

**Round 4 Data Questions and Answers for
RFP Number 2013-CMFD-01**

Question	Response
<p>Question 1: What is the process /business rule to handle the adjusted claims? What is the timeline for adjusted claims?</p>	<p>A claim with ICN-Region (1st two bytes) = 50 – 59 is an adjustment of another claim</p> <p>Claims with the above ICN-Region values have data in the following field: OHDR-ICN or ODTL-ICN field</p> <p>The value in the OHDR-ICN or ODTL-ICN field represents the ICN of the claim being adjusted</p> <p>For example (the ICNs below are not valid numbers):</p> <p>Claim A: ICN = 2098745259743</p> <p>Claim B adjusts Claim A: ICN = 5099999521469 and OHDR-ICN = 2098745259743</p> <p>Claim C adjusts Claim B: ICN = 5277885321456 and OHDR-ICN = 5099999521469</p>
<p>Question 2: File Name: T_RE_BASE_DN.docx What is the difference between a recipient and a beneficiary? Does this refer to the same person?</p>	<p>A beneficiary is eligible for coverage by the Medicaid program. A recipient has received services that Medicaid has paid for. There is a tendency to use the terms interchangeably</p>
<p>Question 3: Why is there an address listed both for beneficiary and recipient?</p>	<p>This is basically the same person. Beneficiary is the recipient and vice versa. The address that has phys in the field name is the physical address (where they live). We use this GIS and Managed Care doctor assignments. The other address is their mailing address. Of course, a lot of times they are the same, but not always.</p>
<p>Question 4: What is the difference between "Lock-in" and "Lock-out"?</p>	<p>Lock-in means that a recipient can be locked in to see a provider. This means they must go to that provider for their medical care or be referred by him/her except in the case of an emergency. For Pharmacy, they can be locked in to receiving their drugs from a specific pharmacy and also may be locked into only getting prescriptions written by a specific physician.</p> <p>Lock-out: The only “lock-out” criteria that is in play now is the</p>

	<p>recently added “Locked out of Maintenance Supply” category. This was added to provide a mechanism to lock-out certain recipients from the requirement of obtaining a maintenance supply (84, 90, or 91 day supply) of their prescription when the drug required a maintenance supply based on the criteria established by the Agency. This mechanism has not been utilized at this point, but is available if needed.</p>
<p>Question 5: Is there data available that links a beneficiary ID with a provider ID during the "lock-in" period?</p>	<p>Yes data is available that links a beneficiary ID with a provider ID during the “lock-in” period. This lockin data comes from the assignment tables.(t_re_assign_plan-contains pharmacy lockin and t_re_pmp_assign-contains Physician lockin). The Agency does not receive this data currently but there is a CSR for the fiscal agent to create the data for the Agency.</p>
<p>Question 6: What is the meaning of a medical assistance program? How do providers or beneficiaries qualify for medical assistance programs?</p>	<p>This is the benefit plan for which they receive Medicaid Coverage. This can be Full Medicaid (TXIX), SOBRA (SBRW), Plan First (PLNF), TA Waiver (TAWV) – these are assigned by virtue of the aid category that the Eligibility system (AMAES and soon E&E) assign to the recipient.</p> <p>Recipients must complete an application to determine eligibility for the Medicaid program. Providers must complete an enrollment application to qualify to be a provider for the Medicaid program.</p>
<p>Question 7: May we request the: Key for IND_RESTRICT_LI values (i.e., what value indicates locked in and what value indicates locked out?)</p>	<p>IND_RESTRICT_LI field is not being used and is not populated with actual values.</p>
<p>Question 8: Key for CDE_PGM_HEALTH_LI values</p>	<p>Refer to “Response 8 – t_pub_hlth_pgm” and “Response 8a” on the Agency’s website.</p> <p>The values for this field are as follows for lockin: These values are in t_pub_hlth_pgm.</p> <ul style="list-style-type: none"> • LKCNT - Locked Into Controlled • LKND2 - Locked Into Tramadol • LKND1 - Locked Into Neurontin/Gabapentin • LKPH - Locked In Pharmacy • LCKIN - Locked In Physician
<p>Question 9: Key for CDE_REASON_LI values</p>	<p>Field is not being used and is not populated with actual</p>

