
Find File/Folder:
Find File
Folder Quota Info: 0 KB of 7000 MB used (0%)
Name
Created
Size/Contents
Creator
Actions
Parent Folder
3RD Party Requests
10/2/2012 12:00:42 PM
ABQ Operations
7/31/2008 2:54:14 PM
BCBS
5/23/2008 9:42:18 AM
BHSD
2/24/2015 1:33:47 PM
BISF
1/29/2013 12:27:18 PM

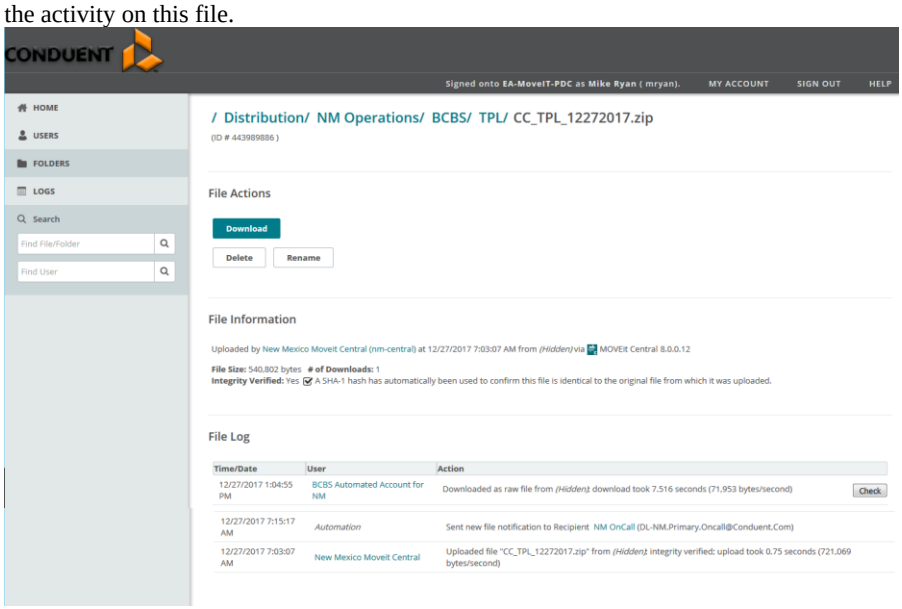
The results from the above selection are show below. You will notice that the column titled 'Size/Contents' shows 2 values. The number before the folder icon indicates the number of sub folders to this folder and the number before the sheet of paper icon is the number of files contained in this folder.



The selection of the 'TPL' folder will display the files contained in the folder. This is the lowest level in this chain. This screen shows when the files were placed in this folder, the size of the file, the entity that placed the files there, the number of times the file has been down loaded, an option to delete the file (if you have that permission for this folder) and the download button.
You can now select a single file to get further detail on the file by clicking on the file you want the details for.



You will now have the details on this file. This is the lowest level for any chain. The screen received will show you the Actions that you can take against this file, File Information such as the entity that uploaded the file, the file size, how many time it has been downloaded, and if it was verified when it was uploaded. You will also get a Log of the activity on this file.

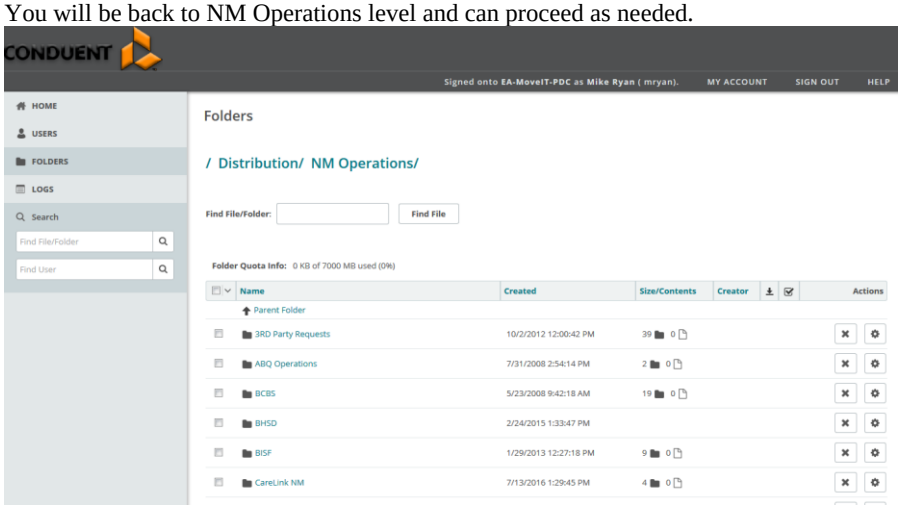


To find the next file you want to work with, you can click on 

to start the process over or you can go directly to any of the levels displayed at the top of the screen 

by clicking on the level you want. To go directly to NM Operations just click on it.

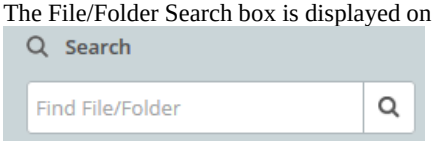
You will be back to NM Operations level and can proceed as needed.



The File/Folder Search Method

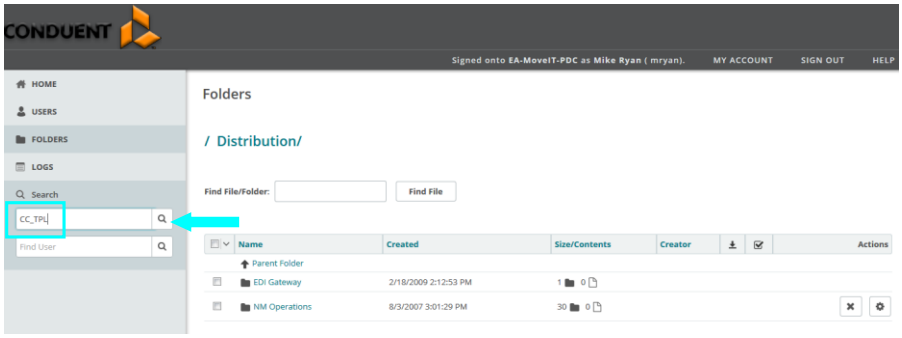
The File/Folder Search Method will allow you to enter a file or folder name or partial name and it will return a list of matches to which you have access. From the list you just need to click on the one you want and you will be taken there.

The File/Folder Search box is displayed on all pages.

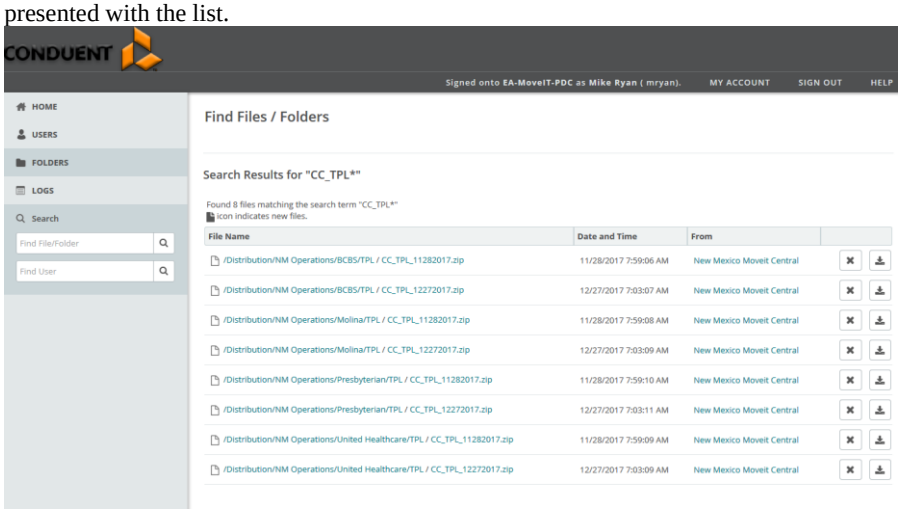


This box is displayed in the upper left quadrant of each page.

Let's find the CC_TPL_12272017.zip file for BCBS since we know we have access to that file. We will enter CC_TPL in the Find File/Folder Box and click on  .



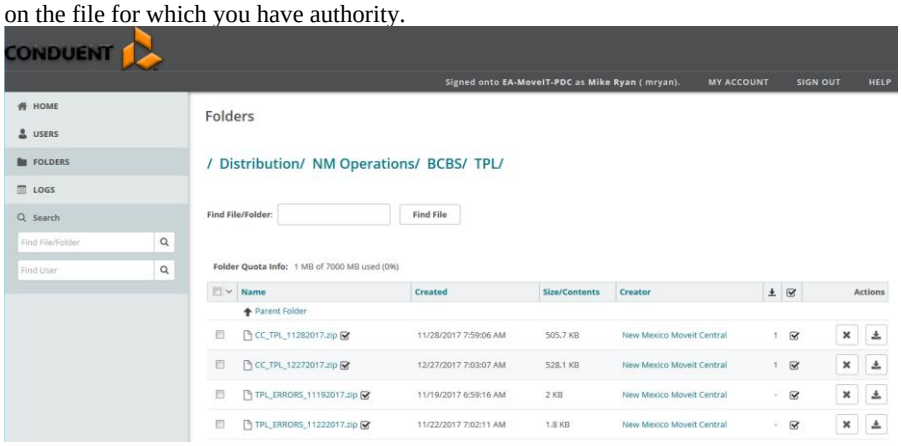
This user has access to 8 File/Folders that contain CC_TPL in the name and we are presented with the list.



Now just scroll down until we find the file we are looking for. Once found just click on the path for that file. /Distribution/NM Operations/BCBS/TPL / CC_TPL_12272017.zip

File Name	Date and Time	From
/Distribution/NM Operations/BCBS/TPL / CC_TPL_11282017.zip	11/28/2017 7:59:06 AM	New Mexico Moveit Central
/Distribution/NM Operations/BCBS/TPL / CC_TPL_12272017.zip	12/27/2017 7:03:07 AM	New Mexico Moveit Central
/Distribution/NM Operations/Molina/TPL / CC_TPL_11282017.zip	11/28/2017 7:59:08 AM	New Mexico Moveit Central
/Distribution/NM Operations/Molina/TPL / CC_TPL_12272017.zip	12/27/2017 7:03:09 AM	New Mexico Moveit Central
/Distribution/NM Operations/Presbyterian/TPL / CC_TPL_11282017.zip	11/28/2017 7:59:10 AM	New Mexico Moveit Central
/Distribution/NM Operations/Presbyterian/TPL / CC_TPL_12272017.zip	12/27/2017 7:03:11 AM	New Mexico Moveit Central
/Distribution/NM Operations/United Healthcare/TPL / CC_TPL_11282017.zip	11/28/2017 7:59:09 AM	New Mexico Moveit Central
/Distribution/NM Operations/United Healthcare/TPL / CC_TPL_12272017.zip	12/27/2017 7:03:09 AM	New Mexico Moveit Central

You will be taken to the folder that contains that file. You can now perform any action on the file for which you have authority.

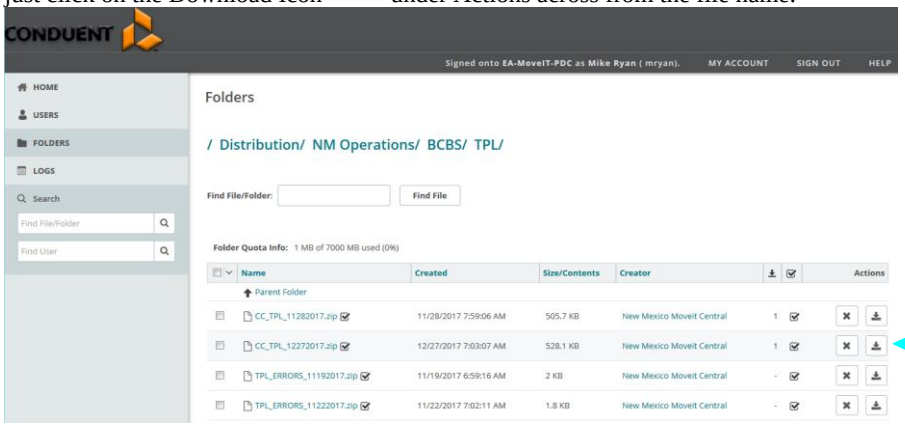


File Activities

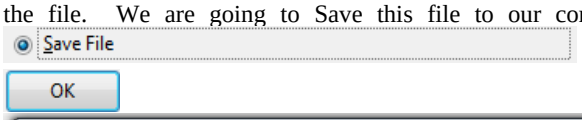
Downloading Files

In order to be able to download a file from MOVEit DMZ you will need to first locate the file using one of the methods described in the previous section and you will have to have the necessary authority for that file. As a general rule, if you have permission to view a file, you will also be able to download that file.

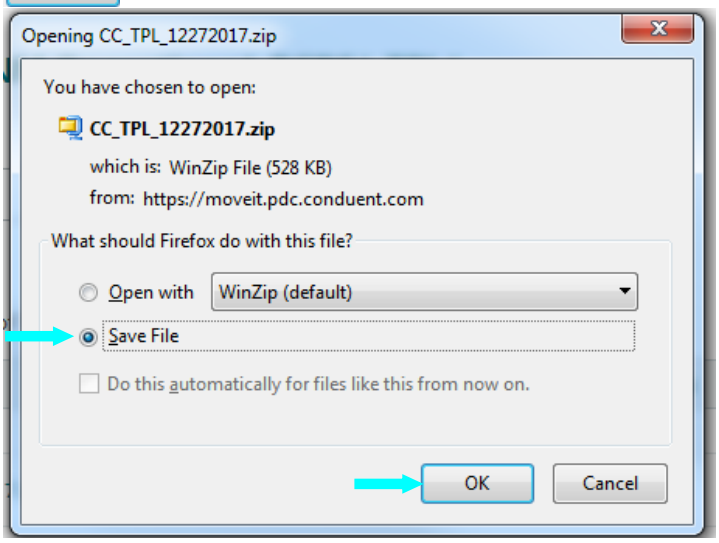
We will use the file we located in the previous section to download. To start the Download just click on the Download Icon  under Actions across from the file name.



The Download Wizard box will be presented and this will give the option to Open or Save the file. We are going to Save this file to our computer so we will select the

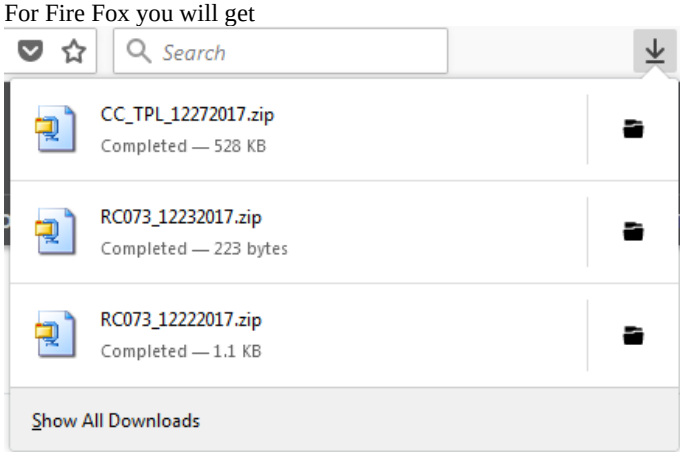


button and then click



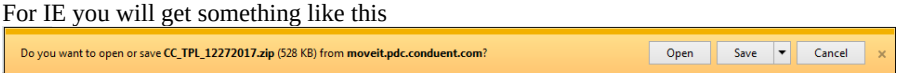
The file will be download into your browsers download area.

For Fire Fox you will get



From here you can Open the file, Open the folder and then from either do standard "Save" or "Save As" function and place the file where you want it.

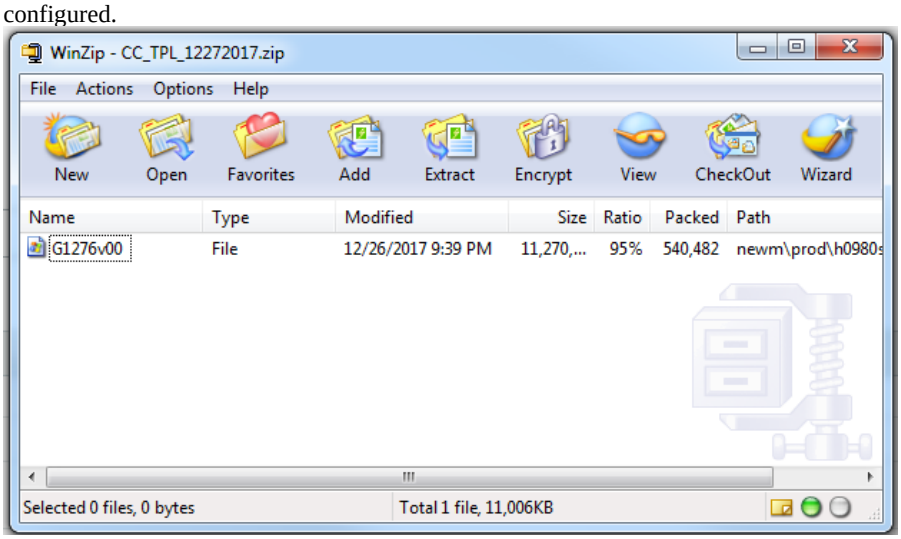
For IE you will get something like this



When you click on save the file will be downloaded and you get a message like this

From here you can Open the file, Open the folder and then from either do standard "Save" or "Save As" function and place the file where you want it.

If you select the Open option on any of the above screen you will be presented with the Zip utility you have installed and set as the default for zip files. In this case the WinZip window to unzip the file will be presented. This may vary depending on what software you have installed on your compute that you use to unzip a file and how you have it configured.



Process the Unzip according to the product you are using.

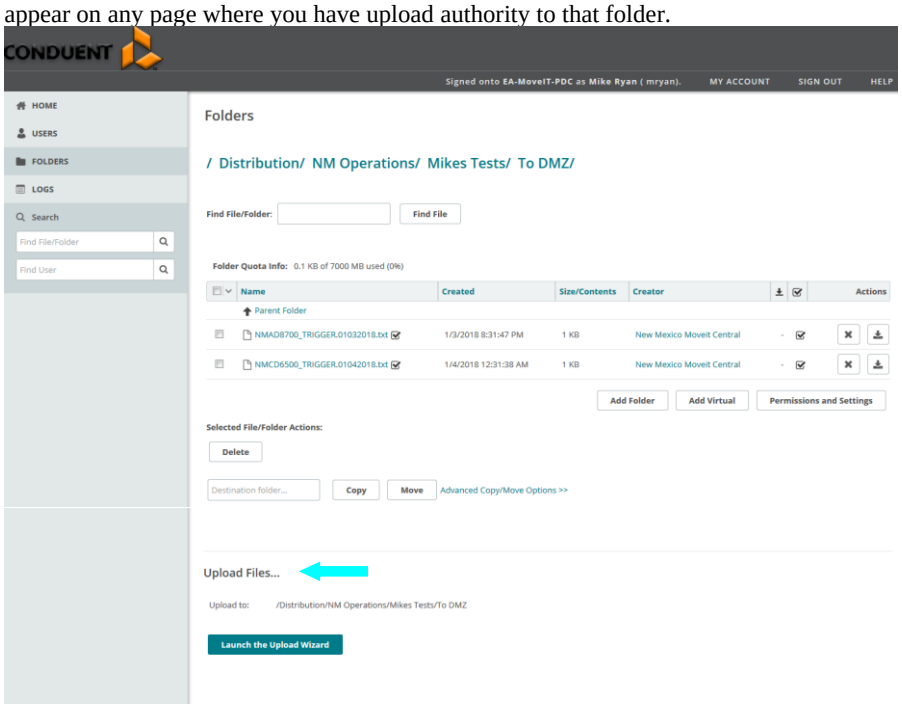
Uploading Files

Please refer to the 'File Naming Convention for DMZ Procedures' document if you are uploading a file that will be processed by Conduent.

