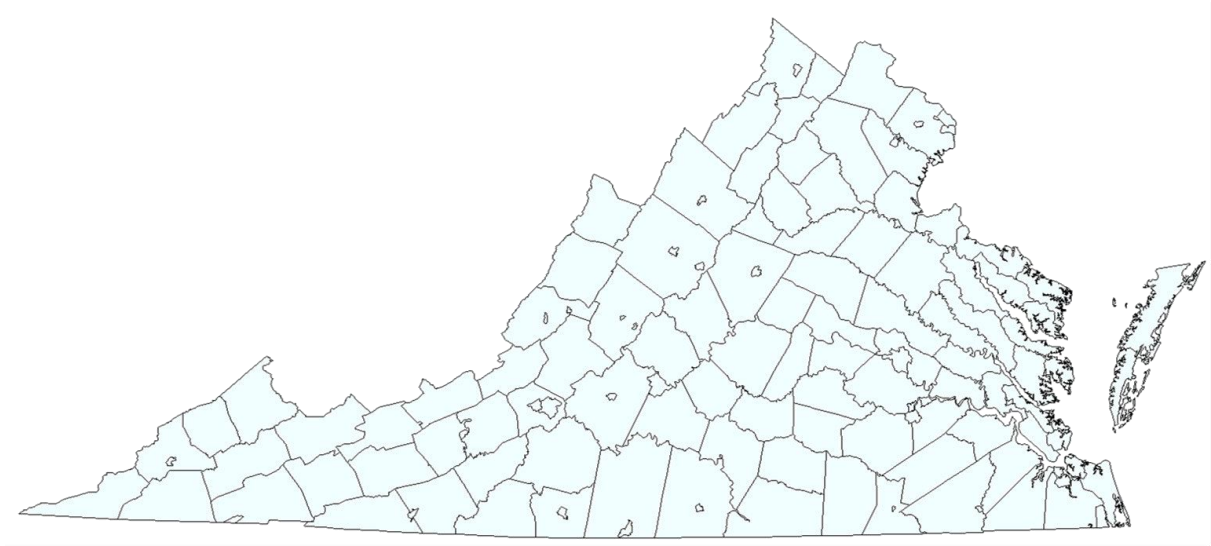
Managed Care Technical Manual



Virginia Department of Medical Assistance

Health Care Services Division

Version 2.5

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Version Change Summary

Version.	Description	Date
2.0	All Sections: Changed all contract references from 'Medallion II' to 'Medallion 3.0'	07/01/2014
2.0	Sections 1.2.4.4 & 1.2.4.5: Updated language related to status codes and 'fatal errors'.	07/01/2014
2.0	Section 1.2.6 - Updated encounter submission calendar for new fiscal year	07/01/2014
2.0	Section 3: Updated contact points for deliverables; removing Mary Mitchell and Tammy Driscoll, and adding Tom Lawson	07/01/2014
2.0	Section 3.2: Removed 'Member Address Changes Report'. Deliverable is no longer required per contract.	07/01/2014
2.0	Section 3.3: Added 'Reinsurance' invoice deliverable. This is a new optional deliverable per the Medallion 3.0 contract.	07/01/2014
2.0	Section 3.4: Removed 'Medallion Care System Partnership Proposal' report. This deliverable was related to the startup of this program and is no longer applicable.	07/01/2014
2.0	Section 3.4: Removed 'FAMIS Moms Report'. Deliverable is no longer required per contract.	07/01/2014
2.0	Section 3.5: Removed 'Co-Pay Changes' deliverable. Deliverable is no longer required per contract.	07/01/2014
2.0	Section 3.5: Added deliverables for 'Third Party Administrator (TPA) Contracts' and 'Third Party Administrator (TPA) Firewall' deliverables. These are new deliverables per the Medallion 3.0 contract.	07/01/2014
2.1	Section 3.3.8: Updated field requirements, due dates, and additional reporting requirements for this deliverable.	07/31/2014
2.2	Section 3.5.8: Corrected Requirements section to comply with current contract requirements.	08/31/2014
2.2	Section 4.1.21.2: Updated Medallion 3.0 contract reference.	08/31/2014
2.2	Section 1.2.5.11: Corrected error in EFL file layout.	08/31/2014
2.2	Section 5.1.3: Updated DMAS process for Newborn Reconciliation	08/31/2014
2.2	Section 4.1.21: Updated DMAS Newborn Reconciliation Return File	08/31/2014
2.2	Section 3.2.17: Updated MCO Newborn Reconciliation File	08/31/2014
2.2	Section 3.2.6: Added additional examples and documentation for assessment reporting	08/31/2014
2.2	Section 1.2.4.3: Removed this section temporarily pending further development by DMAS	08/31/2014
2.3	Section 3.4.9: Added due date	09/05/2014

Version.	Description	Date
2.3	Section 3.4.10: Added due date	09/05/2014
2.3	Section 3.4.10: Added report requirements	09/05/2014
2.4	Section 4.1.21.3: Added standard file name for newborn reconciliation certification form to instructions.	09/17/2014
2.4	Section 1.2.6: Updated Encounter Submission Calendar for Jan-Jun 2015	12/18/2014
2.4	Section 1.3.6: Added NCPDP compound drug encounters must be submitted with multiple ingredients.	12/18/2014
2.4	Section 1.3.5: Rewrote entire section on Line-Level processing	12/18/2014
2.4	Section 2.1: Updated enrollment roster (834) schedule for 2015	12/18/2014
2.4	Section 2.2.1: Updated capitation payment (820) schedule for 2015	12/18/2014
2.4	Section 3.3.7: Added field definitions for required data elements and requirement for separate submissions by line of business	12/18/2014
2.4	Section 3.4.27: Added new deliverable for annual Health Insurer Fee Certification submission.	12/18/2014
2.4	Section 3.3.8.2: Updated File Specifications for Status, Proc_Cd, NDC, and Disp_Fee	12/18/2014
2.4	Section 3.3.9.2: Updated file specifications for member ID editing on newborns.	12/18/2014
2.4	Section 4.1.9.3: Added new table to identify source values for the Service Code field in the DMAS Medical Transition Report	12/18/2014
2.4	Section 5.1.2: Updated DMAS process description in MCTM for incarcerated members to reflect content of DMAS memo to MCOs dated 09/01/2012.	12/18/2014
2.4	Section 4.1.5: Eliminated monthly DMAS report. This report was replaced by the 'Behavioral Health Service Authorizations Report' (4.1.20)	12/18/2014
2.5	Section 2.1: Correct placement of 2015 Enrollment Roster (834) schedule from Section 2.2 to 2.1	01/27/2015
2.5	Section 1.2.6: Updated Encounter Submission Calendar to reflect requested holiday submission dates (Jan, May)	01/27/2015
2.5	Section 1.2.5: Add documentation for BZF file and reworded zip file documentation.	01/27/2015

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 to 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)
   - Include the 999/RSP file as an attachment

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 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. All MMIS edits should be reviewed by the MCO. Error codes from the "Encounter Exception Error Code List" (See Section 1.4.5) should be researched carefully and resolved when possible. These errors may be appropriate for the encounter and may indicate potential data encounter issues (e.g., failed adjust/voids, invalid code values) should be reviewed and corrected by the MCO as appropriate. The MCO must strive to adjust/void any encounters that contain error(s) that affect the accuracy and integrity of the State's encounter data.