	values.
Question 10: Key and definition for CDE_LEVEL_OF_CARE values	<p>Refer to “Response 8 - t_pub_hlth_pgm” on the Agency’s website. The specific level of care codes are listed below:</p> <p>CDE_LEVEL_OF_CARE values are:</p> <ul style="list-style-type: none"> • SLWV - HCBS - SAIL • PIC - Hospice • EDWV - Elderly and Disabled Waiver • PEC - Post Extended Hospital • NHV - Nursing Home Ventilator • PAC - PACE • MEPD - Med Emergency Psych Demonstration • HAWV - HCBS - HA Waiver • LHWV - HCBS - Living at Home • SNF - Skilled Nursing Facility • ACWR AL - Community Transition ACT Waiver • MRWV - HCBS - Mental Retardation • ICFMR- ICF/MR
Question 11: Key for CDE_REASON_RLOC values	Refer to “Response 11 - t_re_assign_reason” and “Response 11a” on the Agency’s website.
Question 12: Key for "CDE_PGM_HEALTH values	Refer to “Response 8 – t_pub_hlth_pgm”.
Question 13: Key for "Patient Status Indicator" values	Refer to “Response 21 – patient_status.txt” on the Agency’s website.
Question 14: File Name: Provider Extract from Batch.docx May we request the: Key for the "Provider Enroll Program" code values Key for the "Provider Type" values Key for the "Specialty Code" values	Refer to “Response 14A - t_pr_enroll_status”, “Response 14B - provider type description list_20131209”, and “Response 14C - provider specialty descriptions _20131209” on the Agency’s website.
Question 15: What is the meaning of the start and end date of the specialty? What kind of registration process must providers complete before they are recognized for a certain specialty? Is this registration process with the State	The start and end date of the specialty is when an individual can practice as a particular specialty. All physicians, practitioners, and other suppliers who provide services to Medicaid beneficiaries must enroll in the Medicaid program before claims can be submitted. Only physicians who are fully licensed and possess a

<p>government or other professional certifying association? How are these specialty codes different from those listed for CMS here: http://wpsmedicare.com/j5macpartb/departments/enrollment/specialty_codes.shtml</p>	<p>current license to practice medicine may enroll to become an Alabama Medicaid Provider. The Alabama State Board of Medical Examiners is the administrative and regulatory agency of the state of Alabama. The Medical Licensure Commission of Alabama is the state agency which has the exclusive power and authority to issue, revoke and reinstate all licenses to practice medicine or osteopathy in the State of Alabama.</p> <p>When a provider enrolls with the State of Alabama Medicaid program, the provider must meet the requirements of the Board to be licensed to practice medicine in the state of Alabama. The specialty is determined based upon their license issued by the Commission. Alabama Medicaid uses a three-digit code for the specific specialty when a provider enrolls with Medicaid. CMS uses a two-digit code. The start and end date of the specialty is determined by the license issued by the Commission.</p>
<p>Question 16: File Name: Claims 2010.10-2011.06 Tab: H1 Institutional What is the meaning of the "type" column containing the letter "A" in the claims tables?</p>	<p>Alphanumeric (Character)</p>
<p>Question 17: Row 6: May we clarify the meaning of the label Institutional crossover? Professional crossover?</p>	<p>Institutional crossover claims are submitted by Institutions: Hospitals, Dialysis Clinics, Long Term Care Facilities.</p> <p>Professional crossovers are submitted by Physicians.</p>
<p>Question 18: Row 8: What does the "Number of details on claim" mean?</p>	<p>Claim records consist of a header record and one or more detail records – the number of details on the claim is the number of detail records associated with that claim – the Header and associated Details are linked using the value in the ICN field</p>
<p>Question 19: Row 27: For HIC, if ZZZ follows social security number, does this indicate patient is not Medicaid recipient? What is the coding system for HIC?</p>	<p>No. The HIC number is used to indicate Medicare entitlement. A HIC with a ZZZ suffix is a pseudo HIC number assigned by Medicaid’s Eligibility system and indicates the individual has no valid Medicare HIC number assigned by the Social Security Administration (SSA). A HIC with a ZZZ suffix indicates an individual with no Medicare entitlement in Medicaid’s system.</p> <p>The coding system for HIC is established by SSA.</p>