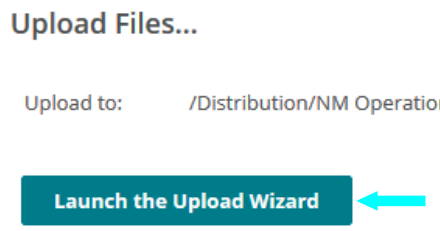
Using the Upload Wizard

The upload process is easiest when using the MOVEit Upload Wizard. The wizard will allow you to upload multiple files at one time. The file will be named on DMZ as they appear in the Upload Wizard window.

You will have to navigate to a folder to which you have upload authority then your page will look something like this. Notice the Upload Files... banner, this banner will appear on any page where you have upload authority to that folder.

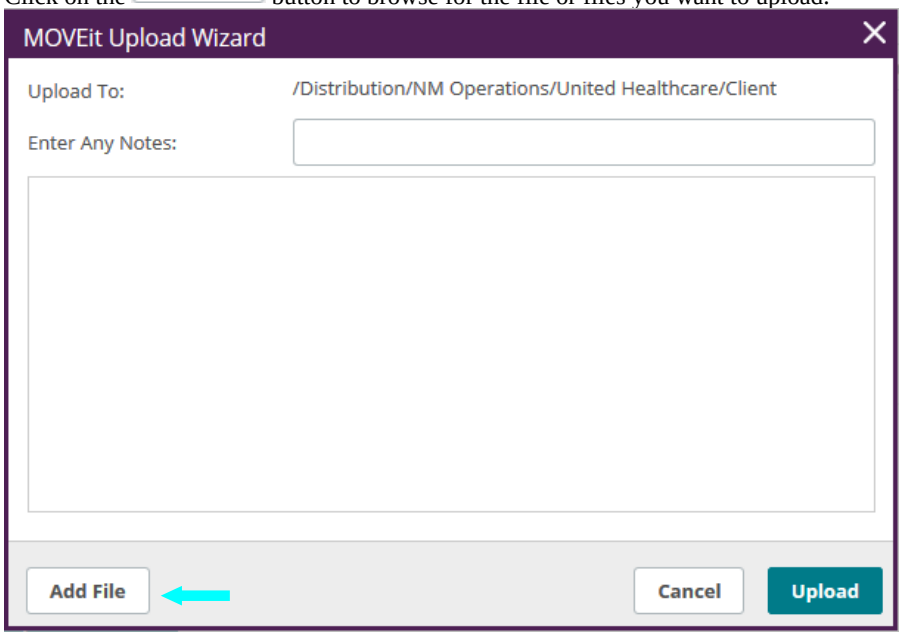


The next step is to activate the Upload Wizard by clicking on the **Launch the Upload Wizard** box.

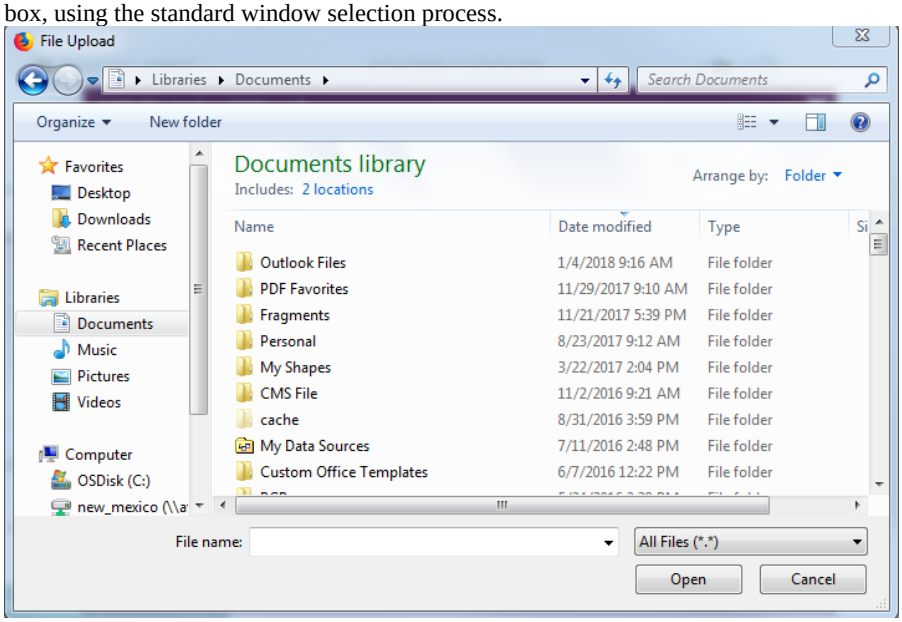


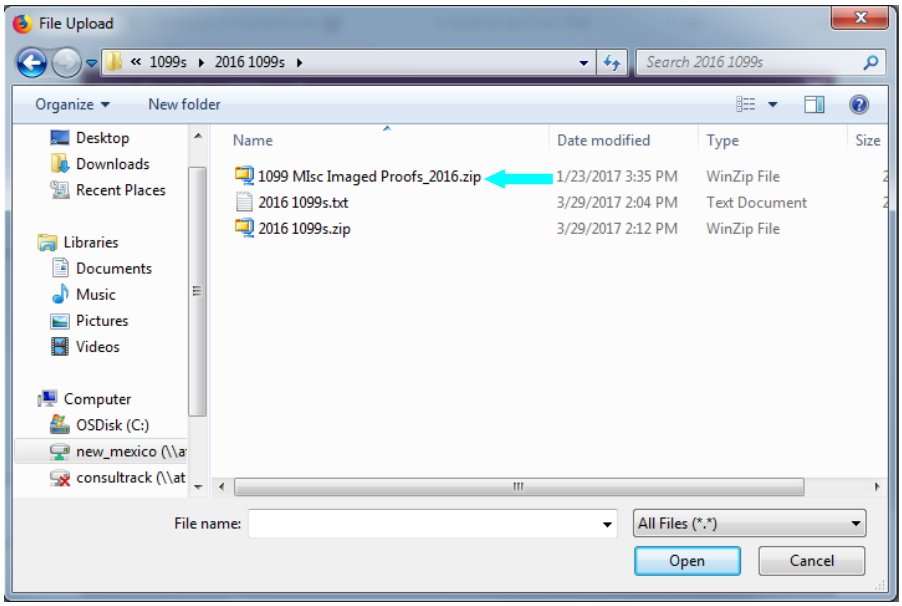
The Upload Wizard dialogue box will be displayed next.

Click on the **Add File** button to browse for the file or files you want to upload.



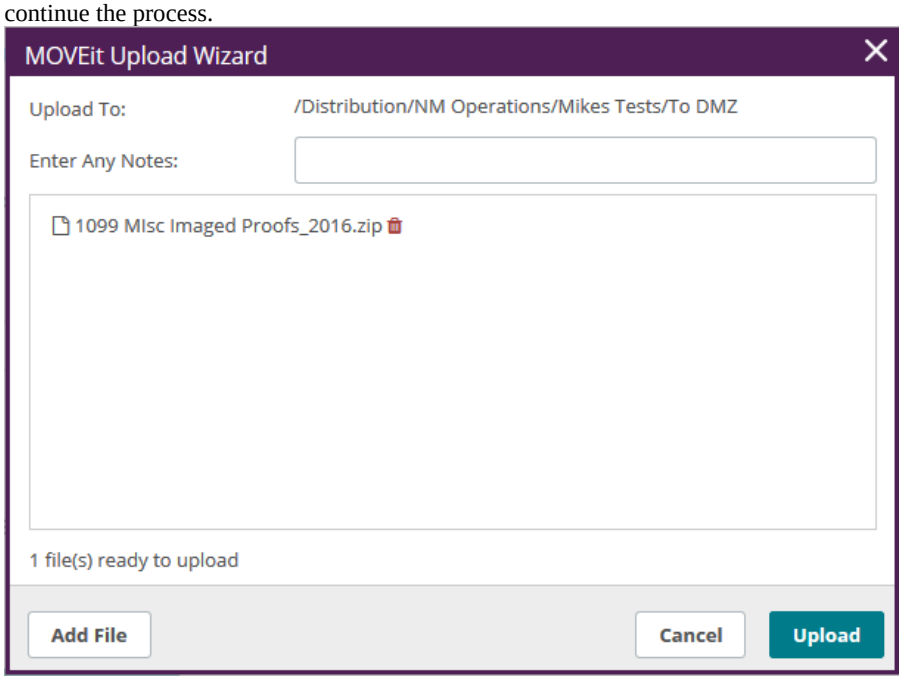
Select the file you want to upload and it will be placed in the Upload Wizard dialogue box, using the standard window selection process.





You can repeat the above process if you want to upload multiple files to the same folder.

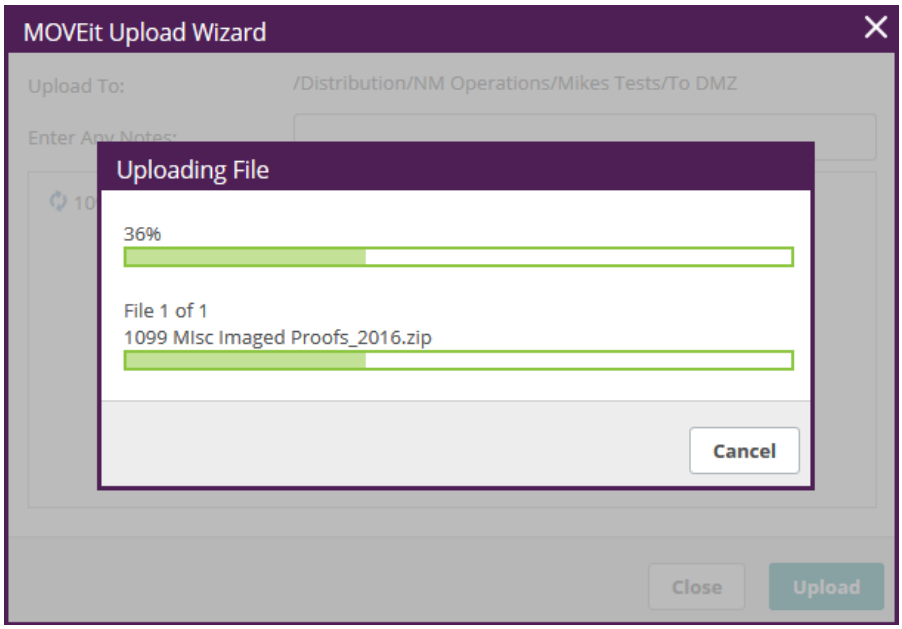
Once you have selected the file or files to upload, click on the Upload button to continue the process.



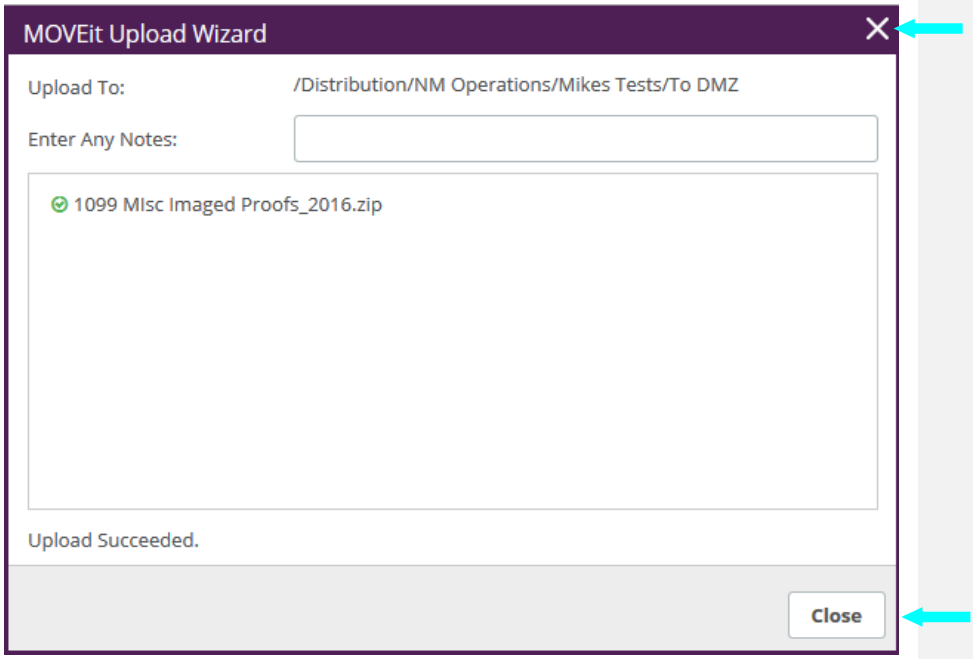
Our standard is that all files placed on DMZ will be in the ZIPPED format. This will require you to transfer a file that is already zipped. The 'Upload file/s' must already have the correct DMZ name associated with it.

Click the 'Upload" button and you will receive the progress box showing that the file/s

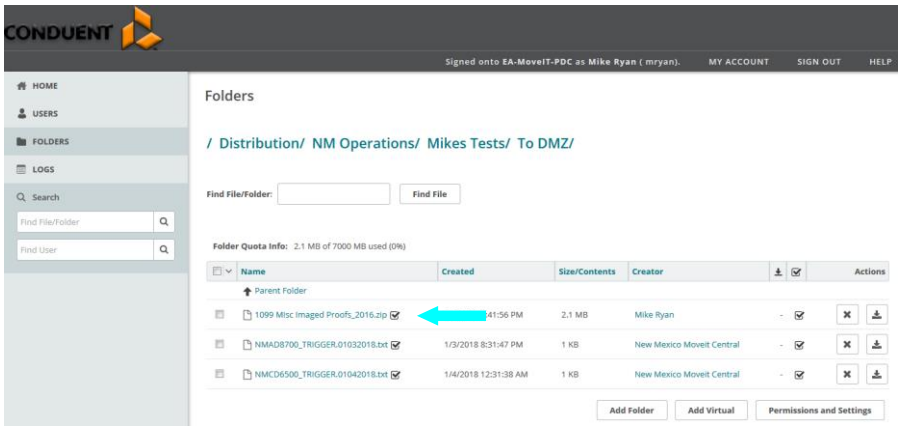
are being uploaded to DMZ.



When the transfer is complete you will see ‘Upload Succeeded’ message at the bottom of the ‘Upload Wizard’ window.

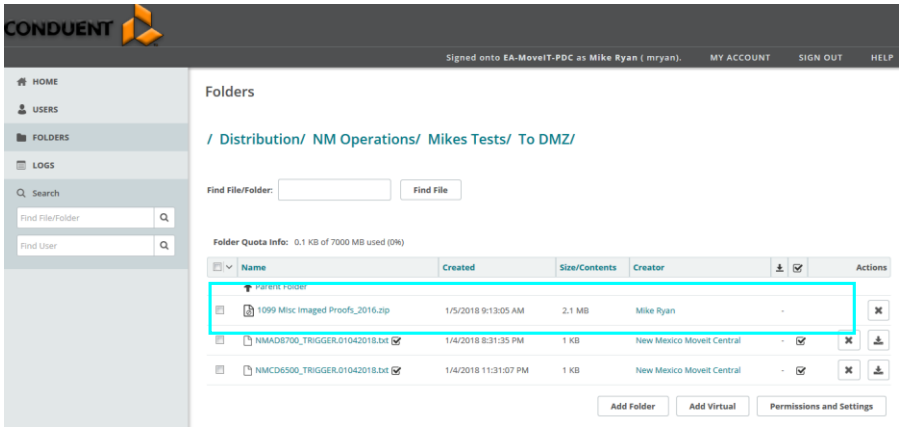


You may now close this 'Upload Wizard' window and then navigate to any folder you need to access or upload files to. When you close this window you should now see the file you uploaded in the folder page you were on. Please notice that the file verification indicator is present since the Upload Wizard was used to upload the file



If a file is not verified when it is uploaded it will appear with a before the file name and without the after the file name and should be deleted and then reloaded. This will only occur when the Upload Wizard is used to upload a file.

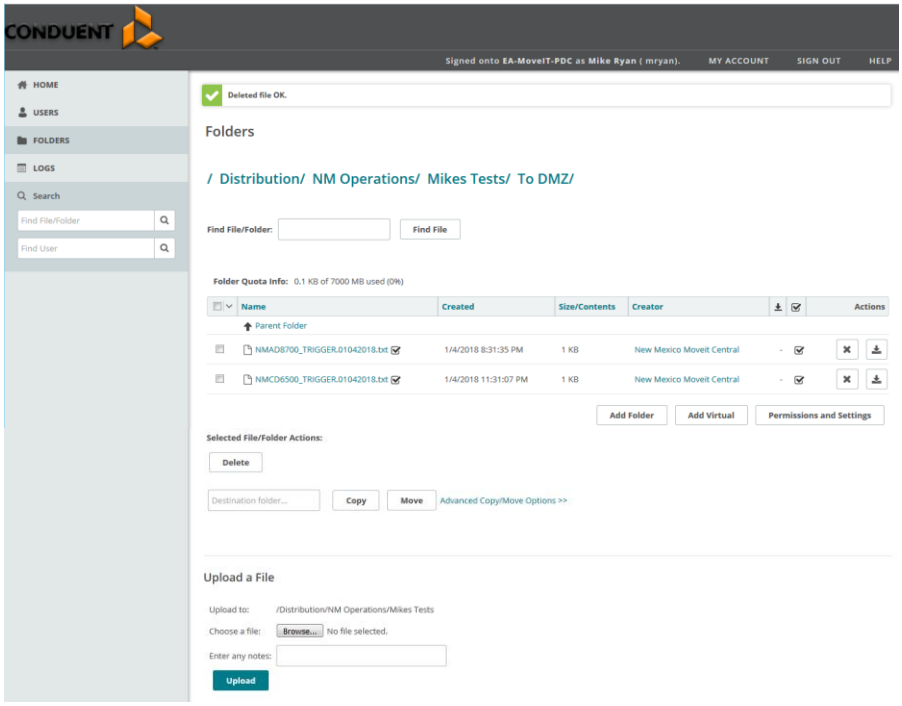
Basic View



Without the Upload Wizard

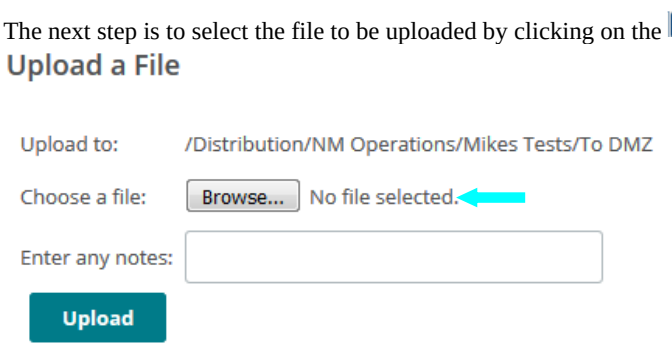
When the Upload Wizard is not active you will still be able to upload files using the following process. Remember that the file to be uploaded should be in zipped format and if it is to be processed by Conduent the file name will have to be set to the proper DMZ name prior to the upload.