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                    07121312013071712 00P125148010900
▯▯G10012759394D0B11A011255434981
20130605▯▯▯AM21▯ANC▯F320131989000001010▯▯AM22▯EM1▯D2865969▯▯G10012758185D0B11A011467597096
   20130604▯▯▯AM21▯ANC▯F320131989000002010▯▯AM22▯EM1▯D2174978▯▯99071213100000000004
                         ▯
```

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 (11) (12)
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 (51)	ZZ9.99 (52)
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

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.

No.	Field Name	Source/Calculations
12	QTY	Claim Number of Units/Visits/Studies
13	(Proc Cd)	Procedure Code
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,ZZ9
RUN DATE: MM/DD/CCYY                          ENCOUNTER DETAIL REPORT
 (1)
MCN: 9999999      (28)                  (29)
SERVICE VENDOR: XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                          (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

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 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
Nation Provider ID (NPI)	X(10)	73	82
DOS From Date (CCYYMMDD)	X(08)	83	90

Field Name	Data Type / Length X=alphanumeric 9=numeric V=implied decimal S=sign	Start Position	End Position
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.

January 2015 **Encounter Submission Calendar**				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
			1 OP: HCFA, UB, RX MC: HCFA, UB, RX *------- DMAS holiday -------* *New Year's Day*	2 *------- DMAS holiday -------* *New Year's Day*
5 IT: HCFA, UB, RX KP: RX	6 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	7 VP: RX	8 OP: HCFA, UB, RX MC: HCFA, UB, RX	9 CC: RX
12 IT: HCFA, UB, RX KP: RX	13 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	14 VP: RX	15 OP: HCFA, UB, RX MC: HCFA, UB, RX	16 *------ DMAS holiday -------* *Lee-Jackson Day*
19 ~~IT: HCFA, UB, RX~~ (rescheduled to 01/23) KP: RX *------- DMAS holiday -------* *Martin Luther King, Jr. Day*	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 IT: HCFA, UB, RX (holiday schedule)
26 IT: HCFA, UB, RX CC: HCFA, UB KP: 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

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

February 2015 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
2 IT: HCFA, UB, RX KP: RX	3 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	4 VP: RX	5 OP: HCFA, UB, RX MC: HCFA, UB, RX	6
9 IT: HCFA, UB, RX KP: RX	10 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	11 VP: RX	12 OP: HCFA, UB, RX MC: HCFA, UB, RX	13 CC: RX
16 IT: HCFA, UB, RX KP: RX *------- DMAS holiday -------* *George Washington Day*	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: 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	27 CC: 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

March 2015 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
2 IT: HCFA, UB, RX KP: RX	3 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	4 VP: RX	5 OP: HCFA, UB, RX MC: HCFA, UB, RX	6
9 IT: HCFA, UB, RX KP: RX	10 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	11 VP: RX	12 OP: HCFA, UB, RX MC: HCFA, UB, RX	13 CC: RX
16 IT: HCFA, UB, RX KP: 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: 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	27 CC: RX
30 IT: HCFA, UB, RX KP: RX	31 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: 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

April 2015 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
		1 VP: RX	2 OP: HCFA, UB, RX MC: HCFA, UB, RX	3
6 IT: HCFA, UB, RX KP: RX	7 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	8 VP: RX	9 OP: HCFA, UB, RX MC: HCFA, UB, RX	10 CC: RX
13 IT: HCFA, UB, RX KP: 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 KP: 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: RX	28 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	29 VP: 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

May 2015 **Encounter Submission Calendar**				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
				1
4 IT: HCFA, UB, RX KP: RX	5 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	6 VP: RX	7 OP: HCFA, UB, RX MC: HCFA, UB, RX	8 CC: RX
11 IT: HCFA, UB, RX KP: RX	12 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	13 VP: RX	14 OP: HCFA, UB, RX MC: HCFA, UB, RX	15
18 IT: HCFA, UB, RX KP: RX	19 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	20 VP: HCFA, UB, RX	21 OP: HCFA, UB, RX MC: HCFA, UB, RX	22 CC: RX
25 ~~IT: HCFA, UB, RX~~ (rescheduled to 05/29) CC: HCFA, UB KP: RX *------- DMAS holiday -------* *Memorial Day*	26 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	27 VP: HCFA, UB, RX	28 OP: HCFA, UB, RX MC: HCFA, UB, RX	29 IT: HCFA, UB, RX (holiday schedule)

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

June 2015 Encounter Submission Calendar				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
1 IT: HCFA, UB, RX KP: RX	2 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	3 VP: RX	4 OP: HCFA, UB, RX MC: HCFA, UB, RX	5
8 IT: HCFA, UB, RX KP: RX	9 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	10 VP: RX	11 OP: HCFA, UB, RX MC: HCFA, UB, RX	12 CC: RX
15 IT: HCFA, UB, RX KP: RX	16 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	17 VP: HCFA, UB, RX	18 OP: HCFA, UB, RX MC: HCFA, UB, RX	19
22 IT: HCFA, UB, RX CC: HCFA, UB KP: RX	23 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	24 VP: HCFA, UB, RX	25 OP: HCFA, UB, RX MC: HCFA, UB, RX	26 CC: RX
29 IT: HCFA, UB, RX KP: RX	30 HK: HCFA, UB, RX *PE: HCFA, UB, RX *PR: HCFA, UB, RX	31 VP: 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
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

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
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
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

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
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
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

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
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	
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	Non standard 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

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
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 supporting documentation if required.	1/27/2008	9/30/2012
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

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
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
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

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk					
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	Last Modified
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

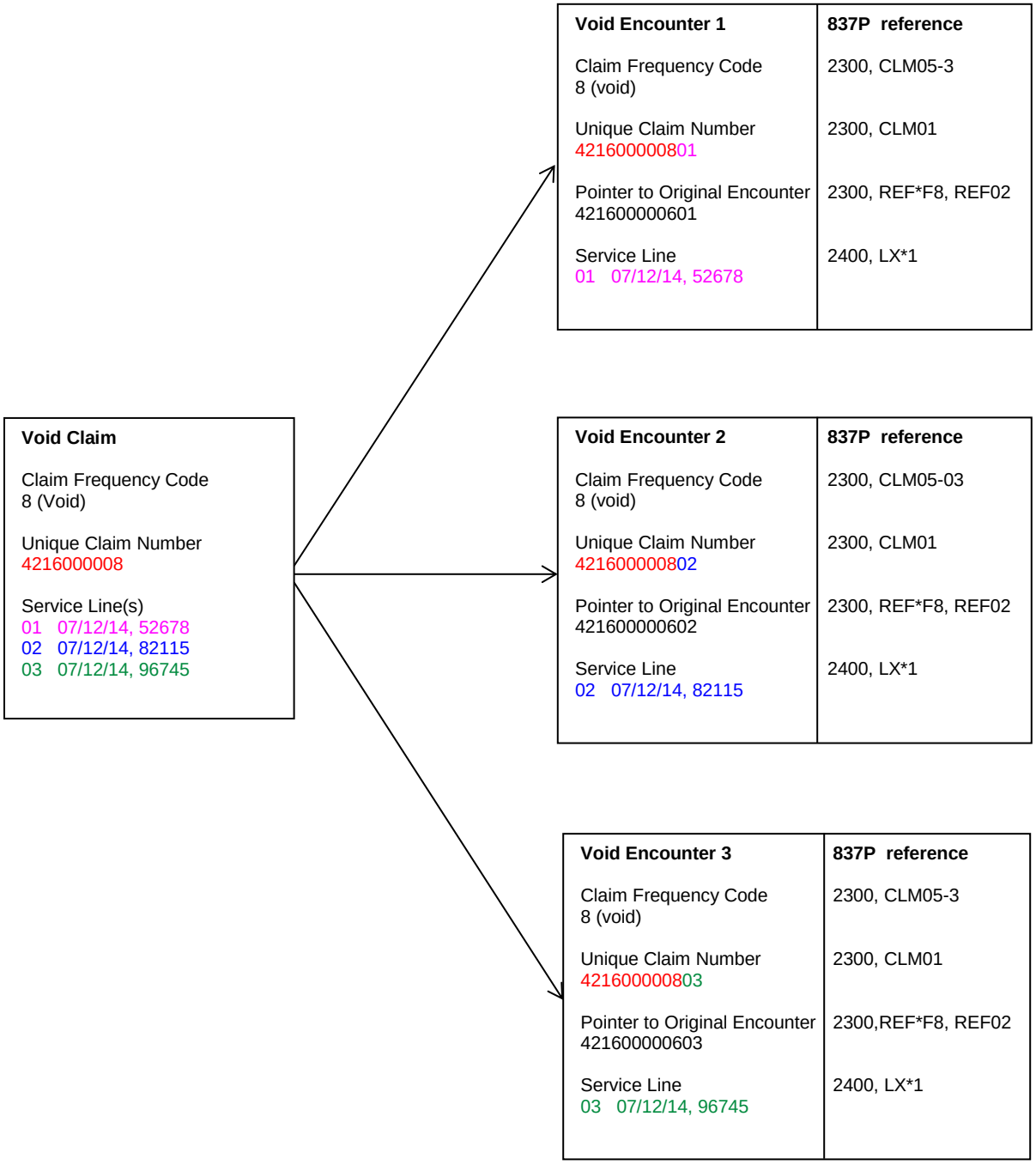
Service Line(s)
01 07/12/14, 45321
02 07/12/14, 82115
03 07/12/14, 26743

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 who are enrolled in a managed care arrangement. For successful rebate collection, pharmacy/drug encounters should be submitted with a NDC code.

NCPDP compound drug encounters must be submitted with multiple ingredients. 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).

DMAS has developed a weekly report to identify encounters with one or more errors that would prevent the collection of drug rebates from the manufacturer. Contractors must research these errors and correct the encounters so that the State is able to collect the full drug rebate.

The report includes all pharmacy encounters, and any outpatient or medical encounters that are eligible for drug rebate. The following conditions are being identified on the DMAS weekly report:

- MCO payment amount is missing/zero.
- MCO paid date is missing.
- MCO paid date is less than the date of service on the encounter.

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).

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:

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*M
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

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~
```

1.3.7.5 Sample NCPDP – Contractor Payment Only

Example to be provided by Xerox.

