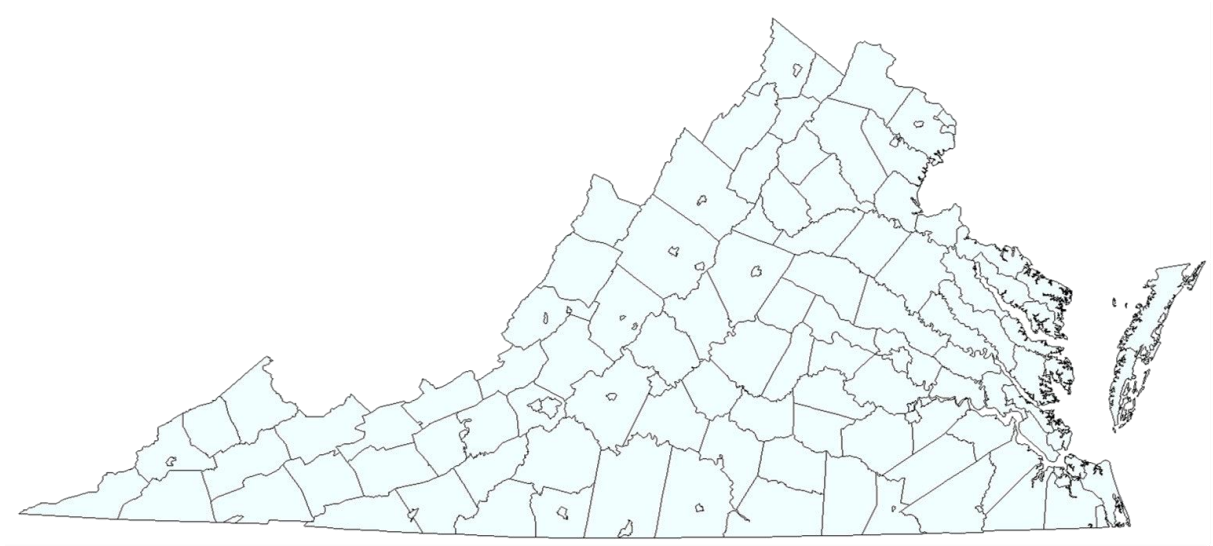
Managed Care Technical Manual



Virginia Department of Medical Assistance

Health Care Services Division

Version 3.4

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Table of Contents

Version Change Summary 10
MCTM Version Effective Dates 17
1 Encounters 19
1.1 HIPAA Administrative Simplification 20
1.1.1 Version and Model 21
1.1.2 EDI Resources 22
1.2 Encounter Submission Process 23
1.2.1 Service Center Registration 24
1.2.2 Transmission Protocol 25
1.2.3 Test Transmissions 26
1.2.4 Production Transmissions 29
1.2.5 Submission Response Reports 32
1.2.6 Encounter Submission Calendar 45
1.3 Encounter Processing Requirements 52
1.3.1 Encounter Data Certification 53
1.3.2 Adjustments & Voids 54
1.3.3 Denied Services 55
1.3.4 National Provider Identifier 62
1.3.5 Line-Level Processing 63
1.3.6 Drug Rebate Collection 67
1.3.7 MCO Payment Amount & Date 69
1.3.8 Enrollment Determination Based on Admit Date 74
1.3.9 Newborns Without Medicaid IDs 75
1.3.10 Procedure, Diagnosis, Revenue Code 76
1.4 Proprietary MMIS Code Sets 77
1.4.1 MMIS Claim Type 78
1.4.2 Provider Class Type 79
1.4.3 Provider Specialty 82
1.4.4 Edit Codes / Error Sequence Codes (ESC) 85
1.4.5 Encounter Exception Error Code List 90
1.5 Encounter Data Quality (EDQ) Process 91
1.5.1 DMAS Reporting 92
1.5.2 Compliance and Corrections 93
1.5.3 Critical Issues 94
1.5.4 Emerging Issues 96

2 Enrollment Roster & Payment Files....105
2.1 Enrollment Roster (834)....106
2.2 Capitation Payment Remittance (820)....107
2.2.1 Capitation Payment Remittance (820) Schedule....108
2.2.2 Capitation Payment Remittance (820) – “Best Practices” in Reconciliation....109
3 MCO Contract Deliverables....111
3.1 Reporting Standards....112
3.1.1 DMAS Secure FTP Server....113
3.1.2 Deliverable Scoring....114
3.1.3 Creating Comma Separated Value (CSV) File Using Excel....116
3.2 Monthly Deliverables....117
3.2.1 Enrollment Broker Provider File....118
3.2.2 MCO Claims Report....120
3.2.3 Live Births....122
3.2.4 Returned ID Cards....124
3.2.5 Patient Utilization and Safety Management Program (PUMS) Members....126
3.2.6 Assessments Age/Blind/Disabled and Children with Special Health Care Needs....128
3.2.7 Appeals & Grievances Summary....130
3.2.8 Monthly Provider File for Encounter Processing....133
3.2.9 Encounter File Submissions (Eliminated)....135
3.2.10 Encounter Data Certification....136
3.2.11 Monies Recovered by Third Parties....138
3.2.12 Comprehensive Health Coverage....139
3.2.13 Workers' Compensation....141
3.2.14 Estate Recoveries....142
3.2.15 Other Coverage....143
3.2.16 PCP Provider Attestation Listing (Eliminated)....144
3.2.17 MCO Newborn Reconciliation File....145
3.2.18 Assessment Exception Report....147
3.2.19 Assessments Foster Care Children....149
3.2.20 MCO Call Center Statistics....152
3.2.21 Behavioral Health Home (BHH) Enrollment Roster....154
3.2.22 Behavioral Health Homes Quality Report....205
3.3 Quarterly Deliverables....207
3.3.1 Provider Network File....208
3.3.2 Providers Failing Accreditation/Credentialing and Terminations....215

3.3.3 Case Managers List (Eliminated) 216
3.3.4 Members with Physical and Behavioral Health Limitations and Conditions (Eliminated) 217
3.3.5 Program Integrity Activities 218
3.3.6 BOI Filing - Quarterly 219
3.3.7 Financial Report 220
3.3.8 Reinsurance 222
3.3.9 PCP Incentive Payments 225
3.3.10 Disproportionate Share Hospital (Eliminated) 228
3.3.11 Patient Utilization Management and Safety Outcome Report 229
3.3.12 Provider GeoAccess® GeoNetworks® File 231
3.4 Annual Deliverables 232
3.4.1 List of Subcontractors 233
3.4.2 Physician Incentive Plan 235
3.4.3 Provider Satisfaction Survey Instrument 236
3.4.4 Provider Satisfaction Survey Methodology 237
3.4.5 Provider Satisfaction Survey Results 238
3.4.6 Marketing Plan 239
3.4.7 Member Handbook 240
3.4.8 Health Plan Assessment Plan 241
3.4.9 Medallion Care System Partnership Annual Plan 242
3.4.10 Medallion Care System Partnership Performance Results 246
3.4.11 Quality Improvement Plan 247
3.4.12 Quality Assessment & Performance Improvement Plan 248
3.4.13 HEDIS Results 249
3.4.14 HEDIS Corrective Action Plan (Eliminated) 250
3.4.15 CAHPS Survey Results 251
3.4.16 Performance Improvement Project (PIP) 252
3.4.17 Wellness and Member Incentive Programs 253
3.4.18 Complex Care Management Plan 254
3.4.19 Prenatal Program Outcomes (Eliminated) 255
3.4.20 Program Integrity Plan 256
3.4.21 Program Integrity Activities Annual Summary 257
3.4.22 Organizational Charts 258
3.4.23 Program Integrity Compliance Audit (PICA) 259
3.4.24 BOI Filing - Annual 260
3.4.25 Audit by Independent Auditor (Required by BOI) 261

3.4.26 Company Background History 262
3.4.27 Health Insurer Fee 263
3.4.28 Patient Utilization Management and Safety (PUMS) Prior Authorization Requirements 264
3.4.29 Behavioral Health Home Pilot Care Team....265
3.4.30 Behavioral Health Home Plan Outreach and Marketing Plan 266
3.4.31 Maternity Program Summary Report....267
3.4.32 Maternity Program Policy Report 268
3.4.33 Interventions Targeted to Prevent Controlled Substance Abuse 269
3.4.34 Abortion Services....270
3.5 Other Reporting Requirements 271
3.5.1 NCQA Deficiencies 272
3.5.2 NCQA Accreditation Status Changes....273
3.5.3 Provider Agreements 274
3.5.4 MCO Staffing Changes 275
3.5.5 Provider Network Change Affecting Member Access to Care 276
3.5.6 Hospital Contract Changes 277
3.5.7 Provider Credentialing Policies and Procedures 278
3.5.8 Practitioner Infractions 279
3.5.9 PCP Assignment Policies & Procedures 280
3.5.10 Inpatient Hospital Contracting Changes....281
3.5.11 Changes to Claims Operations 282
3.5.12 Provider Disenrollment Policies & Procedures 283
3.5.13 Enrollment – Excluding Members 284
3.5.14 Newborn Identification Procedures 285
3.5.15 Member Education & Outreach....286
3.5.16 Member Marketing Materials....287
3.5.17 Member Incentive Awards 288
3.5.18 Member Enrollment, Disenrollment, and Educational Materials 289
3.5.19 Program Changes....290
3.5.20 Member Rights - Policies & Procedures....291
3.5.21 Member Health Education & Prevention Plan 292
3.5.22 EPSDT Second Review Process 293
3.5.23 Services Not Covered Due to Moral or Religious Objections....294
3.5.24 Sentinel Event 295
3.5.25 Patient Utilization Management and Safety (PUMS) Program Policies and Procedures 296

3.5.26 Compliance for Sterilizations & Hysterectomies 297
3.5.27 Substance Abuse Services for Pregnant Women 298
3.5.28 Access to Services for Disabled Children & Children with Special Health Care Needs 299
3.5.29 Utilization Management Plan 300
3.5.30 Atypical Drug Utilization Reporting 301
3.5.31 Drug Formulary & Authorization Requirements 302
3.5.32 Incarcerated Members 303
3.5.33 Enhanced Services 304
3.5.34 NCQA Accreditation Renewal 305
3.5.35 Prenatal Programs and Services Policies and Procedures (Eliminated) 306
3.5.36 Fraud, Waste and Abuse Policies & Procedures 307
3.5.37 Provider Appeals Process 308
3.5.38 Fraud and/or Abuse Incident 309
3.5.39 Marketing Fraud/Waste/Abuse 310
3.5.40 Medicaid Fraud Control Unit (MFCU) Referrals 311
3.5.41 Member Grievance & Appeals Policies & Procedures 312
3.5.42 Enrollment Verification for Providers Policies & Procedures 313
3.5.43 Encounter Data Plan for Completeness 314
3.5.44 Encounter Data Deficiencies 315
3.5.45 Encounter Data Corrective Action Plan 316
3.5.46 BOI Filing - Revisions 317
3.5.47 Independent Audit 318
3.5.48 Financial Report - Revisions 319
3.5.49 Basis of Accounting Changes 320
3.5.50 Reserve Requirements Changes 321
3.5.51 FQHC/RHC Arrangements 322
3.5.52 FQHC/RHC Reimbursement Methodology 323
3.5.53 Contractor Non-Compliance Remedy 324
3.5.54 Corrective Action Plan for Failure to Perform Administrative Function(s) 325
3.5.55 Disclosure of Ownership & Control Interest Statement (CMS 1513) 326
3.5.56 Transaction with Other Party of Interest 327
3.5.57 Acquisition/Merger/Sale 328
3.5.58 Ownership Change 329
3.5.59 MCO Principal Conviction or Criminal Offense 330
3.5.60 Contractor or Subcontractor on LEIE 331
3.5.61 Other Categorically Prohibited Affiliations 332

3.5.62 Ownership/Control of Other Entity....333
3.5.63 MCO Medicaid Managed Care Business Changes....334
3.5.64 Disputes between DMAS and MCO Arising Out of the Contract....335
3.5.65 PHI Breach/Disclosure Notification to DMAS....336
3.5.66 Data Security Plan for Department Data....337
3.5.67 Data Confidentiality Policies & Procedures....338
3.5.68 Request for Exemption from Contract Requirement(s)....339
3.5.69 Notification of Potential Conflict of Interest....340
3.5.70 Third Party Administrator (TPA) Contracts....341
3.5.71 Third Party Administrator (TPA) Firewall....342
3.5.72 Notification of Opt Out of Automatic Contract Renewal Clause....343
3.5.73 Insurance Coverage Verification....344
3.5.74 Notification of Potential MCO Liability....345
3.5.75 Medical Record Safeguards....346
3.5.76 Practice Guidelines....347
3.5.77 Request for Publication or Presentation of DMAS-Related Subjects....348
3.5.78 Bankruptcy Petition....349
3.5.79 Provider Manual Managed Care References....350
3.5.80 Notification of Changes to Subcontractor Method of Payment....351
3.5.81 New Agreements and Changes in Approved Agreements....352
3.5.82 Expansion Request (Letter of Intent)....353
3.5.83 MCO Improvement Plan (MIP) for Failure to Perform Administrative Function(s)....354
4 DMAS Reports....355
4.1 Reports Generated by DMAS....356
4.1.1 Provider File....357
4.1.2 Pregnancy Due Date....360
4.1.3 Plan Change Report....362
4.1.4 Community Mental Health Rehabilitation Services (CMHRS)....363
4.1.5 Behavioral Health Service Authorizations (Eliminated)....365
4.1.6 TPL....366
4.1.7 New Members on 820 but not on (previous) Mid-Month 834....367
4.1.8 Medical Transition....369
4.1.9 Managed Care Enrollment (Flash)....371
4.1.10 EOM 834 Summary....372
4.1.11 MID 834 Summary....373
4.1.12 Patient Utilization Management and Safety (PUMS)....374

4.1.13 School PDN Claims 375
4.1.14 School PDN Prior Authorization 376
4.1.15 Newborns 377
4.1.16 Error Report 378
4.1.17 Quarterly ABD Enrollment (Eliminated) 379
4.1.18 Encounter Lag Report (Eliminated) 380
4.1.19 Behavioral Health Service Authorizations Report 381
4.1.20 DMAS Newborn Reconciliation Return File 383
4.1.21 Behavioral Health (BHSA) Claims History 386
4.1.22 Assessments Summary Report 388
4.1.23 Assessments Detail Report 390
4.1.24 Encounter Data Quality (EDQ) Critical and Emerging Issues Report 392
4.1.25 Encounter Data Quality (EDQ) Critical Issue Detail File 395
4.1.26 Encounter Data Quality (EDQ) Emerging Issue Detail File 397
4.2 DMAS Forms 398
5 Operational Business Processes 400
5.1 DMAS Processes 401
5.1.1 PCP Provider Incentive Payments 402
5.1.2 Incarcerated Members 403
5.1.3 Newborn Reconciliation 404
5.1.4 Assessment Population Determination 407
5.1.5 Behavioral Health Home Pilot Enrollment Roster 410

Version Change Summary

Ver	Description	Date
3.0	Section 1.2.6: Updated Encounter Submission Calendar for Jul-Dec 2015	05/15/15
3.0	Section 1.3.6: Added clarification to requirements for encounters related to DMAS collection of drug rebates.	05/15/15
3.0	Section 1.3.7: Removed subsections 1.3.7.5 and 1.3.7.6	05/15/15
3.0	Section 1.3.10: Added ESC 0995	05/15/15
3.0	Section 1.4.4: Added ESC 0001 and 0002	05/15/15
3.0	Section 1.4.5: Eliminated 'Encounter Exception Error Code List'. All of these error codes have been transferred to the new 'Encounter Data Quality' (EDQ) process and will be tracked via the new process effective 07/01/2015.	05/15/15
3.0	Section 1.5: Added Encounter Data Quality (EDQ) section	05/15/15
3.0	Section 3.2.1: 'Enrollment Broker Provider File' updated contract reference	05/15/15
3.0	Section 3.2.2: Updated requirements for number 3 to remove 'Pended Claims' as part of 'Total Claims Processed'.	05/15/15
3.0	Section 3.2.5: Changed title from 'Lock-In' to 'Patient Utilization and Safety Management Program (PUMS) Members'. Updated contract reference to 7.1.M.III. Changed file name to 'PUMS.csv'. Added text to Requirements description.	05/15/15
3.0	Section 3.2.6: 'Assessments Aged/Blind/Disabled and Children with Special Health Care Needs' changed requirements text.	05/15/15
3.0	Section 3.2.9: Eliminated 'Encounter File Submissions' deliverable. The list of encounter files has been integrated into the revised 'Encounter Data Certification' deliverable.	05/15/15
3.0	Section 3.2.10: 'Encounter Data Certification' Numerous revisions to requirements, content, and format for 'Encounter Data Certification' form.	05/15/15
3.0	Section 3.2.11 'Monies Recovered by Third Parties' updated contract reference	05/15/15
3.0	Section 3.2.16: Eliminated 'PCP Provider Attestation Listing' as PCP incentive payment program ended 12/31/2014.	05/15/15
3.0	Section 3.2.18: Added "Assessment Exception Report" deliverable.	05/15/15
3.0	Section 3.2.19: Added 'Assessments Foster Care Children' deliverable.	05/15/15
3.0	Section 3.2.20: Added 'MCO Call Center Statistics' section	05/15/15
3.0	Section 3.2.21: Added 'Behavioral Health Home (BHH) Enrollment Roster' section	05/15/15
3.0	Section 3.2.22: Added 'Behavioral Health Home (BHH) Quality Report' section	05/15/15

Ver	Description	Date
3.0	Section 3.3.1: 'Provider Network File' added taxonomy code/specialty table to Requirements	05/15/15
3.0	Section 3.3.3: Eliminated 'Case Managers List' deliverable due to contract changes.	05/15/15
3.0	Section 3.3.4: Eliminated 'Members With Physical and Behavioral Health Limitations and Conditions' deliverable due to contract changes.	05/15/15
3.0	Section 3.3.9: 'PCP Incentive Payments' updated contract reference	05/15/15
3.0	Section 3.3.10: 'Disproportionate Share Hospital' updated contract reference	05/15/15
3.0	Section 3.3.11: Added 'Patient Utilization Management and Safety Outcome Report' section.	05/15/15
3.0	Section 3.4.8: 'Health Plan Assessment Plan' updated contract reference	05/15/15
3.0	Section 3.4.9: 'Medallion Care System Partnership Annual Plan' updated contract reference and modified reporting requirements.	05/15/15
3.0	Section 3.4.10: 'Medallion Care System Partnership Performance Results' updated contract reference and modified reporting requirements.	05/15/15
3.0	Section 3.4.14: Eliminated 'HEDIS Corrective Action Plan' due to contract changes.	05/15/15
3.0	Section 3.4.17: 'Wellness and Member Incentive Programs' updated contract reference.	05/15/15
3.0	Section 3.4.18: 'Complex Care Management Plan' updated contract reference.	05/15/15
3.0	Section 3.4.19: 'Prenatal Program Outcomes' updated contract reference.	05/15/15
3.0	Section 3.4.20: 'Program Integrity Plan' updated contract reference.	05/15/15
3.0	Section 3.4.21: 'Program Integrity Activities Annual Summary' updated contract reference	05/15/15
3.0	Section 3.4.22: 'Organizational Charts' updated contract reference	05/15/15
3.0	Section 3.4.24: 'Program Integrity Compliance Audit (PICA)' added reference to form on DMAS web site	05/15/15
3.0	Section 3.4.28: Added "Patient Utilization Management and Safety (PUMS) Prior Authorization Requirements" section.	05/15/15
3.0	Section 3.4.29: Added "Behavioral Health Home Pilot Care Team' section	05/15/15
3.0	Section 3.4.30: Added "Behavioral Health Home Outreach and Marketing Plan" section	05/15/15
3.0	Section 3.4.31: Added "Maternity Program Summary Report" section	05/15/15
3.0	Section 3.4.32: Added "Maternity Program Policy Report" section	05/15/15
3.0	Section 3.4.33: Added "Interventions Targeted to Prevent Controlled Substance Abuse" section	05/15/15

Ver	Description	Date
3.0	Section 3.5.10: 'Inpatient Hospital Contracting Changes' updated Requirements to correct reference to attachment.	05/15/15
3.0	Section 3.5.23: 'Services Not Covered Due to Moral or Religious Objections' updated contract reference.	05/15/15
3.0	Section 3.5.24: 'Sentinel Event' updated contract reference.	05/15/15
3.0	Section 3.5.25: Changed title to "Patient Utilization Management and Safety (PUMS) Program Policies and Procedures". Changed contract reference to section 7.1.M.II. Changed File Name to PUMS_OUTCM.pdf. Changed Trigger to Annual, Due Date to September 30th. Added Requirements description.	05/15/15
3.0	Section 3.5.35: 'Prenatal Programs and Services Policies and Procedures' updated contract reference.	05/15/15
3.0	Section 3.5.38: 'Fraud and/or Abuse Incident' updated Requirements to include reference to template on DMAS web site	05/15/15
3.0	Section 3.5.39: 'Marketing Fraud/Waste/Abuse' updated Requirements to include reference to template on DMAS web site.	05/15/15
3.0	Section 3.5.51: 'FQHC/RHC Arrangements' updated contract reference.	05/15/15
3.0	Section 3.5.52: 'FQHC/RHC Reimbursement Methodology' updated contract reference.	05/15/15
3.0	Section 3.5.54: 'Corrective Action Plan for Failure to Perform Administrative Function(s)' Updated the Contract Reference Section to 13.2.D.II. Changed the File Specifications method to new email address. Changed the DMAS responsibility to "HCS Compliance". Added text and copy of Corrective Action Plan form to Requirements.	05/15/15
3.0	Section 3.5.60: 'Contractor or Subcontractor on LEIE' updated contract reference.	05/15/15
3.0	Section 3.5.62: 'Ownership/Control of Other Entity' updated contract reference.	05/15/15
3.0	Section 3.5.63: 'MCO Medicaid Managed Care Business Changes' updated contract reference.	05/15/15
3.0	Section 3.5.68: 'Request for Exemption from Contract Requirement(s)' Changed File Specification method to new email address. Changed due date to 30 days prior to effective date. Changed file format to Adobe .pdf file. Changed File Name to "CONTRACT_EXEMPT.pdf". Added Requirements description.	05/15/15
3.0	Section 3.5.72: 'Notification of Opt Out of Automatic Contract Renewal Clause' updated contract reference.	05/15/15
3.0	Section 3.5.78: 'Bankruptcy Petition' updated contract reference.	05/15/15
3.0	Section 3.5.83: Added "MCO Improvement Plan (MIP) for Failure to Perform Administrative Function(s)" section	05/15/15

Ver	Description	Date
3.0	Section 4.1.5: Eliminated DMAS 'Behavioral Health Service Authorizations'. Duplicate of section 4.1.18	05/15/15
3.0	Section 4.1.12: Changed report name to "Patient Utilization Management and Safety (PUMS)". Changed file name to "PUMS_yyyymm.xlsx".	05/15/15
3.0	Section 4.1.18: Eliminated DMAS 'Encounter Lag Report'. This reporting is being incorporated into by the new Encounter Data Quality (EDQ) process and reporting.	05/15/15
3.0	Section 4.1.22: Added 'Assessments Summary Report' section	05/15/15
3.0	Section 4.1.23: Added 'Assessments Detail Report' section	05/15/15
3.0	Section 4.1.24: Added 'EDQ Critical and Emerging Issues Report' section	05/15/15
3.0	Section 4.1.25: Added 'EDQ Critical Issues Detail File' section	05/15/15
3.0	Section 4.1.26: Added 'EDQ Emerging Issues Detail File' section	05/15/15
3.0	Section 5.0: Renamed section from 'DMAS Processes' to 'Operational Business Processes'	05/15/15
3.0	Section 5.1.4: Added 'Assessment Population Determination' section	05/15/15
3.0	Section 5.1.5: Added 'Behavioral Health Home Pilot Enrollment Roster' section	05/15/15
3.0	MCTM Version Effective Dates (page 14) – Added clarification about which MCTM to use for submitting reports in July and August	06/01/15
3.0	Section 1.3.7: Added requirements for MCO payment date and amount	06/01/15
3.0	Section 1.5.3 & 1.5.4 – Moved Rebates from Critical to Emerging issues	06/01/15
3.0	Section 3.2.17: Removed date as part of the file name	06/01/15
3.0	Section 3.2.19: Removed description of assessment for 'Assessments Foster Care Children' report. Refer to Medallion 3.0 contract for assessment detail. Changed wording in requirements from "within applicable timeframe" to "within the two month continuous enrollment period."	06/01/15
3.0	Section 3.2.22: Added "licensed clinical behavioral health case managers" to list of acceptable behavioral health providers for the 'Behavioral Health Homes Quality Report'.	06/01/15
3.0	Section 3.2.5: Added new effective date for report and criteria for program participation for 'Patient Utilization Management and Safety (PUMS) Program Members'.	06/01/15
3.0	Section 3.2.7: 'Appeals and Grievances Summary' updated contract references.	06/01/15
3.0	Section 3.24.28: Added new effective date for 'Patient Utilization Management and Safety (PUMS) Program Prior Authorization Requirements'	06/01/15
3.0	Section 3.3.2: Added requirement to include MCO-terminated providers in the 'Providers Failing Accreditation/Credentialing' report.	06/01/15

Ver	Description	Date
3.0	Section 3.3.12: Added 'Provider GeoAccess File' section	06/01/15
3.0	Section 3.4.33: Added clarification regarding controlled substances to 'Interventions to Prevent Controlled Substance Abuse' requirements.	06/01/15
3.0	Section 3.5.25: Changed due date for 'Patient Utilization Management and Safety (PUMS) Program Policies and Procedures'	06/01/15
3.0	Section 4.1.23: Modified example in 'Assessments Detail Report' to remove invalid eligibility code.	06/01/15
3.0	Section 4.1.24: Added report examples to 'EDQ Critical and Emerging Issues Report' section	06/01/15
3.1	Section 3.2.10: Removed "Vendor ID" from the file specifications for 'Encounter Data Certification'	06/10/15
3.1	Section 1.2.4.5: Updated description to include new EDQ requirements and remove description of previous encounter error process.	06/15/15
3.1	Section 3.2.2: Added sentence regarding extraneous characters in numeric fields for the 'MCO Claims' report.	06/15/15
3.1	Section 3.2.5: Removed detail from Requirements of 'Patient Utilization and Management Safety (PUMS) Program' as requirements are in development.	06/15/15
3.1	Section 3.2.7: Added sentence regarding extraneous characters in numeric fields for the 'Appeals and Grievances' report.	06/15/15
3.1	Section 3.2.20: Modified the format of the last 4 fields in the 'Call Center' report to reflect a time format (mm:ss). Added sentence regarding extraneous characters in numeric fields.	06/15/15
3.1	Section 3.3.7: Revised file format, specifications and requirements for the 'Financial Report'. File format is now Excel (.xlsx). Added picture of report to Examples section.	06/15/15
3.1	Section 3.3.11: Added language to file specifications and requirements to indicate that reporting of 'Patient Utilization and Management Safety (PUMS) Program Outcomes' begins October 1, 2015. Added sentence regarding extraneous characters in numeric fields.	06/15/15
3.1	Section 4.1.22: Revised description of field name for PERCENT_GT120DAY field to "Percent of Members Not Completing Assessments Within 120 Days of Enrollment".	06/15/15
3.1	Section 1.5.4.5: Added Implementation Date of 09/01/2015 for 'Enrollment' EDQ Emerging Issue.	07/08/15
3.1	Section 1.3.6.3: Added max number of supported occurrences for Submission Clarification Code.	07/14/15
3.1	Section 1.2.6: Reschedule encounter file submissions for INTotal Health due to Labor Day holiday.	07/14/15
3.1	Section 1.5.3: Added Critical Issues Implementation Schedule	07/14/15

Ver	Description	Date
3.2	Section 1.5.4.5: Added documentation about newborns without a Medicaid Id to Enrollment issue/ESC 0004, 0983.	07/27/15
3.2	Section 1.5.3 & 1.5.4.5: Changed Implementation Date of 09/01/2015 to 10/01/2015 for 'Enrollment' EDQ Emerging Issue.	07/27/15
3.3	Section 3.2.20: Added information regarding file submission format.	09/01/15
3.3	Section 3.2.22: Added information regarding file submission format.	09/01/15
3.3	Section 3.4.1: Added information regarding file submission format and changed due date of deliverable to within 90 calendar days of effective contract date.	09/01/15
3.3	Section 3.4.16: Added information regarding the submission of multiple files on the same day.	09/01/15
3.3	Section 3.5.13: Added information regarding submission using Member Action Form.	09/01/15
3.3	Section 3.5.24: Added information regarding submission using Member Action Form.	09/01/15
3.3	Section 3.5.32: Added information regarding submission using Member Action Form.	09/01/15
3.4	Section 1.5.3: Added "Internal errors" as part of the EDQ process; Updated Implementation Schedule: Promoted 10/01/2015 Anticipated Critical Issues to the Critical Issues list. Added Internal errors to Anticipated Critical Issues with anticipated implementation date of 12/01/2015.	10/01/15
3.4	Section 1.5.3.2: New section for recently promoted Enrollment Critical Issues	10/01/15
3.4	Section 1.5.4.3: Added Internal error codes I011, I014, I024 with anticipated implementation date of 12/01/2015. Added Internal error code I023 with anticipated implementation date TBD.	10/01/15
3.4	Section 1.5.4.6: Added Internal error codes I012, I015, I017, I022, I102, I103, I105, I106 with anticipated implementation date of 12/01/2015. Added Internal error code I104 with anticipated implementation date TBD.	10/01/15
3.4	Section 1.5.4.7: Added Internal error codes I020 with anticipated implementation date of 12/01/2015. Added Internal error code I018 with anticipated implementation date TBD.	10/01/15
3.4	Section 3.1.2: Modified the grading scale for grade of "F" to correct scoring method.	10/1/15
3.4	Section 3.2.5: Modified the requirements of the PUMS Members report to show values for PUMS Type codes.	10/1/15
3.4	Section 3.2.6: Modified requirements for report to exclude children in foster care (Aid Category 076) who are eligible for Early Intervention (EI) benefit.	10/1/15

Ver	Description	Date
3.4	Section 3.3.2: Changed title of report to “Providers Failing Accreditation/Credentialing and Terminations”. Changed contract reference section. Modified requirements to include all providers terminated by the MCO. Added reference to template on Managed Care website.	10/1/15
3.4	Section 3.3.10: Eliminated “Disproportionate Share Hospital” report	10/1/15
3.4	Section 3.4.1: Updated file format to be comma-separated value (.csv) format	10/1/15
3.4	Section 3.4.10: Updated due date to standard annual submission language	10/1/15
3.4	Section 3.4.17: Updated due date to standard annual submission language	10/1/15
3.4	Section 3.4.19: Eliminated “Prenatal Program Outcomes” report	10/1/15
3.4	Section 3.4.23: Changed file format to Excel (.xlsx) format.	10/1/15
3.4	Section 3.4.27: Changed file format to Adobe (.pdf) format.	10/1/15
3.4	Section 3.4.29: Added due date of within 10 days of change	10/1/15
3.4	Section 3.4.31: Updated due date to standard annual submission language	10/1/15
3.4	Section 3.4.32: Updated due date to standard annual submission language	10/1/15
3.4	Section 3.4.33: Updated due date to standard annual submission language	10/1/15
3.4	Section 3.4.34 – Abortion Services: Added new annual report. Specifications for report will be provided in a future version.	10/1/15
3.4	Section 3.4.6: Updated due date to standard annual submission language	10/1/15
3.4	Section 3.5.32: Changed reference to reporting template on Managed Care website to “Member Event Reporting Template”.	10/1/15
3.4	Section 3.5.35: Eliminated “Prenatal Programs and Services Policies and Procedures” report	10/1/15

MCTM Version Effective Dates

Version	Effective Date
1.0	04/01/13
1.5	06/01/13
1.6	08/01/13
1.7	09/01/13
1.8	10/01/13
1.9	11/01/13
1.10	01/01/14
1.11	02/01/14
1.12	04/01/14
2.0	07/01/15
2.1	08/01/15
2.2	09/01/14
2.3	10/01/14
2.4	01/01/15
2.5	02/01/15
2.7	04/01/15
2.8	05/01/15
3.0	06/01/15
3.1	07/01/15
3.2	08/01/15
3.3	09/01/15
3.4	10/01/15

Version 3.2 of the MCTM should be used for monthly reports submitted for August 15, 2015.

Version 2.8 of the MCTM should be used for monthly reports submitted for July 15, 2015.

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1 Encounters

This section contains information to assist existing and prospective Virginia Medicaid managed care contractors with the development of processes and procedures for encounter data submission. This information intended to supplement the Virginia Medicaid Medallion 3.0 and FAMIS contracts and the ANSI X12 Implementation Guide (IG). Hereafter the terms 'Contractor' and/or 'MCO' will refer to the Contractor and any subcontractor used by the Contractor.

The HIPAA Implementation Guides and Addenda are the official standard for electronic submission of health care encounter data. However, there are many areas in these IGs that are situational, open to interpretation, or that require further clarification by the receiving entity. The following documentation is specific to managed care encounter data submitted by a Medallion 3.0 or FAMIS contractor. Nothing in this documentation is intended to conflict or contradict the ANSI X12 / NCPDP Implementation Guides (IG). If you identify any conflicts, please notify DMAS by contacting HCSEncounter@dmas.virginia.gov.

Note that DMAS's fiscal agent, Xerox, has published separate fee for service Companion Guides, and these are published on DMAS' web site. Those Companion Guides do not apply to managed care encounter data and are not to be used for submission of encounter data.

Once the contractor is an established Service Center, any updates to their contact information should be made in writing and directed to the EDI coordinator at Xerox.

1.1 HIPAA Administrative Simplification

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all covered entities must use standard transaction sets when exchanging certain information. HIPAA did not specifically define the exchange of encounter data between a Medicaid plan and a managed care organization as a covered transaction. However, since health care claim transaction sets are national standards for data exchange, DMAS has elected to use the HIPAA transaction sets as its standard for Virginia Medicaid encounter data submission.

HIPAA adopted national code sets for use in all transaction sets. These code sets include most of the information currently codified in the UB92 and CMS 1500 paper claims and their electronic counterparts. Information about the required code sets can be found at the wpc-edi and NCPDP web sites referenced below. One impact of this provision of HIPAA was the use of local procedure codes. These codes are no longer considered valid; only valid procedure codes adopted for national use should be coded in transaction sets.

1.1.1 Version and Model

DMAS currently requires use of a variation of the Provider-to-Payer-to-Payer COB model of the 837 transaction sets, Version 5010, Addendum 1 for facility and professional services. For prescription drugs, the mandated transaction set is the NCPDP Batch Version D.0 Telecommunication Standard. As new versions of the transaction sets are adopted by HIPAA, DMAS will use the newer versions in accordance with HIPAA requirements.

Contractors should use the matrix below to determine which transaction set is appropriate for the type of encounter to be reported (based on billing entity):

Billing Entity	Transaction
Inpatient Urgent Care Facility	837 Institutional
Outpatient Urgent Care Facility	837 Institutional
Inpatient Mental Health Facility	837 Institutional
Outpatient Mental Health Facility	837 Institutional
Federally Qualified Health Center	837 Professional
Long Term Care Facility	837 Institutional
Skilled Nursing Facility	837 Institutional
Home Health Provider	Either 837 Institutional or 837 Professional, depending on contract between the MCO and the provider.
Pharmacy Benefit Manager	NCPDP
Retail Pharmacy	NCPDP
Hospital Pharmacy	837 Institutional
Independent Laboratory	837 Professional
Hospital-based Laboratory	837 Institutional
Non-Emergency Transportation	837 Professional
Emergency Transportation	837 Professional
Hospital-based Clinic	837 Institutional
Free-standing Clinic	837 Professional
Physicians	837 Professional
Other medical professionals	837 Professional
Dentist	837 Dental

If in doubt about the transaction to use for a specific type of claim, please contact the Health Care Services Division at: HCSEncounter@dmas.virginia.gov.

1.1.2 EDI Resources

1.1.2.1 Implementation Guides

Detailed information on how each of the 837 transaction sets should be used is contained in each Implementation Guide (IG) and its corresponding Addendum. There are separate IGs and Addenda for professional and institutional services and they can be downloaded for free at www.wpc-edi.com. The same site also has purchase options for the IGs, which can be quite lengthy and take some time to download and/or print.

The IGs and Addenda provide details about which loops, segments and data elements are required in various health care situations. If Contractors carefully follow the instructions in these IGs and Addenda, the certification and testing processes outlined in Sections IV.C and IV.D of this guide should be completed smoothly and expeditiously.

For prescription drug encounters, the NCPDP documentation is available through its Web site: www.ncpdp.org. This site also contains other helpful information for implementing this transaction set.

1.1.2.2 Other EDI Documentation

WEDI, the Workgroup for Electronic Data Interchange, is an organization that was formed specifically to promote and assist in the development of better information exchange and management in health care. WEDI's Strategic National Implementation Process or SNIP was formed to facilitate the implementation of national standards, such as HIPAA, within the health care industry. The SNIP Web site provides a wealth of information from white papers on numerous topics to workgroups and LISTSERVS. You can access the WEDI site at www.wedi.org and follow the links to SNIP.

Other Web sites Contractors may find helpful in understanding the HIPAA regulations and in preparing HIPAA-compliant transaction sets include:

- www.cms.gov - Follow the links for Regulations and Guidance and scroll down to the HIPAA Administrative Simplification selection to access information on the regulations, education, and code sets
- www.x12.org - ACS X12 is the Accredited Standard Committee and maintains electronic data interchange standards globally. Work and task groups under X12 developed the transactions sets and implementation guides that have been adopted under HIPAA.
- www.hipaa-dsmo.org - This site contains information on Designated Standard Maintenance Organization (DSMO). These DSMOs have formed a committed to focus on managing HIPAA standard change requests.
- www.wedi.org - Workgroup for Electronic Data Interchange or WEDI is committed to the implementation of electronic commerce in healthcare and EDI standards for the healthcare industry. WEDI's members include providers, health plans, consumers, vendors, government organizations and standards groups.

Most of the above sites also contain links to other sites that may provide additional assistance with implementation of outbound HIPAA transaction sets.

1.2 Encounter Submission Process

1.2.1 Service Center Registration

All Contractors must submit encounters to DMAS electronically using the appropriate HIPAA-mandated transaction sets noted in Section I.B above. Contractors must be registered with the EDI Coordinator at DMAS's fiscal intermediary, Xerox, as a Service Center.

Registration as a Service Center involves the completion of three forms: Submission of Electronic Transactions Agreement for Service Centers (Form 101); Service Center Operational Information Sheet (Form 102); and Provider Service Center Authorization Agreement (Form 103). Once completed, these forms are faxed or emailed to the EDI coordinator at Xerox to initiate the enrollment process. These forms and instruction for completing them are available in the Electronic Claims Submission Enrollment Packet at the following link: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDIFormsLinks

Once Xerox has received these forms from the Contractor and verified their accuracy, it will assign a four-digit Service Center ID within 24 hours of receipt of completed forms. If the service center ID is not received within that time period, the contractor should follow up with Xerox at 1-866-352-0766 Monday – Friday between 8:00 am and 5:00 pm EST. This four-digit number will identify the Contractor as a registered Service Center that has the ability to submit electronic transactions. Once the contractor is a registered Service Center, any updates needed to contact information should be made in writing and directed to the EDI Coordinator via email or fax.

1.2.2 Transmission Protocol

Virginia Medicaid requires a secure method of transferring files electronically utilizing a SSL (Secure Socket Layer) connection. Contractors will need to send and receive data electronically using FTP server/client software that supports 128-bit Explicit SSL encryption. See the Electronic Claims Submission Enrollment Packet referenced above for additional information on FTP software requirements. This packet also provides instructions for connecting to the Xerox server, including password requirements and minimum setting requirements.

1.2.3 Test Transmissions

Prior to submitting production files each Contractor is required to submit test files for any event that will impact the submission and/or content of the encounter data. Examples of an event are: a new Contractor, a change to the Contractor's subcontractor, a system change, etc. A test plan may be issued by DMAS if the event affects multiple claim types or the source of the data (i.e. new subcontractor) is changed. Test files will be reviewed by DMAS and the Contractor to determine if the file is acceptable, with ultimate approval by DMAS.

Within twelve weeks of the start of a new Contractor, subcontractor change, system change or any event that impacts the encounter submission, testing should be submitted and successfully completed.

1.2.3.1 Limit on Number of Records in Test Transmission

For 837 file types the maximum number of records in a test file is limited to 5,000 claims or 10% of a normal production month, whichever is less. For NCPDP files, the limit is 3,000 claims or 10% or a normal production month, whichever is less. DMAS defines a claim as the individual line items, not a document.

1.2.3.2 Test File Delivery / Test Results Pickup

- MCO test files must be delivered to the following folder using the VaMMIS file transfer website: **/Distribution/EDI/<*service center ID*>/Test/To-VAMMIS/**

- DMAS will post all response files and MMIS reports relating to test file submissions in the following folder using the VaMMIS file transfer website: **/Distribution/EDI/<*service center ID*>/Test/From-VAMMIS/**
- Emails relating to testing should be sent to: **HCSEncounters@dmas.virginia.gov**

1.2.3.3 Testing Procedures

1. The MCO must notify DMAS via email when testing is needed due to an event such as a new subcontractor or software/system changes on the MCO's side.
2. Test files may be submitted at will (without prior notification or authorization) as long as the test file record limit is respected (see section 1.2.3.1).
3. The following events will <u>automatically</u> occur within one hour of receipt of the test file submission:
   - An Acknowledgement Report (ACK) will be available for pickup from the VaMMIS FTP website. This report will contain an eight-digit Media Control Number (MCN) that is associated with the submitted test file. The MCN format is shown below. See Section 1.2.5.2 for additional ACK report details.

     Example: MCN 32940043

     - Position 1 = 3 last digit of year CCYY (2013)
     - Position 2-4 = 294 julian date (Oct. 21)
     - Position 5-8 = 0043 sequential number (43rd file received on this date)

- The Sybase Compliance check will execute and the following reports/files will be available for pickup from the FTP VAMMIS website.
  - 999 File - for 837 test files only (see section 1.2.5.3)
  - NCPDP Response File – for NCPDP test files only (see section 1.2.5.6)

    Note: If the 999/RSP file is not returned, it may indicate that there is a structural or envelope issue. When this happens, the ANSI translator is unable to generate the appropriate response file. Please review the submitted file and/or perform a local compliance check before contacting DMAS.
  - Compliance Error Report Summary (CER) - exception report (see section 1.2.5.4)
  - Compliance Error Report (CED) – exception report (see section 1.2.5.5).

4. The MCO must review the 999/NCPDP Response files. If compliance errors are present, the CER/CED Compliance reports must be reviewed (837 test files).

   The 999 or NCPDP Response file will indicate a positive or negative result for the compliance check. If compliance errors exist on an 837 test file, the CER/CED Compliance reports may be used for error resolution. If compliance errors exist on a NCPDP test file, NCPDP Response file may be used for error resolution as DMAS does not have a compliance error report available for NCPDP files.

5. If the records/file fail(s) compliance, the MCO may submit a corrected file to the FTP VAMMIS website, at will. This step must be repeated until ALL compliance errors are resolved.

6. If the records/file passé(s) compliance please send an email to DMAS that contains the following information:

   - Indicate TEST file in email subject line
   - Indicate that test file is ready for adjudication
   - MCN
   - File Type (837P, 837I, or NCPDP)
   - Submitter name or service center
   - Approximate number of encounters
   - High level description of what is being tested (i.e. adjustment/void processing)

7. Upon email receipt, DMAS will request adjudication for the test file. The MMIS adjudication reports listed below will be available for pickup from the FTP VAMMIS website within 2-3 business days. See sections 1.2.5.8, 9, 10, and 11 for detailed report information.

   - Encounter Summary Report (CP-O-507)
   - Encounter Error Report (CP-O-506-01)
   - Encounter Detail Report (CP-O-506-02)
   - EFL File (CP-F-010)

8. MMIS adjudication reports should be carefully reviewed. Once test results are approved by the MCO, an email should be sent to indicate that reports are ready for DMAS review. Please include the MCN and the “As Of” date from the reports.

   Note: If the adjudication fails, **different** test data is required (i.e., different unique MCO claim identifiers). Encounters in the MMIS test system are deleted only when the test

system is refreshed (approximately twice a year). Correcting the same data and resending will result in the failure of all resubmitted records as fatal edits for duplicates.

9. Upon email receipt, DMAS will review the MMIS adjudication reports and send an email indicating approval for production file submission.

1.2.3.4 Approval for Production

After the test file passes compliance, passes adjudication, and the adjudication results are accepted by DMAS and the Contractor, production approval will be established.

If any backlog of data has occurred, a submission plan should be developed and sent to DMAS. Unless otherwise approved, backlogs of encounter data should be submitted with oldest dates first and in file sizes consistent with what would have been submitted in production. For example, if in production weekly files are submitted, weekly catch-up files would be expected. Do not combine into one or more larger files, unless approved in advance.

1.2.4 Production Transmissions

1.2.4.1 Production Encounter Data Submission Requirements

After the Contractor receives authorization for production transmission, they may submit files on a monthly, semi-monthly or weekly schedule as approved by DMAS. DMAS will work with the Contractor to determine an appropriate submission schedule. Xerox plans its work around the encounter submission calendar (see below). The MCO must notify DMAS (at HCSEncounter@dmas.virginia.gov) ahead of schedule if a scheduled submission will be missed. You can also schedule a new date for submission at that time.

The following are DMAS expectations of the contractor regarding encounters:

- All encounters (production or test) should be not be scheduled or submitted without DMAS approval.
- Production encounters cannot be submitted on Friday's, unless agreed to in advance. Test encounters can be submitted on Friday when previously scheduled and approved by DMAS.
- Any process change, vendor change, format change, etc. by the Contractor, fiscal agent or DMAS will require the Contractor to pass a testing stage before resuming production
- The Contractor will submit all encounters to DMAS. DMAS will not accept files from a subcontractor. Service center agreements are between the State's fiscal agent and the MCO. Subcontractors are not included.
- If the Contractor subcontracts with an entity to process claims or provide services, the Contractor is responsible for assuring that data from this vendor contains all the information necessary to create the appropriate encounter record for DMAS. This includes, but is not limited to: pharmacy benefits, laboratory, transportation, vision, and mental health. Prior to delivery to DMAS, the Contractor is responsible for verifying the accuracy of the encounter data being sent to DMAS, particularly with respect to the format and edits. Pass through files cannot be delivered to DMAS.
- For any services rendered under a global billing arrangement (e.g., maternity and delivery), an encounter must be submitted for every service. The MCO cannot submit an encounter just for the initial service that triggered the global payment. The Contractor is responsible for ensuring that providers submit all appropriate records in connection with services paid under a global billing arrangement.
- Compliance errors must be reviewed and corrected. Files failed as non-compliant have not made it into the Virginia MMIS system.
- Failures within an ST/SE segment (negative 999 or RSP) must be reviewed and corrected. ST/SE segment failed have not made it into the Virginia MMIS system.
- The Contractor must review the response files and forward to their appropriate subcontractors (when applicable). The Contractors will act upon all response files to correct.
- The Contractor should employ all of its resources to ensure that duplicate encounter files are not passed to DMAS. DMAS incurs expense for every encounter processed by our Fiscal Agent.
- Encounters that have been adjudicated by the Contractor and denied as a duplicate should not be submitted to DMAS.

1.2.4.2 Production Processing

Production files will be delivered to the Contractor's mailbox on the VaMMIS File Transfer Website using the folder: ***Distribution/EDI/Service Center ID/Prod/To-VAMMIS/***. NOTE: If the MCO drops files in a folder other than "***To-VAMMIS***", the file will not be acknowledged or processed.

Every 15 minutes, the File Transfer System checks for newly posted production files. All files found will be automatically picked-up and processing begins.

The file is renamed by assigning an eight digit Media Control Number or MCN. The MCN is a "smart" number and would breakdown as follows: YJJJSSSS - Sample MCN: 21270043

- Position 1 = Last digit of the calendar year (2012)
- Position 2-4 = Julian Date (127 / May 6th)
- Position 5-8 = Sequential number (43rd file received by DMAS on this day)

An ACK report is returned to the Contractor with the MCN number within an hour of receipt. See below for a sample ACK report. This report shows the original file name and the MCN assigned by the MMIS.