<p>Question 20: Rows 31-33: Do Referring, Attending, and surgical provider ID's refer to NPPES NPI?</p>	<p>Yes. If the number has 10 digits it is a NPI. Less than 10 digits represent a Medicaid ID.</p>
<p>Question 21: Row 51: What is the meaning of "Patient Status Indicator"? May we request the key for these values?</p>	<p>Patient Status Indicator is a code which indicates the status of the recipient as of the ending service date of the period covered on a UB92 claim. This indicates whether the recipient is still in the hospital, discharged to home, deceased, etc. on the last day of the claim.</p> <p>See "Response 21 – patient_status.txt" on Agency's website for the key for these values.</p>
<p>Question 22: Row 60: What is an "encounter claim" and what does "S" stand for?</p>	<p>Encounter Indicator values should be Y/N, an encounter record represents a claim for services that were covered by an alternate (not fee for service) payment methodology.</p>
<p>Question 23: Row 73: What are the different values and definitions for the "Error code"?</p>	<p>Refer to "Response 23 – Error Code" on the Agency's website.</p>
<p>Question 24: Row 76: What is the difference in definition of "TPL in indicator" versus "TPL out indicator"?</p>	<p>Insurance Indicator - This field indicates on the claim whether this recipient has other insurance. (TPL Input)</p> <p>TPL Output Indicator - These codes reflect the outcome of TPL editing in the claims processing system. The TPL output code reflects both the input code and the result of editing against the TPL policy file. (TPL Output)</p>
<p>Question 25: Row 103: What is an "Occurrence claim" and may we have the Occurrence code value key?</p>	<p>See "Response 25 – Occurrence Codes" on the Agency's website.</p>
<p>Question 26: Tab: D1 Institutional Row 8: What is the meaning of "Detail number on claims"? Does this match the same information provided in "Detail number on claims in the "H1 Institutional" Tab?</p>	<p>The detail number on claims identifies the specific detail. The numbers are related, If Detail number in H1 = 15, there will be "D1" records with Detail Number = 1, 2, 3,...15</p>
<p>Question 27: Row 27: May we have the key for the "Pricing Action Code" values?</p>	<p>See "Response 27- Pricing_indicator" on the Agency's website.</p>
<p>Question 28: Row 31: What is the meaning of "Detail status indicator", Paid/Denied? How is</p>	<p>P= Paid and D=Denied</p> <p>Claims pay at the header or detail level depending on</p>

<p>this different from "Claims status indicator"?</p>	<p>claim type. A paid claim (header status = P) may include denied details – Header status = P, detail status = D</p>
<p>Question 29: Row 14: What is the meaning of "Number of units associated with detail"?</p>	<p>Number of units for the associate revenue/procedure code</p>
<p>Question 30: Tab: D3 (detail pharmacy) Row 15: What is the definition of "Units of Service"? Is this only relevant to pharmacy claims? (units occur across all claim types)</p>	<p>“Units of Service” is how much of the pharmaceutical was dispensed. No. Units occur across all claim types.</p>
<p>Question 31: Row 46: Indicates that "0 = Original Claim, >0 Refill of existing prescription" begins at column 383, which contains only alphabetical values (ex: "N"). Is this intentional (i.e N = original prescription and Y = refill) or a data entry error? (swp will follow-up)</p>	<p>Answer will be posted by January 3, 2014.</p>
<p>Question 32: File Name: Claims 2011.07 – 2013.09 Tab: H1 Institutional Row 121 and 124: Why are there fields for both "diagnosis codes" AND "diagnosis code"? Do these contain different data?</p>	<p>Line 121 – is the label for the diagnosis code group, which includes 10 sets of diagnosis codes. Line 124 – is the label for a specific (single) occurrence of diagnosis code w/in the larger group.</p>
<p>Question 33: Tab: D1 Institutional: Row 29 in D1 Institutional and Row 43 in H1 Institutional: What is the difference between "Detail billed amount" and "Total billed amount"?</p>	<p>Detail billed amount is the amount billed by the provider for that specific detail (procedure/revenue code...). Total billed amount is the total amount billed for the entire claim.</p>
<p>Question 34: Why are certain members replicated multiple times in the member database with the same start/end date? Are these duplicates of the same entry?</p>	<p>Examples are required to answer this question.</p>
<p>Question 35: What does the value "0" indicate when filled in for "Last day of service"?</p>	<p>An example is required to answer this question.</p>