1.3.7.6 Sample NCPDP – Contractor and Other Carrier Payments

Example to be provided by Xerox.

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 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

Code	Description
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
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

Code	Description
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

Code	Description
105	Certified Professional Midwives
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

Code	Description
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
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

Code	Description
067	Neonatology, Pediatrics
068	Phys 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 Pr Room Rate
092	Rehabilitation
093	Durable Equip/Supp
094	Health Dept Phar
095	Not used
096	Not used
097	Not used
098	Not used
099	Not used
100	Mammography

Code	Description
101	Plastic Surgery
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
119	Early Intervention Targeted Case Management
120	EPSDT Behavioral Therapy

1.4.4 Edit Codes / Error Sequence Codes (ESC)

ESC	Error Description	Status
0003	Invalid Billing Provider Number	8
0004	Invalid or Missing Enrollee ID	8
0005	Invalid Accident Indicator/Hour	2
0007	Invalid Date of Service	8
0009	Invalid Tooth Code (dental)	6
0010	Invalid Surface Code (dental)	6
0012	Invalid Procedure Code	8
0022	Servicing Provider is Not Eligible to Bill this Payment Request Type	2
0023	Units Missing/Not in Valid Format	8
0025	Service 'Thru' Date Missing/Invalid	8
0028	Admit Date Missing or Invalid	4
0030	Primary Diagnosis Not on File/Invalid	8
0031	Patient Status is Missing or Invalid	2
0033	Total Charge Omitted/Out of Balance	4
0035	Missing/Invalid Accommodation Code	8
0038	Invalid Place of Treatment Code	8
0038	Invalid Place of Treatment Code	8
0040	Invalid Type of Service	2
0041	Invalid Procedure Modifier	6
0044	NDC Missing or Not in Valid Format	8
0045	Invalid Metric Quantity	8
0054	Principal procedure date is invalid or is outside dates of service billed.	2
0055	Type of Bill Missing or Invalid	8
0056	Prescription Number Missing	6
0057	Refill Indicator Invalid	2
0065	The number of passengers is invalid.	2
0066	Invalid wait time	2
0071	Invalid Void/Adjustment Reason Code	2
0077	Adjustment Denied - Original Payment Request Already Adjusted	2
0078	Void Denied - Original Payment Request Already Voided	2
0085	Admit Source Code Missing/Invalid	2
0098	Key Entry Error	8
0100	Invalid Mileage	8

ESC	Error Description	Status
0101	Date of Service After Date Payment Request Received	8
0103	Admission Date After Date Received	8
0104	Thru DOS is After Date Payment Request Received	8
0107	Surgical Procedure Omitted for O/R Charge	6
0109	Diagnosis Code Does Not Agree with Sex Code	8
0110	Diagnosis Code Does Not Agree with Age	8
0111	From Service Date After Thru Date	8
0112	Admit Date After From Date of Service	8
0113	ICD-9-CM Procedure/Sex Restriction	8
0116	Invalid/Missing Prescribing Physician Number	4
0117	Invalid Service/Modifier Combination	4
0119	The statement covers period disagrees with the service units.	6
0129	Revenue Code Not Covered	2
0130	Billing Provider Number Not On File	8
0131	The first other procedure code is not in the correct format or not on file.	6
0133	Revenue Code Missing	8
0143	Enrollee Not Eligible on DOS	6
0144	Billing Provider Not Eligible on DOS	6
0146	The Procedure Code Billed is Not on File	6
0147	Procedure Code Not In Use on Service Date	6
0148	Rendering provider is not certified to perform procedure.	2
0153	Invalid Tooth Number/Procedure	2
0176	Bill Mother and Baby Separately	4
0178	Invalid Diagnosis Code	8
0179	Invalid Discharge Status for Type Bill	4
0183	Procedure Code Does Not Agree with Service	2
0186	Procedure code billed not compatible with enrollee's sex.	2
0201	Duplicate Payment Request - Same Provider, Same DOS	8
0202	Duplicate of History File Record - Different Provider, Same DOS	8
0211	Enrollee Less than Minimum Age	6
0212	Enrollee Greater Than Maximum Age	2
0231	Verify Enrollee Eligibility in HMO	2
0249	Duplicate Payment Request - Same Provider, Overlap DOS	8
0257	Length of Stay Exceeds Percentile Limit	2

ESC	Error Description	Status
0301	Duplicate Payment Request - Same Provider, Same DOS	8
0302	Duplicate of History Record - Same Provider, Same DOS	8
0305	Contraindicated Audit - Same Provider, Within 32 Days	0
0307	Drug Not Covered for Enrollee's Age 21 or Older	2
0318	Enrollee Not Eligible on DOS	6
0330	Duplicate of History File Record - Same Provider, Overlap DOS	8
0360	Contraindicated Audit - Same Provider, Same DOS	2
0374	Duplicate HMO Copay Payment Request	6
0394	Drug Not Covered	6
0396	Adjustment Denied - Original Payment Request Not on File	8
0397	Void Denied - Original Payment Request Not on File	8
0400	Duplicate Rx Number/Different Drug Code	6
0401	Charges exceed maximum allowance	2
0403	NDC Not Covered	6
0415	Servicing provider ID is not the approved provider.	6
0423	NDC Not on File, Check NDC	8
0435	Invalid Drug Code for Compound Rx	6
0448	Neonatal/Nurse Days not Allowed Patient Over 3 Yrs	2
0449	Adult and nursery/neonatal days are not allowed on the same pmt request	2
0451	Two Nursery Revenue Codes on Same Invoice	2
0452	Overlapping Program Eligibilities	6
0453	Enrolled in HMO or Encounter Claim for FFS	8
0461	Units/Visits/Studies Not Equal Days	2
0464	Invalid Drug Code; Not a Compound	6
0482	Unable to Validate Enrollee in HMO	6
0493	Prescribing Physician Not on File	6
0706	Invalid Third Diagnosis	6
0707	Invalid Fourth Diagnosis	6
0708	Invalid Fifth Diagnosis	6
0709	Invalid Sixth Diagnosis	6
0710	Invalid Seventh Diagnosis	6
0711	Invalid Eighth Diagnosis	6
0712	Invalid Ninth Diagnosis	6
0713	Second Other Procedure Invalid	6

ESC	Error Description	Status
0714	Third Other Procedure Code Invalid	6
0715	Fourth Other Procedure Code Invalid	6
0716	Fifth Other Procedure Code Invalid	6
0717	First Other Procedure Date Is Missing or Invalid	6
0718	Second Other Procedure Date is Missing or Invalid	6
0719	Third Other Procedure Date is Missing or Invalid	6
0724	Admit Type is Missing or Invalid	8
0729	Servicing Provider Not on File	8
0731	Servicing Provider Not Eligible on DOS	6
0732	Servicing Provider Invalid	8
0733	Admitting Diagnosis Missing or Invalid	8
0734	Covered Days Entered Exceed Statement Period	6
0735	Invalid Procedure for Anesthesia	2
0736	Invalid Surface Code/Procedure	8
0739	Personal Care Begin Date > From DOS	6
0740	Same Procedure, Same Day, Different Modifiers	2
0747	Duplicate Payment Request - Different Provider, Overlap DOS	8
0748	Duplicate of History File Record - Different Provider, Overlapping DOS	8
0752	Missing HMO Claim Number	8
0753	Fourth Other Procedure Date is Missing or Invalid	6
0754	Fifth Other Procedure Date is Missing or Invalid	6
0756	Billing Provider is Not a Group Provider	8
0757	Servicing Provider Cannot Be a Group Provider	8
0758	Provider Cannot Bill as an Individual	8
0759	Inpatient Hospital Payment > $500,000	2
0820	Review Enrollee Birth Date	8
0821	Outpatient Days Billed Exceeds 1	4
0825	Limitation Audit - Once in a Lifetime, Any Provider - Deny	4
0826	Limitation Audit - Three in a Lifetime, Any Provider - Deny	4
0827	Unable to Assign Object Code	2
0828	Inpatient versus Outpatient, Possible Duplicate	6
0829	Inpatient versus Title 18, Possible Duplicate	6
0830	Outpatient versus Title 18, Possible Duplicate	6
0831	SNF versus Title 18, Possible Duplicate	6