The screens where you have upload authority will have a different look under the Upload a File at the bottom of the screen when the wizard is not active.

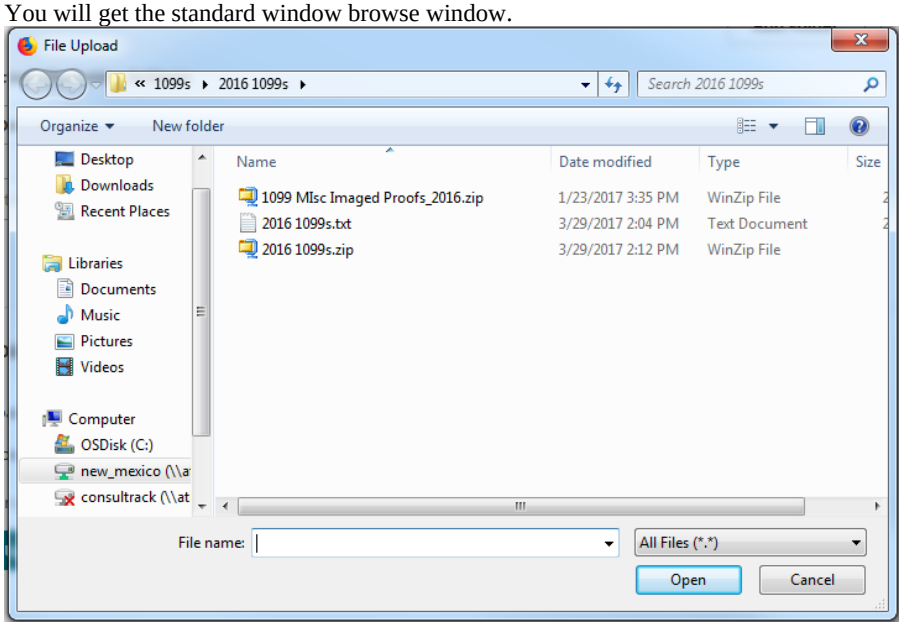


You will now be able to upload a file to this folder.

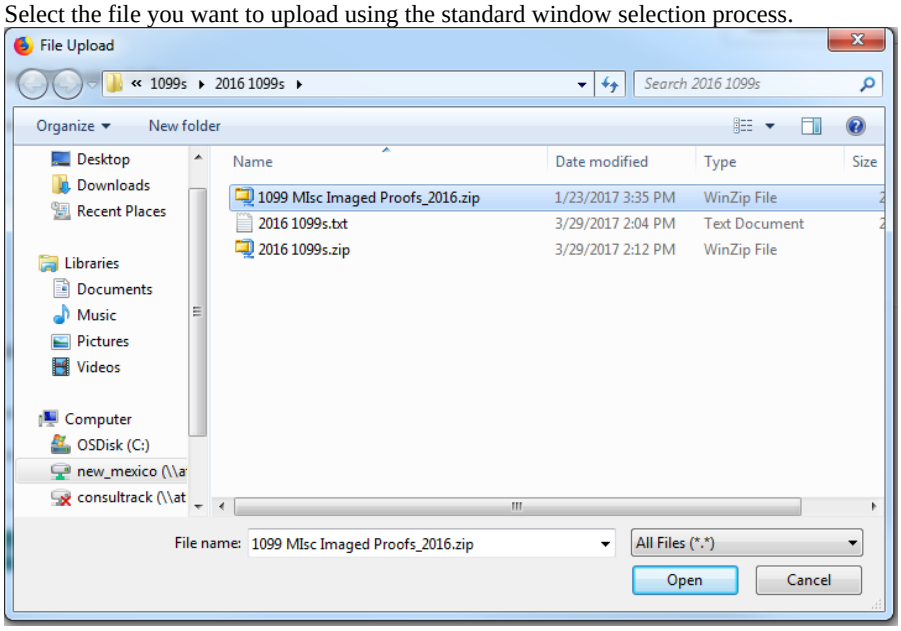
The next step is to select the file to be uploaded by clicking on the Browse... button.



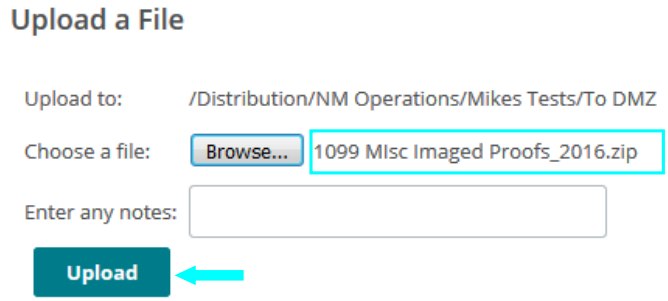
You will get the standard window browse window.



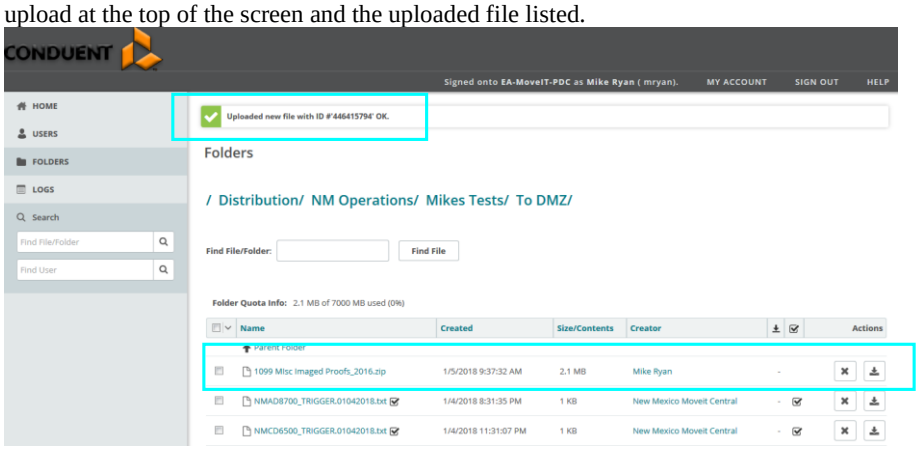
Select the file you want to upload using the standard window selection process.



This will place the file name in the upload area. Now, just click on the **Upload** button to upload the file.



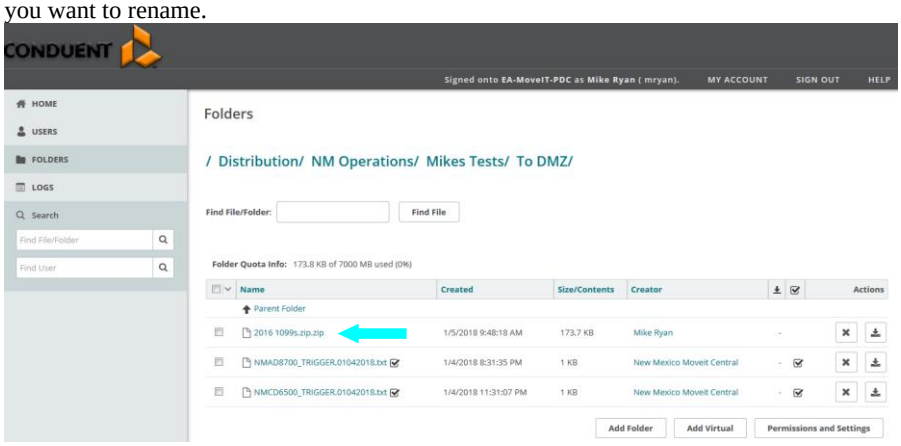
You will get your starting screen back, with a message showing the outcome of the upload at the top of the screen and the uploaded file listed.



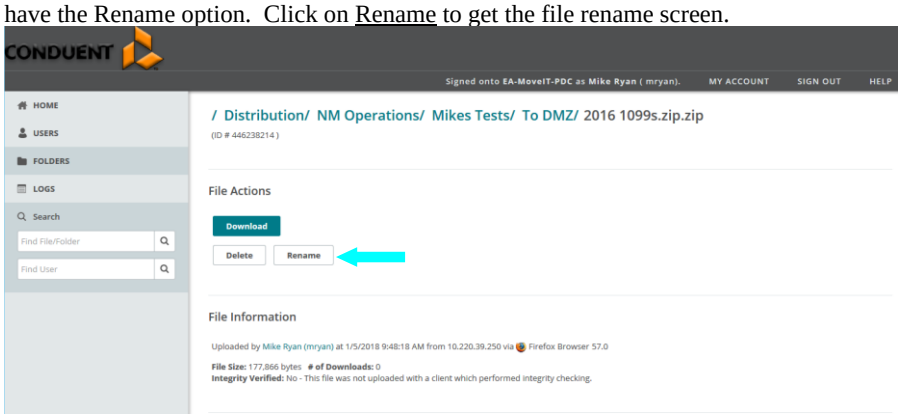
Renaming a File

If you have upload authority to a folder you will be able to rename the files in that folder. The Rename function should only be used if necessary. If you upload a file and then discover that it is not named correctly this function can save you time by allowing you to just change the name and not having to delete and upload the file again under the correct name.

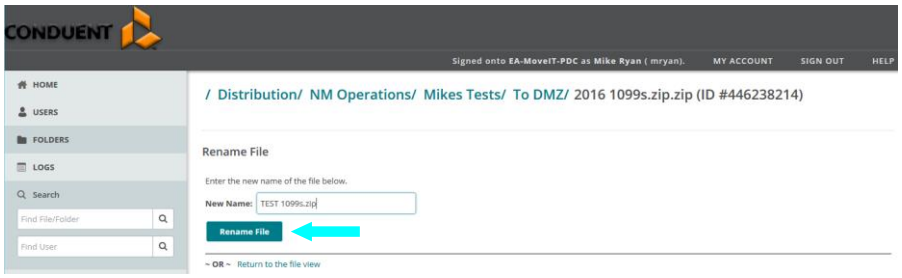
First you will need to navigate to the folder containing the file to be renamed. We will use the file just uploaded in the previous section. Now click on the name of the file that you want to rename.



You will receive the File Detail screen. Under the **File Actions** heading you will have the Rename option. Click on Rename to get the file rename screen.

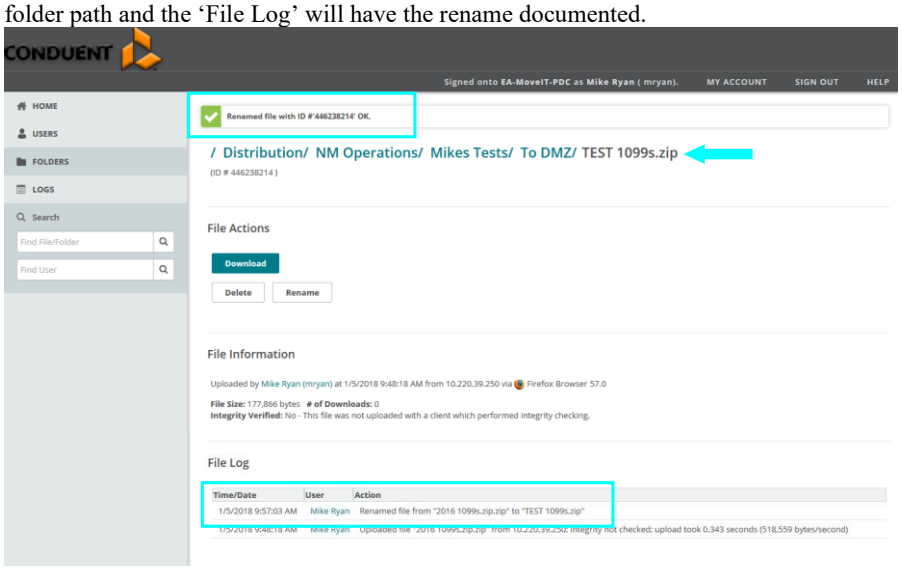


On this screen just over type the file name to the correct name and then click the **Rename File** button. We changed the date of 2016 to TEST and removed the extra '.ZIP' from the file name.



You will receive the File Detail screen back, with a message at the top showing if the

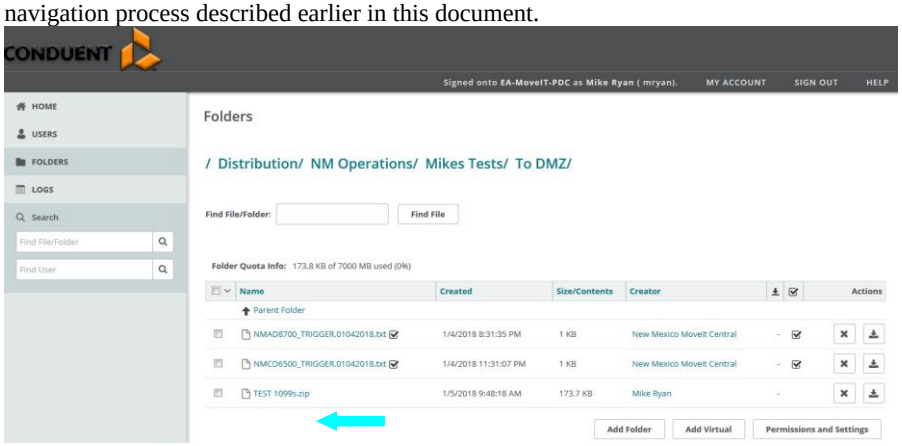
rename process was successful or not. The new file name will be displayed after the folder path and the 'File Log' will have the rename documented.



Deleting Files

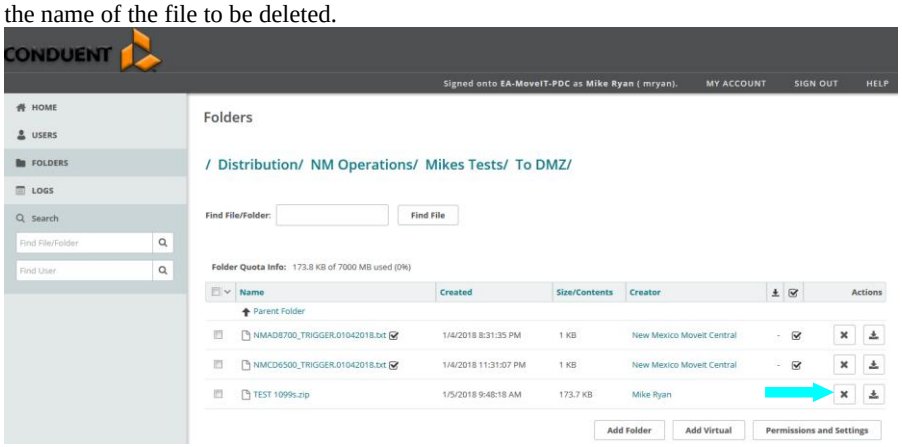
In order to delete a file from MOVEit DMZ you will have to have Delete authority to the folder containing the file. As a normal rule, if you have upload authority to a folder you will also have delete authority. In some cases you may only have one or the other of these authorities.

To delete a file from DMZ you will need to navigate to the folder containing the file you want to delete. We want to delete the file we just renamed for this example. Navigate to the /Distribution/NM Operations/Mikes Tests/To DMZ/ folder using either of the navigation process described earlier in this document.

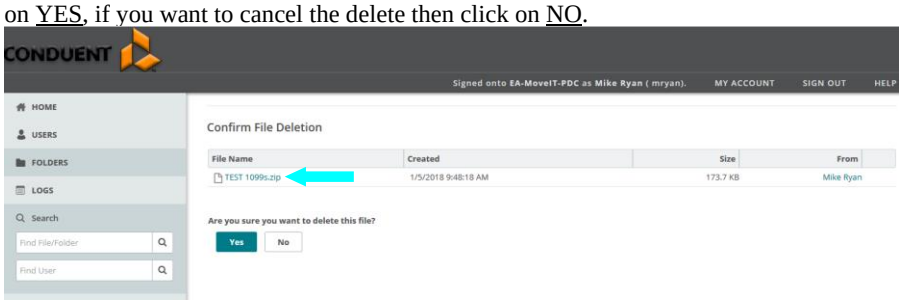


We now want to click on the Delete icon  under the 'Actions' column across from

the name of the file to be deleted.

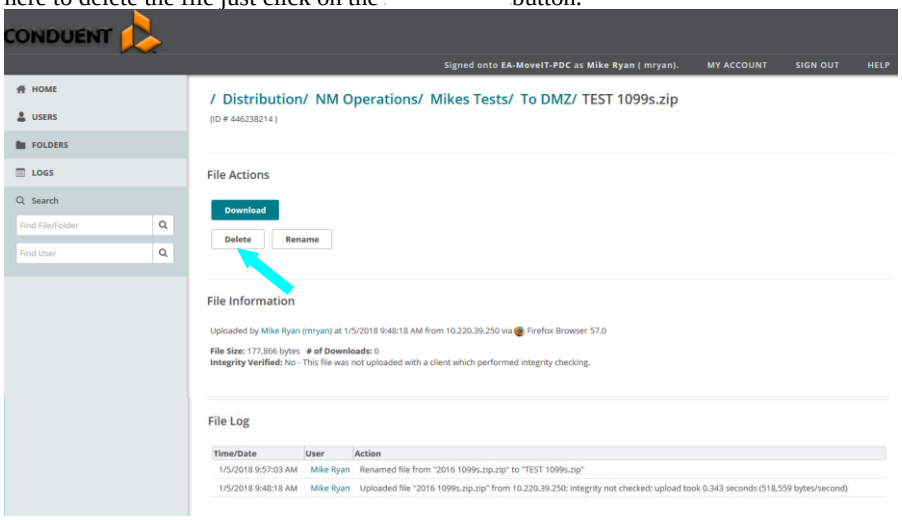


You will now be asked to confirm the delete. If you want to process the delete, then click on YES, if you want to cancel the delete then click on NO.

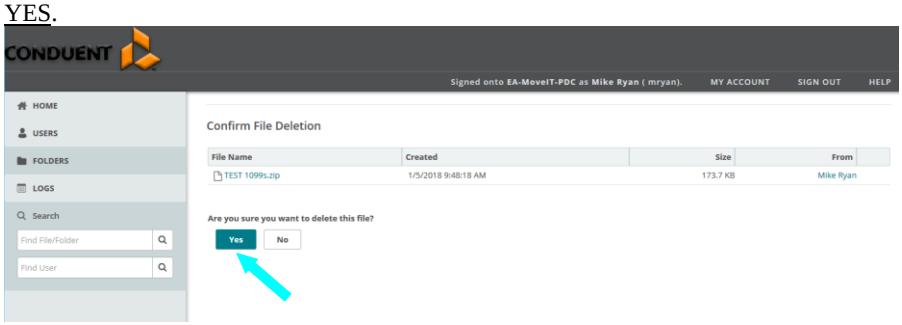


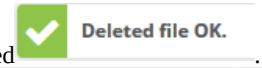
If you want to see the activity on this file and the details about this file before actually deleting it just click on the file name and you will be taken to the file details screen. From

here to delete the file just click on the **Delete** button.



You will now be asked to confirm the delete. If you want to process the delete, then click on YES, if you want to cancel the delete then click on NO. In this case we will click on YES.



