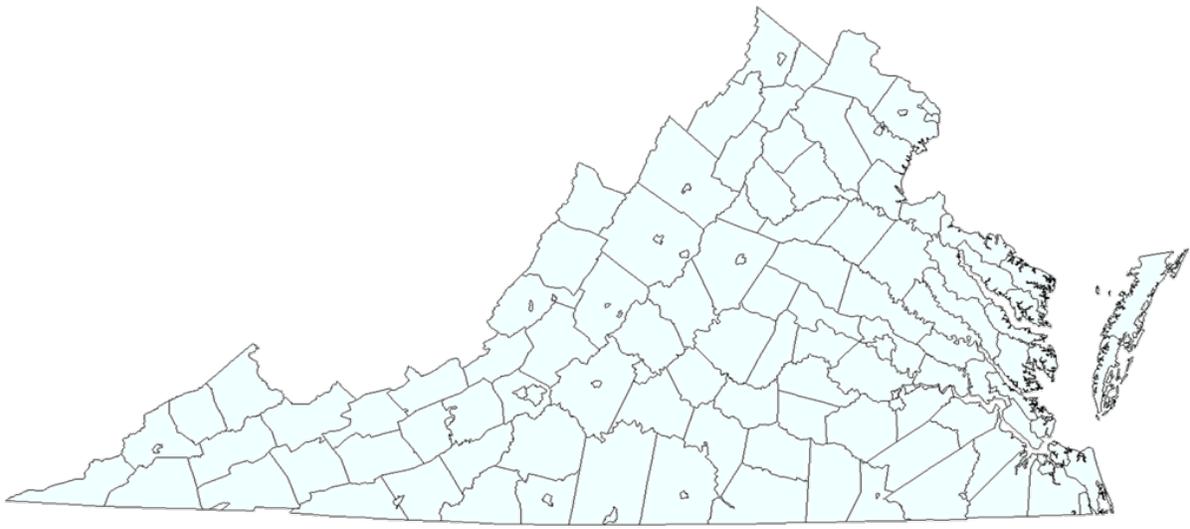


# Managed Care Technical Manual

---



---

**Virginia Department of Medical Assistance**  
Health Care Services Division  
*Version 1.7*

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**Table of Contents**

Version Change Summary .....	9
1 Encounters .....	11
1.1 HIPAA Administrative Simplification .....	12
1.1.1 Version and Model.....	13
1.1.2 EDI Resources .....	14
1.2 Encounter Submission Process.....	15
1.2.1 Service Center Registration .....	16
1.2.2 Transmission Protocol .....	17
1.2.3 Test Transmissions .....	18
1.2.4 Production Transmissions .....	20
1.2.5 Submission Response Reports.....	25
1.2.6 Encounter Submission Calendar .....	35
1.3 Encounter Processing Requirements .....	48
1.3.1 Encounter Data Certification.....	49
1.3.2 Adjustments & Voids .....	50
1.3.3 Denied Services .....	51
1.3.4 National Provider Identifier .....	65
1.3.5 Line-Level Processing .....	66
1.3.6 Drug Rebate Collection.....	67
1.3.7 MCO Payment Amount & Date .....	68
1.3.8 Enrollment Determination Based on Admit Date.....	73
1.3.9 Newborns Without Medicaid IDs.....	74
1.3.10 Procedure, Diagnosis, Revenue Code .....	75
1.4 Proprietary MMIS Code Sets .....	76
1.4.1 MMIS Claim Type .....	77
1.4.2 Provider Class Type .....	78
1.4.3 Provider Specialty.....	82
1.4.4 Edit Codes / Error Sequence Codes (ESC) .....	86
2 Enrollment Roster & Payment Files .....	93
2.1 Enrollment Roster (834) .....	94
2.2 Capitation Payment Remittance (820) .....	95
3 MCO Contract Deliverables .....	96
3.1 Reporting Standards .....	97
3.1.1 DMAS Secure FTP Server.....	98
3.1.2 Deliverable Scoring .....	99

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

3.1.3	Creating Comma Separated Value (CSV) File Using Excel .....	100
3.2	Monthly Deliverables .....	101
3.2.1	Enrollment Broker Provider File .....	102
3.2.2	MCO Claims Report .....	104
3.2.3	Live Births.....	106
3.2.4	Returned ID Cards.....	108
3.2.5	Lock-In .....	110
3.2.6	Children with Special Health Care Needs .....	112
3.2.7	Assessments for Aged, Blind and Disabled .....	114
3.2.8	Appeals & Grievances Summary .....	116
3.2.9	Monthly Provider File for Encounter Processing .....	118
3.2.10	Encounter File Submissions .....	120
3.2.11	Encounter Data Certification .....	121
3.2.12	Monies Recovered by Third Parties .....	122
3.2.13	Comprehensive Health Coverage .....	123
3.2.14	Workers' Compensation.....	124
3.2.15	Estate Recoveries.....	125
3.2.16	Other Coverage .....	126
3.2.17	PCP Provider Attestation Listing .....	127
3.2.18	Member Address Changes .....	129
3.3	Quarterly Deliverables .....	131
3.3.1	Provider Network File .....	132
3.3.2	Providers Failing Accreditation/Credentialing.....	134
3.3.3	Case Managers List.....	135
3.3.4	Members with Physical and Behavioral Health Limitations and Conditions .....	136
3.3.5	.....	137
3.3.6	Program Integrity Activities .....	138
3.3.7	BOI Filing - Quarterly .....	139
3.3.8	Financial Report .....	140
3.3.9	PCP Incentive Payments .....	141
3.3.10	Disproportionate Share Hospital .....	144
3.4	Annual Deliverables .....	145
3.4.1	List of Subcontractors .....	146
3.4.2	Physician Incentive Plan.....	147
3.4.3	Provider Satisfaction Survey.....	148
3.4.4	Marketing Plan .....	149

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

3.4.5	Member Handbook .....	150
3.4.6	Health Plan Assessment Plan.....	151
3.4.7	Medallion Care System Partnership Annual Plan.....	152
3.4.8	Medallion Care System Partnership Proposal.....	153
3.4.9	Medallion Care System Partnership Performance Results.....	154
3.4.10	Quality Improvement Plan.....	155
3.4.11	Quality Assessment & Performance Improvement Plan .....	156
3.4.12	HEDIS Results.....	157
3.4.13	HEDIS Corrective Action Plan .....	158
3.4.14	CAHPS Survey Results .....	159
3.4.15	Performance Improvement Project (PIP) .....	160
3.4.16	Wellness and Member Incentive Programs.....	161
3.4.17	Complex Care Management Plan .....	162
3.4.18	Program Integrity Plan .....	163
3.4.19	Program Integrity Activities Annual Summary .....	164
3.4.20	Organizational Charts .....	165
3.4.21	Program Integrity Compliance Audit (PICA) .....	166
3.4.22	BOI Filing - Annual.....	167
3.4.23	Audit by Independent Auditor (Required by BOI) .....	168
3.4.24	FAMIS Moms Report .....	169
3.5	Other Reporting Requirements.....	170
3.5.1	NCQA Deficiencies .....	171
3.5.2	NCQA Accreditation Status Changes .....	172
3.5.3	Provider Agreements.....	173
3.5.4	MCO Staffing Changes.....	174
3.5.5	Provider Network Change Affecting Member Access to Care .....	175
3.5.6	Hospital Contract Changes.....	176
3.5.7	Provider Credentialing Policies and Procedures .....	177
3.5.8	Practitioner Infractions.....	178
3.5.9	PCP Assignment Policies & Procedures.....	179
3.5.10	Inpatient Hospital Contracting Changes.....	180
3.5.11	Changes to Claims Operations .....	181
3.5.12	Provider Disenrollment Policies & Procedures.....	182
3.5.13	Enrollment – Excluding Members .....	183
3.5.14	Newborn Identification Procedures .....	184
3.5.15	Member Education & Outreach.....	185

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

3.5.16	Member Marketing Materials .....	186
3.5.17	Member Incentive Awards .....	187
3.5.18	Member Enrollment, Disenrollment, and Educational Materials .....	188
3.5.19	Program Changes.....	189
3.5.20	Member Rights - Policies & Procedures.....	190
3.5.21	Member Health Education & Prevention Plan .....	191
3.5.22	Co-Pay Changes .....	192
3.5.23	EPSDT Second Review Process .....	193
3.5.24	Scoring Criteria Services Not Covered Due to Moral or Religious Objections ...	194
3.5.25	Sentinel Event .....	195
3.5.26	Pharmacy Management Program .....	196
3.5.27	Compliance for Sterilizations & Hysterectomies.....	197
3.5.28	Substance Abuse Services for Pregnant Women .....	198
3.5.29	Access to Services for Disabled Children & Children with Special Health Care Needs 199	
3.5.30	Utilization Management Plan .....	200
3.5.31	Atypical Drug Utilization Reporting.....	201
3.5.32	Drug Formulary & Authorization Requirements.....	202
3.5.33	Incarcerated Members.....	203
3.5.34	Enhanced Services.....	204
3.5.35	NCQA Accreditation Renewal.....	205
3.5.36	Prenatal Programs and Outcomes Policies and Procedures.....	206
3.5.37	Fraud, Waste and Abuse Policies & Procedures.....	207
3.5.38	Provider Appeals Process.....	208
3.5.39	Fraud and/or Abuse Incident.....	209
3.5.40	Marketing Fraud/Waste/Abuse.....	210
3.5.41	Medicaid Fraud Control Unit (MFCU) Referrals .....	211
3.5.42	Member Grievance & Appeals Policies & Procedures.....	212
3.5.43	Enrollment Verification for Providers Policies & Procedures .....	213
3.5.44	Encounter Data Plan for Completeness .....	214
3.5.45	Encounter Data Deficiencies.....	215
3.5.46	Encounter Data Corrective Action Plan.....	216
3.5.47	BOI Filing - Revisions .....	217
3.5.48	Independent Audit.....	218
3.5.49	Financial Report - Revisions .....	219
3.5.50	Basis of Accounting Changes .....	220
3.5.51	Reserve Requirements Changes.....	221

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

3.5.52	FQHC/RHC Arrangements .....	222
3.5.53	FQHC/RHC Reimbursement Methodology .....	223
3.5.54	Contractor Non-Compliance Remedy .....	224
3.5.55	Corrective Action Plan for Failure to Perform Administrative Function(s) .....	225
3.5.56	Disclosure of Ownership & Control Interest Statement (CMS 1513) .....	226
3.5.57	Transaction with Other Party of Interest.....	227
3.5.58	Acquisition/Merger/Sale.....	228
3.5.59	Ownership Change.....	229
3.5.60	MCO Principal Conviction or Criminal Offense.....	230
3.5.61	Contractor or Subcontractor on LEIE .....	231
3.5.62	Other Categorically Prohibited Affiliations .....	232
3.5.63	Ownership/Control of Other Entity .....	233
3.5.64	MCO Medicaid Managed Care Business Changes .....	234
3.5.65	Disputes between DMAS and MCO Arising Out of the Contract .....	235
3.5.66	PHI Breach/Disclosure Notification to DMAS .....	236
3.5.67	Data Security Plan for Department Data .....	237
3.5.68	Data Confidentiality Policies & Procedures .....	238
3.5.69	Request for Exemption from Contract Requirement(s).....	239
3.5.70	Notification of Potential Conflict of Interest.....	240
3.5.71	None Notification of Opt Out of Automatic Contract Renewal Clause.....	241
3.5.72	Insurance Coverage Verification .....	242
3.5.73	Notification of Potential MCO Liability .....	243
3.5.74	Medical Record Safeguards.....	244
3.5.75	Practice Guidelines.....	245
3.5.76	Request for Publication or Presentation of DMAS-Related Subjects.....	246
3.5.77	Bankruptcy Petition.....	247
3.5.78	Provider Manual Managed Care References .....	248
3.5.79	Notification of Changes to Subcontractor Method of Payment .....	249
3.5.80	New Agreements and Changes in Approved Agreements .....	250
3.5.81	Expansion Request (Letter of Intent) .....	251
4	DMAS Reports.....	252
4.1	Reports Generated by DMAS.....	253
4.1.1	Provider File .....	254
4.1.2	Pregnancy Due Date .....	257
4.1.3	Plan Change Report.....	259
4.1.4	Community Mental Health Rehabilitation Services (CMHRS) .....	260

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

4.1.5	Community Mental Health Rehabilitation Services (CMHRS) Prior Auths.....	261
4.1.6	TPL.....	262
4.1.7	New Members on 820 but not on (previous) Mid-Month 834.....	263
4.1.8	Medical Transition .....	265
4.1.9	Managed Care Enrollment (Flash).....	267
4.1.10	EOM 834 Summary .....	268
4.1.11	MID 834 Summary.....	269
4.1.12	Lock-In.....	270
4.1.13	School PDN Claims .....	271
4.1.14	School PDN Prior Authorization .....	272
4.1.15	Newborns .....	273
4.1.16	Error Report.....	274
4.1.17	Quarterly ABD Enrollment.....	275
4.1.18	Encounter Lag Report.....	276
4.2	DMAS Forms.....	280
5	DMAS Processes.....	281
5.1	DMAS Processes .....	282
5.1.1	PCP Provider Incentive Payments.....	283
5.1.2	Incarcerated Members.....	284

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

## Version Change Summary

---

Version.	Description	Date
1.0	Original Implementation	01/01/2013
1.4	Added 'Wellness & Member Incentive Programs' report 3.4.16	04/25/2013
1.5	Revised based on MCO feedback	05/06/2013
1.5	Added three reports, Members with Limited Conditions, CMHRS Prior Auths and Enrollment – Excluding Members	05/09/2013
1.5	Changed DMAS report formats in Section 4 that were .csv to .txt	05/09/2013
1.5	Added table to ABD Assessments section	05/09/2013
1.5	Updated Specifications sections that stated “text” with specific character lengths	05/09/2013
1.5	Updated Contract References sections to match the contract locations	05/10/2013
1.6	Updated File Specifications for MCO Claims Report	05/31/2013
1.6	Changed due date for Wellness and Member Incentive Programs from July 31 <sup>st</sup> to October 1 <sup>st</sup> .	06/18/2013
1.6	Moved assessment requirements for aged and disabled members to annual section	07/08/2013
1.6	Updated requirements of CSHCN reporting “Date of member’s visit to PCP” to optional	07/08/2013
1.6	Updated contract reference in section 3.3.5 from 7.7.B to 7.7.A	07/25/2013
1.6	Updated definition of new member from two to six months previous enrollment and removed examples in section 3.2.6 CSHCN	07/30/2013
1.6	Updated field specifications in section 3.2.8 Provider Request for Encounter Processing	07/30/2013
1.6	Updated Resolution subsection under Requirements section of Appeals and Grievances Summary	07/30/2013
1.7	Changed due date for Health Plan Assessment Plan from September 1 <sup>st</sup> to September 30 <sup>th</sup>	08/13/2013
1.7	Renamed the .csv file for Children with Special Health Care Needs monthly report from CHSCN to CSHCN	08/13/2013
1.7	Updated requirements throughout manual to not include headers in .csv files	08/19/2013
1.7	Update instructions for naming Sentinel event report	08/19/2013
1.7	Changed delivery due date for Provider Attestations from	08/19/2013

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

	weekly to monthly and moved to monthly section of manual	
1.7	Moved Assessments from annual to monthly section, renamed to for Assessments for Aged, Blind and Disabled and updated language in Requirements section	08/20/2013
1.7	Removed "Confidential" from footer of document	08/20/2013
1.7	Added comment regarding submitting blank reports in Deliverable Scoring section	08/20/2013
1.7	Added Report Card and grading scale to Deliverable Scoring section	08/20/2013
1.7	Renamed Provider Request for Encounter Processing report to Monthly Provider File for Encounter Processing and made updates to NPI and Tax ID file specifications	08/20/2013
1.7	Added "or blank" to DMAS Newborn ID Number file specifications on Live Births report	08/22/2013
1.7	Updated file specifications for Policy Number on Worker's Compensation report	08/22/2013
1.7	Updated file specifications for Payment Quarter on PCP Incentive Payments quarterly report	08/22/2013
1.7	Changed Due Dates for Medallion Care System Partnership Annual Plan and Performance Results from July 1 to TBD	08/22/2013
1.7	Updated Format sections of APP_GRIEV and MCO_RPT reports to clarify how to complete the templates	08/22/2013
1.7	Quarterly reports 3.3.4 'Members with Limited Conditions' and 3.3.5 'Chronic Care Members and Members with Physical and/or Behavioral Health Conditions' have been consolidated into one report under 3.3.4 and titled 'Members with Physical and Behavioral Health Limitations and Conditions'. Reflects reporting requirements in most recent version of Medallion II contract (posted on DMAS web site).	
1.7	Section 1.2.1 - Added directions for updating MCO contact info	08/28/2013
1.7	Section 1.2.4.5 - Added explanation of inconsistent encounter status codes	08/28/2013
1.7	Section 1.2.5 - Reworked section with the addition of documentation and examples	08/28/2013
1.7	Section 1.3.3 - Added pharmacy (NCPDP) denials should not be submitted to DMAS	08/28/2013
1.7	Section 1.3.6 - For successful rebate collection, pharmacy/drug encounters should be submitted with a NDC code	08/28/2013
1.7	Section 4.1.18 - Added documentation for new DMAS generated MCO Encounter Lag Report	08/28/2013

# 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 is intended to supplement the Virginia Medicaid Medallion II 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 II 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 [HCSSEncounter@dmas.virginia.gov](mailto:HCSSEncounter@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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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](mailto:HCSEncounter@dmas.virginia.gov).