At the half-hour, any files picked up will post a 999 (837) or an RSP (NCPDP). The naming convention is: ***<Service Center ID>_RSP_<MCN number>_<EDI Runid>***. These files will be zipped. NOTE: The EDI Runid is used internally by the EDI System. (See below for a sample of this file.)

ALL 999/RSP files should be picked-up and reviewed by the Contractor. This will indicate if the file was accepted for adjudication, or if the file or any of segment(s) within the file have failed or rejected.

In the event that the ISA or ISE segments are invalid and a 999 cannot be created, Xerox will contact the Contractor directly using the Virginia.EDISupport@xerox.com e-mail address. If there is a negative 999 (that is, the ST and/or SE segments fail), a trace report will be downloaded to the FTP site. (See example below.) Contact Xerox for assistance reading this report at 1-866-352-0766. The naming convention for this report is: ***<4-digit Service Center ID>_ERROR_<MCN>***.

If at any time the Contractor fails to meet the expected production standards, DMAS may retract production approval and place the Contractor back into test in whole or in part. The Contractor would then be required to correct, retest and resume production within the twelve-week time frame as specified in the Medallion 3.0 and FAMIS contracts.

1.2.4.3 File Notification

Process is being developed by DMAS.

1.2.4.4 Data Submission Feedback

837 encounters received from a Contractor during the week are adjudicated that weekend. NCPDP encounters will be processed as they are received. Several adjudication reports are generated and posted on the ftp site for the MCO. These reports are zipped and posted in the

"***OUTGOING***" folder on Monday morning for the 837 encounters and daily for the NCPDP encounters. The naming convention for this file is <***Four-digit service center ID>_<MCN>***. Once the file is unzipped, four reports are displayed:

- CP-O-507: Encounter Summary Report – summarizes the entire submission
- CP-O-506-01: Encounter Error Report – lists every claim that was submitted with an error status of 2 or higher
- CP-O-506-02: Encounter Detail Report – includes **all** claims submitted, including those passed with an error code of zero
- CP-F-010: EFL – electronic version of the Encounter Error Report

DMAS considers status codes 0 through 8 to be paid claims and REQUIRES a payment amount and date to be submitted for each encounter. DMAS considers status 9 to be a claim denied by the contractor and would expect the amount paid to be zero. Exceptions to this rule are:

- FAMIS pharmacy encounter where the co-pay covers the complete cost of prescription
- Contractor coordinating benefits and primary payer paid - No payment made by MCO

1.2.4.5 Contractor Responsibilities for Correction and/or Resubmission

Files with HIPAA defined level 1 or level 2 errors in the ISA, GS, GE, or ISE records will be rejected and a negative 999 sent back to the submitter. If there is a negative 999, two compliance error reports will be sent to the MCO: CED and CER. Both will contain detail of the compliance errors found in the negative 999. The entire file must be resubmitted after the problem is fixed. Files with HIPAA defined level 1 or level 2 errors inside a ST-SE loop will have that ST-SE loop rejected and a negative 999 will be sent back to the submitter identifying the loop. Any other ST-SE loops, which do not have level 1 or level 2 errors, will be processed. Only the rejected ST-SE loops should be resubmitted after fixing the problem. Errors on rejected files or ST-SE loops must be corrected and resubmitted within thirty (30) days of the date.

When an entire file is rejected (i.e., has only a 999 transaction in the OUTGOING folder), the Contractor must correct any formatting or syntax errors in the file and resubmit.

Once an encounter has passed all front-end compliance checks, it is processed in the MMIS using the existing fee for service (FFS) claims adjudication logic. Every encounter that passes the EDI compliance checks is processed in the Virginia MMIS and captured in the DMAS encounter data warehouse.

During MMIS processing, the FFS logic may assign one or more 'edit' codes (AKA Error Sequence Codes / ESC). These codes identify error conditions based on the existing payment logic that is applied to FFS provider claim submissions. **Refer to section 1.5 of this document for a detailed explanation of the Encounter Data Quality (EDQ) process that is effective July 1, 2015.** This process includes the State's error identification/reporting process and correction requirements.

Whenever possible, all corrections (adjust/void) should be re-submitted as part of the MCO's normal submission schedule. In cases where a large volume of accumulated encounter corrections needs to be resubmitted, the MCO must request a special schedule for this submission from DMAS via HCSEncounter@dmas.virginia.gov. A large volume is defined as 10,000 or more encounter lines.

1.2.5 Submission Response Reports

1.2.5.1 Unzip Results file - Successful

Purpose: To report unzip result of submitted zip file
Frequency: A report is returned for each zip file indicating unzip success or failure
Transaction Type: 837, NCPDP
File Format: Text

Sample File Name: `1003_ZIP_20130619094930_ALLHC_D05_50.zip.rpt`
<*ServiceCenter*><**ZIP**><*CCYYMMDDHHMMSS*><*MCOfilename*><.rpt>

Sample File Contents:

```
The Zip file you uploaded has been successfully unzipped.  You will
receive individual acknowledgement report(s) for the contents.
```

1.2.5.2 Unzip Results file - Unsuccessful

Purpose: To report unzip result of submitted zip file
Frequency: A report is returned for each zip file indicating unzip success or failure
Transaction Type: 837, NCPDP
File Format: Text

Sample File Name: `1003_BZF_20130619094930_VPHP_File_07112014032730.zip.rpt`
<*ServiceCenter*><**BZF**><*CCYYMMDDHHMMSS*><*MCOfilename*><.rpt>

Sample File Contents:

```
The Zip file you uploaded was unable to be unzipped.  Please verify
the file is a valid Zip and upload again.
```

1.2.5.3 Acknowledgement (ACK) Report

Purpose: Returns Media Control Number (MCN) and basic info about the submitted file
Frequency: An acknowledgement report is returned for each file in the zipped file submission
Transaction Type: 837, NCPDP
File Format: Text

Sample File Name:
1003_ACK_20130619094930_31700124_ALLHC_D05_50_2821.txt.rpt

<*ServiceCenter*><**ACK**><*CCYYMMDDHHMMSS*><*MCN*><*MCOfilename*><.rpt>

Sample File Contents:

```
MCN:       31700124
Submitter: 1003
Type:      Virginia Medicaid
Prod:      P
Date:      06/19/2013
Time:      09:49:30
Bytes:          53260
Records:        53260
File Name: 1003_20130619094930_ALLHC_D05_50_2821.TXT
```

File Content Description:

MCN:	Eight-digit MCN assigned to the file by MMIS
Submitter:	MCO's four-digit Service Center ID
Type:	Virginia Medicaid
Prod:	Valid values are 'P' (Production) and 'T' (Test)
Date:	mm/dd/yyyy
Time:	hh:mm:ss
Bytes:	Size of file in bytes
Records:	Size of file in bytes (Same as Bytes field above)
File Name:	Name of the file as it was labeled by the MCO

1.2.5.4 999 Report

Purpose:	ANSI positive or negative response to 837 transactions
Frequency:	An ANSI 999 file is returned for each ANSI 837 file
Transaction Type:	837
File Format:	Compressed

Sample File Name: `1003_999_31700124_5468335.zip`
<*ServiceCenter*><**999**><*MCN*><*EDIrunID* ><.zip>

Sample File Contents (unwrapped):

```
ISA*00*              *00*              *ZZ*VAMMIS  FA         *ZZ*1003
*130619*0949*^*00501*000000638*0*P*>~
GS*FA*VAMMIS FA*1003*20130619*094930*55*X*005010X231A1~
ST*999*55001*005010X231A1~
AK1*HC*696*005010X222A1~
AK2*837*000000006*005010X222A1~
IK5*A~
AK9*A*1*1*1~
SE*6*55001~
GE*1*55~
IEA*1*000000638~
```

1.2.5.5 Compliance Error Report (CER) Summary

Purpose:	Displays compliance error location and description
Frequency:	Exception report – only returned when compliance errors are found
Transaction Type:	837
File Format:	Compressed

Sample File Name: `1003_CER_20130619094930_31700124_5468335.zip`
<*ServiceCenter*><**CER**><*CCYYMMDDHHMMSS*><*MCN*><*EDIrunID*><.zip>

Sample File Contents:

```
Compliance Error Report for MCN: XXXXXXXX
Input filename: XXXX_XXXXXXXXXXXXXX.txt
RunID:    895677
Service Center ID: XXXX
Run date and time: CCYY-MM-DD 12:50:20

Error: 1 Segment No. 92 Element: GE01 (7025) - ERROR: GE  Control
Count Mismatch 708 vs 1

Compliance report Complete: 1 Errors Encountered.
```

1.2.5.6 Compliance Error (CED) Report

Purpose: Displays compliance error location, description, and error data image
Frequency: Exception report – only returned when compliance errors are found
Transaction Type: 837
File Format: Compressed

Sample File Name: `1003_CED_20130619094930_31700124_5468335.zip`
<ServiceCenter><**CED**>*<CCYYMMDDHHMMSS><MCN><EDIrunID>*<.zip>

Sample File Contents: See Managed Care Technical Manual, Section 1.2.5

```
Compliance Error Report for MCN: XXXXXXXX
Input filename: XXXX_XXXXXXXXXXXXXX.txt
RunID:    895677
Service Center ID: XXXX
Run date and time: CCYY-MM-DD 12:50:20

SKIP GOOD TRANSACTIONS flag is ON.   This report will only list
transactions with compliance errors.

ISA*00*            *00*            *ZZ*1003             *ZZ*VAMMIS FA
*121112*1549*^*00501*000000256*0*P*|~
GS*HC*1003*VAMMIS FA*20121112*1549*256*X*005010X223A2~

Skipping Transaction Sequence Number: 000008448 - From segment:
3 to:        45

GE*708*256~
IEA*1*000000256~
Error: 1 Segment No. 49 Element: GE01 (7025) - ERROR: GE   Control
Count Mismatch 708 vs 1

Compliance report Complete: 1 Errors Encountered.
```

1.2.5.7 NCPDP Response File

Purpose:	Positive and/or negative response to NCPDP transactions
Frequency:	A NCPDP response file is returned for each NCPDP file
Transaction Type:	NCPDP
File Format:	Compressed

Sample File Name: `1003_RSP_31700124_5468335.zip`
<ServiceCenter><**RSP**>*<MCN><EDIrunID>*<.zip>

Sample File Contents:

```
▯00R1003                    071213120130717120 0P125148010900
▯▯G10012759394D0B11A011255434981
20130605▯▯▯AM21▯ANC▯F3201319890000010 1▯▯AM22▯EM1▯D2865969▯▯G10012758185D0B11A011467597096
   20130604▯▯▯AM21▯ANC▯F3201319890000020 1▯▯AM22▯EM1▯D2174978▯▯990712131000000000 4
                        ▯
```

1.2.5.8 NCPDP Compliance Report

There is no compliance error report available for NCPDP transactions at this point in time. The NCPDP Response file may be used for detecting compliance errors in a NCPDP transaction file (see Virginia Medicaid NCPDP Companion Guide for NCPDP Response file definition).

1.2.5.9 Encounter Summary Report (CP-O-507)

Purpose:	The following reports are produced during adjudication and are compressed into one file: SUM (CP-O-507) – Encounter Summary Report, DTL (CP-O-506-02) – Encounter Detail Report, ERR (CP-O-506-01) – Encounter Error Report, EFL (CP-F-010) – Electronic Encounter Error file
Frequency:	Adjudication occurs once per week for 837 transactions and daily for NCPDP transactions
Transaction Type:	837, NCPDP
File Format:	Compressed

Sample File Name: `1003_31700124_2013170.zip`
<ServiceCenter><MCN><CCYYJJJ><.zip>

Sample File Contents:

CPD320 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO. CP-O-507
AS OF MM/DD/CCYY PAGE NO. ZZ,ZZ9
RUN DATE: MM/DD/CCYY HH:MM ENCOUNTER SUMMARY REPORT
(1)
MCN: 9999999 (1.1) (1.2)
SERVICE VENDOR: XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

	TOTAL	% OF PROCESSED
TOTAL ENCOUNTERS RECEIVED	(4) ZZZ,ZZ9	
HMO DENIALS RECEIVED	ZZ,ZZ9 (5)	
TOTAL ENCOUNTERS PROCESSED	ZZ,ZZ9 (6)	ZZ9.99 (7)
ENCOUNTERS WITH NO WARNINGS	ZZ,ZZ9 (8)	ZZ9.99 (9)
ENCOUNTERS WITH WARNINGS	ZZ,ZZ9 (10)	ZZ9.99 (11)
LEVEL 2 WARNINGS	ZZ,ZZ9 (12)	ZZ9.99 (13)
LEVEL 4 WARNINGS	ZZ,ZZ9 (14)	ZZ9.99 (15)
LEVEL 6 WARNINGS	ZZ,ZZ9 (15.1)	ZZ9.99 (15.2)
ENCOUNTERS WITH FATAL ERRORS (LEVEL 8)	ZZ,ZZ9 (16)	ZZ9.99 (17) [TRANSMISSION NOT ACCEPTED/TRANSMISSION ACCEPTED]
ENCOUNTERS WITH DUPLICATE ERRORS	ZZ,ZZ9 (18)	ZZ9.99 (19)
ORIGINAL ENCOUNTERS	ZZ,ZZ9 (20)	ZZ9.99 (21)
ADJUSTMENT ENCOUNTERS	ZZ,ZZ9 (22)	ZZ9.99 (23)
VOID (REVERSAL) ENCOUNTERS	ZZ,ZZ9 (24)	ZZ9.99 (25)

MSG CODE (26)	DESCRIPTION (27)	STATUS (28)	COUNT (29)	% OF ERRORS (30)	% OF ERR RECS (31)	% OF PROC RECS (32)
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	9	Z,ZZ9	ZZ9.99	ZZ9.99	ZZ9.99
			(33)	(34)		
	ALL ERROR CODES		ZZ,ZZ9	ZZ9.99	N/A	N/A

*** END OF REPORT ***

Report Notes:

5. HMO Denials Received = Number of encounters where Status = 9
6. Total Encounters Processed = Number of encounters processed for this Service Center
7. Total Encounters Processed % = (Total Encounters Processed / Total Encounters Processed for all Service Centers during this cycle)*100
8. Encounters with No Warnings = Number of encounters where Status = 0
9. Encounters with No Warnings % = (Encounters with No Warning / Total Encounters Processed)*10
10. Encounters with Warnings = Number of encounters where Status > 0 and < 8
11. Encounters with Warnings % = (Encounters with Warnings / Total Encounters Processed)*100
12. Level 2 Warnings = Number of encounters where Status = 2
13. Level 2 Warnings % = (Level 2 Warnings / Total Encounters Processed)*100

14. Level 4 Warnings = Number of encounters where Status = 4
15. Level 4 Warnings % = (Level 4 Warnings / Total Encounters Processed)*100
16. Level 6 Warnings = Number of encounters where Status = 6
17. Level 6 Warnings % = (Level 6 Warnings / Total Encounters Processed)*100
18. Encounters with Fatal Errors (Level 8) = Number of encounters where Status = 8
19. Encounters with Fatal Errors (Level 8) % = (Encounters with Fatal Errors / Total Encounters Processed)*100
20. Encounters with Duplicate Errors = Number of encounters where ESC = 510 (duplicate error)
21. Encounters with Duplicate Errors % =(Encounters with Duplicate Errors / Total Encounters Processed)*100
22. Original Encounters = Number of encounters where Claim Type Modifier = 1
23. Original Encounters % = (Original Encounters / Total Encounters Processed)*100
24. Adjustment Encounters = Number of encounters where Claim Type Modifier = 2
25. Adjustment Encounters % = (Adjustment Encounters / Total Encounters Processed)*100
26. Void (Reversal) Encounters = Number of encounters where Claim Type Modifier = 4
27. Void (Reversal) Encounters % = (Void Encounters / Total Encounters Processed)*100
28. MSG Code = MMIS ESC
29. Description=MMIS ESC short description
30. Status = Status assigned by MMIS
31. Count = Number of occurrences of each ESC
32. % of Errors = (Count / Total Count)*100
33. % of Err Recs = Percentage of Error Records
34. % of Proc Recs = Percentage of Processed Records
35. All Error Codes = Total number of all occurrences of an ESC
36. % of Errors = (All Error Codes / Total Encounters Processed)*100

1.2.5.10 Encounter Error Report (CP-O-506-01)

Purpose: The following reports are produced during adjudication and are

	compressed into one file: SUM (CP-O-507) – Encounter Summary Report, DTL (CP-O-506-02) – Encounter Detail Report, ERR (CP-O-506-01) – Encounter Error Report, EFL (CP-F-010) – Electronic Encounter Error file
Frequency:	Adjudication occurs once per week for 837 transactions and daily for NCPDP transactions
Transaction Type:	837, NCPDP
File Format:	Compressed

Sample File Name: `1003_31700124_2013170.zip`
<ServiceCenter><MCN><CCYYJJJ><.zip>

Sample File Contents:

```
CPD320                          VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES          REPORT NO: CP-O-506-01
AS OF MM/DD/CCYY                                                                            PAGE NO: ZZ,ZZ9
RUN DATE: MM/DD/CCYY                          ENCOUNTER ERROR REPORT
  (1)
MCN: 9999999        (28)                  (29)
SERVICE VENDOR: XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   (16)/ (18)/
    (5)        (4)          (6)(7)(7.1)     (8)   (9)    (10) (10.1)  (11)        (12)    (14)    (15)  (17)  (19)        (20)          (21)

HMO CLM NO/FH        ENROL/SRVC-BILL      FR/TO DOS      DXS/SERVICE       QTY   CHRGS/PYMT   T/D  PRV  MESSAGE/ERROR CODES  STAT
                          PROV-IDS                                                            MOD  TYP
999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX  Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999  9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX  Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999  9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX  Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999  9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX  Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999  9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX  Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999  9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX  Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999  9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

999999999999999999999999  999-999999-99-9  MM/DD/CCYY  XXXXXXX XXXXXXX  Z,ZZ9  Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999  9
99999999999999999         9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999  Z,ZZZ,ZZ9.99  9   999   999 999 999 999 999

                                  (23) TOTAL ERROR ENCOUNTERS          Z,ZZ9
                                  (24) STATUS 8 (FATAL) ENCOUNTERS     Z,ZZ9
                                  (25) STATUS 6 ENCOUNTERS             Z,ZZ9
                                  (26) STATUS 4 ENCOUNTERS             Z,ZZ9
                                  (27) STATUS 2 ENCOUNTERS             Z,ZZ9

                                        *** END OF REPORT ***

                              ****** CONFIDENTIAL INFORMATION ******
```

No.	Field Name	Source/Calculations
1	MCN	Claims MCN Number
4	FH	Claim Request ICN
5	HMO Clm No	Claim Patient Account Number
6	Enroll	Enrollee Identification Number
7	Service Provider ID	National Provider Identifier
7.1	Billing Provider ID	National Provider Identifier
8	FR DOS	Claim Service From Date
9	TO DOS	Claim Service Through Date
10	DXS	Diagnosis Code
10.1	DXS	Diagnosis Code
11	Service	Category of Service. If the service is Practitioner, then the service number is Proc/Mod code. If the service is UB, then the service number is Rev Code1, Code2, Code3 and Code4. If the service is Dental, then the service number Dent Proc and Quad Code. If the service is Pharmacy, then the service number is NDC.
12	QTY	Claim Number of Units/Visits/Studies
13	(Proc Cd)	Procedure Code

No.	Field Name	Source/Calculations
14	Chrgs	Claim Billed Charge
15	Pymt	Payment Amount. THIS IS NOT THE MCO PAID AMOUNT but rather the DMAS allowed or Tentative Payment Amount.
16	Inv Type	Claim Type
17	Disposition	Claim Type Modifier
18	PRV TYP	Provider Type
19	PRV	Provider Specialty Code
20	Message/Error Codes	Error Text Error Code
21	Stat	Claim Status
23	Total Error Encounters	Add 1 to total error encounters
24	State 8 (Fatal) Encounter	If status equal 8, add 1 to status 8 encounter errors
25	Status 6 Encounters	If status equal 6, add 1 to status 6 encounter errors
26	Status 4 Encounters	If status equal 4, add 1 to status 4 encounter errors
27	Status 2 Encounters	It status equal 2, add 1 to status 2 encounter errors
28	Service Vendor	Provider Service Center
29	Service Vendor Name	Service Center Name

1.2.5.11 Encounter Detail Report (CP-O-506-02)

Purpose: The following reports are produced during adjudication and are compressed into one file: SUM (CP-O-507) – Encounter Summary Report, DTL (CP-O-506-02) – Encounter Detail Report, ERR (CP-O-506-01) – Encounter Error Report, EFL (CP-F-010) – Electronic Encounter Error file

Frequency: Adjudication occurs once per week for 837 transactions and daily for NCPDP transactions

Transaction Type: 837, NCPDP

File Format: Compressed

Sample File Name: `1003_31700124_2013170.zip`
<ServiceCenter><MCN><CCYYJJJ><.zip>

Sample File Contents:

```
CPD320                                VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES                REPORT NO: CP-O-506-0:
AS OF MM/DD/CCYY                                                                                        PAGE NO: ZZ,ZZ5
RUN DATE: MM/DD/CCYY                              ENCOUNTER DETAIL REPORT
 (1)
MCN: 9999999          (28)                  (29)
SERVICE VENDOR: XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                          (16)/ (18)/
   (5)        (4)          (6)(7)(7.1)     (8)  (9)     (10) (10.1) (11)      (12)    (14)    (15)  (17)  (19)      (20)                    (21)
HMO CLM NO/FH          ENROL/SRVC-BILL.   FR/TO DOS      DXS/SERVICE         QTY    CHRGS/PYMT  T/D  PRV  MESSAGE/ERROR CODES  STAT
                          PROV-IDS                                                                MOD  TYP
99999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9   Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
9999999999999999          9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999 999 999 999 999

99999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9   Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
9999999999999999          9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999 999 999 999 999

99999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9   Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
9999999999999999          9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999 999 999 999 999

99999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9   Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
9999999999999999          9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999 999 999 999 999

99999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9   Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
9999999999999999          9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999 999 999 999 999

99999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9   Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
9999999999999999          9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999 999 999 999 999

99999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9   Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
9999999999999999          9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999 999 999 999 999

99999999999999999999999999  999-999999-99-9   MM/DD/CCYY  XXXXXXX XXXXXXX   Z,ZZ9   Z,ZZZ,ZZ9.99  09   999   999 999 999 999 999   9
9999999999999999          9999999999 9999999999  MM/DD/CCYY  9999 9999 9999 9999 9999  9999   Z,ZZZ,ZZ9.99  9    999   999 999 999 999 999

                    (23)   TOTAL ENCOUNTERS                    Z,ZZ9
                  (23.1)   TOTAL STATUS 9 ENCOUNTERS           Z,ZZ9
                    (24)   STATUS 8 (FATAL) ENCOUNTERS         Z,ZZ9
                    (25)   STATUS 6 ENCOUNTERS                 Z,ZZ9
                    (26)   STATUS 4 ENCOUNTERS                 Z,ZZ9
                    (27)   STATUS 2 ENCOUNTERS                 Z,ZZ9
                  (27.1)   STATUS 0 ENCOUNTERS                 Z,ZZ9

                                  *** END OF REPORT ***

                      ****** CONFIDENTIAL INFORMATION ******
```

No.	Field Name	Source/Calculations
1	MCN	Claims MCN Number
4	FH	Claim Request ICN
5	HMO Clm No	Claim Patient Account Number
6	Enroll	Enrollee Identification Number
7	Service Provider ID	National Provider Identifier
7.1	Billing Provider ID	National Provider Identifier
8	FR DOS	Claim Service From Date
9	TO DOS	Claim Service Through Date
10	DXS	Diagnosis Code
10.1	DXS	Diagnosis Code
11	Service	Category of Service - If the service is Practitioner, then the service number is Proc/Mod code. If the service is UB, then the service number is Rev Code1, Code2, Code3 and Code4. If the service is Dental, then the service number Dent Proc and Quad Code. If the service is Pharmacy, then the service number is NDC.
12	QTY	Claim Number of Units/Visits/Studies
13	(Proc Cd)	Procedure Code
14	Chrgs	Claim Billed Charge
15	Pymt	Payment Amount – This represents the DMAS fee for service calculated payment amount. It is not the MCO's paid amount.
16	Inv Type	Claim Type
17	Disposition	Claim Type Modifier
18	PRV TYP	Provider Type
19	PRV	Provider Specialty Code
20	Message/Error Codes	Error Text Error Code
21	Stat	Claim Status
23	Total Error Encounters	Add 1 to total error encounters
23.1	Status 9 Encounters	
24	State 8 (Fatal) Encounter	If status equal 8, add 1 to status 8 encounter errors

No.	Field Name	Source/Calculations
25	Status 6 Encounters	If status equal 6, add 1 to status 6 encounter errors
26	Status 4 Encounters	If status equal 4, add 1 to status 4 encounter errors
27	Status 2 Encounters	It status equal 2, add 1 to status 2 encounter errors
28	Service Vendor	Provider Service Center
29	Service Vendor Name	Service Center Name

1.2.5.12 Electronic Error 'EFL' File (CP-F-010)

Purpose: The following reports are produced during adjudication and are compressed into one file: SUM (CP-O-507) – Encounter Summary Report, DTL (CP-O-506-02) – Encounter Detail Report, ERR (CP-O-506-01) – Encounter Error Report, EFL (CP-F-010) – Electronic Encounter Error file

Frequency: Adjudication occurs once per week for 837 transactions and daily for NCPDP transactions

Transaction Type: 837, NCPDP

File Format: Compressed, Logical Record Length = 295 characters

Sample File Name: `1003_31700124_2013170.zip`
<ServiceCenter><MCN><CCYYJJJ><.zip>

Sample File Contents:

```
10093108002000000010112330895                                                    2013108900001201
52002110601513169648932013040220130402
10093108002000000020112330910                                                    2013108900002701
16902296406710433137452013040320130403
10093108002000000030112330911                                                    2013108900002801
16902296406710433137452013040320130403
31080020100000099 0TOTAL ERROR ENCOUNTERS                        0000003
31080020100000099 1STATUS 9 ENCOUNTERS                           0000000
31080020100000099 2STATUS 8 (FATAL) ENCOUNTERS                   0000003
31080020100000099 3STATUS 6 ENCOUNTERS                           0000000
31080020100000099 4STATUS 4 ENCOUNTERS                           0000000
31080020100000099 5STATUS 2 ENCOUNTERS                           0000000
31080020100000099 6STATUS 0 ENCOUNTERS                           0000000
```

File Description:

Field Name	Data Type / Length X=alphanumeric 9=numeric V=implied decimal S=sign	Start Position	End Position
DETAIL RECORD			
MCO Service Center	X(04)	1	4
Media Control Number (MCN)	X(08)	5	12
Sequence Number	9(07)	13	19
MCO Claim Number	X(24)	20	43
Internal Sequence Number (ICN)	X(17)	44	60
Enrollee ID Number	X(12)	61	72

Field Name	Data Type / Length X=alphanumeric 9=numeric V=implied decimal S=sign	Start Position	End Position
Nation Provider ID (NPI)	X(10)	73	82
DOS From Date (CCYYMMDD)	X(08)	83	90
DOS Thru Date (CCYYMMDD)	X(08)	91	98
Diagnosis Code-1	X(07)	99	105
Diagnosis Code-2	X(07)	106	112
Procedure Code	X(07)	113	119
Procedure Code Modifier	X(02)	120	121
Place of Service	X(02)	122	123
Principle Procedure Code	X(07)	124	130
Dental Quadrant	X(02)	131	132
Dental Surface Codes	X(05)	133	137
Pharmacy - National Drug Code (NDC)	X(11)	138	148
Pharmacy - Prescription Number	X(09)	149	157
Quantity - Number of Units/Visits	S9(07)V999	158	167
Claim Bill Charge	S9(09)V99	168	178
Claim Payment Amount	S9(09)V99	179	189
Claim Type	X(02)	190	191
Error Disposition	X(01)	192	192
Provider Type	X(03)	193	195
Provider Specialty Code	X(03)	196	198
Claim Status	X(02)	199	200
Encounter Status	X(02)	201	202
Error Code-1	9(04)	203	206
Error Code-2	9(04)	207	210
Error Code-3	9(04)	211	214
Error Code-4	9(04)	215	218
Error Code-5	9(04)	219	222
Error Code-6	9(04)	223	226
Error Code-7	9(04)	227	230
Error Code-8	9(04)	231	234
Error Code-9	9(04)	235	238
Error Code-10	9(04)	239	242
UB Revenue Code-1	9(04)	243	246
UB Revenue Code-2	9(04)	247	250
UB Revenue Code-3	9(04)	251	254
Filler	X(01)	295	295
TOTAL RECORD			
Total Key	X(18)	1	18
Total Count Description	X(46)	19	64
Total Count (calculated)	9(07)	65	71
Filler	X(224)	72	295

1.2.6 Encounter Submission Calendar

The following pages represent the calendar for MCO encounter submissions for the current contract year.

The VAMMIS FTP server is available to accept encounters on holidays. If an automated script is used for file submission and the submission date falls on a holiday, encounter files may be submitted as scheduled. Please note that there will be limited or no human support available. If an alternate date is required or desired, please send a request to the HCS encounters mailbox. DMAS will not assign alternate submission dates, unless requested.

July 2015 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
		1 VP: HCFA, UB, RX	2 OP: HCFA, UB, RX MC: HCFA, UB, RX	3 *------- DMAS holiday ------- July 4th observed*
6 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	7 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	8 VP: HCFA, UB, RX	9 OP: HCFA, UB, RX MC: HCFA, UB, RX	10 CC: RX
13 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	14 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	15 VP: HCFA, UB, RX	16 OP: HCFA, UB, RX MC: HCFA, UB, RX	17
20 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	21 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	22 VP: HCFA, UB, RX	23 OP: HCFA, UB, RX MC: HCFA, UB, RX	24 CC: RX
27 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	28 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	29 VP: HCFA, UB, RX	30 OP: HCFA, UB, RX MC: HCFA, UB, RX	31

Key: IT=INTotal Health; OP=Optima, MC=MajestaCare; VP=VA Premier; CC=CoventryCares; KP=Kaiser Permanente; HK=Anthem HealthKeepers; *PR=Anthem Priority; *PE=Anthem Peninsula;

*Only encounters with DOS < 11/01/2014

August 2015 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
3 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	4 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	5 VP: HCFA, UB, RX	6 OP: HCFA, UB, RX MC: HCFA, UB, RX	7
10 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	11 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	12 VP: HCFA, UB, RX	13 OP: HCFA, UB, RX MC: HCFA, UB, RX	14 CC: RX
17 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	18 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	19 VP: HCFA, UB, RX	20 OP: HCFA, UB, RX MC: HCFA, UB, RX	21
24 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	25 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	26 VP: HCFA, UB, RX	27 OP: HCFA, UB, RX MC: HCFA, UB, RX	28 CC: RX
31 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX				

Key: IT=INTotal Health; OP=Optima, MC=MajestaCare; VP=VA Premier; CC=CoventryCares; KP=Kaiser Permanente; HK=Anthem HealthKeepers; *PR=Anthem Priority; *PE=Anthem Peninsula;

*Only encounters with DOS < 11/01/2014

September 2015 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
	1 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	2 VP: HCFA, UB, RX	3 OP: HCFA, UB, RX MC: HCFA, UB, RX	4
7 ~~IT: HCFA, UB, RX~~ (rescheduled to 9/10) CC: HCFA, UB KP: HCFA, UB, RX *------- DMAS holiday -------* *Labor Day*	8 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	9 VP: HCFA, UB, RX	10 OP: HCFA, UB, RX MC: HCFA, UB, RX IT: HCFA, UB, RX (IT: holiday schedule)	11 CC: RX
14 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	15 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	16 VP: HCFA, UB, RX	17 OP: HCFA, UB, RX MC: HCFA, UB, RX	18
21 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	22 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	23 VP: HCFA, UB, RX	24 OP: HCFA, UB, RX MC: HCFA, UB, RX	25 CC: RX
28 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	29 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	30 VP: HCFA, UB, RX		

Key: IT=INTotal Health; OP=Optima, MC=MajestaCare; VP=VA Premier; CC=CoventryCares; KP=Kaiser Permanente; HK=Anthem HealthKeepers; *PR=Anthem Priority; *PE=Anthem Peninsula;

*Only encounters with DOS < 11/01/2014

October 2015 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
			1 OP: HCFA, UB, RX MC: HCFA, UB, RX	2
5 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	6 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	7 VP: HCFA, UB, RX	8 OP: HCFA, UB, RX MC: HCFA, UB, RX	9 CC: RX
12 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX *------- DMAS holiday ------- Columbus Day*	13 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	14 VP: HCFA, UB, RX	15 OP: HCFA, UB, RX MC: HCFA, UB, RX	16
19 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	20 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	21 VP: HCFA, UB, RX	22 OP: HCFA, UB, RX MC: HCFA, UB, RX	23 CC: RX
26 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	27 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	28 VP: HCFA, UB, RX	29 OP: HCFA, UB, RX MC: HCFA, UB, RX	30

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*Only encounters with DOS < 11/01/2014

November 2015 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
2 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	3 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	4 VP: HCFA, UB, RX	5 OP: HCFA, UB, RX MC: HCFA, UB, RX	6
9 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	10 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	11 VP: HCFA, UB, RX *------- DMAS holiday ------- Veteran's Day*	12 OP: HCFA, UB, RX MC: HCFA, UB, RX	13 CC: RX
16 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	17 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	18 VP: HCFA, UB, RX	19 OP: HCFA, UB, RX MC: HCFA, UB, RX	20
23 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	24 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	25 VP: HCFA, UB, RX	26 OP: HCFA, UB, RX MC: HCFA, UB, RX *------- DMAS holiday ------- Thanksgiving*	27 CC: RX *------- DMAS holiday ------- Thanksgiving*
30 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX				

Key: IT=INTotal Health; OP=Optima, MC=MajestaCare; VP=VA Premier; CC=CoventryCares; KP=Kaiser Permanente; HK=Anthem HealthKeepers; *PR=Anthem Priority; *PE=Anthem Peninsula;

*Only encounters with DOS < 11/01/2014

December 2015 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
	1 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	2 VP: HCFA, UB, RX	3 OP: HCFA, UB, RX MC: HCFA, UB, RX	4
7 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	8 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	9 VP: HCFA, UB, RX	10 OP: HCFA, UB, RX MC: HCFA, UB, RX	11 CC: RX
14 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	15 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	16 VP: HCFA, UB, RX	17 OP: HCFA, UB, RX MC: HCFA, UB, RX	18
21 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	22 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	23 VP: HCFA, UB, RX	24 OP: HCFA, UB, RX MC: HCFA, UB, RX *------- DMAS holiday ------- Christmas*	25 CC: RX *------- DMAS holiday ------- Christmas*
28 IT: HCFA, UB, RX CC: HCFA, UB KP: HCFA, UB, RX	29 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	30 VP: HCFA, UB, RX	31 OP: HCFA, UB, RX MC: HCFA, UB, RX	

Key: IT=INTotal Health; OP=Optima, MC=MajestaCare; VP=VA Premier; CC=CoventryCares; KP=Kaiser Permanente; HK=Anthem HealthKeepers; *PR=Anthem Priority; *PE=Anthem Peninsula;

*Only encounters with DOS < 11/01/2014

1.3 Encounter Processing Requirements

1.3.1 Encounter Data Certification

By the 15th of each month, Contractors must certify the completeness and accuracy of all encounter data submitted in the prior calendar month. Please reference the data certification reporting requirements in the Medallion 3.0 and FAMIS contracts, as well as the detailed reporting specifications provided in the 'MCO Contract Deliverables' section of this document.

The Encounter Data Certification Form includes protection of the privacy and confidentiality of MCO payment information that is collected from the Contractor on the encounter records. It is important that you use the current version of the Data Certification form in order to insure MCO payment information is not released under Freedom of Information Act requests.

1.3.2 **Adjustments & Voids**

If the Contractor adjusts or voids a claim that has been or will be submitted to DMAS, the Contractor must submit that void or adjustment to DMAS as well. DMAS has the following requirements with respect to adjustments and/or voids:

Virginia's MMIS uses a line level adjudication process for all 837P records. MMIS adjustment processing of 837P encounters is based on the MCO claim control number provided by the MCO on the encounter record. In order for adjustments and voids to be correctly applied within the MMIS, the MCO must provide a unique identifier for each line of an 837P encounter. Note that MCOs may choose to utilize document level processing within their own claims payment processing, but a unique identifier must be provided on the encounters submitted to DMAS.

The claim number that appeared on the original encounter must be coded in Loop 2300, REF Segment of the 837 (see page 196 of the professional or page 166 of the institutional ASC X12N Implementation Guide, Version 5010A1). If the number in this segment does not match the original claim number, the record will receive a fatal error. Sample:

Original Encounter: `CLM*123456*20***11:B:8*Y*A*Y*Y*P`

Adjustment:
```
CLM*123456_A*20***11:B:8*Y*A*Y*Y*P
REF*F8*123456
```

The unique number allows the MMIS to identify the single line being adjusted. Submitting adjustment/voids for all lines on an encounter document and submitting those lines in the same order as the original is no longer required. If the Contractor's adjustment process still requires that the entire encounter document be adjusted, DMAS will accommodate those adjustments.

Replacements and Voids should not be submitted in the same adjudication cycle as the original claim. The MMIS sorts all incoming claim and encounter files as follows: voids, originals, and replacements. Failure to submit voids/adjustments in separate adjudication cycles will result in MMIS fatal error codes 0396 or 0397.

The following MMIS 'claim type modifier' code values are used by the MMIS to identify original, adjustment, and void encounters in the MMIS. The MCO will see these code values on MMIS reporting on encounters that have been processed in the MMIS.

Code	Description
1	Original Claim
2	Debit Adjustment
3	Credit Adjustment *
4	Voided Claim

* Internally created by MMIS

If an MCO submits a file that contains only voids and there are no errors on the file, the file will be processed by the MMIS, but the proprietary reports will not be generated.

1.3.3 Denied Services

All encounters adjudicated by the Contractor or any subcontractor used by the Contractor, should be submitted to DMAS in the prescribed format, including any denied claims, except for the following:

- Encounters that are rejected (the term reject used here does not refer to denied encounters)
- Encounters that are duplicates of records previously submitted
- Encounters that contain an invalid Medicaid member ID
- Encounters for Medicaid members who are not enrolled

If the encounter being submitted is one that has been denied, the encounter should be submitted to DMAS with the appropriate denial reason code from the HIPAA Adjustment Reason Code set (code source 139) appearing in the CAS segment of the encounter. Refer to the table below to see how these codes are mapped to the MMIS error code values (ESC).

Codes identified in the table as 'deny' will be assigned a four-digit DMAS ESC. This is the code that will display on the proprietary error reports, internal system and ad-hoc reports.

The HIPAA adjustment reason code is critical to setting the status of the encounter. Unless the encounter is submitted and interpreted as a denial, all other reason codes are considered approved. Additionally, as this status determines if the encounter will be a paid or denied, each HIPAA adjustment reason code was assigned a status. Mixing paid and denied statuses is not permitted. Each encounter will have only one status value.

The MMIS crosswalk process to identify MCO denials based on the HIPAA adjustment reason code value was implemented only for professional and institutional encounters. Pharmacy (NCPDP) encounter denials are not recognized by the MMIS and should not be submitted to DMAS.

In addition to providing the proper HIPAA adjustment reason code, denied encounters should also include the denial date.

The DMAS crosswalk table below has been updated with new denial codes that are available for use starting on **February 24, 2014**.

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	**MMIS ESC**	**Type**	**Description**	**Begin Date**	**Last Modified**
4	0500	Deny	The procedure code is inconsistent with the modifier used or a required modifier is missing.	1/1/1995	9/20/2009
5	0501	Deny	The procedure code/bill type is inconsistent with the place of service.	1/1/1995	9/20/2009
6	0502	Deny	The procedure/revenue code is inconsistent with the patient's age.	1/1/1995	9/20/2009
7	0503	Deny	The procedure/revenue code is inconsistent with the patient's gender.	1/1/1995	9/20/2009
8	0504	Deny	The procedure code is inconsistent with the provider type / specialty (taxonomy).	1/1/1995	9/20/2009
9	0505	Deny	The diagnosis is inconsistent with the patient's age.	1/1/1995	9/20/2009

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
10	0506	Deny	The diagnosis is inconsistent with the patient's gender.	1/1/1995	9/20/2009
11	0507	Deny	The diagnosis is inconsistent with the procedure.	1/1/1995	9/20/2009
12	0508	Deny	The diagnosis is inconsistent with the provider type.	1/1/1995	9/20/2009
13	0509	Deny	The date of death precedes the date of service.	1/1/1995	
14	0510	Deny	The date of birth follows the date of service.	1/1/1995	
16	0512	Deny	Claim/service lacks information which is needed for adjudication.	1/1/1995	9/20/2009
18	0514	Deny	Exact duplicate claim/service.	1/1/1995	9/30/2012
19	0515	Deny	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	1/1/1995	9/30/2007
20	0516	Deny	This injury/illness is covered by the liability carrier.	1/1/1995	9/30/2007
21	0517	Deny	This injury/illness is the liability of the no-fault carrier.	1/1/1995	9/30/2007
26	0521	Deny	Expenses incurred prior to coverage.	1/1/1995	
27	0522	Deny	Expenses incurred after coverage terminated.	1/1/1995	
29	0523	Deny	The time limit for filing has expired.	1/1/1995	
31	0524	Deny	Patient cannot be identified as our insured.	1/1/1995	9/30/2007
32	0525	Deny	Our records indicate that this dependent is not an eligible dependent as defined.	1/1/1995	
33	0526	Deny	Insured has no dependent coverage.	1/1/1995	9/30/2007
34	0527	Deny	Insured has no coverage for newborns.	1/1/1995	9/30/2007
35	0528	Deny	Lifetime benefit maximum has been reached.	1/1/1995	10/31/2002
39	0530	Deny	Services denied at the time authorization/pre-certification was requested.	1/1/1995	
40	0531	Deny	Charges do not meet qualifications for emergent/urgent care.	1/1/1995	10/16/2003
49	0535	Deny	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.	1/1/1995	9/20/2009
50	0536	Deny	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	1/1/1995	9/20/2009
51	0537	Deny	These are non-covered services because this is a pre-existing condition.	1/1/1995	9/20/2009
53	0539	Deny	Services by an immediate relative or a member of the same household are not covered.	1/1/1995	
54	0540	Deny	Multiple physicians/assistants are not covered in this case.	1/1/1995	9/20/2009

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
55	0541	Deny	Procedure/treatment is deemed experimental/investigational by the payer.	1/1/1995	9/20/2009
56	0542	Deny	Procedure/treatment has not been deemed 'proven to be effective' by the payer	1/1/1995	9/20/2009
60	0546	Deny	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	1/1/1995	6/1/2008
78	0550	Deny	Non-Covered days/Room charge adjustment.	1/1/1995	
95	0552	Deny	Plan procedures not followed.	1/1/1995	9/30/2007
96	0553	Deny	Non-covered charge(s).	1/1/1995	9/20/2009
97	0554	Deny	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	1/1/1995	9/20/2009
107	0557	Deny	The related or qualifying claim/service was not identified on this claim.	1/1/1995	9/20/2009
109	0559	Deny	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	1/1/1995	1/29/2012
110	0560	Deny	Billing date predates service date.	1/1/1995	
111	0561	Deny	Not covered unless the provider accepts assignment.	1/1/1995	
114	0564	Deny	Procedure/product not approved by the Food and Drug Administration.	1/1/1995	
116	0566	Deny	The advance indemnification notice signed by the patient did not comply with requirements.	1/1/1995	9/30/2007
119	0568	Deny	Benefit maximum for this time period or occurrence has been reached.	1/1/1995	2/29/2004
128	0570	Deny	Newborn's services are covered in the mother's Allowance.	2/28/1997	
129	0571	Deny	Prior processing information appears incorrect	2/28/1997	1/30/2011
133	0572	Deny	The disposition of the claim/service is pending further review	2/28/1997	9/30/2012
135	0573	Deny	Interim bills cannot be processed.	10/31/1998	9/30/2007
138	0575	Deny	Appeal procedures not followed or time limits not met.	6/30/1999	9/30/2007
140	0576	Deny	Patient/Insured health identification number and name do not match.	6/30/1999	
146	0578	Deny	Diagnosis was invalid for the date(s) of service reported.	6/30/2002	9/30/2007
147	0579	Deny	Provider contracted/negotiated rate expired or not on file.	6/30/2002	
148	0580	Deny	Information from another provider was not provided or was insufficient/incomplete.	6/30/2002	9/20/2009
149	0543	Deny	Lifetime benefit maximum has been reached for this service/benefit category.	10/31/2002	
155	2004	Deny	Patient refused the service/procedure.	6/30/2003	9/30/2007

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
157	0563	Deny	Service/procedure was provided as a result of an act of war.	9/30/2003	9/30/2007
158	2032	Deny	Service/procedure was provided outside of the United States.	9/30/2003	9/30/2007
159	2005	Deny	Service/procedure was provided as a result of terrorism.	9/30/2003	9/30/2007
160	2007	Deny	Injury/illness was the result of an activity that is a benefit exclusion.	9/30/2003	9/30/2007
165	2008	Deny	Referral absent or exceeded.	10/31/2004	9/30/2007
166	0533	Deny	These services were submitted after this payers responsibility for processing claims under this plan ended.	2/28/2005	
167	0534	Deny	This (these) diagnosis(es) is (are) not covered.	6/30/2005	9/20/2009
168	0599	Deny	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	6/30/2005	9/30/2007
170	0584	Deny	Payment is denied when performed/billed by this type of provider.	6/30/2005	9/20/2009
171	2015	Deny	Payment is denied when performed/billed by this type of provider in this type of facility.	6/30/2005	9/20/2009
174	0594	Deny	Service was not prescribed prior to delivery.	6/30/2005	9/30/2007
175	2016	Deny	Prescription is incomplete.	6/30/2005	9/30/2007
176	2017	Deny	Prescription is not current.	6/30/2005	9/30/2007
177	2020	Deny	Patient has not met the required eligibility requirements.	6/30/2005	9/30/2007
178	2021	Deny	Patient has not met the required spend down requirements.	6/30/2005	9/30/2007
179	2024	Deny	Patient has not met the required waiting requirements.	6/30/2005	9/20/2009
180	2027	Deny	Patient has not met the required residency requirements.	6/30/2005	9/30/2007
181	0595	Deny	Procedure code was invalid on the date of service.	6/30/2005	9/30/2007
182	2019	Deny	Procedure modifier was invalid on the date of service.	6/30/2005	9/30/2007
183	0538	Deny	The referring provider is not eligible to refer the service billed.	6/30/2005	9/20/2009
184	0548	Deny	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	6/30/2005	9/20/2009
185	0549	Deny	The rendering provider is not eligible to perform the service billed.	6/30/2005	9/20/2009
188	2028	Deny	This product/procedure is only covered when used according to FDA recommendations.	6/30/2005	
189	2009	Deny	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	6/30/2005	
190	2010	Deny	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	10/31/2005	

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
191	2029	Deny	Not a work related injury/illness and thus not the liability of the workers' compensation carrier.	10/31/2005	10/17/2010
192	2012	Deny	Nonstandard adjustment code from paper remittance.	10/31/2005	9/30/2007
193	0532	Deny	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	2/28/2006	1/27/2008
194	0545	Deny	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	2/28/2006	9/30/2007
195	2006	Deny	Refund issued to an erroneous priority payer for this claim/service.	2/28/2006	9/30/2007
197	0513	Deny	Precertification/authorization/notification absent.	10/31/2006	9/30/2007
198	0518	Deny	Precertification/authorization exceeded.	10/31/2006	9/30/2007
199	0583	Deny	Revenue code and Procedure code do not match.	10/31/2006	
200	0547	Deny	Expenses incurred during lapse in coverage	10/31/2006	
201	2011	Deny	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement.	10/31/2006	9/30/2012
202	0588	Deny	Non-covered personal comfort or convenience services.	2/28/2007	9/30/2007
203	2013	Deny	Discontinued or reduced service.	2/28/2007	9/30/2007
204	0519	Deny	This service/equipment/drug is not covered under the patient's current benefit plan	2/28/2007	
206	0544	Deny	National Provider Identifier - missing.	7/9/2007	9/30/2007
207	0551	Deny	National Provider identifier - Invalid format	7/9/2007	6/1/2008
208	0555	Deny	National Provider Identifier - Not matched.	7/9/2007	9/30/2007
209	2018	Deny	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected.	7/9/2007	9/30/2012
210	0596	Deny	Payment adjusted because pre-certification/authorization not received in a timely fashion	7/9/2007	
211	0597	Deny	National Drug Codes (NDC) not eligible for rebate, are not covered.	7/9/2007	
212	0574	Deny	Administrative surcharges are not covered	11/5/2007	
213	2022	Deny	Non-compliance with the physician self-referral prohibition legislation or payer policy.	1/27/2008	
214	2023	Deny	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.	1/27/2008	10/17/2010
216	0556	Deny	Based on the findings of a review organization	1/27/2008	
220	0567	Deny	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and	1/27/2008	9/30/2012

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
			supporting documentation if required.		
221	2025	Deny	Workers' Compensation claim is under investigation. Claim is under investigation.	1/27/2008	
222	2026	Deny	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.	6/1/2008	9/20/2009
224	0577	Deny	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.	6/1/2008	
226	0569	Deny	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete.	9/21/2008	9/30/2012
227	0558	Deny	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete.	9/21/2008	9/20/2009
228	2030	Deny	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	9/21/2008	
230	0562	Deny	No available or correlating CPT/HCPCS code to describe this service.	1/25/2009	
231	2014	Deny	Mutually exclusive procedures cannot be done in the same day/setting.	7/1/2009	9/20/2009
234	0565	Deny	This procedure is not paid separately.	1/24/2010	
236	2001	Deny	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	1/30/2011	9/30/2012
238	2002	Deny	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period.	3/1/2012	9/30/2012
239	2003	Deny	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	3/1/2012	1/29/2012
240	2033	Deny	The diagnosis is inconsistent with the patient's birth weight.	6/3/2012	
242	2034	Deny	Services not provided by network/primary care providers.	6/3/2012	
243	2035	Deny	Services not authorized by network/primary care providers.	6/3/2012	
244	2036	Deny	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation.	9/30/2012	
246	2037	Deny	This non-payable code is for required reporting only.	9/30/2012	
250	2038	Deny	The attachment content received is inconsistent with the expected content.	9/30/2012	
251	2039	Deny	The attachment content received did not contain the content required to process this claim or service.	9/30/2012	
252	2040	Deny	An attachment is required to adjudicate this claim/service.	9/30/2012	
A1	0511	Deny	Claim/Service denied.	1/1/1995	9/20/2009
A6	2031	Deny	Prior hospitalization or 30 day transfer requirement not met.	1/1/1995	
A8	0581	Deny	Ungroupable DRG.	1/1/1995	9/30/2007

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
B1	0582	Deny	Non-covered visits.	1/1/1995	
B7	0585	Deny	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	1/1/1995	9/20/2009
B8	0586	Deny	Alternative services were available, and should have been utilized.	1/1/1995	9/20/2009
B9	0587	Deny	Patient is enrolled in a Hospice.	1/1/1995	9/30/2007
B11	0589	Deny	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	1/1/1995	
B12	0590	Deny	Services not documented in patients' medical records.	1/1/1995	
B13	0591	Deny	Previously paid. Payment for this claim/service may have been provided in a previous payment.	1/1/1995	
B14	0592	Deny	Only one visit or consultation per physician per day is covered.	1/1/1995	9/30/2007
B15	0593	Deny	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	1/1/1995	9/20/2009
B16	0520	Deny	'New Patient' qualifications were not met.	1/1/1995	9/30/2007
B23	0598	Deny	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	1/1/1995	9/30/2007
W3	2041	Deny	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	9/30/2012	
Y1	2042	Deny	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable.	9/30/2012	

1.3.4 National Provider Identifier

The final rule on National provider Identifiers (NPI) specifies that a covered provider must use its assigned NPI where called for on all HIPAA-specified electronic transactions exchanged between covered entities.