Once you have confirmed the delete, you will be returned to the screen showing the files (if any) still in the folder, from which this file was deleted. You will also receive the conformation that the delete succeeded 

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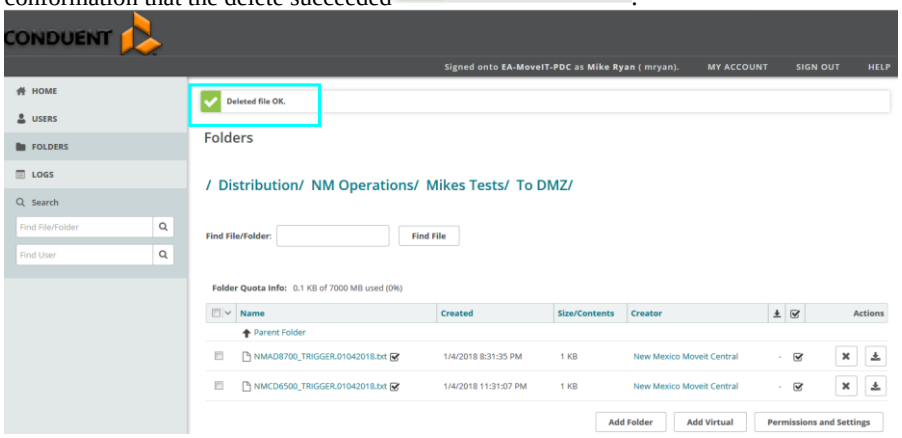
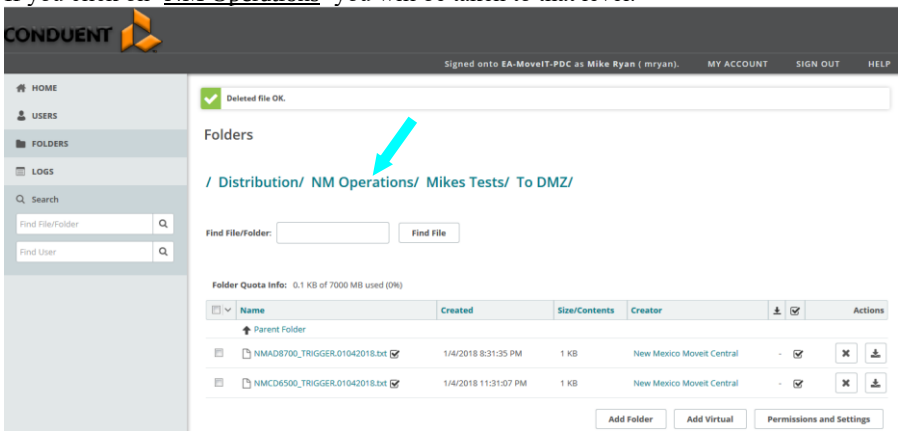


To navigate away from this screen, you can go directly to any level in the path shown by

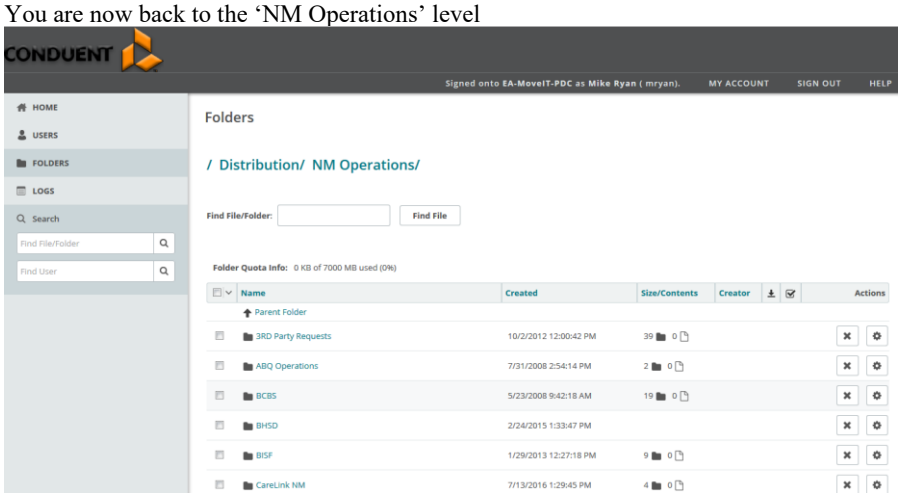
just clicking on the level you want.

/ Distribution/ NM Operations/ Mikes Tests/ To DMZ/

If you click on 'NM Operations' you will be taken to that level.



You are now back to the 'NM Operations' level



Administrator Functions

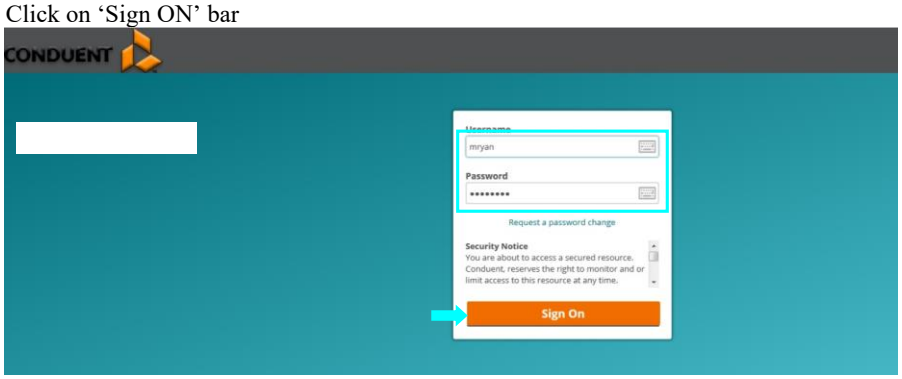
The following activities may be performed by designated MOVEit DMZ Administrators. All of the current Administrators have the authority to perform all of the user related functions. The folder functions are reserved for certain designated Administrators.

Adding a User

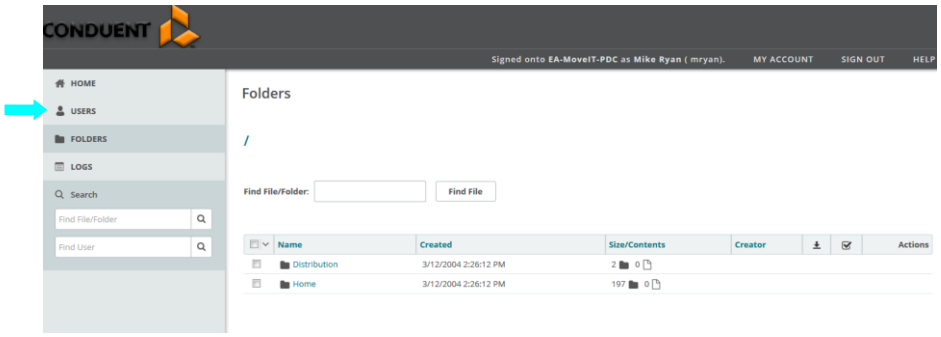
Adding users in DMZ is easy and there are two methods that can be used. The best way to add a new user is to identify an existing user, who has close to the same accesses that the new user will want, and to then clone that user. The second way to add a new user is to start from scratch with the Add User function. Once a user is added the Add User function way, the folder permission for that user will have to be established.

Cloning an Existing User

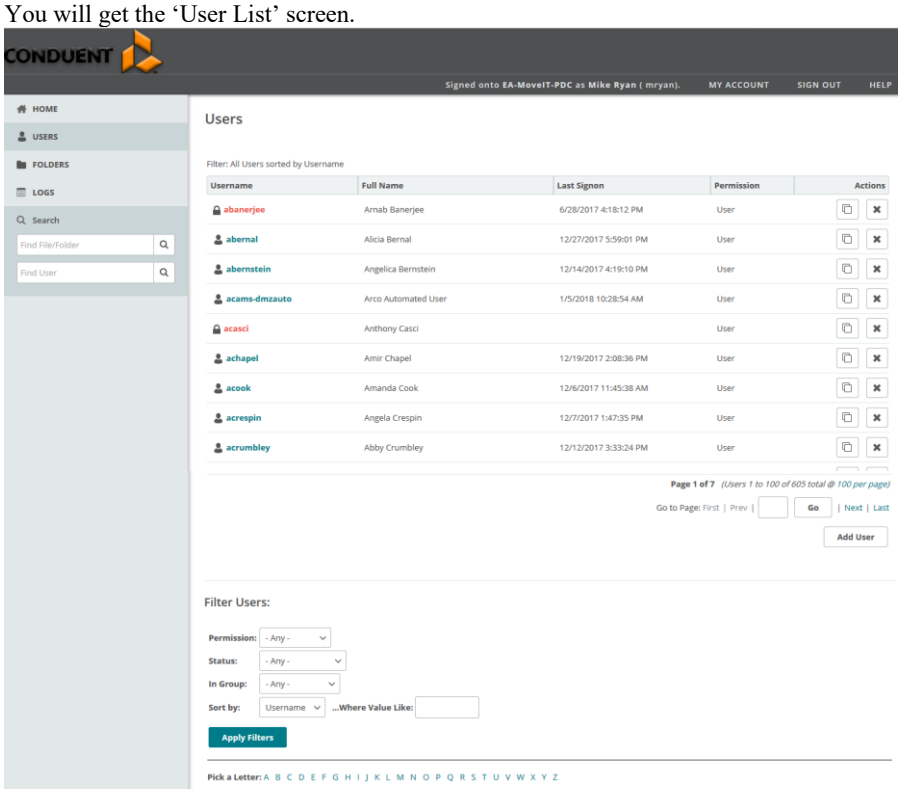
Log on as the Administrator.
Enter Username and Password
Click on 'Sign ON' bar



You will now be on your default sign on screen.
Click on 'Users'

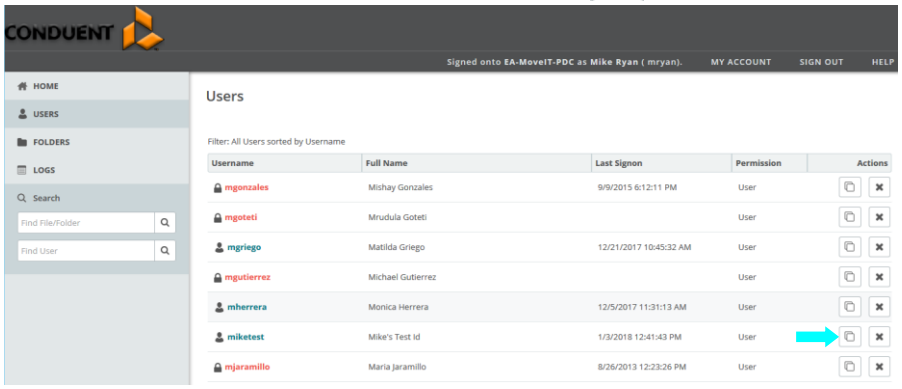


You will get the 'User List' screen.

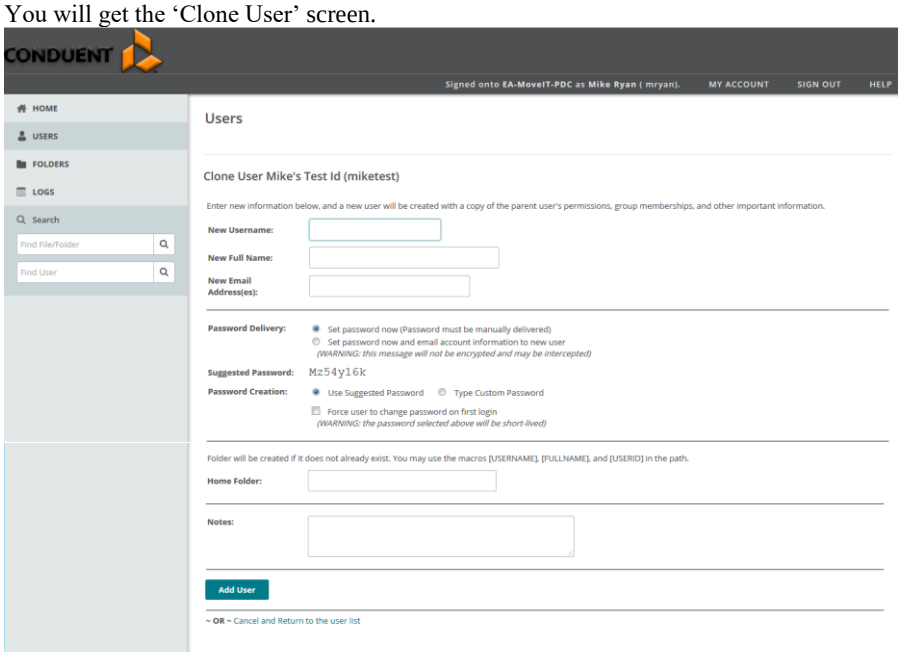


Scroll and or page to find the user that you want to use as the basis for cloning the new user.
We will now add the user ‘Demo User’ by cloning the user id ‘miketest’

On the line for ‘miketest’ click on the ‘Clone’ icon 

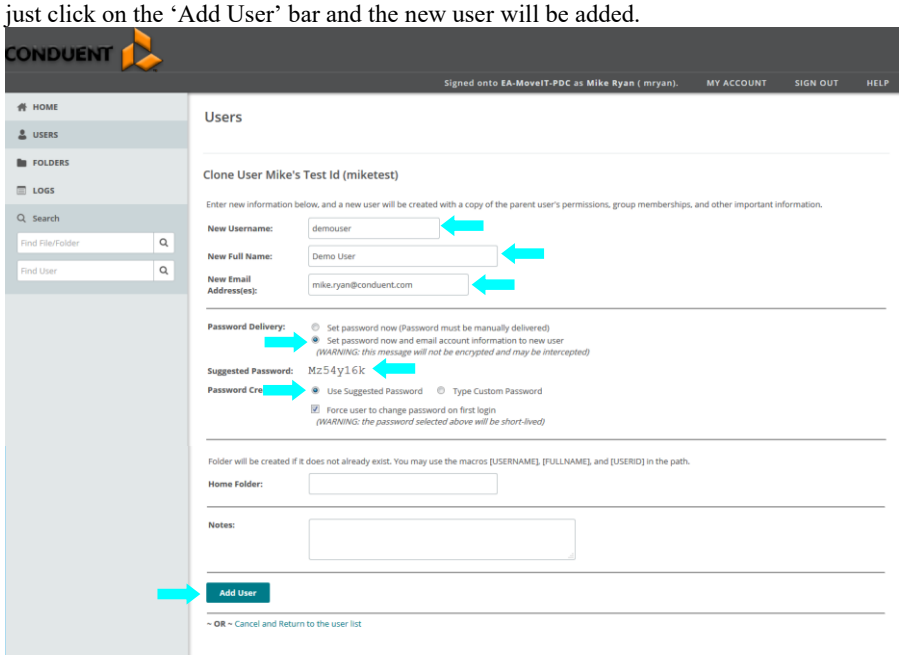


You will get the ‘Clone User’ screen.

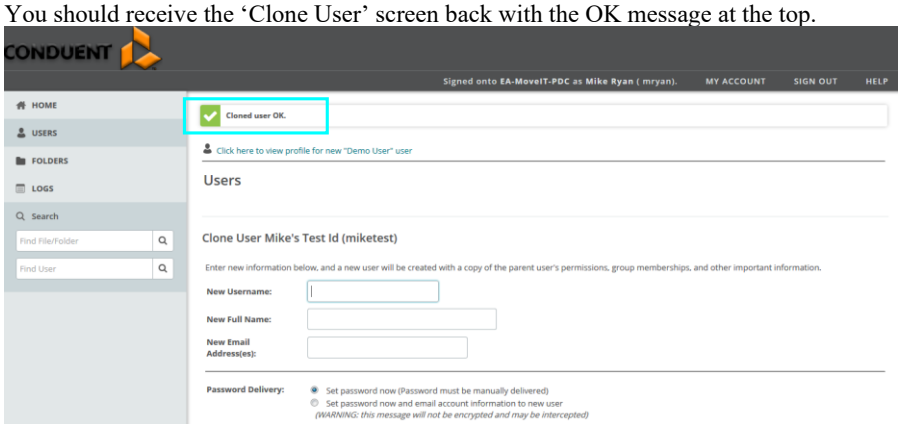


On this screen you will enter the ‘Username’, ‘Full Name’, and ‘Email Address’. Leave

the ‘Use Suggested Password’ button marked. Click on the check box for ‘Email new password to user’ and ‘Force user to change password on first login’. Once this is done just click on the ‘Add User’ bar and the new user will be added.

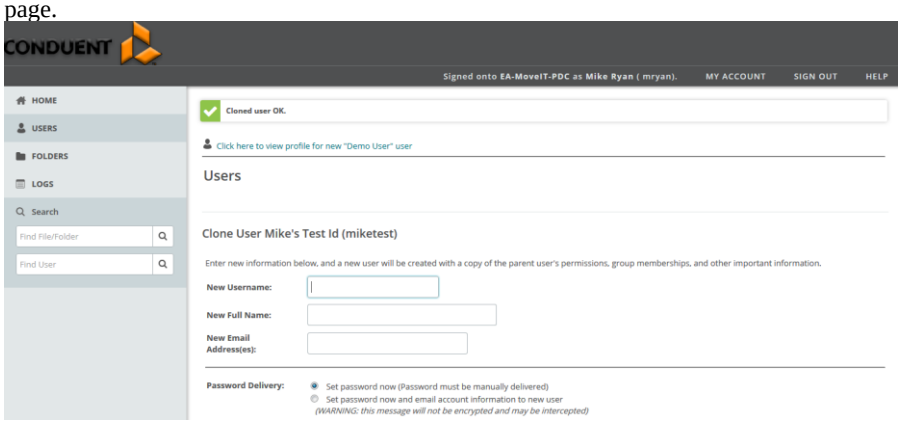


You should receive the ‘Clone User’ screen back with the OK message at the top.

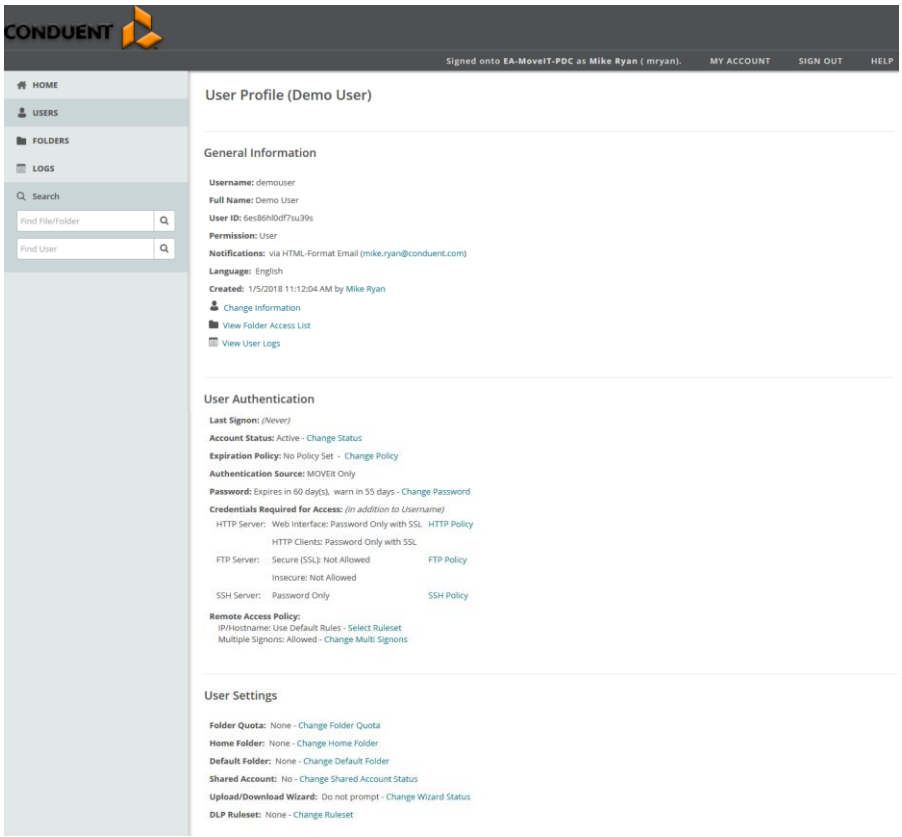


From here, you should to go to the user profile for the user that was just added, by

clicking on the ‘Click here to view profile for new ‘username’ user’ link at the top of the page.