ESC	Error Description	Status
0833	Transportation versus Title 18, Possible Duplicate	6
0838	Missing/Invalid PA Tran Request End Date	8
0840	Quantity Dispensed > Intended Quantity	6
0841	Multiple Partial Fill Prescriptions Not Allowed	6
0842	Different NDC Between Partial & Completion Fill	6
0843	Intended Quantity Exceeds Maximum	6
0844	Missing/Invalid Associated Rx Number on Completion Transaction	6
0845	Missing/Invalid Associated DOS on Completion Transaction	6
0846	Associated Partial Fill Transaction Not On File	6
0847	Partial Fill Transaction Not Supported for Compounds	6
0848	Completion Transaction not Permitted with Same DOS as Partial	6
0849	Intended Days Supply Exceeds Maximum Allowed	6
0850	Intended Days Supply Missing or Invalid	6
0852	Intended Quantity Missing or Invalid	6
0853	Dispensing Status Missing or Invalid	6
0856	Missing/Invalid Basis of Request	8
0857	Missing/Invalid PA Tran Request Begin Date	8
0858	Bill Type 111/112 Admit Date Not = From Date	8
0866	Duplicate Provider, Rx #, and Date of Service	8
0871	Invalid Secondary Diagnosis	8
0874	Drug Daily Dose Exceeded	6
0875	Drug Total Dose Quantity Exceeded	6
0877	Same Cycle Reversal with Diff Media Not Allowed	8
0878	Early Refill Override Due to Increase in Dosage	2
0893	Days Supply for Partial Fill Components Exceeds Intended Days	6
0894	Quantity for Partial Fill Components Exceeds Intended Quantity	6
0902	Assistant Surgeon Modifier & Co-Surgeon Modifier Not Allowed On Same	6
0919	Inpatient versus Nursing Home - Possible Duplicate	6
0932	Related Component Radiology Procs Not Payable when Global Paid	2
0933	Components of Surgical Care Not Payable when Global Surgery Paid	2
0934	Umbrella Audit - Postpartum Visits, Same Provider	6
0936	Tooth/Procedure - Invalid Combination	8
0937	Limitation Audit - Twice in a Lifetime, Any Provider - Deny	6
0938	Limitation Audit - Four in a Lifetime, Any Provider - Deny	6

ESC	Error Description	Status
0939	Limitation Audit - Six in a Lifetime, Any Provider - Deny	6
0940	Limit Audit - Only One New Patient Medical Visit per Lifetime	4
0954	Inpatient versus Outpatient, Same Provider	8
0970	Enrollee Not Enrolled in a Covered Plan for This Service on the DOS	8
0970	Enrollee Not Enrolled in a Covered Plan for This Service on the DOS	8
0971	Enrollee in Plan that Provider is Not	2/8
0979	Duplicate Ingredient(s) on Compound Claim Not Paid	8
0983	Enrollee not on File	8
0986	DRG Rate Not On File	8
0990	Revenue Code Not on File	8
0991	Revenue Code Not Valid for Dates of Service	8
0992	Revenue Code Not Valid for Enrollee's Age	8
0993	Revenue Code Not Valid for Enrollee's Sex	8
0994	Revenue Code Not Valid for Provider Type, Specialty	6
0995	Revenue HCPCS Not on File	2
0996	Revenue HCPCS Not Valid for Dates of Service	8
1008	Wheelchair Van Passenger Limit Exceeded	2
1009	Mileage Limit or Charge Exceeded	2
1470	More than 30 Errors	8
1503	Negative PA on File/Physician Must Approve for PA	2
1505	Angiotensin Receptor Blockers - Non PDL, PA Required	2
1506	ACE Inhibitor - Non PDL, PA Required	2
1507	ACE Inhibitor/Calcium Channel Blocker Combo - Non PDL, PA Required	2
1509	Nondihydropryidine Calcium Channel Blockers - Non PDL, PA Required	2
1510	Proton Pump Inhibitor Non PDL	2
1511	Sedative Hypnotics - Non PDL, PA Required	2
1512	Beta Adrenergic Agent - Non PDL, PA Required	2
1515	Beta Blockers - Non PDL, PA Required	2
1516	Cholesterol Lowering Drugs (Statins) - Non PDL, PA Required	2
1517	Inhaled Corticosteroids - Non PDL, PA Required	2
1518	Nasal Steroids - Non PDL, PA Required	2
1519	COX-II Inhibitors - Non PDL, PA Required	2
1520	Low Sedating Antihistamines - Non PDL, PA Required	2
1521	Histamine 2 Receptor Antagonist - Non PDL, PA Required	2

ESC	Error Description	Status
1522	Oral Hypoglecemics - PDL PA Required	2
1523	Leukotriene Modifiers - PDL PA Required	2
1524	NSAID - PDL PA Required	2
1525	Bisphosphonates - PDL PA Required	2
1526	Oral Antifungals for Onychomysis - PDL PA Required	2
1527	Serotonin Receptor Agonists - PDL PA Required	2
1528	Cephalosporins - PDL PA Required	2
1529	Macrolides - PDL PA Required	2
1530	Quinolones - PDL PA Required	2
1531	Glaucoma Agents - PDL PA Required	2
1532	CNS Stimulant/ADHD Medications - PDL PA Required	2
3500	Dummy Edit for Newborn Encounters	6

1.4.5 Encounter Exception Error Code List

ESC	Description
0003	Invalid Billing Provider Number
0004	Invalid Or Missing Enrollee ID
0007	Invalid Date Of Service
0012	Invalid Procedure Code
0014	Billed Amount Missing Or Invalid
0015	Primary Carrier Pay Missing/Invalid
0023	Units Missing/Not In Valid Format
0025	Service 'Thru' Date Missing/Invalid
0028	Admit Date Missing/Invalid
0030	Primary Diag Not On File/Invalid
0038	Invalid Place Of Treatment Code
0041	Invalid Procedure Modifier
0044	NDC Missing Or Not In Valid Format
0045	Invalid Metric Quantity
0055	Type Of Bill Missing Or Invalid
0071	Invalid Void/Adjustment Reason Code
0077	Adjustment Denied - Original Payment Request Already Adjusted
0078	Void Denied - Original Payment Request Already Voided
0100	Invalid Mileage
0101	Date Of Service After Date Payment Request Received
0103	Admission Date After Date Received
0104	Thru DOS Is After The Date Payment Request Received
0111	From Service Date After Thru Date
0112	Admit Date After The From Date Of Service
0133	Revenue Code Missing
0146	Procedure Code Not On File
0147	Procedure Code Not In Use On Service Date
0178	Invalid Diagnosis Code
0201	Duplicate Payment Request - Different Provider, Same DOS
0202	Duplicate of History File Record - Different Provider, Same DOS
0301	Duplicate Payment Request - Same Provider, Same DOS
0302	Duplicate of History File Record - Same Provider, Same DOS
0328	Services Incurred Prior To Coverage.

ESC	Description
0330	Duplicate of History File Record - Same Provider, Overlap DOS
0396	Adjust. Denied - Orig Payment Request Not On File
0397	Void Denied - Orig Payment Request Not On File
0404	Invalid Service Vendor For Date Of Service
0453	Enrolled in HMO or an Encounter FFS
0467	M/I Product/Service ID Qualifier
0423	NDC Not On File, Check NDC
0453	Enrolled in HMO or an Encounter FFS
0681	Invalid CAS Adjustment Reason
0724	Admit Type is Missing or Invalid
0733	Admitting Diagnosis Missing Or Invalid
0752	Missing HMO Claim Number
0773	Conflicting CAS Adjustment Reasons
0858	Bill Type 111/112 Admit Date Not = From Date
0866	Duplicate Provider, Rx # and Date of Service
0877	Same Cycle Reversal with Diff Media Not Allowed
0979	Duplicate Ingredient(s) on Compound Claim Not Paid
0983	Enrollee not on File
0993	Revenue Code Not Valid For the Enrollee's Sex
0995	Revenue HCPCS Not On File
1254	Same Procedure, Same Day, Different Modifiers
1255	Same Procedure, Same Day, Different Modifiers
1335	Duplicate Payment Request - Same Provider, Same DOS
1336	Duplicate Payment Request - Same Provider, Same DOS
1337	Duplicate Payment Request - Same Provider, Same DOS
1338	Duplicate Payment Request - Different Provider, Same DOS
1339	Duplicate Payment Request - Different Provider, Same DOS
1340	Duplicate Payment Request - Different Provider, Same DOS
1341	Duplicate Payment Request - Different Provider, Same DOS
1342	Duplicate Payment Request - Same Provider, Overlap DOS
1343	Duplicate Payment Request - Same Provider, Overlap DOS
1344	Duplicate Payment Request - Same Provider, Overlap DOS
1345	Duplicate Payment Request - Different Provider, Overlap DOS
1346	Duplicate Payment Request - Different Provider, Overlap DOS