DMAS will issue an atypical provider identifier (API) for providers who are not already on the MMIS provider master file. These include non-healthcare providers who cannot obtain an NPI (e.g., taxi drivers), and any providers who are not already enrolled in Virginia Medicaid fee for service. The API number is ten-digits long and mimics the NPI (although using a different algorithm than the one for NPPES).

The Contractor is responsible to ensure that all encounter claims are submitted with a National Provider Identification (NPI) or Administrative Provider Identification (API) number that is on file and active in the MMIS. DMAS produces a monthly provider listing that includes all active and terminated Virginia Medicaid Providers. The Contractor is responsible for maintaining the correct provider identification number for the claim and service date. The Contractor will make maximum effort that all providers, including ancillary providers, (i.e. vision, pharmacy, etc.), apply for enrollment in the Medicaid program.

Upon receipt of the DMAS provider file, the Contractor will add, update, edit, etc. their system with the MMIS NPI/API information, to include effective dates as appropriate. The Contractor will submit a monthly request file to DMAS for every provider who is not on file in the MMIS. Detailed specifications for this request file are provided in the 'Reports' section of this document.

An encounter cannot be processed in the MMIS unless the servicing and billing provider on the encounter have a record (NPI/API) on the MMIS provider master file, and that record is active on the encounter date(s) of service. A provider request must be processed by DMAS and confirmation sent to the MCO before the MCO can submit any encounter(s) for a provider who is not on the MMIS.

1.3.5 Line-Level Processing

The MMIS adjudicates professional (837P) encounters at the service line level. The MCO claim identifier at the document level is used to uniquely identify each service. For the MMIS to successfully process the encounter, multi-service line claims must be split into individual encounters with each encounter containing only one service line. Because the MMIS uses a document/claim level X12 value to uniquely identify each service line, the claim must be split when multiple service lines are present. MMIS line-level processing requirements for 837P encounters are listed below.

- The MCO is responsible for providing a unique claim identifier for each claim within their system.
- When the MCO generates the encounter, multi-service line claims must be split into individual encounters with each encounter containing only one service line.
- The encounter must contain a "combined" identifier that uniquely identifies the encounter and uniquely identifies the service line within the encounter. The encounter will contain only the service line that is reflected in the identifier.
- The MCO may use any method that uniquely identifies the claim and service line. One recommended approach is to append the service line number to the unique claim id as shown in the example below.

  Example: MCO unique claim id = 4216000006
  Service line number on claim = 01
  837P claim number (unique claim id/unique service line id) = 421600000601
- 837P EDI reference:
  Loop 2300, CLM01 = 837P claim number (unique claim id/unique service line id)
- Loop 2300, CLM01 may contain a maximum of 20 characters.

See examples below.

ORIGINAL ENCOUNTER

New Claim

Claim Frequency Code
1 (original)

Unique Claim Number
4216000006

Service Line(s)
01 07/12/14, 52678
02 07/12/14, 82115
03 07/12/14, 96745

Original - Encounter 1	**837P reference**
Claim Frequency Code 1 (original)	2300, CLM05-3
Unique Claim Number 421600000601	2300, CLM01
Service Line 01 07/12/14, 52678	2400, LX*1

Original - Encounter 2	**837P reference**
Claim Frequency Code 1 (original)	2300, CLM05-3
Unique Claim Number 421600000602	2300, CLM01
Service Line 01 07/12/14, 82115	2400, LX*1

Original - Encounter 3	**837P reference**
Claim Frequency Code 1 (original)	2300, CLM05-03
Unique Claim Number 421600000603	2300, CLM01
Service Line 01 07/12/14, 96745	2400, LX*1

REPLACEMENT ENCOUNTER

Example where provider updates service line 1 & 3 and generates a replacement claim accordingly

Replacement Claim

Claim Frequency Code
7 (replacement)

Unique Claim Number
4216000007

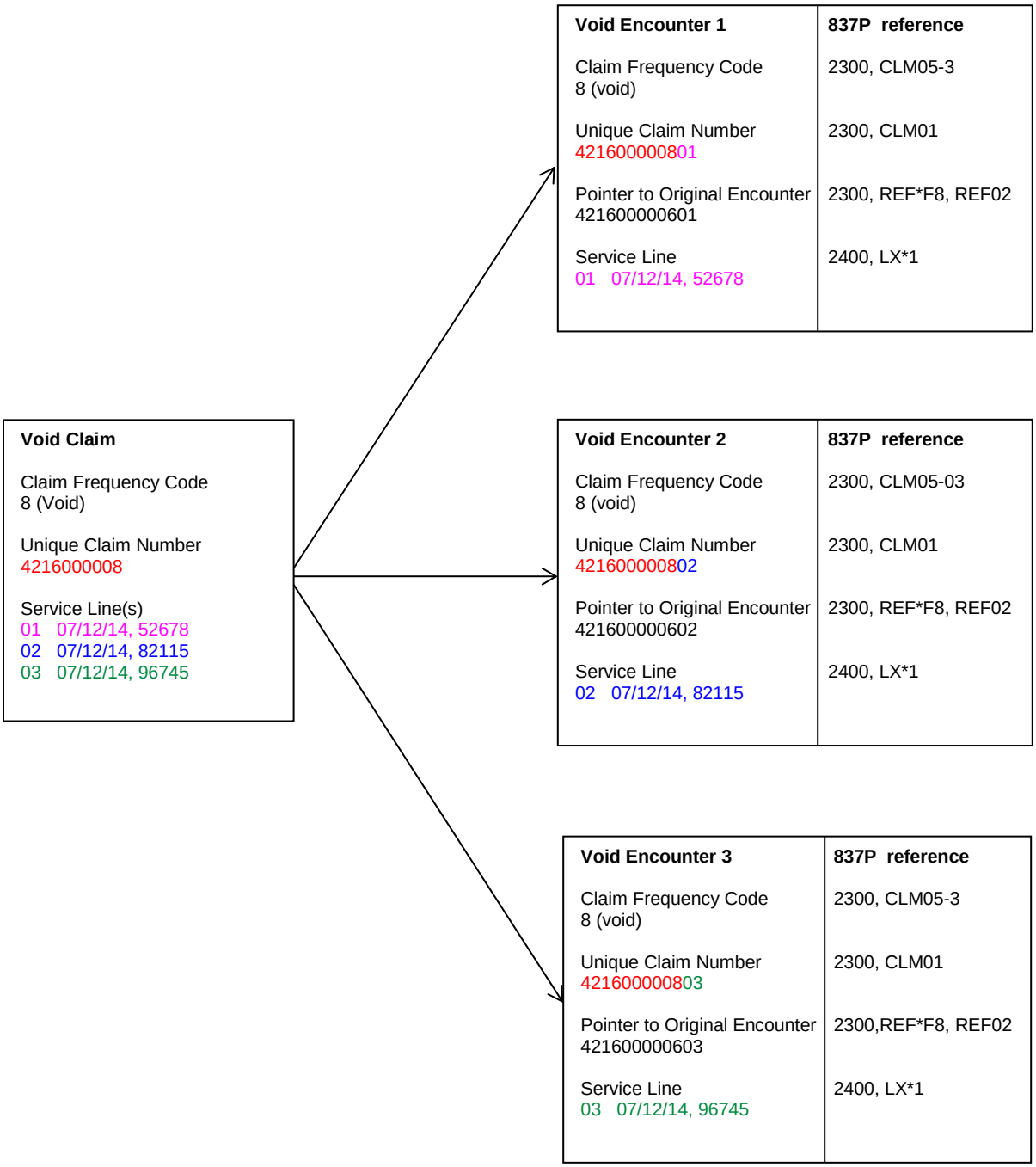
Service Line(s)
01 07/12/14, 45321
02 07/12/14, 82115
03 07/12/14, 26743

Replacement - Encounter 1	**837P Reference**
Claim Frequency Code 7 (replacement)	2300, CLM05-03
Unique Claim Number 421600000701	2300, CLM01
Pointer to Original Encounter 421600000601	2300, REF*F8, REF02
Service Line 01 07/12/14, 45321	2400, LX*1

Replacement - Encounter 2	**837P reference**
Claim Frequency Code 7 (replacement)	2300, CLM05-03
Unique Claim Number 421600000703	2300, CLM01
Pointer to Original Encounter 421600000603	2300, REF*F8, REF02
Service Line 03 07/12/14, 26743	2400, LX*1

VOID ENCOUNTER

Example where the provider voids the original claim



1.3.6 Drug Rebate Collection

DMAS is required by the Affordable Care Act to collect pharmacy rebates for drugs provided to Medicaid members in an outpatient setting who are enrolled in a managed care arrangement. For successful rebate collection, pharmacy/drug encounters have to contain certain required fields, e.g., NDC, MCO payment date, MCO payment amount. Drugs may be submitted as pharmacy or medical for the following transaction types: Pharmacy (NCPDP), Professional (837P), and Institutional (837I).

1.3.6.1 Required Data for Rebate Collection on Eligible Drugs

The following data elements must be populated on the EDI transaction to DMAS for successful rebate collection from the manufacturer.

Data Element	EDI Reference		
	NCPDP Field	**837P Loop.Segment.Element**	**837I (outpatient only) Loop.Segment.Element**
MCO payment amount	431-DV	2430.SVD.02	Claim level: 2320.AMT.01=D 2320.AMT.02 OR Service level: 2430.SVD.02
MCO payment date	443-E8	2430.DTP.01=573 2430.DTP.03	Claim level: 2330B.DTP01=573 2330B.DTP03 OR Service level: 2430.DTP.01=573 2430.DTP.03
Medicaid member ID	302-C2	2010BA.NM1.09	2010BA.NM1.09
NDC	407-D7	2410.LIN.02=N4 2410.LIN.03	2410.LIN.02=N4 2410.LIN.03
Drug unit of measure (837 only)	N/A	2410.CTP.05-1	2410.CTP.05-1
Drug unit/quantity	442-E7	2410.CTP.04	2410.CTP.04

Effective 07/01/2015, DMAS will begin to identify and track errors that prevent collection of rebates through the Encounter Data Quality (EDQ) process. These errors will be subject to compliance assessment.

1.3.6.2 Compound Drugs

NCPDP compound drug encounters must be submitted with multiple ingredients. A NCPDP single-ingredient compound must be submitted as a non-compound, single drug. If a NCPDP compound drug encounter is submitted with only one ingredient, it will be flagged by the MMIS with an ESC error code 0044 (NDC missing or not in valid format).

1.3.6.3 340B Drugs

340B drugs are not eligible for rebate. The MCO must have a process in place to identify 340B drugs so that the drug may be excluded from rebate collection. The technical requirements for 340B drug identification are shown below.

Transaction	Field/Data Element	EDI Reference Field Id/Element	Value
NCPDP	Submission Clarification Code Basis of Cost Determination	420-DK 423-DN	20 08
Note: Submission Clarification Code AND Basis of Cost Determination must be populated. Maximum number of occurrences supported for Submission Clarification Code is 1.			
837P	Procedure Modifier	2400.SV1.01 (3-6)	UD
837I	Procedure Modifier	2400.SV2.02 (3-6)	UD
Note: Each drug line must be submitted with modifier UD on the revenue line with the procedure code and NDC code.			

1.3.7 MCO Payment Amount & Date

The amount that the Contractor paid the servicing provider must be submitted to the State on each encounter record for a paid (non-denied) claim. Each encounter must also include the MCO's payment/check/remit date. The paid amount should reflect what the servicing provider was paid to render care to the member and should not reflect a capitated or salaried reimbursement arrangement.

A member with other insurance coverage (TPL) will be disenrolled from the MCO once that coverage has been verified by DMAS and added to the State's MMIS system. Until the member is disenrolled, the Contractor is required to submit the primary carrier's payment on the encounter along with the MOC payment amount (if any).

For all transaction types, values must be present for the MCO payment amount and MCO payment / remit date (including denials). MMIS will not recognize MCO payment date values that are submitted without a corresponding MCO payment amount value. Zero is an acceptable value for MCO payment amount when appropriate.

1.3.7.1 Sample 837P – Contractor Payment Only

The CN1 segment on the 837 record should be used to identify the method of payment. Refer to the 837 IG for valid values for the CN1 segment. The information below shows an example of how an 837P record should look when the only payment made was made by the Contractor:

<u>2000B Subscriber Loop</u>

```
HL*2*1*22*0
SBR*P*18*******MC
NM1*IL*1*SMITH*BARNEY****MI*999999999999
N3*17 BROADWAY
N4*RICHMOND *VA*23229
DMG*D8*19430621*M
NM1*PR*2*BOMBAY,DOCTOR*****PI*547777777
```

<u>2300 Claim Loop</u>

```
CLM*4995757*115***21||1*Y*A*Y*Y*C**01
DTP*431*D8*20120501
DTP*435*D8*20120501
CN1*04
HI*BK|51884*BF|49121
NM1*82*1*BOMBAY*DOCTOR****XX*1234567890
```

<u>2320 Other Subscriber Information Loop</u>

This is the loop where the Contractor will indicate the paid amount. NM109 = 7777 = MCO Service Center ID. This is associated with the appropriate SVD segment = 7777 to pick up the paid amount of $80.00 The DTP segment (with qualifier 573) is used for the MCO paid date.

```
SBR*S*18***HM****HM
DMG*D8*19430621*M
OI***Y*B**A
```

```
NM1*IL*1*SMITH*BARNEY****MI*999999999999
NM1*PR*2*MCO CARE*****PI*7777
LX*1
SV1*HC|99239*213*UN*1*21**1****Y
DTP*472*D8*20120501
SVD*7777*80*HC|99239**1
CAS*CO*45*133
DTP*573*D8*20120811
```

1.3.7.2 Sample 837P – Contractor and Other Carrier Payments

The following is an example of how an 837P record should look when there is other TPL coverage also involved:

2000B Subscriber Loop

```
HL*2*1*22*0
SBR*P*18*******MC
NM1*IL*1*SMITH*BARNEY****MI*999999999999
N3*17 BROADWAY
N4*RICHMOND*VA*23229
DMG*D8*19430621*F
NM1*PR*2*BOMBAY,DOCTOR*****PI*547777777
```

2300 Claim Loop

```
CLM*4995757*115***21||1*Y*A*Y*Y*C**01
DTP*431*D8*20120501
DTP*435*D8*20120501
CN1*04
HI*BK|51884*BF|49121
NM1*82*1*BOMBAY*DOCTOR****XX*1234567890
```

2320 Other Subscriber Information Loop

2 loops (Contractor and Other Carrier) – NM109 = 7777 = MCO Service Center ID. This is associated with the appropriate SVD segment = 7777 to pick up the paid amount of $75 on this claim. Other Carrier 1234 paid $30.00 on this claim. The DTP segment (with qualifier 573) is used for the MCO's paid date (carrier 7777).

```
SBR*S*18***HM****HM
DMG*D8*19430621*M
OI***Y*B**A
NM1*IL*1*SMITH*BARNEY****MI*999999999999
NM1*PR*2*MCO CARE*****PI*7777
SBR*S*18***OT****CI
DMG*D8*19430621*M
OI***Y*B**A
NM1*IL*1*SMITH*BARNEY****MI*999999999999
NM1*PR*2*OTHER INSUR*****PI*1234
LX*1
```

```
SV1*HC|99232*115*UN*1*21**1****Y
DTP*472*D8*20120501
SVD*7777*75*HC|99232**1
CAS*CO*45*40

DTP*573*D8*20120811
SVD*1234*30*HC|99232**1
CAS*CO*45*85

DTP*573*D8*20120811
```

1.3.7.3 Sample 837I – Contractor Payment Only

The following is an example of how an 837I record would look like when the only payment made was made by the Contractor:

2000B Subscriber Loop

```
HL*2*1*22*0~
SBR*P*18*SSSSS******MC~
NM1*IL*1*JOHNSON*FRED****MI*999999999999~
N3*4 BROAD WAY~
N4*RICHMOND *VA*23229~
DMG*D8*19901008*M~
NM1*PR*2*MCO CARE*****PI*9999~
```

2300 Claim Loop

```
CLM*0523155346*367.7***13:A:1*Y*A*Y*Y*********N~
DTP*096*TM*1900~
DTP*434*RD8*20120810-20120810~
CL1*1*1*01~
CN1*02*30~
REF*D9*052999346~
HI*BK:3129*ZZ:4489~
HI*BF:3009*BF:31401~
HI*BE:A3:::36770~
NM1*71*2*SMITH*****XX*1014567890~
```

2320 Other Subscriber Information Loop

This is the loop where the Contractor will indicate the paid amount. NM109 = 7777 = MCO Service Center ID. This is associated with the appropriate SVD segment = 7777 to pick up the paid amount of $100. The DTP segment is used for the paid date.

```
SBR*S*18*7777*559999504051*****HM~
DMG*D8*19901008*M~
OI***Y***Y~
NM1*IL*1*JOHNSON*FRED****MI*999999999999~
NM1*PR*2*MCO CARE*****PI*7777~
LX*1~
SV2*0450*HC:99284*367.7*UN*1~
DTP*472*RD8*20120810-20120810~
```

```
SVD*7777*100*HC:99284*0450*1~
CAS*CO*45*267.7~
DTP*573*D8*20120904~
```

Another HL or end of transaction.

1.3.7.4 Sample 837I – Contractor and Other Carrier Payments

The following is an example of how an 837I record would look when there is other coverage involved:

2000B Subscriber Loop

```
HL*2*1*22*0~
SBR*T*18*SSSSS******MC~
NM1*IL*1*JOHNSON*FRED****MI*999999999999~
N3*4 BROAD WAY~
N4*RICHMOND*VA*23229~
DMG*D8*19901008*M~
NM1*PR*2*MCO CARE*****PI*9999~
```

2300 Claim Loop

```
CLM*0523155346*367.7***13:A:1*Y*A*Y*Y*********N~
DTP*096*TM*1900~
DTP*434*RD8*20120810-20120810~
CL1*1*1*01~
CN1*02*30~
REF*D9*052999346~
HI*BK:3129*ZZ:4489~
HI*BF:3009*BF:31401~
HI*BE:A3:::36770~
NM1*71*2*SMITH*****24*1014567890~
```

2320 Other Subscriber Information Loop

2 loops (Contractor and Other Carrier) – Carrier 7777 paid $50 on this claim. Carrier 1234 paid $100 on this claim. The $50 TPL payment needs to be in the amount segment (AMT) in the appropriate 2320 loop.

```
SBR*S*18*2222*GROUP NAME*****CI~
AMT*C4*50~
DMG*D8*19901008*M~
OI***Y***Y~
NM1*IL*1*JOHNSON*FRED****MI*999999999999~
NM1*PR*2*CIGNA*****PI*1234~
SBR*T*18*1234*GROUP NAME*****HM~
DMG*D8*19901008*M~
OI***Y***Y~
NM1*IL*1*JOHNSON*FRED****MI*999999999999~
NM1*PR*2*MCO CARE*****PI*7777~
LX*1~
```

```
SV2*0450*HC:99284*367.7*UN*1~
DTP*472*RD8*20050810-20050810~
SVD*7777*100*HC:99284*0450*1~
CAS*CO*42*217.7**23*50~
DTP*573*D8*20050904~
```

1.3.8 Enrollment Determination Based on Admit Date

Member eligibility in the MMIS is being determined based on the discharge date (MMIS edit 0453). A system change has been submitted to correct the edit logic to use the admission date. Eligibility for member's coverage is actually based on the member's enrollment at the start of the admission (admit date).

1.3.9 Newborns Without Medicaid IDs

Originally, DMAS had instructed the MCOs to use a workaround when submitting encounters for newborns who have not been assigned a Medicaid ID. For this workaround, the MCO would submit the newborn encounter(s) with a identifier that consists of the first 9 digits of the mother's ID with a 3 digit sequence number representing each unique child for that mother (e.g., 001 for the first child, 002 for the second, etc.). The MCOs were instructed to submit this identifier instead of a valid Medicaid ID on the newborn encounters whenever a valid Medicaid ID was not available.

A potential issue was identified with this workaround in 2012. It is possible that this newborn identifier value may actually be the same as a valid Medicaid ID assigned to another unrelated Medicaid member. This situation occurs very rarely.

DMAS submitted a systems service request in 2012 for our Fiscal Agent contractor to develop a new process for submission of encounters for newborns that have not been issued a Medicaid ID. Until that new process is developed, MCOs are to continue using the original workaround.

1.3.10 **Procedure, Diagnosis, Revenue Code**

A workaround was previously implemented in MMIS to accept invalid diagnosis, revenue, and procedure codes in encounter submissions when submitted with all X's in the field. The original intent was for the MCO to use these values when a claim was denied for an invalid or missing code. Effective 01/01/2010, the X codes have been end dated in the MMIS, resulting a 0995 or 0996 edit being set on the encounter.

1.4 Proprietary MMIS Code Sets

The following proprietary code sets are used in the Virginia MMIS for processing and reporting. The MCO is not required to submit these values on the encounters. However, the MCO may need to utilize the coding values for reconciliation and/or error correction of encounter data.

1.4.1 MMIS Claim Type

The MMIS assigns a proprietary claim type value to each encounter record submitted by the MCO. This claim type value is used extensively in the MMIS to drive reporting and editing. The following table lists the claim types along with their associated 'form' and description.

Code	Form	Description
01	FAC	Inpatient Hospital
02	FAC	Skilled Nursing Home (SNF)
03	FAC	Outpatient Hospital/Home Health
04	MED	Personal Care
05	MED	Practitioner
06	DRUG	Pharmacy
08	MED	Lab
10	FAC	Intermediate Care (ICF)
11	MED	Dental
13	MED	Transportation

1.4.2 Provider Class Type

Code	Description
001	Hospital, in-state, General
002	State Mental Hospital (Aged)
003	Private Mental Hospital (inpatient psych)
004	Long Stay Hospital
005	TB Hospital
006	Skilled Nursing Home Mental Health
007	State Mental Hospital (less than age 21)
008	State Mental Hospital (Med-Surge)
009	Medical Surgery - Mentally Retarded
010	Skilled Nursing Home Non Mental Health
011	Skilled Nursing Facility - Mentally Retarded
012	Long Stay Inpatient Hospital - Mental Health
013	Med-Surge Mental Health Retardation
014	Rehab Hospital
015	Intermediate Care Facility
016	Intermediate Care Facility - Mental Health
017	ICF - Mentally Retarded - State Owned
018	ICF - Mentally Retarded - Community Owned
019	CORF (Outpatient Rehab Facility)
020	Physician
021	Licensed Professional Counselor
022	Treatment Foster Care Program
023	Nurse Practitioner
024	Licensed Psychologist
025	Clinical Psychologist
026	Chiropractor
027	Christian Science SNF
028	Skilled Nursing Facility - State
029	Intermediate Care Facility - State
030	Podiatrist
031	Optometrist
032	Optician
033	Nurse Anesthetist
034	Clinical Nurse Specialist - Psychiatric only
035	Nurse Midwife
036	Case Management
037	Prenatal Nutrition
038	Hearing Aid
039	Respiratory Therapist
040	Dentist
041	Dental Clinic
042	Dental Clinic MH/MR
043	Speech/Language Pathologist
044	Audiologist
045	Occupational Therapist
046	Hospice
047	Respite Care
048	Adult Day Health Care
049	Ambulatory Surgical Center

Code	Description
050	Renal Unit
051	Health Department Clinic
052	Federally Qualified Health Center
053	Rural Health Clinic
054	Physical Therapist
055	Personal Care
056	Mental Health Mental Retardation
057	Rehab Agencies
058	Home Health Agency - State
059	Home Health Agency - Private
060	Pharmacy
061	Family Caregiver Training
062	Durable Medical Equipment/Supplies
063	Private Duty
064	Prosthetic Services
065	Eldercare Program
067	HMO Medallion 3.0 - Immunization
070	Independent Laboratory
071	Substance Abuse Clinic (FAMIS)
072	Education Services
073	Case Management Waiver
074	Head Start Clinic
075	Mental Retardation Waiver Services
076	Licensed Clinical Social Worker
077	Psych Residential Inpatient Facility
078	Licensed Social Worker
079	Assisted Living
080	Transportation
081	Registered Driver
082	Emergency Air Ambulance
083	Out-of-State Transportation
084	Out-of-State Emergency Air Ambulance
085	Out-of-State Rehab Hospital
086	Out-of-State Intermediate Care Facility
087	HMO Medallion 3.0
088	Tax Group
090	Out-of-State Supply Equipment
091	Out-of-State Hospital
092	Out-of-State Skilled Care Facility
093	Out-of-State Clinic
094	Out-of-State Home Health
095	Out-of-State Physician
096	Out-of-State Pharmacy
097	Out-of-State Dental
098	Out-of-State Laboratory
099	Medicare Crossover
100	Non-Medicaid TDO
101	School Psychologist
102	Marriage and Family Therapist
103	Substance Abuse Practitioner
104	PACE Provider
105	Certified Professional Midwives

Code	Description
106	Transition Coordinator
107	MMIS Contractors or Vendors
108	Early Intervention
109	Out of State ICF Provider

1.4.3 Provider Specialty

Code	Description
000	No Specialty
001	Ambulance
002	Wheelchair Van
003	Taxi
004	Ambulance/WC Van
005	Ambulance/Taxi
006	Ambulance/WC Van/Taxi
007	Wheelchair Van/Taxi
008	Taxi Non-Enrolled
009	Neo-natal Ambulance
010	Not used
011	Registered Driver
012	Locked Facility
013	Unlocked Facility
014	Fiscal Agent - State
015	Fiscal Agent - Private
016	DD Waiver
017	DD Waiver Support Coord
018	Special ED Audiologist
019	Special ED Personal Care Services
020	Special ED Transportation
021	Air Ambulance
022	OB/GYN Nurse Practitioner
023	Family Nurse Practitioner
024	Pediatric Nurse Practitioner
025	Special ED Nursing Services
026	Special ED PSYCH services
027	Physical Therapy
028	Occupational Therapy
029	Speech/Language
030	ACR (Adult Care Residence)-AAA
031	ACR-CSB
032	ACR-DOH
033	ACR-CILS
034	ACR-DSS
035	EPSDT Special
036	Case Management
037	Nutrition
038	Patient Education
039	Homemaker Services
040	Consumer-Directed Personal Attendant
041	Mental Health Clinic
042	CSB Mental Health
043	CSB MR St Plan
044	MR Waiver: CSB ONLY
045	Private MHSA Services
046	MR Waiver: MR
047	Substance abuse
048	Regular Assisted Living
049	Intensive Assisted Living

Code	Description
050	Not used
051	School Practitioner
052	Quality Health Center
053	Family Practice
054	Hosp-Home Health
055	Free Standing Home Health
056	General Practice
057	Anesthesiology
058	Colon/Rectal Surgery
059	Dermatology
060	Internal Medicine
061	Neurological Surgery
062	Obstetrics and Gynecology
063	Ophthalmology
064	Orthopedic Surgery
065	Otolaryngology
066	Pathology
067	Neonatology, Pediatrics
068	Physical Med/Rehab
069	Unit Dose/Plastic Surgery
070	Preventive Medicine
071	PSY and NEUR
072	Radiology
073	General Surgery
074	Thoracic Surgery
075	Urology
076	Other
077	Psychologist
078	Dentist (General Practice)
079	Orthodontist
080	Oral Surgery
081	Periodontist
082	Pedodontist
083	Endodontist
084	Other
085	Not used
086	Ventilator
087	AIDS
088	Unknown
089	Complex
090	Elderly Case Mg
091	NF Private Room Rate
092	Rehabilitation
093	Durable Equipment/Supply
094	Health Department Pharmacy
095	Not used
096	Not used
097	Not used
098	Not used
099	Not used
100	Mammography
101	Plastic Surgery

Code	Description
102	LTC Pharmacy Non-UD
103	Public Transportation
104	Stretcher Van
105	Alzheimer's Assisted Living
106	E Medicaid
107	Adult Nurse Practitioner
108	Geriatric Nurse Practitioner
109	Neonatal Nurse Practitioner
110	Acute Care Nurse Practitioner
111	Psychiatric Nurse Practitioner
112	Certified Nurse Midwife Nurse Practitioner
113	Full PACE(Program for All Inclusive Care for Elderly)
114	Children's Group Home Level A
115	Therapeutic Group Home Level B
116	Early Intervention Provider Specialty
117	CMHP Transition Coordinator
118	Residential Respite Care
119	Early Intervention Targeted Case Management
120	EPSDT Behavioral Therapy
121	Board Certified
122	60% E&M Threshold Attestation
123	ORP Physician Assistant
124	ORP Intern
125	ORP Other
126	DME Incontinence Supplies
127	Telemedicine
128	BHSA

1.4.4 Edit Codes / Error Sequence Codes (ESC)

ESC	Error Description
0001	Provider Not Certified for Neonatal Care
0002	Invalid Reference Number
0003	Invalid Billing Provider Number
0004	Invalid or Missing Enrollee ID
0005	Invalid Accident Indicator/Hour
0007	Invalid Date of Service
0009	Invalid Tooth Code (dental)
0010	Invalid Surface Code (dental)
0012	Invalid Procedure Code
0022	Servicing Provider is Not Eligible to Bill this Payment Request Type
0023	Units Missing/Not in Valid Format
0025	Service 'Thru' Date Missing/Invalid
0028	Admit Date Missing or Invalid
0030	Primary Diagnosis Not on File/Invalid
0031	Patient Status is Missing or Invalid
0033	Total Charge Omitted/Out of Balance
0035	Missing/Invalid Accommodation Code
0038	Invalid Place of Treatment Code
0038	Invalid Place of Treatment Code
0040	Invalid Type of Service
0041	Invalid Procedure Modifier
0044	NDC Missing or Not in Valid Format
0045	Invalid Metric Quantity
0054	Principal procedure date is invalid or is outside dates of service billed.
0055	Type of Bill Missing or Invalid
0056	Prescription Number Missing
0057	Refill Indicator Invalid
0065	The number of passengers is invalid.
0066	Invalid wait time
0071	Invalid Void/Adjustment Reason Code
0077	Adjustment Denied - Original Payment Request Already Adjusted
0078	Void Denied - Original Payment Request Already Voided
0085	Admit Source Code Missing/Invalid
0098	Key Entry Error
0100	Invalid Mileage
0101	Date of Service After Date Payment Request Received
0103	Admission Date After Date Received
0104	Thru DOS is After Date Payment Request Received
0107	Surgical Procedure Omitted for O/R Charge
0109	Diagnosis Code Does Not Agree with Sex Code
0110	Diagnosis Code Does Not Agree with Age
0111	From Service Date After Thru Date
0112	Admit Date After From Date of Service
0113	ICD-9-CM Procedure/Sex Restriction
0116	Invalid/Missing Prescribing Physician Number

ESC	Error Description
0117	Invalid Service/Modifier Combination
0119	The statement covers period disagrees with the service units.
0129	Revenue Code Not Covered
0130	Billing Provider Number Not On File
0131	The first other procedure code is not in the correct format or not on file.
0133	Revenue Code Missing
0143	Enrollee Not Eligible on DOS
0144	Billing Provider Not Eligible on DOS
0146	The Procedure Code Billed is Not on File
0147	Procedure Code Not In Use on Service Date
0148	Rendering provider is not certified to perform procedure.
0153	Invalid Tooth Number/Procedure
0176	Bill Mother and Baby Separately
0178	Invalid Diagnosis Code
0179	Invalid Discharge Status for Type Bill
0183	Procedure Code Does Not Agree with Service
0186	Procedure code billed not compatible with enrollee's sex.
0201	Duplicate Payment Request - Same Provider, Same DOS
0202	Duplicate of History File Record - Different Provider, Same DOS
0211	Enrollee Less than Minimum Age
0212	Enrollee Greater Than Maximum Age
0231	Verify Enrollee Eligibility in HMO
0249	Duplicate Payment Request - Same Provider, Overlap DOS
0257	Length of Stay Exceeds Percentile Limit
0301	Duplicate Payment Request - Same Provider, Same DOS
0302	Duplicate of History Record - Same Provider, Same DOS
0305	Contraindicated Audit - Same Provider, Within 32 Days
0307	Drug Not Covered for Enrollee's Age 21 or Older
0318	Enrollee Not Eligible on DOS
0330	Duplicate of History File Record - Same Provider, Overlap DOS
0360	Contraindicated Audit - Same Provider, Same DOS
0374	Duplicate HMO Copay Payment Request
0394	Drug Not Covered
0396	Adjustment Denied - Original Payment Request Not on File
0397	Void Denied - Original Payment Request Not on File
0400	Duplicate Rx Number/Different Drug Code
0401	Charges exceed maximum allowance
0403	NDC Not Covered
0415	Servicing provider ID is not the approved provider.
0423	NDC Not on File, Check NDC
0435	Invalid Drug Code for Compound Rx
0448	Neonatal/Nurse Days not Allowed Patient Over 3 Yrs
0449	Adult and nursery/neonatal days are not allowed on the same pmt request
0451	Two Nursery Revenue Codes on Same Invoice
0452	Overlapping Program Eligibilities
0453	Enrolled in HMO or Encounter Claim for FFS
0461	Units/Visits/Studies Not Equal Days

ESC	Error Description
0464	Invalid Drug Code; Not a Compound
0482	Unable to Validate Enrollee in HMO
0493	Prescribing Physician Not on File
0706	Invalid Third Diagnosis
0707	Invalid Fourth Diagnosis
0708	Invalid Fifth Diagnosis
0709	Invalid Sixth Diagnosis
0710	Invalid Seventh Diagnosis
0711	Invalid Eighth Diagnosis
0712	Invalid Ninth Diagnosis
0713	Second Other Procedure Invalid
0714	Third Other Procedure Code Invalid
0715	Fourth Other Procedure Code Invalid
0716	Fifth Other Procedure Code Invalid
0717	First Other Procedure Date Is Missing or Invalid
0718	Second Other Procedure Date is Missing or Invalid
0719	Third Other Procedure Date is Missing or Invalid
0724	Admit Type is Missing or Invalid
0729	Servicing Provider Not on File
0731	Servicing Provider Not Eligible on DOS
0732	Servicing Provider Invalid
0733	Admitting Diagnosis Missing or Invalid
0734	Covered Days Entered Exceed Statement Period
0735	Invalid Procedure for Anesthesia
0736	Invalid Surface Code/Procedure
0739	Personal Care Begin Date > From DOS
0740	Same Procedure, Same Day, Different Modifiers
0747	Duplicate Payment Request - Different Provider, Overlap DOS
0748	Duplicate of History File Record - Different Provider, Overlapping DOS
0752	Missing HMO Claim Number
0753	Fourth Other Procedure Date is Missing or Invalid
0754	Fifth Other Procedure Date is Missing or Invalid
0756	Billing Provider is Not a Group Provider
0757	Servicing Provider Cannot Be a Group Provider
0758	Provider Cannot Bill as an Individual
0759	Inpatient Hospital Payment > $500,000
0820	Review Enrollee Birth Date
0821	Outpatient Days Billed Exceeds 1
0825	Limitation Audit - Once in a Lifetime, Any Provider - Deny
0826	Limitation Audit - Three in a Lifetime, Any Provider - Deny
0827	Unable to Assign Object Code
0828	Inpatient versus Outpatient, Possible Duplicate
0829	Inpatient versus Title 18, Possible Duplicate
0830	Outpatient versus Title 18, Possible Duplicate
0831	SNF versus Title 18, Possible Duplicate
0833	Transportation versus Title 18, Possible Duplicate
0838	Missing/Invalid PA Tran Request End Date

ESC	Error Description
0840	Quantity Dispensed > Intended Quantity
0841	Multiple Partial Fill Prescriptions Not Allowed
0842	Different NDC Between Partial & Completion Fill
0843	Intended Quantity Exceeds Maximum
0844	Missing/Invalid Associated Rx Number on Completion Transaction
0845	Missing/Invalid Associated DOS on Completion Transaction
0846	Associated Partial Fill Transaction Not On File
0847	Partial Fill Transaction Not Supported for Compounds
0848	Completion Transaction not Permitted with Same DOS as Partial
0849	Intended Days Supply Exceeds Maximum Allowed
0850	Intended Days Supply Missing or Invalid
0852	Intended Quantity Missing or Invalid
0853	Dispensing Status Missing or Invalid
0856	Missing/Invalid Basis of Request
0857	Missing/Invalid PA Tran Request Begin Date
0858	Bill Type 111/112 Admit Date Not = From Date
0866	Duplicate Provider, Rx #, and Date of Service
0871	Invalid Secondary Diagnosis
0874	Drug Daily Dose Exceeded
0875	Drug Total Dose Quantity Exceeded
0877	Same Cycle Reversal with Diff Media Not Allowed
0878	Early Refill Override Due to Increase in Dosage
0893	Days Supply for Partial Fill Components Exceeds Intended Days
0894	Quantity for Partial Fill Components Exceeds Intended Quantity
0902	Assistant Surgeon Modifier & Co-Surgeon Modifier Not Allowed On Same
0919	Inpatient versus Nursing Home - Possible Duplicate
0932	Related Component Radiology Procs Not Payable when Global Paid
0933	Components of Surgical Care Not Payable when Global Surgery Paid
0934	Umbrella Audit - Postpartum Visits, Same Provider
0936	Tooth/Procedure - Invalid Combination
0937	Limitation Audit - Twice in a Lifetime, Any Provider - Deny
0938	Limitation Audit - Four in a Lifetime, Any Provider - Deny
0939	Limitation Audit - Six in a Lifetime, Any Provider - Deny
0940	Limit Audit - Only One New Patient Medical Visit per Lifetime
0954	Inpatient versus Outpatient, Same Provider
0970	Enrollee Not Enrolled in a Covered Plan for This Service on the DOS
0970	Enrollee Not Enrolled in a Covered Plan for This Service on the DOS
0971	Enrollee in Plan that Provider is Not
0979	Duplicate Ingredient(s) on Compound Claim Not Paid
0983	Enrollee not on File
0986	DRG Rate Not On File
0990	Revenue Code Not on File
0991	Revenue Code Not Valid for Dates of Service
0992	Revenue Code Not Valid for Enrollee's Age
0993	Revenue Code Not Valid for Enrollee's Sex
0994	Revenue Code Not Valid for Provider Type, Specialty
0995	Revenue HCPCS Not on File

ESC	Error Description
0996	Revenue HCPCS Not Valid for Dates of Service
1008	Wheelchair Van Passenger Limit Exceeded
1009	Mileage Limit or Charge Exceeded
1470	More than 30 Errors
1503	Negative PA on File/Physician Must Approve for PA
1505	Angiotensin Receptor Blockers - Non PDL, PA Required
1506	ACE Inhibitor - Non PDL, PA Required
1507	ACE Inhibitor/Calcium Channel Blocker Combo - Non PDL, PA Required
1509	Nondihydropryidine Calcium Channel Blockers - Non PDL, PA Required
1510	Proton Pump Inhibitor Non PDL
1511	Sedative Hypnotics - Non PDL, PA Required
1512	Beta Adrenergic Agent - Non PDL, PA Required
1515	Beta Blockers - Non PDL, PA Required
1516	Cholesterol Lowering Drugs (Statins) - Non PDL, PA Required
1517	Inhaled Corticosteroids - Non PDL, PA Required
1518	Nasal Steroids - Non PDL, PA Required
1519	COX-II Inhibitors - Non PDL, PA Required
1520	Low Sedating Antihistamines - Non PDL, PA Required
1521	Histamine 2 Receptor Antagonist - Non PDL, PA Required
1522	Oral Hypoglecemics - PDL PA Required
1523	Leukotriene Modifiers - PDL PA Required
1524	NSAID - PDL PA Required
1525	Bisphosphonates - PDL PA Required
1526	Oral Antifungals for Onychomysis - PDL PA Required
1527	Serotonin Receptor Agonists - PDL PA Required
1528	Cephalosporins - PDL PA Required
1529	Macrolides - PDL PA Required
1530	Quinolones - PDL PA Required
1531	Glaucoma Agents - PDL PA Required
1532	CNS Stimulant/ADHD Medications - PDL PA Required
3500	Dummy Edit for Newborn Encounters

1.4.5 Encounter Exception Error Code List

This section has been eliminated effective 07/01/2015.

Error (ESC) codes that were previously listed here have now been transferred to the new 'Encounter Data Quality' (EDQ) process (MCTM 1.5).

Effective 07/01/2015, all encounter data quality issues will be tracked via the new EDQ process.

1.5 Encounter Data Quality (EDQ) Process

The DMAS Encounter Data Quality (EDQ) process described in this section is effective for all encounters submitted July 1, 2015 and after. EDQ supersedes the encounter requirements and reporting used in prior contract cycles.

The goals of EDQ are as follows:

- Define and document each critical encounter data quality issue
- Identify and report encounter data issues when they occur
- Prioritize each MCOs' efforts to resolve and correct encounter issues
- Ensure that each encounter that has a critical data quality issue is corrected in a timely manner
- Integrate encounter processing requirements with DMAS' Compliance Monitoring Process (CMP)

Two categories of issues are identified and reported to the MCOs. Each issue represents a specific measurable encounter data requirement:

- Critical Issues – MCOs must correct each Critical Issue that is identified by DMAS on an encounter. All Critical Issues are subject to CMP penalties.
- Emerging Errors – MCOs should attempt to correct these issues, but DMAS will not be tracking these corrections. Emerging Issues are not subject to CMP penalties.

DMAS monitors and evaluates the Emerging Issues on an ongoing basis for volume and impact to operations. The Emerging Issues are used as a staging area for Critical Issues. DMAS will evaluate new issues as Emerging Issues prior to designating them as a Critical Issue. For each Emerging Issue, DMAS will provide an anticipated 'Implementation Date' indicating when the issue will be moved to the Critical Issue category. This allows the MCO to evaluate potential impacts and to prioritize their remedial efforts.

Component	Critical Issue	Emerging Issue
Compliance	Subject to CMP assessment	Not subject to CMP
Correction	Must be corrected by MCO	MCO should attempt to correct
DMAS Tracking	Issues are reported until corrected by MCO	Reported for current month only DMAS does not track corrections
Disposition	Issues remain on the Critical list indefinitely and are continuously evaluated	May eventually be promoted to 'Critical' or may be removed from list altogether
Report Level	Reported at Issue level (i.e. multiple ESC may be rolled up to a single Critical Issue)	Reported individually by ESC/ error condition to provide more granularity for evaluation

1.5.1 DMAS Reporting

DMAS will generate several EDQ deliverables for each MCO. Reports are generated weekly on Mondays and reflect month to date encounter processing. The calendar monthly reporting period is based on the date each file was submitted by the MCO and received by the State's fiscal agent processor (as confirmed by MCN assignment).

- Critical Issue Report – A summary exception report showing any current month Critical Issues. This report also shows any Critical Issues submitted in prior months that have yet to be corrected by the MCO.

- Critical Issue Detail File – A data file that lists every encounter with one or more Critical Issues. Each issue is reported as a separate record. The detail file matches what is reported on the Critical Issue Report. This file includes all data elements required for the MCO to identify the specific issue and the type of issue.

- Emerging Issue Report – A summary exception report showing any Emerging Issues that occurred for the current month. This report does not include any prior month issues.

- Emerging Issue Detail File – A data file that lists every encounter with one or more Emerging Issues. Each issue is reported as a separate record. The detail file matches what is reported on the Emerging Issue Report. This file includes all data elements required for the MCO to identify the specific issue and the type of issue. Encounters may appear on the Critical and Emerging detail files if the encounter contains errors from both categories.

Refer to sections 1.5.2 through 1.5.4 of this document for detailed specifications for each of these deliverables.

In order to be included in the EDQ reporting process, an encounter must meet all of the following criteria:

- Must represent a 'paid' claim as identified by the MCO.
- Must be an original, replacement, or failed void.
- Must be fully adjudicated by the MMIS as of the report date (including extraction to the DMAS data warehouse).

1.5.2 Compliance and Corrections

Each month, DMAS will use the final end of month (EOM) EDQ Critical Error Report to determine if there are any outstanding compliance violations for the MCO for the month. The EOM Critical Issue report reflects all encounters submitted for the current calendar month.

Each issue (report line) on the EDQ Critical Issue Report represents a compliance violation. Refer to the Medallion 3.0 contract 'Compliance Monitoring Process' section (13.2) for further details about assessment and tracking of compliance penalties.

Compliance violation penalties will be assessed only once per month based on the content of the final EOM report. Note that each unique issue is counted only once per calendar month, even if the same issue occurs in multiple weeks and /or files.