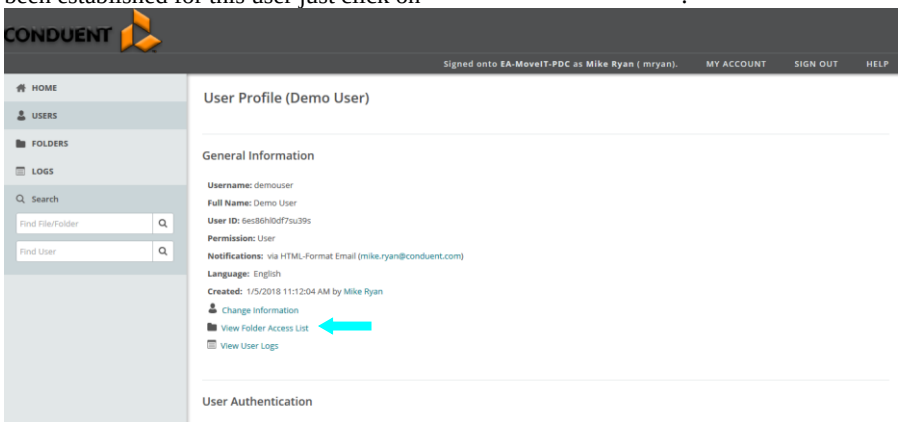


The ‘User Profile’ screen looks like this. You may also get to this screen by clicking on a user name form the ‘User List’ screen. You may click on any of the links for more detailed information.

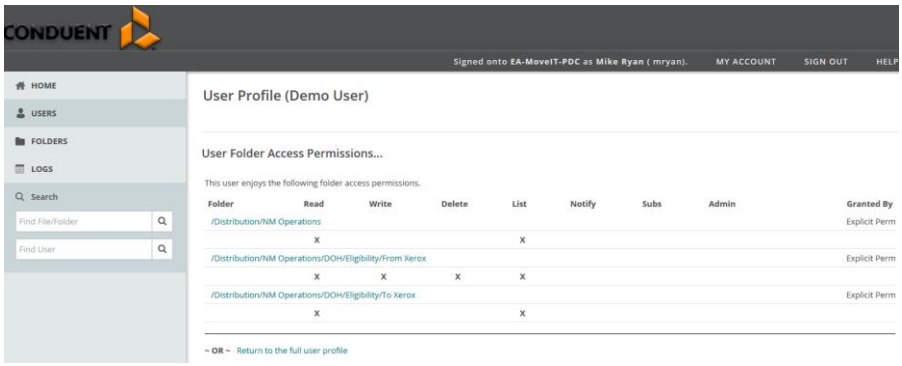


This user has now been added and is fully active. To view the folder accesses that have

been established for this user just click on View Folder Access List .



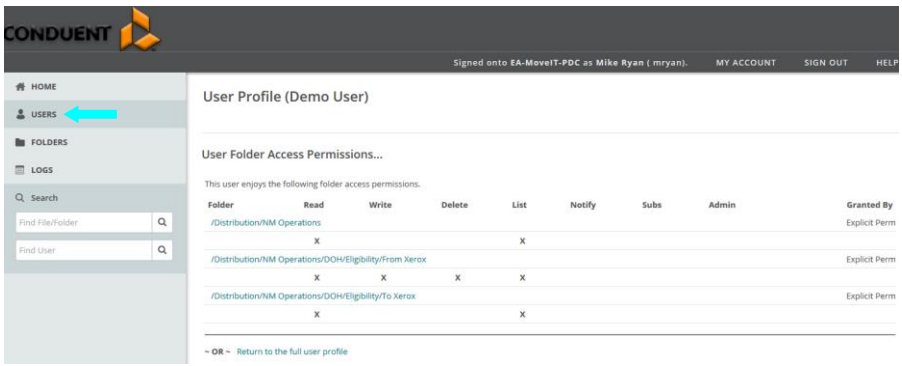
Since this is a cloned user this user will have folder accesses the same as the user from which he/she was cloned.



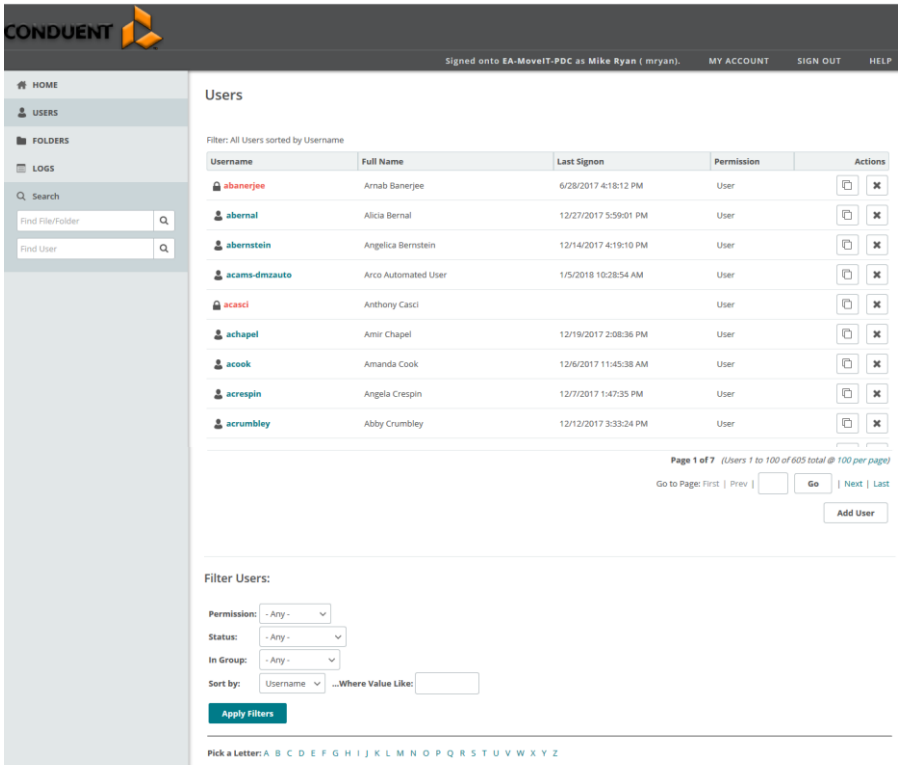
Creating a New User

To create a new user from scratch you will start by selecting the 

icon from any screen you are on.

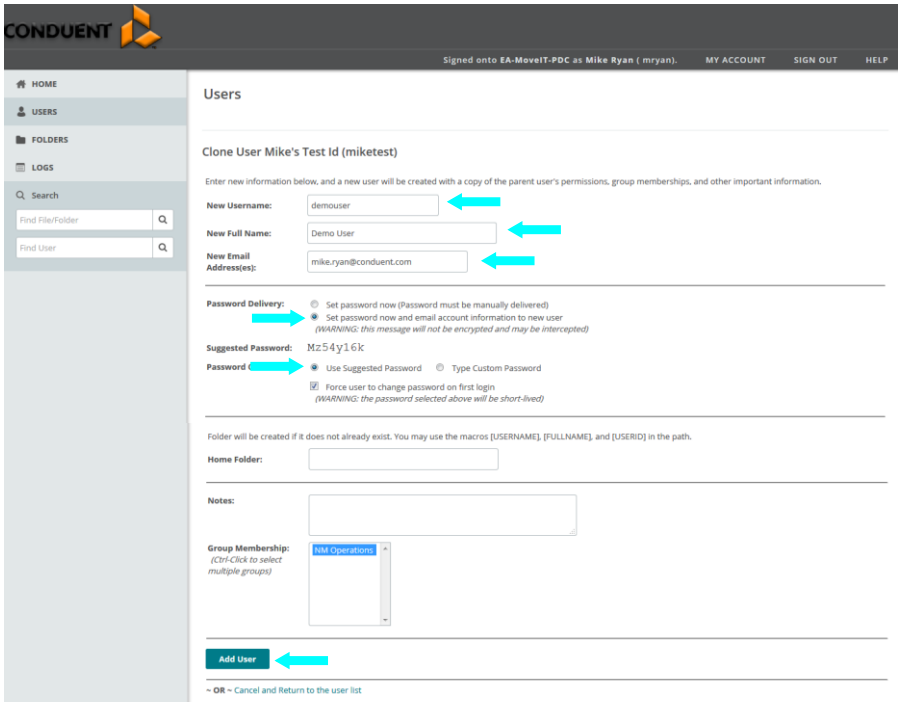


You will receive the 'Users List' screen.

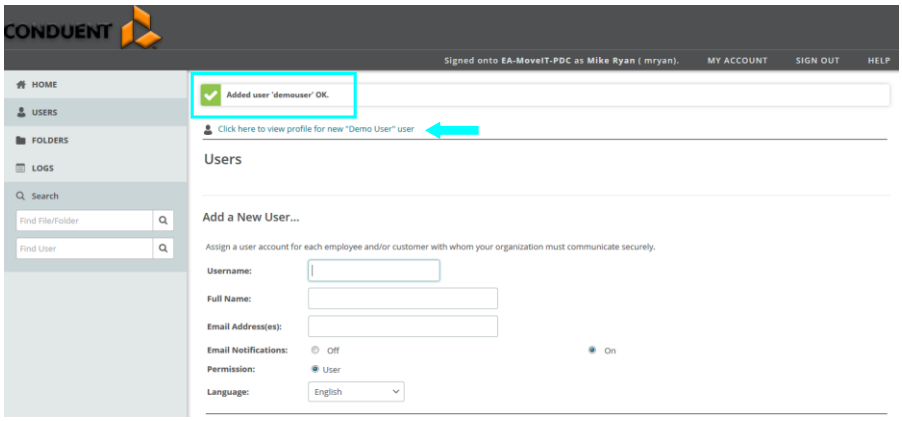


Scroll to the bottom of the list of users and click on '<u>Add New User</u>'.

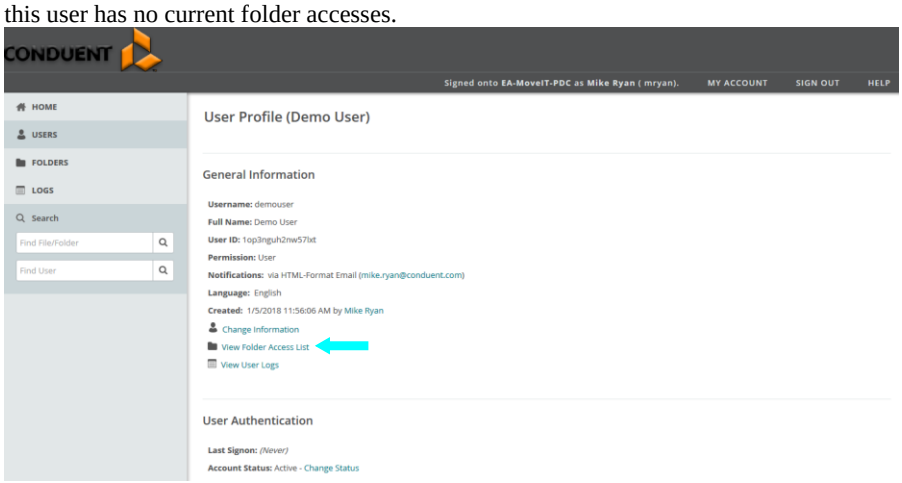
You will receive the ‘Add a New User’ Screen. On this screen you will enter the ‘Username’, ‘Full Name’, and ‘Email Address’. Leave the ‘Use Suggested Password’ button marked. Click on the check box for ‘Email new password to user’ and ‘Force user to change password on first login’. Once this is done just click on the ‘Add User’ button and the new user will be added.



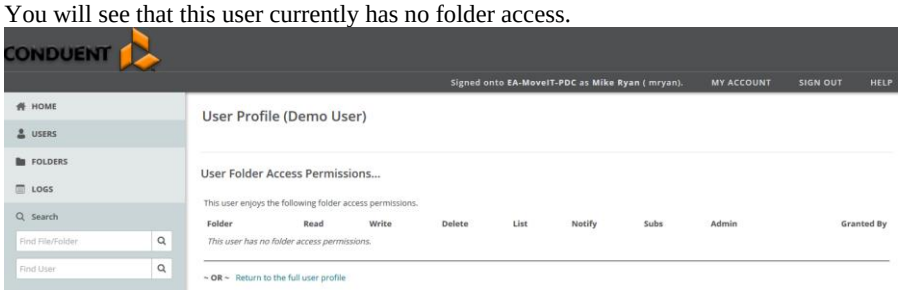
You should receive the 'Added User (username) OK' message at the top of the 'Add User' screen. To verify that the user information is as you want it, just click on Click here to view profile for new "Demo User" user to go to the user profile screen.



On the 'User Profile' screen you can verify that the information you entered is correct. With this user you will have to set the folder accesses, as opposed to a cloned user that will have the accesses of the cloned user. Click on View Folder Access List to see that this user has no current folder accesses.



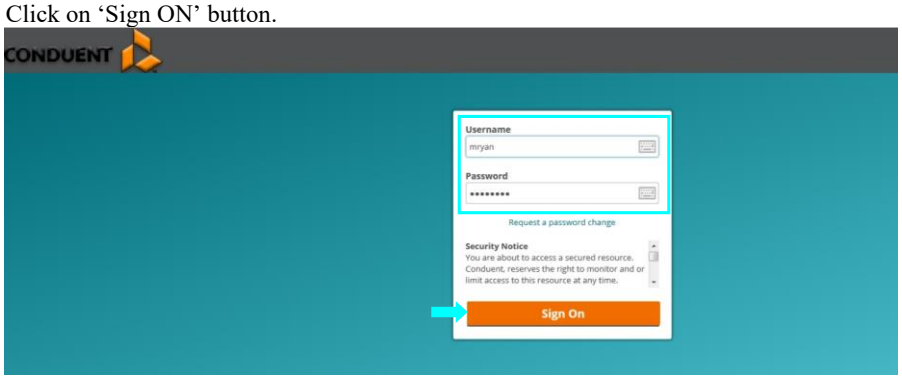
You will see that this user currently has no folder access.



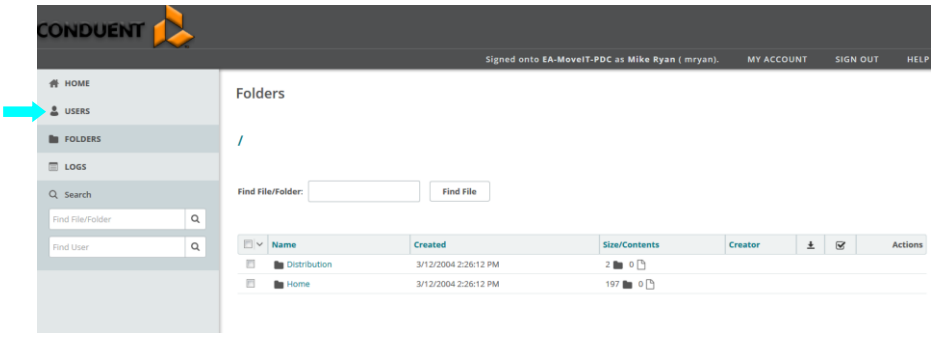
Resetting a User's Password and/or Unlocking a User

This section will present the basics in resetting a user's password and also show how to unlock a user once the system has locked them out. A user has their DMZ account locked once their password becomes 60 days old.

Log on as the Administrator.
Enter Username and Password
Click on 'Sign ON' button.

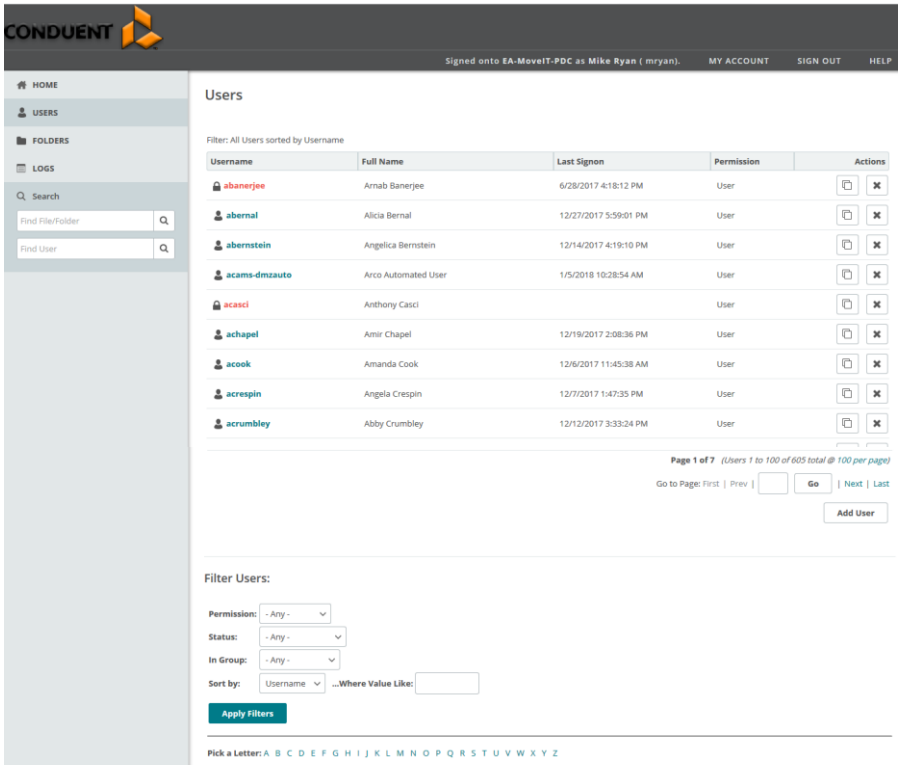


You will now be on your default sign on screen.
Click on 'Users'

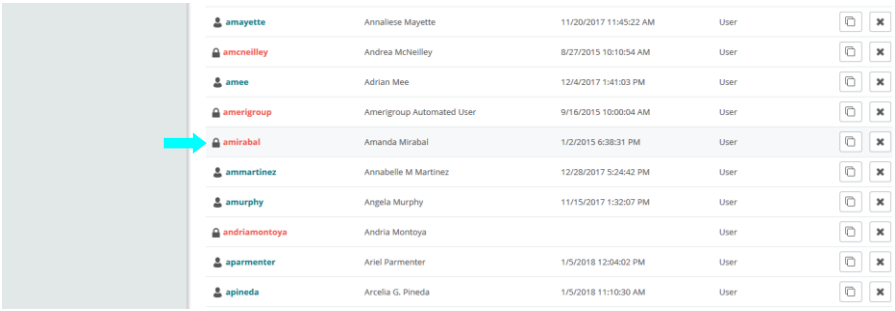


You will get the 'User List' screen.