ESC	Description
1347	Duplicate Payment Request - Different Provider, Overlap DOS
1348	Duplicate Payment Request - Different Provider, Overlap DOS
1349	Duplicate Payment Request - Same Provider, Same DOS
1350	Duplicate Payment Request - Different Provider, Same DOS
1351	Duplicate Payment Request - Same Provider, Overlap DOS
1352	Duplicate Payment Request - Different Provider, Overlap DOS
1353	Duplicate Payment Request - Same Provider, Same DOS
1354	Duplicate Payment Request - Different Provider, Same DOS
1355	Duplicate Payment Request - Same Provider, Overlap DOS
1356	Duplicate Payment Request - Different Provider, Overlap DOS
1357	NPI Servicing Provider Not on File
1358	Zip Code Does Not Exist On LOC_ZIP Data
1364	Service NPI Not Found On Claim
1393	No Srvc Taxonomy Code On The Claim
1435	Duplicate of History File Record - Same Provider, Same DOS
1436	Duplicate of History File Record - Same Provider, Same DOS
1437	Duplicate of History File Record - Same Provider, Same DOS
1438	Duplicate of History File Record - Different Provider, Same DOS
1439	Duplicate of History File Record - Different Provider, Same DOS
1440	Duplicate of History File Record - Different Provider, Same DOS
1441	Duplicate of History File Record - Different Provider, Same DOS
1442	Duplicate of History File Record - Same Provider, Overlap DOS
1443	Duplicate of History File Record - Same Provider, Overlap DOS
1444	Duplicate of History File Record - Same Provider, Overlap DOS
1445	Duplicate of History File Record - Different Provider, Overlapping DOS
1446	Duplicate of History File Record - Different Provider, Overlapping DOS
1447	Duplicate of History File Record - Different Provider, Overlapping DOS
1448	Duplicate of History File Record - Different Provider, Overlapping DOS
1459	Duplicate of History File Record - Same Provider, Same DOS
1460	Duplicate of History File Record - Different Provider, Same DOS
1461	Duplicate of History File Record - Same Provider, Overlap DOS
1462	Duplicate of History File Record - Different Provider, Overlapping DOS
1463	Duplicate of History File Record - Same Provider, Same DOS
1464	Duplicate of History File Record - Different Provider, Same DOS

ESC	Description
1465	Duplicate of History File Record - Same Provider, Overlap DOS
1466	Duplicate of History File Record - Different Provider, Overlapping DOS
1470	More Than 30 Errors

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
12/16/2014 Tue	12/18/2014 Thu	12/20/2014 Sat	12/31/2014 Wed	01/02/2015 Fri
01/16/2015 Fri	01/18/2015 Sun	01/20/2015 Tue	01/31/2015 Sat	02/02/2015 Mon
02/16/2015 Mon	02/18/2015 Wed	02/20/2015 Fri	02/28/2015 Sat	03/02/2015 Mon
03/16/2015 Mon	03/18/2015 Wed	03/20/2015 Fri	03/31/2015 Tue	04/02/2015 Thu
04/16/2015 Thu	04/18/2015 Sat	04/20/2015 Mon	04/30/2015 Thu	05/02/2015 Sat
05/16/2015 Sat	05/18/2015 Mon	05/20/2015 Wed	05/31/2015 Sun	06/02/2015 Tue
06/16/2015 Tue	06/18/2015 Thu	06/20/2015 Sat	06/30/2015 Tue	07/02/2015 Thu
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

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
12/26/2014 Fri	12/29/2014 Mon	01/02/2015 Fri
01/30/2015 Fri	02/02/2015 Mon	02/06/2015 Fri
02/27/2015 Fri	03/02/2015 Mon	03/06/2015 Fri
03/27/2015 Fri	03/30/2015 Mon	04/03/2015 Fri
04/24/2015 Fri	04/27/2015 Mon	05/01/2015 Fri
05/29/2015 Fri	06/01/2015 Mon	06/05/2015 Fri
06/26/2015 Fri	06/29/2015 Mon	07/03/2015 Fri
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

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.

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: 91 – 100 = A; 81 – 90 = B; 71 – 80 = C; 61 – 70 = D, less than 60 = F.

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.

3.1.3 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.B

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

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 Approved	Value must be ≥ 0
Number Limited	Value must be ≥ 0
Number 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. 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

- **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).

- **Claims Volume:** The Month Begin Claims Inventory should be equal to the prior month's Month End Claims Inventory.
- **Claims Processed:** Number Of Claims Paid This Month + Number Of Claims Denied This Month + Number Of Claims Pended This Month = Claims Processed (Paid Or Denied) This Month.
- **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, Article II, Section D.4

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

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 **Lock-In**

3.2.5.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.L.IV, 7.1.M.III

FAMIS Contract, Article II, Sections R.20.m & R.20.n

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
Lock-in Start Date	Must be a valid date Format: mm/dd/yyyy
Lock-in End Date	Must be a valid date Format: mm/dd/yyyy
Lock-in Pharmacy/Provider Name	Must be 40 characters or less
Lock-in Pharmacy/Provider ID Number	Must be 10 characters or less Must be a valid Provider ID
Lock-in Pharmacy/Provider Address	Must be 40 characters or less
Lock-in Pharmacy/Provider City	Must be 17 characters or less
Lock-in Pharmacy/Provider State	Must be 2 characters or less Must be valid state code (USPS standards)
Lock-in Pharmacy/Provider Zip	Must be 9 characters or less
Lock-in Type	Must be 1 character or less Valid Values: 1, 2, 3, 4
Lock-in 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: LOCK_IN.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: Program Integrity Division

3.2.5.3 Requirements

Include members enrolled in Medicaid and FAMIS.

Use the following codes for Lock-in Type: 1 = Physician, 2 = Pharmacy, 3 = Physician Notice, 4 = Pharmacy Notice

Only include members who are currently in the lock-in program.

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

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 Visit date <= last day of reporting period Visit date >= first day of reporting period
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

- Required Assessments: Per the Medallion 3.0 contract, members must be assessed by the MCO when they meet one or more of the following eligibility criteria:
  - Member is in Aid Category 049, 051, 052, 059, 060, 061, 062 (ABD), 072 (AA), 076 (FC), 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.

  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.
- New Members: All new or newly identified ABD/CSHCN 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**.

- 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 look back period, i.e., current and previous calendar months. Assessments are only required for members who were enrolled with the MCO during the entire look back 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 ABD/CSHCN enrollment on the December 834.
- Assessment: Assessments are to be done on every ABD/CSHCN member who is newly enrolled with the MCO and on every member previously enrolled in the MCO but who has been newly identified as ABD/CSHCN. (Refer to criteria above.) A successful assessment is considered contact by the health plan that results in a fully completed health assessment questionnaire which assesses health care needs, including mental health, interventions received, and any additional services required including referrals to other resources and programs with completion of an approved assessment tool. Only include those members who have received a successful assessment and/or PCP visit on this report.
- 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.

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

3.2.6.4 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.

#	Look Back		Prior Months Enrollment Period						Assessment Required?	Reason
	Dec 834	Nov 834	Oct 834	Sep 834	Aug 834	Jul 834	Jun 834	May 834		
1.	ABD	ABD	Not Elig	Not Elig	Not Elig	Not Elig	Not Elig	Not Elig	Yes	New member
2.	ABD	ABD	LIFC	LIFC	LIFC	LIFC	LIFC	LIFC	Yes	New ABD
3.	ABD	ABD	Not Elig	Not Elig	Not Elig	Not Elig	Not Elig	ABD	No	Prior ABD (not new)
4.	ABD	ABD	Not Elig	Not Elig	LIFC	LIFC	LIFC	LIFC	Yes	New ABD
5.	ABD	ABD	ABD	Not Elig	Not Elig	Not Elig	Not Elig	Not Elig	No	Not new
6.	ABD	ABD	LIFC	LIFC	LIFC	EI Bnft	EI Bnft	EI Bnft	No	EI during prior 6 months
7.	Not Elig	ABD	LIFC	LIFC	LIFC	LIFC	LIFC	LIFC	No	Did not meet criteria for entire look back

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.
- Performance: The number of assessed new members reported by the MCO who meet the ABD/CSHCN criteria DIVIDED BY the total number of new members who met the ABD/CSHCN criteria (as determined by DMAS based on the MCO's 834).

3.2.7 Appeals & Grievances Summary

3.2.7.1 Contract Reference:

Medallion 3.0 Contract, Section 10.1.E.II

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. 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, Article II, Section N.7

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

3.2.9.1 Contract Reference

Medallion 3.0 Contract, Section 11.5.A

3.2.9.2 File Specifications

Field Description	Specifications
Contractor	Must not be blank
Submission Date	Must be a valid date Format: mm/dd/yyyy
For Date	Must not be blank
Encounter Type	Must not be blank
MCO File Name	Must not be blank
MCN Number	Must not be blank

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_FILES.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

3.2.9.3 Requirements

Include all encounter files submitted during the calendar month.