The MCO must correct all Critical Issues that are listed on the EDQ Critical Issue Report, unless otherwise instructed by DMAS. DMAS will track and report every encounter with a Critical Issue until it has been corrected.

In order for a Critical Issue to be considered 'corrected', the MCO must submit a void or replacement transaction that causes that encounter record to be successfully voided (or credited) in the MMIS encounter history. DMAS prefers for MCOs to use replacement transactions for corrections instead of voids whenever possible. If the MCO chooses to use void transactions, then the MCO must also submit a corrected original encounter after the void has been successfully applied in the MMIS.

1.5.3 Critical Issues

This section provides a detailed description of each current Critical Issue. The Managed Care Technical Manual will be updated throughout the year as new Critical Issues are implemented.

Issues may represent ESC codes, data fields, Internal edits (edits outside of the MMIS), or other contractual requirements. A single Critical Issue may represent multiple ESC codes or Internal error codes.

The chart below shows an implementation schedule for Critical Issues and anticipated Critical Issues (Emerging Issues that will be promoted to the Critical Issue list).

IMPLEMENTATION SCHEDULE Critical Issues				
Scheduled Implementation Date	**Implementation Date**	**EDQ Category**	**ESC/Internal Error**	**Section Reference**
07/01/2015	07/01/2015	Lag Days	Not applicable	1.5.3.1
10/01/2015	10/01/2015	Enrollment	0004, 0983	1.5.4.5
Anticipated Critical Issues				
12/01/2015		Date	I011, I014, I024	1.5.4.3
12/01/2015		M/I Value	I012, I015, I017, I022, I102, I103, I103, I105, I106	1.5.4.6
12/01/2015		Provider	I020	1.5.4.7

1.5.3.1 Lag Days

Description	Failure to meet the contractual requirement for timely reporting of encounter data to DMAS
Implementation Date	07/01/2015
Contract	Medallion 3.0, Section 11.5.C
Criteria	For each encounter, the lag days are calculated as the difference between the MCO's payment date (provided by the MCO on each encounter record) and the date that the file was submitted to DMAS (based on the Julian date from the MCN number assigned by Xerox when the EDI file is received). Calculation of the percentage = Encounters that met the timeliness threshold divided by total encounters submitted for the month. Encounters with missing or invalid MCO payment dates are assigned a default lag

	days value of 9999 and included in the 'Fail' count for reporting purposes. The timeliness requirement is applied only to original encounters. It is not applied to voids or adjustments. This requirement is assessed as a whole for all encounters and not by individual transaction type.
Correction	MCO is not required to correct encounter records for this issue.
Updates	N/A

1.5.3.2 Enrollment

Description	Error related to member's enrollment / eligibility
Implementation Date	10/01/2015
Contract	Medallion 3.0, Section 11.5
Criteria	One or more encounters receiving one or more of the following ESC codes: **0004 Invalid Or Missing** • Medicaid member ID is missing (spaces or zeros) or not numeric. **0983 Enrollee not on File** • Medicaid member ID is not on the DMAS MMIS Member database • This edit is bypassed for encounters that are using the instructions in section 1.3.9 for newborns. **NEWBORNS WITHOUT MEDICAID MEMBER IDS** See section 1.3.9 in this document for instructions on how to submit a newborn encounter when the newborn does not have a Medicaid member id. When using this procedure, the newborn member id (mother 9-digit id + 3 digit original sequence number) will not be found on the DMAS MMIS Member database and ESC 0983 will be bypassed. (These encounters may receive ESC 1500 to flag the encounter as having a fabricated member id to bypass ESC 0983.)
Correction	MCO must correct all encounters identified by MMIS with one or more of these ESC values. Void/replacement transactions must be successfully processed by the MMIS for the issue to be considered corrected. If possible, a replacement transaction should be used to correct issues for tracking purposes. However, DMAS will accept separate void and original replacement transactions if necessary.
Updates	10/01/2015

1.5.4 Emerging Issues

1.5.4.1 Pharmacy Rebates

Description	Encounter data quality errors that affect DMAS' ability to collect pharmacy rebates
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 7.2.S.I
Criteria	One or more encounters receiving one or more of the following ESC codes or errors: **0044 NDC Missing Or Not In Valid Format:** • NCPDP: If NDC is missing or not 11 digits numeric. • NCPDP Compound: NDC must be zeroes in the primary NDC field. Ingredient NDCs are entered individually in the compound portion. • 837I: If Bill Type '13X' and provider type '001', '014', '085', '091' and revenue code is between 0250-0259 or 0630-0639 and NDC is missing. • 837P: If Jcode was submitted and NDC is missing, or NDC is present and is not at least 10 digits. • 837P: If procedure code requires NDC and NDC is missing or NDC is present and is not at least 10 digits. **0045 Invalid Metric Quantity** • If the metric decimal quantity field is not present, not numeric, or not greater than zero, set the edit. **0467 M/I Product/Service ID Qualifier** • 837P/837I: If Product / Service qualifier is not "99". • NCPDP: If Product / Service qualifier is not "00" or "03". • NCPDP: If Product / Service qualifier is "00" and the compound indicator is not "2". • NCPDP: If Product / Service qualifier is not "03" and the compound indicator is "2". **0023 Units of Service Missing or Not in the Valid Format** **0423 NDC Not On File, Check NDC** **Valid MCO Payment Date (must be populated with a valid date, date must be greater than or equal to Date of Service)** **Invalid MCO Payment Amount (Value may be = 0 in special cases)** **Drug unit of measure - 837 only (valid values are F2, GR, ME, ML, UN)** **Drug unit/quantity (must be an appropriate value for NDC)**
Correction	MCO must correct all encounters identified by MMIS with one or more of these ESC values. Void/replacement transactions must be successfully processed by the MMIS for the issue to be considered corrected. If possible, a replacement transaction should be used to correct issues for tracking purposes. However, DMAS will accept separate void and original replacement transactions if necessary.

Updates	N/A

1.5.4.2 Adj/ Void

Description	Successful processing of adjustment and void transaction submitted by the MCO in MMIS
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 11.5
Criteria	One or more encounters receiving one or more of the following ESC codes: 0071 Invalid Void/Adjustment Reason Code 0077 Adjust Denied - Original Already Adjust 0078 Void Denied - Original Already Voided 0396 Adjust Denied- Orig Pmt Req Not On File 0397 Void Denied - Orig Pmt Req Not On File 0752 Missing HMO Claim Number 0877 Same Cycle Rev w Diff Media Not Allow
Correction	MCO must correct all encounters identified by MMIS with one or more of these ESC values. Void/replacement transactions must be successfully processed by the MMIS for the issue to be considered corrected. If possible, a replacement transaction should be used to correct issues for tracking purposes. However, DMAS will accept separate void and original replacement transactions if necessary.
Updates	N/A

1.5.4.3 Date

Description	Error in a date field on a 'paid' encounter
Anticipated Implementation Date	**12/01/2015**
Contract	Medallion 3.0, Section 11.5
Criteria	One or more 'paid' encounters receiving one or more of the following Internal error codes: **I011 From DOS is greater than Thru DOS** **I014 From DOS is greater than MCO Payment Date** **I024 MCO payment date is more than 3 years old**
Correction	MCO must correct all encounters identified by MMIS with one or more of these ESC values. Void/replacement transactions must be successfully processed by the MMIS

	for the issue to be considered corrected. If possible, a replacement transaction should be used to correct issues for tracking purposes. However, DMAS will accept separate void and original replacement transactions if necessary.
Updates	10/01/2015

Description	Error in a date field on a 'paid' encounter
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 11.5
Criteria	One or more 'paid' encounters receiving one or more of the following ESC or Internal error codes: 0025 Service 'Thru' Date Missing/Invalid 0101 Date Of Svc After Date Pmt Req Rcvd 0103 Admission Date After Date Received 0104 Thru DOS Is After The Date Pmt Req Rcvd 0111 From Service Date After Thru Date 0112 Admit Date After The From Date Of Svc 0328 Srvices Incurred Prior To Coverage 0404 Invalid Service Vendor For Date Of Svc 0858 Bill Type 111/112 Adm Dt Not=From Date I023 From DOS is more than 3 years old
Correction	MCO must correct all encounters identified by MMIS with one or more of these ESC values. Void/replacement transactions must be successfully processed by the MMIS for the issue to be considered corrected. If possible, a replacement transaction should be used to correct issues for tracking purposes. However, DMAS will accept separate void and original replacement transactions if necessary.
Updates	10/01/2015

1.5.4.4 Duplicate

Description	Duplicate service paid by the MCO
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 11.5
Criteria	One or more encounters receiving one or more of the following ESC codes:

	0201 Duplicate - Diff Prov, Same DOS 0202 Duplicate History - Diff Prov, Same DOS 0301 Duplicate - Same Provider, Same DOS 0302 Duplicate History - Same Prov, Same DOS 0330 Duplicate Hist - Same Prov, Overlap DOS 0866 Duplicate Provider, Rx # and Dt of Svc 0979 Duplicate Ingred on Compound Clm Not Pd 1254 Same Procedure, Same Day, Different Mod 1255 Same Procedure, Same Day, Different Mod 1335 Duplicate - Same Prov, Same DOS 1336 Duplicate - Same Provider, Same DOS 1337 Duplicate - Same Provider, Same DOS 1338 Duplicate - Different Prov, Same DOS 1339 Duplicate - Different Prov, Same DOS 1340 Duplicate - Different Prov, Same DOS 1341 Duplicate - Different Prov, Same DOS 1342 Duplicate - Same Provider, Overlap DOS 1343 Duplicate - Same Provider, Overlap DOS 1344 Duplicate - Same Provider, Overlap DOS 1345 Duplicate - Different Prov, Overlap DOS 1346 Duplicate - Different Prov, Overlap DOS 1347 Duplicate - Different Prov, Overlap DOS 1348 Duplicate - Different Prov, Overlap DOS 1349 Duplicate - Same Provider, Same DOS 1350 Duplicate - Different Prov, Same DOS 1351 Duplicate - Same Provider, Overlap DOS 1352 Duplicate - Different Prov, Overlap DOS 1353 Duplicate - Same Provider, Same DOS 1354 Duplicate - Different Prov, Same DOS 1355 Duplicate - Same Provider, Overlap DOS 1356 Duplicate - Different Prov, Overlap DOS 1435 Duplicate History - Same Prov, Same DOS 1436 Duplicate History - Same Prov, Same DOS 1437 Duplicate History - Same Prov, Same DOS 1438 Duplicate History - Diff Prov, Same DOS 1439 Duplicate History - Diff Prov, Same DOS

	1440 Duplicate History - Diff Prov, Same DOS 1441 Duplicate History - Diff Prov, Same DOS 1442 Duplicate History-Same Prov,Overlap DOS 1443 Duplicate History-Same Prov,Overlap DOS 1444 Duplicate History-Same Prov,Overlap DOS 1445 Duplicate History-Diff Prov,Overlap DOS 1446 Duplicate History-Diff Prov,Overlap DOS 1447 Duplicate History-Diff Prov,Overlap DOS 1448 Duplicate History-Diff Prov,Overlap DOS 1459 Duplicate History-Same Prov, Same DOS 1460 Duplicate History-Diff Prov, Same DOS 1461 Duplicate History-Same Prov,Overlap DOS 1462 Duplicate History-Diff Prov,Overlap DOS 1463 Duplicate History - Same Prov, Same DOS 1464 Duplicate History - Diff Prov, Same DOS 1465 Duplicate History-Same Prov,Overlap DOS 1466 Duplicate History-Diff Prov,Overlap DOS
Correction	MCO must correct all encounters identified by MMIS with one or more of these ESC values. Void/replacement transactions must be successfully processed by the MMIS for the issue to be considered corrected. If possible, a replacement transaction should be used to correct issues for tracking purposes. However, DMAS will accept separate void and original replacement transactions if necessary.
Updates	N/A

1.5.4.5 Enrollment

Description	Error related to member's enrollment / eligibility
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 11.5
Criteria	One or more encounters receiving one or more of the following ESC codes: 0143 Enrollee Not Eligible on DOS 0318 Enrollee Not Eligible on DOS 0970 Enrollee Not Covered In Plan on DOS
Correction	MCO must correct all encounters identified by MMIS with one or more of these ESC values. Void/replacement transactions must be successfully processed by the MMIS for the issue to be considered corrected.

	If possible, a replacement transaction should be used to correct issues for tracking purposes. However, DMAS will accept separate void and original replacement transactions if necessary.
Updates	N/A

1.5.4.6 M/I Value

Description	Missing or invalid value in required field on a 'paid' encounter
Anticipated Implementation Date	**12/01/2015**
Contract	Medallion 3.0, Section 11.5
Criteria	One or more encounters receiving one or more of the following Internal error codes: **I012 From DOS is missing** **I015 MCO Payment Date is missing** **I017 Billed Charge Amount is missing** **I022 Procedure Code is missing - 837P** **I102 NDC is missing - NCPDP** **I103 Bill Type is missing – UB92** **I105 Units are zero – 837P/837I** **I106 Units are zero - NCPDP**
Correction	MCO must correct all encounters identified by MMIS with one or more of these ESC values. Void/replacement transactions must be successfully processed by the MMIS for the issue to be considered corrected. If possible, a replacement transaction should be used to correct issues for tracking purposes. However, DMAS will accept separate void and original replacement transactions if necessary.
Updates	10/01/2015

Description	Missing or invalid value in required field on a 'paid' encounter
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 11.5
Criteria	One or more encounters receiving one or more of the following ESC or Internal error codes: 0006 Invalid Patient Account Number 0012 Invalid Procedure Code 0014 Billed Amount Missing Or Invalid

	0023 Units Missing/Not In Valid Format 0028 Admit Date Missing/Invalid 0030 Primary Diag Not On File/Invalid 0038 Invalid Place Of Treatment Code 0041 Invalid Procedure Modifier 0055 Type Of Bill Missing Or Invalid 0100 Invalid Mileage 0133 Revenue Code Missing 0146 Procedure Code Not On File 0147 Procedure Code Not In Use On Svc Date 0178 Invalid Diagnosis Code 0681 Invalid CAS Adjustment Reason 0724 Admit Type is Missing or Invalid 0733 Admitting Diagnosis Missing Or Invalid 0773 Conflicting CAS Adjustment Reasons 0995 Revenue HCPCS Not On File I104 Diagnosis Code missing – 837P/837I
Correction	MCO must correct all encounters identified by MMIS with one or more of these ESC values. Void/replacement transactions must be successfully processed by the MMIS for the issue to be considered corrected. If possible, a replacement transaction should be used to correct issues for tracking purposes. However, DMAS will accept separate void and original replacement transactions if necessary.
Updates	10/01/2015

1.5.4.7 Provider

Description	Servicing provider-related error on a ‘paid’ encounter
Anticipated Implementation Date	**12/01/2015**
Contract	Medallion 3.0, Section 11.5
Criteria	One or more encounters receiving one or more of the following Internal error codes: **I020 MCO NPI has been submitted as Servicing Provider NPI**
Correction	MCO must correct all encounters identified by MMIS with one or more of these ESC values. Void/replacement transactions must be successfully processed by the MMIS for the issue to be considered corrected. If possible, a replacement transaction should be used to correct issues for tracking purposes. However, DMAS will accept separate void and original replacement transactions if necessary.

Updates	10/01/2015

Description	Servicing provider-related error on a 'paid' encounter
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 11.5
Criteria	One or more encounters receiving one or more of the following ESC or Internal error codes: 0003 Invalid Billing Provider Number 0732 Servicing Provider Invalid 1357 NPI Servicing Provider Not on File 1364 Service NPI Not Found On Claim 1393 No Srvc Taxonomy Code On The Claim I018 Servicing Provider zip code is Invalid • Servicing Provider is "000000000" or "00000 " or "999999999" or "99999 "
Correction	MCO must correct all encounters identified by MMIS with one or more of these ESC values. Void/replacement transactions must be successfully processed by the MMIS for the issue to be considered corrected. If possible, a replacement transaction should be used to correct issues for tracking purposes. However, DMAS will accept separate void and original replacement transactions if necessary.
Updates	10/01/2015

1.5.4.8 340B Providers

Description	Pharmacy encounters submitted by 340 Providers
Anticipated Implementation Date	TBD
Contract	Medallion 3.0, Section 7.2.S.I
Criteria	MMIS Associated edits for 340B drugs: • 1620: Missing/invalid Submission Clarification Code. • 1621: Pharmacy is not authorized for 340B pricing. • 1622: Invalid combination of Basis of Cost and Submission Clarification Code.
Correction	TBD
Updates	N/A

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2 Enrollment Roster & Payment Files

2.1 Enrollment Roster (834)

For each month of coverage throughout the term of the Contract, the Department shall post an Enrollment Roster to DMAS' secure FTP EDI server using the 834 electronic data interchange (EDI) transaction set to the Contractor. Unless otherwise notified by the Department, these files will be available on the 20th (mid-month) and 2nd (end of month) of each calendar month. The 834 Enrollment Roster shall provide the Contractor with ongoing information about its active and disenrolled members.

The 834 Mid-Month and End of the Month rosters will list all of the Contractor's members for the prospective enrollment month as of the report generation date. The Mid-Month 834 will be provided to the Contractor on the twentieth (20th) day of the month prior to member enrollment. The End of the Month Enrollment Report will be provided to the Contractor on the second (2nd) day of the current member enrollment month.

ELIGIBILITY CUT-OFF	MID-MONTH 834 RUN	MID-MONTH 834 AVAILABILITY	END OF MONTH 834 RUN	END OF MONTH 834 AVAILABILITY
07/16/2015 Thu	07/18/2015 Sat	07/20/2015 Mon	07/31/2015 Fri	08/02/2015 Sun
08/16/2015 Sun	08/18/2015 Tue	08/20/2015 Thu	08/31/2015 Mon	09/02/2015 Wed
09/16/2015 Wed	09/18/2015 Fri	09/20/2015 Sun	09/30/2015 Wed	10/02/2015 Fri
10/16/2015 Fri	10/18/2015 Sun	10/20/2015 Tue	10/31/2015 Sat	11/02/2015 Mon
11/16/2015 Mon	11/18/2015 Wed	11/20/2015 Fri	11/30/2015 Mon	12/02/2015 Wed
12/16/2015 Wed	12/18/2015 Fri	12/20/2015 Sun	12/31/2015 Thu	01/02/2016 Sat
01/16/2016 Sat	01/18/2016 Mon	01/20/2016 Wed	01/31/2016 Sun	02/02/2016 Tue
02/16/2016 Tue	02/18/2016 Thu	02/20/2016 Sat	02/29/2016 Mon	03/02/2016 Wed
03/16/2016 Wed	03/18/2016 Fri	03/20/2016 Sun	03/31/2016 Thu	04/02/2016 Sat
04/16/2016 Sat	04/18/2016 Mon	04/20/2016 Wed	04/30/2016 Sat	05/02/2016 Mon
05/16/2016 Mon	05/18/2016 Wed	05/20/2016 Fri	05/31/2016 Tue	06/02/2016 Thu
06/16/2016 Thu	06/18/2016 Sat	06/20/2016 Mon	06/30/2016 Thu	07/02/2016 Sat

2.2 Capitation Payment Remittance (820)

The 820 Capitation Payment file will list all of the members for whom the Contractor is being reimbursed in the current weekly payment cycle. For current month enrollments, the 820 is processed on the last Friday of the calendar month, and is available to the Contractor on the following Monday. The file includes individual member month detail. The 820 includes current and retroactive capitation payment adjustments.

2.2.1 Capitation Payment Remittance (820) Schedule

CAPITATION 820 RUN	CAPITATION 820 AVAILABILITY	CAPITATION CHECK DATE
07/31/2015 Fri	08/03/2015 Mon	08/07/2015 Fri
08/28/2015 Fri	08/31/2015 Mon	09/04/2015 Fri
09/25/2015 Fri	09/28/2015 Mon	10/02/2015 Fri
10/30/2015 Fri	11/02/2015 Mon	11/06/2015 Fri
11/27/2015 Fri	11/30/2015 Mon	12/04/2015 Fri
12/25/2015 Fri	12/28/2015 Mon	01/01/2016 Fri
01/29/2016 Fri	02/01/2016 Mon	02/05/2016 Fri
02/26/2016 Fri	02/29/2016 Mon	03/04/2016 Fri
03/25/2016 Fri	03/28/2016 Mon	04/01/2016 Fri
04/29/2016 Fri	05/02/2016 Mon	05/06/2016 Fri
05/27/2016 Fri	05/30/2016 Mon	06/03/2016 Fri
06/24/2016 Fri	06/27/2016 Mon	07/01/2016 Fri

2.2.2 Capitation Payment Remittance (820) – "Best Practices" in Reconciliation

- If the MCO receives payment on the 820 file for a member that was not listed on the previous 834 enrollment file, the member is retroactively enrolled to the MCO for the dates listed.

- If the MCO receives a retraction of payment on the 820 file, the member is retroactively terminated for the dates listed.

- If a member is listed on the 834 enrollment file but no payment is received for the member on the 820 file, the member should not be terminated. The MCO must research the member on the DMAS eligibility website. If the member is no longer eligible on the website, the MCO will terminate the member. However, if the member still is shown as active on the website, the member will not be terminated.

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3 MCO Contract Deliverables

3.1 Reporting Standards

Beginning with the contract cycle starting on July 1, 2013, DMAS will no longer require use of the Excel template for monthly report submissions. Files previously submitted via the Excel template are now to be submitted as separate comma separated value (CSV) files. Refer to the detailed specifications provided for each report in this section.

DMAS **strongly recommends** that the MCOs develop automated reporting processes for each deliverable in order to maintain the consistency and accuracy of ongoing deliverable submissions. It has been DMAS' experience that manual reporting processes are prone to errors and inconsistencies. DMAS also recommends that each MCO develop and implement standardized processing for each deliverable submission, including comprehensive quality control procedures.

All deliverable submissions must conform to the specifications documented in the current versions of this Technical Manual, including all documented formatting requirements. It is the MCO's responsibility to comply with these specifications. Any submission that does not comply with these specifications may be rejected by DMAS in total or in part. The MCO will be required to correct and re-submit deliverables as necessary to comply with the reporting requirements set forth in this document.

DMAS will post the current version of the Managed Care Technical Manual on the Virginia Medicaid Managed Care web site, and also in the report directory of the DMAS secure FTP server. The version number of the Managed Care Technical Manual will be incremented whenever any change is made within the document. Every change will be documented in the 'Version Change Summary' section at the front of the document.

The Managed Care Technical Manual will be updated no more frequently than monthly. The revised Managed Care Technical Manual will be posted to the Managed Care web site and to the FTP server no later than the last calendar day of each month. The MCOs must check the web site or server at the beginning of each month to ensure that they are using the most current version of the program specs for their next submission to DMAS.

3.1.1 DMAS Secure FTP Server

DMAS has established a secure FTP server to facilitate transfer of files with the MCOs. Each MCO has their own secure login and dedicated folders on the DMAS report server. Each MCO can have one and only one login / account. The login account for new MCOs will be set up as part of the Department's standard implementation process for new MCOs, usually one to two months prior to go live.

Within the MCO's folder, there are two subfolders: TO-DMAS and FROM-DMAS. Any files sent from DMAS to the MCO will be in the FROM-DMAS folder. Any files that the MCO is submitting to DMAS should be placed in the TO-DMAS folder. The server is swept daily at 6:00 PM EST, and any files in the TO-DMAS folder are moved to DMAS' local intranet server for user retrieval.

When the files are moved to the DMAS' local intranet server, the system assigns a prefix to the MCO file that allows DMAS to identify which MCO sent the file. The system also assigns a date and time stamp within the filename prefix that identifies when the file was originally posted to the server by the MCO.

3.1.2 Deliverable Scoring

DMAS will evaluate each deliverable submission and assign a numeric score based on the whether the submission meets all of the reporting parameters specified for that deliverable in this document. Scoring will be on a 100 point scale. The grading scale is as follows:

A: >=91
B: >=81 and <91
C: >=71 and <81
D: >=61 and <71
F: <61
0: = 0

3.1.2.1 Transmittal Requirements

Any deliverable submission that does not meet the basic transmittal requirements set forth for the deliverable will be scored as a zero. In particular, each of the following requirements must be met in order for a submission to be accepted by DMAS for processing:

- Submission must be transmitted via the method specified for the deliverable (e.g., DMAS secure FTP).
- File must be formatted as specified for the deliverable (e.g., comma separated values, Excel 2007, Adobe PDF).
- The filename on the report must exactly match the filename specified for the deliverable (including extension).
- All columns / fields specified for the deliverable must be included in the submission in the order specified, and no additional columns/ fields are included. Do not include a header row in .csv files. If there is no data to report for a specific report, submit the report but leave it blank without headers or any other text.
- Except as otherwise specified, only one consolidated deliverable per report cycle is submitted. The MCO cannot submit separate deliverables for their subcontractor(s).

3.1.2.2 Timeliness

Points will be deducted if the deliverable is submitted after the specified due date. For each business day late, the overall score will be reduced by ten (10) points. Note that the cut-off for delivery via the DMAS secure FTP is 6:00 PM EST each day.

3.1.2.3 Field-Level Editing

All deliverables that meet the Transmittal Requirements will be edited for compliance with the specific field-level format and content criteria specified for the particular report. Additional scoring deductions will be applied based on the criteria specified for the report.

3.1.2.4 Report Card Generation Schedule

The standard schedule for generation of the report cards is as follows:

- Preliminary report cards are generated on the morning of the 15th and returned to the MCOs via FTP in the mid-day batch transfer. This allows several hours for the MCO to make corrections if necessary and re-submit prior to the cut-off at close of business on the 15th.

- Report cards are generated again on the morning of the 16th using the most recent MCO submissions received via the batch transfer process. These report cards are returned to the MCOs via FTP in the mid-day batch transfer. If the MCO did not resubmit any deliverables, their scores will be the same as the report generated previously on the 15th. This is the first 'official' report card.
- On the 16th, the MCO can submit correction (replacement) file(s) if desired. However, note that when a deliverable is submitted or re-submitted after the cut-off on the 15th, the grade for that deliverable on the report card will be adjusted according to the editing and timeliness criteria specified above. It is DMAS' intent for all reports to be submitted according to the specified standards prior to the deadline on the 15th as specified in the Medallion 3.0 contract.
- DMAS will run the report card generation process up to a total of 5 business days in order to collect all corrections submitted by the MCOs. The report grades are not final until the end of this period or until all MCOs have completed all submissions (whichever is earlier).
- Report cards are not generated on weekends or state holidays. The delivery schedule is adjusted accordingly for these events. For example, if the 15th falls on a Sunday, deliverables are not due until close of business on the 16th.

3.1.3 Creating Comma Separated Value (CSV) File Using Excel

Comma-delimited files are text files in which data is separated by commas. Listed below are instructions on how to manually create .csv files from Excel.

- Open your Excel file in Excel.
- Choose ‘Save As’ from the Office Button in the top upper left of the application window.
- Select ‘CSV (Comma Delimited) (*.csv)’ as the type.
- Enter the file name in the ‘File Name’ box.
- Click ‘Save’.

3.2 Monthly Deliverables

Unless otherwise noted, the reporting period for all monthly reports is the previous calendar month. For example, the deliverables submitted on February 15th should include activity occurring during the reporting period from January 1st through the 31st. Certain reports reflect different reporting periods, and these exceptions are defined in the detailed reporting specifications for that deliverable.

3.2.1 Enrollment Broker Provider File

3.2.1.1 Contract Reference

Medallion 3.0 Contract, Section 3.2.D

FAMIS Contract, Section 3.2.D

3.2.1.2 File Specifications

Field	Specifications	Type	Beg	End
MCO Code	Required	NUM(10)	1	10
Action Ind	Required. Valid values are A (active) and D (delete)	CHAR(01)	11	11
Clinic/PCP Ind	Required. Valid values are P (PCP) and C (Clinic)	CHAR(01)	12	12
Provider Number	Value must be unique per provider and office location	CHAR(15)	13	27
Program Code	Required-Default value is M2	CHAR(02)	28	29
Provider Last Name	Required	CHAR(30)	30	59
Provider First Name	Required	CHAR(30)	60	89
Address Line 1	Required	CHAR(30)	90	119
Address Line 2		CHAR(30)	120	149
City	Required	CHAR(30)	150	179
Zip Code	Required	NUM(09)	180	188
Phone Area Code		NUM(03)	189	191
Phone Number		NUM(07)	192	198
Phone Extension		NUM(04)	199	202
Office Hours		CHAR(25)	203	227
Specialty Code	C=Clinic F=Family G=General I=Internist O=OB/GYN P=Pediatrics X=Other	CHAR(01)	228	228
Language 1	SP=Spanish GR=German FR=French IT=Italian RS=Russian	CHAR(02)	229	230
Language 2		CHAR(02)	231	232
Language 3		CHAR(02)	233	234
Language 4		CHAR(02)	235	236
Language 5		CHAR(02)	237	238

Method: As specified by DMAS' Managed Care Enrollment Broker

Format: As specified by DMAS' Managed Care Enrollment Broker

File Name: As specified by DMAS' Managed Care Enrollment Broker

Trigger: Monthly

Due Date: As specified by DMAS' Managed Care Enrollment Broker

DMAS: Managed Care Enrollment Broker

3.2.1.3 Requirements

As specified above. Must conform to requirements provided by DMAS current enrollment broker (Maximus)

3.2.1.4 Examples

N/A

3.2.1.5 Scoring Criteria

N/A

3.2.2 MCO Claims Report

3.2.2.1 Contract Reference

Medallion 3.0 Contract, Section 4.4

FAMIS Contract, Section 4.4

3.2.2.2 File Specifications

Field Description	Specifications
Month Begin Claims Inventory	Value must be ≥ 0
Claims Received This Month	Value must be ≥ 0
Claims Processed (Paid Or Denied) This Month	Value must be ≥ 0
Number Of Claims Paid This Month	Value must be ≥ 0
Number Of Claims Denied This Month	Value must be ≥ 0
Number Of Claims Pended This Month	Value must be ≥ 0
Claims Processed This Month: PMT DT - Receipt DT < 30	Value must be ≥ 0
Claims Processed This Month Within 31-90 Days Of Receipt	Value must be ≥ 0
Claims Processed In 91-365 Days	Value must be ≥ 0
Claims Processed Over 365 Days	Value must be ≥ 0
Number of Inpatient Authorizations Approved	Value must be ≥ 0
Number of Inpatient Authorizations Limited	Value must be ≥ 0
Number of Inpatient Authorizations Denied	Value must be ≥ 0
Number Of PCPs With Open Panels	Value must be ≥ 0
Number Of PCPs With Closed Panels	Value must be ≥ 0
Number Of PCPs With Restricted Panels	Value must be ≥ 0

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file (a template of this report format, named MCO_RPT_FMT is available in the forms section on the DMAS Managed Care Web Site). All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files. Numeric fields should not include commas, dollar signs, or other extraneous characters. When populating this report please do not replace the information that is currently populated in the first column of the template. Begin dropping your data in column B.

File Name: MCO_RPT.csv

Trigger: Monthly

Due Date: By close of business on the 15th calendar day of the month following the end of the reporting month.

DMAS: Managed Care Contract Monitor

CMS

3.2.2.3 Requirements

1. **Claims:** For those claims that have multiple denial or pend reasons, report that claim under each reason (i.e., some claims may be reported multiple times).
2. **Claims Volume:** The Month Begin Claims Inventory should be equal to the prior month's Month End Claims Inventory.
3. **Claims Processed:** Number Of Claims Paid This Month + Number Of Claims Denied This Month = Claims Processed (Paid Or Denied) This Month.
4. **Claim Processing Turnaround:** Claims Processed This Month: PMT DT - Receipt DT < 30 + Claims Processed This Month Within 31-90 Days Of Receipt + Percent Processed In 91-365 Days + Percent Processed Over 365 Days = Claims Processed (Paid Or Denied) This Month.

3.2.2.4 Examples

None

3.2.2.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.3 Live Births

3.2.3.1 Contract Reference

Medallion 3.0 Contract, Section 5.7

FAMIS Contract, Section 5.7

3.2.3.2 File Specifications

Field Description	Specifications
Mother Last Name	Must be 20 characters or less
Mother First Name	Must be 13 characters or less
Mother ID Number	Must be a valid Medicaid ID Format: Numeric 12 bytes with leading zeros
Newborn Last Name	Must be 20 characters or less
Newborn First Name	Must be 13 characters or less
Date of Birth	Must be a valid date Format = mm/dd/yyyy Must be <= report date
MCO Newborn ID Number	Must be 13 characters or less
DMAS Newborn ID Number	Must be a valid Medicaid ID or blank Format: 12 bytes with leading zeros
Mother Enrolled MCO Prenatal Program	Valid values are 'Y' and 'N'.
Newborn Birth Weight	Numeric value must be >= 244 and <=11,000. (Optional)
Estimated Gestation Period	Numeric value must be >= 22 and <= 54. (Optional)

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.

File Name: BIRTHS.csv

Trigger: Monthly

Due Date: By close of business on the 15th calendar day of the month following the end of the reporting month.

DMAS: Managed Care Contract Monitor

3.2.3.3 Requirements

Eligibility: Report all newborn live births that occurred during the reporting period, plus any live births identified during the current reporting period that were not reported to DMAS by the MCO in a previous submission. Note that the MCO should not report the same newborn to DMAS more than once.

MCO Newborn ID Number: ID number assigned to the newborn by the MCO. This should be a unique number for that newborn.

DMAS Newborn ID Number: ID number assigned to the newborn by DMAS in the MMIS. Enter the Medicaid ID if known. Otherwise, leave blank. DMAS will research all newborns reported without valid Medicaid IDs and report back to the MCO on the weekly newborn report.

Mother Enrolled MCO Prenatal Program: Use the following values: Y = Yes or N = No.

Newborn Birth Weight: Report newborn weight at birth in grams. Reporting this information is optional.

Estimated Gestation Period: Report mother's gestation period in weeks. Reporting this information is optional.

3.2.3.4 Examples

In the examples below, the reporting cycle is August. This report is submitted to DMAS on September 15th.

#	Scenario	Outcome
1	**Program**: Medicaid Date of Birth: 08/12/xxxx First Time Member Reported? Y	Member should be included in the report.
2	**Program**: FAMIS Date of Birth: 09/08/xxxx First Time Member Reported? Y	Member should NOT be included in the report because they should be reported in next month's cycle.
3	**Program**: FAMIS **Age**: Date of birth 07/12/xxxx First Time Member Reported? Y	Member should be included in the report because even though they were born in prior month they were not previously reported.
4	**Program**: Medicaid Date of Birth: 07/12/xxxx First Time Member Reported? N	Member should NOT be included in the report because they were previously reported in prior cycle.

3.2.3.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.4 Returned ID Cards

3.2.4.1 Contract Reference

Medallion 3.0, Section 6.5

FAMIS Contract, Section 6.5

3.2.4.2 File Specifications

Field Description	Specifications
MII or FAMIS	Must be 5 characters or less Valid Values: MII or FAMIS
Medicaid ID	Must be a valid Medicaid ID Format: 12 bytes with leading zeros
Member Last Name	Must be 20 characters or less
Member First Name	Must be 13 characters or less
Old Address 1	Must be 40 characters or less
Old Address 2	Must be 40 characters or less
Old City	Must be 17 characters or less
Old State	Must be 2 characters or less
Old Zip	Must be 9 characters or less
New Address 1	Must be 40 characters or less
New Address 2	Must be 40 characters or less
New City	Must be 17 characters or less
New State	Must be 2 characters or less
New Zip	Must be 9 characters or less

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.

File Name: RETURNED_ID.csv

Trigger: Monthly

Due Date: By close of business on the 15th calendar day of the month following the end of the reporting month.

DMAS: Managed Care Contract Monitor

3.2.4.3 Requirements

Include members enrolled in Medicaid and FAMIS.

3.2.4.4 Examples:

NONE

3.2.4.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.5 Patient Utilization and Safety Management Program (PUMS) Members

3.2.5.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.M.IV

FAMIS Contract, Sections 7.1.M

3.2.5.2 File Specifications

Field Description	Specifications
Member Last Name	Must be 20 characters or less
Member First Name	Must be 13 characters or less
Member Medicaid or FAMIS ID	Must be a valid Medicaid or FAMIS ID Format: xx bytes with leading zeros
PUMS Start Date	Must be a valid date Format: mm/dd/yyyy
PUMS End Date	Must be a valid date Format: mm/dd/yyyy
PUMS Pharmacy/Provider Name	Must be 40 characters or less
PUMS Pharmacy/Provider ID Number	Must be 10 characters or less Must be a valid Provider ID
PUMS Pharmacy/Provider Address	Must be 40 characters or less
PUMS Pharmacy/Provider City	Must be 17 characters or less
PUMS Pharmacy/Provider State	Must be 2 characters or less Must be valid state code (USPS standards)
PUMS Pharmacy/Provider Zip	Must be 9 characters or less
PUMS Type	Must be 1 character or less Valid Values: 1, 2, 3, 4
PUMS Reason	Must be 30 characters or less

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.

File Name: PUMS.csv

Trigger: Monthly

Due Date: [Beginning October 1, 2015] By close of business on the 15th calendar day of the month following the end of the reporting month.

DMAS: Program Integrity Division

3.2.5.3 Requirements

Beginning October 1, 2015 members may be placed into a PUMS program for a period of 12 months. Include members who were in the PUMS program at least one day during the reporting period. Include members enrolled in Medicaid and FAMIS.

Use the following codes for PUMS Type:

1 = Physician

2 = Pharmacy

3 = Physician Notice

4 = Pharmacy Notice

3.2.5.4 Examples

None

3.2.5.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.6 Assessments Age/Blind/Disabled and Children with Special Health Care Needs

3.2.6.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.O.III.b and 7.7

FAMIS Contract, Section 7.1.O.III.b and 7.7

3.2.6.2 File Specifications

Field Description	Specifications
Medicaid ID	Must be a valid Medicaid ID Format: Numeric 12 bytes with leading zeros
Date assessment completed	Must be a valid date Format = mm/dd/yyyy
Date of member's visit to PCP (if reported)	Must be a valid date Format = mm/dd/yyyy Visit date <= last day of reporting period Visit date >-first day of reporting period (Optional)

Method:	DMAS secure FTP server
Format:	Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.
File Name:	ASSESSMENTS.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
DMAS:	Managed Care Contract Monitor

3.2.6.3 Requirements

Data Source: All enrollment and eligibility determinations should be based the eligibility and enrollment data from the end of month (EOM) 834 files sent to the MCOs. The process for determining the appropriate members for this report is detailed in Section 5.1.4.

Per the Medallion 3.0 contract, members must be assessed by the MCO when they fall into one or more of the eligible category groups:

- Member is in Aid Category 049, 051, 052, 059, 060, 061, 062 (ABD), 072 (AA), and/or
- Member is enrolled in the early intervention benefit (01010100EI) but not in Aid Category 076 (Foster Care), and/or

- Member has one or more special needs as specified in the Managed Care contract, and/or
- Member is enrolled in one of the HAP waiver benefits (01010100S, 01010100T, 01010100R, 01010100Y, 010101009). The assessment requirement for HAP members was added in Contract Modification (Amendment Number III) dated 12/01/2014. (DMAS' evaluation of HAP members will start effective with June 1, 2015 member enrollments.)

The MCO may choose to include other members who do not meet these criteria on this report, but those members will not be included in DMAS' calculation of the MCO's performance metric.

The MCO should report all assessments completed in the previous month for an ABD or CSHCN member. The MCO may also include any assessments not previously reported to DMAS.

PCP Visit: Reporting this information is optional. If provided, include only those members who actually visited their PCP during the 60 day reporting period: i.e., those members who visited a PCP within the first two calendar months of being newly enrolled in the MCO. Do not report members who did not visit their PCP during the report period, and do not include PCP visits that occurred outside the 60 day report period.

3.2.6.4 Examples

None

3.2.6.5 Scoring Criteria

Formatting: Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.7 Appeals & Grievances Summary

3.2.7.1 Contract Reference:

Medallion 3.0 Contract, Section 10.1.E.IV

FAMIS Contract, Section 10.1.E.I

3.2.7.2 File Specifications

Field Description	Provider Specifications	Member Specifications
Transportation (Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
MCO Administrative Issue (Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Benefit or Denial or Limitation (Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Resolved This Month (Resolution)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Carried Forward (Resolution)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Resolved Prior Month (Resolution)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
MCO Customer Service (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Access to Services/Providers (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Provider Care & Treatment (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Transportation (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Administrative Issues (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Reimbursement Related (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file (a template of this report format, named APP_GRIEV_FMT is available in the forms section on the DMAS Managed Care Web Site). All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Numeric fields should not include commas, dollar signs, or other extraneous characters. Do not include a header row in .csv files. When populating this report please do not replace the information that is currently populated in the first column of the template. Begin dropping your data in column B.

File Name: APP_GRIEV.csv

Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
DMAS:	Managed Care Contract Monitor CMS

3.2.7.3 Requirements

Provider & Member Appeals:

- Total from Members includes Appeals submitted by a provider on behalf of a member.
- Total from Providers includes Appeals submitted by a provider on behalf of the provider.

Type of Appeal**:**

Categorize appeals under the most appropriate type.

- Transportation - Any transportation related appeal.
- MCO Administrative Issues - MCO's failure to provide services in a timely manner or to act within timeframes set forth in the Contract and 42CFR438.408 (b).
- Benefit Denial or Limitation - The reduction, suspension or termination of a previously authorized service; denial in whole/part of payment for services; and denial/limited (reduced) authorization for a service authorization request.

Resolution**:**

- Total End of Month Unresolved should be carried forward in the 'Total Carried Forward' field on the Appeals Report next month.

Provider & Member Grievances:

Only report on grievances received this month. Do not report any grievances carried forward from prior month(s). Report Provider and Member grievances separately.

Type of Grievance**:**

Categorize grievances in the most appropriate column.

- MCO Customer Service - Treatment by member or provider services, call center availability, not able to reach a person, non-responsiveness, dissatisfaction with call center treatment, etc.
- Access to Services/Providers - Limited access to services or specialty providers, unable to obtain timely appointments, PCP abandonment, access to urgent or emergent care, etc.
- Provider Care & Treatment - Appropriateness of provider care, including services, timeliness, unsanitary physical environment, waited too long in office, etc.
- Transportation - Any transportation related grievance including transportation did not pick up member, waited too long for transportation provider, etc.
- Administrative Issues - Did not receive member ID card, member materials, etc.
- Reimbursement Related - Member billed for covered services, inappropriate co-pay charge, timeliness of clean claim payment by MCO, etc.

3.2.7.4 Examples

N/A

3.2.7.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.8 Monthly Provider File for Encounter Processing

3.2.8.1 Contract Reference

Medallion 3.0 Contract, Section 11.4

FAMIS Contract, Section 11.4

3.2.8.2 File Specifications

Field Description	Specifications
Provider NPI	Must be a valid NPI # or blank Format: 10 bytes with leading zeros
Provider Type	Must be 30 characters or less
Last Name	Must be 40 characters or less
First Name	Must be 12 characters or less
MI	Must be 1 character or less
Suffix	Must be 3 characters or less (examples: JR, SR, III)
Title	Must be 5 characters or less (examples: MD, CRNA, LCSW, PHD, LPC)
Address	Must be 40 characters or less
City	Must be 17 characters or less
State	Must be 2 characters or less Must be valid state code (USPS standards)
Zip Code (Plus 4)	Must be 9 characters or less
Contact Name	Must be 40 characters or less
Phone Number	Format: 999-999-9999 Do not include extension
Provider Begin Date	Must be a valid date Format = mm/dd/yyyy
License Number	Must be 15 characters or less
State of License	Must be 2 characters or less Must be valid state code (USPS standards)
License Begin Date	Must be a valid date Format = mm/dd/yyyy (Required)
License End Date	Must be a valid date or blank Format = mm/dd/yyyy (Optional)
Specialty	40 characters or less (Optional)
Language	10 characters or less (Optional)
Tax ID	Must be 9 characters

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.

File Name: ENC_PROV.csv

Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
DMAS:	Managed Care Encounter Analyst

3.2.8.3 Requirements

Include all providers who are not active in the MMIS, but for whom the MCO will submit one or more encounters.

3.2.8.4 Examples

NONE

3.2.8.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.9 Encounter File Submissions (Eliminated)

Deliverable eliminated effective 07/01/2015.

The list of encounter file submissions is now included in the revised 'Encounter Data Certification' deliverable (MCTM 3.2.10).

3.2.10 **Encounter Data Certification**

3.2.10.1 Contract Reference

Medallion 3.0 Contract, Section 11.5.B

FAMIS Contract, Section 11.5.B

3.2.10.2 File Specifications

Field Description	Specifications
Signature	Signature of authorized MCO representative
Print Name	Print name of signee above
Title	Title of signee within the MCO
Date	Date certification form was signed
Name of MCO	MCO corporate name
Service Center	MCO service center (vendor) ID issued by DMAS and used to submit EDI file. Four digit numeric.
MCN	Must match the unique MCN identifier assigned for the file when it was submitted to DMAS / Xerox for processing
Transaction Type	EDI transaction type for the submitted file. Valid values are: NCPDP, 837P, and 837I Must not be blank
Source	When possible, identify the MCOs original source of the encounter / claims data, e.g., PBM, transportation vendor, MCO, etc. Must not be blank
MCO File Name	MCO's unique file name submitted to DMAS / Xerox. Must not be blank
Number of Encounters	Number of encounters on the submitted file.

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	ENC_CERT.pdf
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
DMAS:	Managed Care Encounter Analyst

3.2.10.3 Requirements

MCO must list and certify monthly encounter data files via signature on the current version of the Encounter Data Certification Form (available on DMAS Managed Care web site).

Include all encounter files that were submitted and processed successfully by the MMIS during the calendar month being reported.

Include encounters for all claims paid for members enrolled in Medicaid and FAMIS programs.

Include encounter files from subcontractors.

Do not include any submitted encounter files where all of the transactions fail compliance (and therefore are not accepted into the MMIS for processing).

All encounter files that are submitted and processed in MMIS must be certified by the MCO on this monthly form. The MCO cannot certify any files that were not received and processed in the MMIS. DMAS will perform a reconciliation of the MCO's certification every month. The MCO will be required to submit a corrected Encounter Data Certification Form if any discrepancies are identified as a result of this reconciliation.

3.2.10.4 Examples

N/A

3.2.10.5 Scoring Criteria

Form submitted using current version of encounter certification form.

Form is complete and contains all required fields and signatures.

Form is submitted on time per contract requirements.

3.2.11 **Monies Recovered by Third Parties**

3.2.11.1 Contract Reference

Medallion 3.0 Contract, Section 12.10

FAMIS Contract, Section 12.10

3.2.11.2 File Specifications

Field Description	Specifications
Member First Name	Must be 13 characters or less
Member Last Name	Must be 20 characters or less
Medicaid ID	Must be a valid Medicaid ID Format: 12 bytes with leading zeros
Third Party	Must be 50 characters or less
Amount Recovered	Must be 10 characters or less

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.

File Name: MNY_RECOV.csv

Trigger: Monthly

Due Date: By close of business on the 15th calendar day of the month following the end of the reporting month.

DMAS: Third Party Liability Unit

3.2.11.3 Requirements

Program: Include members enrolled in Medicaid and FAMIS.

Amount Recovered: Include only actual recoveries received (e.g., checks) in this field. Do not include Cost Avoidance or coordination of benefits amounts.

3.2.11.4 Examples

NONE

3.2.11.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.12 **Comprehensive Health Coverage**

3.2.12.1 Contract Reference

Medallion 3.0 Contract, Section 12.10.A

FAMIS Contract, Section 12.10.A

3.2.12.2 File Specifications

Field Description	Specifications
Member First Name	Must be 13 characters or less
Member Last Name	Must be 20 characters or less
Medicaid ID	Must be a valid Medicaid ID Format: 12 bytes with leading zeros
Other Carrier Name	Must be 50 characters or less
Policy Number	Must be 15 characters or less
Eff Date	Must be a valid date Format: mm/dd/yyyy
End Date	Must be a valid date Format: mm/dd/yyyy

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.

File Name: COMP_CVG.csv

Trigger: Monthly

Due Date: By close of business on the 15th calendar day of the month following the end of the reporting month.