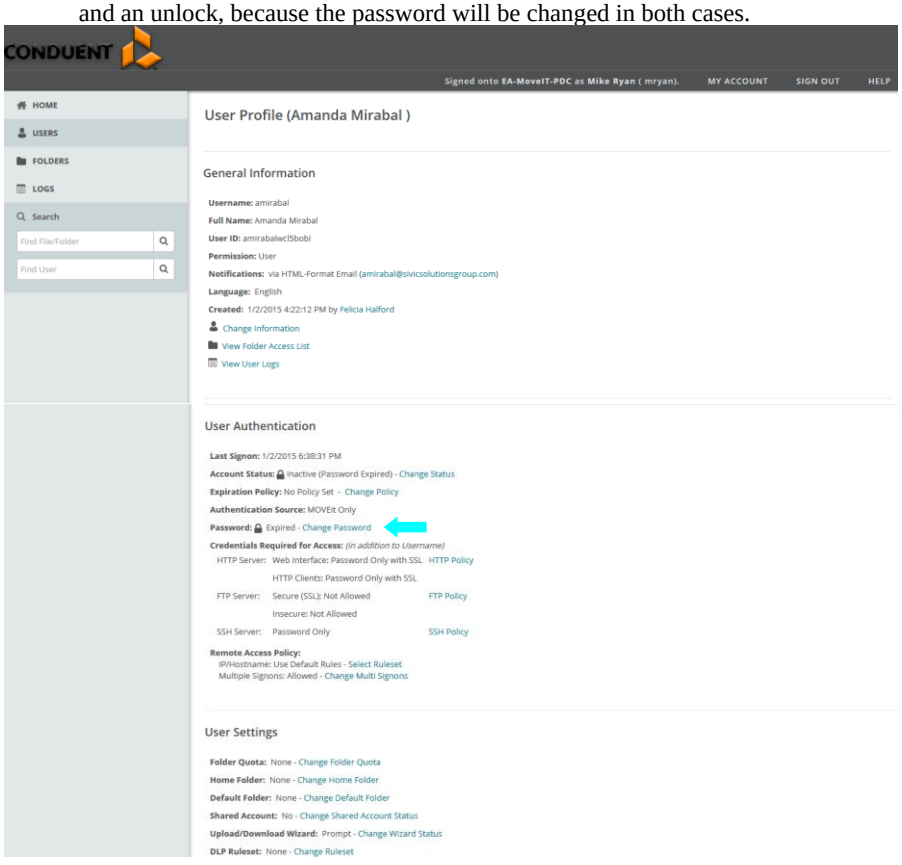
Active Users are shown with the icon preceding the User Id.
Locked Users are shown with the icon preceding the User Id and the User Id will be red in color.



Scroll down to the User that you plan on updating
Click on the User Id



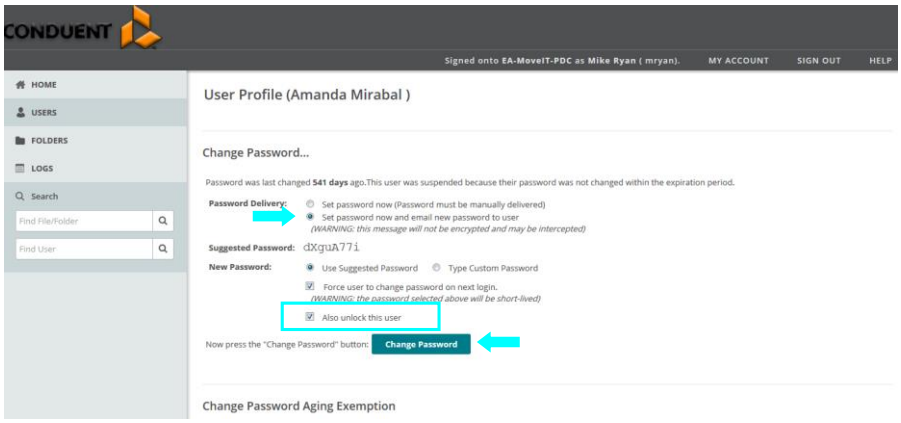
You will get the User Profile General Information and User Authentication screen.
Click on Change Password. This can be used in both cases, a password change and an unlock, because the password will be changed in both cases.



You will now have the User Profile Change Password… screen
Use the Suggested Password and click the box for 'Email new password to user'
This will also check the 'Force user to change password on next login' box.
If this is an Unlock the 'Also unlock this user' box will be checked.

Click the **Change Password** button.

If you are changing the password for an active user the 'Also unlock this user' box' will not be shown on the screen.

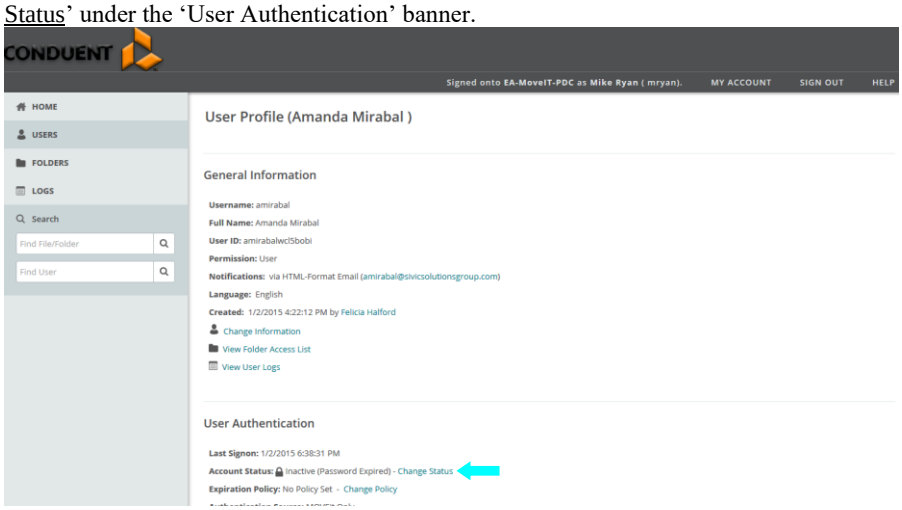


This will send the User their new password and if the account was locked it will also be unlocked.

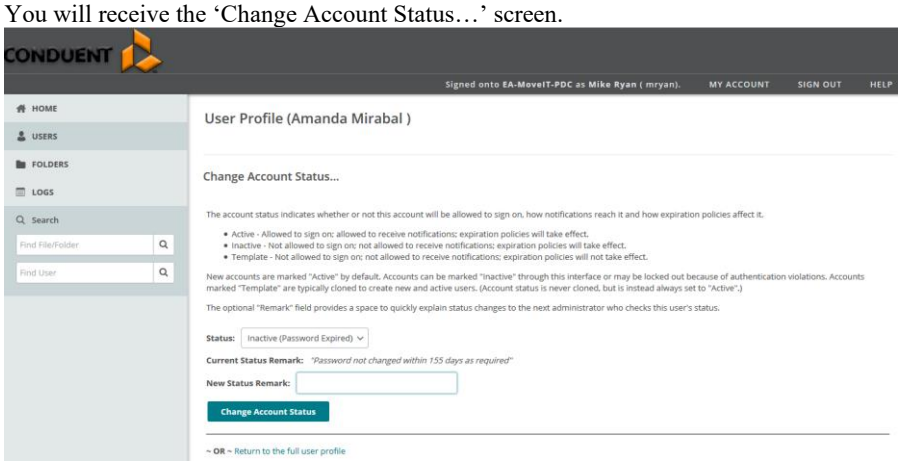
There is a way to Unlock a user without updating the password and a way to Unlock the user and update their password, but not notify the user from MOVEit DMZ of their new password, which can be sent in a separate email. This is not recommended because it may not force the user to update their password when they sign on after the change.

To Unlock the user, change their password and not notify the user from MOVEit DMZ, you can do exactly what was shown above with the exception of changing the 'Pasword Delivery:' to ◉ Set password now (Password must be manually delivered) box.
If you want to force the user to change their password on their next sign on, just check the ☐ Force user to change password on next login. box.

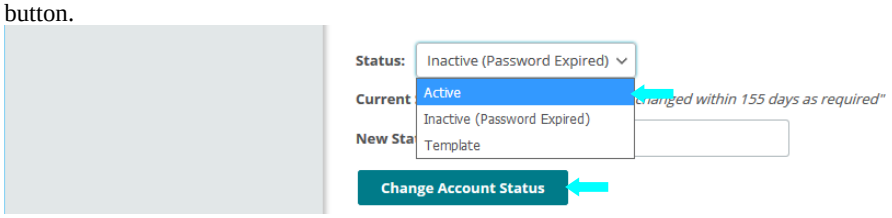
To just unlock the user without a password update you will need to click on 'Change Status' under the 'User Authentication' banner.



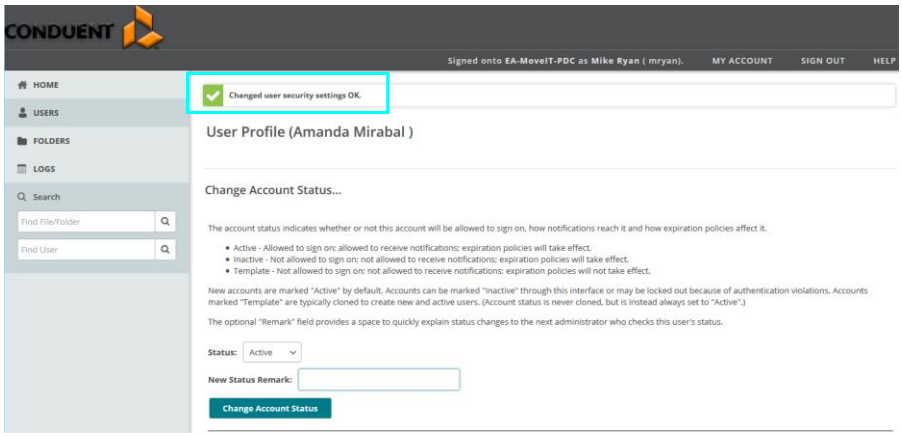
You will receive the 'Change Account Status…' screen.



Click on the down arrow on the drop down box after 'Status:' for the change options. Select 'Active', you may also enter something in the 'New Status Remark:' box if needed, to explain the status change and then click on the 'Change Account Status' button.



You should get the ‘Change Account Status’ screen back with the ‘Changed user security setting OK’ message at the top.



This user will now show as an Active User on the User List screen but still has an expired password so this user will not be able to access MOVEit DMZ until the password is reset.

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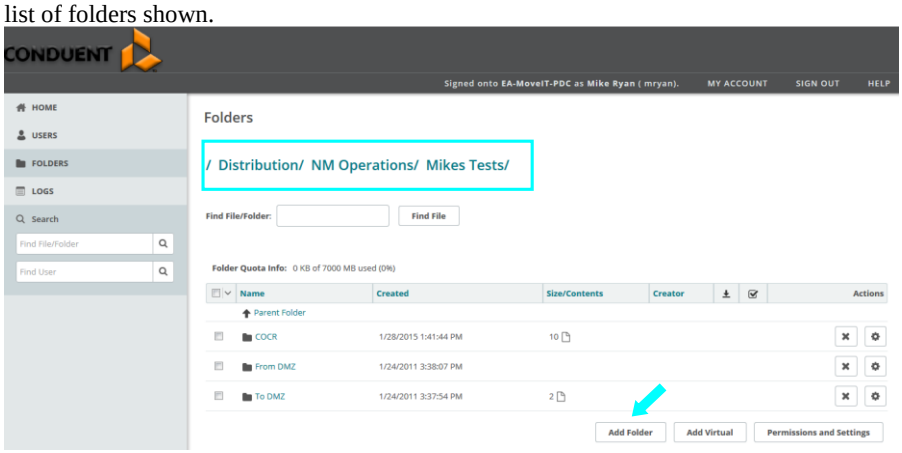
Adding Folders

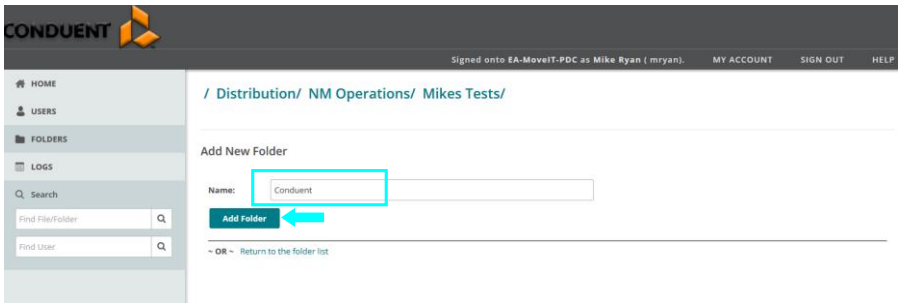
Adding folders in MOVEit DMZ is a simple process. You will need to sign on as usual and navigate to the level above where you want the new folder to be added. No new folders may be added above the 'Distribution/NM Operations' level. If a folder is needed at the NM Operations level you will need to request that through the Helpdesk to the EA – MOVEit group.

When adding new folders some consideration should be given to the accesses to be allowed to the new folders. Sometimes it is advantageous to add the first level of new folders, set the user accesses to this folder and then continue to add any subfolders to that level to make the setting of the sublevel folder access simpler. See the next section on setting folder access.

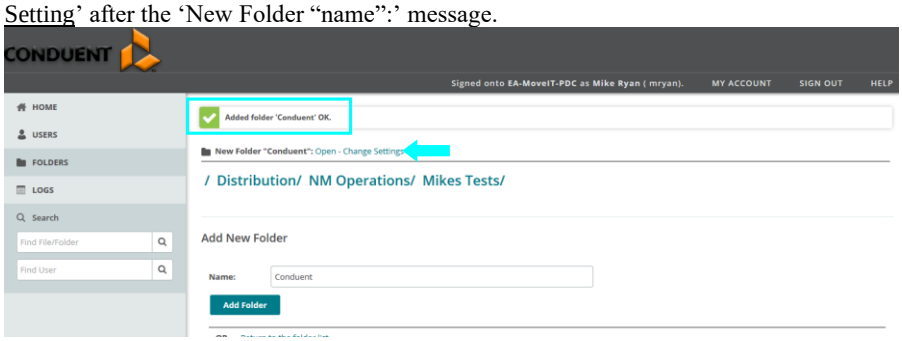
We will add a new folder under the 'Mikes Tests' folder to be used for Conduent files. First navigate to the 'State of NM' folder. Then click on 'Add Folder' at the end of the list of folders shown.



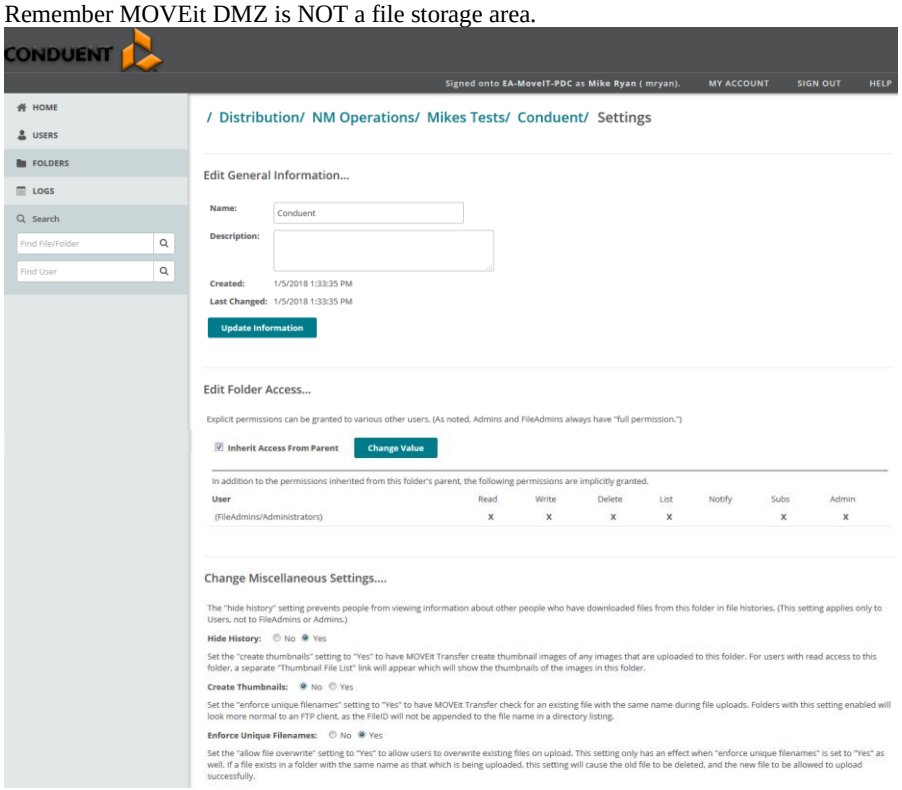
You will receive the 'Add New Folder' screen. In the 'Name:' box type the name for the new folder and then click on the 'Add Folder' button.

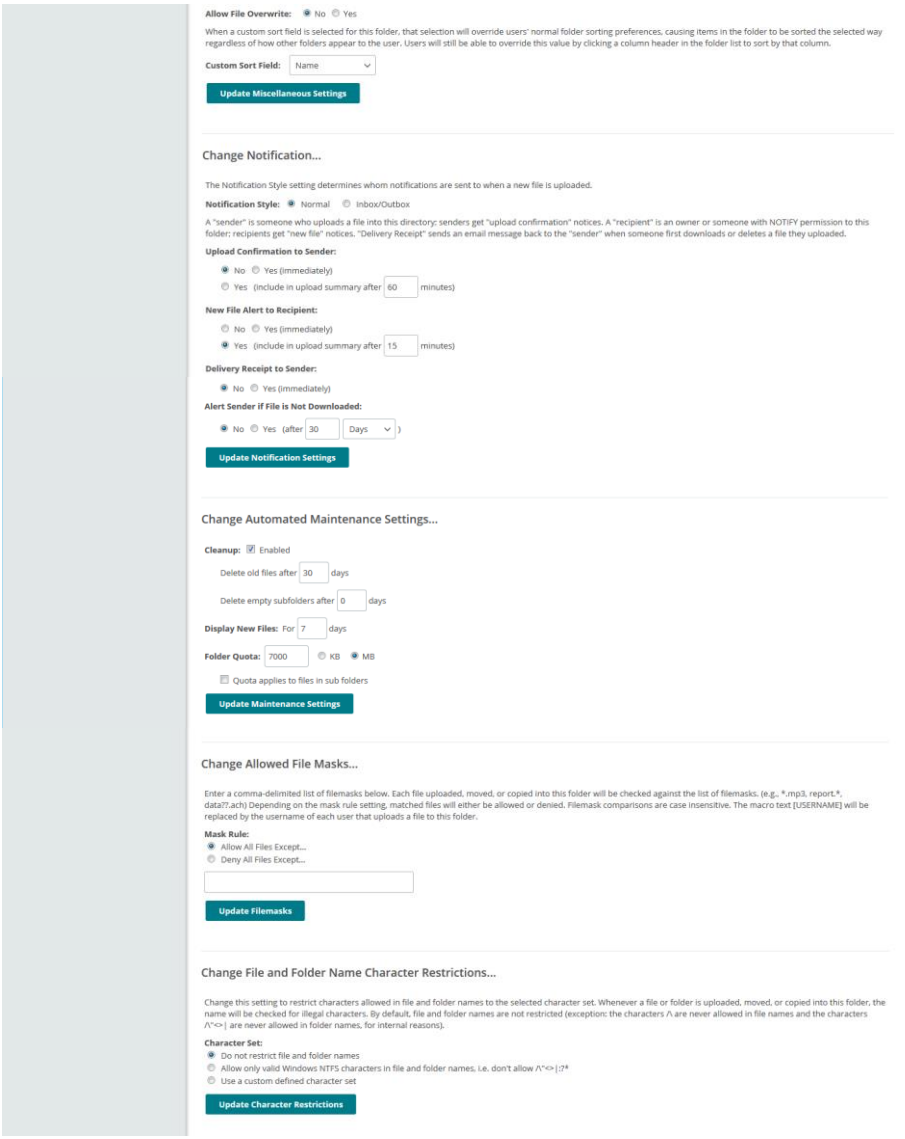


You should get the 'Add New Folder' screen returned with the 'Added Folder (name) OK' message at the top. You may enter the name of another folder to be added at this same level on this screen and click the 'Add Folder' button to that folder. This may be repeated as many time as necessary to add the folders needed under the 'Mikes Tests' folder. The folders added here will have the same user access as the parent folder and the folder setting will be the system defaults. To modify the folder setting click on 'Change Setting' after the 'New Folder "name":' message.