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

Include encounter files from subcontractors.

3.2.9.4 Examples

None

3.2.9.5 Scoring Criteria

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

3.2.10 **Encounter Data Certification**

3.2.10.1 Contract Reference

Medallion 3.0 Contract, Section 11.5.B

3.2.10.2 File Specifications

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

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

Include encounters for all members enrolled in Medicaid and FAMIS.

3.2.10.4 Examples

N/A

3.2.10.5 Scoring Criteria

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

3.2.11 **Monies Recovered by Third Parties**

3.2.11.1 Contract Reference

Medallion 3.0 Contract, Section 12.10.A

Article IV, D, 1 (FAMIS)

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

Article IV, D, 1 (FAMIS)

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 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

Article IV, D, 2 (FAMIS)

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 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

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

Article IV, D, 3 (FAMIS)

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**

3.2.16.1 Contract Reference

Medallion 3.0 Contract, Section 12.14.B

3.2.16.2 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
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.
Attestation Date	Date that the provider's attestation form was received by the MCO.	Must be a valid date. Format = mm/dd/yyyy. Must be greater than 01/01/2013.
Begin Date	Effective date when the provider's attestation begins. See requirements for details.	Must be a valid date. Format = mm/dd/yyyy. Must be greater than 01/01/2013.
End Date	In cases where a provider terminates participation with the MCO or requests that his attestation be terminated, this represents the end date.	Must be a valid date. Format = mm/dd/yyyy. Must be greater than 01/01/2013. For active providers, use 12/31/9999.
Board Certification	On the attestation form submitted, the provider checked the box indicating that he/she is board certified in one of the specified specialties/ subspecialties.	Valid values are Y or N.
Percent of Services	On the attestation form submitted, the provider checked the box indicating that 60% of their services rendered are for one of the specified E&N or vaccine procedures.	Valid values are Y or N.

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:	PCP_PROV.csv
Frequency:	Monthly
Due Date:	By close of business on the 15th calendar day of the month. Include all provider attestations current up to your submission date.
DMAS:	Managed Care Contract Monitor

3.2.16.3 Requirements

- Include all providers where the MCO has received a valid completed attestation form.
- Each submission should be a full replacement file, i.e., include all providers who have attested since the beginning of the program.
- Do not include a header row in the file.
- Submit one file per MCO.
- Submit an unduplicated list. Each NPI should appear only once in the list.
- If more than 5% of the rows in a submitted file have rows with one or more errors, that file will not be accepted by DMAS and the MCO must submit a corrected file within three (3) business days.
- For providers who attest during the first quarter of 2013, the Begin Date is effective January 1, 2013. For providers who attest after March 31, 2013, their Begin Date is effective the first day of the calendar month in which they attest (based on Attestation Date).
- The End Date should represent the earliest of the following:
  - The end date of the provider's participation agreement with the MCO.
  - The end date specified by a provider who notifies the MCO that he wishes to terminate his enrollment in the PCP increased payment program,
  - Otherwise, use 12/31/9999 for the End Date, indicating that the provider's enrollment in the program is active and ongoing.

3.2.16.4 Examples

None

3.2.16.5 Scoring Criteria

None

3.2.17 **MCO Newborn Reconciliation File**

3.2.17.1 Contract Reference

Medallion 3.0 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_yyyymm.csv (The yyyymm represents the newborn DOB's included in the file submission. Newborns with July 2013 DOBs will be submitted as NB_Recon_201307.)
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.

3.3 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.

The reporting periods for quarterly reporting are as follows: January – March, April – June, July – September and October – December. For example, fourth quarter deliverables are submitted no later than January 31st 5th and the reporting period is October - December. 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 and s III, Section C

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.

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

3.3.2.1 Contract Reference

Medallion 3.0 Contract, Section 3.4.A

FAMIS Contract, Article V

3.3.2.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PRV_CRED.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

3.3.2.3 Requirements

Include providers participating in Medicaid and FAMIS.

3.3.2.4 Examples

None

3.3.2.5 Scoring Criteria

None

3.3.3 Case Managers List

3.3.3.1 Contract Reference

Medallion 3.0 Contract, Section 7.6.B

FAMIS Contract, Article II, Section A.11

3.3.3.2 File Specifications

Field Description	Specifications
Case Manager Last Name	Required. Must be 20 characters or less.
Case Manager First Name	Required. Must be 20 characters or less.
Case Manager Qualifications	Optional. Must be 25 characters or less.
Region Served - Tidewater	Required. Valid values are 'Y' and 'N'.
Region Served – Northern Virginia	Required. Valid values are 'Y' and 'N'.
Region Served – Central Virginia	Required. Valid values are 'Y' and 'N'.
Region Served – Upper Southwest Virginia	Required. Valid values are 'Y' and 'N'.
Region Served – Lower Southwest Virginia	Required. Valid values are 'Y' and 'N'.
Region Served – Halifax	Required. Valid values are 'Y' and 'N'.
Region Served – Far Southwest Virginia	Required. Valid values are 'Y' and 'N'.

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:	CASE_MGR.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 Operations

3.3.3.3 Requirements

As specified in the Medallion 3.0 and FAMIS contracts.

3.3.3.4 Examples

None

3.3.3.5 Scoring Criteria

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

3.3.4 Members with Physical and Behavioral Health Limitations and Conditions

3.3.4.1 Contract Reference

Medallion 3.0 Contract, Section 7.7.A

3.3.4.2 File Specifications

Field Description	Specifications
Member ID	Must be a valid Medicaid ID Format: 12 bytes with leading zeros
Diagnosis Code 1	Must be less than or equal to 5 characters without decimal points
Diagnosis Code 2	Must be less than or equal to 5 characters without decimal points
Diagnosis Code 3	Must be less than or equal to 5 characters without decimal points
Diagnosis Code 4	Must be less than or equal to 5 characters without decimal points
Diagnosis Code 5	Must be less than or equal to 5 characters without decimal points

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: LC_MBRS.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 Operations

3.3.4.3 Requirements

As specified by the ICD-9 coding standards.

3.3.4.4 Examples

None

3.3.4.5 Scoring Criteria

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

None

3.3.5 Program Integrity Activities

3.3.5.1 Contract Reference

Medallion 3.0 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, Article II, Section A.3

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

N/A

3.3.6.4 Examples

N/A

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

3.3.7.2 File Specifications

Field Description	Specifications
Member Months	Required. Numeric value.
Total Revenues	Required. Numeric value.
Hospital & Medical Benefits	Required. Numeric value.
Other Professional Services	Required. Numeric value.
Outside Referrals	Required. Numeric value.
ER and Out of Area	Required. Numeric value.
Prescription Drugs	Required. Numeric value.
Aggregate Write-ins for Hospital & Medical	Required. Numeric value.
Incentive Pool, Withhold Adj, Bonus Amts.	Required. Numeric value.
Reinsurance Recoveries	Required. Numeric value.
Total Hospital & Medical Expenses	Required. Numeric value.
General Admin & Claims Adj. Expenses	Required. Numeric value.
Total Expenses	Required. Numeric value.

Method: DMAS secure FTP server

Format: Adobe .pdf file

File Name: FIN_QTRLY.pdf

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.

Prepare financial results by line of business in the same manner and following the same guidelines as are followed for BOI reporting. Include 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 (as specified above).

If the MCO has multiple lines of business, provide separate columns by line of business.

3.3.7.4 Examples

None

3.3.7.5 Scoring Criteria

None

3.3.8 Reinsurance

3.3.8.1 Contract Reference

Medallion 3.0 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
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

Field	Specifications
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
SUB_CAP	Format: CHAR(1) Indicates whether claim is paid FFS or is a capitated service; Valid Values: 'F' =FFS, 'C' = Capitated Required

Field	Specifications
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

Medallion 3.0 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**

3.3.10.1 Contract Reference

Medallion 3.0 Contract, Section 12.17

3.3.10.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	DISP_SHARE.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:	Provider Reimbursement Division

3.3.10.3 Requirements

Include members enrolled in Medicaid and FAMIS.

3.3.10.4 Examples

None

3.3.10.5 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

3.4.1.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	SUBCONTRACT.pdf
Trigger:	Annually and prior to any changes
Due Date:	Within 30 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

- 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, or provider services.
- Report submission must include a listing of these subcontractors and the services each provides, making note of any changes from previous submissions.