DMAS: Third Party Liability Unit

3.2.12.3 Requirements

Include members enrolled in Medicaid and FAMIS.

Include any other member health insurance coverage that is identified during the reporting month.

When multiple coverages are present for a member, enter each type of coverage on a separate line for that member.

3.2.12.4 Examples

None

3.2.12.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.13 **Workers' Compensation**

3.2.13.1 Contract Reference

Medallion 3.0 Contract, Section 12.10.B

FAMIS Contract, Section 12.10.B

3.2.13.2 File Specifications

Field Description	Specifications
Member First Name	Must be 13 characters or less
Member Last Name	Must be 20 characters or less
Medicaid ID	Must be a valid Medicaid ID Format: 12 bytes with leading zeros
Other Carrier Name	Must be 50 characters or less
Policy Number	Must be ≤ 15 characters or blank
Eff Date	Must be a valid date Format: mm/dd/yyyy
End Date	Must be a valid date Format: mm/dd/yyyy

Method:	DMAS secure FTP server
Format:	Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.
File Name:	WKR_COMP.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
DMAS:	Third Party Liability Unit

3.2.13.3 Requirements

Include members enrolled in Medicaid and FAMIS.

When multiple coverages are present for a member, enter each type of coverage on a separate line for that member.

3.2.13.4 Examples

NONE

3.2.13.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.14 **Estate Recoveries**

3.2.14.1 Contract Reference

Medallion 3.0 Contract, Section 12.10.C

FAMIS Contract, Section 12.10.C

3.2.14.2 File Specifications

Field Description	Specifications
Member First Name	Must be 13 characters or less
Member Last Name	Must be 20 characters or less
Medicaid ID	Must be a valid Medicaid ID Format: 12 bytes with leading zeros
Date of Death (Member Over Age 55)	Must be a valid date Format: mm/dd/yyyy

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.

File Name: EST_RECOV.csv

Trigger: Monthly

Due Date: By close of business on the 15th calendar day of the month following the end of the reporting month.

DMAS: Third Party Liability Unit

3.2.14.3 Requirements

Member must be enrolled under the Medicaid program. Do not include FAMIS members on this report.

Member must be over the age of 55 at time of death.

3.2.14.4 Examples

None

3.2.14.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.15 **Other Coverage**

3.2.15.1 Contract Reference

Medallion 3.0 Contract, Section 12.10.D

FAMIS Contract, Section 12.10.D

3.2.15.2 File Specifications

Field Description	Specifications
Member First Name	Must be 13 characters or less
Member Last Name	Must be 20 characters or less
Medicaid ID	Must be a valid Medicaid ID Format: 12 bytes with leading zeros
Other Coverage Type	Must be 2 characters or less Valid Values: CA, LI, CS, PI, TI, NA
If reporting Injury or Trauma - date	Must be a valid date Format: mm/dd/yyyy

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.

File Name: OTH_COVG.csv

Trigger: Monthly

Due Date: By close of business on the 15th calendar day of the month following the end of the reporting month.

DMAS: Third Party Liability Unit

3.2.15.3 Requirements

Include members enrolled in Medicaid and FAMIS.

Use the following codes: CA = Casualty; LI = Liability; CS = Child Support; PI = Personal Injury; TI = Trauma Injury; NA = Not Available

Provide one-time member trauma injury reporting per trauma date. Do not report ongoing member trauma injury.

3.2.15.4 Examples

NONE

3.2.15.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.16 **PCP Provider Attestation Listing (Eliminated)**

This requirement was eliminated effective 07/01/2015.

3.2.17 **MCO Newborn Reconciliation File**

3.2.17.1 Contract Reference

Medallion 3.0 Contract, Sections 5.7 and 12.8

FAMIS Contract, Sections 5.7 and 12.8

3.2.17.2 File Specifications

Field Description	Specifications
Mother Last Name	Must be 20 characters or less
Mother First Name	Must be 13 characters or less
Mother ID Number	Must be a valid Medicaid ID Format: Numeric 12 bytes with leading zeros
Newborn Last Name	Must be 20 characters or less
Newborn First Name	Must be 13 characters or less
Date of Birth	Must be a valid date Format = mm/dd/yyyy
MCO Newborn ID Number	Must be 13 characters or less. Required field. Must uniquely identify each child when there is a multiple birth.
DMAS Newborn ID Number	Must be a valid Medicaid ID or blank Format: 12 bytes with leading zeros

Method:	DMAS secure FTP server
Format:	Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.
File Name:	NB_Recon.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month after the month the newborn turned age one.
DMAS:	Managed Care Contract Monitor

3.2.17.3 File Specifications

The MCO NB_Recon_yyyymm file is submitted monthly by the MCO for each MCO newborn (live birth) when a payment was not received on the 820 payment report for the birth month (BM1), and/or birth month plus 1 (BM2) and/or birth month plus 2 (BM3). The report is submitted monthly. The submission month is the month following the month in which the newborn turned age one.

MCO Newborn ID Number: ID number assigned to the newborn by the MCO. This should be a unique number for that newborn. Twins should be submitted individually each with a unique MCO ID Number.

DMAS Newborn ID Number: ID number assigned to the newborn by DMAS in the MMIS. Enter the Medicaid ID if known. Otherwise, leave blank.

3.2.17.4 Examples

MCO newborns with a date of birth (DOB) in the month of January 2013. If a payment was not received by the MCO for the BM1 - January 2013, and/or BM2-Feburary 2013, and/or BM3-March 2013, the MCO newborn should be included on the February 2014 monthly NB_Recon_yyyymm submission report.

Upon receipt, the file submission is validated against MMIS data and a return file, DMAS Newborn Reconciliation Return File (**NB_Recon_Return_yyyymm**), is generated for the MCO (see Section 4.1.x.).

3.2.17.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.18 **Assessment Exception Report**

3.2.18.1 Contract Reference

Medallion 3.0 Contract, Section 7.7.C

FAMIS Contract, Section 7.7.C

3.2.18.2 File Specifications

Field Description	Specifications
Medicaid ID	Must be a valid Medicaid ID Format: Numeric 12 bytes with leading zeros
Reason for Lack of Assessment	Must be 1 character or less Valid Values: 1,2,3,4,9

Method:	DMAS secure FTP server
Format:	Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.
File Name:	ASSESS_EXCEPTION.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following receipt of the detail report
DMAS:	Managed Care Operations

3.2.18.3 Requirements

The data source for this file is the DMAS Detailed Assessments Report, Section 4.1.23. The file should include only members who did not have a completed assessment within 120 days of enrollment. Include members if they did not have an assessment within 120 days of enrollment or if the time from enrollment to completion of the assessment was over 120 days.

Only the primary reason for a member's lack of or delay in assessment should be included in the file, that is, the file should not contain duplicate member ID records. The file should include only members in the DMAS Detailed Assessments Report.

Use the following codes for Exception Reason: 1 = Member/Parent Refusal, 2 = Invalid contact information, 3 = Unable to make contact with Member/Parent, 4 = Member's eligibility was retroactive to prior month(s), 9 = Other.

3.2.18.4 Examples

N/A

3.2.18.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.19 **Assessments Foster Care Children**

3.2.19.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.O.III.b

FAMIS Contract, Section 7.1.O.III.b

3.2.19.2 File Specifications

Field Description	Specifications
Medicaid ID	Must be a valid Medicaid ID Format: Numeric 12 bytes with leading zeros
Date assessment completed	Must be a valid date Format = mm/dd/yyyy

Method:	DMAS secure FTP server
Format:	Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.
File Name:	FC_ASSESSMENTS.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
DMAS:	Managed Care Contract Monitor

3.2.19.3 Requirements

- Required Assessments: Per the Medallion 3.0 contract, members must be assessed by the MCO when they meet the following eligibility criteria:
    - Member is in Aid Category 076 (Foster Care)
- New Members: All new or newly identified foster care members who were assessed should be included on this report. A new or newly identified member is defined as a member who is on the 'current' EOM 834, but who did not meet the above criteria / was not on the EOM 834 files in all of the previous **six months as a foster care member**.
- Data Source: All enrollment and eligibility determinations should be based the eligibility and enrollment data from the end of month (EOM) 834 files sent to the MCOs.
- Report Period: This report reflects a 60 day continuous foster care enrollment period from the initial enrollment, i.e., current and previous calendar months. Assessments are only required for members who were enrolled with the MCO during the entire continuous foster care enrollment period. For example: The report due to DMAS on January 15 should reflect members who were enrolled as of November 1, and who maintained their foster care enrollment on the December 834.
- Assessment: Assessments are to be done on every foster care member who is newly enrolled with the MCO and on every member previously enrolled in the MCO but who has been newly identified as foster care. (Refer to criteria above.) If a member was

previously identified and assessed as a child with special health care needs (CSHCN) and changes to a foster care member within the two month continuous enrollment period, then he or she will require a new assessment. Only include those members who have completed a successful assessment on this report.

Report submission dates with their associated enrollment and look-back periods:

Report	Enrollment Dates		EOM Lookback	
Submit Dt	**Begin**	**End**	**Begin**	**End**
Jul 15th	May 1st	Jun 30th	Nov 1st	Apr 30th
Aug 15th	Jun 1st	Jul 31st	Dec 1st	May 31st
Sep 15th	Jul 1st	Aug 31st	Jan 1st	Jun 30th
Oct 15th	Aug 1st	Sep 30th	Feb 1st	Jul 31st
Nov 15th	Sep 1st	Oct 31st	Mar 1st	Aug 31st
Dec 15th	Oct 1st	Nov 30th	Apr 1st	Sep 30th
Jan 15th	Nov 1st	Dec 31st	May 1st	Oct 31st
Feb 15th	Dec 1st	Jan 31st	Jun 1st	Nov 30th
Mar 15th	Jan 1st	Feb 28th	Jul 1st	Dec 31st
Apr 15th	Feb 1st	Mar 31st	Aug 1st	Jan 31st
May 15th	Mar 1st	Apr 30th	Sep 1st	Feb 28th
Jun 15th	Apr 1st	May 31st	Oct 1st	Mar 31st

3.2.19.4 Examples

The following examples demonstrate criteria for the members who are required to be assessed. The following examples are based on a report date of January 15th.

#	Enrollment		Prior Months Look Back Period						Assessment Required?	Reason
	Dec 834	Nov 834	Oct 834	Sep 834	Aug 834	Jul 834	Jun 834	May 834		
1.	FC	FC	Not Elig	Not Elig	Not Elig	Not Elig	Not Elig	Not Elig	Yes	New member
2.	FC	FC	LIFC	LIFC	LIFC	LIFC	LIFC	LIFC	Yes	New FC
3.	FC	FC	Not Elig	Not Elig	Not Elig	Not Elig	Not Elig	FC	No	Prior FC (not new)
4.	FC	FC	Not Elig	Not Elig	LIFC	LIFC	LIFC	LIFC	Yes	New FC
5.	Left FC	FC	LIFC	LIFC	LIFC	LIFC	LIFC	LIFC	No	Did not meet criteria for continuous enrollment
6.	FC	FC	EI	EI	EI	EI	EI	EI	Yes	New FC; change from CSHCN

3.2.19.5 Scoring Criteria

Formatting: Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.20 **MCO Call Center Statistics**

3.2.20.1 Contract Reference

Medallion 3.0 Contract, Section 4.9 (Provider), Section 6.11 (Member)

FAMIS Contract, Section 4.9 (Provider), Section 6.11 (Member)

3.2.20.2 File Specifications

Field Description	Specifications
Total Member Calls Received	Value must be ≥ 0
Total Member Calls Answered	Value must be ≥ 0
Total Provider Calls Received	Value must be ≥ 0
Total Provider Calls Answered	Value must be ≥ 0
Total Member Calls Abandoned	Value must be ≥ 0
Total Provider Calls Abandoned	Value must be ≥ 0
Average Member Speed of Answer	Format = mm:ss
Average Member Handle Time	Format = mm:ss
Average Provider Speed of Answer	Format = mm:ss
Average Provider Handle Time	Format = mm:ss

Method:	DMAS secure FTP server
Format:	Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Numeric fields should not include commas, dollar signs, or other extraneous characters. Do not include a header row in .csv files. Data file will contain only one row.
File Name:	CALL_CENTER.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
DMAS:	Managed Care Operations

3.2.20.3 Requirements

Calls Abandoned are the number of calls where the caller disconnects while on hold waiting for an agent. The Average Speed of Answer is equal to the Total Waiting Time (in seconds) for Answered Calls divided by the Total Number of Answered Calls for the reporting period. The Average Handle Time is the time in seconds an agent is talking to the caller, from answering a call to the caller hanging up.

3.2.20.4 Examples

N/A

3.2.20.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.2.21 **Behavioral Health Home (BHH) Enrollment Roster**

3.2.21.1 Contract Reference

Medallion 3.0 Contract, Section 7.9.E.V

FAMIS Contract, Section 7.9.E.V

3.2.21.2 File Specifications

Field Description	Specifications/Validation Rules
Medicaid ID	Must be a valid Medicaid ID Format: 12 bytes with leading zeros
BHH Enrollment Begin Date	Format = mm/dd/yyyy. Must be a valid date. Must be greater than 07/01/2015.
BHH Enrollment End Date	Format = mm/dd/yyyy. Must be a valid date. Must be greater than 07/01/2015. For active / ongoing member enrollment, use value = 12/31/9999.

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included.

File Name: BHH_ENROLL.csv

Frequency: Monthly

Due Date: By close of business on the 15th calendar day of the month.

DMAS: HCS Systems & Reporting

3.2.21.3 Requirements

- Do not include a header row in this file.
- Only include members who are actually enrolled in the Behavioral Health Home pilot program. Do not include members who are eligible but not enrolled.
- Only Medicaid members are eligible for this pilot program.
- Each monthly file submission must be a full replacement file, i.e., Include all members who were previously enrolled or who will be enrolled in the BHH.
- Members must be enrolled with the MCO for their entire BHH enrollment period.
- A member may have more than one record the file, but each member record must have a different Begin and End Date. Date spans on different records for the same member within the file must not overlap.

- Members should not be enrolled in a BHH for a partial month. Enrollment Begin Date and End Date should start on the first / last day of a calendar month. The only exception would be when the member's MCO enrollment ends on a date other than the end of month.
- A diagram showing the input and output files for the BHH enrollment process is provided in Section 5.5.5.

- To be enrolled in an Virginia Mental Health Home pilot, a member must meet at least one of the following four criteria during a one year period. Selection should be based on the MCO's claims plus the Magellan encounter data provided by DMAS.

1. Mental Health Services History

A. Six or more visits with one or more of the following Mental Health codes: 99605, 99606, 99607, H0004, H0004, S9484, S0201, H0035, and H0036.

AND

B. One or more claims containing a primary Mental Health Diagnosis (see list below).

AND

C. Total claims (Medical & BH) during the period of at least $10,471.

OR

2. Mental Health Pharmaceutical History

A. Received six or more prescriptions for any combination of mental health NDCs (see list below) **OR** physician-administered J-codes (see list below). For purposes of this calculation, one prescription is equivalent to one month of medication.

AND

B. One or more claims containing a primary Mental Health Diagnosis (see list below).

AND

C. Total claims (Medical & BH) during the period of at least $10,471.

OR

3. Hospital Inpatient Admission History

A. One or more inpatient psychiatric hospitalizations in the period year. (This criterion may be met immediately upon discharge from the hospital prior to the receipt of claims with Medical Director approval and if patient meets the other criteria within this section.)

AND

B. One or more claims containing a primary Mental Health Diagnosis (see list below).

AND

C. Total claims (Medical & BH) during the period of at least $10,471.

OR

4. History of Emergency Room Use

A. Four or more visits to a hospital emergency department for **any** (physical medicine or BH) primary diagnosis

AND

B. One or more claims containing a primary Mental Health Diagnosis (see list below).

AND

C. Total claims (Medical & BH) during the period of at least $10,471.

Mental Health Diagnosis List

293.81
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298.8
298.9

NDC Code List

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68405068026	57866341501	33261067630	68115006290	61392003839
63402020430	57664053388	33261067628	68115006260	61392003834
63402020660	57664053318	33261067621	68115006230	49158050450
63402020230	57664053313	33261067620	68084044411	61392003831
63402020830	57480030801	33261067614	68084044401	00839717706
59075055410	55887034590	33261067607	67544058380	61392003890
62856058446	55887034560	33261067602	68084056111	54569279501
62856058230	55887034530	49158050401	60346077730	66336084130
62856058252	57866341504	63874049260	63874049201	58016050115
62856058352	16590047530	63739004515	60505018305	58016050110
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54868014706	21695072430	66336073130	60505018300	57664034288
54868014705	61392003832	66336073128	60429093210	57664034213
54868014704	18837031390	66267027891	60429093201	54868246203
54868014703	17236035210	66267027890	60429003212	54868246202
54868014702	17236035205	65162035250	60429003210	58016050130
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54569265503	16590047560	67544058360	60346077728	51672404102
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54569265501	13668026810	63874049240	58016096890	51079087020
54569265500	13668026805	63874049230	58016096860	51079087019
52446007528	13668026801	63874049220	58016096840	51079087017
51672400503	00904617261	63874049210	58016096830	51079087001
51672400502	00904385580	63874049204	58016096828	49999078260
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57866341502	51079038517	68084056211	63739004501	62584063980
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58016096812	49999061660	00781508801	61392003891	58016050120
58016096810	49999061600	68084056121	60760010960	61392009754
58016096802	49158050410	66689000560	61392003860	23490520101
58016096800	58016096820	60429093701	58016096821	61392009745

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61392009731	00247123160	00403089430	51552065325	63739039210
61392009730	00247123130	00364210601	54092017112	68001000700
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00093551389	00814147014	37803038208	68084062511	66336056760
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58016013430	16590010282	00378542705	33261004802	00378542605
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58016013421	10544043684	00440755901	31722022105	00228266550
58016013420	10544043681	00093103993	33261004840	00904563140
58016013415	10544043660	00093103919	23490651308	00185009110
58016013414	10544043645	00093103910	23490651307	00904563161
58016013410	10544043630	00093103905	23490651306	00185009101
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58016013490	10544043600	76282032105	23490651301	00172438170
62756013705	16590010286	76282032101	21695005590	00172438160
63739037415	14550051204	76282022105	21695005560	00172438110
63739037410	16590098382	76282022101	21695005530	00172438100
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68084008065	55045342101	33261005028	16590049290	43353059192
68084008090	51991033905	33261005030	43547026750	43353059194
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60505327600	00093524565	00093576901	00378521291	60505314003
59746030732	00378551093	00093576956	13668016630	68084052901
59746030712	13668008630	55111026279	42254020330	62756055618
55111026381	66993046105	55111026281	51079015201	62756055683
55111026379	51079015320	59746030612	51079015220	66993046505
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66993005205	00002411501	66105055409	13411013703	67544006453
00093576856	00002411504	13411013603	58864096815	68115080330
65862056699	00002411530	13411013606	13411013709	68115080360
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00904295661	17236046710	00364216902	00677114901	52544070801
17236046601	17236046711	00378501001	00364216702	52544070805
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00904185061	00904184560	61392007160	54868148201	61392011151
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00904184561	00781127305	00006094628	00093722528	00172295980
00904763940	00781127313	00006093474	00093722628	00615158713
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00904763640	00904763760	59417040171	11845024803	61392011132
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00182151801	00078010106	49884025011	42291065530	00002323233
00904066280	00078010105	00093550556	00781219231	00002323230
00904066270	00078007006	00781219331	00093550356	00002323201
00904066260	00078007005	49884025111	42291065230	00002323030
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00536385701	00078007008	49884027711	00002323333	
00536385601	51655021521	42291065430	00002323330	

J Code List

J1630
J1631
J2060
J2358
J2426
J2680
J2794
J3360

3.2.21.4 Examples

None

3.2.21.5 Scoring Criteria

None

3.2.22 **Behavioral Health Homes Quality Report**

3.2.22.1 Contract Reference

Medallion 3.0 Contract, Section 7.9.E.VI

FAMIS Contract, Section 7.9.E.VI

3.2.22.2 File Specifications

Field Description	Specifications
Total BHH members enrolled	Value must be ≥ 0
Number of BHH members enrolled with contact between PCP and behavioral health provider	Value must be ≥ 0
Number of BHH members with behavioral health inpatient discharge	Value must be ≥ 0
Number of BHH members with behavioral health ambulatory care follow-up within 30 days after behavioral health inpatient discharge	Value must be ≥ 0
Report month	Format (text) *mm_yyyy*

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files. Each month's data should be contained on one row.

File Name: BHH_QUALITY.csv

Trigger: Monthly

Due Date: By close of business on the 15th calendar day of the month following the end of the reporting month.

DMAS: Managed Care Operations

3.2.22.3 Requirements

Indicators should be reported for all individuals participating in the BHH program for at least one day during the reporting month.

Number of BHH Month Enrollment with At Least One Contact is the number of members whose primary care provider (PCP) had at least one contact *with the member's behavioral health provider* during the reporting period. Behavioral health providers include: psychiatrists, doctoral-level psychologists, licensed professional counselors, licensed clinical social workers, and licensed clinical behavioral health case managers. MCO case mangers/care managers are not considered behavioral health providers; however, if the member does not have a treating behavioral health provider, then the MCO's consulting psychiatrist would be expected to have monthly contact with the enrolled member's PCP. Valid contact types include: in-person meetings, phone conversations, and telemedicine. Email messages/letters are not considered a

valid form of contact. Information on the provider types and recommended contacts or encounters related to integrated behavioral health in primary care is available from: http://integrationacademy.ahrq.gov/sites/default/files/AHRQ_AcadLitReview.pdf

The number of BHH members with ambulatory care follow-up should be determined using the Healthcare Effectiveness and Information Set (HEDIS) specifications for the Follow-up After Hospitalization for Mental Illness measure. For more information on this measure see:

http://www.qualitymeasures.ahrq.gov/content.aspx?id=48641&search=follow-up+hospitalization.

The report should reflect cumulative results for the BHH program, i.e., the MCO should report additional discharges and follow up visits each month as claims are received. Report members with a behavioral health inpatient discharge in the month of the discharge. Report members with follow-up visits in the month of the inpatient discharge.

3.2.22.4 Examples

Note that the header row is for information purposes only – no header row should be included in the submitted file.

BHH_QUALITY.CSV (for October 2015)				
Total BHH Members Enrolled	**Number of BHH members enrolled with contact between PCP and behavioral health provider**	**Number of BHH members with behavioral health inpatient discharge**	**Number of BHH members with behavioral health ambulatory care follow-up within 30 days after behavioral health inpatient discharge**	**Report month**
100	90	3	3	07_2015
105	95	2	1	08_2015
120	100	4	3	09_2015

3.2.22.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.3 Quarterly Deliverables

All quarterly reporting deliverables are due to DMAS by the last calendar day of the month following the end of the reporting quarter, or as noted by specific report. If the last calendar day falls on a Saturday, Sunday, or state holiday, then the quarterly report deliverables are due by close of business of the next full business day.

Unless otherwise stated, the reporting periods and submission dates for quarterly reporting are as follows:

Report Period	Submission Due
January – March,	April 30th
April – June,	July 31st
July – September	October 31st
October – December	January 31st

Certain reports reflect different reporting periods, and these differences are defined in the detailed reporting specifications within this document.

3.3.1 Provider Network File

3.3.1.1 Contract Reference

Medallion 3.0 Contract, Section 3.2.E

FAMIS Contract, Article II, Section I.1.d

3.3.1.2 File Specifications

Field	Specifications
NPI/API	Required. 10 bytes numeric with leading zeros.
PCP Status	Required field. Must contain a valid value. Valid values are Y and N.
Provider Last Name	Required
Provider First Name	Leave blank if facility
Address line 1	Required
Address line 2	Optional
City	Required
State	Required
Zip code	Required. 5 byte numeric with leading zeros.
Taxonomy Code	Required. Current taxonomy code values are listed on the WPC's web site: http://www.wpc-edi.com/reference/ under the link: 'Health Care Provider Taxonomy Code Set'
Provider Type	Required. Examples: Ancillary, CSB, Health Department, Hospital, Independent Lab, OB/GYN, Optical, Pediatric, Pharmacy, Psychiatric
Provider Specialty	Required. Examples: Anesthesiologist, Cardiologist, DME, Hospital, Infectious Disease, Internal Medicine, OB/GYN, Pediatrician, Transportation, etc.

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.

File Name: PROV_NTWK.csv

Trigger: Quarterly, or on a more frequent basis as requested by the Department.

Due Date: By close of business on the last calendar day of the month following the end of the reporting quarter.

DMAS: Managed Care Systems Analyst

3.3.1.3 Requirements

Include providers participating in Medicaid and FAMIS.

The complete provider file; i.e., all PCPs, specialists, and subcontractor networks (this includes transportation, psychiatric, optical, and/or pharmacy, etc.) must be submitted. The entire network should be in a single file submission, formatted as above; not separate files.

Include only network participating providers. Do not include any out of network providers in this file.

For providers with multiple service office locations, each office location must be listed on a different line.

Each provider and service location should be listed only once in the MCO's submission. Do not include multiple lines for the same provider and location with different class types / taxonomy values. Provide the primary class type / taxonomy code only.

The address provided should represent the provider's actual servicing address (not billing, mailing, or corporate). Do not submit P.O. boxes for the provider's servicing address.

Provider last name field must contain the valid individual or business name for the NPI/API provided. Do not use default values for the provider last name.

The following table shows the mapping of NPPES Taxonomy Codes to provider specialty that will be used to evaluate provider networks:

NPPES Taxonomy Code(s)	**Specialty**
207KA0200X 207K00000X	Allergy & Immunology
207L00000X 207LC0200X 207LP2900X 207LP3000X	Anesthesiology
208C00000X	Colon and Rectal Surgery
207N00000X 207ND0900X 207ND0101X 207NP0225X 207NS0135X	Dermatology
207PE0004X 207P00000X 207PH0002X 207PT0002X 207PP0204X 207PE0005X	Emergency Medicine
207QA0401X 207QA0000X 207QA0505X 207Q00000X 207QG0300X 207QH0002X 207QS1201X 207QS0010X	Family Medicine
208D00000X	General Practice

NPPES Taxonomy Code(s)	Specialty
208M00000X	Hospitalist
207RA0401X 207RA0000X 207RA0201X 207RB0002X 207RC0000X 207RC0001X 207RC0200X 207RE0101X 207RG0100X 207RG0300X 207RH0000X 207RH0003X 207RI0008X 207RH0002X 207RI0200X 207R00000X 207RI0011X 207RX0202X 207RN0300X 207RP1001X 207RR0500X 207RS0012X 207RS0010X	Internal Medicine
207SG0202X 207SG0201X	Medical Genetics
207T00000X	Neurological Surgery
207UN0901X 207UN0902X 207U00000X	Nuclear Medicine
207VC0200X 207VF0040X 207VX0201X 207VG0400X 207VH0002X 207VM0101X 207VX0000X 207V00000X 207VE0102X	Obstetrics & Gynecology
207W00000X 152W00000X	Ophthalmology
204E00000X	Oral Surgery
207XS0114X 207XX0004X 207XS0106X 207X00000X 207XS0117X 207XX0801X 207XP3100X 207XX0005X	Orthopedic Surgery

NPPES Taxonomy Code(s)	Specialty
207YS0123X 207YX0602X 207Y00000X 207YX0905X 207YX0901X 207YP0228X 207YX0007X 207YS0012X	Otolaryngology
208VP0014X 208VP0000X	Pain Medicine
207ZP0101X 207ZP0102X 207ZB0001X 207ZP0105X 207ZC0500X 207ZD0900X 207ZH0000X 207ZN0500X 207ZP0213X	Pathology
2080A0000X 2080P0006X 2080H0002X 2080N0001X 2080P0008X 2080P0201X 2080P0202X 2080P0203X 2080P0204X 2080P0205X 2080P0206X 2080P0207X 2080P0208X 2080P0210X 2080P0214X 2080P0216X 208000000X 2080S0012X 2080S0010X	Pediatrics
183500000X 3336C0002X 3336H0001X 332900000X	Pharmacy
2081H0002X 2081N0008X 2081P2900X 2081P0010X 208100000X 2081P0004X 2081S0010X	Physical Medicine and Rehabilitation
208200000X 2082S0099X 2082S0105X	Plastic Surgery

NPPES Taxonomy Code(s)	Specialty
2083A0100X 2083T0002X 2083X0100X 2083P0500X 2083P0901X 2083P0011X	Preventive Medicine
2084A0401X 2084P0802X 2084B0040X 2084P0804X 2084N0600X 2084D0003X 2084F0202X 2084P0805X 2084P0005X 2084N0400X 2084N0402X 2084P2900X 2084P0800X 2084P0015X 2084S0012X 2084V0102X	Psychiatry & Neurology
2085B0100X 2085D0003X 2085R0202X 2085U0001X 2085N0700X 2085N0904X 2085P0229X 2085R0001X 2085R0203X 2085R0204X	Radiology
2086S0120X 2086S0122X 208600000X 2086S0105X 2086S0102X 2086X0206X 2086S0127X 2086S0129X	Surgery
208G00000X	Thoracic Surgery
204F00000X	Transplant Surgery
2088P0231X 208800000X	Urology
101Y00000X 106H00000X 103T00000X 103TC0700X 104100000X 1041C0700X 101YM0800X 101YP2500X	Behavioral Health and Social Service Providers

NPPES Taxonomy Code(s)	Specialty
367A00000X 363L00000X 363LA2100X 363LA2200X 363LF0000X 363LP0200X 363A00000X 363AM0700X 363AS0400X 367500000X	Physician Assistants and Advanced Practice Nursing Providers
225X00000X 225100000X 227800000X 227900000X 231H00000X 235Z00000X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers
282N00000X	Acute Care Hospital
291U00000X	Clinical Medical Laboratory
251S00000X	Community Service Boards
332BC3200X 332B00000X 332BX2000X	Durable Medical Equipment Supplier
261QE0700X	End-Stage Renal Disease Facility
261QF0050X 261QF0400X	Federally-Qualified Health Centers (FQHC)
261QP0904X 251K00000X	Health Department
251E00000X	Home Health
333600000X 3336C0003X 3336L0003X	Pharmacy
335E00000X	Prosthetic Supplier
261QR1100X	Rural Health Care Clinic (RHC)
314000000X	Skilled Nursing Facility
344800000X 341600000X 3416L0300X 347B00000X 343900000X 343800000X 344600000X	Transportation
261QU0200X	Urgent Care Center

3.3.1.4 Examples

None

3.3.1.5 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

3.3.2 Providers Failing Accreditation/Credentialing and Terminations

3.3.2.1 Contract Reference

Medallion 3.0 Contract, Section 3.1

FAMIS Contract, Section 3.1

3.3.2.2 File Specifications

Method:	DMAS secure FTP server
Format:	Excel (.xlsx file)
File Name:	PRV_CRED.xlsx
Trigger:	Quarterly
Due Date:	By close of business on the last calendar day of the month following the end of the reporting quarter.
DMAS:	Program Integrity Division

3.3.2.3 Requirements

Include providers participating in Medicaid and FAMIS. Include all MCO-terminated providers in this report. The template is located on the DMAS web site, titled "Providers Failing Accreditation/Credentialing and Terminations."

3.3.2.4 Examples

None

3.3.2.5 Scoring Criteria

None

3.3.3 **Case Managers List (Eliminated)**

Deliverable eliminated effective 07/01/2015

3.3.4 Members with Physical and Behavioral Health Limitations and Conditions (Eliminated)

Deliverable eliminated effective 07/01/2015

3.3.5 Program Integrity Activities

3.3.5.1 Contract Reference

Medallion 3.0 Contract, Section 9.2

FAMIS Contract, Section 9.2

3.3.5.2 File Specifications

Method:	DMAS secure FTP server
Format:	PDF file
File Name:	PI_ACTIV.pdf
Trigger:	Quarterly
Due Date:	By close of business on the last calendar day of the month following the end of the reporting quarter.
DMAS:	Program Integrity Division

3.3.5.3 Requirements

Include all components as specified by the contract. The template is located on the DMAS web site, titled “Quarterly PI Abuse Overpayment-Recovery Report”.

3.3.5.4 Examples

None

3.3.5.5 Scoring Criteria

None

3.3.6 **BOI Filing - Quarterly**

3.3.6.1 Contract Reference

Medallion 3.0 Contract, Section 12.1.A

FAMIS Contract, Section 12.1.A

3.3.6.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	BOI_QTRLY.pdf
Trigger:	Quarterly
Due Date:	On the same day on which it is submitted to the Bureau of Insurance
DMAS:	Provider Reimbursement Division

3.3.6.3 Requirements

All data for this deliverable must be submitted to DMAS in a single PDF file via the FTP as specified above. Do not submit any hardcopy files to DMAS.

3.3.6.4 **Examples**

None

3.3.6.5 Scoring Criteria

None

3.3.7 Financial Report

3.3.7.1 Contract Reference

Medallion 3.0 Contract, Section 12.1.B

FAMIS Contract, Section 12.1.B

3.3.7.2 File Specifications

Method:	DMAS secure FTP server
Format:	Excel (.xlsx) file
File Name:	FIN_QTRLY.xlsx
Trigger:	Quarterly
Due Date:	First, second and third quarter reports are due by the close of business 45 days following the end of the reporting quarter. Fourth quarter, CY and the Annual Statement to BOI are due by the close of business 60 days following the end of the reporting quarter.
DMAS:	Provider Reimbursement Division

3.3.7.3 Requirements

As specified by contract and additional guidance provided by DMAS Provider Reimbursement Division. The template for submission of this report is provided on the Managed Care web site.

All data for this deliverable must be submitted to DMAS in a single Excel (.xlsx) file via the FTP as specified above. Do not submit any hardcopy files to DMAS.

3.3.7.4 Examples

	For the quarter ended [date]					
	Analysis of Operations By Line Of Business					
		Medallion 3.0 Medicaid (Title XIX)	FAMIS + FAMIS MOMS SCHIP (Title XXI)	Commonwealth Coordinated Care (CCC) Medicaid + Medicare	All Other Lines of Business	Total
1	Net Premium Income					
	1a. Medicaid					
	1b. Medicare					
	1c. Total					
2	Change In unearned premium reserves and reserve for rate credit					
3	Fee-for-Service (net of $0 medical expenses)					
4	Risk revenue					
5	Aggregate write Ins for other health care related revenues					
6	Aggregate write ins for other non-health care related revenues					
7	Total revenues (lines 1 through 6)					
8	Hospital/medical Benefits					
9	Other professional Services					
10	Outside referrals					
11	Emergency Room and Out of Area					
12	Prescription drugs					
13	Aggregate write-Ins for other hospital and medical					
14	Incentive pool, withhold adjustments and bonus amounts					
15	Subtotal (line 8 to 14)					
16	Net reinsurance recoveries					
17	Total hospital and medical (15 minus 16)					
18	Non-health claims (net)					
19	Claims adjustment expenses including cost containment expense					
20	General and administrative expenses					
21	Increase in reserves for life and A&H contracts					
22	Increase in reserve for life contracts					
23	Total underwriting deductions (Line 17 to 22)					
24	Net Underwriting gain or (loss) (Line 7 less 23)					
1401	Outpatient facility claims					
1402	Ancillary provider claims					
1403						
1498	Summary of remaining write-ins for Line 13 from overflow page					
1499	Total (Lines 1401 through 1403 plus 1498) (from Line 14 above)					
	Fully Insured Membership					
	Fully Insured Member Months					
	Premiums PMPM					

3.3.7.5 Scoring Criteria

None

3.3.8 Reinsurance

3.3.8.1 Contract Reference

Medallion 3.0 Contract, Section 12.12

FAMIS Contract, Section 12.12

3.3.8.2 File Specifications

Field	Specifications
CLAIM_ID	Format: CHAR(20) Unique MCO or MMIS claim identification number (ICN/CCN) Required
FROM_DATE	Format: MM/DD/YYYY(10) First date on which service provided Required
FILL_DATE	Format: DATE(10) - MM/DD/YYYY Date prescription was filled Optional
PAID_DATE	Format: DATE(10) - MM/DD/YYYY Date claim paid; important for calculating IBNR/trend estimates Required
RECIP_ID	Format: CHAR(12) Member's Medicaid ID number Required
SSN	Format: CHAR(9) No dashes. Fill with spaces if SSN is not available. Optional
BIRTH	Format: DATE(10) - MM/DD/YYYY Member's birth date Optional
SEX	Format: CHAR(1) Valid Values: 'F' = female; 'M' = male; 'U' = unknown Optional
CTY_CNTY	Format: CHAR(3) FIPS code of member's residence – Must be valid Virginia city/county code Optional
ELIG_CAT	Format: CHAR(10) Member's aid category code If provided, must be a valid Virginia Medicaid/FAMIS aid category Optional
PROV_NPI	Format: CHAR(10) Provider NPI or API number Required
PROV_TAXID	Format: CHAR(9) Provider tax ID Optional

Field	Specifications
BILLED_AMT	Format: Numeric with 2 decimal places, no leading zeroes, no commas, and no dollar sign. Must be greater than zero. Billed/charged amount Required
PAID_AMT	Format: Numeric with 2 decimal places, no leading zeroes, no commas, and no dollar sign. Must be greater than zero. Paid amount- INGREDIENT COST + DISPENSING FEE Required
COPAY_AMT	Format: Numeric with 2 decimal places, no leading zeroes, no commas, and no dollar sign. Must be greater than zero. Co-pay collected Required
DISPENSE_FEE	Format: Numeric with 2 decimal places, no leading zeroes, and no dollar sign. Dispensing fee Required
BRAND_GEN	Format: CHAR(1) Brand/Generic indicator. Valid values are: 'B'=brand, 'G'=generic Optional
DRUG	Format: CHAR(50) Drug name Optional
DAW	Format: CHAR(1) Dispensed as written indicator. Valid values are: 0 = No product selection indicated (Default); 1 = Substitution not allowed by prescribing physician; 2 = Substitution allowed - patient requested product dispensed; 3 = Substitution allowed - pharmacist selected product dispensed; 4 = Substitution allowed - generic drug not in stock; 5 = Substitution allowed - brand drug dispensed as generic; 6 = Override; 7 = Substitution not allowed - brand drug mandated by law; 8 = Substitution allowed - generic drug not available in marketplace; 9 = Other. Optional
NDC	Format: CHAR(11) Must be a valid NDC National drug code (NDC) Situational based on claim type (pharmacy / medical).
THER_CLS	Format: CHAR(2) Standard therapeutic class code Optional
REFILL	Format: CHAR(1) Refill indicator: Valid Values: ‘Y’ = refill; ‘N’ = not refill Optional
STATUS	Format: CHAR(1) Claim status; please submit final adjudicated paid claims only. Identifies whether this claim record represents an original payment or an adjustment / void to a prior quarter payment Valid Values: O = Original; A = Adjustment (full replacement); V = Void. ‘A’ and ‘V’ values are used for corrections to prior period claims Required

Field	Specifications
SUB_CAP	Format: CHAR(1) Indicates whether claim is paid FFS or is a capitated service; Valid Values: 'F' =FFS, 'C' = Capitated Required
PROC_CD	Format: Char(5) HCPCS / CPT/ J-code used for medical claims. Situational based on claim type (pharmacy / medical).

Method: DMAS secure FTP server

Format: Comma Separated Values

File Name: REINSURE.csv

Trigger: Quarterly

Due Date: Q3 – Due by DMAS close of business on October 31st
Q4 – Due by DMAS close of business on January 31st
Q1 – Due by DMAS close of business on April 30th
Q2 – Due by DMAS close of business September 30th

DMAS: Provider Reimbursement Division

3.3.8.3 Requirements

Include members enrolled in Medicaid and FAMIS.

Only include members whose total MCO payment amount for all drug costs for the current contract year is over the $150,000 threshold. Includes pharmacy, physician, and outpatient hospital costs.

Data submitted each quarter must be cumulative year to date. For example, if a member exceeds the threshold in the first quarter, then report all prescription drug costs associated with that member in each successive quarter along with any new prescription drug costs.

In order to be processed for reimbursement by DMAS, MCO reinsurance requests must be submitted within five (5) business days of the due date specified for this deliverable.

Any submitted claim records that do not meet the specifications (editing criteria) specified for this deliverable in the MCTM will not be accepted and not considered for reimbursement.

3.3.8.4 Examples

None

3.3.8.5 Scoring Criteria

None

3.3.9 PCP Incentive Payments

3.3.9.1 Contract Reference

2014 Medallion 3.0 Contract, Section 12.14.E

FAMIS Contract, Section 12.14.E

3.3.9.2 File Specifications

Field Description	Description	Validation Rules
MCO Code	Identifies the MCO submitting the file.	Must be one of the following values: AGP, ANT, CNT, MJC, OFC, VAP
Submission Quarter	Identifies the quarter of the submission for DMAS.	Format: yyyyq (e.g., 20131). Every record in the file must have the same value in this field.
Payment Quarter	Identifies the quarter in which the **original** claim was paid.	Format: yyyyq (e.g., 20131). Based on calendar year quarter
Provider NPI	NPI of the servicing PCP who has attested, or For PA/NP, this must be the NPI of the directly supervising provider (who must also have attested).	Format: 10 bytes with leading zeroes. Must be a valid NPI.
Medicaid ID	Member's Medicaid ID.	Must be a valid Medicaid ID. For newborns where the Medicaid ID is not available, use the mother's ID. Format: 12 bytes with leading zeros.
Claim Status	Identifies whether this claim record represents an original payment or an adjustment / void to a prior quarter payment.	Valid values are: O = Original A = Adjustment (full replacement) V = Void
MCO Claim Identifier	MCO's unique identifier for the claim. For adjustments, this value must match the MCO Claim Identifier previously submitted to DMAS on the original.	Must be unique value within the MCO's quarterly file. Must be 20 characters or less. If 'Claim Status' is 'V' or 'A', this identifier must match the original claim in the MCO's previous submission file that is indicated in the 'Payment Quarter' field.
From Date of Service	From date of service.	Must be a valid date. Format = mm/dd/yyyy. Must be greater than 01/01/2013.
Thru Date of Service	Thru date of service. Use From Date if single day service.	Must be a valid date. Format = mm/dd/yyyy. Must be greater than 01/01/2013.
Date of Birth	Member's date of birth.	Must be a valid date. Format = mm/dd/yyyy. Must be less than From Date if Service.

Field Description	Description	Validation Rules
Region Code	This code value identifies where the service was rendered (based on provider location), and is used to validate the appropriate Medicare reimbursement rate.	Valid Values: NOVA = Provider servicing location is in northern Virginia (Alexandria city, Arlington, Fairfax county, Fairfax city, and Falls Church city). OTHR = Provider servicing location is not in northern Virginia.
Procedure code	Identifies the service rendered on the claim.	Cannot be blank. Should be a valid procedure code in the range of E&M (99201 – 99499) or immunization codes (e.g., 90460 - 90799).
Payment Method	Identifies the payment methodology that the MCO is using for reimbursement of the increased PCP rate for providers who have attested.	Valid Values: R = MCO pays increased PCP rate as a separate incremental amount on a quarterly 'reconciliation' basis. C = MCO pays increased amount to providers through their individual claims payment request process.
Billed Charge	The amount billed by the provider on the claim payment request submitted to the MCO.	Format: Numeric with 2 decimal places, no leading zeroes, and no dollar sign. Must be greater than zero.
TPL / COB Amt	Third Party Payer amount(s) applied on this claim.	Format: Numeric with 2 decimal places, no leading zeroes, and no dollar sign. Must be less than or equal to the 'Billed Charge'.
Base Payment Amount	• For MCOs who reimburse quarterly, this is the payment amount from the initial claim payment to the provider. • For MCOs who reimburse on a claims basis, this is the payment amount that would have been made for this claim if the provider had not attested as a PCP.	Format: Numeric with 2 decimal places, no leading zeroes, and no dollar sign. Must be less than or equal to the 'Billed Charge' minus 'TPL Amt'.

Field Description	Description	Validation Rules
Increased PCP Final Payment Amount	• For MCOs who reimburse quarterly, this is the sum of the payment amount from the original claim payment to the provider plus the amount of the incremental payment made in the quarterly reconciliation. • For MCOs who reimburse on a claims basis, this is the total payment amount that was made to the provider.	Format: Numeric with 2 decimal places, no leading zeroes, and no dollar sign. Must be greater than or equal to the 'Base Payment Amount'.

Method:	DMAS secure FTP server
Format:	Comma separated values. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.
File Name:	PCP_PMT.csv
Trigger:	Quarterly
Due Date:	By close of business on the last calendar day of the month following the end of the reporting quarter.
DMAS:	Managed Care Contract Monitor and Provider Reimbursement Division

3.3.9.3 Requirements

As specified above.

3.3.9.4 Examples

None

3.3.9.5 Scoring Criteria

None

3.3.10 **Disproportionate Share Hospital (Eliminated)**

This deliverable was eliminated effective 10/01/2015.

3.3.11 **Patient Utilization Management and Safety Outcome Report**

3.3.11.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.M.IV

FAMIS Contract, Section 7.1.M.IV

3.3.11.2 File Specifications

Field Description	Specifications
Total number of members referred to PUMS program	Value must be ≥ 0
Number of members under PUMS referral reason #1	Value must be ≥ 0
Number of members under PUMS referral reason #2	Value must be ≥ 0
Number of members under PUMS referral reason #3	Value must be ≥ 0
Number of members restricted to a pharmacy	Value must be ≥ 0
Number of members restricted to a provider	Value must be ≥ 0
Number of members with a case management referral	Value must be ≥ 0
Number of members with a substance abuse treatment referral	Value must be ≥ 0
Number of members with Contractor action #1	Value must be ≥ 0

Method: DMAS secure FTP server

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Numeric fields should not include commas, dollar signs, or other extraneous characters. Do not include a header row in .csv files.

File Name: PUMS_OUTCOME.csv

Trigger: Quarterly

Due Date: [Beginning October 1, 2015] By close of business on the last calendar day of the month following the end of the reporting quarter.

DMAS: Managed Care Operations

3.3.11.3 Requirements

The reporting for this deliverable begins October 1, 2015. Only include members referred to the PUMS program during the reporting quarter. The referral reasons and actions should only reflect those for members referred to the PUMS during the reporting quarter. A member may be counted in more than one referral action type and more than one type of action category.

3.3.11.4 Examples

None

3.3.11.5 Scoring Criteria

None

3.3.12 **Provider GeoAccess® GeoNetworks® File**

3.3.12.1 Contract Reference

Medallion 3.0 Contract, Section 3.2.G

FAMIS Contract, Section 3.2.G

3.3.12.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PROVIDER_ACCESS.pdf
Trigger:	Quarterly, or on a more frequent basis as requested by the Department
Due Date:	By close of business on the last calendar day of the month following the end of the reporting quarter
DMAS:	Managed Care Operations

3.3.12.3 Requirements

The Contractor shall submit to the Department a file using GeoAccess® GeoNetworks® or equivalent software on a quarterly basis. The file must provide information on travel time and/or distance access standards for PCPs, Obstetrical Providers, and Specialists as noted in Sections 3.11.A and 3.11.B of the Medallion 3.0 contract. The standards must be provided for members at the county/FIPS level for all applicable urban and rural service areas. The file must indicate the date of the membership file used in the calculations.

MCOs may elect to provide either travel time or distance access standards.

The file must show the standards in a numeric format – maps are not acceptable.

Member to provider ratios may be included in the report but should be provided only in addition to the time and distance standards.

3.3.12.4 Examples

None

3.3.12.5 Scoring Criteria

None

3.4 Annual Deliverables

All annual reporting deliverables are due to DMAS within 90 calendar days after the effective contract date, or as noted by specific report. If the last calendar day falls on a Saturday, Sunday, or state holiday, then the report deliverables are due by close of business of the next full business day. The reporting period for annual reporting is the twelve month period July – June. Certain reports reflect different reporting periods, and these differences are defined in the detailed reporting specifications within this document.

3.4.1 List of Subcontractors

3.4.1.1 Contract Reference

Medallion 3.0 Contract, Section 3.16.B

FAMIS Contract, Section 3.16.B

3.4.1.2 File Specifications

Field Description	Specifications
Name of Subcontractor	Must not be blank – 100 character limit
Effective Date	Must be a valid date Format = mm/dd/yyyy
Term of Contract	Must not be blank – 25 character limit
Status	Valid values: New Existing Revised
Scope of Service	Valid Values: Planning Finance Reporting Systems Administration Quality Assessment Credentialing/Recredentialing Utilization Management Member Services Claims Processing Provider Services Transportation Vision Behavioral Health Prescription Drugs Other Providers

Method: DMAS secure FTP server

Format: Comma-separated value (.csv) file

File Name: SUBCONTRACT.csv All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included.