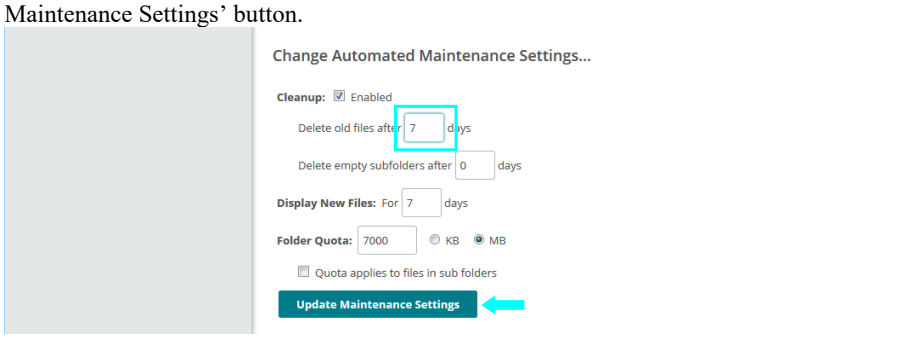


You will receive a screen that has the various folder settings available for change. There are two sections that we are concerned with. The first is 'Edit Folder Access…' where we control the user's accesses to this folder. The system default is to grant the same accesses as the parent folder. Changing the folder access will be covered in the next section. The other area we need to look at is the 'Change Automated Maintenance Setting…'. Here we will set the number of days that a file will be retained in this folder, before it is automatically deleted from MOVEit DMZ. The number of days to retain a file will depend on many factors, but should be set to the minimum number possible. Remember MOVEit DMZ is NOT a file storage area.

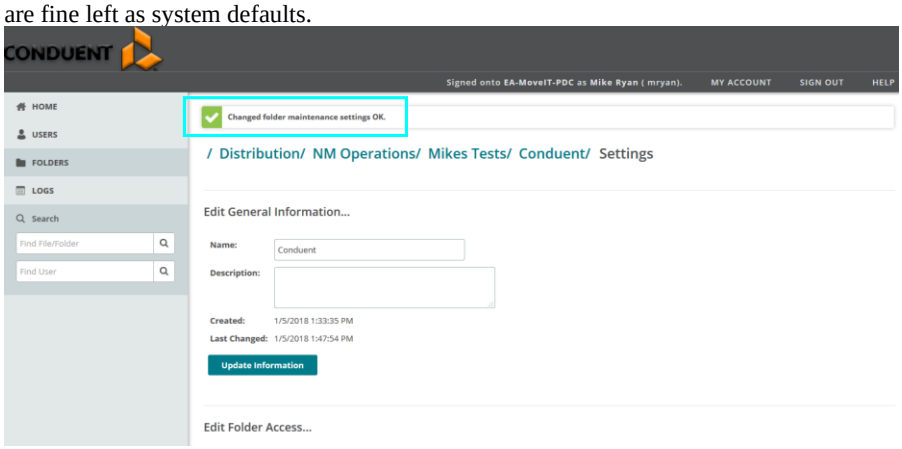



Allow File Overwrite: No Yes
When a custom sort field is selected for this folder, that selection will override users' normal folder sorting preferences, causing items in the folder to be sorted the selected way regardless of how other folders appear to the user. Users will still be able to override this value by clicking a column header in the folder list to sort by that column.
Custom Sort Field: Name
Update Miscellaneous Settings
Change Notification...
The Notification Style setting determines whom notifications are sent to when a new file is uploaded.
Notification Style: Normal Inbox/Outbox
A "sender" is someone who uploads a file into this directory; senders get "upload confirmation" notices. A "recipient" is an owner or someone with NOTIFY permission to this folder; recipients get "new file" notices. "Delivery Receipt" sends an email message back to the "sender" when someone first downloads or deletes a file they uploaded.
Upload Confirmation to Sender:
No Yes (immediately)
Yes (include in upload summary after 60 minutes)
New File Alert to Recipient:
No Yes (immediately)
Yes (include in upload summary after 15 minutes)
Delivery Receipt to Sender:
No Yes (immediately)
Alert Sender if File is Not Downloaded:
No Yes (after 30 Days)
Update Notification Settings
Change Automated Maintenance Settings...
Cleanup: Enabled
Delete old files after 30 days
Delete empty subfolders after 0 days
Display New Files: For 7 days
Folder Quota: 7000 KB MB
Quota applies to files in sub folders
Update Maintenance Settings
Change Allowed File Masks...
Enter a comma-delimited list of filemasks below. Each file uploaded, moved, or copied into this folder will be checked against the list of filemasks. (e.g., *.mp3, report.*, data??.ach) Depending on the mask rule setting, matched files will either be allowed or denied. Filemask comparisons are case insensitive. The macro text [USERNAME] will be replaced by the username of each user that uploads a file to this folder.
Mask Rule:
Allow All Files Except...
Deny All Files Except...
Update Filemasks
Change File and Folder Name Character Restrictions...
Change this setting to restrict characters allowed in file and folder names to the selected character set. Whenever a file or folder is uploaded, moved, or copied into this folder, the name will be checked for illegal characters. By default, file and folder names are not restricted (exception: the characters /\ are never allowed in file names and the characters /*<>| are never allowed in folder names, for internal reasons).
Character Set:
Do not restrict file and folder names
Allow only valid Windows NTFS characters in file and folder names, i.e. don't allow /*<>|:?*
Use a custom defined character set
Update Character Restrictions

In the ‘Change Automated Maintenance Settings…’ section we will be changing the Delete old files after 30 days Number of day’s value. Since we have determined that the files normally placed in this folder will be move off of DMZ the same day we will set the retention to 7 days. Once the value has been updated, click on the ‘Update Maintenance Settings’ button.



You should receive the ‘Folder Settings’ screen again and at the top will be the ‘Changed folder maintenance settings OK’ message. The other values in the maintenance section are fine left as system defaults.

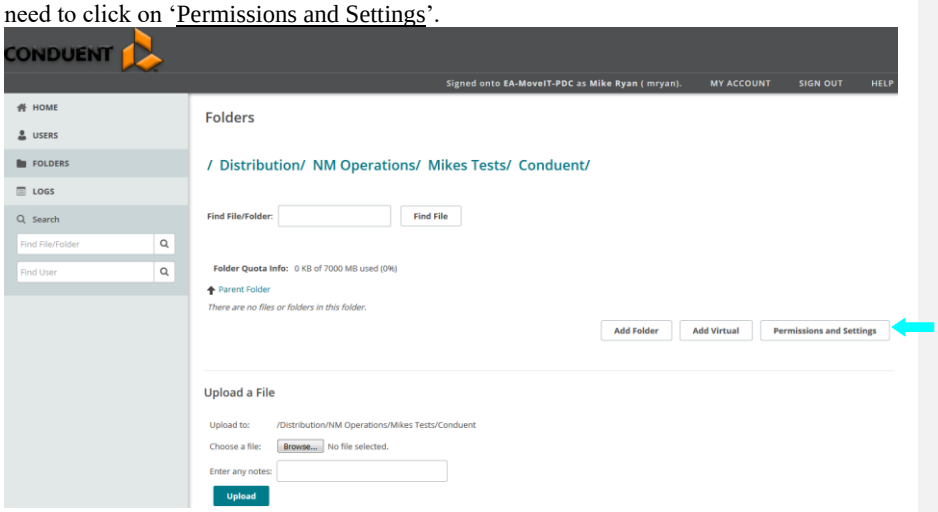


This folder is now ready for use and any files placed in this folder will be deleted after 7 calendar days.

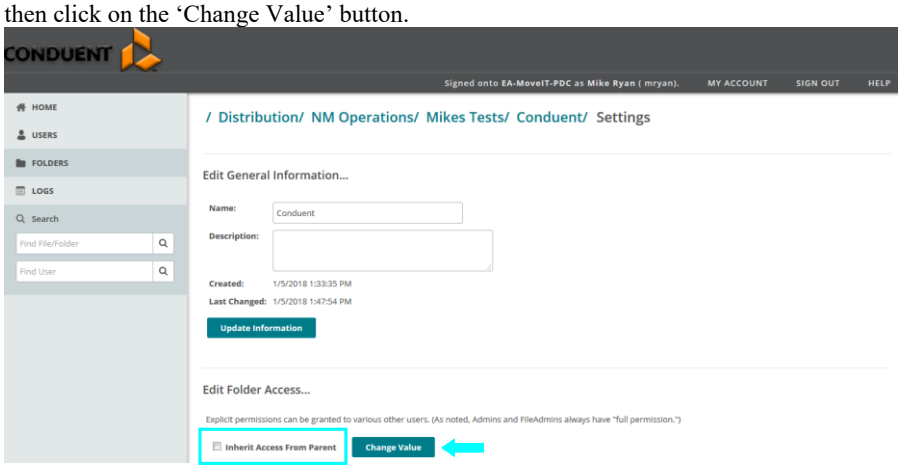
Setting Folder Access Authority

This is one of the most important features of MOVEit DMZ, controlling which users have access to the files in a given folder and what action that user may perform on the files in a given folder. All user access in MOVEit DMZ is controlled at the folder level. This has its good points and some drawbacks. MOVEit DMZ automatically gives a folder the same accesses as the parent folder, which can save setting individual user access. This can also be a drawback, in that, when adding a new sublevel that folder will have the same accesses as the parent and there may be only a limited number of users that should have access to this subfolder.

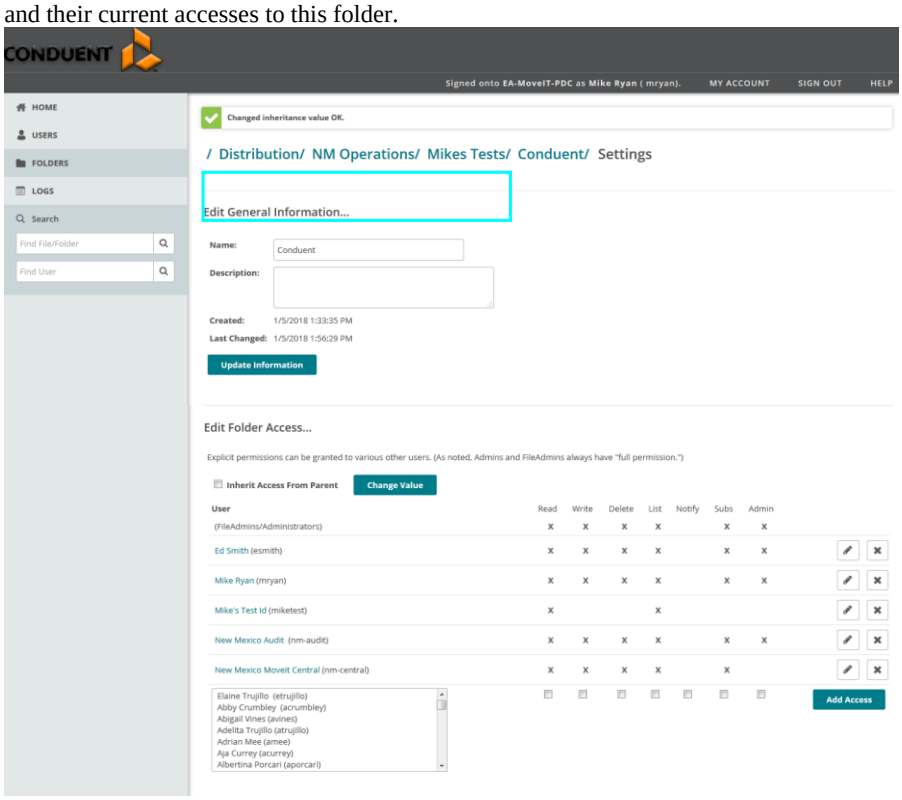
This section will show you how to modify the user's access to the various folders. Sign on and navigate to the folder where you want change the user's access. Here you will need to click on 'Permissions and Settings'.



When you receive the ‘Folder Settings’ screen you will need to uncheck the ☑ **Inherit Access From Parent** check box under the ‘Edit Folder Access…’ banner and then click on the ‘Change Value’ button.



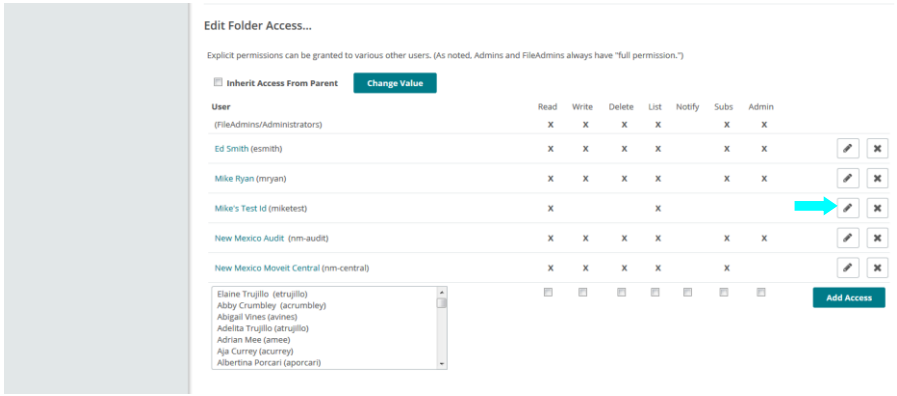
You should now be back at the top of the 'Folder Settings' screen and you should have received the 'Changed inheritance value OK' message. You will also notice that the area under the 'Edit Folder Access…' banner has now changed and is displaying a list of users and their current accesses to this folder.



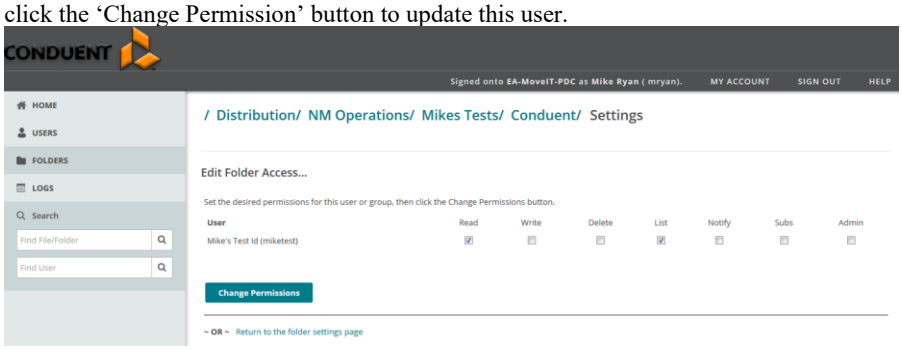
From here you can modify an existing user's accesses, remove the user to eliminate all accesses to this folder, or add additional users and designate the accesses those users will have.

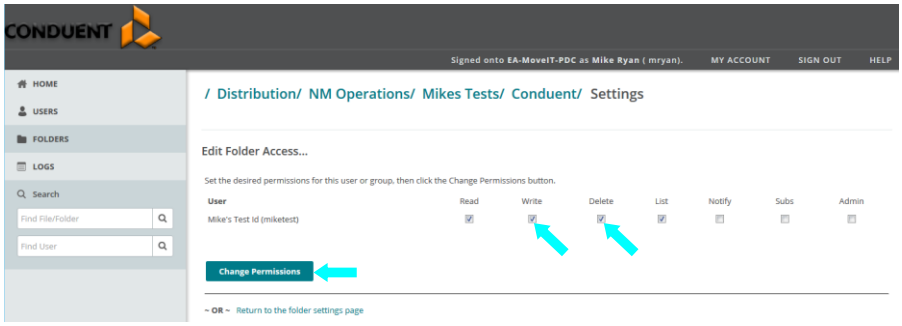
Let's change an existing user's accesses to this folder. Across from the user's name,

click on the 'Edit' icon  .

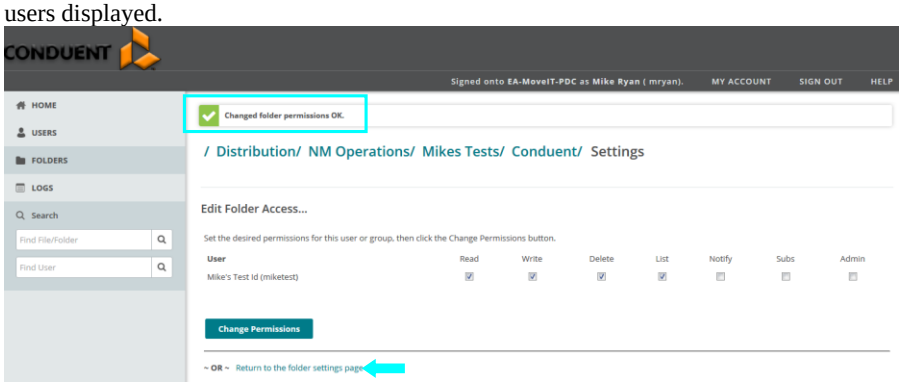


You will receive a detail screen for this user with check boxes for each of the various accesses. By checking a box, you are granting that access for this user. By clearing a check box, you are removing that access for this user. Our standard practice on folder accesses are to allow 'Read' and 'List' together, also allow 'Write' and 'Delete' together. Notify is set on, an on request basis and is normally not granted. 'Subs' and 'Admin' should only be granted to system administrators. Once you have made your changes just click the 'Change Permission' button to update this user.