## Virginia Department of Medical Assistance Managed Care Technical Manual

### 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](http://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.ncdp.org](http://www.ncdp.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](http://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](http://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](http://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](http://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](http://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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**1.2 Encounter Submission Process**

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

### **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. Test files will be reviewed by DMAS and the Contractor to determine if the file is acceptable.

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 scheduled, submitted and successfully completed. DMAS will work with each Contractor to establish a test schedule. Test files should be planned and never sent without prior approval by DMAS. Please contact [HCSEncounter@dmas.virginia.gov](mailto:HCSEncounter@dmas.virginia.gov) to set up delivery of test file(s).

#### **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% of a normal production month, whichever is less. DMAS defines a claim as the individual line items, not a document.

#### **1.2.3.2 Connectivity to Xerox for Testing**

Test files are delivered using the VaMMIS File Transfer Website in the folder: **'Distribution/EDI/Service Center ID/Test/To-VAMMIS'**.

Within an hour of receipt, the system renames the file and assigns an eight digit Media Control Number or MCN. The MCN is a "smart" number as follows: YJJSSSS - Sample '21270043'

- Position 1 = Last digit of the calendar year (2012)
- Position 2-4 = Julian Date (127 / May 6<sup>th</sup>)
- Position 5-8 = Sequential number (43<sup>rd</sup> 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. Aside from the assignment of the MCN and the return of an ACK report, there is no further automation to a test file. After dropping the test file, the Contractor must notify DMAS that a file has been delivered by sending an email to [HCSEncounter@dmas.virginia.gov](mailto:HCSEncounter@dmas.virginia.gov)

This notification must include the following details:

- Identify that this is a TEST file in the subject line
- Submitter (Contractor Name)
- Service Center ID (4-digit number assigned by Xerox)
- MCN (8-digit number assigned by the system)
- File Type (UB, CMS1500, Pharmacy, Lab, Transportation, Vision, etc.)
- Number of records submitted

When a test request is received, DMAS will log a service ticket with the DMAS' Fiscal Agent technical support team. Until this information is received and the ticket is generated, the test file is not acknowledged and will not be processed.

#### **1.2.3.3 Test File Adjudication and Error Notification**

Adjudication of test files, processing error reports, and passing the file through the adjudication procedure are manual processes. Test files are normally processed by Xerox within two business days of receipt of the OmniTrack ticket.

## Virginia Department of Medical Assistance Managed Care Technical Manual

All test files are run through Xerox's compliance checker (currently Sybase). If Level I through Level IV errors are found, the file will fail compliance and will not be processed through adjudication. CED/CER reports will be posted to the contractor in the folder: ***Distribution/EDI/Service Center ID/Test/From-VAMMIS/***

If the test file fails compliance, the compliance errors must be fixed before the test file can be re-scheduled and resubmitted. See examples below for sample CED and CER reports.

Test files that pass the compliance check will then be manually processed through the MMIS adjudication process. Once this processing is completed, the system creates three proprietary reports and one electronic file:

- 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)

If the adjudication fails, **different** test data are 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.

### ***1.2.3.4 Approval for Production***

If 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 [HCSEncounter@dmas.virginia.gov](mailto:HCSEncounter@dmas.virginia.gov). 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

## **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 [HCSSEncounter@dmas.virginia.gov](mailto:HCSSEncounter@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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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: YJJSSSS - Sample MCN: 21270043

- Position 1 = Last digit of the calendar year (2012)
- Position 2-4 = Julian Date (127 / May 6<sup>th</sup>)
- Position 5-8 = Sequential number (43<sup>rd</sup> 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](mailto: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 II and FAMIS contracts.

**1.2.4.3 File Notification**

Once the Contractor has delivered all scheduled files for the day and the ACK report has been returned identifying the MCN number assigned to your files, DMAS requires that the Contractor submit a notification spreadsheet confirming the files delivered. All files posted should be identified, even those that the Contractor received notification of compliance failures.

Complete the following spreadsheet. Do not add or delete columns. This spreadsheet will be used to feed monitoring reports used by DMAS and Xerox:

**INSERT LINK (DMAS)**

The MCO should complete the following columns:

- MCO file name – the name of your file
- MCN – Number assigned and returned in the Acknowledgement or "ACK" Report
- Service Center – Contractors four-digit service center ID
- MCO No. of Records

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

- 837I, 837P, NCPDP – select one
- File Type – Fixed field identifying what claim types are included
- Month/Year – The month/year of when the Contractor adjudicated the data
- The remaining fields will be completed by the fiscal agent and used by DMAS to monitor the encounter process.

Once the spreadsheet is completed by the Contractor, post the spreadsheet to the ftp site at the path:  
***Distribution/EDI/Service Center ID/Prod/Reports /***

The file naming convention should be: ***XXXX\_Report\_MMDDCCYY*** where XXXX equals the Contractor's four-digit service center ID and MMDDCCYY equals the day the Contractor is posting the report.

This report should be posted at least weekly and can be posted more frequently as needed. MCN information should not be duplicated. The file name should always be unique to prevent a previous notification from being overwritten. The files will remain in the Report folder for forty-five days when they will be archived.

**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

Encounters can be assigned one of the following status codes:

Status 0	No error
Status 2	Minor error
Status 4	Moderate error
Status 6	Critical error
Status 8	Fatal error
Status 9	Denied by MCO

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

Fatal edits/errors must be reviewed by the MCO and corrected whenever possible. Encounters with fatal edits reside in the Virginia MMIS until corrected by the MCO. These errors will be included in drug rebates, quality studies, and reports, unless corrected by the MCO. The MCO must strive to adjust or void all encounters with fatal errors in order to maintain the accuracy and integrity of the State's encounter data. The total number fatal errors should not exceed 5% of the number of total encounters processed in the MMIS for the MCO for each calendar month.

Encounters with a fatal error (status = 8) must be corrected, if possible, and resubmitted as an adjustment or a void and replacement. Corrections must be made within 30 days of error notification date.

It is expected that corrections for errors (compliance or edits) will be re-submitted as part of the normal submission schedule. In cases where a large volume of encounters needs to be resubmitted, the MCO must request permission from DMAS to resend once the problem is identified and corrected. A large volume is being defined as encounters totaling a line count of 10,000 records/lines or more. NOTE: This is one total, not a per file limit. If more than 10,000 records/lines require re-submission, request a schedule for when DMAS will be able to accept that file delivery through [HCSEncounter@dmass.virginia.gov](mailto:HCSEncounter@dmass.virginia.gov).

Encounters returned to the Contractor with a critical status (6) should be researched and if a mapping, processing, submission, etc. error is found, then make the necessary corrections on future submissions, no need to adjust previous submissions.

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.

Transactions assigned an error code of "2" (non-severe error) or "4" (moderate error) require no action on the part of the Contractor. However, if a high volume of these errors occurs because the VaMMIS edits are set incorrectly, the Contractor should report this situation to DMAS for investigation and possible correction to [HCSEncounter@dmass.virginia.gov](mailto:HCSEncounter@dmass.virginia.gov).

Encounters with a status of "6" (critical error) should be reviewed by the Contractor. There is no need to correct and resubmit transactions with this error code. It is anticipated, however, that these errors will become fatal errors in the future. By reviewing these errors now, the Contractor may be able to identify errors that they are introducing or, in some cases, that DMAS is incorrectly setting. If the Contractor and/or DMAS can correct these errors now, future data submissions will result in fewer fatal errors.

It should be noted that the MMIS is designed to edit for as many errors as possible during processing. Each error is associated with an ESC (Error Sequence Code) and each ESC is associated with a status code. Because an encounter can be assigned multiple ESC codes but only one status code, the HIGHEST level status code will be assigned in this situation. This can create a scenario where the status codes are inconsistent across encounters that share some of the same errors.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

Encounters that were denied by a Contractor (status code = 9) require no further action by the Contractor, unless the encounter is subsequently corrected and “paid”. In that case, the corrected encounter should be submitted as an adjustment.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**1.2.5 Submission Response Reports**

**1.2.5.1 Zip File Receipt**

Purpose: Confirms receipt and successful unzipping of submitted zip file  
Frequency: A zip file receipt is returned for each zip file submission  
For 837, NCPDP  
Transaction  
Type:  
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 Acknowledgement (ACK) Report**

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.  
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 837, NCPDP  
Type:  
File Format: Text



**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**1.2.5.4 Compliance Error Report (CER) Summary**

Purpose: Displays compliance error location and description  
Frequency: Exception report – only returned when compliance errors are found  
Transaction 837  
Type:  
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_XXXXXXXXXXXXXXXX.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.
```

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**1.2.5.5 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 837  
Type:  
File Format: Compressed

Sample File Name: 1003\_CED\_20130619094930\_31700124\_5468335.zip  
<ServiceCenter><CED><CCYYMMDDHHMMSS><MCN><EDRunID><.zip>

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

```
Compliance Error Report for MCN: XXXXXXXX
Input filename: XXXX_XXXXXXXXXXXXXXXX.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.
```

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**1.2.5.6 NCPDP Response File**

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

Sample File Name: 1003\_RSP\_31700124\_5468335.zip  
<ServiceCenter><RSP><MCN><EDRunID><.zip>

Sample File Contents:

```
000R1003 0712131201307171200P125148010900
00G10012759394D0B11A011255434981
20130605000AM210ANC0F3201319890000010100AM220EM10D286596900G10012758185D0B11A011467597096
20130604000AM210ANC0F3201319890000020100AM220EM10D2174978009907121310000000004
0
```

**1.2.5.7 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).

**1.2.5.8 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: 837, NCPDP  
Type:  
File Format: Compressed

Sample File Name: 1003\_31700124\_2013170.zip  
<ServiceCenter><MCN><CCYYJJJ><.zip>





**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

No.	Field Name	Source/Calculations
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 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	If status equal 2, add 1 to status 2 encounter errors
28	Service Vendor	Provider Service Center
29	Service Vendor Name	Service Center Name

**1.2.5.10 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><CCYYJJ><.zip>



**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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	If 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 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

**Sample File Name:** 1003\_31700124\_2013170.zip  
<ServiceCenter><MCN><CCYYJJJ><.zip>

**Sample File Contents:**