<p>Question 36: While browsing through both member files, I noticed that there are many with a SSN represented by all zeros, are members without or missing SSN's still eligible for Medicaid? Or perhaps this was a data entry error?</p>	<p>No (check to see if the claim paid or denied). The recipient Medicaid ID is used in claims processing – a claim filed for a missing or invalid Medicaid ID should deny.</p>
<p>Question 37: We've noticed that many members with the same unique SSN have multiple unique Medicaid ID's associated with them. Are members assigned new, unique Medicaid ID's each time they enroll in the program?</p>	<p>Over the course of an individual's Medicaid history, multiple Medicaid IDs may be assigned.</p>
<p>Question 38: Are there any members who share Medicaid ID's (I.e children who share their parent's Medicaid ID)</p>	<p>No.</p>
<p>Question 39: The file layouts for the Claims data shows the data type for all columns in all schemas is "A". Are we to assume that this data type is a CHAR? Or is there a designated data type for each of these columns? If so, what are the types?</p>	<p>The data is sent to the state in fixed format text files, so all fields are defined as alphanumeric (character) fields. Amount and Unit fields may contain explicit decimals.</p>
<p>Question 40: regarding the document "Provider Extract from Batch.docx"</p> <p>We would like to request the meaning and value key for "provider contracts" ("program_code") and their status ("status_code").</p>	<p>See "Response 40" on Agency website.</p>
<p>Question 41: We are seeing ~2.3mm unique social security numbers represented in the database for members who are active Medicaid beneficiaries (as indicated by ind_active='Y', and still living, as indicated by dte_death='2299-12-31'). We wanted to inquire about the number you have for total beneficiaries at this point in time to make sure any discrepancy is not due to entry errors in the database. The Kaiser Family foundation estimated roughly ~1mm Medicaid beneficiaries for Alabama in 2010, so the ~2.3mm number seemed high to us.</p>	<p>The field ind_active = 'Y' does not mean eligible; it means that the ID has not been linked to another ID.</p> <p>T_RE_BASE_DN has DTE_ELIG_EFF and DTE_ELIG_END. If these dates start before and end after the current date, the recipient is currently eligible for a Medicaid Program.</p> <p>Without using that, you are getting a count of all IDs that are currently in the MMIS who may never have been eligible or have not been eligible in years.</p>
<p>Question 42: While browsing through both member files, I noticed that there are many with a SSN represented by all zeros, are members without or missing SSN's still eligible for</p>	<p>No, did you check to see if the claim paid or denied? The recipient Medicaid ID is used in claims processing – a claim filed for a missing or invalid Medicaid ID should deny.</p>

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Question 43: We've noticed that many members with the same unique SSN have multiple unique Medicaid ID's associated with them. Are members assigned new, unique Medicaid ID's each time they enroll in the program?	Over the course of an individual's Medicaid history, multiple Medicaid IDs may be assigned.
Question 44: Are there any members who share Medicaid ID's (I.e children who share their parent's Medicaid ID)	No.