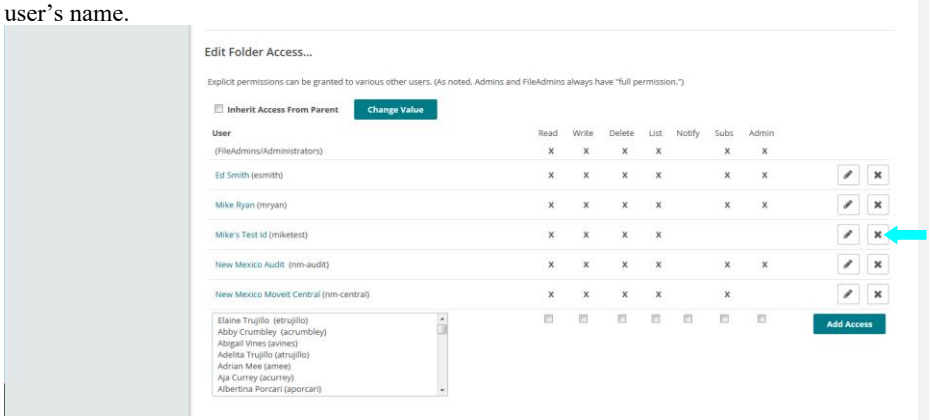




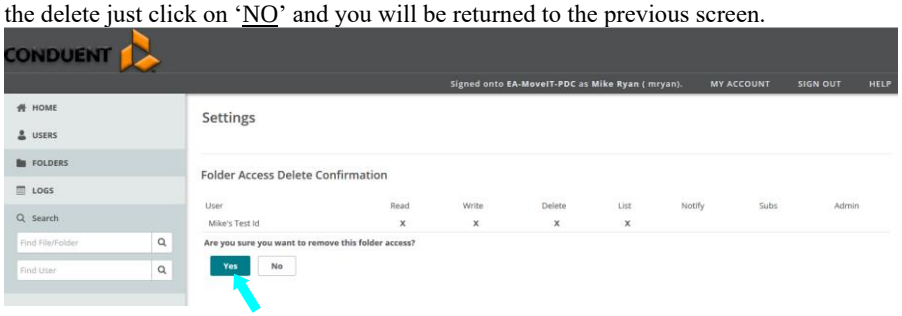
You will receive the same screen back, with the 'Changed folder permissions OK' message at the top. If you have additional users to work on, just click on 'Return to the folder settings page' and you will be back to the 'Folder Settings' screen with the list of users displayed.



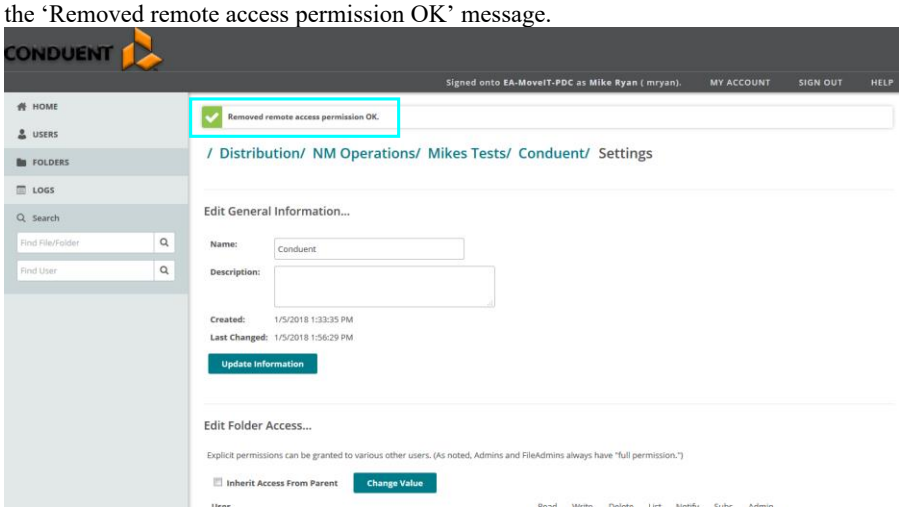
To remove all accesses for a user, click on the word 'Delete' icon  across from that user's name.



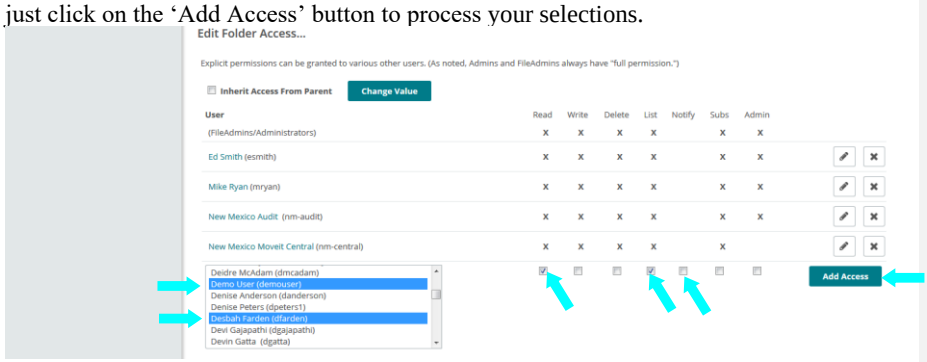
You will now be asked to confirm that you want to delete all access for this user to this folder. If this is correct, just click on 'YES' to process the delete, if you want to cancel the delete just click on 'NO' and you will be returned to the previous screen.



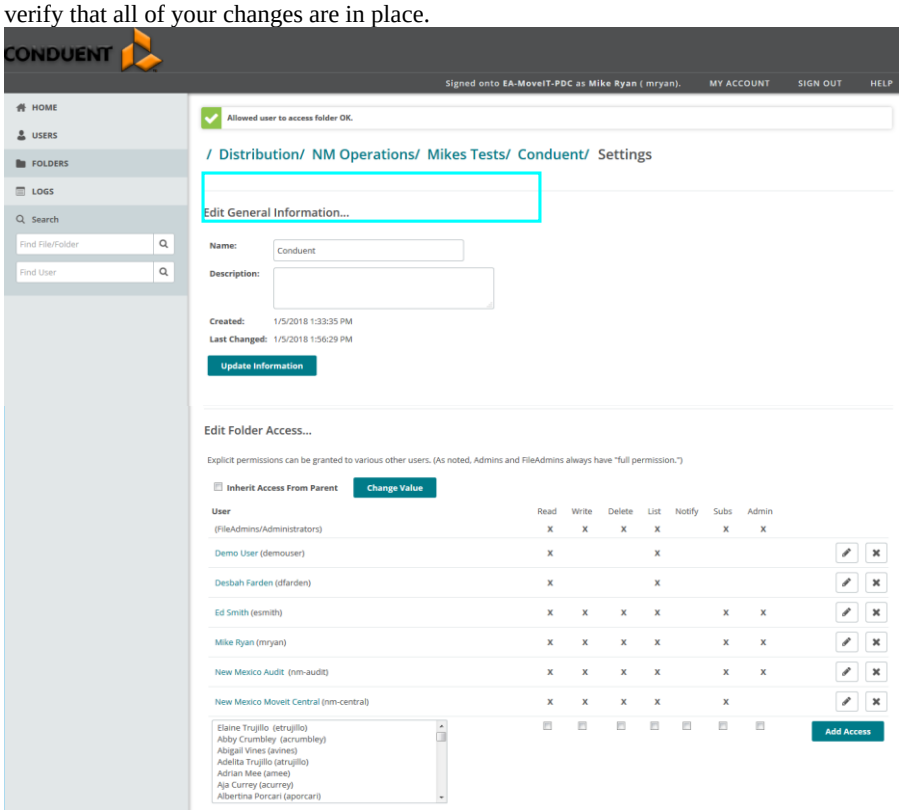
If you confirmed the delete, then you will be returned to the 'Folder Settings' screen with the 'Removed remote access permission OK' message.



If you want to add folder access for a user, that currently does not have any access to this folder, you will need to go to the scroll box after the list of current users. From this scroll box you can select a single user by clicking on that users name, a range of users by clicking on the first user and scrolling to the last and 'Shift' click on the last user in the range, or any combinations of users by clicking on the first users and then scrolling to the next user and 'CNTL' clicking on each additional user. When selecting multiple users they will all be granted the same accesses when you add them. Click on the check boxes for each access you want to grant to this/these user/s. As a system default, when you click on the 'READ' access box the 'LIST' and 'NOTIFY' boxes will automatically be checked. In most cases you will want to clear the 'NOTIFY' check box before adding these users accesses. Once you have selected your users and check the accesses wanted just click on the 'Add Access' button to process your selections.



You will be returned to the 'Folder Settings' screen and at the top you should see the 'Allowed user to access folder OK' message. You can review the list of current users to verify that all of your changes are in place.



Unfortunately with the current version of MOVEit DMZ when working with users that have existing access to a folder you are only able to process one user at a time.

Messages

MOVEit DMZ will generate and email messages to MOVEit DMZ users in a number of cases. These are automated messages from MOVEit DMZ and are not controlled by the users. Administrators may set the file notification permission for a user on a folder but the notification message is generated automatically by MOVEit DMZ and sent to the users who are to be notified according to the permissions set.

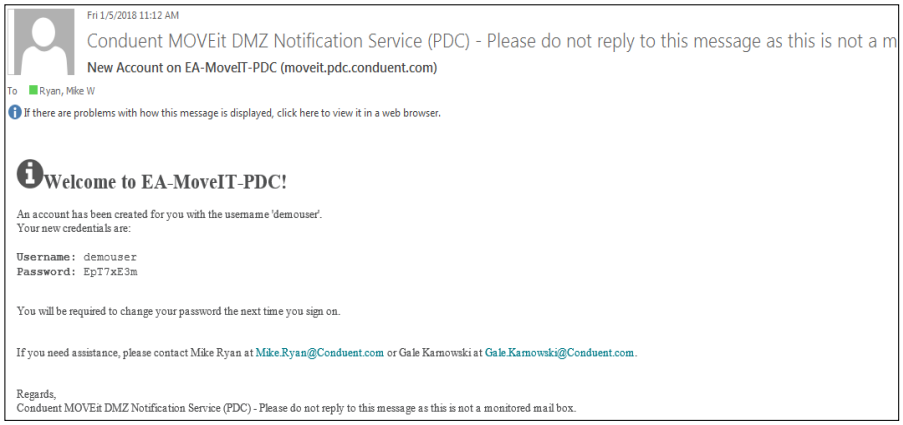
NOTE:

Please make sure that your email system will allow messages from MoveITDMZ@Conduent.com so that you will receive the messages sent from MOVEit DMZ.

User Account Messages

These messages are sent to users when certain activities have taken place on their user account.

The first message any user should receive is the 'New Account on EA-MoveIT-PDC (moveit.pdc.conduent.com)' message that is sent when a new user account is established. This message will give you your MOVEit DMZ user id and your initial password.



Fri 1/5/2018 11:12 AM

Conduent MOVEit DMZ Notification Service (PDC) - Please do not reply to this message as this is not a m

New Account on EA-MoveIT-PDC (moveit.pdc.conduent.com)

To Ryan, Mike W

If there are problems with how this message is displayed, click here to view it in a web browser.

Welcome to EA-MoveIT-PDC!

An account has been created for you with the username 'demouser'.
Your new credentials are:

Username: demouser
Password: EpT7xE3m

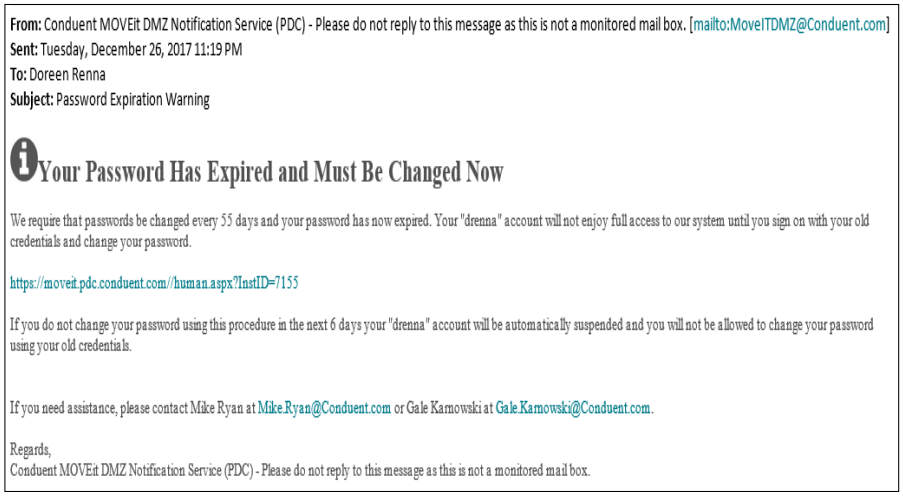
You will be required to change your password the next time you sign on.

If you need assistance, please contact Mike Ryan at Mike.Ryan@Conduent.com or Gale Karnowski at Gale.Karnowski@Conduent.com.

Regards,
Conduent MOVEit DMZ Notification Service (PDC) - Please do not reply to this message as this is not a monitored mail box.

The next user account message that a user may receive is that your password is about to expire. This message is sent 5 days before your password expires. This message states that your password has expired but you have 5 calendar days to use your current password and sign on and enter a new password.

When you receive this message please sign on to MOVEit DMZ and change your password.



From: Conduent MOVEit DMZ Notification Service (PDC) - Please do not reply to this message as this is not a monitored mail box. [mailto:MoveITDMZ@Conduent.com]
Sent: Tuesday, December 26, 2017 11:19 PM
To: Doreen Renna
Subject: Password Expiration Warning

Your Password Has Expired and Must Be Changed Now

We require that passwords be changed every 55 days and your password has now expired. Your "drenna" account will not enjoy full access to our system until you sign on with your old credentials and change your password.

https://moveit.pdc.conduent.com//human.aspx?InstID=7155

If you do not change your password using this procedure in the next 6 days your "drenna" account will be automatically suspended and you will not be allowed to change your password using your old credentials.

If you need assistance, please contact Mike Ryan at Mike.Ryan@Conduent.com or Gale Karnowski at Gale.Karnowski@Conduent.com.

Regards,
Conduent MOVEit DMZ Notification Service (PDC) - Please do not reply to this message as this is not a monitored mail box.

If you have ignored or just missed the password expired warning message above then the next message you will receive is the password expired message stating that your account has been suspended. At this point you will have to contact your Conduent or New Mexico state contact to have your account reactivated. You may contact either or both of the individuals listed in the message. You may also contact Ed Smith at Edward.Smith@Conduent.com and/or Darlene Martinez at DarleneE.Martinez@state.nm.us .

From: Conduent MOVEit DMZ Notification Service (PDC) - Please do not reply to this message as this is not a monitored mail box. [mailto:MoveITDMZ@Conduent.com]
Sent: Monday, December 25, 2017 11:16 PM
To: Cindy Wilcox <cwilcox@rec6.net>
Subject: Password Expiration Notification

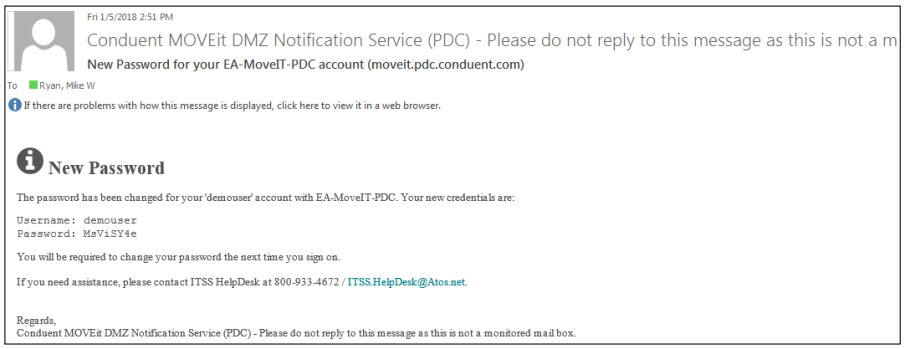
Password Expiration Notification

Your "cwilcox" account has been suspended because you have not changed your password in the last 60 days.

If you need to reactivate your account, you will need to contact Mike Ryan at Mike.Ryan@Conduent.com or Gale Karnowski at Gale.Karnowski@Conduent.com.

Regards,
Conduent MOVEit DMZ Notification Service (PDC) - Please do not reply to this message as this is not a monitored mail box.

If you have requested an unlock or password reset you will receive this message once that has been processed.



Fri 1/5/2018 2:51 PM

Conduent MOVEit DMZ Notification Service (PDC) - Please do not reply to this message as this is not a m

New Password for your EA-MoveIT-PDC account (moveit.pdc.conduent.com)

To Ryan, Mike W

If there are problems with how this message is displayed, click here to view it in a web browser.

New Password

The password has been changed for your 'demouser' account with EA-MoveIT-PDC. Your new credentials are:

```
Username: demouser
Password: MsViSY4e
```

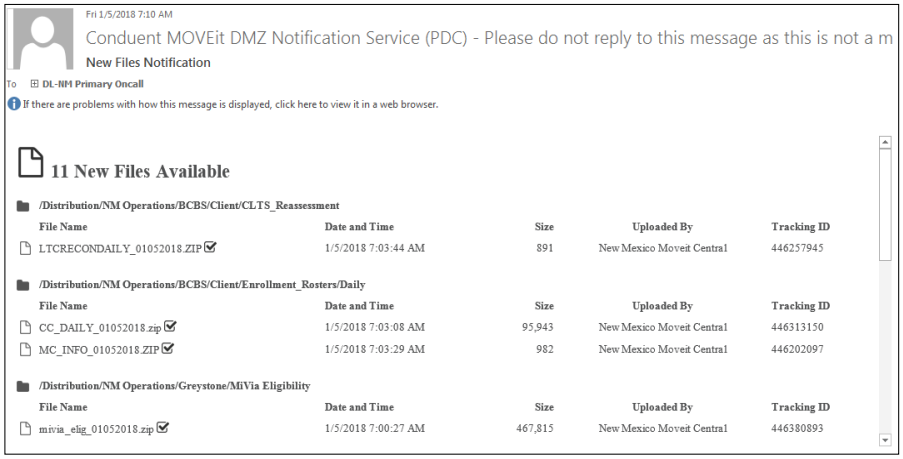
You will be required to change your password the next time you sign on.

If you need assistance, please contact ITSS HelpDesk at 800-933-4672 / ITSS.HelpDesk@Atos.net.

Regards,
Conduent MOVEit DMZ Notification Service (PDC) - Please do not reply to this message as this is not a monitored mail box.

File Notification Message

If you have any folder with the notify access activated then when a new file is placed in that folder you will receive a 'New File Notification' message from MOVEit DMZ. This message is generated every 10 to 15 minutes by MOVEit DMZ and will contain all of the new files added to all of the folders to which you have notification access set on, in that time frame.



Fri 1/5/2018 7:10 AM

Conduent MOVEit DMZ Notification Service (PDC) - Please do not reply to this message as this is not a m

New Files Notification

To DL-NM Primary Oncall

If there are problems with how this message is displayed, click here to view it in a web browser.

11 New Files Available

/Distribution/NM Operations/BCBS/Client/CLTS_Reassessment

File Name	Date and Time	Size	Uploaded By	Tracking ID
LTCRECONDAILY_01052018.ZIP	1/5/2018 7:03:44 AM	891	New Mexico Moveit Central	446257945

/Distribution/NM Operations/BCBS/Client/Enrollment_Rosters/Daily

File Name	Date and Time	Size	Uploaded By	Tracking ID
CC_DAILY_01052018.zip	1/5/2018 7:03:08 AM	95,943	New Mexico Moveit Central	446313150
MC_INFO_01052018.ZIP	1/5/2018 7:03:29 AM	982	New Mexico Moveit Central	446202097

/Distribution/NM Operations/Greystone/MiVia Eligibility

File Name	Date and Time	Size	Uploaded By	Tracking ID
mivia_elig_01052018.zip	1/5/2018 7:00:27 AM	467,815	New Mexico Moveit Central	446380893