```

10093108002000000010112330895          2013108900001201 52002110601513169648932013040220130402
10093108002000000020112330910          2013108900002701 16902296406710433137452013040320130403
10093108002000000030112330911          2013108900002801 16902296406710433137452013040320130403
310800201000000990TOTAL ERROR ENCOUNTERS          0000003
310800201000000991STATUS 9 ENCOUNTERS          0000000
310800201000000992STATUS 8 (FATAL) ENCOUNTERS          0000003
310800201000000993STATUS 6 ENCOUNTERS          0000000
310800201000000994STATUS 4 ENCOUNTERS          0000000
310800201000000995STATUS 2 ENCOUNTERS          0000000
310800201000000996STATUS 0 ENCOUNTERS          0000000

```

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**1.2.6 Encounter Submission Calendar**

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>July 2013 Encounter Submission Calendar</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
1 IT: HCFA, UB, RX	2 HK: RX PE: RX PR: RX	3 VP: RX OP: HCFA, UB, RX MC: HCFA, UB, RX	4	5
8 IT: HCFA, UB, RX	9 HK: HCFA, UB, RX PE: RX PR: RX	10 VP: RX	11 OP: HCFA, UB, RX MC: HCFA, UB, RX	12 CC: RX
15 IT: HCFA, UB, RX	16 HK: RX PE: RX PR: RX	17 VP: HCFA, UB, RX	18 OP: HCFA, UB, RX MC: HCFA, UB, RX	19
22 IT: HCFA, UB, RX CC: HCFA, UB	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	30 HK: RX PE: RX PR: RX	31 VP: RX		

**Key:** IT= InTotal Health; OP=Optima, MC=MC; VP= VA Premier; CC: Coventry; HK= Anthem Healthkeepers; PR= Anthem Priority; PE= Anthem Peninsula

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>August 2013 Encounter Submission Calendar</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
			1 OP: HCFA, UB, RX MC: HCFA, UB, RX	2
5 IT: HCFA, UB, RX	6 HK: RX PE: RX PR: RX	7 VP: RX	8 OP: HCFA, UB, RX MC: HCFA, UB, RX	9 CC: RX
12 IT: HCFA, UB, RX	13 HK: HCFA, UB, RX PE: RX PR: RX	14 VP: HCFA, UB, RX	15 OP: HCFA, UB, RX MC: HCFA, UB, RX	16
19 IT: HCFA, UB, RX	20 HK: RX PE: RX PR: RX	21 VP: HCFA, UB, RX	22 OP: HCFA, UB, RX MC: HCFA, UB, RX	23 CC: RX
26 IT: HCFA, UB, RX CareNet	27 HK: HCFA, UB, RX PE: HCFA, UB, RX PR: HCFA, UB, RX	28 VP: RX	29 OP: HCFA, UB, RX MC: HCFA, UB, RX	30

**Key:** IT= InTotal Health; OP=Optima, MC=MC; VP= VA Premier; CC: Coventry; HK= Anthem Healthkeepers; PR= Anthem Priority; PE= Anthem Peninsula

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>September 2013 Encounter Submission Calendar</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
2	3 IT: HCFA, UB, RX HK: RX PE: RX PR: RX	4 VP: RX	5 OP: HCFA, UB, RX MC: HCFA, UB, RX	6
9 IT: HCFA, UB, RX	10 HK: HCFA, UB, RX PE: RX PR: RX	11 VP: RX	12 OP: HCFA, UB, RX MC: HCFA, UB, RX	13 CC: RX
16 IT: HCFA, UB, RX	17 HK: RX PE: RX PR: RX	18 VP: HCFA, UB, RX	19 OP: HCFA, UB, RX MC: HCFA, UB, RX	20
23 IT: HCFA, UB, RX CareNet	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				

**Key:** IT= InTotal Health; OP=Optima, MC=MC; VP= VA Premier; CC: Coventry; HK= Anthem Healthkeepers; PR= Anthem Priority; PE= Anthem Peninsula

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>October 2013 Encounter Submission Calendar</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
	1 HK: RX PE: RX PR: RX	2 VP: RX	3 OP: HCFA, UB, RX MC: HCFA, UB, RX	4
7 IT: HCFA, UB, RX	8 HK: HCFA, UB, RX PE: RX PR: RX	9 VP: RX	10 OP: HCFA, UB, RX MC: HCFA, UB, RX	11 CC – RX
14 IT: HCFA, UB, RX	15 HK: RX PE: RX PR: RX	16 VP: RX	17 OP: HCFA, UB, RX MC: HCFA, UB, RX	18
21 IT: HCFA, UB, RX	22 HK: HCFA, UB, RX PE: HCFA, UB, RX PR: HCFA, UB, RX	23 VP: HCFA, UB, RX	24 OP: HCFA, UB, RX MC: HCFA, UB, RX	25 CC: RX
28 IT: HCFA, UB, RX CareNet	29 HK: RX PE: RX PR: RX	30 VP: HCFA, UB, RX	31 OP: HCFA, UB, RX MC: HCFA, UB, RX	

**Key:** IT= InTotal Health; OP=Optima, MC=MC; VP= VA Premier; CC: Coventry; HK= Anthem Healthkeepers; PR= Anthem Priority; PE= Anthem Peninsula

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

November 2013 Encounter Submission Calendar				
Monday	Tuesday	Wednesday	Thursday	Friday
				1
4 IT: HCFA, UB, RX	5 HK: RX PE: RX PR: RX	6 VP: RX	7 OP: HCFA, UB, RX MC: HCFA, UB, RX	8 CC: RX
11 IT: HCFA, UB, RX	12 HK: HCFA, UB, RX PE: RX PR: RX	13 VP – RX	14 OP: HCFA, UB, RX MC: HCFA, UB, RX	15
18 IT: HCFA, UB, RX	19 HK: RX PE: RX PR: RX	20 VP: HCFA, UB, RX	21 OP: HCFA, UB, RX MC: HCFA, UB, RX	22 CC – RX
25 IT: HCFA, UB, RX CareNet MC MC – RX	26 HK: HCFA, UB, RX PE: HCFA, UB, RX PR: HCFA, UB, RX	27 VP: HCFA, UB, RX OP OP – RX	28(	29

**Key:** IT= InTotal Health; OP=Optima, MC=MC; VP= VA Premier; CC: Coventry; HK= Anthem Healthkeepers; PR= Anthem Priority; PE= Anthem Peninsula

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>December 2013 Encounter Submission Calendar</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
2 IT: HCFA, UB, RX	3 HK: RX PE: RX PR: RX	4 VP: RX	5 OP: HCFA, UB, RX MC: HCFA, UB, RX	6
9 IT: HCFA, UB, RX	10 HK: HCFA, UB, RX PE: RX PR: RX	11 VP: HCFA, UB, RX	12 OP: HCFA, UB, RX MC: HCFA, UB, RX	13 CC – RX
16 IT: HCFA, UB, RX	17 HK: RX PE: RX PR: RX	18 VP: HCFA, UB, RX	19 OP: HCFA, UB, RX MC: HCFA, UB, RX	20
23 IT: HCFA, UB, RX CareNet	24 HK: HCFA, UB, RX PE: HCFA, UB, RX PR: HCFA, UB, RX	25	26 OP: HCFA, UB, RX MC: HCFA, UB, RX	27 CC: RX VP: RX
30 IT: HCFA, UB, RX	31 HK: RX PE: RX PR: RX			

**Key:** IT= InTotal Health; OP=Optima, MC=MC; VP= VA Premier; CC: Coventry; HK= Anthem Healthkeepers; PR= Anthem Priority; PE= Anthem Peninsula

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>January 2014</b>				
<b>Encounter Submission Calendar (Tentative Pending Xerox Approval)</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
		1 VP: RX	2 OP: HCFA, UB, RX MC: HCFA, UB, RX	3
6 IT: HCFA, UB, RX	7 HK: RX PE: RX PR: RX	8 VP: RX	9 OP: HCFA, UB, RX MC: HCFA, UB, RX	10 CC: RX
13 IT: HCFA, UB, RX	14 HK: HCFA, UB, RX PE: RX PR: RX	15 VP: HCFA, UB, RX	16 OP: HCFA, UB, RX MC: HCFA, UB, RX	17
20 IT: HCFA, UB, RX	21 HK: RX PE: RX PR: RX	22 VP: HCFA, UB, RX	23 OP: HCFA, UB, RX MC: HCFA, UB, RX	24 CC: RX
27 IT: HCFA, UB, 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=MC; VP= VA Premier; CC: Coventry; HK= Anthem Healthkeepers; PR= Anthem Priority; PE= Anthem Peninsula

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>February 2014</b>				
<b>Encounter Submission Calendar (Tentative Pending Xerox Approval)</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
3 IT: HCFA, UB, RX	4 HK: RX PE: RX PR: RX	5 VP: RX	6 OP: HCFA, UB, RX MC: HCFA, UB, RX	7
10 IT: HCFA, UB, RX	11 HK: HCFA, UB, RX PE: RX PR: RX	12 VP: RX	13 OP: HCFA, UB, RX MC: HCFA, UB, RX	14 CC: RX
17 IT: HCFA, UB, RX	18 HK: RX PE: RX PR: RX	19 VP: HCFA, UB, RX	20 OP: HCFA, UB, RX MC: HCFA, UB, RX	21
24 IT: HCFA, UB, RX	25 HK: HCFA, UB, RX PE: HCFA, UB, RX PR: HCFA, UB, RX	26 VP: HCFA, UB, RX	27 OP: HCFA, UB, RX MC: HCFA, UB, RX	28 CC: RX

**Key:** IT= InTotal Health; OP=Optima, MC=MC; VP= VA Premier; CC: Coventry; HK= Anthem Healthkeepers; PR= Anthem Priority; PE= Anthem Peninsula

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>March 2014</b>				
<b>Encounter Submission Calendar (Tentative Pending Xerox Approval)</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
3 IT: HCFA, UB, RX	4 HK: RX PE: RX PR: RX	5 VP: RX	6 OP: HCFA, UB, RX MC: HCFA, UB, RX	7
10 IT: HCFA, UB, RX	11 HK: HCFA, UB, RX PE: RX PR: RX	12 VP: RX	13 OP: HCFA, UB, RX MC: HCFA, UB, RX	14 CC: RX
17 IT: HCFA, UB, RX	18 HK: RX PE: RX PR: RX	19 VP: HCFA, UB, RX	20 OP: HCFA, UB, RX MC: HCFA, UB, RX	21
24 IT: HCFA, UB, RX	25 HK: HCFA, UB, RX PE: HCFA, UB, RX PR: HCFA, UB, RX	26 VP: HCFA, UB, RX	27 OP: HCFA, UB, RX MC: HCFA, UB, RX	28 CC: RX
31 IT: HCFA, UB, RX				

**Key:** IT= InTotal Health; OP=Optima, MC=MC; VP= VA Premier; CC: Coventry; HK= Anthem Healthkeepers; PR= Anthem Priority; PE= Anthem Peninsula

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>April 2014</b>				
<b>Encounter Submission Calendar (Tentative Pending Xerox Approval)</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
	1 HK: RX PE: RX PR: RX	2 VP: RX	3 OP: HCFA, UB, RX MC: HCFA, UB, RX	4
7 IT: HCFA, UB, RX	8 HK: HCFA, UB, RX PE: RX PR: RX	9 VP: RX	10 OP: HCFA, UB, RX MC: HCFA, UB, RX	11 CC: RX
14 IT: HCFA, UB, RX	15 HK: RX PE: RX PR: RX	16 VP: HCFA, UB, RX	17 OP: HCFA, UB, RX MC: HCFA, UB, RX	18
21 IT: HCFA, UB, RX	22 HK: HCFA, UB, RX PE: HCFA, UB, RX PR: HCFA, UB, RX	23 VP: HCFA, UB, RX	24 OP: HCFA, UB, RX MC: HCFA, UB, RX	25 CC: RX
28 IT: HCFA, UB, RX	29 HK: RX PE: RX PR: RX	30 VP: RX		

**Key:** IT= InTotal Health; OP=Optima, MC=MC; VP= VA Premier; CC: Coventry; HK= Anthem Healthkeepers; PR= Anthem Priority; PE= Anthem Peninsula

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>May 2014</b>				
<b>Encounter Submission Calendar (Tentative Pending Xerox Approval)</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
			1 OP: HCFA, UB, RX MC: HCFA, UB, RX	2
5 IT: HCFA, UB, RX	6 HK: RX PE: RX PR: RX	7 VP: RX	8 OP: HCFA, UB, RX MC: HCFA, UB, RX	9 CC: RX
12 IT: HCFA, UB, RX	13 HK: HCFA, UB, RX PE: RX PR: RX	14 VP: RX	15 OP: HCFA, UB, RX MC: HCFA, UB, RX	16
19 IT: HCFA, UB, RX	20 HK: RX PE: RX PR: RX	21 VP: HCFA, UB, RX	22 OP: HCFA, UB, RX MC: HCFA, UB, RX	23 CC: RX
26 IT: HCFA, UB, RX	27 HK: HCFA, UB, RX PE: HCFA, UB, RX PR: HCFA, UB, RX	28 VP: HCFA, UB, RX	29 OP: HCFA, UB, RX MC: HCFA, UB, RX	30

**Key:** IT= InTotal Health; OP=Optima, MC=MC; VP= VA Premier; CC: Coventry; HK= Anthem Healthkeepers; PR= Anthem Priority; PE= Anthem Peninsula

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>June 2014</b>				
<b>Encounter Submission Calendar (Tentative Pending Xerox Approval)</b>				
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
2 IT: HCFA, UB, RX	3 HK: RX PE: RX PR: RX	4 VP: RX	5 OP: HCFA, UB, RX MC: HCFA, UB, RX	6
9 IT: HCFA, UB, RX	10 HK: HCFA, UB, RX PE: RX PR: RX	11 VP: RX	12 OP: HCFA, UB, RX MC: HCFA, UB, RX	13 CC: RX
16 IT: HCFA, UB, RX	17 HK: RX PE: RX PR: RX	18 VP: HCFA, UB, RX	19 OP: HCFA, UB, RX MC: HCFA, UB, RX	20
23 IT: HCFA, UB, RX	24 HK: HCFA, UB, RX PE: HCFA, UB, RX PR: HCFA, UB, RX	25 VP: HCFA, UB, RX	26 OP: HCFA, UB, RX MC: HCFA, UB, RX	27 CC: RX
30 IT: HCFA, UB, RX				

**Key:** IT= InTotal Health; OP=Optima, MC=MC; VP= VA Premier; CC: Coventry; HK= Anthem Healthkeepers; PR= Anthem Priority; PE= Anthem Peninsula

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**1.3 Encounter Processing Requirements**

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**1.3.1 Encounter Data Certification**

By the 15<sup>th</sup> 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 II 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

<u>Code</u>	<u>Description</u>
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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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. Codes identified as 'app' are not assigned to a DMAS code.

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.

As part of DMAS' current ICD-10 project, the DMS crosswalk table will be updated and expanded with 500 additional encounter only reason codes.

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.

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
1		App	Deductible Amount.	01/01/95		
2		App	Coinsurance Amount.	01/01/95		
3		App	Co-payment Amount.	01/01/95		
4	0500	Deny	The procedure code is inconsistent with the modifier used or a required modifier is missing.	01/01/95		09/20/09
5	0501	Deny	The procedure code/bill type is inconsistent with the place of service.	01/01/95		09/20/09
6	0502	Deny	The procedure/revenue code is inconsistent with the patient's age.	01/01/95		09/20/09
7	0503	Deny	The procedure/revenue code is inconsistent with the patient's gender.	01/01/95		09/20/09
8	0504	Deny	The procedure code is inconsistent with the provider type/specialty (taxonomy).	01/01/95		09/20/09

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
9	0505	Deny	The diagnosis is inconsistent with the patient's age.	01/01/95		09/20/09
10	0506	Deny	The diagnosis is inconsistent with the patient's gender.	01/01/95		09/20/09
11	0507	Deny	The diagnosis is inconsistent with the procedure.	01/01/95		09/20/09
12	0508	Deny	The diagnosis is inconsistent with the provider type.	01/01/95		09/20/09
13	0509	Deny	The date of death precedes the date of service.	01/01/95		
14	0510	Deny	The date of birth follows the date of service.	01/01/95		
15		App	The authorization number is missing, invalid or does not apply to the billed services or provider.	01/01/95		09/30/07
16	0512	Deny	Claim/service lacks information which is needed for adjudication.	01/01/95		09/20/09
17		App	Requested information was not provided or was insufficient/incomplete.	01/01/95	07/01/09	02/21/08
18	0514	Deny	Duplicate claim/service.	01/01/95		
19	0515	Deny	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	01/01/95		09/30/07
20	0516	Deny	This injury/illness is covered by the liability carrier.	01/01/95		09/30/07
21	0517	Deny	This injury/illness is the liability of the no-fault carrier.	01/01/95		09/30/07
22		App	This care may be covered by another payer per coordination of benefits.	01/01/95		09/30/07
23		App	The impact of prior payer(s) adjudication including payments and/or adjustments.	01/01/95		09/30/07
24		App	Charges are covered under a capitation agreement/managed care plan.	01/01/95		09/30/07
25	0599	Deny	Payment denied. Your Stop loss deductible has not been met.	01/01/95	04/01/08	
26	0521	Deny	Expenses incurred prior to coverage.	01/01/95		
27	0522	Deny	Expenses incurred after coverage terminated.	01/01/95		
28			Coverage not in effect at the time the service was provided.	01/01/95	10/16/03	
29	0523	Deny	The time limit for filing has expired.	01/01/95		
30	0599	Deny	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	01/01/95	02/01/06	
31	0524	Deny	Patient cannot be identified as our insured.	01/01/95		09/30/07
32	0525	Deny	Our records indicate that this dependent is not an eligible dependent as defined.	01/01/95		
33	0526	Deny	Insured has no dependent coverage.	01/01/95		09/30/07

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
34	0527	Deny	Insured has no coverage for newborns.	01/01/95		09/30/07
35	0528	Deny	Lifetime benefit maximum has been reached.	01/01/95		10/31/02
36			Balance does not exceed co-payment amount.	01/01/95	10/16/03	
37			Balance does not exceed deductible.	01/01/95	10/16/03	
38	0529	Deny	Services not provided or authorized by designated (network/primary care) providers.	01/01/95		06/30/03
39	0530	Deny	Services denied at the time authorization/pre-certification was requested.	01/01/95		
40	0531	Deny	Charges do not meet qualifications for emergent/urgent care.	01/01/95		09/20/09
41			Discount agreed to in Preferred Provider contract.	01/01/95	10/16/03	
42		App	Charges exceed our fee schedule or maximum allowable amount.	01/01/95	06/01/07	10/31/06
43		App	Gramm-Rudman reduction.	01/01/95	07/01/06	
44		App	Prompt-pay discount.	01/01/95		
45		App	Charges exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	01/01/95		10/31/06
46			This (these) service(s) is (are) not covered.	01/01/95	10/16/03	
47	0534	Deny	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	01/01/95	02/01/06	
48			This (these) procedure(s) is (are) not covered.	01/01/95	10/16/03	
49	0535	Deny	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.	01/01/95		09/20/09
50	0536	Deny	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	01/01/95		09/20/09
51	0537	Deny	These are non-covered services because this is a pre-existing condition.	01/01/95		09/20/09
52	0538	Deny	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	01/01/95	02/01/06	
53	0539	Deny	Services by an immediate relative or a member of the same household are not covered.	01/01/95		
54	0540	Deny	Multiple physicians/assistants are not covered in this case.	01/01/95		09/20/09
55	0541	Deny	Procedure/treatment is deemed experimental/investigational by the payer.	01/01/95		09/20/09
56	0542	Deny	Procedure/treatment has not been deemed 'proven to be effective' by the payer.	01/01/95		09/20/09

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
57	0543		Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	01/01/95	06/30/07	
58		App	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	01/01/95		09/20/09
59		App	Processed based on multiple or concurrent procedure rules. (For example, multiple surgery or diagnostic imaging, concurrent anesthesia).	01/01/95		09/20/09
60	0546	Deny	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	06/01/08		
61		App	Penalty for failure to obtain second surgical opinion.	01/01/95		09/20/09
62	0548	Deny	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	01/01/95	04/01/07	10/31/06
63			Correction to a prior claim.	01/01/95	10/16/03	
64			Denial reversed per Medical Review.	01/01/95	10/16/03	
65			Procedure code was incorrect. This payment reflects the correct code.	01/01/95	10/16/03	
66		App	Blood Deductible.	01/01/95		
67			Lifetime reserve days. (Handled in QTY, QTY01=LA).	01/01/95	10/16/03	
68			DRG weight. (Handled in CLP12).	01/01/95	10/16/03	
69		App	Day outlier amount.	01/01/95		
70		App	Cost outlier - Adjustment to compensate for additional costs.	01/01/95		06/30/01
71	0549		Primary Payer amount.	01/01/95	06/30/00	
72			Coinsurance day. (Handled in QTY, QTY01=CD).	01/01/95	10/16/03	
73			Administrative days.	01/01/95	10/16/03	
74		App	Indirect Medical Education Adjustment.	01/01/95		
75		App	Direct Medical Education Adjustment.	01/01/95		
76		App	Disproportionate Share Adjustment.	01/01/95		
77			Covered days. (Handled in QTY, QTY01=CA).	01/01/95	10/16/03	
78	0550	Deny	Non-Covered days/Room charge adjustment.	01/01/95		
79			Cost Report days (Handled in MIA15).	01/01/95	10/16/03	
80			Outlier days. (Handled in QTY, QTY01=OU).	01/01/95	10/16/03	
81			Discharges.	01/01/95	10/16/03	

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
82			PIP days.	01/01/95	10/16/03	
83			Total visits.	01/01/95	10/16/03	
84			Capital Adjustment. (Handled in MIA).	01/01/95	10/16/03	
85		App	Patient Interest Adjustment.	01/01/95		07/09/07
86			Statutory Adjustment.	01/01/95	10/16/03	
87		App	Transfer amount.	01/01/95	01/01/12	09/20/09
88		App	Adjustment amount represents collection against receivable created in prior overpayment.	01/01/95	06/30/07	
89		App	Professional fees removed from charges.	01/01/95		
90		App	Ingredient cost adjustment.	01/01/95		07/01/09
91		App	Dispensing fee adjustment.	01/01/95		
92			Claim Paid in full.	01/01/95	10/16/03	