Trigger: Annually and prior to any changes

Due Date: Within 90 calendar days of the start of contract cycle each year and 30 calendar days prior to implementation of any changes

DMAS: Managed Care Operations

3.4.1.3 Requirements

Report should utilize form available from DMAS Managed Care web site and submit file in comma-separated value (.CSV) format.

Include all subcontractors who provide any delegated administrative and medical services in the areas of planning, finance, reporting systems, administration, quality assessment, credentialing/ re-credentialing, utilization management, member services, claims processing, provider services, transportation, vision, behavioral health, prescription drugs, or other providers.

Report submission must include a listing of these subcontractors and the services each provides.

3.4.1.4 Examples

N/A

3.4.1.5 Scoring Criteria

None

3.4.2 Physician Incentive Plan

3.4.2.1 Contract Reference

Medallion 3.0 Contract, Section 4.7

FAMIS Contract, Section 4.7

3.4.2.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PRV_INCENT.pdf
Trigger:	Annual
Due Date:	Within 90 calendar days of the effective contract date
DMAS:	Managed Care Operations

3.4.2.3 Requirements

As specified in the contract.

3.4.2.4 Examples

None

3.4.2.5 Scoring Criteria

None

3.4.3 Provider Satisfaction Survey Instrument

3.4.3.1 Contract Reference

Medallion 3.0 Contract, Section 4.11

FAMIS Contract, Section 4.11

3.4.3.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PROV_SRVY.pdf
Trigger:	Bi-Annual
Due Date:	Submit copy of the survey instrument 30 days prior to distribution
DMAS:	Managed Care Quality Analyst

3.4.3.3 Requirements

As specified in the Medallion 3.0 contract section referenced above.

3.4.3.4 Examples

None

3.4.3.5 Scoring Criteria

None

3.4.4 Provider Satisfaction Survey Methodology

3.4.4.1 Contract Reference

Medallion 3.0 Contract, Section 4.11

FAMIS Contract, Section 4.11

3.4.4.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PROV_SRVY_METH.pdf
Trigger:	Bi-Annual
Due Date:	Submit copy of methodology 30 days prior to distribution
DMAS:	Managed Care Quality Analyst

3.4.4.3 Requirements

As specified in the Medallion 3.0 contract section referenced above.

3.4.4.4 Examples

None

3.4.4.5 Scoring Criteria

None

3.4.5 Provider Satisfaction Survey Results

3.4.5.1 Contract Reference

Medallion 3.0 Contract, Section 4.11

FAMIS Contract, Section 4.11

3.4.5.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PROV_SRVY._RSLTS.pdf
Trigger:	Bi-Annual
Due Date:	Submit results within 120 days after conducting the survey
DMAS:	Managed Care Quality Analyst

3.4.5.3 Requirements

As specified in the Medallion 3.0 contract section referenced above.

3.4.5.4 Examples

None

3.4.5.5 Scoring Criteria

None

3.4.6 Marketing Plan

3.4.6.1 Contract Reference

Medallion 3.0 Contract, Section 6.1.B

FAMIS Contract, Section 6.1.B

3.4.6.2 File Specifications

Method:	DMAS secure FTP server
Format:	Word document
File Name:	MKTG_PLAN.docx
Trigger:	Annually and prior to any changes
Due Date:	Within 90 calendar days of the start of contract cycle each year and 30 calendar days prior to implementation of any changes
DMAS:	Managed Care Operations

3.4.6.3 Requirements

As specified in contract.

3.4.6.4 Examples

None

3.4.6.5 Scoring Criteria

None

3.4.7 Member Handbook

3.4.7.1 Contract Reference

Medallion 3.0 Contract, Section 6.8

FAMIS Contract, Section 6.8

3.4.7.2 File Specifications

Method:	DMAS secure FTP server (MII and FAMIS)
Format:	Adobe .pdf file
File Name:	MBR_HNDBK.pdf
Trigger:	Prior to Signing Original Contract Annually and prior to any changes
Due Date:	60 calendar days prior to printing (new or revised). Within 10 business days of receipt of DMAS request
DMAS:	Managed Care Operations

3.4.7.3 Requirements

The updated handbook must address changes in policies through submission of a cover letter identifying sections that have changed and/or red-lined showing the before and after language.

Include separate handbooks for Medicaid and FAMIS.

3.4.7.4 Examples

None

3.4.7.5 Scoring Criteria

None

3.4.8 Health Plan Assessment Plan

3.4.8.1 Contract Reference

Medallion 3.0 Contract, Section 7.7.D

FAMIS Contract, Section 7.7.D

3.4.8.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	ASSMT_PLAN.pdf
Trigger:	Annual
Due Date:	October 1st of each year.
DMAS:	Managed Care Operations

3.4.8.3 Requirements

Plan must outline MCO's Medicaid assessment plan for the contract year. The submission must include the assessment tools.

3.4.8.4 Examples

None

3.4.8.5 Scoring Criteria

None

3.4.9 Medallion Care System Partnership Annual Plan

3.4.9.1 Contract Reference

Medallion 3.0 Contract, Section 7.8.C

FAMIS Contract, Section 7.8.C

3.4.9.2 File Specifications

Medallion Care System Partnership (MCSP) - Requirement	MCSP #1	Additional References to Attachments	Reason for Changes to MCSPs (use this column only if modifying an existing MCSP)
1.1 - What specified model options and incentive types are to be used as part of the proposed agreement (MCOs may combine options and incentive types within a single MCSP). Reference the types listed in Chart form in the Medallion 3.0 Contract, Section 7.8.D.IV. **Example: Model 1.1.A - Performance Rewards, MCO Contracts with Primary Care Providers**			
2.1 - What type of service delivery and care coordination models are part of the proposed MCSP arrangement?			
2.2 - What is the target population of each proposed agreement? How does this MCSP focus on Pediatric Services and pediatric populations? An MCSP may also target adults**.**			
2.3 - What is the projected enrollment numbers for each proposed agreement?			
2.4 - What service area would be supported by each agreement?			
2.5 - Describe the process for assigning or attributing members within each agreement. Attach Policies & Procedures if necessary.			
2.6 - Describe the method that will be used for tracking cost of care or total costs of care needed to implement the model chosen. Attach Policies & Procedures if necessary.			

Medallion Care System Partnership (MCSP) - Requirement	MCSP #1	Additional References to Attachments	Reason for Changes to MCSPs (use this column only if modifying an existing MCSP)
2.7 - What type of incentive arrangement (specific proprietary financial terms not required) have been set up as a part of the MCSP agreement?			
2.8 - What types of arrangements are being implemented for remedies for non-performance as part of the MCSP agreement?			
2.9 - Include an overarching timeline with milestones pertaining to the proposals- include planned completion dates for the MCSP.			
3.1 - Which Providers included in each MCSP arrangement are designated as a Health Care Home or Health Home? Indicate if some portions of the provider entity are and others are not. Reference & include Attachments if necessary. If currently accredited by NCQA or URAC as a patient centered medical home, please include that information.			
3.2 - Describe how providers involved in the MCSP shall demonstrate adherence (to both DMAS & the MCO) to the core set of Medical Home/Health Home Principles, specified in section 7.8.A of the Medallion 3.0 Contract. Attach Polices & Procedures if necessary.			
3.3 - Describe the process by which the MCO through its Health Care Homes will identify and monitor members with complex or chronic health conditions who are enrolled with the MCO within the context of the MCSP. Attach Policies & Procedures if necessary and a sample report that would be given to the provider, if applicable.			

Medallion Care System Partnership (MCSP) - Requirement	MCSP #1	Additional References to Attachments	Reason for Changes to MCSPs (use this column only if modifying an existing MCSP)
3.4 - Describe the process which the MCO through its Health Care Homes will assign enrollment in the Health Care Home to the medical group/practitioner site and identify member specific care needs. Attach Policies & Procedures if necessary.			
4.1 What quality indicators will be used to measure each participating providers performance and how will measurement be integrated into the MCSP? Reference MCSP Quality Document, as found in **Medallion 3.0 Attachment XV. (Select one measure Menu #1 and Menu #2 for each MCSP).**			
4.2 - What types of (targeted) population health outcomes are expected as a result of the MCSP agreement?			
4.3 - What benchmarks or standards will be used to determine whether the Provider entity is effectively implementing the agreement, including, cost of care expectations? How often will evaluation occur?			
4.4 - What is the MCO's process for monitoring and evaluating the effectiveness of and cost benefit of the MCSP? Attach Policies & Procedures if necessary.			

Method: DMAS secure FTP server

Format: Adobe .pdf file

File Name: MCSP_PLAN.pdf

Trigger: Annual

Due Date: November 1

DMAS: Senior Health Care Services Manager

3.4.9.3 Requirements

MCO shall submit a written description of its proposed MCSPs to the Department as an MCSP Annual Plan. The Department will review each proposed MCSP Annual Plan and determine whether the MCSP criteria have been met prior to approving the Annual Plan.

If this MCSP Annual Plan proposal is based on the previous year's final approved proposal (50% or more of the proposal being the same or only slightly changed), new MCSP Annual Plan submissions must use the final approved proposal as a starting point, with additions, deletions, and changes to the proposal RED-LINED or Highlighted to expedite the Department's review.

3.4.9.4 Examples

N/A

3.4.9.5 Scoring Criteria

None

3.4.10 **Medallion Care System Partnership Performance Results**

3.4.10.1 Contract Reference

Medallion 3.0 Contract, Section 7.8.D.I and 7.8.C.I.k

FAMIS Contract, Section 7.8.D.I and 7.8.C.I.k

3.4.10.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	MCSP_PERF.pdf
Trigger:	Annual
Due Date:	Within 90 calendar days of the start of contract cycle each year and 30 calendar days prior to implementation of any changes
DMAS:	Senior Health Care Services Manager

3.4.10.3 Requirements

The report shall not exceed 15 pages in total length, including attachments, and must be based on the Final Version of the MCSPs that has been approved by the Department, if applicable.

Must include the following elements:

Section I: Introduction and Summary Description of MCSP (including population covered and partners)

Section II: Findings

Section II: Ongoing Evaluation Plans and Outcomes

Section IV: Conclusions/Next Steps (to include narrative about whether the MCSP is working. If functioning as anticipated, why is it successful? If not functioning as anticipated, why is it unsuccessful and how will the MCO modify this MCSP?)

Section V: Graphics or supporting documentation/attachments

3.4.10.4 Examples

N/A

3.4.10.5 Scoring Criteria

None

3.4.11 **Quality Improvement Plan**

3.4.11.1 Contract Reference

Medallion 3.0 Contract, Section 8.2.A

FAMIS Contract, Section 8.2.A

3.4.11.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	QI_PLAN.pdf
Trigger:	Enrollment as a new MCO with Virginia Medicaid
Due Date:	At least 60 days prior to receipt of the first enrollment file from DMAS
DMAS:	Managed Care Quality Analyst

3.4.11.3 Requirements

The plan should clearly define the MCO's quality improvement structure for Medicaid and FAMIS members. The plan must include, at a minimum, all of Element A (quality improvement structure) from the most recent version of NCQA's standards.

3.4.11.4 Examples

None

3.4.11.5 Scoring Criteria

None

3.4.12 **Quality Assessment & Performance Improvement Plan**

3.4.12.1 Contract Reference

Medallion 3.0 Contract, Section 8.2.A

FAMIS Contract, Section 8.2.A

3.4.12.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	QAPI_PLAN.pdf
Trigger:	Annual
Due Date:	July 31st
DMAS:	Managed Care Quality Analyst

3.4.12.3 Requirements

As specified in the contract.

3.4.12.4 Examples

None

3.4.12.5 Scoring Criteria

None

3.4.13 **HEDIS Results**

3.4.13.1 Contract Reference

Medallion 3.0 Contract, Section 8.3

FAMIS Contract, Section 8.3

3.4.13.2 File Specifications

Method:	DMAS secure FTP server
Format:	Excel file
File Name:	HEDIS.xlsx
Trigger:	Annual
Due Date:	July 31st
DMAS:	Managed Care Quality Analyst

3.4.13.3 Requirements

As specified in the contract.

3.4.13.4 Examples

None

3.4.13.5 Scoring Criteria

None

3.4.14 **HEDIS Corrective Action Plan (Eliminated)**

Requirement eliminated effective 07/01/2015.

3.4.15 **CAHPS Survey Results**

3.4.15.1 Contract Reference

Medallion 3.0 Contract, Section 8.3

FAMIS Contract, Section 8.3

3.4.15.2 File Specifications

Method:	DMAS secure FTP server
Format:	Excel or PDF file
File Name:	CAHPS.pdf or CAHPS.xlsx
Trigger:	Annual
Due Date:	July 31st
DMAS:	Managed Care Quality Analyst

3.4.15.3 Requirements

As specified in the contract, including all detailed survey results.

3.4.15.4 Examples

None

3.4.15.5 Scoring Criteria

None

3.4.16 **Performance Improvement Project (PIP)**

3.4.16.1 Contract Reference

Medallion 3.0 Contract, Section 8.4.A

FAMIS Contract, Section 8.4.A

3.4.16.2 File Specifications

Method:	DMAS secure FTP server
Format:	PDF file
File Name:	PIP.pdf
Trigger:	Annual
Due Date:	July 31st.
DMAS:	Managed Care Quality Analyst

3.4.16.3 Requirements

As specified in the contract. Report must comply with all reporting and content criteria as defined by DMAS Quality Analyst and/or EQRO.

Submit each Performance Improvement Project report to DMAS in a separate file.

When there is more than one report submitted in a day, append a sequence number to the file name, e.g., PIP1.pdf, PIP2.pdf, etc.

3.4.16.4 Examples

None

3.4.16.5 Scoring Criteria

None

3.4.17 **Wellness and Member Incentive Programs**

3.4.17.1 Contract Reference

Medallion 3.0 Contract, Section 7.10

FAMIS Contract, Section 7.10

3.4.17.2 File Specifications

Method:	DMAS secure FTP server
Format:	PDF file
File Name:	MBR_WELL.pdf
Trigger:	Annual
Due Date:	Within 90 calendar days of the start of contract cycle each year and 30 calendar days prior to implementation of any changes
DMAS:	Managed Care Operations

3.4.17.3 Requirements

As specified in the contract. Summarize all wellness and member incentive programs used to encourage active patient participation in health and wellness activities to both improve health and control costs.

3.4.17.4 Examples

None

3.4.17.5 Scoring Criteria

None

3.4.18 **Complex Care Management Plan**

3.4.18.1 Contract Reference

Medallion 3.0 Contract, Section 8.6.A.IV

FAMIS Contract, Section 8.6.A.IV

3.4.18.2 File Specifications

Method:	DMAS secure FTP server
Format:	PDF file
File Name:	CCM_PLAN.pdf
Trigger:	Annual
Due Date:	September 30th
DMAS:	Managed Care Operations

3.4.18.3 Requirements

As specified in the contract.

3.4.18.4 Examples

None

3.4.18.5 Scoring Criteria

None

3.4.19 **Prenatal Program Outcomes (Eliminated)**

This deliverable was eliminated effective 10/01/2015.

3.4.20 **Program Integrity Plan**

3.4.20.1 Contract Reference

Medallion 3.0 Contract, Section 9.2

FAMIS Contract, Section 9.2

3.4.20.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PI_PLAN.pdf
Trigger:	Annual
Due Date:	Within 90 calendar days of the effective contract date.
DMAS:	Program Integrity Division

3.4.20.3 Requirements

As specified in the contract.

3.4.20.4 Examples

None

3.4.20.5 Scoring Criteria

None

3.4.21 **Program Integrity Activities Annual Summary**

3.4.21.1 Contract Reference

Medallion 3.0 Contract, Section 9.2

FAMIS Contract, Section 9.2

3.4.21.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PRI_OUTCM.pdf
Trigger:	Annual
Due Date:	September 30th
DMAS:	Program Integrity Division

3.4.21.3 Requirements

Include members enrolled in Medicaid and FAMIS

3.4.21.4 Examples

None

3.4.21.5 Scoring Criteria

None

3.4.22 **Organizational Charts**

3.4.22.1 Contract Reference

Medallion 3.0 Contract, Section 14.6.A

FAMIS Contract, Section 14.6.A

3.4.22.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	ORG_CHART.pdf
Trigger:	Annual
Due Date:	Within 90 calendar days of the effective contract date.
DMAS:	Managed Care Operations

3.4.22.3 Requirements

As specified in contract.

3.4.22.4 Examples

None

3.4.22.5 Scoring Criteria

None

3.4.23 **Program Integrity Compliance Audit (PICA)**

3.4.23.1 Contract Reference

Medallion 3.0 Contract, Section 9.3

FAMIS Contract, Section 9.3

3.4.23.2 File Specifications

Method:	DMAS secure FTP server
Format:	Excel (.xlsx) file
File Name:	PICA.xlsx
Trigger:	Annual
Due Date:	January 1st
DMAS:	Program Integrity Division

3.4.23.3 Requirements

Contractor must utilize Program Integrity Compliance Audit (PICA) form available on the DMAS Managed Care web site. Contractors shall produce a standard audit report for each completed audit that includes, at a minimum:

- Purpose
- Methodology
- Findings
- Determination of Action and Final Resolution
- Claims Detail List

In developing the types of audits to include in the plan Contractors shall:

- Determine which risk areas will most likely affect their organization and prioritize the monitoring and audit strategy accordingly.
- Utilize statistical methods in:
  - Randomly selecting facilities, pharmacies, providers, claims, and other areas for review;
  - Determining appropriate sample size; and
  - Extrapolating audit findings to the full universe.
- Assess compliance with internal processes and procedures.
- Review areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.

3.4.23.4 Examples

None

3.4.23.5 Scoring Criteria

None

3.4.24 **BOI Filing - Annual**

3.4.24.1 Contract Reference

Medallion 3.0 Contract, Section 12.1.A

FAMIS Contract, Section 12.1.A

3.4.24.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	BOI_ANNUAL.pdf
Trigger:	Annual
Due Date:	On the same day on which it is submitted to the Bureau of Insurance
DMAS:	Provider Reimbursement Division

3.4.24.3 Requirements

All data for this deliverable must be submitted to DMAS in a single PDF file via the FTP as specified above. Do not submit any hardcopy files to DMAS.

3.4.24.4 Examples

None

3.4.24.5 Scoring Criteria

None

3.4.25 **Audit by Independent Auditor (Required by BOI)**

3.4.25.1 Contract Reference

Medallion 3.0 Contract, Section 12.1.A.I

FAMIS Contract, Section 12.1.A

3.4.25.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	IND_AUDIT.pdf
Trigger:	Annual
Due Date:	At the time it is submitted to the Bureau of Insurance or within 30 days of completion of audit (whichever is sooner)
DMAS:	Provider Reimbursement Division

3.4.25.3 Requirements

As specified in contract.

All data for this deliverable must be submitted to DMAS in a single PDF file via the FTP as specified above. Do not submit any hardcopy files to DMAS.

3.4.25.4 Examples

None

3.4.25.5 Scoring Criteria

None

3.4.26 **Company Background History**

3.4.26.1 Contract Reference

Medallion 3.0 Contract, Section 14.6.D

FAMIS Contract, Section 14.6.D

3.4.26.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe.pdf file
File Name:	BACK_HIST.pdf
Trigger:	Annual
Due Date:	Within 90 calendar days of the effective contract date.
DMAS:	Managed Care Operations

3.4.26.3 Requirements

The Contractor shall submit annually an updated company background history that includes any awards, major changes or sanctions imposed since the last annual report. The Contractor shall also submit the same information for all of its subcontractors.

3.4.26.4 Examples

None

3.4.26.5 Scoring Criteria

None

3.4.27 **Health Insurer Fee**

3.4.27.1 Contract Reference

Medallion 3.0 Contract, Section 12.5.B

FAMIS Contract, Section 12.5.B

3.4.27.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe (.pdf) file
File Name:	Health Insurer Fee (HIF) Certification.pdf
Trigger:	Annual
Due Date:	September 15th
DMAS:	Provider Reimbursement Division

3.4.27.3 Requirements

Use the template posted on the 'HIF Certification' template posted on the DMAS Managed Care web site, 'Studies and Reports' tab, 'Reporting Documentation' section.

The Medallion 3.0 contract provides for the reimbursement of that portion of the ACA Health Insurer Fee allocated to the Virginia Medicaid line of business. Use the provided Microsoft Word template to certify the calculation of the Virginia Medicaid portion of the fee. Complete the certification and submit it via FTP along with the calculation of the Virginia Medicaid portion including gross up and the Final Fee calculation letter 5067C.

3.4.27.4 Examples

None

3.4.27.5 Scoring Criteria

None

3.4.28 Patient Utilization Management and Safety (PUMS) Prior Authorization Requirements

3.4.28.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.M.IV

FAMIS Contract, Section 7.1.M.IV

3.4.28.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PUMS_PRIOR_AUTH.pdf
Trigger:	Annual
Due Date:	Within 90 calendar days of the effective contract date
DMAS:	Managed Care Operations

3.4.28.3 Requirements

Beginning October 1, 2015, the contractor shall submit its prior authorization mechanism for members enrolled in its PUMS program.

3.4.28.4 Examples

N/A

3.4.28.5 Scoring Criteria

None

3.4.29 **Behavioral Health Home Pilot Care Team**

3.4.29.1 Contract Reference

Medallion 3.0 Contract, Section 7.9.E.III

FAMIS Contract, Section 7.9.E.III

3.4.29.2 File Specifications

Field Description	Specifications
Role	Required. Must be 1 character Valid values: 1,2,3,4,5
Team Member Name	Required. Must be 40 characters or less
Phone Number	Required. Format 10 bytes
Email Address	Required. Must be valid email address format (localpart@domain)

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	BHH_TEAM.pdf
Trigger:	Annual Upon Change
Due Date:	Within 90 calendar days of the effective contract date or within 10 days of change
DMAS:	Managed Care Operations

3.4.29.3 Requirements

Use the following codes to indicate the members of the behavioral health home pilot care team: 1 = BHH Pilot Lead, 2 = Psychiatrist, 3 = Case Manager, 4 = Pharmacist, 5 = Primary Care Physician. Names and contact information must be submitted to the Department at the beginning of the pilot and upon changes. If membership on the Care Team will rotate, please include all members.

3.4.29.4 Examples

None

3.4.29.5 Scoring Criteria

None

3.4.30 **Behavioral Health Home Plan Outreach and Marketing Plan**

3.4.30.1 Contract Reference

Medallion 3.0 Contract, Section 7.9.E.IV

FAMIS Contract, Section 7.9.E.IV

3.4.30.2 File Specifications

Method:	Email: Todd.Clark@dmas.virginia.gov,Daniel.Plain@dmas.virginia.gov (Identify as "Behavioral Health Home Outreach and Marketing Plan" in subject line of email)
Format:	Adobe .pdf file
File Name:	BHH_OUTREACH.pdf
Trigger:	Annually Prior to Signing Original Contract Prior to Any Changes
Due Date:	60 calendar days prior to printing (new or revised) Within 10 business days of receipt of DMAS request
DMAS:	Managed Care Operations

3.4.30.3 Requirements

Provide a one-page description of the BHH Pilot Member education process which shall include: how members are notified of BHH enrollment, identification of resources available to help enrolled members, and how enrolled members may navigate the system. BHH member education materials, including any web-based materials, must be submitted to the Department for approval. The Department will have 30 days to review such documents.

3.4.30.4 Examples

None

3.4.30.5 Scoring Criteria

None

3.4.31 **Maternity Program Summary Report**

3.4.31.1 Contract Reference

Medallion 3.0 Contract, Section 8.7.E.II

FAMIS Contract, Section 8.7.E.II

3.4.31.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	MAT_PGM_SUM.pdf
Trigger:	Annual
Due Date:	Within 90 calendar days of the start of contract cycle each year and 30 calendar days prior to implementation of any changes
DMAS:	Managed Care Operations

3.4.31.3 Requirements

Provide a 3 to 5 page description of the MCO's accomplishments, challenges, and partnerships during the last contract year. Include the number of participating pregnant women and how many were identified as high risk. Also include any changes in the MCO's maternity program from the previous contract year and the results of one initiative to support positive birth outcomes.

3.4.31.4 Example

N/A

3.4.31.5 Scoring Criteria

None

3.4.32 **Maternity Program Policy Report**

3.4.32.1 Contract Reference

Medallion 3.0 Contract, Section 8.7.E.II

FAMIS Contract, Section 8.7.E.II

3.4.32.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	MAT_PGM_POLICY.pdf
Trigger:	Annual
Due Date:	Within 90 calendar days of the start of contract cycle each year and 30 calendar days prior to implementation of any changes
DMAS:	Managed Care Operations

3.4.32.3 Requirements

Complete the Managed Care Maternity Care Program matrix as provided on the DMAS Managed Care web site. Scan files (if necessary) and import into matrix document. Submit all information as one file.

3.4.32.4 Example

None

3.4.32.5 Scoring Criteria

None

3.4.33 **Interventions Targeted to Prevent Controlled Substance Abuse**

3.4.33.1 Contract Reference

Medallion 3.0 Contract, Section 7.2.S.II

FAMIS Contract, Section 7.2.S.II

3.4.33.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PREVENT_ABUSE.pdf
Trigger:	Annual
Due Date:	Within 90 calendar days of the start of contract cycle each year and 30 calendar days prior to implementation of any changes
DMAS:	Managed Care Operations

3.4.33.3 Requirements

The contractor must submit an annual report that describes its interventions targeted to prevent controlled substance abuse. The actions described in this report should reflect the Contractor's entire Medicaid membership. The report must describe actions taken by the Contractor to prevent the inappropriate use of controlled substances, including but not limited to, any clinical treatment protocols, a detailed definition of what, if any substances the Contractor targets that are not scheduled substances under the Controlled Substances Act (21 U.S.C. § 801 et seq.) but may place an individual at higher risk for abuse, prior authorization requirements, quantity limits, poly-pharmacy considerations, and related clinical edits.

3.4.33.4 Examples

N/A

3.4.33.5 Scoring Criteria

None

3.4.34 **Abortion Services**

3.4.34.1 Contract Reference

Medallion 3.0 Contract, Section 7.3.B

FAMIS Contract, Section 7.3.B

3.4.34.2 File Specifications

Method:	DMAS secure FTP server
Format:	To be determined
File Name:	To be determined
Trigger:	Annual
Due Date:	Beginning after October 1, 2015
DMAS:	Managed Care Operations

3.4.34.3 Requirements

The requirements for this report will be determined in a future version of the MCTM.

3.4.34.4 Examples

N/A

3.4.34.5 Scoring Criteria

None

3.5 Other Reporting Requirements

This section documents reporting deliverables that fall outside of the usual monthly, quarterly, and annual report cycles.

Each deliverables in this section is required by contract. Contract references are provided for each deliverable.

This section provides additional detail for each deliverable, including the specific trigger event(s) and the time frame (due date) in which the deliverable is required to be provided to DMAS.

Where applicable, this section also describes and specific content that is required for the particular deliverable.

3.5.1 NCQA Deficiencies

3.5.1.1 Contract Reference

Medallion 3.0 Contract, Section 2.3

FAMIS Contract, Section 2.3

3.5.1.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	NCQA_DEF.pdf
Trigger:	MCO receipt of notification from NCQA of deficiency(s)
Due Date:	30 calendar days after NCQA notification
DMAS:	Managed Care Quality Analyst

3.5.1.3 Requirements

N/A

3.5.1.4 Examples

N/A

3.5.1.5 Scoring Criteria

None

3.5.2 NCQA Accreditation Status Changes

3.5.2.1 Contract Reference

Medallion 3.0 Contract, Section 2.3.B and 8.2.A

FAMIS Contract, Sections 2.3.B and 8.2.A

3.5.2.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	NCQA_ACRED.pdf
Trigger:	Notification by NCQA of Change in MCO's Accreditation Status
Due Date:	10 calendar days after NCQA notification
DMAS:	Managed Care Quality Analyst

3.5.2.3 Requirements

N/A

3.5.2.4 Examples

N/A

3.5.2.5 Scoring Criteria

None

3.5.3 Provider Agreements

3.5.3.1 Contract Reference

Medallion 3.0 Contract, Section 3.1 and Attachment III, Section A

FAMIS Contract, Section 3.1 and Attachment III, Section A

3.5.3.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PRV_AGRMT_CHG.pdf
Trigger:	Creation of new provider network agreement or modification of existing agreement (includes MCO and subcontractor)
Due Date:	At least 30 days prior to effective date
DMAS:	Managed Care Operations

3.5.3.3 Requirements

See detailed contract requirements for this deliverable.

3.5.3.4 Examples

N/A

3.5.3.5 Scoring Criteria

None

3.5.4 MCO Staffing Changes

3.5.4.1 Contract Reference

Medallion 3.0 Contract, Section 3.16.B and 14.6

FAMIS Contract, Section 3.16.B and 14.6

3.5.4.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Change in key staff position at MCO as specified in the Medallion 3.0 contract
Due Date:	Must be reported to DMAS within 5 business days of each change
DMAS:	Managed Care Operations

3.5.4.3 Requirements

MCO must provide all of the relevant documentation for each staffing change as specified in the Medallion 3.0 contract.

3.5.4.4 Examples

N/A

3.5.4.5 Scoring Criteria

None

3.5.5 Provider Network Change Affecting Member Access to Care

3.5.5.1 Contract Reference

Medallion 3.0 Contract, Section 3.2.B

FAMIS Contract, Section 3.2.B

3.5.5.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Change to the provider network affecting member access to care
Due Date:	Within 30 business days
DMAS:	Managed Care Operations

3.5.5.3 Requirements

N/A

3.5.5.4 Examples

N/A

3.5.5.5 Scoring Criteria

None

3.5.6 Hospital Contract Changes

3.5.6.1 Contract Reference

Medallion 3.0 Contract, Section 3.2.B

FAMIS Contract, Section 3.2.B

3.5.6.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Change to hospital contract
Due Date:	Within 30 business days
DMAS:	Managed Care Operations

3.5.6.3 Requirements

N/A

3.5.6.4 Examples

N/A

3.5.6.5 Scoring Criteria

None

3.5.7 Provider Credentialing Policies and Procedures

3.5.7.1 Contract Reference

Medallion 3.0 Contract, Section 3.4.A

FAMIS Contract, Section 3.4.A

3.5.7.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PROV_CRED.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to receipt of first 834 enrollment roster 10 business days prior to any published revision to the Provider Manual Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations

3.5.7.3 Requirements

Submission must adhere to all content and format requirements set forth in Medallion 3.0 contract language.

3.5.7.4 Examples

N/A

3.5.7.5 Scoring Criteria

None

3.5.8 Practitioner Infractions

3.5.8.1 Contract Reference

Medallion 3.0 Contract, Section 3.4.A and Attachment III, A

FAMIS Contract, Section 3.4.A and Attachment III, A

3.5.8.2 File Specifications

Method:	Email: ManagedCare.Reporting@dmas.virginia.gov
Format:	Adobe .pdf file
File Name:	N/A
Trigger:	Suspension or termination of a practitioner's license
Due Date:	Within 5 business days
DMAS:	Managed Care Contract Monitor and forward to Program Integrity Division

3.5.8.3 Requirements

Submission must adhere to all content and format requirements set forth in Medallion 3.0 contract language.

3.5.8.4 Examples

N/A

3.5.8.5 Scoring Criteria

None

3.5.9 PCP Assignment Policies & Procedures

3.5.9.1 Contract Reference

Medallion 3.0 Contract, Section 3.6

FAMIS Contract, Section 3.6

3.5.9.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PCP_ASSIGN.pdf
Trigger:	Prior to signing of original contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations

3.5.9.3 Requirements

N/A

3.5.9.4 Examples

N/A

3.5.9.5 Scoring Criteria

None

3.5.10 **Inpatient Hospital Contracting Changes**

3.5.10.1 Contract Reference

Medallion 3.0 Contract, Section 3.8

FAMIS Contract, Section 3.8

3.5.10.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	Adobe .pdf file
File Name:	IP_CONTRACT.pdf
Trigger:	Any changes to MCO contract(s) with inpatient hospital
Due Date:	Within 15 calendar days of any change(s)
DMAS:	Managed Care Operations

3.5.10.3 Requirements

Refer to Attachment III of the Medallion 3.0 contract for complete details.

3.5.10.4 Examples

N/A

3.5.10.5 Scoring Criteria

None

3.5.11 **Changes to Claims Operations**

3.5.11.1 Contract Reference

Medallion 3.0 Contract, Section 4.4

FAMIS Contract, Section 4.4

3.5.11.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Any significant changes to the MCO's) claims processing operations
Due Date:	45 calendar days in advance of any change
DMAS:	Managed Care Operations

3.5.11.3 Requirements

As specified in contract.

3.5.11.4 Examples

N/A

3.5.11.5 Scoring Criteria

None

3.5.12 **Provider Disenrollment Policies & Procedures**

3.5.12.1 Contract Reference

Medallion 3.0 Contract, Section 4.5

FAMIS Contract, Section 4.5

3.5.12.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PROV_DISENROLL.pdf
Trigger:	Initial Medallion 3.0 contract signature
Due Date:	45 calendar days prior to contract signature
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations and file

3.5.12.3 Requirements

As specified in the Medallion 3.0 contract language, including all subsections within this section.

3.5.12.4 Examples

N/A

3.5.12.5 Scoring Criteria

None

3.5.13 **Enrollment – Excluding Members**

3.5.13.1 Contract Reference

Medallion 3.0 Contract, Section 5.1.B

FAMIS Contract, Section 5.1.B

3.5.13.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	ENROL_EXCLUSION.pdf
Trigger:	Upon learning that a member meets one or more of the exclusion criteria
Due Date:	Within 48 hours of discovery
DMAS:	Managed Care Operations

3.5.13.3 Requirements

As specified in the Medallion 3.0 contract language. Contractor must utilize Member Action Form available on the DMAS Managed Care web site.

Submit each member enrollment exclusion request to DMAS in a separate file.

When there is more than one exclusion request per day, append a sequence number to the file name, e.g., ENROL_EXCLUSION1.pdf, ENROL_EXCLUSION2.pdf, etc.

3.5.13.4 Examples

N/A

3.5.13.5 Scoring Criteria

None

3.5.14 **Newborn Identification Procedures**

3.5.14.1 Contract Reference

Medallion 3.0 Contract, Section 5.7

FAMIS Contract, Section 5.7

3.5.14.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	NEWBORN_ID.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations and file

3.5.14.3 Requirements

N/A

3.5.14.4 Examples

N/A

3.5.14.5 Scoring Criteria

None

3.5.15 **Member Education & Outreach**

3.5.15.1 Contract Reference

Medallion 3.0 Contract, Section 6.1

FAMIS Contract, Section 6.1

3.5.15.2 File Specifications

Method:	DMAS secure FTP server (MII and FAMIS)
Format:	Adobe .pdf file
File Name:	OUTREACH.pdf
Trigger:	Community education, networking or outreach program event
Due Date:	2 calendar weeks prior to event
DMAS:	Managed Care Operations

3.5.15.3 Requirements

N/A

3.5.15.4 Examples

N/A

3.5.15.5 Scoring Criteria

None

3.5.16 **Member Marketing Materials**

3.5.16.1 Contract Reference

Medallion 3.0 Contract, Section 6.1.C

FAMIS Contract, Section 6.1.C

3.5.16.2 File Specifications

Method:	DMAS secure FTP server (MII and FAMIS)
Format:	Adobe .pdf file
File Name:	MKTG_MATL.pdf
Trigger:	Planned distribution of marketing materials as defined in the Medallion 3.0 contract
Due Date:	30 days prior to their planned distribution
DMAS:	Managed Care Operations

3.5.16.3 Requirements

As specified in the Medallion 3.0 contract.

3.5.16.4 Examples

N/A

3.5.16.5 Scoring Criteria

None

3.5.17 **Member Incentive Awards**

3.5.17.1 Contract Reference

Medallion 3.0 Contract, Section 6.2.I

FAMIS Contract, Section 6.2.I

3.5.17.2 File Specifications

Method:	DMAS secure FTP server (MII and FAMIS)
Format:	Adobe .pdf file
File Name:	INCENT_AWD.pdf
Trigger:	Implementation of incentive award program
Due Date:	30 days prior to implementation
DMAS:	Managed Care Operations

3.5.17.3 Requirements

N/A

3.5.17.4 Examples

N/A

3.5.17.5 Scoring Criteria

None

3.5.18 **Member Enrollment, Disenrollment, and Educational Materials**

3.5.18.1 Contract Reference

Medallion 3.0 Contract, Sections 6.4, 6.6, 6.12

FAMIS Contract, Sections 6.4, 6.6, 6.12

3.5.18.2 File Specifications

Method:	DMAS secure FTP server (MII and FAMIS)
Format:	Adobe .pdf file
File Name:	MBR_EDE.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any published revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Operations

3.5.18.3 Requirements

Including, but not limited to the following:

- New Member Packet
- All enrollment, disenrollment, and educational materials made available to members by the MCO
- All member health education materials, including any newsletters sent to members

3.5.18.4 Examples

N/A

3.5.18.5 Scoring Criteria

None

3.5.19 **Program Changes**

3.5.19.1 Contract Reference

Medallion 3.0 Contract, Section 6.8.M.I

FAMIS Contract, Section 6.8.M.I

3.5.19.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	When they occur
Due Date:	30 calendar days prior to implementation
DMAS:	Managed Care Operations

3.5.19.3 Requirements

N/A

3.5.19.4 Examples

N/A

3.5.19.5 Scoring Criteria

None

3.5.20 **Member Rights - Policies & Procedures**

3.5.20.1 Contract Reference

Medallion 3.0 Contract, Section 6.9

FAMIS Contract, Section 6.9

3.5.20.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	MBR_RIGHTS.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations and file

3.5.20.3 Requirements

N/A

3.5.20.4 Examples

N/A

3.5.20.5 Scoring Criteria

None

3.5.21 **Member Health Education & Prevention Plan**

3.5.21.1 Contract Reference

Medallion 3.0 Contract, Section 6.12

FAMIS Contract, Section 6.12

3.5.21.2 File Specifications

Method:	DMAS secure FTP server (MII and FAMIS)
Format:	Adobe .pdf file
File Name:	EDUC_PGM.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any published revision to the Provider Manual Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Operations

3.5.21.3 Requirements

As specified in contract.

3.5.21.4 Examples

N/A

3.5.21.5 Scoring Criteria

None

3.5.22 **EPSDT Second Review Process**

3.5.22.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.D.III

FAMIS Contract, Section 7.1.D.III

3.5.22.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Prior to Implementation or Upon Request
Due Date:	Within 10 business days
DMAS:	Managed Care Operations

3.5.22.3 Requirements

N/A

3.5.22.4 Examples

N/A

3.5.22.5 Scoring Criteria

None

3.5.23 **Services Not Covered Due to Moral or Religious Objections**

3.5.23.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.I

FAMIS Contract, Section 7.1.I

3.5.23.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	OBJ_SRVCS.pdf
Trigger:	With the initiation of the Contract Upon adoption of such policy Upon Request
Due Date:	Upon signing of the original contract 30 calendar days prior to implementation of any change(s) Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations and file

3.5.23.3 Requirements

N/A

3.5.23.4 Examples

N/A

3.5.23.5 Scoring Criteria

None

3.5.24 **Sentinel Event**

3.5.24.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.J

FAMIS Contract, Section 7.1.J

3.5.24.2 File Specifications

Method	DMAS secure FTP server
Format	Adobe .pdf file
File Name	SENTINEL.pdf.
Trigger	Identification by the MCO of any member sentinel event
Due Date	Within 48 hours of identification
DMAS	Managed Care Contract Monitor forward to Compliance Analyst for processing

3.5.24.3 Requirements

Contractor must utilize the Member Action Form provided on DMAS Managed Care website.

Submit each sentinel event report to DMAS in a separate file.

When there is more than one sentinel event report per day, append a sequence number to the file name, e.g., SENTINEL1.pdf, SENTINEL2.pdf, etc.

3.5.24.4 Examples

N/A

3.5.24.5 Scoring Criteria

None

3.5.25 Patient Utilization Management and Safety (PUMS) Program Policies and Procedures

3.5.25.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.M.IV

FAMIS Contract, Section 7.1.M.IV

3.5.25.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PUMS_OUTCM.pdf
Trigger:	Annual
Due Date:	October 1
DMAS:	Managed Care Operations

3.5.25.3 Requirements

Plan must provide MCO's applicable policies and procedures, including clinical protocols used to determine appropriate intervention(s) and referral(s) to other services that may be needed (such as substance abuse treatment services, etc.).

3.5.25.4 Examples

N/A

3.5.25.5 Scoring Criteria

None

3.5.26 **Compliance for Sterilizations & Hysterectomies**

3.5.26.1 Contract Reference

Medallion 3.0 Contract, Sections 7.2.N.III and 7.2.N.IV

FAMIS Contract, Sections 7.2.N.III and 7.2.N.IV

3.5.26.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	STERL_HYST.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations

3.5.26.3 Requirements

N/A

3.5.26.4 Examples

N/A

3.5.26.5 Scoring Criteria

None

3.5.27 **Substance Abuse Services for Pregnant Women**

3.5.27.1 Contract Reference

Medallion 3.0 Contract, Section 7.2.N.V.j

FAMIS Contract, Section 7.2.N.V.j

3.5.27.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	SUBS_ABS_PREG.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any published revision to the Provider Manual Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations and file

3.5.27.3 Requirements

N/A

3.5.27.4 Examples

N/A

3.5.27.5 Scoring Criteria

None

3.5.28 Access to Services for Disabled Children & Children with Special Health Care Needs

3.5.28.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.O.III

FAMIS Contract, Section 7.1.O.III

3.5.28.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	CSHCN_ACCESS.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations and file

3.5.28.3 Requirements

N/A

3.5.28.4 Examples

N/A

3.5.28.5 Scoring Criteria

None

3.5.29 **Utilization Management Plan**

3.5.29.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.P

FAMIS Contract, Section 7.1.P

3.5.29.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	UM_PLAN.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any published revision to the Provider Manual Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations and file

3.5.29.3 Requirements

As specified in the contract.

3.5.29.4 Examples

N/A

3.5.29.5 Scoring Criteria

None

3.5.30 **Atypical Drug Utilization Reporting**

3.5.30.1 Contract Reference

Medallion 3.0 Contract, Section 7.2.S

FAMIS Contract, Section 7.2.S

3.5.30.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	DMAS request
Due Date:	Within 30 calendar days of request
DMAS:	Managed Care Operations

3.5.30.3 Requirements

N/A

3.5.30.4 Examples

N/A

3.5.30.5 Scoring Criteria

None

3.5.31 **Drug Formulary & Authorization Requirements**

3.5.31.1 Contract Reference

Medallion 3.0 Contract, Section 7.2.S

FAMIS Contract, Section 7.2.S

3.5.31.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	FORMULARY.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any published revision to the Provider Manual Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations and file

3.5.31.3 Requirements

N/A

3.5.31.4 Examples

N/A

3.5.31.5 Scoring Criteria

None

3.5.32 **Incarcerated Members**

3.5.32.1 Contract Reference

Medallion 3.0 Contract, Section 7.3.A.V

FAMIS Contract, Section 7.3.A.V

3.5.32.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	INCAR_999999999999.pdf (where 9s are the member ID)
Trigger:	Identification of incarcerated member
Due Date:	Within 48 hours of knowledge
DMAS:	Managed Care Contract Monitor forward to Compliance Analyst for processing

3.5.32.3 Requirements

Contractor must utilize the Member Event reporting template provided on DMAS Managed Care website.

Submit each incarcerated member report to DMAS in a separate file.

3.5.32.4 Examples

N/A

3.5.32.5 Scoring Criteria

None

3.5.33 **Enhanced Services**

3.5.33.1 Contract Reference

Medallion 3.0 Contract, Section 7.4

FAMIS Contract, Section 7.4

3.5.33.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Upon Revision
Due Date:	30 calendar days prior to implementing any new enhanced services
DMAS:	Managed Care Operations

3.5.33.3 Requirements

As specified in the contract.

3.5.33.4 Examples

N/A

3.5.33.5 Scoring Criteria

None

3.5.34 **NCQA Accreditation Renewal**

3.5.34.1 Contract Reference

Medallion 3.0 Contract, Section 8.2.A

FAMIS Contract, Section 8.2.A

3.5.34.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	NCQA_RENEW.pdf
Trigger:	NCQA Accreditation Assessment or Renewal
Due Date:	Within 30 calendar days after NCQA notification to the MCO
DMAS:	Managed Care Quality Analyst

3.5.34.3 Requirements

Must include all components as specified in the contract.

3.5.34.4 Examples

N/A

3.5.34.5 Scoring Criteria

None

3.5.35 **Prenatal Programs and Services Policies and Procedures (Eliminated)**

This deliverable was eliminated effective 10/01/2015.

3.5.36 **Fraud, Waste and Abuse Policies & Procedures**

3.5.36.1 Contract Reference

Medallion 3.0 Contract, Section 9.2.A.III

FAMIS Contract, Section 9.2.A.III

3.5.36.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	FWA_POLICY.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Program Integrity Division

3.5.36.3 Requirements

N/A

3.5.36.4 Examples

N/A

3.5.36.5 Scoring Criteria

None

3.5.37 **Provider Appeals Process**

3.5.37.1 Contract Reference

Medallion 3.0 Contract, Section 9.2.A.VIII

FAMIS Contract, Section 9.2.A.VIII

3.5.37.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PROV_APPEALS.pdf
Trigger:	Prior to Signing Original Contract Upon Revision
Due Date:	Upon Revision
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations and file

3.5.37.3 Requirements

N/A

3.5.37.4 Examples

N/A

3.5.37.5 Scoring Criteria

None

3.5.38 **Fraud and/or Abuse Incident**

3.5.38.1 Contract Reference

Medallion 3.0 Contract, Section 9.2.I

FAMIS Contract, Section 9.2.I

3.5.38.2 File Specifications

Method:	Email: ManagedCare.Reporting@dmas.virginia.gov
Format:	Adobe .pdf file
File Name:	N/A
Trigger:	Initiation of any investigative action by the Contractor or notification to the Contractor that another entity is conducting such an investigation of the Contractor, its network providers or members
Due Date:	Within 48 hours of initiation or notification and before initial investigation
DMAS:	Program Integrity Division

3.5.38.3 Requirements

Report must use either the “Notice of Suspected Recipient Fraud or Misconduct” template or the “Notification of Provider Investigation” template available from DMAS Managed Care web site.

3.5.38.4 Examples

N/A

3.5.38.5 Scoring Criteria

None

3.5.39 **Marketing Fraud/Waste/Abuse**

3.5.39.1 Contract Reference

Medallion 3.0 Contract, Section 9.2.I

FAMIS Contract, Section 9.2.I

3.5.39.2 File Specifications

Method:	Email: ManagedCare.Reporting@dmas.virginia.gov
Format:	Adobe .pdf file
File Name:	N/A
Trigger:	Discovery of an incident of potential or actual marketing services fraud, waste and abuse
Due Date:	Within 48 hours of discovery of incident
DMAS:	Program Integrity Division

3.5.39.3 Requirements

Report must use the “Notification of Provider Investigation” template available from DMAS Managed Care web site.

3.5.39.4 Examples

N/A

3.5.39.5 Scoring Criteria

None

3.5.40 **Medicaid Fraud Control Unit (MFCU) Referrals**

3.5.40.1 Contract Reference

Medallion 3.0 Contract, Section 9.2.I

FAMIS Contract, Section 9.2.I

3.5.40.2 File Specifications

Method:	Email: ManagedCare.Reporting@dmas.virginia.gov
Format:	Adobe .pdf file
File Name:	N/A
Trigger:	Referral to MFCU
Due Date:	Upon discovery
DMAS:	Program Integrity Division

3.5.40.3 Requirements

Report must use either the “Referral of Suspected Provider Fraud” template or the “Notice of Suspected Recipient Fraud or Misconduct” template available from the DMAS Managed Care website.