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, Article II, Section J.8

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, Article II, Section J.13

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, Article II, Section J.13

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

3.4.5 Provider Satisfaction Survey Results

3.4.5.1 Contract Reference

Medallion 3.0 Contract, Section 4.11

FAMIS Contract, Article II, Section J.13

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

3.4.6 **Marketing Plan**

3.4.6.1 Contract Reference

Medallion 3.0 Contract, Section 6.1.B

FAMIS Contract, Article II, Section C

3.4.6.2 File Specifications

Method:	DMAS secure FTP server
Format:	Word document
File Name:	N/A
Trigger:	Annually and prior to any changes
Due Date:	Within 30 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, Article II, Section D.16

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.B

3.4.8.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	ASSMT_PLAN.pdf
Trigger:	Annual
Due Date:	September 30th 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 tool.

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.A.II

3.4.9.2 File Specifications

Commonwealth of Virginia Department of Medical Assistance Services Medallion Care System Partnership (MCSP) Annual Plan				
Medallion Care System Partnership (MCSP) - Requirement	**MCSP #1**	**MCSP #2**	**Additional References to Attachments**	**Reason for Changes to MCSPs** (use this column only if modifying an existing MCSP)
1. MODEL OPTIONS				
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. MCSP FRAMEWORK				
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?				
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.				
2.7 - What type of incentive arrangement (specific proprietary financial terms not requirement) have been set up as a part of each MCSP agreement?				
2.8 - What types of arrangements are being implemented for remedies for non-performance as part of each MCSP agreement?				
2.9 - Include an overarching timeline with milestones pertaining to the proposals- include planned completion dates for the MCSP				
3. HEALTH HOME COMPONENTS				
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. Include, for each one, if currently accredited by NCQA or URAC as a patient centered medical home.				
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.				

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. QUALITY AND PERFORMANCE EVALUATION				
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 each 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's? 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

3.4.10.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	MCSP_PERF.pdf
Trigger:	Annual
Due Date:	Due close of business 12/31/ (2014, but each year on this date)
DMAS:	Senior Health Care Services Manager

3.4.10.3 Requirements

The report shall not exceed 20 pages in total length, including attachments, and must be based on the Final Version of the MCSPs that has been approved by the Department.

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, Article II, Section K

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

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, Article II, Section K

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**

3.4.14.1 Contract Reference

Medallion 3.0 Contract, Section 8.3

3.4.14.2 File Specifications

Method:	DMAS secure FTP server
Format:	PDF file
File Name:	HEDIS_CAP.pdf
Trigger:	Annually as needed based on MCO HEDIS scores
Due Date:	Within 30 days following the release of NCQA Quality Compass
DMAS:	Managed Care Quality Analyst

3.4.14.3 Requirements

As specified in the contract and template provided by DMAS.

3.4.14.4 Examples

None

3.4.14.5 Scoring Criteria

None

3.4.15 **CAHPS Survey Results**

3.4.15.1 Contract Reference

Medallion 3.0 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

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. Must comply with all reporting and content criteria as defined by DMAS Quality Analyst and/or EQRO.

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 8.4.F

3.4.17.2 File Specifications

Method:	DMAS secure FTP server
Format:	PDF file
File Name:	MBR_WELL.pdf
Trigger:	Annual
Due Date:	October 1st.
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.a

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**

3.4.19.1 Contract Reference

Medallion 3.0 Contract, Section 8.6.B.III

3.4.19.2 File Specifications

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

3.4.19.3 Requirements

As specified in contract.

3.4.19.4 Examples

N/A

3.4.19.5 Scoring Criteria

None

3.4.20 **Program Integrity Plan**

3.4.20.1 Contract Reference

Medallion 3.0 Contract, Section 9

FAMIS Contract, Article II, R

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 9.1

FAMIS Contract, Articles II, Section K and & Section R.1

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 9.1.E

FAMIS Contract, Article II, Section O, and R

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

3.4.23.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PICA.pdf
Trigger:	Annual
Due Date:	January 1st
DMAS:	Program Integrity Division

3.4.23.3 Requirements

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, Article II, Section A.3

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

N/A

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, Article II, Section U

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.

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, Article II, Section A.8.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

3.4.27.2 File Specifications

Method:	DMAS secure FTP server
Format:	Word file
File Name:	HIF_CERT.doc
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

3.5 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

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 & 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

3.5.3.2 File Specifications

Method:	DMAS secure FTP server
Format:	.pdf
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

Include specifications from Attachment V here

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 & 14.6

3.5.4.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

3.5.5.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	There is a 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

3.5.6.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

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

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

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

3.5.10.2 File Specifications

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

3.5.10.3 Requirements

Refer to Attachment 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

3.5.11.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

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

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.

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

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

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

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.

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, Section 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.

3.5.19.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

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

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

3.5.22.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

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

3.5.23.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.H

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.I

3.5.24.2 File Specifications

Method	DMAS secure FTP server
Format	Adobe .pdf file
File Name	SENTINEL.pdf. If you submit more than one event on the same day, name the subsequent documents SENTINEL1, SENTINEL2 etc.
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

Use the form provided on DMAS website.

3.5.24.4 Examples

N/A

3.5.24.5 Scoring Criteria

None

3.5.25 **Pharmacy Management Program**

3.5.25.1 Contract Reference

Medallion 3.0 Contract, Section 7.1.L

3.5.25.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	MCO implementation of any program to proactively manage misuse or abuse by members of prescription drug benefits
Due Date:	At least 90 days prior to implementation
DMAS:	Managed Care Operations

3.5.25.3 Requirements

N/A

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, Section 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

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

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

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

3.5.30.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

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

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

Submit on the form provided by DMAS. Form is available on the DMAS Managed Care web site.

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

3.5.33.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

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**

3.5.35.1 Contract Reference

Medallion 3.0 Contract, Section 8.6.B.III

3.5.35.2 File Specifications

Method:	DMAS secure FTP server
Format:	Adobe .pdf file
File Name:	PRENATAL.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 files

3.5.35.3 Requirements

As specified in contract.

3.5.35.4 Examples

N/A

3.5.35.5 Scoring Criteria

None

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

3.5.36.1 Contract Reference

Medallion 3.0 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

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

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

N/A

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

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

N/A

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

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

As specified in contract.

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

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

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

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

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

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

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

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

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

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

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 12.15

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 12.15

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

3.5.53.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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:	Managed Care Operations

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.B.II.b

3.5.54.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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:	Managed Care Operations

3.5.54.3 Requirements

As specified in the contract.

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

3.5.55.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

3.5.56.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

3.5.57.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

3.5.58.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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)

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.c(vii)

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

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 13.2.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.b.iv

3.5.62.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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.v

3.5.63.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

3.5.64.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

3.5.65.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@dmas.virginia.gov
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

3.5.65.6 Examples

N/A

3.5.65.7 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

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

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

3.5.68.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

3.5.68.3 Requirements

As specified in the contract

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

3.5.69.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

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

3.5.70.1 Contract Reference

Medallion 3.0 Contract, Section 14.7.A

3.5.70.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

3.5.71.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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 14.7

3.5.72.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

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

3.5.74.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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, Section 14.19.A.I & 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

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

3.5.77.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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 14.28.B.VIII

3.5.78.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

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

3.5.80.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

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

3.5.82.2 File Specifications

Method:	Email: Tom.Lawson@dmas.virginia.gov, Daniel.Plain@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

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

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
BEGDT021	PRIOR1 BEGIN DATE 02

Field Description	Specifications
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.
CLS_TP2	PROVIDER CLASS TYPE 2

Field Description	Specifications
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	Ernollment 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, 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

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

4.1.5.1 Contract Reference

Medallion 3.0 Contract Section 7.2.A

4.1.5.2 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	Magellan will map to DMAS SA Type
AUADMDTE	8	Action Date CCYYMMDD	
AUSTRDTE	8	Auth Start Date CCYYMMDD	
AUENDDTE	8	Auth End Date CCYYMMDD	
AUDENIAL	3	Denial Reason	Magellan Value Descriptions Supplied
AUCPTCD	5	CPT Code	
AUCPTDSC	50	CPT Code Description	
AUTTLRQD	3	Total Requested	
AUTTLAPP	3	Total Approved	

Method	DMAS secure FTP server
Format	Excel file
File Name	BHSA_yyyymmdd.xlsx
Trigger	Weekly
Schedule	TBD
DMAS	N/A

4.1.5.3 Description

This report reflects prior authorizations on enrolled MCO members that have had a behavioral health authorization. Although these services are carved-out from the MCO contract, this information is provided to help identify members who may need additional behavioral health services or referral to an MCO behavioral health case manager.