93			No Claim level Adjustments.	01/01/95	10/16/03	
94		App	Processed in Excess of charges.	01/01/95		
95	0552	Deny	Plan procedures not followed.	01/01/95		09/30/07
96	0553	Deny	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	01/01/95		09/20/09
97	0554	Deny	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	01/01/95		09/20/09
98			The hospital must file the Medicare claim for this inpatient non-physician service.	01/01/95	10/16/03	
99			Medicare Secondary Payer Adjustment Amount.	01/01/95	10/16/03	
100		App	Payment made to patient/insured/responsible party/employer.	01/27/08		
101		App	Predetermination: anticipated payment upon completion of services or claim adjudication.	01/01/95		02/28/99
102		App	Major Medical Adjustment.	01/01/95		
103		App	Provider promotional discount (e.g., Senior citizen discount).	01/01/95		06/30/01
104		App	Managed care withholding.	01/01/95		
105		App	Tax withholding.	01/01/95		
106		App	Patient payment option/election not in effect.	01/01/95		
107	0557	Deny	The related or qualifying claim/service was not identified on this claim.	01/01/95		09/20/09

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
108		App	Rent/purchase guidelines were not met.	01/01/95		09/20/09
109	0559	Deny	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	01/01/95		
110	0560	Deny	Billing date predates service date.	01/01/95		
111	0561	Deny	Not covered unless the provider accepts assignment.	01/01/95		
112		App	Service not furnished directly to the patient and/or not documented.	01/01/95		09/30/07
113	0563	Deny	Payment denied because service/procedure was provided outside the United States or as a result of war.	01/01/95	06/30/07	02/28/01
114	0564	Deny	Procedure/product not approved by the Food and Drug Administration.	01/01/95		
115		App	Procedure postponed, canceled or delayed.	01/01/95		09/30/07
116	0566	Deny	The advance indemnification notice signed by the patient did not comply with requirements.	01/01/95		09/30/07
117		App	Transportation is only covered to the closest facility that can provide the necessary care.	01/01/95		09/30/07
118		App	ESRD network support adjustment.	01/01/95		09/30/07
119	0568	Deny	Benefit maximum for this time period or occurrence has been reached.	01/01/95		02/29/04
120			Patient is covered by a managed care plan.	01/01/95	06/30/07	
121		App	Indemnification adjustment - compensation for outstanding member responsibility.	01/01/95		09/30/07
122		App	Psychiatric reduction.	01/01/95		
123			Payer refund due to overpayment.	01/01/95	06/30/07	
124			Payer refund amount - not our patient.	01/01/95	06/30/07	06/30/99
125		App	Submission/billing error(s).	01/01/95		09/20/09
126		App	Deductible -- Major Medical.	02/28/97	04/01/08	09/30/07
127		App	Coinsurance -- Major Medical.	02/28/97	04/01/08	09/30/07
128	0570	Deny	Newborn's services are covered in the mother's Allowance.	01/01/95		
129	0571	Deny	Prior processing information appears incorrect.	02/28/97		09/30/07
130		App	Claim submission fee.	02/28/97		06/30/01
131		App	Claim specific negotiated discount.	02/28/97		
132		App	Prearranged demonstration project adjustment.	02/28/97		
133	0572	Deny	The disposition of this claim/service is pending further review.	02/28/97		10/31/99
134		App	Technical fees removed from charges.	10/31/98		

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
135	0573	Deny	Interim bills cannot be processed.	10/31/98		09/30/07
136		App	Failure to follow prior payer's coverage rules.	10/31/98		09/30/07
137		App	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	02/28/99		09/30/07
138	0575	Deny	Appeal procedures not followed or time limits not met.	06/30/99		09/30/07
139		App	Contracted funding agreement - Subscriber is employed by the provider of services.	06/30/99		
140	0576	Deny	Patient/Insured health identification number and name do not match.	06/30/99		
141		App	Claim spans eligible and ineligible periods of coverage.	06/30/99		09/30/07
142		App	Monthly Medicaid patient liability amount.	06/30/00		09/30/07
143		App	Portion of payment deferred.	02/28/01		
144		App	Incentive adjustment, e.g. preferred product/service.	06/30/01		
145		App	Premium payment withholding.	06/30/02	04/01/08	09/30/07
146	0578	Deny	Diagnosis was invalid for the date(s) of service reported.	06/30/02		09/30/07
147	0579	Deny	Provider contracted/negotiated rate expired or not on file.	06/30/02		
148	0580	Deny	Information from another provider was not provided or was insufficient/incomplete.	06/30/02		09/20/09
149	0543	Deny	Lifetime benefit maximum has been reached for this service/benefit category.	10/31/02		
150		App	Payer deems the information submitted does not support this level of service.	10/31/02		09/30/07
151		App	Payment adjusted because the payer deems the information submitted does not support this many services.	10/31/02		01/27/08
152		App	Payer deems the information submitted does not support this length of service.	10/31/02		09/20/09
153		App	Payer deems the information submitted does not support this dosage.	10/31/02		09/30/07
154		App	Payer deems the information submitted does not support this day's supply.	10/31/02		09/30/07
155	0783	Deny	Patient refused the service/procedure.	06/30/03		09/30/07
156		App	Flexible spending account payments.	09/30/03	10/01/09	01/25/09
157	0563	Deny	Service/procedure was provided as a result of an act of war.	09/30/03		09/30/07
158	0563	Deny	Service/procedure was provided outside of the United States.	09/30/03		09/30/07
159	0784	Deny	Service/procedure was provided as a result of terrorism.	09/30/03		09/30/07

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
160	0785	Deny	Injury/Illness was the result of an activity that is a benefit exclusion.	09/30/03		09/30/07
161		App	Provider performance bonus.	02/29/04		
162		App	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.	02/29/04		
163		App	Attachment referenced on the claim was not received.	06/30/04		09/30/07
164		App	Attachment referenced on the claim was not received in a timely fashion.	06/30/04		09/30/07
165	0787	Deny	Referral absent or exceeded.	10/31/04		09/30/07
166	533 523	Deny	These services were submitted after this payers responsibility for processing claims under this plan ended.	02/28/05		
167	0534	Deny	This (these) diagnosis(es) is (are) not covered.	06/30/05		09/20/09
168	0599	Deny	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	06/30/05		09/30/07
169		App	Alternate benefit has been provided.	06/30/05		09/30/07
170	0584	Deny	Payment is denied when performed/billed by this type of provider.	06/30/05		09/20/09
171	0584	Deny	Payment is denied when performed/billed by this type of provider in this type of facility.	06/30/05		09/20/09
172		App	Payment is adjusted when performed/billed by a provider of this specialty.	06/30/05		09/20/09
173		App	Service was not prescribed by a physician.	06/30/05		09/30/07
174	0594	Deny	Service was not prescribed prior to delivery.	06/30/05		09/30/07
175	0594	Deny	Prescription incomplete.	06/30/05		09/30/07
176	0594	Deny	Prescription is not current.	06/30/05		09/30/07
177	0599	Deny	Patient has not met the required eligibility requirements.	06/30/05		09/30/07
178	0599	Deny	Patient has not met the required spend down requirements.	06/30/05		09/30/07
179	0599	Deny	Patient has not met the required waiting requirements.	06/30/05		09/20/09
180	0599	Deny	Patient has not met the required residency requirements.	06/30/05		09/30/07
181	0595	Deny	Procedure code was invalid on the date of service.	06/30/05		09/30/07
182	0595	Deny	Procedure modifier was invalid on the date of service.	06/30/05		09/30/07
183	0538	Deny	The referring provider is not eligible to refer the service billed.	06/30/05		09/20/09

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
184	0538	Deny	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	06/30/05		09/20/09
185	0538	Deny	The rendering provider is not eligible to perform the service billed.	06/30/05		09/20/09
186		App	Level of care change adjustment.	06/30/05		09/30/07
187		App	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.).	06/30/05		01/25/09
188	0599	Deny	This product/procedure is only covered when used according to FDA recommendations.	06/30/05		
189	0789	Deny	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	06/30/05		
190	0790	Deny	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	10/31/05		
191	0599	Deny	Not a work related injury/illness and thus not the liability of the workers' compensation carrier.	10/31/05		09/30/07
192	0791	Deny	Non standard adjustment code from paper remittance.	10/31/05		09/30/07
193	532 523	Deny	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	02/28/06		01/27/08
194	0545	Deny	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	02/28/06		09/30/07
195		Deny	Refund issued to an erroneous priority payer for this claim/service.	02/28/06		09/30/07
196		Deny	Claim/service denied based on prior payer's coverage determination.	06/30/06	02/01/07	
197	0513	Deny	Precertification/authorization/notification absent.	10/31/06		09/30/07
198	0518	Deny	Precertification/authorization exceeded.	10/31/06		09/30/07
199	0583	Deny	Revenue code and procedure code do not match.	10/31/06		
200	0547	Deny	Expenses incurred during lapse in coverage.	10/31/06		
201		Deny	Workers Compensation case settler. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement.	10/31/06		
202	0588	Deny	Non-covered personal comfort or convenience services.	02/28/07		09/30/07
203		App	Discontinued or reduced service.	02/28/07		09/30/07
204	0519	Deny	This service/equipment/drug is not covered under the patient's current benefit plan.	02/28/07		
205		App	Pharmacy discount card processing fee.	07/09/07		

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
206	0544	Deny	National Provider Identifier - missing.	07/09/07		09/30/07
207	0551	Deny	National Provider Identifier - Invalid format.	07/09/07		06/01/08
208	0555	Deny	National Provider Identifier - Not matched.	07/09/07		09/30/07
209		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.	07/09/07		
210	0596	Deny	Payment adjusted because pre-certification/authorization not received in a timely fashion.	07/09/07		
211	0597	Deny	National Drug Code (NDC) not eligible for rebate, are not covered.	07/09/07		
212	0574	Deny	Administrative surcharges are not covered.	11/05/07		
213		Deny	Non-compliance with the physician self referral prohibition legislation or payer policy.	01/27/08		
214		Deny	Worker's Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.	01/27/08		
215		App	Based on subrogation of a third party settlement.	01/27/08		
216	0556	Deny	Based on the findings of a review organization.	01/27/08		
217		App	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.	01/27/08		
218		App	Based on entitlement to benefits.	01/27/08		
219		App	Based on extent of injury.	01/27/08		
220	0567	Deny	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required.	01/27/08		
221		Deny	Workers' Compensation claim is under investigation. Claim pending final resolution.	01/27/08		
222		Deny	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.	06/01/08		09/20/09
223		App	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.	06/01/08		
224	0577	Deny	Patient identification compromised by identify theft. Identity verification required for processing this and future claims.	06/01/08		
225		App	Penalty or Interest Payment by Payer.	06/01/08		

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
226	0569	Deny	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	09/21/08		09/20/09
227	0558	Deny	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete.	09/21/08		09/20/09
228		Deny	Denied for failure of this provider, another provider or the subscriber to supply required information to a previous payer for their adjudication.	09/21/08		
229		App	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X.	01/25/09		
230	0562	Deny	No available or correlating CPT/HCPCS code to describe this service.	01/25/09		
231		Deny	Mutually exclusive procedures cannot be done in the same day/setting.	07/01/09		09/20/09
232		App	Institutional Transfer Amount.	11/01/09		
233		Deny	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	03/01/10		
234	0565	Deny	This procedure is not paid separately.	03/01/10		
A0		App	Patient refund amount.	01/01/95		
A1	511 <del>599</del>	Deny	Claim/Service denied.	01/01/95		09/30/09
A2		App	Contractual adjustment.	01/01/95	01/01/08	02/28/07
A3			Medicare Secondary Payer liability met.	01/01/95	10/16/03	
A4		App	Medicare Claim PPS Capital Day Outlier Amount.	01/01/95	04/01/08	09/30/07
A5		App	Medicare Claim PPS Capital Cost Outlier Amount.	01/01/95		
A6	0599	Deny	Prior hospitalization or 30 day transfer requirement not met.	01/01/95		
A7		App	Presumptive Payment Adjustment.	01/01/95		
A8	0581	Deny	Ungroupable DRG.	01/01/95		09/30/07
B1	0582	Deny	Non-covered visits.	01/01/95		
B2			Covered visits.	01/01/95	10/16/03	
B3			Covered charges.	01/01/95	10/16/03	
B4		App	Late filing penalty.	01/01/95		
B5		App	Coverage/program guideline were not met or were exceeded.	01/01/95		09/30/07
B6		App	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	01/01/95	02/01/06	

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
B7	0585	Deny	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	01/01/09		09/20/09
B8	0586	Deny	Alternative services were available, and should have been utilized.	01/01/95		09/20/09
B9	0587	Deny	Patient is enrolled in a Hospice.	01/01/95		09/30/07
B10		App	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	01/01/95		
B11	0589	Deny	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	01/01/95		
B12	0590	Deny	Services not documented in patients' medical records.	01/01/95		
B13	0591	Deny	Previously paid. Payment for this claim/service may have been provided in a previous payment.	01/01/95		
B14	0592	Deny	Only one visit or consultation per physician per day is covered.	01/01/95		09/30/07
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.	01/01/95		09/20/09
B16	0520	Deny	New Patient' qualifications were not met.	01/01/95		09/30/07
B17	0594	Deny	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.	01/01/95	02/01/06	
B18	0595	Deny	This procedure code and modifier were invalid on the date of service.	01/01/95	03/01/09	09/21/08
B19			Claim/service adjusted because of the finding of a Review Organization.	01/01/95	10/16/03	
B20		App	Procedures/service was partially or fully furnished by another provider.	01/01/95		09/30/07
B21			The charges were reduced because the service/care was partially furnished by another physician.	01/01/95	10/16/03	
B22		App	This payment is adjusted based on the diagnosis	01/01/95		02/28/01
B23	0598	Deny	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	01/01/95		09/30/07
D1			Claim/service denied. Level of subluxation is missing or inadequate.	01/01/95	10/16/03	

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
D2			Claim lacks the name, strength, or dosage of the drug furnished.	01/01/95	10/16/03	
D3			Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.	01/01/95	10/16/03	
D4			Claim/service does not indicate the period of time for which this will be needed.	01/01/95	10/16/03	
D5			Claim/service denied. Claim lacks individual lab codes included in the test.	01/01/95	10/16/03	
D6			Claim/service denied. Claim did not include patient's medical record for the service.	01/01/95	10/16/03	
D7			Claim/service denied. Claim lacks date of patient's most recent physician visit.	01/01/95	10/16/03	
D8			Claim/service denied. Claim lacks indicator that 'x-ray is available for review'.	01/01/95	10/16/03	
D9			Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.	01/01/95	10/16/03	
D10			Claim/service denied. Completed physician financial relationship form not on file.	01/01/95	10/16/03	
D11			Claim lacks completed pacemaker registration form.	01/01/95	10/16/03	
D12			Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.	01/01/95	10/16/03	
D13			Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.	01/01/95	10/16/03	
D14			Claim lacks indication that plan of treatment is on file.	01/01/95	10/16/03	
D15			Claim lacks indication that service was supervised or evaluated by a physician.	01/01/95	10/16/03	
D16			Claim lacks prior payer payment information.	01/01/95	06/30/07	
D17			Claim/Service has invalid non-covered days.	01/01/95	06/30/07	
D18			Claim/Service has missing diagnosis information.	01/01/95	06/30/07	
D19			Claim/Service lacks Physician/Operative or other supporting documentation.	01/01/95	06/30/07	
D20			Claim/Service missing service/product information.	01/01/95	06/30/07	
D21	0534	Deny	This (these) diagnosis(es) is (are) missing or are invalid.	01/01/95	06/30/07	
D22		App	Reimbursement was adjusted for the reasons to be provided in separate correspondence.	01/27/08	01/01/09	

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

HIPAA Adjustment Reason Code to MMIS ESC Crosswalk						
HIPAA AdjRsn	MMIS ESC	Type	Description	Begin Date	End Date	Last Update
D23		Deny	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility.	11/01/09	01/01/12	
W1		App	Workers Compensation State Fee Schedule Adjustment.	02/29/00		

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**1.3.5 Line-Level Processing**

All transactions submitted in an 837P (Professional) transaction must be adjudicated at the line (service) level. Within the 837P transaction, the Contractor's claim number must be identified. For service or line level encounters, this number must be unique for each line.

Institutional transactions (837I) for *outpatient* services that contain procedure codes should be adjudicated at the service level. Other institutional transactions may be adjudicated at either the claim or service level.

Revenue Codes on inpatient institutional transactions are always provided at the service level; Contractors adjudicating inpatient transactions at the claim level should "roll" like Revenue Codes into a single service line with associated costs; e.g., all ancillary services reported on one line as Revenue Code 0240 (All Inclusive Ancillary – General Classification). Contractors are NOT required to summarize like Revenue Codes; each code may be reported separately if that is how the Contractor stores the information.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

### 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
```