3.5.40.4 Examples

N/A

3.5.40.5 Scoring Criteria

None

3.5.41 **Member Grievance & Appeals Policies & Procedures**

3.5.41.1 Contract Reference

Medallion 3.0 Contract, Section 10.1.D

FAMIS Contract, Section 10.1.D

3.5.41.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	MEMBER_GA.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations

3.5.41.3 Requirements

As specified in contract.

3.5.41.4 Examples

N/A

3.5.41.5 Scoring Criteria

None

3.5.42 **Enrollment Verification for Providers Policies & Procedures**

3.5.42.1 Contract Reference

Medallion 3.0 Contract, Section 11.3.E

FAMIS Contract, Section 11.3.E

3.5.42.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	ENROL_VER.pdf
Trigger:	Prior to signing of original contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations and file

3.5.42.3 Requirements

N/A

3.5.42.4 Examples

N/A

3.5.42.5 Scoring Criteria

None

3.5.43 **Encounter Data Plan for Completeness**

3.5.43.1 Contract Reference

Medallion 3.0 Contract, Section 11.5.D

FAMIS Contract, Section 11.5.D

3.5.43.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	ENC_PLAN.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Systems & Reporting Supervisor

3.5.43.3 Requirements

As specified in the contract.

3.5.43.4 Examples

N/A

3.5.43.5 Scoring Criteria

None

3.5.44 **Encounter Data Deficiencies**

3.5.44.1 Contract Reference

Medallion 3.0 Contract, Section 11.5.D

FAMIS Contract, Section 11.5.D

3.5.44.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	ENC_DEFIC.pdf
Trigger:	Identification of deficiency(s) in encounter data processes
Due Date:	Within 60 calendar days of identification
DMAS:	Systems & Reporting Supervisor

3.5.44.3 Requirements

As specified in the contract.

3.5.44.4 Examples

N/A

3.5.44.5 Scoring Criteria

None

3.5.45 **Encounter Data Corrective Action Plan**

3.5.45.1 Contract Reference

Medallion 3.0 Contract, Section 11.5.D

FAMIS Contract, Section 11.5.D

3.5.45.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	ENC_CAP.pdf
Trigger:	Notification to DMAS of deficiency(s) in encounter data processes
Due Date:	Within 30 calendar days of notification
DMAS:	Systems & Reporting Supervisor

3.5.45.3 Requirements

As specified in the contract.

3.5.45.4 Examples

N/A

3.5.45.5 Scoring Criteria

None

3.5.46 **BOI Filing - Revisions**

3.5.46.1 Contract Reference

Medallion 3.0 Contract, Section 12.1.A

FAMIS Contract, Section 12.1.A

3.5.46.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	BOI_REVISION.pdf
Trigger:	Upon Revision
Due Date:	On the same day on which it is submitted to the Bureau of Insurance
DMAS:	Provider Reimbursement Division

3.5.46.3 Requirements

N/A

3.5.46.4 Examples

None

3.5.46.5 Scoring Criteria

None

3.5.47 **Independent Audit**

3.5.47.1 Contract Reference

Medallion 3.0 Contract, Section 12.1.A.I

FAMIS Contract, Section 12.1.A.I

3.5.47.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	AUDIT.pdf
Trigger:	DMAS request in writing or via email
Due Date:	Within 30 days of audit completion
DMAS:	Provider Reimbursement Division

3.5.47.3 Requirements

N/A

3.5.47.4 Examples

N/A

3.5.47.5 Scoring Criteria

None

3.5.48 **Financial Report - Revisions**

3.5.48.1 Contract Reference

Medallion 3.0 Contract, Section 12.1.B

FAMIS Contract, Section 12.1.B

3.5.48.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	FIN_REVISION.pdf
Trigger:	Upon Revision
Due Date:	On the same day on which it is submitted to the Bureau of Insurance
DMAS:	Provider Reimbursement Division

3.5.48.3 Requirements

As specified by contract and additional guidance provided by DMAS Provider Reimbursement Division.

Includes detail medical expenditure categories, total member months related to the expenditures, Incurred but Not Reported (IBNR) amounts, and all administrative expenses associated with the Medallion 3.0 Program.

Department reserves the right to approve the final format of the report.

3.5.48.4 Examples

None

3.5.48.5 Scoring Criteria

None

3.5.49 **Basis of Accounting Changes**

3.5.49.1 Contract Reference

Medallion 3.0 Contract, Section 12.2

FAMIS Contract, Section 12.2

3.5.49.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	BOA_CHANGE.pdf
Trigger:	Implementation of any change(s) to the MCO's basis of accounting
Due Date:	Must be submitted to DMAS 30 calendar days prior to implementation of change(s)
DMAS:	Provider Reimbursement Division

3.5.49.3 Requirements

N/A

3.5.49.4 Examples

N/A

3.5.49.5 Scoring Criteria

None

3.5.50 **Reserve Requirements Changes**

3.5.50.1 Contract Reference

Medallion 3.0 Contract, Section 12.4

FAMIS Contract, Section 12.4

3.5.50.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	RESERVE.pdf
Trigger:	Written notification received by the MCO from BOI or any other entity requiring sanctions or/or changes to the MCO's reserve requirements
Due Date:	Must be submitted to DMAS within 2 business days
DMAS:	Provider Reimbursement Division

3.5.50.3 Requirements

As specified in the contract.

3.5.50.4 Examples

N/A

3.5.50.5 Scoring Criteria

None

3.5.51 **FQHC/RHC Arrangements**

3.5.51.1 Contract Reference

Medallion 3.0 Contract, Section 12.14

FAMIS Contract, Section 12.14

3.5.51.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	FQHC_ARRANGE.pdf
Trigger:	Original contract signature Establishment of a financial arrangement with an FQHC or RHC, or changes to an existing arrangement
Due Date:	60 calendar days prior to contract signature Within 10 business days of establishing or changing arrangement
DMAS:	Provider Reimbursement Division

3.5.51.3 Requirements

N/A

3.5.51.4 Examples

N/A

3.5.51.5 Scoring Criteria

None

3.5.52 **FQHC/RHC Reimbursement Methodology**

3.5.52.1 Contract Reference

Medallion 3.0 Contract, Section 12.14

FAMIS Contract, Section 12.14

3.5.52.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	FQHC_REIMBS.pdf
Trigger:	DMAS request
Due Date:	Within 30 calendar days of the request
DMAS:	Provider Reimbursement Division

3.5.52.3 Requirements

N/A

3.5.52.4 Examples

N/A

3.5.52.5 Scoring Criteria

None

3.5.53 **Contractor Non-Compliance Remedy**

3.5.53.1 Contract Reference

Medallion 3.0 Contract, Section 13.2.A.I

FAMIS Contract, Section 13.2.A.I

3.5.53.2 File Specifications

Method:	Email: ManagedCare.Compliance@dmas.virginia.gov
Format:	Adobe .pdf file
File Name:	COMPLIANCE_RMDY.pdf
Trigger:	DMAS Notifies the MCO of specific areas of non-compliance
Due Date:	Remedy must be implemented within the time frame specified by DMAS in the notification
DMAS:	HCS Compliance

3.5.53.3 Requirements

N/A

3.5.53.4 Examples

N/A

3.5.53.5 Scoring Criteria

None

3.5.54 **Corrective Action Plan for Failure to Perform Administrative Function(s)**

3.5.54.1 Contract Reference

Medallion 3.0 Contract, Section 13.2.D.II

FAMIS Contract, Section 13.2.D.II

3.5.54.2 File Specifications

Method:	Email: ManagedCare.Compliance@dmas.virginia.gov
Format:	Adobe .pdf file
File Name:	ADMIN_CAP.pdf
Trigger:	Notification to contractor in writing by DMAS
Due Date:	Within 30 calendar days of notification
DMAS:	HCS Compliance

3.5.54.3 Requirements

The Corrective Action Plan form is available from the DMAS web site. A separate plan must be submitted for each identified compliance violation, failure or deficiency. The plan must contain:

- Compliance Violation/Failure/Deficiency to be addressed (one per report);
- A description of the “root cause” process that the MCO used to determine the reason for the compliance violation/failure/deficiency;
- Intervention(s) that are intended to correct the identified issue;
- Timeline for intervention implementation;
- Individuals responsible for intervention implementation; and
- Improvement goal(s)/benchmark(s) for the noted deficiency.

3.5.54.4 Examples

N/A

3.5.54.5 Scoring Criteria

None

3.5.55 **Disclosure of Ownership & Control Interest Statement (CMS 1513)**

3.5.55.1 Contract Reference

Medallion 3.0 Contract, Section 13.3.A.II

FAMIS Contract, Section 13.3.A.II

3.5.55.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	Adobe .pdf file
File Name:	CMS1513.pdf
Trigger:	Annually at Contract signing Department request
Due Date:	Annually at Contract signing Within 35 days of request by the Department
DMAS:	Managed Care Operations

3.5.55.3 Requirements

As specified in the contract.

3.5.55.4 Examples

N/A

3.5.55.5 Scoring Criteria

None

3.5.56 **Transaction with Other Party of Interest**

3.5.56.1 Contract Reference

Medallion 3.0 Contract, Section 13.3.A.II.a

FAMIS Contract, Section 13.3.A.II.a

3.5.56.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	Adobe .pdf file
File Name:	OTH_INTEREST.pdf
Trigger:	Occurrence of material transaction between the Contractor (MCO) and other party of Interest
Due Date:	Must be submitted to DMAS within 5 business days after transaction occurs
DMAS:	Managed Care Operations

3.5.56.3 Requirements

As specified in the contract, so include all required components.

3.5.56.4 Examples

N/A

3.5.56.5 Scoring Criteria

None

3.5.57 **Acquisition/Merger/Sale**

3.5.57.1 Contract Reference

Medallion 3.0 Contract, Section 13.3.A.II.b

FAMIS Contract, Section 13.3.A.II.b

3.5.57.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	Adobe .pdf file
File Name:	MERGER.pdf
Trigger:	Public announcement of agreement as identified in the Medallion 3.0 contract.
Due Date:	Within 5 calendar days of any such agreement
DMAS:	Managed Care Operations

3.5.57.3 Requirements

As specified in the contract.

3.5.57.4 Examples

N/A

3.5.57.5 Scoring Criteria

None

3.5.58 **Ownership Change**

3.5.58.1 Contract Reference

Medallion 3.0 Contract, Section 13.3.A.II.c

FAMIS Contract, Section 13.3.A.II.c

3.5.58.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	Adobe .pdf file
File Name:	OWNERSHIP.pdf
Trigger:	Change to MCO's ownership as identified in the Medallion 3.0 contract
Due Date:	5 calendar days prior to change
DMAS:	Managed Care Operations

3.5.58.3 Requirements

As specified in the contract.

3.5.58.4 Examples

N/A

3.5.58.5 Scoring Criteria

None

3.5.59 **MCO Principal Conviction or Criminal Offense**

3.5.59.1 Contract Reference

Medallion 3.0 Contract, Section 13.3.A.II.c(v)

FAMIS Contract, Section 13.3.A.II.c(v)

3.5.59.2 File Specifications

Method:	Email: ManagedCare.Reporting@dmas.virginia.gov
Format:	PDF
File Name:	OFFENSE.pdf
Trigger:	Identification any person, principal, agent, managing employee, or key provider of health care services who (1) has been convicted of a criminal offense related to that individual's or entity's involvement in any program under Medicaid or Medicare since the inception of those programs (1965) or (2) has been excluded from the Medicare and Medicaid programs for any reason.
Due Date:	Within 48 hours of identification
DMAS:	Program Integrity Division

3.5.59.3 Requirements

As specified in the contract.

3.5.59.4 Examples

N/A

3.5.59.5 Scoring Criteria

None

3.5.60 **Contractor or Subcontractor on LEIE**

3.5.60.1 Contract Reference

Medallion 3.0 Contract, Section 13.3.A.I.d

FAMIS Contract, Section 13.3.A.I.d

3.5.60.2 File Specifications

Method:	Email: ManagedCare.Reporting@dmas.virginia.gov
Format:	PDF
File Name:	SUB_LEIE.pdf
Trigger:	Identification of any Contractor or subcontractor owners or managing employees on the Federal List of Excluded Individuals/Entities (LEIE) database.
Due Date:	Within 5 business days of identification
DMAS:	Program Integrity Division

3.5.60.3 Requirements

As specified in the contract.

3.5.60.4 Examples

N/A

3.5.60.5 Scoring Criteria

None

3.5.61 **Other Categorically Prohibited Affiliations**

3.5.61.1 Contract Reference

Medallion 3.0 Contract, Section 13.3.B

FAMIS Contract, Section 13.3.B

3.5.61.2 File Specifications

Method:	Email: ManagedCare.Reporting@dmas.virginia.gov
Format:	PDF
File Name:	OTH_EXCL.pdf
Trigger:	Action taken by contractor to exclude entity(s) based on the provisions of section 13.3.B
Due Date:	Within 48 hours of action
DMAS:	Program Integrity Division

3.5.61.3 Requirements

As specified in the contract.

3.5.61.4 Examples

N/A

3.5.61.5 Scoring Criteria

None

3.5.62 **Ownership/Control of Other Entity**

3.5.62.1 Contract Reference

Medallion 3.0 Contract, Section 13.3.A.II.c.iv

FAMIS Contract, Section 13.3.A.II.c.iv

3.5.62.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Prior to initial contract signing
	Change in MCO's ownership and/or control of another entity
Due Date:	5 calendar days prior to change in ownership
DMAS:	Managed Care Operations

3.5.62.3 Requirements

N/A

3.5.62.4 Examples

N/A

3.5.62.5 Scoring Criteria

None

3.5.63 **MCO Medicaid Managed Care Business Changes**

3.5.63.1 Contract Reference

Medallion 3.0 Contract, Section 13.3.A.II.b

FAMIS Contract, Section 13.3.A.II.b

3.5.63.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Change to MCO's Medicaid managed care business as identified in the Medallion 3.0 contract
Due Date:	Within 5 business days
DMAS:	Managed Care Operations

3.5.63.3 Requirements

N/A

3.5.63.4 Examples

N/A

3.5.63.5 Scoring Criteria

None

3.5.64 **Disputes between DMAS and MCO Arising Out of the Contract**

3.5.64.1 Contract Reference

Medallion 3.0 Contract, Section 13.4.B

FAMIS Contract, Section 13.4.B

3.5.64.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	PDF
File Name:	DISPUTE.pdf
Trigger:	Contractor knowledge of the occurrence giving rise to the dispute or the beginning date of the work upon which the dispute is based, whichever is earlier
Due Date:	within sixty (60) calendar days of trigger event
DMAS:	Managed Care Operations

3.5.64.3 Requirements

As specified in the contract, including requirements for prior notification of intent to file.

3.5.64.4 Examples

N/A

3.5.64.5 Scoring Criteria

None

3.5.65 **PHI Breach/Disclosure Notification to DMAS**

3.5.65.1 Contract Reference

Medallion 3.0 Contract, Section 13.5.B

FAMIS Contract, Section 13.5.B

3.5.65.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.govv
Format:	N/A
File Name:	N/A
Trigger:	Refer to contract language
Due Date:	Refer to contract language
DMAS:	Managed Care Operations

3.5.65.3 Requirements

As specified in contract

3.5.65.4 Examples

N/A

3.5.65.5 Scoring Criteria

None

3.5.66 **Data Security Plan for Department Data**

3.5.66.1 Contract Reference

Medallion 3.0 Contract, Section 13.5.B.III and Attachment V

FAMIS Contract, Section 13.5.B.III and Attachment V

3.5.66.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	DATA_SECUR.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations

3.5.66.3 Requirements

As specified in the contract

3.5.66.4 Examples

N/A

3.5.66.5 Scoring Criteria

None

3.5.67 **Data Confidentiality Policies & Procedures**

3.5.67.1 Contract Reference

Medallion 3.0 Contract, Section 13.5.C

FAMIS Contract, Section 13.5.C

3.5.67.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	DATA_CONFID.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations

3.5.67.3 Requirements

N/A

3.5.67.4 Examples

N/A

3.5.67.5 Scoring Criteria

None

3.5.68 **Request for Exemption from Contract Requirement(s)**

3.5.68.1 Contract Reference

Medallion 3.0 Contract, Section 14

FAMIS Contract, Section 14

3.5.68.2 File Specifications

Method:	Email: ManagedCare.Compliance@dmas.virginia.gov
Format:	Adobe .pdf file
File Name:	CONTRACT_EXEMPT.pdf
Trigger:	Signing of contract
Due Date:	30 days prior to effective date
DMAS:	HCS Compliance

3.5.68.3 Requirements

The request for contract exemption must use the MCO Request for Exemption Form (available from the DMAS web site) and include the following: date of request, MCO name, MCO contact and phone, contract cycle period, relevant contract section, and reason for request for exemption. Submit separate requests for each relevant contract section and contract cycle. Requests should be submitted annually for approval.

3.5.68.4 Examples

N/A

3.5.68.5 Scoring Criteria

None

3.5.69 **Notification of Potential Conflict of Interest**

3.5.69.1 Contract Reference

Medallion 3.0 Contract, Section 14.7

FAMIS Contract, Section 14.7

3.5.69.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Signing of contract
Due Date:	Sixty days or more prior to contract signing
DMAS:	Managed Care Operations

3.5.69.3 Requirements

As specified in the contract.

3.5.69.4 Examples

N/A

3.5.69.5 Scoring Criteria

None

3.5.70 **Third Party Administrator (TPA) Contracts**

3.5.70.1 Contract Reference

Medallion 3.0 Contract, Section 14.7.A

FAMIS Contract, Section 14.7.A

3.5.70.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	(10) days prior to execution, and then annually or upon amendment thereafter
Due Date:	As defined in trigger
DMAS:	Managed Care Operations

3.5.70.3 Requirements

As specified in the contract.

3.5.70.4 Examples

N/A

3.5.70.5 Scoring Criteria

None

3.5.71 **Third Party Administrator (TPA) Firewall**

3.5.71.1 Contract Reference

Medallion 3.0 Contract, Section 14.7.B

FAMIS Contract, Section 14.7.B

3.5.71.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	(10) days prior to execution, and then annually or upon amendment thereafter
Due Date:	As defined in trigger
Trigger:	Signing of contract
Due Date:	Sixty days or more prior to contract signing
DMAS:	Managed Care Operations

3.5.71.3 Requirements

The Contractor must provide demonstrable assurances of adequate physical and virtual firewalls whenever utilizing a Third Party Administrator (TPA) for additional services beyond those referenced in Section 14.7.A, or when there is a change in an existing or new TPA relationship. Assurances must include an assessment, performed by an independent contractor/third party, that demonstrates proper interconnectivity with the Department and that firewalls meet or exceed the industry standard. Contractors and TPAs must provide assurances that all service level agreements with the Department will be met or exceeded. Contractor staff must be solely responsible to the single health plan entity contracted with the Department.

3.5.71.4 Examples

N/A

3.5.71.5 Scoring Criteria

None

3.5.72 **Notification of Opt Out of Automatic Contract Renewal Clause**

3.5.72.1 Contract Reference

Medallion 3.0 Contract, Section 14.8

FAMIS Contract, Section 14.8

3.5.72.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Signing of contract
Due Date:	Six months or more prior to renewal date
DMAS:	Managed Care Operations

3.5.72.3 Requirements

As specified in the contract

3.5.72.4 Examples

N/A

3.5.72.5 Scoring Criteria

None

3.5.73 **Insurance Coverage Verification**

3.5.73.1 Contract Reference

Medallion 3.0 Contract, Section 14.16

FAMIS Contract, Section 14.16

3.5.73.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	INS_COVG.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations

3.5.73.3 Requirements

As specified in the contract, including all required components

3.5.73.4 Examples

N/A

3.5.73.5 Scoring Criteria

None

3.5.74 **Notification of Potential MCO Liability**

3.5.74.1 Contract Reference

Medallion 3.0 Contract, Section 14.17

FAMIS Contract, Section 14.17

3.5.74.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Involvement in a situation in which the contractor or one of its subcontractors may be held liable for damages or claims against the contractor or subcontractor
Due Date:	Within 24 hours of involvement
DMAS:	Managed Care Operations

3.5.74.3 Requirements

N/A

3.5.74.4 Examples

N/A

3.5.74.5 Scoring Criteria

None

3.5.75 **Medical Record Safeguards**

3.5.75.1 Contract Reference

Medallion 3.0 Contract, Sections 14.19.A.I and 14.19.A.II

FAMIS Contract, Sections 14.19.A.I and 14.19.A.II

3.5.75.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	MED_REC_SAFE.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations

3.5.75.3 Requirements

N/A

3.5.75.4 Examples

N/A

3.5.75.5 Scoring Criteria

None

.

3.5.76 **Practice Guidelines**

3.5.76.1 Contract Reference

Medallion 3.0 Contract, Section 14.24.B

FAMIS Contract, Section 14.24.B

3.5.76.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PRACT_GUIDE.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations

3.5.76.3 Requirements

As specified in the contract, including all required components

3.5.76.4 Examples

N/A

3.5.76.5 Scoring Criteria

None

3.5.77 **Request for Publication or Presentation of DMAS-Related Subjects**

3.5.77.1 Contract Reference

Medallion 3.0 Contract, Section 14.26

FAMIS Contract, Section 14.26

3.5.77.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Presentation or publication of any DMAS data to any third party entity
Due Date:	30 calendar days prior to the publication / presentation / release of data
DMAS:	Managed Care Operations

3.5.77.3 Requirements

N/A

3.5.77.4 Examples

N/A

3.5.77.5 Scoring Criteria

None

3.5.78 **Bankruptcy Petition**

3.5.78.1 Contract Reference

Medallion 3.0 Contract, Section 14.29.B.VI

FAMIS Contract, Section 14.29.B.VI

3.5.78.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Filing a petition in bankruptcy by a principle network provider or subcontractor
Due Date:	Within 24 hours of filing
DMAS:	Managed Care Operations

3.5.78.3 Requirements

N/A

3.5.78.4 Examples

N/A

3.5.78.5 Scoring Criteria

None

3.5.79 **Provider Manual Managed Care References**

3.5.79.1 Contract Reference

Medallion 3.0 Contract, Attachment III, Section B

FAMIS Contract, Attachment III, Section B

3.5.79.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PROV_MANUAL.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations

3.5.79.3 Requirements

N/A

3.5.79.4 Examples

N/A

3.5.79.5 Scoring Criteria

None

3.5.80 **Notification of Changes to Subcontractor Method of Payment**

3.5.80.1 Contract Reference

Medallion 3.0 Contract, Attachment III, Section C

FAMIS Contract, Attachment III, Section C

3.5.80.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Change in MCO's method of payment of subcontractor
Due Date:	Thirty calendar days or more prior to change
DMAS:	Managed Care Operations

3.5.80.3 Requirements

As specified in the contract

3.5.80.4 Examples

N/A

3.5.80.5 Scoring Criteria

None

3.5.81 **New Agreements and Changes in Approved Agreements**

3.5.81.1 Contract Reference

Medallion 3.0 Contract, Attachment III, Section C

FAMIS Contract, Attachment III, Section C

3.5.81.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PHI_AGREE.pdf
Trigger:	Prior to Signing Original Contract Upon Revision Upon Request
Due Date:	60 calendar days prior to signing of the original contract 10 business days prior to any revision Within 10 business days of receiving a request from DMAS
DMAS:	Managed Care Contract Monitor notifies Managed Care Operations

3.5.81.3 Requirements

N/A

3.5.81.4 Examples

N/A

3.5.81.5 Scoring Criteria

None

3.5.82 **Expansion Request (Letter of Intent)**

3.5.82.1 Contract Reference

Medallion 3.0 Contract, Attachment X

FAMIS Contract, Attachment X

3.5.82.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Todd.Clark@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Initiated by MCO
Due Date:	At least six months prior to the desired expansion date
DMAS:	Managed Care Operations

3.5.82.3 Requirements

As specified in contract, including all required components.

3.5.82.4 Examples

N/A

3.5.82.5 Scoring Criteria

None

3.5.83 MCO Improvement Plan (MIP) for Failure to Perform Administrative Function(s)

3.5.83.1 Contract Reference

Medallion 3.0 Contract, Section 13.2.D.I

FAMIS Contract, Section 13.2.D.I

3.5.83.2 File Specifications

Method:	Email: ManagedCare.Compliance@dmas.virginia.gov
Format:	Adobe .pdf file
File Name:	ADMIN_MIP.pdf
Trigger:	Notification to Contractor in writing by DMAS
Due Date:	Within 30 calendar days of notification
DMAS:	HCS Compliance

3.5.83.3 Requirements

This report must be submitted using the MCO Improvement Plan (MIP) form available from the DMAS web site. A separate plan must be submitted for each identified compliance violation, failure or deficiency.

The report must contain:

- Compliance Violation/Failure/Deficiency to be addressed (one per report);
- Description of area of non-compliance;
- Action steps(s) that are intended to correct the performance issue; and
- Timeline for intervention implementation.

3.5.83.4 Examples

N/A

3.5.83.5 Scoring Criteria

None

4 DMAS Reports

4.1 Reports Generated by DMAS

The following reports are prepared by DMAS and sent to the MCOs.

DMAS has established a secure FTP server for transfer of files with the MCOs, and each MCO has its own secure login. All DMAS reports will be transmitted via DMAS' secure FTP server and should be picked up by the MCO.

The Department will notify the MCO in a timely manner of any changes to the reporting requirements. Changes may be communicated via memo or electronic.

4.1.1 Provider File

4.1.1.1 Contract Reference

Medallion 3.0 Contract, Section 11.4

FAMIS Contract, Section 11.4

4.1.1.2 File Specifications

Field Description	Specifications
PROV	PROVIDER NUMBER
LICENSE	PROVIDER LICENSE NUMBER
PROVBASE	PROVIDER BASE ID
CITY_CNTY	PROVIDER LOCALITY CODE
PROVIDERNAME	PROVIDER NAME
PATTN	PAYTO ATTENTION LINE
PADDR	PAYTO ADDRESS LINE
PCITY	PAYTO CITY
PSTATE	PAYTO STATE
PZIP5	PAYTO ZIP
SATTN	SVC ATTENTION LINE
SADDR	SVC ADDRESS LINE
SCITY	SVC CITY
SSTATE	SVC STATE
SZIP5	SVC ZIP
SOPHONE	SVC OFFICE PHONE NUMBER
IRS_NO	IRS NO.
PCPIND	PCP IND
P_PROG01	PROVIDER PROGRAM CODE 01
BEGDT01C	ELIG BEGIN DATE CURRENT 01
ENDDT01C	ELIG END DATE CURRENT 01
CAN_RN01	CANCEL REASON 01
BEGDT011	PRIOR1 BEGIN DATE 01
ENDDT011	PRIOR1 END DATE 01
CANRN011	PRIOR1 CANCEL REASON 01
BEGDT012	PRIOR2 BEGIN DATE 01
ENDDT012	PRIOR2 END DATE 01
CANRN012	PRIOR2 CANCEL REASON 01
P_PROG02	PROVIDER PROGRAM CODE 02
BEGDT02C	ELIG BEGIN DATE CURRENT 02
ENDDT02C	ELIG END DATE CURRENT 02
CAN_RN02	CANCEL REASON 02

Field Description	Specifications
BEGDT021	PRIOR1 BEGIN DATE 02
ENDDT021	PRIOR1 END DATE 02
CANRN021	PRIOR1 CANCEL REASON 02
BEGDT022	PRIOR2 BEGIN DATE 02
ENDDT022	PRIOR2 END DATE 02
CANRN022	PRIOR2 CANCEL REASON 02
P_PROG03	PROVIDER PROGRAM CODE 03
BEGDT03C	ELIG BEGIN DATE CURRENT 03
ENDDT03C	ELIG END DATE CURRENT 03
CAN_RN03	CANCEL REASON 03
BEGDT031	PRIOR1 BEGIN DATE 03
ENDDT031	PRIOR1 END DATE 03
CANRN031	PRIOR1 CANCEL REASON 03
BEGDT032	PRIOR2 BEGIN DATE 03
ENDDT032	PRIOR2 END DATE 03
CANRN032	PRIOR2 CANCEL REASON 03
P_PROG04	PROVIDER PROGRAM CODE 04
BEGDT04C	ELIG BEGIN DATE CURRENT 04
ENDDT04C	ELIG END DATE CURRENT 04
CAN_RN04	CANCEL REASON 04
BEGDT041	PRIOR1 BEGIN DATE 04
ENDDT041	PRIOR1 END DATE 04
CANRN041	PRIOR1 CANCEL REASON 04
BEGDT042	PRIOR2 BEGIN DATE 04
ENDDT042	PRIOR2 END DATE 04
CANRN042	PRIOR2 CANCEL REASON 04
P_PROG05	PROVIDER PROGRAM CODE 05
BEGDT05C	ELIG BEGIN DATE CURRENT 05
ENDDT05C	ELIG END DATE CURRENT 05
CAN_RN05	CANCEL REASON 05
BEGDT051	PRIOR1 BEGIN DATE 05
ENDDT051	PRIOR1 END DATE 05
CANRN051	PRIOR1 CANCEL REASON 05
BEGDT052	PRIOR2 BEGIN DATE 05
ENDDT052	PRIOR2 END DATE 05
CANRN052	PRIOR2 CANCEL REASON 05
CLS_TP1	PROVIDER CLASS TYPE 1
CLS_BEG1	PROVIDER CLASS TYPE 1 BEGIN DATE
CLS_END1	PROVIDER CLASS TYPE 1 END DATE.
CLS_RN1	PROVIDER CLASS TYPE 1 REASON CODE.

Field Description	Specifications
CLS_TP2	PROVIDER CLASS TYPE 2
CLS_BEG2	PROVIDER CLASS TYPE 2 BEGIN DATE
CLS_END2	PROVIDER CLASS TYPE 2 END DATE.
CLS_RN2	PROVIDER CLASS TYPE 2 REASON CODE.
CLS_TP3	PROVIDER CLASS TYPE 3
CLS_BEG3	PROVIDER CLASS TYPE 3 BEGIN DATE
CLS_END3	PROVIDER CLASS TYPE 3 END DATE.
CLS_RN3	PROVIDER CLASS TYPE 3 REASON CODE.
SPC_CDE1	SPECIALTY CODE 1
SPC_BEG1	PROV SPEC CDE 1 BEGIN DATE
SPC_END1	PROV SPEC CDE 1 END DATE
SPC_CDE2	SPECIALTY CODE 2
SPC_BEG2	PROV SPEC CDE 2 BEGIN DATE
SPC_END2	PROV SPEC CDE 2 END DATE
SPC_CDE3	SPECIALTY CODE 3
SPC_BEG3	PROV SPEC CDE 3 BEGIN DATE
SPC_END3	PROV SPEC CDE 3 END DATE
SPC_CDE4	SPECIALTY CODE 4
SPC_BEG4	PROV SPEC CDE 4 BEGIN DATE
SPC_END4	PROV SPEC CDE 4 END DATE
SPC_CDE5	SPECIALTY CODE 5
SPC_BEG5	PROV SPEC CDE 5 BEGIN DATE
SPC_END5	PROV SPEC CDE 5 END DATE
NPI_ID	NPI_ID (add leading zeroes)
NPI_API	NPI_API
AGREECDE	INDEFINITE AGREEMENT CODE

Method	DMAS secure FTP server
Format	Text .txt file
File Name	Provider_yyyymm.txt
Trigger	Monthly
Schedule	Generated around the 6th of the month, but may vary based on data availability
DMAS	N/A

4.1.1.3 Description

This report lists all Medicaid fee for service providers and those providers who have enrolled in one or more of the MCO networks. Report includes those providers who are currently enrolled and those whose enrollment ended within the past 2 years. This file does not, however, specify which providers may not be accepting new Medicaid patients.

4.1.2 Pregnancy Due Date

4.1.2.1 Contract Reference

N/A

4.1.2.2 File Specifications

Variable	Description
PROVIDER	MCO NPI
REXP_DTE	Member Expected Delivery/Delivery Date
RECIP	Member Identification Number
R_L_NAME	Member Last Name
R_F_NAME	Member First Name
R_M_NAME	Member Middle Initial
R_BIRTH	Member Birth Date
R_SSN	Member SSN
R_SEX	Member Sex
R_STREET	Member Street Address
ADD2	Member Additional Address
R_CITY	Member City
R_STATE	Member State
R_ZIP_9	Member Zip Code
R_PHONE	Member Telephone Number
CTY_CNTY	Member FIPS code
PROGRAM	Program (i.e., FAMIS or Medicaid)
ENR_BEG	Enrollment Begin Date
S_P_NAME_OBGYN	Service Provider Name (OBGYN)

Method	DMAS secure FTP server
Format	Excel 2007
File Name	Pregnancy_yyyymm.xlsx
Trigger	Monthly
Schedule	Monthly after the EOM834 and the first weekend of the month
DMAS	N/A

4.1.2.3 Description

Identifies recipients assigned to the MCO (current and new enrollees) who have an estimated date of delivery (EDD) in the MMIS system. (EDD dates are entered by DSS.) The report also uses FFS and encounter claims to identify providers used by the recipient by practitioner type (05) and provider specialty codes (062 –OB/Gyn). This information should assist the MCO in identifying the OB/GYN their member has used to seek prenatal care. The pregnancy report is

useful in identifying pregnant women as early as possible in order to encourage their enrollment into the MCO's pregnancy or high-risk pregnancy programs, as well as facilitate possible transition of care to a network provider, if required.

4.1.3 Plan Change Report

4.1.3.1 Contract Reference

Medallion 3.0 Contract, Section 5.12

FAMIS Contract, Section 5.12

4.1.3.2 File Specifications

Change Report - MM CCYY

Transferred From MCO	Transfer To MCO	Reason for MCO Change	Reason Description	Total number of Members

Transfer To MCO	Transferred From MCO	Reason for MCO Change	Reason Description	Total number of Members

Method	DMAS secure FTP server
Format	Excel
File Name	Plan_Chg_yyyymm.xlxs
Trigger	Monthly
Schedule	After 18th of the month
DMAS	N/A

4.1.3.3 Description

This report is generated monthly by DMAS' enrollment broker, Maximus, and forwarded to the MCOs around the 18th of the month. The report identifies the total number of recipients in each plan who have contacted the Managed Care Helpline to change MCOs and the reasons for the changes. This report does not contain recipient-specific information but rather is to provide the MCOs with information about why recipients are moving from their health plan. This report may be helpful in identifying potential access issues, barriers, etc.

4.1.4 Community Mental Health Rehabilitation Services (CMHRS)

4.1.4.1 Contract Reference

Medallion 3.0 Contract, Section 7.2.A.III

FAMIS Contract, Section 7.2.A.III

4.1.4.2 File Specifications

Variable	Description
PLAN_PROV	Provider Id (MCO)
RECIP	Member ID
DOB	Member Date of Birth
FROM_DTE	From Date (date of service)
THRU_DTE	Thru Date (date of service)
PROC_CDE	Procedure Code
VUS	Units
PLACE	Place of Service
SRVC_PROV_NPI	Service Provider NPI
S_P_NAME	Service Provider Name
PTL_SOPHONE	Service Provider Phone
ICN	Reference Number
AID_CATEGORY	Aid Category
COV_CHG	Billed Amount
DIAGNOSIS_CODE	Primary Diagnosis
SERVICE_TYPE	Derived from INV_TYPE

Method	DMAS secure FTP server
Format	Text .txt file
File Name	CHMRS_Clm_Chg_yyyymm.txt
Trigger	Monthly
Schedule	After the 18th of the month
DMAS	N/A

4.1.4.3 Description

This report reflects FFS claims on enrolled MCO recipients that have received services in the prior 6 months for the following carved-out community mental health services/codes: H0006, H0015, H0018, H0020, H0023, H0031, H0032, H0035, H0036, H0039, H0046, H0047, H0050, H2012, H2016, H2017, H2019, H2020, and H2022. This report also identifies the number of units for the service, and the servicing provider's NPI number. Although the services/codes listed above are carved-out from the MCO contract, this information is provided to help identify

recipients who may need additional behavioral health services or referral to an MCO behavioral health case manager.

4.1.5 **Behavioral Health Service Authorizations (Eliminated)**

Removed this section effective 07/01/2015

This information is already being sent to the MCOs. Refer to MCTM section 4.1.18 for details.

4.1.6 **TPL**

4.1.6.1 Contract Reference

N/A

4.1.6.2 File Specifications

Variable	Description
RECIP	Member Id
R_L_NAME	Member Last Name
R_F_NAME	Member First Name
R_M_NAME	Member Middle Initial
PROV	Provider NPI (MCO)
ENR_BEG	Benefit Enrollment Begin
ENR_END	Benefit Enrollment End
TPL_INS	TPL Carrier Code
CARRIER_NAME	TPL Carrier Name
TPL_POL	TPL Policy Number
COV	TPL Coverage Code
COV_DESC	TPL Coverage Description
COVBEG	TPL Coverage Begin
COVEND	TPL Coverage End

Method	DMAS secure FTP server
Format	Excel 2007
File Name	TPL_yyyymm
Trigger	Monthly
Schedule	After the 18th of the month
DMAS	N/A

4.1.6.3 Description

This file provides TPL information (except for limited type coverage such as dental) for recipients who have been enrolled in the health plan during the last 12 month period, and who may have also had TPL during that 12 month period. Information contained in the TPL file includes the carrier name, policy, coverage begin and end dates, and coverage type. This information provides health plans with another source of information to coordinate past payments to providers, if needed.

4.1.7 New Members on 820 but not on (previous) Mid-Month 834

4.1.7.1 Contract Reference

N/A

4.1.7.2 File Specifications

Variable	Description
PROVIDER	Provider ID (MCO)
SRV_CTR	Service Center
RECIP	Member ID
CASE	Case ID
R_L_NAME	Member Last Name
R_F_NAME	Member First Name
R_M_NAME	Member Middle Initial
R_S_NAME	Member Suffix
SSN	Member SSN
R_ADDTL	Member Additional Address
R_STREET	Member Street Address
R_CITY	Member City
R_STATE	Member State
R_ZIP9	Member Zip Code
R_FIPS	Member Fips
BIRTH	Member Date of Birth
SEX	Member Sex
R_LANG	Member Language
R_PHONE	Member Phone
RACE	Member Race
ELIG_BEG	Eligibility Begin Date
ELIG_END	Eligibility End Date
AID_CAT	Aid Category
PROGRAM	Program
BNFT_BEG	Benefit Begin Date
BNFT_END	Benefit End Date
BNFT_PKG	Benefit Package

Method	DMAS secure FTP server
Format	Excel 2007
File Name	New_820_Mbr_yyyymm.xlsx
Trigger	Monthly

Schedule	After the first of the month (820)
DMAS	N/A

4.1.7.3 Description

This report identifies recipients on the 820 file who were not on the previous month's mid-month 834. Most of these "additions" are newly added newborns so close attention should be paid to the ID numbers and dates of birth. This information should be used to "link" the newborn's new identification number with the identifiers the MCO has in their file reflecting this newborn as their member.

4.1.8 Medical Transition

4.1.8.1 Contract Reference

N/A

4.1.8.2 File Specifications

Variable	Description
RUN_DATE	Date that the MedTrans file was created.
PLAN_PROV	VAMMIS MCO provider identifier.
RECORD_TYPE	The MedTrans file contains data for claims and prior auths. This field indicates whether this record is for a claim 'C' or prior auth 'P'.
RECIP	VAMMIS recipient identifier.
AID_CAT	VAMMIS eligibility aid category.
R_L_NAME	Recipient last name.
R_F_NAME	Recipient first name.
R_M_NAME	Recipient middle initial.
BIRTH	Recipient birth date.
SEX	Recipient gender.
FIPS	Recipient FIPS (locality) code.
SERVICE_TYPE	General descriptive category indicating type of claim (invoice type) or service (service category).
SRV_PROV	Servicing (or authorizing) provider ID. This is the internal DMAS provider ID.
S_P_NAME	Servicing (or authorizing) provider name.
PROV_CLS	Servicing provider class type.
PRV_SPEC	Servicing provider specialty.
FROM_DTE	Service from date.
THRU_DTE	Service thru date.
DIAGNOSIS_CODE	Primary diagnosis code from claim or prior auth.
PROCCD	On a 1500 claim, this is the servicing procedure code. On a UB claim, this is the principle procedure code. On a pharmacy claim, this is the NDC. On a prior auth, this is the authorized procedure or NDC.
VUS	From claim, units billed or pharmacy quantity dispensed.
REFILL	Code indicating whether a prescription is an original or a refill.
PA_NUM	Prior authorization identifier number.
AUNIT	From the prior auth, this is number of units initially authorized.
AAMNT	From the prior auth, this is number of units initially authorized.
UUNIT	From the prior auth, this is number of units used to date.
SRVC_PROV_NPI	Servicing (or authorizing) provider ID. May be NPI or Medicaid administrative ID (API).
PRESC	Claim Pharmacy Prescription Number
DAYS_SUP	Claim Pharmacy Days Supply
C_NDC	NDC on the Practitioner claim
WAIVER	Waiver
E_I	Early Intervention
FC	Foster Care
ICN	Reference Number

Variable	Description
BILLTYPE	Bill Type
COV_CHG	Billed Amount
PLACE	Location
PRSC_PRV	Prescriber ID

Method	DMAS secure FTP server
Format	Text .txt files
File Name	Med_Trans_yyymm.txt
Trigger	Monthly
Schedule	After the 18th of the month
DMAS	N/A

4.1.8.3 Description

This report provides the prior 24 months of claim activity and the prior 12 months of prior authorizations that is on file for newly-eligible MCO recipients. "Newly eligible" status is determined by looking at the last 3 months of 834 files to see if the recipient was in the same MCO (three or more months prior). If not found, the recipient is considered "new" for the purposes of this report.

The following table identifies the source of the values provided in the 'Service Code' field in this report:

Service Type	EDI	Service Code Source
Hospital IP	837I	Principle Procedure Code (ICD9)
Nrsg Hm/ SNF	837I	Principle Procedure Code (ICD9)
OutPat/Hm Hlth	837I	Principle Procedure Code (ICD9)
Personal Care	837P	Procedure Code (CPT/HCPCS)
Practitioner	837P	Procedure Code (CPT/HCPCS)
Pharmacy	NCPDP	NDC
Laboratory	837P	Procedure Code (CPT/HCPCS)
Medicare Xover A	837I	Principle Procedure Code (ICD9)
Medicare Xover B	837P	Procedure Code (CPT/HCPCS)
ICF	837I	Principle Procedure Code (ICD9)
Dental	837D	Dental Procedure Codes
Transportation	837P	Procedure Code (CPT/HCPCS)

4.1.9 Managed Care Enrollment (Flash)

4.1.9.1 Contract Reference

N/A

4.1.9.2 File Specifications

Method	DMAS secure FTP server
Format	Adobe .pdf file
File Name	Flash_yyyymm.pdf
	Flash_Region_yyyymm.pdf
Trigger	Monthly
Schedule	Approximately the 10th of the month
DMAS	N/A

4.1.9.3 Description

This report summarizes Medicaid enrollment numbers various ways. In addition to the Flash report, an Excel spreadsheet with the regional information is also provided. It contains a summary of the enrollment numbers by program, region, locality, and delivery system.

4.1.10 **EOM 834 Summary**

4.1.10.1 Contract Reference

N/A

4.1.10.2 File Specifications

Variable	Description
PROVIDER	MCO NPI
MAIN_CD	Record Type 21 - Add, 24 - Term, 30 - Audit
RECORD_COUNT	Member Count

Method	DMAS secure FTP server
Format	Excel 2007
File Name	EOM834_Cnts_yyyymm.xlsx
Trigger	Monthly
Schedule	After the 1st of the month (EOM834)
DMAS	N/A

4.1.10.3 Description

This report provides a count of members on the EOM 834.

4.1.11 **MID 834 Summary**

4.1.11.1 Contract Reference

N/A

4.1.11.2 File Specifications

Variable	Description
PROVIDER	MCO NPI
MAIN_CD	Record Type 21 - Add, 24 - Term, 30 - Audit
RECORD_COUNT	Member Count

Method	DMAS secure FTP server
Format	Excel 2007
File Name	MID834_Cnts_yyyymm.xlsx
Trigger	Creation of the mid-month 834 file
Schedule	5 business days after mid-month 834 creation
DMAS	N/A

4.1.11.3 Description

This report provides a count of members on the MID 834 and sent to the MCO after the mid-month run.

4.1.12 **Patient Utilization Management and Safety (PUMS)**

4.1.12.1 Contract Reference

N/A

4.1.12.2 File Specifications

Variable	Description
MEMBER_ID	Member ID
MEMBER_LAST_NAME	Member Last Name
MEMBER_FIRST_NAME	Member First Name
MEMBER_DOB	Member Date of Birth
PROGRAM_TYPE_CODE	Type of PUMS (Pharmacy or Provider)
PROVIDER_NPI	Provider NPI
PROVIDER_NAME	Provider Name
PROVIDER_STREET	Provider Street Address
PROVIDER_CITY	Provider City
PROVIDER_STATE	Provider State
PROVIDER_ZIP	Provider Zip Code
PROVIDER_PHONE	Provider Phone Number
RESTRICTION_BEGIN_DT	Restriction Begin Date
RESTRICTION_END_DT	Restriction End Date
SRV_CTR	Service Center - MCO identifier

Method	DMAS secure FTP server
Format	Excel 2007
File Name	PUMS_yyyymm.xlsx
Trigger	Creation of the mid-month 834
Schedule	5 business days after mid-month 834 creation
DMAS	N/A

4.1.12.3 Description

Identifies members were previously assigned to Client Medical Management (CMM) in Medicaid fee for service prior to being assigned to the MCO. Report includes the provider and/or pharmacy that the members were assigned to. Report is sent to the MCO after the mid-month 834 cycle is executed.

4.1.13 **School PDN Claims**

4.1.13.1 Contract Reference

N/A

4.1.13.2 File Specifications

Variable	Description
PLAN_PROV	Provider Id (MCO)
RECIP	Member ID
DOB	Member Date of Birth
FROM_DTE	From Date (date of service)
THRU_DTE	Thru Date (date of service)
PROC_CDE	Procedure Code
VUS	Units
PLACE	Place of Service
SRVC_PROV_NPI	Service Provider NPI
S_P_NAME	Service Provider Name
PTL_SOPHONE	Service Provider Phone
ICN	Reference Number
AID_CATEGORY	Aid Category
COV_CHG	Billed Amount
DIAGNOSIS_CODE	Primary Diagnosis
SERVICE_TYPE	Derived from INV_TYPE

Method	DMAS secure FTP server
Format	Text .txt files
File Name	School_PDN_Clm_yyyymm.txt
Trigger	Creation of the mid-month 834
Schedule	5 business days after mid-month 834 creation
DMAS	N/A

4.1.13.3 Description

This is a report generated after the mid-month 834 and sent to the MCOs around the 25th of the month. This report reflects FFS claims on enrolled MCO recipients that have received services in the prior 6 months for the following school based private duty services/codes: S9123, S9124, G0162, and G0163. This report also identifies the number of units for the service, and the servicing provider's NPI number.

4.1.14 School PDN Prior Authorization

4.1.14.1 Contract Reference

N/A

4.1.14.2 File Specifications

Variable	Description
PLAN_PROV	Provider Id (MCO)
MEMBER_ID	Member ID
M_L_NAME	Member last name
M_F_NAME	Member first name
M_M_NAME	Member middle initial
BIRTH	Member birth date
SEX	Member gender
SERVICE_TYPE	Service category
SRV_PROV	Authorizing provider internal ID
SRVC_PROV_NPI	Authorizing provider NPI
S_P_NAME	Authorizing provider name
DIAGNOSIS_CODE	Diagnosis code
PROCCD	Authorized procedure
PA_NUM	Service authorization identifier number
FROM_DTE	From date
THRU_DTE	Thru date
AUNIT	Authorized unit
AAMNT	Authorized amount
UUNIT	Number of units used to date

Method	DMAS secure FTP server
Format	Text .txt files
File Name	School_PDN_SA_yyyymm.txt
Trigger	Creation of the mid-month 834
Schedule	5 business days after mid-month 834 creation
DMAS	N/A

4.1.14.3 Description

This report reflects FFS prior authorizations on enrolled MCO members that have had a school base private duty authorization type (0098) in place within the prior six (6) months. Although these services are carved-out from the MCO contract, this information is provided to help identify members who may need additional services.