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 **Lock-In**

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 Lock-in (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	Lockin_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 locked-in 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**

4.1.17.1 Contract Reference

Medallion 3.0, Section 7.7

4.1.17.2 File Specifications

Report content TBD

Method	DMAS secure FTP server
Format	TBD
File Name	ABD_Enroll
Trigger	Upon request of the Contractor
Schedule	15th of the month after the end of the quarter
DMAS	N/A

4.1.18 **Encounter Lag Report**

4.1.18.1 Contract Reference

Medallion 3.0, Section 11.5.C

4.1.18.2 File Specifications

MCO ENCOUNTER LAG REPORT
For the month of 2013_7

mconame=MCO123

trantype	PassN	PassPct	FailN	FailPct	Total
837I MED	0	100%	0	5.0%	0
837I MHLTH	0	100%	0	5.0%	0
837P CHIRO	0	100%	0	5.0%	0
837P LAB	0	100%	0	5.0%	0
837P MED	0	100%	0	5.0%	0
837P MHLTH	0	100%	0	5.0%	0
837P TRANS	0	100%	0	5.0%	0
837P VISIO	0	100%	0	5.0%	0
NCPDP PHARM	0	100%	0	5.0%	0
Total	0	100%	0	5.0%	0

Method	DMAS secure FTP server
Format	PDF
File Name	ENCLAG
Trigger	Monthly
Schedule	15th of the month
DMAS	N/A

4.1.18.3 Description

The Medallion 3.0 contract requires the MCOs to submit their encounter data within 60 days of payment by the MCO. This report assesses the each MCO's compliance with the contractual Encounter Timeliness requirements. Refer to Medallion 3.0 contract section 11.5.C for detailed requirements.

- PassPct values highlighted in yellow represent categories where the MCO failed to meet the for encounter timeliness contractual requirement.

- This report includes all encounters submitted by the MCO during the reported calendar month and processed by the MMIS.
- Lag days is calculated as the difference between the MCO's payment date (provided by the MCO on each encounter record) and the date the file was submitted to DMAS (based on the julian date from the MCN number assigned by Xerox when the EDI file is received).
- 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 'PassN' column represents the number of encounters submitted by the MCO in the service category and time frame that met the 60 day criteria specified in the contract.
- The 'PassPct' column represents the number of submitted encounters that met the 60 day criteria specified in the contract divided by the total number of encounters submitted by the MCO in the service category and time frame.
- The 'FailN' column represents the number of encounters submitted by the MCO in the service category and time frame that did not meet the 60 day criteria specified in the contract.
- The 'FailPct' column represents the number of submitted encounters that did not meet the 60 day criteria specified in the contract divided by the total number of encounters submitted by the MCO in the service category and time frame.
- The 'Total' column represents the number of encounters submitted by the MCO in the service category and time frame.

<u>Service Type Category Definition:</u>

837I MHLTH - Institutional claim for mental health services. Identification of mental health services is based on provider type classification. Includes inpatient and outpatient.

837I MED - Includes all institutional claims that were not captured in the mental health service type. Includes inpatient and outpatient.

837P CHIRO - Professional service rendered by a chiropractor (based on provider type classification).

837P LAB - Professional service rendered by an independent laboratory (based on provider type classification).

837P MHLTH - Professional service rendered by a mental health provider (based on provider type classification).

837P TRANS - Professional service rendered by a transportation provider (based on provider type classification).

837P VISIO - Professional service rendered by a vision provider (based on provider type classification).

837P MED - Includes all non-institutional services that were not captured in one of the other professional service types above.

NCPDP PHARM - Pharmacy service submitted on the NCPDP transaction.

EDI Trans	Service Type Category
837I	If MMIS PROV_CLS in MHLTH PCT value set or MMIS PRV_SPEC in MHLTH SPC value set or SUBMT_SRVC_TXNMY in MHLTH TAX value set or then Srvc_type = 'MHLTH' Else Srvc_Type = 'MED'
837P	If MMIS claim type = '08' (Lab) then Srvc Type = 'LAB' If MMIS claim type = '11' (Dental) then Srvc_Type = 'DENTL' If MMIS claim type = '13' (Transportation) then Srvc_Type = 'TRANS' If MMIS claim type = '04' (PersCare/HmHlth) then Srvc_Type = 'MED' If MMIS PROV_CLS = '026' or SUBMT_SRVC_TXNMY in CHIRO Tax value Set then Srvc_Type = 'CHIRO' If MMIS PROV_CLS in ('031','032') or MMIS PRV_SPEC = '063' or SUBMT_SRVC_TXNMY in VISION Tax value set then Srvc_Type = 'VISIO'; If MMIS PROV_CLS in MHLTH PCT value set or MMIS PRV_SPEC in MHLTH SPC value set or SUBMT_SRVC_TXNMY in MHLTH Tax value set then Srvc_Type = 'MHLTH'; Else Srvc_Type = 'MED'
NCPDP	Srvc_Type = 'PHARM'

- Claims Type is assigned to each encounter during MMIS adjudication processing and based on a combination of variables such as EDI transaction type, provider type, etc.
- Provider Class Types is assigned to each encounter during MMIS adjudication processing. Assignment is based on the servicing provider NPI, servicing provider zip code, and/or servicing provider taxonomy values submitted by the MCO.
- MMIS Provider Specialty is assigned to each encounter during MMIS adjudication processing. Assignment is based on the servicing provider NPI, servicing provider zip code, and/or servicing provider taxonomy values submitted by the MCO.
- Provider Taxonomy values are submitted by the MCO on the encounter record and do not require the provider to be present on the MMIS provider file.

837P
Value Sets

CHIRO Tax
111N00000X
111NI0013X
111NI0900X
111NN0400X
111NN1001X
111NX0100X
111NX0800X
111NP0017X
111NR0200X
111NR0400X
111NS0005X
111NT0100X

VISION Tax
207W00000X
332G00000X
332H00000X
156FX1100X
156FX1800X
152W00000X
152WC0802X
152WL0500X
152WX0102X
152WP0200X
152WS0006X
152WV0400X
156F00000X
156FC0800X
156FC0801X
156FX1700X
156FX1101X
156FX1201X
156FX1202X
156FX1900X

MHLTH PCT
003
007
008
012
013
016
021
022
024
025
034
056
071
076
077
078
101
102
103

MHLTH SPC
026
041
042
043
044
045
046
047
071
077
111
116

MHLTHP Tax
103K00000X
103G00000X
103GC0700X
101Y00000X
101YA0400X
101YM0800X
101YP1600X
101YP2500X
101YS0200X
106H00000X
102X00000X
2084A0401X
2084P0802X
2084B0002X
2084P0804X
2084N0600X
2084D0003X
2084F0202X
2084P0805X
2084H0002X
2084P0005X
2084N0400X
2084N0402X
2084N0008X
2084P2900X
2084P0800X
2084P0015X
2084S0012X
2084S0010X
2084V0102X
102L00000X
103T00000X
103TA0400X
103TA0700X
103TC0700X
103TC2200X
103TB0200X
103TC1900X
103TE1000X
103TE1100X
103TF0000X
103TF0200X
103TP2701X
103TH0004X
103TH0100X
103TM1700X
103TM1800X
103TP0016X
103TP0814X
103TP2700X
103TR0400X
103TS0200X
103TW0100X
104100000X
1041C0700X
1041S0200X

837I
Value Sets

MHLTH PCT
003
007
008
012
013
016
021
022
024
025
034
056
071
076
077
078
101
102
103

MHLTH SPC
026
041
042
043
044
045
046
047
071
077
111
116

MHLTH Tax
103K00000X
103G00000X
103GC0700X
101Y00000X
101YA0400X
101YM0800X
101YP1600X
101YP2500X
101YS0200X
106H00000X
102X00000X
2084A0401X
2084P0802X
2084B0002X
2084P0804X
2084N0600X
2084D0003X
2084F0202X
2084P0805X
2084H0002X
2084P0005X
2084N0400X
2084N0402X
2084N0008X
2084P2900X
2084P0800X
2084P0015X
2084S0012X
2084S0010X
2084V0102X
102L00000X
103T00000X
103TA0400X
103TA0700X
103TC0700X
103TC2200X
103TB0200X
103TC1900X
103TE1000X
103TE1100X
103TF0000X
103TF0200X
103TP2701X
103TH0004X
103TH0100X
103TM1700X
103TM1800X
103TP0016X
103TP0814X
103TP2700X
103TR0400X
103TS0200X
103TW0100X
104100000X
1041C0700X
1041S0200X'

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

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_File_yyyymm.xlsx
Trigger:	Monthly
Schedule:	The week following the MCO submission of the NB_Recon_yyyymm file. (see Section 3.1.x) If a Response file is submitted by the MCO, it must be received no later than the last business day of the reporting month (month after the newborn turns age one). 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.

4.2 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

5 DMAS 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_Return_File_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.