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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~

Virginia Department of Medical Assistance  
Managed Care Technical Manual

**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.**

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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).

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

<b>Code</b>	<b>Form</b>	<b>Description</b>
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**1.4.2 Provider Class Type**

<b>Code</b>	<b>Description</b>
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>Code</b>	<b>Description</b>
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 II - Immunization

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>Code</b>	<b>Description</b>
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 II
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>Code</b>	<b>Description</b>
105	Certified Professional Midwives
106	Transition Coordinator
107	MMIS Contractors or Vendors
108	Early Intervention
109	Out of State ICF Provider

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**1.4.3 Provider Specialty**

<b>Code</b>	<b>Description</b>
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>Code</b>	<b>Description</b>
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>Code</b>	<b>Description</b>
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>Code</b>	<b>Description</b>
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**1.4.4 Edit Codes / Error Sequence Codes (ESC)**

<b>ESC</b>	<b>Error Description</b>	<b>Status</b>
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>ESC</b>	<b>Error Description</b>	<b>Status</b>
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>ESC</b>	<b>Error Description</b>	<b>Status</b>
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>ESC</b>	<b>Error Description</b>	<b>Status</b>
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>ESC</b>	<b>Error Description</b>	<b>Status</b>
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>ESC</b>	<b>Error Description</b>	<b>Status</b>
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	Nondihydropyridine 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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

<b>ESC</b>	<b>Error Description</b>	<b>Status</b>
1522	Oral Hypoglycemics - 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 Onychomycosis - 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

## 2 Enrollment Roster & Payment Files

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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 20<sup>th</sup> (mid-month) and 2<sup>nd</sup> (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 (20<sup>th</sup>) day of the month prior to member enrollment. The End of the Month Enrollment Report will be provided to the Contractor on the second (2<sup>nd</sup>) 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
12/16/2012 Sun	12/18/2012 Tue	12/20/2012 Thu	12/31/2012 Mon	01/02/2013 Wed
01/16/2013 Wed	01/18/2013 Fri	01/20/2013 Sun	01/31/2013 Thu	02/02/2013 Sat
02/16/2013 Sat	02/18/2013 Mon	02/20/2013 Wed	02/28/2013 Thu	03/02/2013 Sat
03/16/2013 Sat	03/18/2013 Mon	03/20/2013 Wed	03/31/2013 Sun	04/02/2013 Tue
04/16/2013 Tue	04/18/2013 Thu	04/20/2013 Sat	04/30/2013 Tue	05/02/2013 Thu
05/16/2013 Thu	05/18/2013 Sat	05/20/2013 Mon	05/31/2013 Fri	06/02/2013 Sun
06/16/2013 Sun	06/18/2013 Tue	06/20/2013 Thu	06/30/2013 Sun	07/02/2013 Tue
07/16/2013 Tue	07/18/2013 Thu	07/20/2013 Sat	07/31/2013 Wed	08/02/2013 Fri
08/16/2013 Fri	08/18/2013 Sun	08/20/2013 Tue	08/31/2012 Fri	09/02/2012 Sun
09/16/2013 Mon	09/18/2013 Wed	09/20/2013 Fri	09/30/2013 Mon	10/02/2013 Wed
10/16/2013 Wed	10/18/2013 Fri	10/20/2013 Sun	10/31/2013 Thu	11/02/2013 Sat
11/16/2013 Sat	11/18/2013 Mon	11/20/2013 Wed	11/30/2013 Sat	12/02/2013 Mon
12/16/2013 Mon	12/18/2013 Wed	12/20/2013 Fri	12/31/2013 Tue	01/02/2014 Thu

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

CAPITATION 820 RUN	CAPITATION 820 AVAILABILITY	CAPITATION CHECK DATE
01/25/2013 Fri	01/28/2013 Mon	02/01/2013 Fri
02/22/2013 Fri	02/25/2013 Mon	03/01/2013 Fri
03/29/2013 Fri	04/01/2013 Mon	04/05/2013 Fri
04/26/2013 Fri	04/29/2013 Mon	05/03/2013 Fri
05/31/2013 Fri	06/03/2013 Mon	06/07/2013 Fri
06/28/2013 Fri	07/01/2013 Mon	07/05/2013 Fri
07/26/2013 Fri	07/29/2013 Mon	08/02/2013 Fri
08/30/2013 Fri	09/02/2013 Mon	09/06/2013 Fri
09/27/2013 Fri	09/30/2013 Mon	10/04/2013 Fri
10/25/2013 Fri	10/28/2013 Mon	11/01/2013 Fri
11/29/2013 Fri	12/02/2013 Mon	12/06/2013 Fri
12/27/2013 Fri	12/30/2013 Mon	01/03/2014 Fri
01/31/2014 Fri	02/03/2014 Mon	02/07/2014 Fri

## 3 MCO Contract Deliverables

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

### **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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

### **3.1.2 Deliverable Scoring**

DMAS will evaluate each deliverable submission and assign a numeric score based on 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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'.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

### **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 15<sup>th</sup> should include activity occurring during the reporting period from January 1<sup>st</sup> through the 31<sup>st</sup>. Certain reports reflect different reporting periods, and these exceptions are defined in the detailed reporting specifications for that deliverable.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.1 Enrollment Broker Provider File**

**3.2.1.1 Contract Reference**

Medallion II 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 <u>must be unique</u> per provider and office location	CHAR(15)	13	27
Program Code	Required -Default value is M2 (Medallion II)	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	CHAR(02)	229	230
Language 2	GR=German	CHAR(02)	231	232
Language 3	FR=French	CHAR(02)	233	234
Language 4	IT=Italian	CHAR(02)	235	236
Language 5	RS=Russian	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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.2 MCO Claims Report**

**3.2.2.1 Contract Reference**

Medallion II Contract, Section 4.4

**3.2.2.2 File Specifications**

Field Description	Specifications
Month Begin Claims Inventory	Value must be $\geq 0$
Claims Received This Month	Value must be $\geq 0$
Claims Processed (Paid Or Denied) This Month	Value must be $\geq 0$
Number Of Claims Paid This Month	Value must be $\geq 0$
Number Of Claims Denied This Month	Value must be $\geq 0$
Number Of Claims Pended This Month	Value must be $\geq 0$
Claims Processed This Month: PMT DT - Receipt DT < 30	Value must be $\geq 0$
Claims Processed This Month Within 31-90 Days Of Receipt	Value must be $\geq 0$
Claims Processed In 91-365 Days	Value must be $\geq 0$
Claims Processed Over 365 Days	Value must be $\geq 0$
Number Approved	Value must be $\geq 0$
Number Limited	Value must be $\geq 0$
Number Denied	Value must be $\geq 0$
Number Of PCPS With Open Panels	Value must be $\geq 0$
Number Of PCPS With Closed Panels	Value must be $\geq 0$
Number Of PCPS With Restricted Panels	Value must be $\geq 0$
Top 20 Denial Reasons	Must be 40 characters or less
Top 20 Denial Reasons (Claims Count)	Value must be $\geq 0$
Top 20 Pend Reasons	Must be 40 characters or less
Top 20 Pend Reasons (Claims Count)	Value must be $\geq 0$

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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:  $\text{PMT DT} - \text{Receipt DT} < 30 + \text{Claims Processed This Month Within 31-90 Days Of Receipt} + \text{Percent Processed In 91-365 Days} + \text{Percent Processed Over 365 Days} = \text{Claims Processed (Paid Or Denied) This Month}$ .
- **Denial Reasons:** Total Denial Reasons must be equal to or greater than the Number of Claims Denied This Month. Submit details for the Top 20 denial reasons only. All other denials should be summed and reported as one line.
- **Pended Reasons:** Total Pended Reasons must be equal to or greater than the Number of Claims Pended This Month. Submit details for the Top 20 pend reasons only. All other pends should be summed and reported as one line.
- **MCO Comments:** The Comment section is provided for the MCO to make any comment they deem appropriate. Comments are optional.

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.3 Live Births**

**3.2.3.1 Contract Reference**

Medallion II 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.
Estimated Gestation Period	Numeric value must be >= 22 and <= 54.

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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Estimated Gestation Period:** Report mother's gestation period in weeks.

**3.2.3.4 Examples**

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

#	Scenario	Outcome
1	<b>Program:</b> Medicaid Date of Birth: 08/12/xxxx First Time Member Reported? Y	Member should be included in the report.
2	<b>Program:</b> 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	<b>Program:</b> FAMIS <b>Age:</b> 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	<b>Program:</b> 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.4 Returned ID Cards**

**3.2.4.1 Contract Reference**

Medallion II, 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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.5 Lock-In**

**3.2.5.1 Contract Reference**

Medallion II 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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.6 Children with Special Health Care Needs**

**3.2.6.1 Contract Reference**

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

**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: CSHCN.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**

- **Program:** Member must be enrolled under the Medicaid program. Do not include FAMIS members on this report.
- **Age:** Member must be under age of 21 as of their first day of enrollment with the MCO. Use the member's date of birth from the 834 to calculate their age for reporting purposes.
- **Eligibility:** Member must meet one or more of the following eligibility criteria:
  - Member is in Aid Category 049, 051, 052, 059, 060, 061, 062, 072, 076, and/or
  - Member is enrolled in the early intervention benefit as identified on the 834, and/or
  - Member has one or more special needs as identified in the Managed Care contract.
- **Report Period:** This report reflects a 60 day look back period, i.e. current and previous calendar months. Include only members who were enrolled on the first calendar day of the first month of the

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

60 day look back period. Member must be enrolled with the MCO for the entire 60 day reporting period.

- **New Members Only**: Include only new members in this report. A new member is defined as a member who is on the end of month 834, but was not on the end of month 834 file in either of the prior six months.
- **Assessment**: 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.
- **PCP Visit**: Reporting this information is optional. If provided, include only those members who actually visited their PCP during the 60 day reporting period: i.e., those members who visited a PCP within the first two calendar months of being newly enrolled in the MCO. Do not report members who did not visit their PCP during the report period, and do not include PCP visits that occurred outside the 60 day report period.

**3.2.6.4 Examples**

None

**3.2.6.5 Scoring Criteria**

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.7 Assessments for Aged, Blind and Disabled**

**3.2.7.1 Contract Reference**

Medallion II Contract, Section 7.7

**3.2.7.2 File Specifications**

Field Description	Specifications
Medicaid ID	Must be a valid Medicaid ID Format: Numeric 12 bytes with leading zeros
Date Assessed	Must be a valid date Format = mm/dd/yyyy Must be <= last day of reporting period Must be >= first day of reporting period
Contact Method	Valid values: P, M, H or O

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: ASSMT\_DSBLD.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

**3.2.7.3 Requirements**

- **Program:** Member must be enrolled under the Medicaid program. Do not include FAMIS members on this report.
- **Eligibility:** Member must meet the following eligibility criteria:
  - Member is in Aid Category 049, 051, 052, 059, 060, 061, or 062.
- **Report Period:** This report reflects a 60 day look back period, i.e. current and previous calendar months. Include only members who were enrolled on the first calendar day of the first month of the 60 day look back period. Member must be enrolled with the MCO for the entire 60 day reporting period.
- **New Members Only:** Include only new members in this report. A new member is defined as a member who is on the end of month 834, but was not on the end of month 834 file in either of the prior six months.
- **Assessment:** 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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

mental health, interventions received, and any additional services required including referrals to other resources and programs with completion of an approved assessment tool.

**3.2.7.4 Examples**

None

**3.2.7.5 Scoring Criteria**

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.8 Appeals & Grievances Summary**

**3.2.8.1 Contract Reference:**

Medallion II Contract, Section 10.1.E.II

**3.2.8.2 File Specifications**

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

DMAS:        Managed Care Contract Monitor  
                 CMS

**3.2.8.3 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.

**3.2.8.4 Examples**

N/A

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.9 Monthly Provider File for Encounter Processing**

**3.2.9.1 Contract Reference**

Managed Care Technical Manual, Section 11.4

FAMIS Contract, Article II, Section N.9

**3.2.9.2 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
Title	Must be 5 characters or less
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	Must be 40 characters or less
Language	Must be 10 characters
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.10 Encounter File Submissions**

**3.2.10.1 Contract Reference**

Medallion II Contract, Section 11.5.A

**3.2.10.2 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

**3.2.10.3 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.

**3.2.10.4 Examples**

None

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.11 Encounter Data Certification**

**3.2.11.1 Contract Reference**

Medallion II Contract, Section 11.5.B

**3.2.11.2 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

**3.2.11.3 Requirements**

Include encounters for all members enrolled in Medicaid and FAMIS.

**3.2.11.4 Examples**

N/A

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.12 Monies Recovered by Third Parties**

**3.2.12.1 Contract Reference**

Medallion II 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
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

**3.2.12.3 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.

**3.2.12.4 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.13 Comprehensive Health Coverage**

**3.2.13.1 Contract Reference**

Medallion II Contract, Section 12.10.A

Article IV, D, 1 (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 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

**3.2.13.3 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.

**3.2.13.4 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.14 Workers' Compensation**

**3.2.14.1 Contract Reference**

Medallion II Contract, Section 12.10.B

Article IV, D, 2 (FAMIS)

**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
Other Carrier Name	Must be 50 characters or less
Policy Number	Must be $\leq$ 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

**3.2.14.3 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.

**3.2.14.4 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.15 Estate Recoveries**

**3.2.15.1 Contract Reference**

Medallion II Contract, Section 12.10.C

**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
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

**3.2.15.3 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.

**3.2.15.4 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.16 Other Coverage**

**3.2.16.1 Contract Reference**

Medallion II Contract, Section 12.10.D

Article IV, D, 3 (FAMIS)

**3.2.16.2 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

**3.2.16.3 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.

**3.2.16.4 Examples**

NONE

**3.2.16.5 Scoring Criteria**

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.17 PCP Provider Attestation Listing**

**3.2.17.1 Contract Reference**

Medallion II Contract, Section 12.13.B

**3.2.17.2 File Specifications**

<b>Field Description</b>	<b>Description</b>	<b>Validation Rules</b>
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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.2.17.3 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.

**3.2.17.4 Examples**

None

**3.2.17.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.2.18 Member Address Changes**

**3.2.18.1 Contract Reference**

FAMIS Contract, Article II, Section O

**3.2.18.2 File Specifications**

Field Description	Specifications
Member Last Name	Must be 20 characters or less
Member First Name	Must be 13 characters or less
Medicaid ID	Must be a valid Medicaid ID Format: 12 bytes with leading zeros
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 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 Zip	Must be 9 characters or less
Date of Last Address Change	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: ADDR\_CHG.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: FAMIS CPU

**3.2.18.3 Requirements**

FAMIS members only.

**3.2.18.4 Examples**

N/A

**3.2.18.5 Scoring Criteria**

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

### **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 31<sup>st</sup> 5<sup>th</sup> 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.3.1 Provider Network File**

**3.3.1.1 Contract Reference**

Medallion II Contract, Section 3.2.E and Attachment III, Section C

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

**3.3.1.2 File Specifications**

<b>Field</b>	<b>Specifications</b>
MCO Code*	Service Center ID
Provider Type*	Required. Examples are: Ancillary, CSB (Community Service Board), , Health Department, Hospital, Independent Lab, OB/GYN, Optical, PCP, PCP – Pediatric, Pharmacy, Psychiatric
Provider Specialty*	Required. Examples are: Anesthesiologist, Cardiologist, DME, Hospital, Infectious Disease, Internal Medicine, OB/GYN, Pediatrician, Transportation, etc.
NPI/API	10 bytes numeric
PCP Status*	Valid values are Y and N
Provider Last Name*	Required
Provider First Name	Leave blank if facility
Address line 1*	Required
Address line 2	
City*	Required
State*	Required
Zip code*	Required. 5 byte numeric.
Phone area code	Format = 999
Phone number	Format = 999-9999
Phone extension	Format = 9999
24 Hour Access*	Valid values are Yes and No
Other Language Spoken 1	Examples are: French, German, Italian, Russian, Spanish, etc.
Other Language Spoken 2	Examples are: French, German, Italian, Russian, Spanish, etc.
PCP maximum panel size**	This field must be included for every PCP record in the file
PCP assigned panel size**	This field must be included for every PCP record in the file

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

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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 subcontractors (this includes transportation, psychiatric, optical, and/or pharmacy, etc.) must be submitted.

The subcontractor network cannot just list the subcontractor name, but must include the vendors they contract with to provide services to members. The entire network should be in one file, formatted as above, not separate files or separate worksheets within one file. For providers with multiple office locations, each office location must be on a different line.

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 subcontractor network must include the complete listing of vendors with whom the subcontractor contracts to provide services to Medallion II and FAMIS program members.

The entire network should be in one file, formatted as above; not separate files or separate worksheets within one file. For providers with multiple office locations, each office location must be listed on a different line.

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.3.2 Providers Failing Accreditation/Credentialing**

**3.3.2.1 Contract Reference**

Medallion II Contract, Section 3.4.A

FAMIS Contract, Article V

**3.3.2.2 File Specifications**

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: PRV\_CRED.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: 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**

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.3.3 Case Managers List**

**3.3.3.1 Contract Reference**

Medallion II Contract, Section 7.6.B

FAMIS Contract, Article II, Section A.11

**3.3.3.2 File Specifications**

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 II 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.3.4 Members with Physical and Behavioral Health Limitations and Conditions**

**3.3.4.1 Contract Reference**

Medallion II 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 13 characters
Diagnosis Code 2	Must be less than 13 characters
Diagnosis Code 3	Must be less than 13 characters
Diagnosis Code 4	Must be less than 13 characters
Diagnosis Code 5	Must be less than 13 characters

Method: DMAS secure FTP server  
 Format: Adobe .pdf file  
 File Name: LC\_MBRS.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: Managed Care Operations

**3.3.4.3 Requirements**

As specified in the contract.

**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

***THIS PAGE  
REMOVED  
INTENTIONALLY***

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.3.6 Program Integrity Activities**

**3.3.6.1 Contract Reference**

Medallion II Contract, Section 9.1

**3.3.6.2 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

**3.3.6.3 Requirements**

Include all components as specified by the contract.

**3.3.6.4 Examples**

None

**3.3.6.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.3.7 BOI Filing - Quarterly**

**3.3.7.1 Contract Reference**

Medallion II Contract, Section 12.1.A

FAMIS Contract, Article II, Section A.3

**3.3.7.2 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

**3.3.7.3 Requirements**

N/A

**3.3.7.4 Examples**

N/A

**3.3.7.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.3.8 Financial Report**

**3.3.8.1 Contract Reference**

Medallion II Contract, Section 12.1.B

**3.3.8.2 File Specifications**

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

**3.3.8.3 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 II Program.

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

**3.3.8.4 Examples**

None

**3.3.8.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.3.9 PCP Incentive Payments**

**3.3.9.1 Contract Reference**

Medallion II Contract, Section 12.13.E

**3.3.9.2 File Specifications**

<b>Field Description</b>	<b>Description</b>	<b>Validation Rules</b>
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 <b>original</b> 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. 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. If 'Claim Status' is 'O' 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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.	Must be a valid procedure code in the range of E&M (99201 – 99499) and VFC codes (90460, 90461, 90471 – 90474) specified in the regulation.
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	<ul style="list-style-type: none"> <li>• For MCOs who reimburse quarterly, this is the payment amount from the initial claim payment to the provider.</li> <li>• 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.</li> </ul>	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'.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

Field Description	Description	Validation Rules
Increased PCP Final Payment Amount	<ul style="list-style-type: none"> <li>• 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.</li> <li>• For MCOs who reimburse on a claims basis, this is the total payment amount that was made to the provider.</li> </ul>	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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.3.10 Disproportionate Share Hospital**

**3.3.10.1 Contract Reference**

Medallion II Contract, Section 12.16

**3.3.10.2 File Specifications**

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: DISP\_SHARE.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: Provider Reimbursement Division

**3.3.10.3 Requirements**

N/A

**3.3.10.4 Examples**

None

**3.3.10.5 Scoring Criteria**

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.1 List of Subcontractors**

**3.4.1.1 Contract Reference**

Medallion II 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: 30 calendar days prior to 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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.2 Physician Incentive Plan**

**3.4.2.1 Contract Reference**

Medallion II 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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.3 Provider Satisfaction Survey**

**3.4.3.1 Contract Reference**

Medallion II 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 instrument and methodology 30 days prior to distribution  
Submit results within 120 days after conducting the survey

DMAS: Managed Care Quality Analyst

**3.4.3.3 Requirements**

As specified in the Medallion II contract section referenced above.

**3.4.3.4 Examples**

None

**3.4.3.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.4 Marketing Plan**

**3.4.4.1 Contract Reference**

Medallion II Contract, Section 6.1.B

FAMIS Contract, Article II, Section C

**3.4.4.2 File Specifications**

Method: Email to Paige.Jones@dmas.virginia.gov

Format: Word document

File Name: N/A

Trigger: Annually and prior to any changes

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

DMAS: Managed Care Operations

**3.4.4.3 Requirements**

As specified in contract.

**3.4.4.4 Examples**

None

**3.4.4.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.5 Member Handbook**

**3.4.5.1 Contract Reference**

Medallion II Contract, Section 6.7

FAMIS Contract, Article II, Section D.16

**3.4.5.2 File Specifications**

Method: Email to [Paige.Jones@dmas.virginia.gov](mailto:Paige.Jones@dmas.virginia.gov) (MII),  
[Tom.Lawson@dmas.virginia.gov](mailto:Tom.Lawson@dmas.virginia.gov) (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

**3.4.5.3 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

**3.4.5.4 Examples**

None

**3.4.5.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.6 Health Plan Assessment Plan**

**3.4.6.1 Contract Reference**

Medallion II Contract, Section 7.7.B

**3.4.6.2 File Specifications**

Method: DMAS secure FTP server  
Format: Adobe .pdf file  
File Name: ASSMT\_PLAN.pdf  
Trigger: Annual  
Due Date: September 30<sup>th</sup> of each year.  
DMAS: Managed Care Operations

**3.4.6.3 Requirements**

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

**3.4.6.4 Examples**

None

**3.4.6.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.7 Medallion Care System Partnership Annual Plan**

**3.4.7.1 Contract Reference**

Medallion II Contract, Section 7.8.A.II

**3.4.7.2 File Specifications**

Method: DMAS secure FTP server  
Format: Adobe .pdf file  
File Name: MCSP\_PLAN.pdf  
Trigger: Annual  
Due Date: TBD  
DMAS: Senior Health Care Services Manager

**3.4.7.3 Requirements**

As specified in the contract.

**3.4.7.4 Examples**

N/A

**3.4.7.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.8 Medallion Care System Partnership Proposal**

**3.4.8.1 Contract Reference**

Medallion II Contract, Section 7.8.C.I

**3.4.8.2 File Specifications**

Method: DMAS secure FTP server  
Format: Adobe .pdf file  
File Name: MCSP\_PROP.pdf  
Trigger: One time report  
Due Date: On or before October 1, 2013  
DMAS: Senior Health Care Services Manager

**3.4.8.3 Requirements**

As specified in the contract.

**3.4.8.4 Examples**

N/A

**3.4.8.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.9 Medallion Care System Partnership Performance Results**

**3.4.9.1 Contract Reference**

Medallion II Contract, Section 7.8.D.I

**3.4.9.2 File Specifications**

Method: DMAS secure FTP server  
Format: Adobe .pdf file  
File Name: MCSP\_PERF.pdf  
Trigger: Annual  
Due Date: TBD  
DMAS: Senior Health Care Services Manager

**3.4.9.3 Requirements**

As specified in the contract.

**3.4.9.4 Examples**

N/A

**3.4.9.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.10 Quality Improvement Plan**

**3.4.10.1 Contract Reference**

Medallion II Contract, Section 8.2.A

FAMIS Contract, Article II, Section K

**3.4.10.2 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

**3.4.10.3 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.

**3.4.10.4 Examples**

None

**3.4.10.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.11 Quality Assessment & Performance Improvement Plan**

**3.4.11.1 Contract Reference**

Medallion II Contract, Section 8.2.A

**3.4.11.2 File Specifications**

Method: DMAS secure FTP server  
Format: Adobe .pdf file  
File Name: QAPI\_PLAN.pdf  
Trigger: Annual  
Due Date: July 31<sup>st</sup>  
DMAS: Managed Care Quality Analyst

**3.4.11.3 Requirements**

As specified in the contract.

**3.4.11.4 Examples**

None

**3.4.11.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.12 HEDIS Results**

**3.4.12.1 Contract Reference**

Medallion II Contract, Section 8.3

FAMIS Contract, Article II, Section K

**3.4.12.2 File Specifications**

Method: DMAS secure FTP server  
Format: Excel file  
File Name: HEDIS.xlsx  
Trigger: Annual  
Due Date: July 31<sup>st</sup>.  
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.13 HEDIS Corrective Action Plan**

**3.4.13.1 Contract Reference**

Medallion II Contract, Section 8.3

**3.4.13.2 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

**3.4.13.3 Requirements**

As specified in the contract and template provided by DMAS.

**3.4.13.4 Examples**

None

**3.4.13.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.14 CAHPS Survey Results**

**3.4.14.1 Contract Reference**

Medallion II Contract, Section 8.3

**3.4.14.2 File Specifications**

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

**3.4.14.3 Requirements**

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

**3.4.14.4 Examples**

None

**3.4.14.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.15 Performance Improvement Project (PIP)**

**3.4.15.1 Contract Reference**

Medallion II Contract, Section 8.4.A

**3.4.15.2 File Specifications**

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

**3.4.15.3 Requirements**

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

**3.4.15.4 Examples**

None

**3.4.15.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.16 Wellness and Member Incentive Programs**

**3.4.16.1 Contract Reference**

Medallion II Contract, Section 8.4.F

**3.4.16.2 File Specifications**

Method: DMAS secure FTP server  
Format: PDF file  
File Name: MBR\_WELL.pdf  
Trigger: Annual  
Due Date: October 1<sup>st</sup>.  
DMAS: Managed Care Operations

**3.4.16.3 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.

**3.4.16.4 Examples**

None

**3.4.16.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.17 Complex Care Management Plan**

**3.4.17.1 Contract Reference**

Medallion II Contract, Section 8.6.A.IV.a

**3.4.17.2 File Specifications**

Method: DMAS secure FTP server  
Format: PDF file  
File Name: CCM\_PLAN.pdf  
Trigger: Annual  
Due Date: September 30<sup>th</sup>  
DMAS: Managed Care Operations

**3.4.17.3 Requirements**

As specified in the contract.

**3.4.17.4 Examples**

None

**3.4.17.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.18 Program Integrity Plan**

**3.4.18.1 Contract Reference**

Medallion II Contract, Section 9

**3.4.18.2 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

**3.4.18.3 Requirements**

As specified in the contract.

**3.4.18.4 Examples**

None

**3.4.18.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.19 Program Integrity Activities Annual Summary**

**3.4.19.1 Contract Reference**

Medallion II Contract, Section 9.1

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

**3.4.19.2 File Specifications**

Method: DMAS secure FTP server

Format: Adobe .pdf file

File Name: PRI\_OUTCM.pdf

Trigger: Annual

Due Date: September 30<sup>th</sup>

DMAS: Program Integrity Division

**3.4.19.3 Requirements**

Include members enrolled in Medicaid and FAMIS

**3.4.19.4 Examples**

None

**3.4.19.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.20 Organizational Charts**

**3.4.20.1 Contract Reference**

Medallion II Contract, Section 9.1.E  
FAMIS Contract, Article II, Section O

**3.4.20.2 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

**3.4.20.3 Requirements**

As specified in contract.

**3.4.20.4 Examples**

None

**3.4.20.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.4.21.1 Contract Reference**

Medallion II Contract, Section 9.2

**3.4.21.2 File Specifications**

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

**3.4.21.3 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.

**3.4.21.4 Examples**

None

**3.4.21.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.22 BOI Filing - Annual**

**3.4.22.1 Contract Reference**

Medallion II Contract, Section 12.1.A

FAMIS Contract, Article II, Section A.3

**3.4.22.2 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

**3.4.22.3 Requirements**

N/A

**3.4.22.4 Examples**

None

**3.4.22.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.4.23.1 Contract Reference**

Medallion II Contract, Section 12.1.A.I

FAMIS Contract, Article II, Section U

**3.4.23.2 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

**3.4.23.3 Requirements**

As specified in contract.

**3.4.23.4 Examples**

None

**3.4.23.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.4.24 FAMIS Moms Report**

**3.4.24.1 Contract Reference**

FAMIS Contract, Article II, Section O

**3.4.24.2 File Specifications**

Method: DMAS secure FTP server  
Format: Adobe .pdf file  
File Name: FAMIS\_MOM.pdf  
Trigger: Annual  
Due Date: Within 90 calendar days of the effective contract date.  
DMAS: FAMIS CPU

**3.4.24.3 Requirements**

Include frequency of ongoing prenatal care, discharge and average length of stay (maternity care), c-section rate, vaginal birth after c-section (VBAC) occurrence, and postpartum care rates for FAMIS members.

**3.4.24.4 Examples**

N/A

**3.4.24.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.1 NCQA Deficiencies**

**3.5.1.1 Contract Reference**

Medallion II 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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.2 NCQA Accreditation Status Changes**

**3.5.2.1 Contract Reference**

Medallion II 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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.3 Provider Agreements**

**3.5.3.1 Contract Reference**

Medallion II 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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.4 MCO Staffing Changes**

**3.5.4.1 Contract Reference**

Medallion II Contract, Section 3.16.B & 14.5

**3.5.4.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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 II 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 II contract.

**3.5.4.4 Examples**

N/A

**3.5.4.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.5 Provider Network Change Affecting Member Access to Care**

**3.5.5.1 Contract Reference**

Medallion II Contract, Section 3.2.B

**3.5.5.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.6 Hospital Contract Changes**

**3.5.6.1 Contract Reference**

Medallion II Contract, Section 3.2.B

**3.5.6.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.7 Provider Credentialing Policies and Procedures**

**3.5.7.1 Contract Reference**

Medallion II 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 II contract language.

**3.5.7.4 Examples**

N/A

**3.5.7.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.8 Practitioner Infractions**

**3.5.8.1 Contract Reference**

Medallion II 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**

Insert Attachment XXI for format

**3.5.8.4 Examples**

N/A

**3.5.8.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.9 PCP Assignment Policies & Procedures**

**3.5.9.1 Contract Reference**

Medallion II 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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.10 Inpatient Hospital Contracting Changes**

**3.5.10.1 Contract Reference**

Medallion II Contract, Section 3.8

**3.5.10.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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: Within 15 calendar days of any change(s)

DMAS: Managed Care Operations

**3.5.10.3 Requirements**

Refer to Attachment of the Medallion II contract for complete details.

**3.5.10.4 Examples**

N/A

**3.5.10.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.11 Changes to Claims Operations**

**3.5.11.1 Contract Reference**

Medallion II Contract, Section 4.4

**3.5.11.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.12 Provider Disenrollment Policies & Procedures**

**3.5.12.1 Contract Reference**

Medallion II 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 II 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 II contract language, including all subsections within this section.

**3.5.12.4 Examples**

N/A

**3.5.12.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.13 Enrollment – Excluding Members**

**3.5.13.1 Contract Reference**

Medallion II 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 II contract language.

**3.5.13.4 Examples**

N/A

**3.5.13.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.14 Newborn Identification Procedures**

**3.5.14.1 Contract Reference**

Medallion II 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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.15 Member Education & Outreach**

**3.5.15.1 Contract Reference**

Medallion II Contract, Section 6.1

**3.5.15.2 File Specifications**

Method: Email: [Paige.Jones@dmas.virginia.gov](mailto:Paige.Jones@dmas.virginia.gov) (MII),  
[Tom.Lawson@dmas.virginia.gov](mailto:Tom.Lawson@dmas.virginia.gov) (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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.16 Member Marketing Materials**

**3.5.16.1 Contract Reference**

Medallion II Contract, Section 6.1.C

**3.5.16.2 File Specifications**

Method: Email: [Paige.Jones@dmas.virginia.gov](mailto:Paige.Jones@dmas.virginia.gov) (MII),  
[Tom.Lawson@dmas.virginia.gov](mailto:Tom.Lawson@dmas.virginia.gov) (FAMIS)

Format: Adobe .pdf file

File Name: MKTG\_MATL.pdf

Trigger: Planned distribution of marketing materials as defined in the Medallion II contract

Due Date: 30 days prior to their planned distribution

DMAS: Managed Care Operations

**3.5.16.3 Requirements**

As specified in the Medallion II contract.

**3.5.16.4 Examples**

N/A

**3.5.16.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.17 Member Incentive Awards**

**3.5.17.1 Contract Reference**

Medallion II Contract,,Section 6.2.I.

**3.5.17.2 File Specifications**

Method: Email: [Paige.Jones@dmas.virginia.gov](mailto:Paige.Jones@dmas.virginia.gov) (MII),  
[Tom.Lawson@dmas.virginia.gov](mailto:Tom.Lawson@dmas.virginia.gov) (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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.18.1 Contract Reference**

Medallion II Contract, Section 6.4, 6.6, 6.11

**3.5.18.2 File Specifications**

Method: Email: [Paige.Jones@dmas.virginia.gov](mailto:Paige.Jones@dmas.virginia.gov) (MII),  
[Tom.Lawson@dmas.virginia.gov](mailto:Tom.Lawson@dmas.virginia.gov) (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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.19 Program Changes**

**3.5.19.1 Contract Reference**

Medallion II Contract, Section 6.7.M.I.

**3.5.19.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.20 Member Rights - Policies & Procedures**

**3.5.20.1 Contract Reference**

Medallion II Contract, Section 6.8

**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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.21 Member Health Education & Prevention Plan**

**3.5.21.1 Contract Reference**

Medallion II Contract, Section 6.11

**3.5.21.2 File Specifications**

Method: Email: [Paige.Jones@dmas.virginia.gov](mailto:Paige.Jones@dmas.virginia.gov) (MII),  
[Tom.Lawson@dmas.virginia.gov](mailto:Tom.Lawson@dmas.virginia.gov) (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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.22 Co-Pay Changes**

**3.5.22.1 Contract Reference**

Medallion II Contract, Section 7.1.A and Section 7.1.L

**3.5.22.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto:Daniel.Plain@dmas.virginia.gov)

Format: Adobe .pdf file

File Name: COPAY.pdf

Trigger: MCO implementation of or change to member co-payments

Due Date: At least 90 days prior to implementation

DMAS: Managed Care Operations

**3.5.22.3 Requirements**

N/A

**3.5.22.4 Examples**

N/A

**3.5.22.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.23 EPSDT Second Review Process**

**3.5.23.1 Contract Reference**

Medallion II Contract, Section 7.1.D.III

**3.5.23.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.23.3 Requirements**

N/A

**3.5.23.4 Examples**

N/A

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.24.1 Contract Reference**

Medallion II Contract, Section 7.1.H

**3.5.24.2 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

**3.5.24.3 Requirements**

N/A

**3.5.24.4 Examples**

N/A

**3.5.24.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.25 Sentinel Event**

**3.5.25.1 Contract Reference**

Medallion II Contract, Section 7.1.1

**3.5.25.2 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

**3.5.25.3 Requirements**

Use the form provided on DMAS website.

**3.5.25.4 Examples**

N/A

**3.5.25.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.26 Pharmacy Management Program**

**3.5.26.1 Contract Reference**

Medallion II Contract, Section 7.1.L

**3.5.26.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.26.3 Requirements**

N/A

**3.5.26.4 Examples**

N/A

**3.5.26.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.27 Compliance for Sterilizations & Hysterectomies**

**3.5.27.1 Contract Reference**

Medallion II Contract, Section 7.2.N.III and 7.2.N.IV

**3.5.27.2 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

**3.5.27.3 Requirements**

N/A

**3.5.27.4 Examples**

N/A

**3.5.27.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.28 Substance Abuse Services for Pregnant Women**

**3.5.28.1 Contract Reference**

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

**3.5.28.2 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

**3.5.28.3 Requirements**

N/A

**3.5.28.4 Examples**

N/A

**3.5.28.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.29.1 Contract Reference**

Medallion II Contract, Section 7.1.O.III

**3.5.29.2 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

**3.5.29.3 Requirements**

N/A

**3.5.29.4 Examples**

N/A

**3.5.29.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.30 Utilization Management Plan**

**3.5.30.1 Contract Reference**

Medallion II Contract, Section 7.1.P

**3.5.30.2 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

**3.5.30.3 Requirements**

As specified in the contract.

**3.5.30.4 Examples**

N/A

**3.5.30.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.31 Atypical Drug Utilization Reporting**

**3.5.31.1 Contract Reference**

Medallion II Contract, Section 7.2.S

**3.5.31.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.31.3 Requirements**

N/A

**3.5.31.4 Examples**

N/A

**3.5.31.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.32 Drug Formulary & Authorization Requirements**

**3.5.32.1 Contract Reference**

Medallion II Contract, Section 7.2.S

**3.5.32.2 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

**3.5.32.3 Requirements**

N/A

**3.5.32.4 Examples**

N/A

**3.5.32.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.33 Incarcerated Members**

**3.5.33.1 Contract Reference**

Medallion II Contract, Section 7.3.A.V

**3.5.33.2 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

**3.5.33.3 Requirements**

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

**3.5.33.4 Examples**

N/A

**3.5.33.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.34 Enhanced Services**

**3.5.34.1 Contract Reference**

Medallion II Contract, Section 7.4

**3.5.34.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.34.3 Requirements**

As specified in the contract.

**3.5.34.4 Examples**

N/A

**3.5.34.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.35 NCQA Accreditation Renewal**

**3.5.35.1 Contract Reference**

Medallion II Contract, Section 8.2.A

**3.5.35.2 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

**3.5.35.3 Requirements**

Must include all components as specified in the contract.

**3.5.35.4 Examples**

N/A

**3.5.35.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.36 Prenatal Programs and Outcomes Policies and Procedures**

**3.5.36.1 Contract Reference**

Medallion II Contract, Section 8.6.B.III

**3.5.36.2 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 fileand files

**3.5.36.3 Requirements**

As specified in contract.

**3.5.36.4 Examples**

N/A

**3.5.36.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.37.1 Contract Reference**

Medallion II Contract, Section 9.1.A.III

**3.5.37.2 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

**3.5.37.3 Requirements**

N/A

**3.5.37.4 Examples**

N/A

**3.5.37.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.38 Provider Appeals Process**

**3.5.38.1 Contract Reference**

Medallion II Contract, Section 9.1.A.VIII

**3.5.38.2 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

**3.5.38.3 Requirements**

N/A

**3.5.38.4 Examples**

N/A

**3.5.38.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.39 Fraud and/or Abuse Incident**

**3.5.39.1 Contract Reference**

Medallion II Contract, Section 9.1.1

**3.5.39.2 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

**3.5.39.3 Requirements**

N/A

**3.5.39.4 Examples**

N/A

**3.5.39.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.40 Marketing Fraud/Waste/Abuse**

**3.5.40.1 Contract Reference**

Medallion II Contract, Section 9.1.1

**3.5.40.2 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

**3.5.40.3 Requirements**

N/A

**3.5.40.4 Examples**

N/A

**3.5.40.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.41.1 Contract Reference**

Medallion II Contract, Section 9.1.1

**3.5.41.2 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

**3.5.41.3 Requirements**

As specified in contract.

**3.5.41.4 Examples**

N/A

**3.5.41.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.42 Member Grievance & Appeals Policies & Procedures**

**3.5.42.1 Contract Reference**

Medallion II Contract, Section 10.1.D

**3.5.42.2 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

**3.5.42.3 Requirements**

As specified in contract.

**3.5.42.4 Examples**

N/A

**3.5.42.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.43.1 Contract Reference**

Medallion II Contract, Section 11.3.E

**3.5.43.2 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

**3.5.43.3 Requirements**

N/A

**3.5.43.4 Examples**

N/A

**3.5.43.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.44 Encounter Data Plan for Completeness**

**3.5.44.1 Contract Reference**

Medallion II Contract, Section 11.5.D

**3.5.44.2 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

**3.5.44.3 Requirements**

As specified in the contract.

**3.5.44.4 Examples**

N/A

**3.5.44.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.45 Encounter Data Deficiencies**

**3.5.45.1 Contract Reference**

Medallion II Contract, Section 11.5.D

**3.5.45.2 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

**3.5.45.3 Requirements**

As specified in the contract.

**3.5.45.4 Examples**

N/A

**3.5.45.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.46 Encounter Data Corrective Action Plan**

**3.5.46.1 Contract Reference**

Medallion II Contract, Section 11.5.D

**3.5.46.2 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

**3.5.46.3 Requirements**

As specified in the contract.

**3.5.46.4 Examples**

N/A

**3.5.46.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.47 BOI Filing - Revisions**

**3.5.47.1 Contract Reference**

Medallion II Contract, Section 12.1.A

**3.5.47.2 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

**3.5.47.3 Requirements**

N/A

**3.5.47.4 Examples**

None

**3.5.47.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.48 Independent Audit**

**3.5.48.1 Contract Reference**

Medallion II Contract, Section 12.1.A.I

**3.5.48.2 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

**3.5.48.3 Requirements**

N/A

**3.5.48.4 Examples**

N/A

**3.5.48.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.49 Financial Report - Revisions**

**3.5.49.1 Contract Reference**

Medallion II Contract, Section 12.1.B

**3.5.49.2 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

**3.5.49.3 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 II Program.

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

**3.5.49.4 Examples**

None

**3.5.49.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.50 Basis of Accounting Changes**

**3.5.50.1 Contract Reference**

Medallion II Contract, Section 12.2

**3.5.50.2 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

**3.5.50.3 Requirements**

N/A

**3.5.50.4 Examples**

N/A

**3.5.50.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.51 Reserve Requirements Changes**

**3.5.51.1 Contract Reference**

Medallion II Contract, Section 12.4

**3.5.51.2 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

**3.5.51.3 Requirements**

As specified in the contract.

**3.5.51.4 Examples**

N/A

**3.5.51.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.52 FQHC/RHC Arrangements**

**3.5.52.1 Contract Reference**

Medallion II Contract, Section 12.14

**3.5.52.2 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

**3.5.52.3 Requirements**

N/A

**3.5.52.4 Examples**

N/A

**3.5.52.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.53 FQHC/RHC Reimbursement Methodology**

**3.5.53.1 Contract Reference**

Medallion II Contract, Section 12.14

**3.5.53.2 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

**3.5.53.3 Requirements**

N/A

**3.5.53.4 Examples**

N/A

**3.5.53.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.54 Contractor Non-Compliance Remedy**

**3.5.54.1 Contract Reference**

Medallion II Contract, Section 13.2.A.I

**3.5.54.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.54.3 Requirements**

N/A

**3.5.54.4 Examples**

N/A

**3.5.54.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.55.1 Contract Reference**

Medallion II Contract, Section 13.2.B.II.b

**3.5.55.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.55.3 Requirements**

As specified in the contract.

**3.5.55.4 Examples**

N/A

**3.5.55.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.56.1 Contract Reference**

Medallion II Contract, Section 13.3.A.II

**3.5.56.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.56.3 Requirements**

As specified in the contract.

**3.5.56.4 Examples**

N/A

**3.5.56.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.57 Transaction with Other Party of Interest**

**3.5.57.1 Contract Reference**

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

**3.5.57.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.57.3 Requirements**

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

**3.5.57.4 Examples**

N/A

**3.5.57.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.58 Acquisition/Merger/Sale**

**3.5.58.1 Contract Reference**

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

**3.5.58.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto:Daniel.Plain@dmas.virginia.gov)

Format: Adobe .pdf file

File Name: MERGER.pdf

Trigger: Public announcement of agreement as identified in the Medallion II contract.

Due Date: Within 5 calendar days of any such agreement

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.59 Ownership Change**

**3.5.59.1 Contract Reference**

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

**3.5.59.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto:Daniel.Plain@dmas.virginia.gov)

Format: Adobe .pdf file

File Name: OWNERSHIP.pdf

Trigger: Change to MCO's ownership as identified in the Medallion II contract

Due Date: 5 calendar days prior to change

DMAS: Managed Care Operations

**3.5.59.3 Requirements**

As specified in the contract.

**3.5.59.4 Examples**

N/A

**3.5.59.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.60 MCO Principal Conviction or Criminal Offense**

**3.5.60.1 Contract Reference**

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

**3.5.60.2 File Specifications**

Method: Email: [ManagedCare.Reporting@dmas.virginia.gov](mailto: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

**3.5.60.3 Requirements**

As specified in the contract.

**3.5.60.4 Examples**

N/A

**3.5.60.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.61 Contractor or Subcontractor on LEIE**

**3.5.61.1 Contract Reference**

Medallion II Contract, Section 13.3.A.I.c(vii)

**3.5.61.2 File Specifications**

Method: Email: [ManagedCare.Reporting@dmas.virginia.gov](mailto: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

**3.5.61.3 Requirements**

As specified in the contract.

**3.5.61.4 Examples**

N/A

**3.5.61.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.62 Other Categorically Prohibited Affiliations**

**3.5.62.1 Contract Reference**

Medallion II Contract, Section 13.3.B

**3.5.62.2 File Specifications**

Method: Email: [ManagedCare.Reporting@dmas.virginia.gov](mailto: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

**3.5.62.3 Requirements**

As specified in the contract.

**3.5.62.4 Examples**

N/A

**3.5.62.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.63 Ownership/Control of Other Entity**

**3.5.63.1 Contract Reference**

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

**3.5.63.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.63.3 Requirements**

N/A

**3.5.63.4 Examples**

N/A

**3.5.63.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.64 MCO Medicaid Managed Care Business Changes**

**3.5.64.1 Contract Reference**

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

**3.5.64.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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 II contract

Due Date: Within 5 business days

DMAS: Managed Care Operations

**3.5.64.3 Requirements**

N/A

**3.5.64.4 Examples**

N/A

**3.5.64.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.65.1 Contract Reference**

Medallion II Contract, Section 13.4.B

**3.5.65.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.65.3 Requirements**

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

**3.5.65.4 Examples**

N/A

**3.5.65.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.66.1 Contract Reference**

Medallion II Contract, Section 13.5.B

**3.5.66.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.66.3 Requirements**

As specified in contract

**3.5.66.4 Examples**

N/A

**3.5.66.5 Scoring Criteria**

None

**3.5.66.6 Examples**

N/A

**3.5.66.7 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.67 Data Security Plan for Department Data**

**3.5.67.1 Contract Reference**

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

**3.5.67.2 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

**3.5.67.3 Requirements**

As specified in the contract

**3.5.67.4 Examples**

N/A

**3.5.67.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.68 Data Confidentiality Policies & Procedures**

**3.5.68.1 Contract Reference**

Medallion II Contract, Section 13.5.C

**3.5.68.2 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

**3.5.68.3 Requirements**

N/A

**3.5.68.4 Examples**

N/A

**3.5.68.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.69.1 Contract Reference**

Medallion II Contract, Section 14

**3.5.69.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.70 Notification of Potential Conflict of Interest**

**3.5.70.1 Contract Reference**

Medallion II Contract, Section 14.7

**3.5.70.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.70.3 Requirements**

As specified in the contract

**3.5.70.4 Examples**

N/A

**3.5.70.5 Scoring Criteria**

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.71 None Notification of Opt Out of Automatic Contract Renewal Clause**

**3.5.71.1 Contract Reference**

Medallion II Contract, Section 14.7

**3.5.71.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.71.3 Requirements**

As specified in the contract

**3.5.71.4 Examples**

N/A

**3.5.71.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.72 Insurance Coverage Verification**

**3.5.72.1 Contract Reference**

Medallion II Contract, Section 14.16

**3.5.72.2 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

**3.5.72.3 Requirements**

As specified in the contract, including all required components

**3.5.72.4 Examples**

N/A

**3.5.72.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.73 Notification of Potential MCO Liability**

**3.5.73.1 Contract Reference**

Medallion II Contract, Section 14.17

**3.5.73.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.73.3 Requirements**

N/A

**3.5.73.4 Examples**

N/A

**3.5.73.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.74 Medical Record Safeguards**

**3.5.74.1 Contract Reference**

Medallion II Contract, Section 14.19.A.I & 14.19.A.II

**3.5.74.2 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

**3.5.74.3 Requirements**

N/A

**3.5.74.4 Examples**

N/A

**3.5.74.5 Scoring Criteria**

None

.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.75 Practice Guidelines**

**3.5.75.1 Contract Reference**

Medallion II Contract, Section 14.24.B

**3.5.75.2 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

**3.5.75.3 Requirements**

As specified in the contract, including all required components

**3.5.75.4 Examples**

N/A

**3.5.75.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.76.1 Contract Reference**

Medallion II Contract, Section 14.27

**3.5.76.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.76.3 Requirements**

N/A

**3.5.76.4 Examples**

N/A

**3.5.76.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.77 Bankruptcy Petition**

**3.5.77.1 Contract Reference**

Medallion II Contract, Section 14.29.B.VIII

**3.5.77.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.77.3 Requirements**

N/A

**3.5.77.4 Examples**

N/A

**3.5.77.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.78 Provider Manual Managed Care References**

**3.5.78.1 Contract Reference**

Medallion II Contract, Attachment III, Section B

**3.5.78.2 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

**3.5.78.3 Requirements**

N/A

**3.5.78.4 Examples**

N/A

**3.5.78.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.79.1 Contract Reference**

Medallion II Contract, Attachment III, Section C

**3.5.79.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.79.3 Requirements**

As specified in the contract

**3.5.79.4 Examples**

N/A

**3.5.79.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**3.5.80 New Agreements and Changes in Approved Agreements**

**3.5.80.1 Contract Reference**

Medallion II Contract, Attachment III, Section C

**3.5.80.2 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

**3.5.80.3 Requirements**

N/A

**3.5.80.4 Examples**

N/A

**3.5.80.5 Scoring Criteria**

None

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**3.5.81.1 Contract Reference**

Medallion II Contract, Attachment X

**3.5.81.2 File Specifications**

Method: Email: [Mary.Mitchell@dmas.virginia.gov](mailto:Mary.Mitchell@dmas.virginia.gov),  
[Tammy.Driscoll@dmas.virginia.gov](mailto:Tammy.Driscoll@dmas.virginia.gov), [Daniel.Plain@dmas.virginia.gov](mailto: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

**3.5.81.3 Requirements**

As specified in contract, including all required components.

**3.5.81.4 Examples**

N/A

**3.5.81.5 Scoring Criteria**

None

## 4 DMAS Reports

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**4.1.1 Provider File**

**4.1.1.1 Contract Reference**

Medallion II Contract: II, B., 3.

**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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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\_yyyyymm.txt  
Trigger        Monthly  
Schedule      Generated around the 6<sup>th</sup> 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**4.1.2 Pregnancy Due Date**

**4.1.2.1 Contract Reference**

N/A

**4.1.2.2 File Specifications**

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

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

**4.1.2.3 Description**

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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**4.1.3 Plan Change Report**

**4.1.3.1 Contract Reference**

Medallion II, 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.xlsx  
 Trigger       Monthly  
 Schedule     After 18<sup>th</sup> 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 18<sup>th</sup> 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**4.1.4 Community Mental Health Rehabilitation Services (CMHRS)**

**4.1.4.1 Contract Reference**

N/A

**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\_CIm\_Chg\_yyyymm.txt  
Trigger       Monthly  
Schedule      After the 18<sup>th</sup> 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**4.1.5 Community Mental Health Rehabilitation Services (CMHRS) Prior Auths**

**4.1.5.1 Contract Reference**

N/A

**4.1.5.2 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     CMHRS\_PRAUTHS\_yyyymm.txt  
Trigger        Creation of the mid-month 834  
Schedule      5 business days after mid-month 834 creation  
DMAS         N/A

**4.1.5.3 Description**

This report reflects FFS prior authorizations on enrolled MCO members that have had a community mental health authorization type (0650) 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 behavioral health services or referral to an MCO behavioral health case manager.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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 18<sup>th</sup> 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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. See list of valid values.
PRV_SPEC	Servicing provider specialty. See list of valid values.
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

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

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 18<sup>th</sup> 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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 10 <sup>th</sup> 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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 1<sup>st</sup> of the month (EOM834)  
DMAS        N/A

**4.1.10.3 Description**

This report provides a count of members on the EOM 834.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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\_yyyyymm.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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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 25<sup>th</sup> 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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**4.1.17 Quarterly ABD Enrollment**

**4.1.17.1 Contract Reference**

Medallion II, Section 7.7

**4.1.17.2 File Specifications**

Report content TBD

Method	DMAS secure FTP server
Format	TBD
File Name	ABD_Enroll
Trigger	Quarterly
Schedule	15 <sup>th</sup> of the month after the end of the quarter
DMAS	N/A

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**4.1.18 Encounter Lag Report**

**4.1.18.1 Contract Reference**

Medallion II, Section 11.5.C

**4.1.18.2 File Specifications**

**MCO ENCOUNTER LAG REPORT  
For the month of 2013\_7**

mconame=MC0123

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
<b>Total</b>	0	100%	0	5.0%	0

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

**4.1.18.3 Description**

The Medallion II 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 II 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.

## **Virginia Department of Medical Assistance Managed Care Technical Manual**

- 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.

### Service Type Category Definition:

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.

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

EDI Trans	Service Type Category
837I	<p>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 <span style="float: right;">then Srvc_type = 'MHLTH'</span></p> <p>Else <span style="float: right;">Srvc_Type = 'MED'</span></p>
837P	<p>If MMIS claim type = '08' (Lab) <span style="float: right;">then Srvc Type = 'LAB'</span></p> <p>If MMIS claim type = '11' (Dental) <span style="float: right;">then Srvc_Type = 'DENTL'</span></p> <p>If MMIS claim type = '13' (Transportation) <span style="float: right;">then Srvc_Type = 'TRANS'</span></p> <p>If MMIS claim type = '04' (PersCare/HmHlth) <span style="float: right;">then Srvc_Type = 'MED'</span></p> <p>If MMIS PROV_CLS = '026' or SUBMT_SRVC_TXNMY in CHIRO Tax value Set <span style="float: right;">then Srvc_Type = 'CHIRO'</span></p> <p>If MMIS PROV_CLS in ('031','032') or MMIS PRV_SPEC = '063' or SUBMT_SRVC_TXNMY in VISION Tax value set <span style="float: right;">then Srvc_Type = 'VISIO';</span></p> <p>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 <span style="float: right;">then Srvc_Type = 'MHLTH';</span></p> <p>Else <span style="float: right;">Srvc_Type = 'MED'</span></p>
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

## **4.2 DMAS Forms**

The following standard forms are available on the DMAS Managed Care Web Site.

- Sentinel Event
- Incarcerated Member
- Program Integrity Compliance Audit – Attachment XX
- Providers who Have Failed Accreditation / Credentialing / Re-Credentialing and Denied Application – Attachment XIX
- MMIS Generated Payment – Attachment XVIII
- Certification of Non-Encounter Data - Attachment XV
- School-Based Service Referral - Attachment XI
- DMAS 213 - Attachment IV
- Encounter Data Certification Form (currently in monthly template)
- Appeals and Grievances Report Format Template
- MCO Report Format Template

## 5 DMAS Processes

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**5.1 DMAS Processes**

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

### **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 3<sup>rd</sup> 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).

**Virginia Department of Medical Assistance  
Managed Care Technical Manual**

**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.