4.1.15 **Newborns**

4.1.15.1 Contract Reference

N/A

4.1.15.2 File Specifications

DATA FIELD	DESCRIPTION
MCO	MCO that submitted report
DATE_SUBMIT	Month and Year of report submission (MM/YY)
MOM_ID	Mother ID of the newborn submitted by MCO
LASTNAME_MCO	Last Name of the newborn's mother submitted by MCO
FIRSTNAME_MCO	First Name of the newborn's mother submitted by MCO
LASTNAME_DMAS	Last Name of the newborn's mother entered in the MMIS (based on the Mother ID submitted by MCO)
FIRSTNAME_DMAS	First name of the newborn's mother entered in the MMIS (based on the Mother ID submitted by MCO)
MOM_WARNING	Identifies Name mismatches for the Newborn's Mother between MCO submission and MMIS data
NB_DOB_MCO	Newborn Date of Birth submitted by MCO
NB_DOB_DMAS	Newborn Date of Birth entered in the MMIS
NB_ID_MCO	Newborn ID submitted by MCO
NB_ID_DMAS	Newborn ID entered in the MMIS
NB_LASTNAME_MCO	Newborn Last Name submitted by MCO
NB_FIRSTNAME_MCO	Newborn First Name submitted by MCO
NB_LASTNAME_DMAS	Newborn Last Name entered in the MMIS
NB_FIRSTNAME_DMAS	Newborn First Name entered in the MMIS
WARNING_NB	Identifies Name mismatches for the Newborn between MCO submission and MMIS data

Method	DMAS secure FTP server
Format	Excel 2007
File Name	NB_ddMMyyyy.xlsx
Trigger	Weekly
Schedule	TBD
DMAS	N/A

4.1.15.3 Description

This report is generated weekly. It provides the member IDs for newborns submitted on the MCO's monthly newborn submission report.

4.1.16 **Error Report**

4.1.16.1 Contract Reference

N/A

4.1.16.2 File Specifications

DATA FIELD	DESCRIPTION
MCO	MCO that submitted report
DATE_SUBMIT (MM/YY)	Month and Year of report submission
RSN_DESC	Mother ID Invalid – does not exist in the MMIS – MCO must research and resubmit on subsequent monthly report
LASTNAME_MCO	Last Name of the newborn's mother submitted by MCO
FIRSTNAME_MCO	First Name of the newborn's mother submitted by MCO
NB_DOB_MCO	Newborn Date of Birth submitted by MCO
NB_ID_MCO	Newborn ID submitted by MCO
NB_LASTNAME_MCO	Newborn Last Name submitted by MCO
NB_FIRSTNAME_MCO	Newborn First Name submitted by MCO

Method	DMAS secure FTP server
Format	
File Name	
Trigger	Submission of contract deliverable reports by MCO
Schedule	
DMAS	N/A

4.1.16.3 Description

This report identifies each instance where a MCO deliverable submission does not comply with the specifications and/or requirements documented in the Technical Manual. Feedback is provided on the overall report and on the detail row / field level where appropriate.

4.1.17 **Quarterly ABD Enrollment (Eliminated)**

Report eliminated effective 07/0/2015.

4.1.18 **Encounter Lag Report (Eliminated)**

Report eliminated effective 07/01/2015.

Encounter lag days are now reported via the EDQ process documented in MCTM section 1.5.

4.1.19 **Behavioral Health Service Authorizations Report**

4.1.19.1 Contract Reference

N/A

4.1.19.2 File Specifications

Field Name	Field Length	Field Description	Notes
AUSTS	1	Record Status	A=Add, C=Change, D=Delete
AUMBRID	15	Member ID	
AUPRVID	10	Provider ID (NPI)	
AUPRVNME	30	Provider Name	
AUPRVADR	25	Provider Address	
AUPRVCTY	20	Provider City	
AUPRVST	2	Provider State	
AUPRVZIP	5	Provider Zip Code	
AUPRVZIP1	4	Provider Zip+4	
AUPRVPHN	10	Provider Phone Number	
AUAUTHNO	9	Magellan Auth Tracking Number (MAT#)	
AUTHSTS	1	Approved/Void/Denied	A,V,D
AUTYPE	4	Service Auth Type	
AUADMDTE	8	Action Date CCYYMMDD	
AUSTRDTE	8	Auth Start Date CCYYMMDD	
AUENDDTE	8	Auth End Date CCYYMMDD	
AUDENIAL	3	Denial Reason	Descriptions supplied below
AUCPTCD	5	CPT Code	
AUCPTDSC	50	CPT Code Description	
AUTTLRQD	3	Total Requested	
AUTTLAPP	3	Total Approved	
MCO	3	MCO Code	Identifies the MCO receiving the file

Denial Reason Code	Denial Reason Description
001	Lacks Medical Necessity
002	Benefits Exhausted
003	Not Notified W/in Contract Terms
004	Non-Contracted Provider
005	Non-Contracted Facility
006	Insufficient Information
007	Non-Panel Provider
008	Treatment not a Covered Benefit
009	Member Not Eligible

010	Precert Not In Timeframe
011	No Out of Network Benefit
012	Provider Not Licensed/Covered
013	Insufficient Information
014	Pre-Existing Condition
015	Quality of Care Issues
016	OON Provider Not Authed as INN
017	Benefit Flexing Not Indicated
018	Experimental/Investigational
019	Magellan Not Follow/Delegated
020	Untimely Filing
021	NMN OP Extended Sessions
022	NMN OP Reduction in Services
023	NMN OP Duplicate Services
096	TPL ACT62 BSC PAHC
097	TPL ACT62 MT PAHC
098	TLP ACT62 TSS PAHC

Method	DMAS secure FTP server
Format	Excel
File Name	BHSA_YYYYMMDD.xlsx
Trigger	Weekly
DMAS	N/A

4.1.19.3 Description

This report is a weekly file containing all service authorizations that were processed during the week (approved and denied) by DMAS behavioral health contractor.

4.1.20 **DMAS Newborn Reconciliation Return File**

4.1.20.1 Contract Reference

Medallion 3.0 Contract, Sections 5.7 and 12.8

FAMIS Contract, Sections 5.7 and 12.8

4.1.20.2 File Specifications

Field Description	Specifications
Mom_LastName	Mother Last Name submitted by MCO
Mom_FirstName	Mother First Name submitted by MCO
Mom_ID	Mother ID Number submitted by MCO
NB_LastName	Newborn Last Name submitted by MCO
NB_FirstName	Newborn First Name submitted by MCO
NB_DOB	Newborn DOB submitted by MCO
NB_ID_MCO	Newborn MCO ID Number submitted by MCO
NB_ID_DMAS MCO	Newborn DMAS ID Number submitted by MCO
NB_LastName_DMAS	Newborn Last Name from DMAS/MMIS
NB_FirstName_DMAS	Newborn First Name from DMAS/MMIS
NB_DOB_DMAS	Newborn DOB from DMAS/MMIS
NB_ID_DMAS	Newborn ID Number from DMAS/MMIS
BM	Reconciliation Status for BM1, BM2, BM3
NB_AC	Newborn Eligibility Aid Category
NB_MCO	Newborn MCO Plan ANT - Anthem CCV – Coventry Cares of Virginia ITH – INTotal Health KPM – Kaiser Permanente MJC - MajestaCare OFC – Optima Family Care VAP – Virginia Premier Blank – newborn not enrolled in MCO/newborn ID not found
Cap_Pymt	Capitation Payment Amount
Ref_Num	ICN - Payment made by MMIS OFFLINE PYMT – Payment made by Recon
DMAS Comment	DMAS explanation when no payment is made 30 bytes
Mom MCO	MCO Plan Mother ID enrolled in at NB DOB
Mom AC	Aid Category Mother ID enrolled in at NB DOB
Mom FIPS	FIPS Code Mother ID enrolled in at NB DOB
Program	Valid Values: 01= Medicaid; 07-= FAMIS
MCO Comment	MCO response regarding newborn nonpayment 30 bytes

Method:	DMAS secure FTP server
Format:	Excel file.
File Name:	NB_Recon_Return_yyyymm.xlsx
Trigger:	Monthly
Schedule:	If possible, DMAS will send this file the week following the MCO submission of the NB_Recon_yyyymm file (see Section 3.2.17). However, delivery of this report may be a delayed if payments need to be generated through the MMIS capitation claim process. Any response files must be submitted by the MCO within ten business days of DMAS' posting the NB_Recon_Return file to the FTP. Submit the response file in Excel Format to the DMAS email box at managedcare.reporting@dmas.virginia.gov. Include the file name, NB_Recon_Return_yyyymm, in the email Subject line.
DMAS:	Systems & Reporting

4.1.20.3 Description

This file is generated from the validation of the MCO Newborn Reconciliation file (**NB_Recon_yyyymm**) submission against MMIS data. The return file contains the data fields submitted by the MCO, additional fields validating the MCO data submission and payment information for the MCO newborn.

The payment information identifies: 1.) the payment amount for the newborn for all three months (BM1, BM2, and BM3); 2.) whether the payment was made by the MMIS (ICN Ref Number provided), or the payment will be made through the offline reconciliation process or that no payment will be made. If no payment will be made, the nonpayment reason is provided in the field DMAS Comment.

A payment will not be processed for the following reasons:

- MOM not in MCO on NB DOB
  - The mother of the newborn must be enrolled in the MCO benefit plan on the newborn's DOB
- NB Deceased (date of death provided)
  - Payment is not processed if the newborn's date of death is a month prior to the BM2 or BM3
- NB in different MCO
  - Newborn changed MCO's for BM2 and/or BM3 and payment was made to that MCO
  - The MCO in which the newborn was enrolled is provided for claims coordination
- NB not found - No Paid Encounter for Live Birth Delivery
  - Newborn was not found in the MMIS and DMAS was unable to locate a paid encounter from the MCO for the live birth delivery

MCO Comment

- The MCO may submit a response file for that newborn and provide the reference number in the MCO Comment field for the paid encounter submitted for the mother for the live birth so that DMAS can research and verify the delivery.

The Return file will include 4 Worksheets tabs:

- **ALL** – Includes all newborns submitted by the MCO on the NB_Recon_yyyymm file. Each newborn will have 3 rows with enrollment/payment information for all three months, BM1-Birth Month, BM2-Birth Month Plus 1, BM3-Birth Month Plus 2.
- **OFFLINE** - A subset of the **ALL** worksheet. Only includes the Newborns for which DMAS **is making** an Offline payment.
- **No Pymt** – A subset of the **ALL** worksheet. Only includes the Newborns for which DMAS **is not making** an Offline payment.

Certify - A Newborn Reconciliation Certification is included with the return file. The certification is acknowledgement that payment will be made for the payment amount for the newborns indentified on the return file. The payment amount will be broken down into 2 payments, one for Medicaid and one for FAMIS and the Total. Once the Certification is signed and received from the MCO, the Newborn Reconciliation File is processed for payment. The signed document should be scanned and submitted using the file name **NB_Recon_CertLetter_YYYYMMDD** in .pdf format through the FTP site. When the signed Certification is received, the Add pay will be processed for payment.

4.1.21 **Behavioral Health (BHSA) Claims History**

4.1.21.1 Contract Reference

N/A

4.1.21.2 File Specifications

Field Description	Type	Description
CLAIM_ICN	CHAR	Unique claim identifier
INV_TYPE	CHAR	Claim type: 01 = Inpatient; 03 = Outpatient; 05 = Professional
DISP	CHAR	
FORM_ICN	CHAR	For adjustments and voids, this is the claim ICN of the original claim
RECIP	CHAR	Enrollee ID
SRVC_NPI	NUM	Servicing provider ID
SRVC_NAME	CHAR	Servicing provider name
SRVC_CLS	CHAR	Servicing provider DMAS class type
SRVC_SPEC	CHAR	Servicing provider DMAS specialty code
SRVC_TXNMY	CHAR	Servicing provider taxonomy code
REFER_NPI	CHAR	Referring provider ID
BILL_AMT	NUM	Billed amount
PAID_AMT	NUM	Payment amount
TPL_AMT	NUM	TPL amount paid
FROM_DTE	DATE	From date of service
THRU_DTE	DATE	Thru date of service
ADM_DATE	DATE	Admission date (inpatient only)
UNITS	NUM	Units billed
PRN_PROC	CHAR	Principle procedure code (institutional only)
PROC_CDE	CHAR	Procedure Code
PROCMOD1	CHAR	Procedure Code modifier
PROCMOD2	CHAR	Procedure Code modifier
PROCMOD3	CHAR	Procedure Code modifier
PROCMOD4	CHAR	Procedure Code modifier
NDC_CODE	CHAR	National Drug Code (physician-administered)
NDC_QTY	NUM	Units associated with drug code billed
ADMIT_DIAG	CHAR	Admitting diagnosis code
PRI_DIAG	CHAR	Primary diagnosis code
OTH_DIAG2	CHAR	Other diagnosis code
OTH_DIAG3	CHAR	Other diagnosis code
OTH_DIAG4	CHAR	Other diagnosis code

Method: DMAS secure FTP server

Format:	Comma separated (.csv) file
File Name:	BHSA_Claims_yyyymm.csv
Trigger:	Monthly
Schedule:	Following the generation of the mid-month 834
DMAS:	Systems & Reporting

4.1.21.3 Description

- Paid claims only.
- Includes two years of BHSA claims.
- Includes claims history for any member who is currently enrolled with the MCO (based on current mid-month 834).

4.1.22 **Assessments Summary Report**

4.1.22.1 Contract Reference

Medallion 3.0 Contract, Section 7.7.B

FAMIS Contract, Section 7.7.B

4.1.22.2 File Specifications

Field Name	Description
PLAN_PROV	Provider ID (MCO)
ENROLL_PERIOD	Monthly Enrollment Period
PERCENT_60DAY	Percent of Members Completing Assessments Within 60 Days of Enrollment
PERCENT_90DAY	Percent of Members Completing Assessments Within 90 Days of Enrollment
PERCENT_120DAY	Percent of Members Completing Assessments Within 120 Days of Enrollment
PERCENT_GT120DAY	Percent of Members Not Completing Assessments Within 120 Days of Enrollment
NBR_OTHER_ASSESS	Number of Members With Completed Assessment But Were Not Required
STATUS	The status code for the measures for the monthly enrollment period (preliminary or final)

Method: DMAS secure FTP server
Format: Comma separated values (.CSV) file
File Name: ASSESSMENT_SUMMARY_yyyymm.csv
Trigger: Monthly
Schedule: DMAS will send this report by the end of the month
DMAS: Systems & Reporting

4.1.22.3 Description

The source for this file is the Assessments Detail Report in Section 4.1.23. This report provides the percentage of members completing an assessment for each applicable enrollment timeframe. In addition, the number of assessments reported by an MCO but not attributable to an eligible member are provided for each enrollment date.

4.1.22.4 Example

ASSESSMENT_SUMMARY_201602.csv (Feb 2016 Report)							
PLAN_PROV	**ENROLL_PERIOD**	**PERCENT_60DAY**	**PERCENT_90DAY**	**PERCENT_120DAY**	**PERCENT_GT120DAY**	**NBR_OTHER_ASSESS**	**STATUS**
MCO1	JUL_2015	50%	65%	85%	15%	15	FINAL
MCO1	AUG_2015	49%	70%	82%	18%	20	FINAL
MCO1	SEP_2015	55%	70%	81%	19%	6	PRELIM
MCO1	OCT_2015	60%	68%	70%	30%	11	PRELIM
MCO1	NOV_2015	62%	67%	75%		12	PRELIM
MCO1	DEC_2015	60%	68%			35	PRELIM
MCO1	JAN_2016	45%				40	PRELIM

4.1.23 **Assessments Detail Report**

4.1.23.1 Contract Reference

Medallion 3.0 Contract, Section 7.7.B

FAMIS Contract, Section 7.7.B

4.1.23.2 File Specifications

Field Name	Field Description	Notes
PLAN_PROV	Provider ID (MCO)	
RECIP	Member ID	
ENROLL_PERIOD	Monthly Enrollment Period	
ASSESS_DTE	Date Member Completed Assessment	Must be a valid date Format = mm/dd/yyyy
TIMEFRAME	Time Category for Assessment Completion	Codes: 1 = Within 60 days 2 = Within 90 days 3 = Within 120 days 4 = Over 120 days 9 = Did not need assessment N = Not assessed
ELIGIBILITY	Reason Member is Eligible for Assessment	Codes: 1 = ABD 2 = Early Intervention 3 = Contract Special Needs 4 = HAP
EXCEPTION_REASON	Reason Member was not assessed (provided by MCO)	1 = Member/Parent Refusal 2 = Invalid contact information 3 = Unable to make contact with Member/Parent 4 = = Member's eligibility was retroactive to prior month(s) 9 = Other

Method: DMAS secure FTP server

Format: Comma separated values (.CSV) file

File Name: ASSESSMENT_DETAIL_yyyymm.csv

Trigger: Monthly

Schedule: DMAS will send this report following receipt of monthly Member Assessments File (ASSESSMENTS.csv) by the end of the month

DMAS: Systems & Reporting

4.1.23.3 Description

The data source for this file is Member Assessments file received from the MCO. The file includes all newly identified/enrolled members and dates with completed assessments. In addition, the file shows the reason a member was not assessed if this information is provided by the MCO in the Assessment Exception Reason report.

4.1.23.4 Example

ASSESSMENT_DETAIL_201511.csv (Nov 2015 Report)						
PLAN_PROV	RECIP	ENROLL_PERIOD	ASSESS_DTE	TIMEFRAME	ELIGIBILITY	EXCEPTION_REASON
MCO1	000000000001	JUL_2015	07/15/2015	1	1	
MCO1	000000000002	JUL_2015	08/15/2015	1	2	
MCO1	000000000003	JUL_2015	09/15/2015	2	3	
MCO1	000000000004	JUL_2015	10/15/2015	3	4	
MCO1	000000000005	JUL_2015		4	4	3
MCO1	000000000006	JUL_2015		9	1	
MCO1	000000000007	AUG_2015	09/07/2015	1	2	
MCO1	000000000008	AUG_2015	09/15/2015	1	3	
MCO1	000000000009	AUG_2015	10/15/2015	2	4	
MCO1	000000000010	AUG_2015		N	4	1
MCO1	000000000011	AUG_2015		9	1	
MCO1	000000000012	SEP_2015	09/15/2015	1	2	
MCO1	000000000013	SEP_2015	10/15/2015	1	3	
MCO1	000000000014	SEP_2015		N	4	1
MCO1	000000000015	SEP_2015		9	4	
MCO1	000000000016	OCT_2015	10/15/2015	1	4	
MCO1	000000000017	OCT_2015		N	3	
MCO1	000000000018	OCT_2015		9	3	
MCO1	000000000019	NOV_2015	11/05/2015	1	3	
MCO1	000000000020	NOV_2015		N	2	3
MCO1	000000000021	NOV_2015		9	2	

4.1.24 Encounter Data Quality (EDQ) Critical and Emerging Issues Report

4.1.24.1 Contract Reference

N/A

4.1.24.2 File Specifications

MCO_NAME - EDQ - CRITICAL ISSUES

Report Date: mm/dd/yyyy

Issue	ESC	Month	Weeks	Issues	Encntrs		Cost
Issue1	N/A	MMMYYYY	9	9,999	9,999	$	-
Issue2	xxxx	MMMYYYY	9	9,999	9,999	$	999.99

MCO_NAME - EDQ - EMERGING ISSUES

Report Date: mm/dd/yyyy

Error_ESC	Issue	ImpDte	Weeks	Encntrs
xxxx ESC Description	Issue1	mm/dd/yyyy	9	9,999
xxxx ESC Description	Issue1	mm/dd/yyyy	9	9,999
xxxx ESC Description	Issue2	mm/dd/yyyy	9	9,999

MCO_NAME - EDQ – SUBMITTED FILES

Report Date: mm/dd/yyyy

Submitted	Day	MCN_Number	Type	Encntrs	Certification
mm/dd/yyyy	Ddd	999999999	837P	99,999	Yes
mm/dd/yyyy	Ddd	999999999	837I	99,999	Yes
mm/dd/yyyy	Ddd	999999999	NCPDP	99,999	Yes

Variable	Description
CRITICAL ISSUES	
ISSUE	Description of the issue being reported. All issues are documented in Section xx of this document.
ESC	Lists the specific MMIS ESC errors present in the MCO data that caused this reported issue.
MONTH	The month in which the error occurred. Report periods are based on file submission dates within the calendar month.
WEEKS	Count of the number of weeks during the report month in which this issue occurred.
ISSUES	Total number of issues identified.
ENCNTRS	Unique count of encounter records on which one or more issues were identified.

Variable	Description
COST	DMAS cost of encounter transaction processing for the reported issue.
EMERGING ISSUES	
ERROR/ESC	MMIS ESC or specific error condition that was present on the encounter causing the issue to set.
ISSUE	Description of the issue being reported. All issues are documented in Section xx of this document.
IMPDTE	The tentative effective date for transition of the emerging issue to the critical issue category.
WEEKS	Count of the number of weeks during the report month in which this issue occurred.
ENCNTRS	Unique count of encounter records on which this particular ESC or error condition was identified.
SUBMITTED FILES	
SUBMITTED	Date that the EDI encounter file was submitted to and accepted by DMAS
DAY	Day of the week associated with 'SUBMITTED' date.
MCN_NUMBER	Unique file identifier assigned by DMAS for the file submitted by the MCO.
TYPE	Type of encounter transaction file. Valid values are" NCPDP, 837I, 837P.
ENCNTRS	Number of encounter records that passed compliance and were processed in MMIS for the submitted file.
CERTIFICATION	Flag indicating whether the MCO provided a certification for the submitted file.

Method	DMAS secure FTP server
Format	Adobe Acrobat (.PDF)
File Name	EDQ_Weekly_yyyymm.xlsx
Trigger	Weekly
Schedule	Monday
DMAS	N/A

4.1.24.3 Description

Refer to section 1.5 in the Managed Care Technical Manual for additional information.

Note that not all Issues have MMIS ESC codes associated with them.

Critical Issue Cost is calculated as the total number of unique encounters to be corrected multiplied by DMAS' encounter transaction processing cost multiplied by the total number of transactions incurred because of the error (original + void/credit). Does not include costs associated with re-submittal of corrected encounter.

4.1.24.4 Examples

[redacted] EDQ - Critical Issues
Reported as of: 05/04/2015

Issue	ESC	Month	Weeks	Issues	Encntrs	Cost
Rebate	0044	APR2015	3	13,497	13,497	$5,128.86
Lag Days	N/A	APR2015	4	755,294	755,294	0

[redacted] - EDQ - Emerging Issues
Reported as of: 05/04/2015

MCO	Error ESC	Issue	ImpDte	Weeks	Encntrs
[redacted]	0396 Adjust Denied- Orig Pmt Req Not On File	Adj/Void	09/01/2015	3	3,594
[redacted]	0397 Void Denied - Orig Pmt Req Not On File	Adj/Void	09/01/2015	2	8
[redacted]	0752 Missing HMO Claim Number	Adj/Void	09/01/2015	1	3
[redacted]	0423 NDC Not On File, Check NDC	Rebate	09/01/2015	2	37
[redacted]	0328 Srvices Incurred Prior To Coverage	Date	01/01/2016	3	52
[redacted]	0858 Bill Type 111/112 Adm Dt Not=From Date	Date	01/01/2016	2	9
[redacted]	0202 Duplicate History - Diff Prov, Same DOS	Duplicate	01/01/2016	3	817
[redacted]	0301 Duplicate - Same Provider, Same DOS	Duplicate	01/01/2016	3	108
[redacted]	0302 Duplicate History - Same Prov, Same DOS	Duplicate	01/01/2016	3	6,677
[redacted]	0866 Duplicate Provider, Rx # and Dt of Svc	Duplicate	01/01/2016	3	118
[redacted]	1463 Duplicate History - Same Prov, Same DOS	Duplicate	01/01/2016	2	4
[redacted]	0143 Enrollee Not Eligible on DOS	Enrollment	10/01/2016	2	7
[redacted]	0318 Enrollee Not Eligible on DOS	Enrollment	10/01/2016	4	116
[redacted]	0970 Enrollee Not Covered In Plan on DOS	Enrollment	10/01/2016	3	182
[redacted]	0983 Enrollee not on File	Enrollment	10/01/2016	2	19
[redacted]	0028 Admit Date Missing/Invalid	M/I Value	11/01/2016	2	458
[redacted]	0038 Invalid Place Of Treatment Code	M/I Value	11/01/2016	2	66
[redacted]	0041 Invalid Procedure Modifier	M/I Value	11/01/2016	3	969
[redacted]	0146 Procedure Code Not On File	M/I Value	11/01/2016	2	8
[redacted]	0147 Procedure Code Not In Use On Svc Date	M/I Value	11/01/2016	2	27
[redacted]	0178 Invalid Diagnosis Code	M/I Value	11/01/2016	2	18
[redacted]	0773 Conflicting CAS Adjustment Reasons	M/I Value	11/01/2016	2	127
[redacted]	0995 Revenue HCPCS Not On File	M/I Value	11/01/2016	2	4,077
[redacted]	1357 NPI Servicing Provider Not on File	Provider	12/01/2016	3	34,675
[redacted]	1393 No Srvc Taxonomy Code On The Claim	Provider	12/01/2016	1	3
[redacted]	0023 Units Missing/Not In Valid Format	Rebate	12/31/9999	3	13,643

4.1.25 **Encounter Data Quality (EDQ) Critical Issue Detail File**

4.1.25.1 Contract Reference

N/A

4.1.25.2 File Specifications

Field Name	Data Type	Begin	End
MCO Service Center	CHAR	1	4
Media Control Number (MCN)	CHAR	5	12
Filler	CHAR	13	19
MCO Claim Number (HMOREF)	CHAR	20	43
MMIS Claim ID (ICN)	CHAR	44	60
Enrollee ID Number	CHAR	61	72
Servicing Provider NPI	CHAR	73	82
DOS From Date (CCYYMMDD)	CHAR	83	90
DOS Thru Date (CCYYMMDD)	CHAR	91	98
Diagnosis Code-1	CHAR	99	105
Diagnosis Code-2	CHAR	106	112
Filler	CHAR	113	178
MCO Claim Payment Amount	NUM	179	189
Claim Type	CHAR	190	191
Filler	CHAR	192	192
Provider Type	CHAR	193	195
Provider Specialty Code	CHAR	196	198
Filler	CHAR	199	202
Error Code-1	NUM	203	206
EDC Issue	CHAR	207	221
File Submitted Date (CCYYMMDD)	CHAR	222	229
Report Date (CCYYMMDD)	CHAR	230	237
Filler	CHAR	238	295

Method	DMAS secure FTP server
Format	Fixed Length Text File (.TXT)
File Name	EDQ_CI_DTL_yyyymm.txt
Trigger	Weekly
Schedule	Monday
DMAS	N/A

4.1.25.3 Description

This file contains encounter level detail for every Issue that was identified on the EDQ Critical Issues Summary Report.

This file lists the encounters for all current and historical uncorrected Critical Issues.

There is a separate record in this detail file for each critical issue or error condition. Therefore, the same encounter may be reported more than once each in the detail file.

Refer to section 1.5 in the Managed Care Technical Manual for additional information about the purpose and usage of this file.

4.1.25.4 Example

N/A

4.1.26 **Encounter Data Quality (EDQ) Emerging Issue Detail File**

4.1.26.1 Contract Reference

N/A

4.1.26.2 File Specifications

Format of this file is identical to 'Encounter Data Quality (EDQ) Critical Issue Detail File' as documented in section 4.1.25

Method	DMAS secure FTP server
Format	Fixed Length Text File (.TXT)
File Name	EDQ_EI_DETAIL_yyyymm.txt
Trigger	Weekly
Schedule	Monday
DMAS	N/A

4.1.26.3 Description

This file contains encounter level detail for issues reported on the EDQ Emerging Issues Summary Report. This file lists only encounters for the most recent rolling 45 day period. Encounter issues older than 45 days roll off of this report.

There is a separate record in this detail file for each error condition. Therefore, the same encounter may be reported more than once each in the detail file.

Refer to section 1.5 in the Managed Care Technical Manual for additional information about the purpose and usage of this file.

4.1.26.4 Example

N/A

4.2 DMAS Forms

The following standard forms are available on the DMAS Managed Care Web Site.

- Sentinel Event Report Form
- Incarcerated Members Report Form
- Program Integrity Compliance Audit (PICA)
- Appeals and Grievances Report Format Template
- MCO Report Format Template
- Quarterly PI Abuse Overpayment-Recovery Report
- Encounter Data Certification Form

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5 Operational Business Processes

5.1 DMAS Processes

5.1.1 PCP Provider Incentive Payments

5.1.1.1 Listing of Attested Providers

The MCO must post the PCP Provider Attestation Listing to the DMAS secure FTP server weekly by 6 PM EST on Friday. An error report will be generated (if applicable) and placed in each MCO's folder on DMAS' secure FTP server. It will be sent in excel format and contain two tabs. The first tab will contain the data that was initially received from the MCO, and the second tab will contain the error report. Column H, labeled 'Valid' contains numbers 1 – 7, that represent the 7 columns that are in the report. Where an 'E' is present, it represents the field in the report that contains the error. For example, if Column H contains '12E4567', that means that the 3rd column, which is C (Attestation Date) contains the error. The MCO must make the appropriate corrections to the listing prior to receiving the consolidated provider attestation file (see below).

DMAS will consolidate the provider attestation files from the different MCOs weekly on Monday. The combined file will be unduplicated by NPI and the MCO identifiers will be removed. Copies of the consolidated file will be placed in the MCO's folder on DMAS' secure FTP server and will be available for MCO pickup on Tuesday morning.

5.1.1.2 Quarterly Reconciliation of MCO Provider Payments

- DMAS will confirm that the provider NPI has attested. DMAS will use the attestation listings from the MCOs and from FFS (Medicaid) providers. DMAS may also request a copy of the provider's attestation form at their discretion.
- Validate that the 'Increased PCP Final Payment Amount' reflects the correct Medicare rate for the procedure code and regional adjustment.
- Validate that the 'Increased PCP Final Payment Amount' reported is equal to or less than the Billed Charge.
- Validate that the 'Increased PCP Final Payment Amount' reported is equal to or greater than the specified Medicare rate (except where Billed Charge is less than the Medicare Rate).

5.1.2 Incarcerated Members

New process effective 07/01/2012:

- MCO completes the Incarcerated Member form within 48 hours of identification. All required fields must be submitted in order to be processed.
- MCO submits completed form to DMAS via the DMAS secure FTP server.
- After receiving the MCO form, the DMAS Managed Care Contract Monitor creates a case record in the HCS Case Tracking System and assigns to Enrollment Analyst.
- Enrollment Analyst contacts facility to confirm incarceration and dates.
- After confirming member incarceration, the Enrollment Analyst retroactively cancels the member's managed care benefit based effective with the day before the date of incarceration.
- As necessary, the Enrollment Analyst will exempt the member from future managed care enrollment.
- The DMAS Eligibility and Enrollment Unit (EEU) will notify the member, close Medicaid eligibility (advanced notice is not required for these individuals), and notify the appropriate DSS Supervisor and DSS Regional Eligibility Specialist of the case closure. EEU will also handle any appeals regarding the enrollee's Medicaid cancellation.
- If the recipient WAS incarcerated but has already been released by the time DMAS receives the information, or is to be released within the month in question, then no action will be taken to end the MCO enrollment or the Medicaid coverage. The case will be referred on to the DMAS Recipient Audit Unit (RAU) for follow-up on any claims/encounters paid during the period of incarceration.

5.1.3 Newborn Reconciliation

5.1.3.1 Newborn Processing

The Medallion 3.0 Contract at 5.7 requires the MCO to cover MCO (live birth) newborns for the birth month plus two additional months when the mother was enrolled in the MCO on the newborn's date of birth. The newborn reconciliation process provides an offline payment to the MCO for newborns when a capitation payment was not made through the MMIS on the 820 payment report. The reconciliation process occurs after the newborn turns age one.

The newborn MCO enrollment process updates the mother's MCO benefit on the newborn's ID. In order for this to occur, the mother's ID must be associated with the newborn ID in the MMIS. Once the association is made between the mother and the newborn, the MMIS will update the MCO benefit for the newborn and the capitation payment is made through the MMIS on the 820 payment report. DMAS utilizes your Live Birth report to identify these newborns to create the linkage and generate the payment through the MMIS 820 reimbursement process. Timely and accurately submission of the Live Birth report provides DMAS staff the opportunity to identify enrolled newborns and connect the mother ID allowing most payments to be made through the MMIS prior to the newborn turning age one. Once a newborn turns age one, the MMIS is not able to up the MCO benefit retroactively for the birth month+2.

There are some instances where even when the linkage is made between the mother and newborn, and the newborn has eligibility coverage in the MMIS that the MCO benefit is not updated for the newborn. The primary reason is that the newborn has other insurance (TPL) and MMIS edits will not allow managed care benefits to update with certain TPL coverages. Regardless if the MCO benefit is not updated on the newborn ID, the MCO is responsible for the newborn for the birth month+2 and payment will be processed through the reconciliation process.

5.1.3.2 Newborn Payment Calculation

For standardization and consistency missing payments for the newborn reconciliation are calculated as follows:

1. Newborn has eligibility in the MMIS:
    - Payment is calculated using:
        - Newborn's MMIS AC for the month in which the payment is missing and
        - FIPS code for the Mother ID in the MMIS on newborn's DOB

2. Newborn has no eligibility in the MMIS (Newborn ID not found):
    - DMAS will validate the live birth by verifying that an encounter was submitted by the MCO for the Mother ID for a live birth delivery
    - Payment is calculated using:
        - Mother ID's AC on Newborn DOB,
            - If AC is Medicaid – AC 093 is used for payment,
            - If AC is 005 or 009 (FAMIS) - AC 008 is used for payment,
            - If AC is 007 (FAMIS) – AC 006 is used for payment
        - FIPS code for Mother ID on the newborn DOB submitted by the MCO

A payment will not be processed for the following reasons:

- Newborn enrollment was cancelled for death and the date of death was in month prior to the birth month+2. Payment is made for partial month enrollment.
  Example: DOB is 7/15/2012, date of death is 8/02/2012. The reconciliation process would issue a payment for 7/2012 and 8/2012 if a payment was not made by the MMIS. No payment is made for 9/2012.
- Newborn changed MCOs after the BM1 and was enrolled in a different MCO for BM2 and/or BM3 Payment is not made for BM2 and/or BM3 to the MCO that the mother was enrolled in on the newborns DOB BM1.
  Example: Mother was enrolled in MCO A on newborns DOB. Newborn enrolled in MCO A for BM1. Newborn/mother chose different MCO and was enrolled in MCO B for BM2 and BM3. No payment is made to MCO A for BM2 or BM3.
- Mother ID submitted not enrolled in MCO on Newborn DOB
- Newborn not enrolled in MMIS on DOB submitted. Newborn DOB submitted by MCO does not match MMIS DOB, month is different. MCO needs to resubmit on the correct monthly report.
- Newborn ID not found in the MMIS and a paid encounter was not submitted by the MCO for a live birth delivery for the Mother ID.
  - The MCO can submit a response and include the reference number for the paid live birth encounter in the comment field. DMAS will research the reference number and if the live birth is verified, correct the NB_Recon_Return_yyyymm to include the payment information. A new Certification form will be included to reflect the corrected offline payment amount.

5.1.3.3 Newborn Reconciliation Processing

The newborn reconciliation process consists of a monthly **NB_Recon_yyyymm** file submission from the MCO identifying newborns where a payment was not made on the MMIS 820 payment report. DMAS will validate the data submitted and return the **NB_Recon_Return_yyyymm** file to the MCO. The **Newborn Reconciliation Certification** is included with the return file. The Certification identifies the payment amount that will be processed for the MCO for newborns included on the reconciliation **NB_Recon_Return_yyyymm** file. The payment amount will be broken down into 2 payments, one for Medicaid and one for FAMIS and the total. Once the Certification is signed by the MCO and received by DMAS, the payment will be processed. The MCO will receive 2 checks one for the Medicaid amount and one for the FAMIS amount.

- **MCO Newborn Reconciliation File (NB_Recon_yyyymm)**
  Report <u>all newborn live births</u> that occurred during the reporting period where payment was not received for the Birth Month (BM1), and/or Birth Month+1 (BM2), and/or Birth Month+2 (BM3). See File layout at Section 3.1.**x**.

- **DMAS Newborn Reconciliation Return File (NB_Recon_Return_yyyymm)**
  DMAS will validate the report against MMIS enrollment and payment information and provide a return file to the MCO indicating that: (1) a payment was made by the MMIS, (2) an Offline payment will be made with the calculated amount, or, (3) a payment will not be processed. See File layout at Section 4.1.**x**.

- **MCO Response to DMAS Newborn Reconciliation Return File (NB_Recon_Return_yyyymm)**
  The MCO may submit a response file by email and include information in the MCO Comment field for any newborn where payment was not received. Information should provide the reference number for the paid encounter submitted for the mother for the live birth so that DMAS can research and verify the delivery. Once DMAS has researched the information provided by the MCO, either a new **DMAS Newborn Reconciliation Return File** will be generated with the revised payment amount or an email response will be sent.

5.1.3.4 Newborn Reconciliation Payment

The Add pay will be processed when the signed Certification is received. 2 payments will be processed, one for the Medicaid payment amount and one for the FAMIS payment amount.

5.1.4 Assessment Population Determination

The Medallion 3.0 Contract requires the MCO to assess members who meet certain aid category and enrollment timeframes. MCOs should identify potential members based on aid category and then determine if the member meets the enrollment criteria for the ABD/CSHCN Assessments Report (Section 3.2.6). Members should be assessed within the timeframes specified in the Assessments Report deliverable.

5.1.4.1 Members Requiring Assessment

Per the Medallion 3.0 contract, members must be assessed by the MCO when they fall into one or more of the eligible category groups:

- Member is in Aid Category 049, 051, 052, 059, 060, 061, 062 (ABD), 072 (AA), and/or
- Member is enrolled in the early intervention benefit (01010100EI), and/or
- Member has one or more special needs as specified in the Managed Care contract, and/or
- Member is enrolled in one of the HAP waiver benefits (01010100S, 01010100T, 01010100R, 01010100Y, 010101009). The assessment requirement for HAP members was added in Contract Modification (Amendment Number III) dated 12/01/2014. (DMAS' evaluation of HAP members will start effective with June 1, 2015 member enrollments.)

The enrollment status of members who belong to one or more of the eligible category groups should be evaluated for the previous six months. Only new or newly identified members are eligible to receive an assessment. A new or newly identified member is defined as a member who is on the 'current' EOM 834, but who did not meet the above criteria / was not on the EOM 834 files in all of the previous **six months**. The following table details the applicable enrollment look-back period for each enrollment begin date:

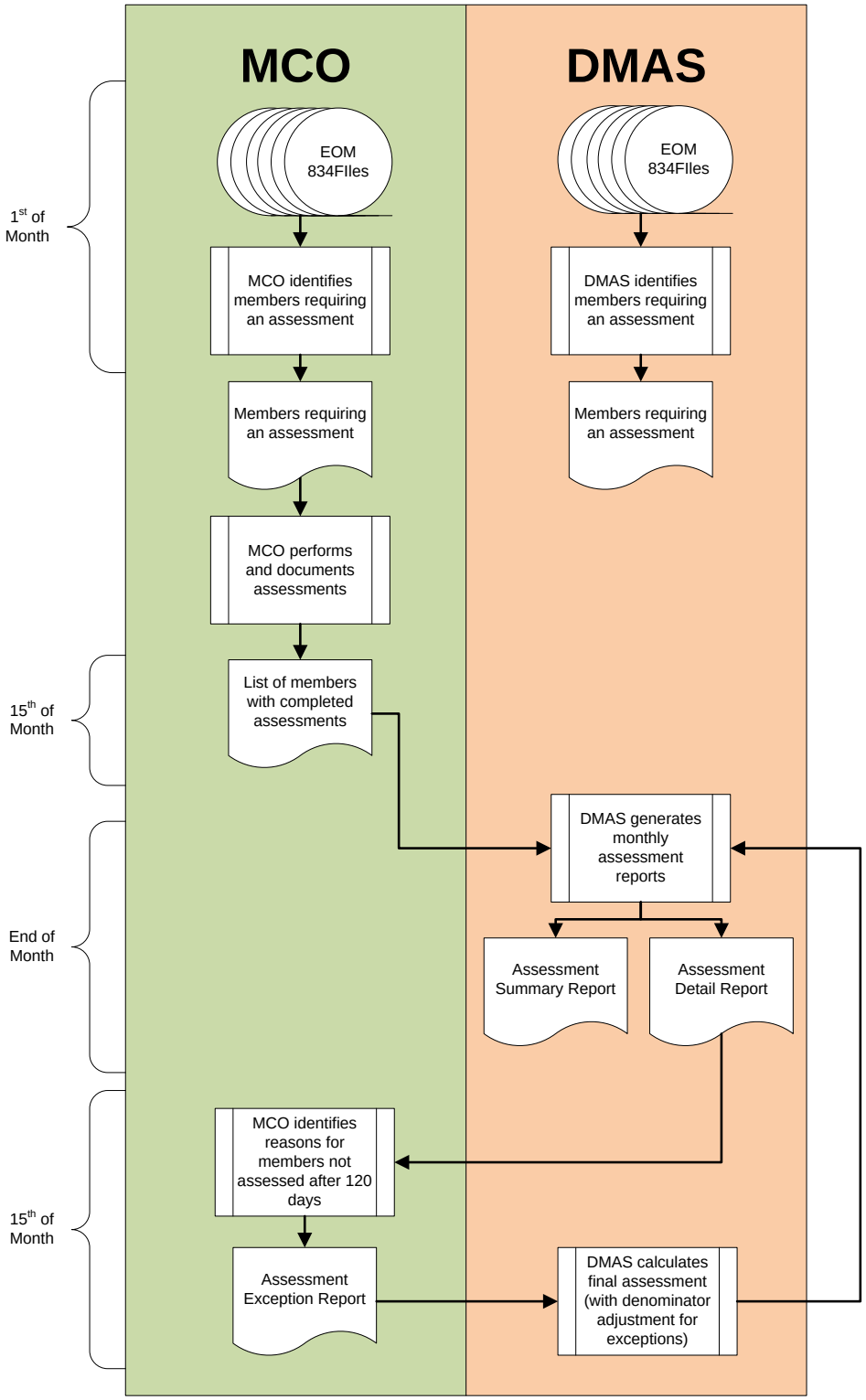
Enrollment Dates and Enrollment Look Back Period		
Enrollment Dates	**EOM Look Back Period**	
Begin	**Begin**	**End**
May 1st	Nov 1st	Apr 30th
Jun 1st	Dec 1st	May 31st
Jul 1st	Jan 1st	Jun 30th
Aug 1st	Feb 1st	Jul 31st
Sep 1st	Mar 1st	Aug 31st
Oct 1st	Apr 1st	Sep 30th
Nov 1st	May 1st	Oct 31st
Dec 1st	Jun 1st	Nov 30th
Jan 1st	Jul 1st	Dec 31st

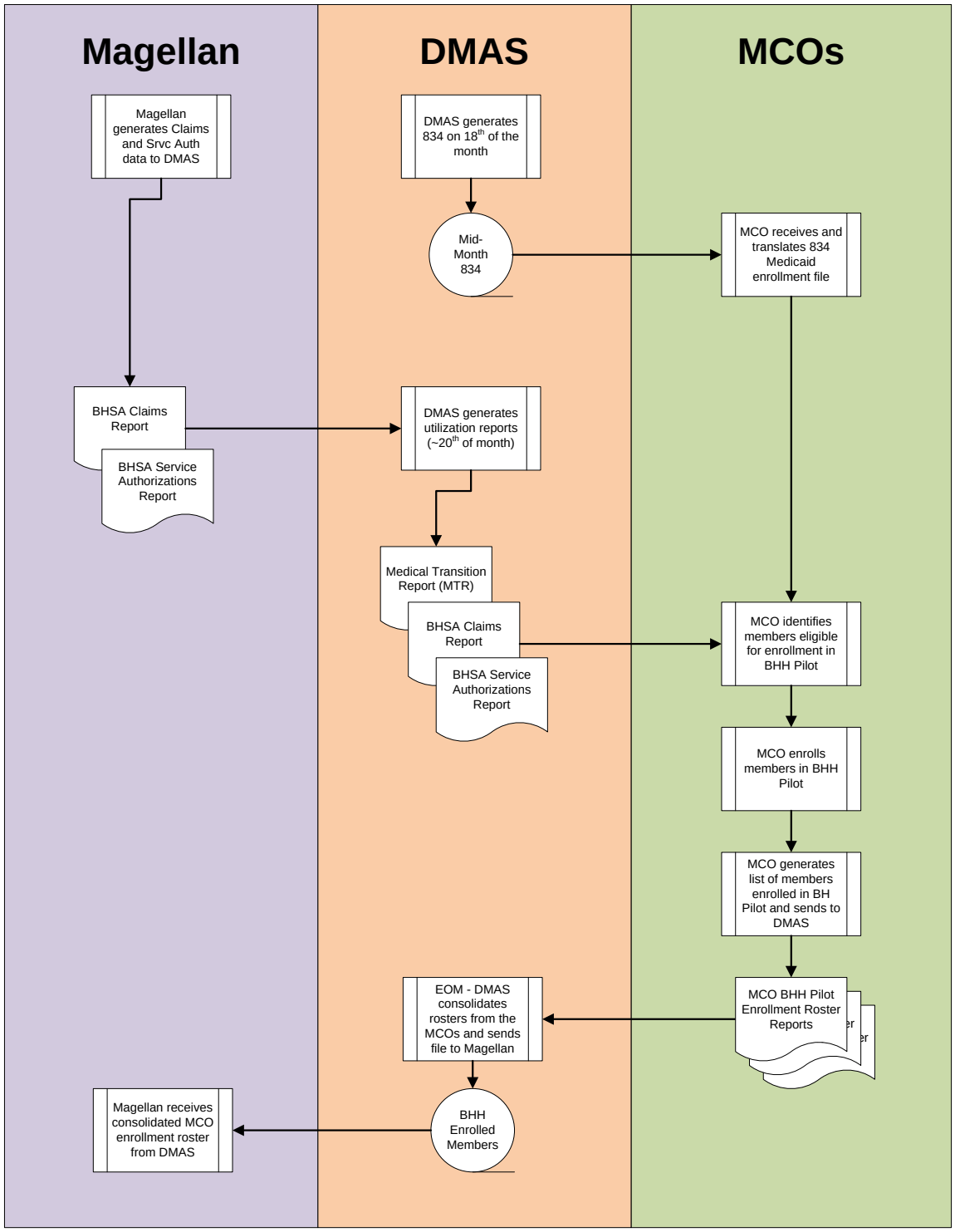
Feb 1st	Aug 1st	Jan 31st
Mar 1st	Sep 1st	Feb 28th
Apr 1st	Oct 1st	Mar 31st

Once the newly enrolled or newly-identified members are determined, the MCO should make every effort to assess the member. However, if a member is not continuously enrolled with the MCO or has a change in aid category during the 60 days after enrollment or identification, then the MCO is not responsible for reporting the assessment of the member. Members whose enrollment was terminated or who had a change in aid category during the 60-day post-enrollment period should not be included in the ABD/CSHCN Assessment Report. The following table provides the applicable enrollment date and 60-day post enrollment period for each report submission.

Report submission dates with the associated enrollment periods		
Report	**Enrollment Dates**	
Submit Dt	**Begin**	**End**
Jul 15th	May 1st	Jun 30th
Aug 15th	Jun 1st	Jul 31st
Sep 15th	Jul 1st	Aug 31st
Oct 15th	Aug 1st	Sep 30th
Nov 15th	Sep 1st	Oct 31st
Dec 15th	Oct 1st	Nov 30th
Jan 15th	Nov 1st	Dec 31st
Feb 15th	Dec 1st	Jan 31st
Mar 15th	Jan 1st	Feb 28th
Apr 15th	Feb 1st	Mar 31st
May 15th	Mar 1st	Apr 30th
Jun 15th	Apr 1st	May 31st

The following diagram provides the data flow process for the assessments for the CSHCN and the ABD populations.



5.1.5 Behavioral Health Home Pilot Enrollment Roster

The following diagram provides the process flow for the determination of the final enrollment roster for the Behavioral Health Home Pilot program: